Salt Lake County
FORM A - MENTAL HEALTH BUDGET NARRATIVE
3 Year Plan (FY 2024-2026)

Local Authority: Salt Lake County

Instructions:

In the cells below, please provide an answer/description for each question. **PLEASE CHANGE THE COLOR TO BLUE, OF SUBSTANTIVE NEW LANGUAGE INCLUDED IN YOUR PLAN THIS YEAR!**

1) Inpatient Services

Adult Services ***Pam Bennett***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.
For Medicaid clientele, DBHS's/Optum's Network consists of contracts with the Huntsman Mental Health Institute (HMHI), University of Utah Inpatient Medical Psychiatry (IMP), Jordan Valley West, and St. Mark's Hospital in Salt Lake County for Adult Inpatient Care. Salt Lake County/Optum will contract with out-of-Network facilities on a client-by-client basis if a client is admitted to a hospital outside of the network. In FY23, Salt Lake Behavioral Health Hospital was added to the network. We will continue to assess our inpatient network needs in the next 3 years. For those who are unfunded, DBHS has contracted with HMHI for Adult Inpatient Care. Other than who is contracted, the process differs for the unfunded as those who are admitted into a hospital do not require a pre authorization. This is due to the fact that the money for unfunded hospitalization is limited and HMHI has repeatedly shown that they provide far more bed days to the unfunded population that regularly exceeds the contracted amount. Valley Behavioral Health (VBH) does work with these clients while in the hospital to either continue or set-up services upon discharge.
Describe your efforts to support the transition from this level of care back to the community.
We continue to use the Adult Care Coordination position to assist those who are transitioning from higher levels of care back into the community. Optum and DBHS meet monthly to review utilization management data identifying trends, overutilization, and underutilization. Follow-up after hospitalization rates and barriers are identified and prioritized for action.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.
DBHS/Optum Network continues to contract with HMHI and Salt Lake Behavioral Health Hospital in Salt Lake County for youth inpatient care. Initial assessment for hospitalization is done either in the primary care unit or by the crisis staff in emergency departments at any hospital. Should HMHI be at

capacity, DBHS/Optum has the ability to implement a single case agreement (SCA) with any willing provider.

Describe your efforts to support the transition from this level of care back to the community.
An Optum Care Coordinator is a licensed mental health therapist (LMHT) dedicated to assisting youth with their transition back to the community after inpatient hospitalization. The parent and the youth are contacted with 24 business hours of discharge and at regular intervals to ensure the child is linked to the services recommended by the attending at discharge. The care coordinator is knowledgeable of community resources and provider specialties to troubleshoot barriers to accessing needed services. Contact with the family, including person-to-person outreach, is ongoing after the initial transition to ensure the youth remains engaged for better treatment outcomes.

2) Residential Care

Adult Services ***Pam Bennett***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

DBHS/Optum continually seek ongoing opportunities to contract with community providers, as needed, to provide residential care for the adult clients.

Co-Occurring Re-entry and Empowerment (CORE) – Valley Behavioral Health (VBH)

CORE is a 16-bed residential facility for mentally ill adult male clients who also have substance use disorder (SUD) treatment needs.

Co-Occurring Re-entry and Empowerment (CORE 2) – VBH CORE 2 is an additional 16-bed residential facility for mentally ill adult female clients as described above.

Odyssey House offers a 16-bed residential facility for mentally ill adult female clients and a 16-bed adult male program. Many of these individuals also have substance use disorder (SUD) treatment needs and are involved in criminal justice services. Treatment focuses on behavioral health issues and criminogenic risk factors.

VBH Steps is a 16-bed co-ed transitional, short-term residential treatment program designed to help stabilize and support adult clients experiencing minimal or no substance use disorder through medication management, therapy, case management, and benefits coordination. Valley Steps provides stabilization services to clients living both in and outside of Valley housing and to introduce potential residents to the structure of Valley housing programs. Clients receive help with medications, obtaining Social Security and Medicaid benefits as well as a treatment plan for further assistance and housing. A mental health diagnosis is a requirement to receive treatment at Valley Steps, and each individual is evaluated based on eligibility. Access to Steps is determined by the Steps intake team (clinical team, medical team, unit leadership, and access coordinator) looking at eligibility (sex offender, age), mental health symptoms and SMI, medical symptoms, substance use needs, and involvement in court-ordered treatment. A LOCUS (Level of Care Utilization System) is also administered to assess level of care

needs.

VOA is proposing opening a 16 bed residential treatment center for adult men who are diagnosed with co-occurring SMI/SUD, are engaged in the criminal justice system, and are also homeless or at risk of homelessness. This facility will open in September 2023 at 252 west Brooklyn Avenue in Salt Lake City. This facility will provide substance use and mental health treatment to individuals who are homeless or at risk of homelessness. Services will include individual/group therapy, medication management, case management and peer support.

The center will be licensed by the Utah DHHS, meeting the standards for providers licensed to provide residential treatment as defined in Utah Code and Administrative Rule. The residential treatment center will also adhere to Medicaid standards in order to meet requirements for Medicaid funding.

Turning Point Centers was added to the network in FY23. This program offers 8 co-ed beds for SMI members.

DBHS/Optum are in conversations with additional providers for more CORE-like programs, as well as a subacute program for future addition to the network.

How is access to this level of care determined? How is the effectiveness and accessibility of residential care evaluated?

DBHS/Optum uses the LOCUS-Level of Care Utilization System for Adults to determine if a residential level of care is indicated for mental health treatment.

Effectiveness is evaluated during concurrent clinical reviews (i.e., utilization management or UM) and audits to ensure members are making progress in treatment and discharge planning is ongoing, and whether there are quality of care issues. During the UM process, the most recent treatment plan review along with at least the required encounter note tied to the treatment plan review are scrutinized to ensure that the tIf there are concerns, these are addressed immediately. During the audit process, all areas of the randomly chosen files to be audited are reviewed. Additionally, each client's file who is to be audited is reviewed to ensure the inputted outcomes meet what is reflected in the file. As part of the audit, if the provider is not meeting the standard for any given outcome measured in SAMHIS, this is included as a finding.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. Please identify your current residential contracts. *Please identify any significant service gaps related to residential services for youth you may be experiencing.*

DBHS/Optum contracts with community providers as needed to provide residential care for adolescents and children.

Salt Lake County Division of Youth Services (DYS) – Shelter Group Home Emergency residential care for youth ages 12 to 18 in DCFS custody or who are in need of specialized shelter placement because

of abuse or neglect or placement disruptions.

New Beginnings
New Beginnings is a 16-bed residential facility for adolescent boys and girls. They are in the process of moving to a new location in Draper. The youth have access to school services along with therapeutic services, including medication management.

Aspire, through Wasatch Behavioral Health, is also now contracted as an in-network provider for adolescent females.

Copa is going to be a 16-bed residential facility for male and female adolescents with mental health issues. They are currently going through final DHHS licensing.

Single Case Agreements
DBHS/Optum contracts with providers offering residential levels of care on an individualized basis. DBHS/Optum also utilizes other qualified service providers as needed through single case agreements to meet the specialized mental health needs of the youth in Salt Lake County.

Optum was recently able to secure a Single Case Agreement with Center for Change for a member with an eating disorder. Eating disorder treatment is still a gap due to limited funding and Medicaid billing limitations.

How is access to this level of care determined? Please describe your efforts to support the transition from this level of care back to the community.

DBHS/Optum uses the ECSII: Early Childhood Service Intensity Instrument for Youth to determine if a residential level of care is indicated.

Through concurrent reviews for ongoing care, Optum Care Advocates evaluate agency discharge planning to ensure the youth's natural supports are included and access to follow-up care is coordinated. The goal is to help youth transition back home and into their community. Access to needed clinical services (i.e., day treatment, intensive outpatient, medication management services, respite care, FPSS referral, school-based supports) is also coordinated. Each discharge plan is expected to be individualized. The Optum Clinical Team is available to staff cases with providers and offer assistance throughout the discharging planning process, while the plan is based on needs identified by the treatment providers. The Recovery & Resiliency Team can offer support to parents dealing with challenges of caring for a child with behavioral health needs and can link parents to community supports like the Utah Parent Association and NAMI.

3) Outpatient Care

Adult Services ***Pam Bennett***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Define the process for referring an individual to a subcontractor for services. Include any planned changes in programming or funding.

DBHS/Optum has a large network of providers who are available to provide a vast array of outpatient

services. Clients have the freedom to choose any provider from the network that provides services to meet their needs. Additionally, in some cases, clients may opt to receive services from a provider not in the network. These services can be provided as long as pre-authorization requirements are met and a Single Case Agreement has been agreed upon and signed.

Treatment services for refugees are primarily provided by the Refugee and Immigrant Center, Asian Association of Utah (RIC-AAU). RIC-AAU provides focused and culturally appropriate treatment to serve the refugee population located in the valley. VBH's outpatient clinics also serve the refugee population.

Medication management services are offered by multiple providers throughout the county to include outpatient clinics, nursing homes, and via telehealth. Prescribers on the ACT (Assertive Community Treatment) teams can meet members where needed, such as the clinic, their home, or elsewhere in the community.

DBHS/Optum have supported providers in incorporating an intensive Case Management model as members step down from higher levels of care. The Critical Time Intervention (CTI) model is a time-limited intervention connecting members with Case Management services through in-reach while in higher levels of care to assure a smooth transition into the community with needed wraparound services and support. We have several providers who have or are training in and adopting this model including VOA and Project Connections.

There are currently 4 functioning ACT teams. Volunteers of America (VOA) has two teams, one with the capacity of 100 clients, the other with a capacity of 50 clients.

Valley Behavioral Health has one ACT team that has the capacity of 100 clients.

Odyssey House has the capacity to serve 100 clients with criminogenic risk factors who can benefit from a Forensic ACT team.

First Step House operates an outpatient mental health program that provides services to tenants at both of their permanent supportive housing projects (Central City Apartment and Medina Place) and to individuals from their SUD programs and the community. Services include prescribing, crisis intervention, personal services, skills development, and individual and group therapy. They also provide supportive living services at Central City Apartments.

DBHS/OPTUM providers continue to offer Telehealth services to members. Most of these providers report planning to attest through credentialing and keep telehealth capabilities as an option for treatment after the pandemic.

Describe the approach to serving individuals with complex behavioral health presentations or who need multiple supports to remain in the community, including the programmatic approach to serving individuals in the least restrictive level of care. Identify your proposed fidelity monitoring and outcome measures.

Volunteers of America ACT
ACT is a national, evidenced-based service delivery model with a primary goal of recovery through

community treatment and habilitation. For consumers with the most challenging and persistent problems, ACT assumes primary responsibility for all services — from psychiatry and social work to rehabilitation and substance use disorder treatment. Rather than referring members to multiple programs and services, the ACT program takes a team approach to provide the treatment and services that members need. The VOA ACT teams follow the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures is completed by VOA and reported to Optum. Depending upon the measure, evaluation is conducted weekly or monthly. DBHS also conducts an annual fidelity review. Outcome measures include increase in community tenure including housing stability and employment/volunteering involvement while simultaneously reviewing reduction of inpatient admissions, criminal charges, and jail stays.

Valley Behavioral Health ACT
ACT is a national, evidenced-based service delivery model with a primary goal of recovery through community treatment and habilitation. For consumers with the most challenging and persistent problems, ACT assumes primary responsibility for all services — from psychiatry and social work to rehabilitation and substance use disorder treatment. Rather than referring members to multiple programs and services, the ACT program takes a team approach to provide the treatment and services that members need. The VBH ACT team follows the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures is completed by VBH and reported to Optum. Depending upon the measure, evaluation is conducted weekly or monthly. DBHS also conducts an annual fidelity review. Outcome measures include increase in community tenure including housing stability and employment/ volunteering involvement while simultaneously reviewing reduction of inpatient admissions, criminal charges, and jail stays.

Odyssey House manages the Forensic ACT Team for individuals who meet criteria for ACT and have legal issues which complicate access to resources and require special consideration. ACT is a national, evidenced-based service delivery model with a primary goal of recovery through community treatment and habilitation. For consumers with the most challenging and persistent problems, ACT assumes primary responsibility for all services — from psychiatry and social work to rehabilitation and substance use disorder treatment. Rather than referring members to multiple programs and services, the ACT program takes a team approach to provide the treatment and services that members need. The ACT team follows the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures is completed by Odyssey House and reported to Optum. Depending upon the measure, evaluation is conducted weekly or monthly. DBHS also conducts an annual fidelity review. Outcome measures include increase in community tenure including housing stability and employment/ volunteering involvement while simultaneously reviewing reduction of inpatient admissions.

See Section 2 above for information regarding Adult Residential programming for those with mental health, SUD, and criminogenic risk.

See Section 8 for information on supportive housing.

Describe the programmatic approach for serving individuals in the least restrictive level of care who are civilly committed or court-ordered to Assisted Outpatient Treatment. Include the process to track the individuals, including progress in treatment.

DBHS/Optum has a large network of providers who are available to provide a vast array of outpatient services. Clients have the freedom to choose any provider from the network that provides services to

meet their needs. All levels of care are available and DBHS/Optum works with all clients to assist them in determining the level of care needed and align them with a provider at their request.

DBHS/Optum uses the ECSII: Early Childhood Service Intensity Instrument for Youth to determine if a residential level of care is indicated.

Optum participates in Commitment Court and has created a spreadsheet that has all individuals within Commitment Court listed. Optum tracks individuals, their benefits, the referral source, their community provider, next court date, and determining next steps based upon court recommendations. Following court, we coordinate with known providers for any needed treatment updates and court notifications for upcoming court dates. Additionally, DBHS maintains within our EHR all known individuals that have ever been civilly committed which contains many of the above elements.

See Section #16 for information regarding fidelity monitoring and outcome measures.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Define the process for referring an individual to a subcontractor for services. Include any planned changes in programming or funding. *Please highlight approaches to engage family systems*.

DBHS/Optum has a large network of providers who are available to provide a vast array of outpatient services. Clients have the freedom to choose any provider from the network that provides services to meet their needs. Additionally, in some cases clients may opt to receive services from a provider not in the network. These services can be provided as long as preauthorization requirements are met.

DBHS's/Optum's network offers a comprehensive outpatient program that serves children 0-18 with mental illness and their families in Salt Lake County. Services include individual, family and group therapy, psychiatric evaluation, medication management, psychological testing, respite, Family Peer Support, inter-agency coordination and crisis intervention.

The network also consists of providers specializing in Abuse and Trauma Treatment to children, identified as victims or perpetrators of sexual abuse, and their families. Treatment consists of individual/family counseling, group therapy, and coordination with other agencies involved with abuse victims, such as DCFS, DJJS, the court, and law enforcement. Objectives of the program include stabilizing family life, while protecting the victim and other children in the home and community.

Key providers for children and youth include:

The Children's Center
Services offered include: assessment and evaluation, medication management, family therapy and trauma treatment for children ages 0-8. In addition, The Children's Center provides Therapeutic Preschool Programs and specialty services for children with autism and mental health issues. The Children's Center employs 5 certified Child Parent Psychotherapy (CPP) providers and is certified in training future in-house clinicians in this modality working with youth and families with domestic violence and trauma issues. They are also completing certification in providing Attachment and Biobehavioral Catch-up (ABC).

Valley Behavioral Health
VBH offers outpatient and medication management services for youth at ValleyWest. Services offered are Intensive Outpatient (ACES - Acute Children's Extended Services), for elementary aged youth, and Children, Youth, and Family Day Treatment Services (formally AIM, DBT, and KIDS) for children and adolescent ages 5-17 with primary mental health diagnoses. Valley is working toward expanding SUD services in their Outpatient and Day Treatment clinics. Valley's children and youth programs are CARF certified.

Valley provides IDD services for youth ages 2-22 at the Pingree School for Autism. Treatment focuses on individuals who have Autism and a dual mental health diagnosis. Services are provided in a Day Treatment setting.

VBH has a new campus that all Child, Youth, and Family services are housed in on 4100 South 3725 West (old Granger medical building). The children's services include the VBH Day Treatment programs (KIDS, ACES, AIM, DBT), outpatient services and VBH Psychological Services. The purpose of the campus is to centralize treatment, increase continuity of care, improve access and collaboration.

Hopeful Beginnings
Hopeful Beginnings provides in-office and in-home services for children, youth and adults. Services include: individual therapy, family therapy, case management, medication management, skills development, and respite care. In addition, Hopeful Beginnings provides in-home crisis stabilization services for children, youth and their families. The Intensive Day Treatment program for adolescents can serve up to 12 DBHS/Optum Medicaid consumers. Hopeful Beginnings employs therapists to provide Trauma specific treatment including the use of EMDR.

Youth Empowerment Services
Youth Empowerment Services offers intensive office-based and in-home therapeutic services for children and youth.

Child and Family Empowerment Services
Multilingual agency that focuses on services with an emphasis on and respect to culturally diverse youth and families.

Multicultural Counseling Center
Bilingual services are offered for a variety of services, with an emphasis on and respect to culturally diverse youth and families.

The following programs are offered through Salt Lake County Division of Youth Services (DYS):
Counseling services include immediate crisis counseling for youth and families, and ongoing mental health and SUD counseling for Medicaid qualified youth and those who are uninsured or underinsured.
In-Home Services
Home based therapeutic and case management are available to youth and families with emotional and behavioral issues when barriers to office-based therapy are present. Barriers include things such as disabilities, lack of transportation, and childcare issues.

Youth Care Coordinator

Optum's Care Coordination Team includes one individual dedicated to youth care coordination activities, including engaging families to support linkages to appropriate services within the community.

Describe the approach to serving individuals with complex behavioral health presentations or who need multiple supports to remain in the community, including the programmatic approach to serving individuals in the least restrictive level of care. Identify your proposed fidelity monitoring and outcome measures.

DBHS/Optum supports both community-based in-home and school-based services whenever viable for the youth and family. We have several providers that offer in-home services to youth/families who have transportation challenges and/or whose needs are better addressed in the client's home. (Some of these providers are listed above.) In addition, DBHS/Optum works with several providers that have designated school-based clinicians assigned to schools within each district at the school districts' discretion. These providers are Valley Behavioral Health, Hopeful Beginnings, Project Connection and Odyssey House. Optum collaborates with Intermountain Healthcare's Stabilization and Mobile Response (SMR) to facilitate transition for youth and families into the Optum SLCo Medicaid Network.

Additionally, Optum participates in the High-Fidelity Wraparound staffings with multiple systems to identify community-based treatment to support their complex needs.

See Section #16 for information regarding fidelity monitoring and outcome measures.

4) 24-Hour Crisis Care

Adult Services **Nichole Cunha**

Please outline plans for the next three years for access to crisis services during daytime work hours, afterhours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care inpatient, residential, etc.) and the criminal justice system. Identify what crisis services are currently provided in your area, where services are provided, and what gaps need to still be addressed to offer a full continuum of care to include access to a crisis line, mobile crisis outreach teams, and facility-based stabilization/receiving centers. Identify plans for meeting any statutory or administrative rule governing crisis services. For each service, identify whether you will provide services directly or through a contracted provider. Describe how you coordinate with state and local partners for services to include the Utah Crisis Line, JJS and other DHHS systems of care, law enforcement and first responders, for the provision of crisis services. Include any planned changes in programming or funding.

For an adult in Salt Lake County experiencing acute emotional or psychiatric distress, a comprehensive array of services and supports on a 24 hour/7 days a week basis are available. These services are structured to address acute needs and also provide for personal and public safety and support individuals in a manner that encourages their recovery and equips them with resources to manage future acute circumstances. This continuum includes telephone crisis-line services, warm-line services, SAFEUT text line, MCOT, close coordination with the Salt Lake Police Department Crisis Intervention Team (CIT) program, a receiving center, subacute treatment, case management, psychotropic medications and, when necessary, access to acute inpatient hospitalization.

Mobile Crisis Outreach Teams (MCOT) – HMHI
The HMHI MCOT is an interdisciplinary team of mental health therapists and Certified Peer Specialists,

who provide a combination of crisis services including crisis intervention, psychiatric emergency care, urgent care, referrals and connection to community resources, and crisis follow-up for residents of Salt Lake County 24/7, 365 days per year. The team is committed to responding within 30 minutes to law enforcement requests and within 60 minutes to community requests. At the time of this writing the average law enforcement response time was 26.10 minutes and the average community response time was 44.24 minutes. The staff assess the situation and make a determination regarding disposition to provide the best possible outcome, by using all the community resources available focusing on the least restrictive alternatives. During FY23, through March, 77.25% of those receiving an outreach visit were diverted from inpatient and emergency room visits. This was a decrease from the previous year. The HMHI MCOT averages almost 230 contacts per month, a decrease of 106 contacts per month compared to last year. Of the 230 contacts, an average of 190 resulted in a direct outreach by the MCOT team.

The decrease in outreaches was largely due to the critical incident that took place in November 2022. Since that event took place, HMHI has revamped their safety protocols and conducted in-person MCOT staff mandatory intensive safety retraining. The number of outreaches continues to increase month after month. Over the next 3 years, we plan on hiring more MCOT professionals to take on an increased amount of outreaches. Additionally, we are working diligently to strengthen statewide partnerships with law enforcement, in an effort to better support them and increase the number of referrals to our team. Our leadership team is also set to expand, which will include a dedicated MCOT manager. This will allow for closer collaboration and management of all MCOT teams.

Receiving Center – HMHI
The Receiving Center (operating 24/7 365 days a year) diverts people from inpatient services and the jail. It is able to receive referrals from law enforcement, MCOT, stakeholders and the community. Consumer-centered crisis services are offered through this “living room” style center and individuals can stay at the center for up to 23 hours to receive what they need to resolve the current crisis — including assessments, medications and other support. During FY23, through March, the center received an average of 85 patients per month, trending up from FY22. Average usage in the most recent quarter (q3) of FY23 was100 patients a month. Of all patients admitted in FY23, only 10.0% continued on to inpatient stays, no one was diverted to the County jail, with 78% returning to their home or family, and the remainder discharged to community programs.

The Receiving Center will be closed for Q4 of FY23 to remodel and expand the space. This expansion, scheduled to open summer 2023, will have double the space and a different staffing pattern that will allow it to function as a bridge between the current model and the expected model for the Kem and Carolyn Gardner Crisis Care Center, currently under construction and scheduled to open early 2025. This bridge model will allow for increased access with a total of 12 chairs, up from 5, and a change in staffing mix that are trained for acceptance of a broader range of patients & removal of unnecessary burdens/barriers of medical clearance prior to acceptance. The top priority, when this expansion opens, is law enforcement and EMS diversion from jail and emergency departments. HMHI is developing those relationships, processes, and protocols in advance of the reopening and plan to use the expanded model to implement, test, and improve this function in preparation for scaling it up when the Crisis Care Center opens.

Crisis Line – HMHI
The Utah Crisis Line, in association with the National Suicide Prevention Lifeline (988), is a statewide

24/7 confidential phone line answered by certified crisis workers. Certified crisis workers will provide crisis intervention, suicide risk assessment, and triage the call to determine if an immediate referral to the MCOT is needed. If immediate referral to MCOT is not necessary, staff work with the caller in an attempt to de-escalate the client. If the caller is not in an emotional crisis and is in need of empathetic listening and support, staff can also immediately connect the caller with the Utah Warm Line (see below). During FY23 through March, the Utah Crisis Line, including Lifeline, has received an average of 3,123 calls per month.

Warm Line – HMHI
The Utah Warm Line is a confidential phone line answered by Peer Support Specialists professionally trained to provide support to callers and share their lived experience with mental health and/or substance use challenges aligned with the Recovery Model to foster hope and healing. Staff are trained to connect with, share, and provide support, hope, and a listening ear for peers in times of stress and uncertainty. Callers are connected with someone who can truly understand their struggle because they have "been there before," or provide a needed local resource or referral. During FY22, through March, the Utah Warm Line has received an average of 1,631 calls per month.

Descriptions of the additional adult crisis services funded through JRI (HMHI/UPD MH Unit) can be found under 20) Justice Treatment Services.

Describe your current and planned evaluation procedures for crisis intervention services that objectively measure access and measurable outcomes for persons with both mental health and substance use disorders using data. Technical assistance with data specifications and key performance indicators are available if needed, please describe any areas for help that are required.

Due to multiple delays in funding and construction delays, the new HMHI Receiving Center will not open until 2025. In preparation for opening the facility, the following performance metrics will be collected through the electronic health record, and the admission and discharge surveys: diversion rates from jail, emergency departments and inpatient hospitalization; satisfaction rates; timely connection to services post-release; client demographics; and other effectiveness of intervention metrics (around stability, release disposition, and symptom reduction).

Children's Services **Nichole Cunha**

Please outline plans for the next three years for access to crisis services during daytime work hours, afterhours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and the criminal justice system. Identify what crisis services are provided, where services are currently provided in your area, where services are provided, and what gaps need to still be addressed to offer a full continuum of care (including access to a Crisis Line, Mobile Crisis Outreach Teams, facility-based stabilization/receiving centersand In-Home Stabilization Services). Including if you provide SMR/Youth MCOT and Stabilization services, if you are not an SMR/Youth MCOT and Stabilization provider, how do you plan to coordinate with SMR providers in your region? For each service, identify whether you will provide services directly or through a contracted provider. Describe how you coordinate with state and local partners for services to include the Utah Crisis Line, JJYS and other DHHS systems of care, law enforcement and first responders, schools, and hospitals for the provision of crisis services to at-risk youth, children, and their families. Include any planned changes in programming or funding.

For youth in Salt Lake County experiencing an acute emotional or psychiatric distress, we offer a comprehensive array of services and supports available on a 24 hour/7 days a week basis. These services are structured to address not only their acute needs but also provide for personal and public safety and support individuals in a manner that encourages their recovery and equips them with skills, resources and tools to manage future acute circumstances. The array of services includes telephone crisis line services, MCOT, referrals to the SMR program, case management, psychotropic medications and, when necessary, access to acute inpatient hospitalization.

Mobile Crisis Outreach Teams
The HMHI MCOT is an interdisciplinary team of mental health therapists and Certified Peer Specialists, who provide a combination of crisis services including crisis intervention, psychiatric emergency care, urgent care, referrals and connection to community resources, and crisis follow-up for residents of Salt Lake County 24/7, 365 days per year. The team is committed to responding within 30 minutes to law enforcement requests and within 60 minutes to community requests. At the time of this writing the average law enforcement response time was 34.50 minutes and the average community response time was 49.69 minutes. The staff will assess the situation and make a determination regarding disposition using all the resources available to provide the best outcome possible using the least restrictive alternatives. The Youth MCOT is flexible, multi-faceted, and immediately accessible to families, children and adolescents at risk for hospitalization or out-of-home placement. They work closely with community partners specialized in child and family issues including DYS, VBH children's outpatient unit, etc. All clinical staff are either State certified Designated Examiners or Mental Health Officers who can evaluate and initiate commitment procedures for those under the age of 18 (i.e., Neutral and Detached Fact Finders).

During FY23, through March, 79.59% of those receiving an outreach visit were diverted from inpatient hospitalizations, which represents a 4% decrease during the same time in FY22. The HMHI MCOT averages 37 youth contacts per month, which is a decrease of 18 per month compared to the same time during FY22, of which an average of 34 resulted in a direct outreach by the MCOT team.

MCOT currently coordinates with SMR by providing SMR as a resource when appropriate based on availability of SMR services at that time of the call and scope of the caller's needs. Additionally, MCOT has monthly calls set up with SMR leadership that assist in coordination of services and bridging any gaps seen across the care continuum.

Salt Lake County DYS-Christmas Box House
This program provides 24-hours, 7 days a week emergency intake, assessment, interim residential care and for children ages 0 to 21 who are taken into temporary protective custody by DCFS or law enforcement for alleged abuse and neglect.

Salt Lake County DYS – Shelter Group Home
This program provides 24-hours, 7 days a week emergency intake, assessment, interim residential care and for children ages 12 to 21 who are taken into temporary protective custody by DCFS or law enforcement for alleged abuse and neglect.

Salt Lake County Division of Youth Services-Juvenile Receiving Center (JRC)
This program offers screening, evaluation and referral services to youth, families and law enforcement 24/7. Services are for youth ages 8 to 17 who need a crisis timeout, are runaway, homeless,

ungovernable youth or youth who have committed minor offenses. Youth may come to the facility on their own, with parents or police may bring in youth who have committed a status offense or delinquent act that does not meet Detention Admission Guidelines. This may include but not limited to running away from home, truancy, substance abuse, curfew violation or acting beyond the control of the youth's parents. No appointment is needed to access the Juvenile Receiving Center services including individual or family crisis counseling. Serving two locations: Salt Lake and West Jordan.

Salt Lake County Division of Youth Services-Crisis Residential
Offers 24/7 crisis timeout service to run away and ungovernable youth ages 10 to 17. These services can only be accessed as part of the JRC.

Salt Lake County Division of Youth Services-Homeless Youth Walk-in Program:
This program provides 24-hour access to food, clothing, laundry, shower facilities and overnight shelter for homeless youth under age 18. Referrals, crisis counseling and therapy are also available resources.

Salt Lake County Division of Youth Services-Safe Place: Youth Services manages the nationwide program called “Safe Place in Utah”, which is dedicated to helping youth in trouble with a safe place to go for help and/or shelter. More than 88 Safe Place sites are spread throughout Salt Lake County in public places such as libraries, fire stations and recreation centers. Locations can be spotted by the yellow Safe Place sign on the building or in the window. Employees at Safe Place sites are trained to call Youth Services if a youth is asking for help. A Youth Services employee will speak with the youth on the phone and, if desired, transport the youth to our facilities.

Any youth can access this help either by going to a Safe Place site or coming directly to the Youth Services Juvenile Receiving Center, or text SAFE and their location to 69866.

Family Support Center - The Family Support Center also offers a free Crisis Nursery 24/7 for families with children ages 0-11 in three locations in the Salt Lake Valley.
Description of the additional youth crisis services funded through JRI (HMHI/UPD Pilot) can be found under 20) Justice Treatment Services.

Hopeful Beginnings provides in-home crisis response interventions in the moment to divert from higher levels of care and utilize community-based treatment.

Describe your current and planned evaluation procedures for children and youth crisis intervention services that objectively measure access and measurable outcomes for persons with both mental health and substance use disorders using data. Technical assistance with data specifications and key performance indicators are available if needed, please describe any areas for help that are required.

Since the crisis services data was reported by the provider directly to DSAMH beginning July 1, 2021, Optum/DBHS has been unable to conduct our historical data analysis. Since the data dashboard is now available, Optum/DBHS will collaborate on a plan to monitor this data and respond accordingly. Additionally, the Youth MCOT team does collect data that is submitted to the state directly.

5) Psychotropic Medication Management

Adult Services ***Pam Bennett***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. **Include any planned changes in programming or funding.** ***Please list any specific procedures related to continuity of medication management during transitions between from or between providers/agencies/level of care settings.***
Medication management services are offered by multiple providers throughout the county to include outpatient clinics, nursing homes, and via telehealth. Prescribers on ACT Teams can meet members where needed, such as the clinic, their home, or elsewhere in the community. All clients have access to a prescriber to adjust, change, or maintain the medication that the client needs. DBHS/Optum encourages their network of prescribers to stay abreast of the advancements in medication and other technologies. Those who provide this service are licensed psychiatrists, APRNs, and RNs. Where possible, LPNs or PAs may provide supportive interventions. This is monitored through the auditing process and highlighted in clinical trainings. DBHS/Optum will continue to seek out prescribers in the community. Currently, DBHS/Optum has 163 prescribers (M.D.s, D.O.s, and APRNs) within the Optum Salt Lake County Medicaid Network. Some prescribers are counted more than once, as some offer their services at more than one contracted agency/provider. Dynamic Psychiatry was added to the network. This includes 3 prescribers. When adults are discharged from inpatient services, a follow-up medication management appointment is to be scheduled as part of the discharge plan. The discharge plan and medication orders are sent to the receiving provider. When a member shifts from an outpatient prescriber to another, the member is asked to sign a release of information so the current/historical medication information may be shared with the receiving prescriber. If a member needs assistance identifying prescribers in the network, Optum Care Advocates, Care Coordinators and Recovery & Resiliency Peers can assist with this process.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. **Include any planned changes in programming or funding.** ***Please list any specific procedures related to continuity of medication management during transitions between providers/agencies/level of care settings*****.**
Medication management services are offered by multiple providers throughout the county to include outpatient clinics and telehealth services. Hopeful Beginnings, New Beginnings, The Children's Center, Valley Behavioral Health, Lotus Center, Primary Children's Safe and Healthy Families, Primary Children's Pediatric Behavioral Health, and others have delivered medication management to children and adolescents in FY22 and will continue into FY23. All youth have access to a prescriber to adjust, change, or maintain the medication that they need. DBHS/Optum encourages their network of prescribers to stay abreast of the advancements in medication and other technologies. Those who provide this service are licensed psychiatrists, APRNs, and RNs. Where possible, LPNs or PAs may provide supportive interventions. Currently, DBHS/Optum has 163 prescribers (M.D.s, D.O.s, and APRNs) within the Optum Salt Lake

County Medicaid Network. Some prescribers are counted more than once, as some offer their services at more than one contracted agency/provider.

DBHS/Optum continues to search for and add prescribing providers to our network. We have added Dynamic Psychiatry. This adds a D.O., Psychiatrist (M.D.) and an A.P.R.N. as well as a psychologist and LCSW all within one practice.

When youth are discharged from inpatient services, a follow-up medication management appointment is to be scheduled as part of the discharge plan. The discharge plan with the medication orders are sent to the receiving provider. When a youth shifts from an outpatient prescriber to another, the guardian is asked to sign a release of information so the current/historical medication information may be shared with the receiving prescriber. If a member needs assistance identifying prescribers in the network, Optum Care Advocates, Care Coordinators and Recovery & Resiliency Peers can assist with this process.

6) Psychoeducation Services & Psychosocial Rehabilitation

Adult Services ***Pam Bennett***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

DBHS/Optum contracts directly with Alliance House, an International Accredited Clubhouse model program, in Salt Lake City to provide skills development programs for adults. The mission of the Alliance House is to help those with a serious mental illness (SMI) gain or recapture the ability to function in the community through meaningful work. The clubhouse incorporates several different work units that are important in the maintenance of the clubhouse. Participation in these units gives members an opportunity to develop skills that fosters their recovery and ultimately their reintegration into the community at large. The education unit has helped members obtain GEDs or high school diplomas, college education skills and support, and increased life skills. The major focus of the program is transitional employment placements. Alliance House has implemented the Individual Placement and Supports (IPS) Supported Employment program at the clubhouse. For additional details on the IPS at Alliance House, please see section 15) Client Employment.

In addition, VBH and Volunteers of America provide Adult Psychoeducation Services.

There are several providers who provide Psychosocial Rehabilitation including: VBH, Volunteers of America, Hopeful Beginnings, Psychiatric Behavioral Solutions, Summit Community Counseling, and others.

Describe how clients are identified for Psychoeducation and Psychosocial Rehabilitation services. How is the effectiveness of the services measured?

Clients are identified for these services through a biopsychosocial assessment and services are prescribed by an independently licensed clinician. Effectiveness of services is measured by a regular review of the objectives developed for each client receiving the service and their progress on these objectives. Members must meet the criteria for 1915(b)(3) services, which includes SMI classification, to qualify for Psychoeducational services.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.
DBHS/Optum contracts with VBH to provide skills development programs for youth and children. They include: School-based Early Intervention Services These services consist of therapy, case management, and parent/teacher consultation and training. Please see section 18 for a more comprehensive description of these services, as well as a list of schools where DBHS and Optum providers are contracted. ACES, an after-school partial day treatment program, serving 24 children (age 5-12) concurrently, who are referred for short-term stabilization of acute emotional and behavioral problems. Services include parent training in behavioral management and family therapy, as well as psychiatric evaluation. Intensive, highly structured adjunct mental health treatment often prevents out-of-home placements. KIDS Intensive Day Services (KIDS) is a short-term, intensive day program for youth ages 5 - 12, with serious behavioral and emotional challenges, with a focus on keeping children in their families and in the community. The goal is to prevent more restrictive mental health placements and/or help youth step down from more restrictive settings. DBT Day Treatment offers an intensive day program option for up to 12 adolescents addressing behavioral and emotional challenges focusing specifically on DBT skill development. The goal is to help the youth and family develop and utilize these skills across settings. Valley BH is in the process of adding a track for youth suffering with mild to moderate eating disorders. AIM Day Treatment is a day program option for youth struggling with behavioral health issues across multiple settings (i.e., home and school). Services include individual, group and family therapy as well as skills training. There are several providers who provide Psychosocial Rehabilitation including: Hopeful Beginnings, Utah Youth Village, Youth Empowerment Services, Summit Community Counseling, Utah Behavior Services, The Children's Center, Lumos Enterprises, and Utah House.
Describe how clients are identified for Psychoeducation and Psychosocial Rehabilitation services. How is the effectiveness of the services measured?
Clients are identified for these services through a biopsychosocial assessment and services are prescribed by an independently licensed clinician. Effectiveness of services is measured by a regular review of the objectives developed for each client receiving the service and their progress on these objectives.

7) Case Management

Adult Services ***Pete Caldwell***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please include how you ensure each case management provider is certified to provide these services. Include any planned changes in programming or funding.
Targeted Case Management (TCM) is provided to clients with SMI (Seriously Mentally Ill) throughout the service continuum from outpatient services to in-home skills training programs. The goals of TCM are to: • Help clients access appropriate services and supports • Assure that services are relevant and meet consumer needs • Ensure continuity and coordination of services provided for eligible clients • Educate clients and their families in how to negotiate the mental health and social system • Empower clients by enabling them to access new roles and responsibilities • Integrate clients into normalized community living: a place to live, community activities and friends with whom to socialize • Educate and support clients and their families in learning how to manage their resources Optum employs a Housing Support Specialist to coordinate case management services for clients who need housing and/or supports to stay housed. Optum has four providers who offer intensive, targeted case management for our clients: Valley Behavioral Health, Project Connection, VOA, and Psychiatric Behavioral Services. These same agencies have committed to delivering services to those who are Medicaid eligible and either homeless or recently housed. VBH offers an intensive Care Navigation program for adult clients who are in need of extra support while transitioning from an inpatient/subacute facility or who are experiencing instability in their care. The team is designed to be flexible so they can respond quickly to both members and others who are in need of their assistance. VBH has successfully operated a similar service called JDOT (Jail Diversion Outreach Team) for criminal justice-involved persons with mental illness. Services emphasize integrated mental health and substance use disorder interventions. This team has been very successful in reducing jail recidivism. The VBH Care Navigation Team helps connect and link members to needed services while transitioning to different programming or levels of care. Project Connection has implemented an evidenced-based program known as Critical Time Intervention (CTI). This program offers intensive case management services designed to start with the client focusing on their interests and treatment needs, what services are available to help them achieve their interests and maintain stability with their mental health issues while moving forward on the recovery path. RIC-AAU offers case management services for the refugee populations, coordinating treatment, employment training, housing, insurance access, and other services to support refugees as they integrate into the community.

Hopeful Beginnings provides case management services for adult clients, to enhance outpatient therapeutic and medication management services.

There are several different licenses (i.e., Division of Occupation and Professional Licensing - DOPL) which can provide case management. In order to ensure that the rendering staff is qualified to provide case management, during provider audits DBHS and Optum will either verify that a qualified DOPL license is providing case management or request verification of required training and certification for non-licensed individuals rendering TCM services. Licensed providers are expected to sign their name with their credentials for all rendered services.

Please describe how eligibility is determined for case management services. How is the effectiveness of the services measured?

Clients are identified for these services through a biopsychosocial assessment, and services are prescribed by an independently licensed clinician. An individualized needs assessment may also be conducted to determine the need for any medical, social, educational or other services. Effectiveness of services is measured by a regular review of the individual's progress toward person centered objectives in the target case management service plan.

Children's Services ***Pete Caldwell***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please include how you ensure each case management provider is certified to provide these services. Include any planned changes in programming or funding.

Youth are significantly impacted by their environments and the systems with which they engage. Therefore, case management is an integral part of working with children and adolescents and is embedded in the treatment continuum. TCM is provided to youth with a serious emotional disturbance (SED) and who are receiving primarily mental health treatment. The goals of TCM are to:

- Help clients access appropriate services and supports
- Assure that services are relevant and meet consumer needs
- Ensure continuity and coordination of services provided for eligible clients
- Educate clients and their families in how to negotiate the mental health and social system
- Empower clients by enabling them to access new roles and responsibilities
- Integrate clients into normalized community living: a place to live, community activities and friends with whom to socialize
- Educate and support clients and their families in learning how to manage their resources

Higher levels of care: VBH, Hopeful Beginnings, New Beginnings and Utah House offer TCM to assist with discharge planning in an effort to link children and their families to ongoing supports as they transition to lower levels of care, or in some cases, more enhanced programming.

Hopeful Beginnings: Hopeful Beginnings offers case management services and assertive outreach for children and youth using the i-WRAP model.

Silverado Counseling, Asian Association, and Youth Empowerment Services offers case management services for youth and families.

Salt Lake County Division of Youth Services-Safe Place: Youth Services manages the nationwide program called "Safe Place in Utah", which is dedicated to helping youth in trouble with a safe place to go for help and/or shelter. More than 88 Safe Place sites are spread throughout Salt Lake County in public places such as libraries, fire stations and recreation centers. Locations can be spotted by the yellow Safe Place sign on the building or in the window. Employees at Safe Place sites are trained to call Youth Services if a youth is asking for help. A Youth Services employee will speak with the youth on the phone and, if desired, transport the youth to a DYS facility. Any youth can access this help either by going to a Safe Place site or coming directly to the Youth Services Juvenile Receiving Center, or text SAFE and their location to 69866.

DYS Milestone Transitional Living Program: The Salt Lake County Youth Services Milestone Transitional Living Program (TLP) assists in ending the cycle of homelessness and dependency by helping young adults become self-sufficient through access to safe housing, stable employment and connections to ongoing support and resources. Milestone TLP serves up to 19 young adults at a time ages 18 to 21 who are experiencing homelessness in Salt Lake County. Each youth in the program works closely with a case manager to set long-term and short-term goals towards obtaining stable employment and educational enhancement. By providing housing and connecting youth with community resources, participants will move toward self-sufficiency, shifting their lives in a positive direction to break the cycle of homelessness and dependency. DYS has three homes in Sandy and a 4-plex apartment in West Valley City that can house up to 19 young adults.

There are several different licenses (i.e., Division of Occupation and Professional Licensing - DOPL) which can provide case management. In order to ensure that the rendering staff is qualified to provide case management, during provider audits DBHS and Optum will either verify that a qualified DOPL license is providing case management or request verification of required training and certification for non-licensed individuals rendering TCM services. Licensed providers are expected to sign their name with their credentials for all rendered services.

Please describe how eligibility is determined for case management services. How is the effectiveness of the service measured?

Clients are identified for these services through a biopsychosocial assessment, and services are prescribed by an independently licensed clinician. An individualized needs assessment completed by a qualified case manager may also be conducted to determine the need for any medical, social, educational or other services. Effectiveness of services is measured by a regular review of the individual's progress toward person centered objectives in the target case management service plan and/or the therapeutic treatment plan.

In addition to the above, for the DYS programs, any youth between the ages of 18 to 21 that is experiencing homelessness is eligible and can submit an application. The Milestone Program measures effectiveness by collecting information about education, employment and housing upon entrance and exit of the program. A successful transition is determined when a client is employed and/or attending school and housed upon exit.

8) **Community Supports (housing services)**

Adult Services *Pete Caldwell*

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.
Valley Plaza – VBH Valley Plaza is a 72-bed 1 & 2 bedroom apartment complex. This program is staffed 24 hours a day with mental health services provided on-site. Clients are in individualized programs with flexible support systems. Valley Woods – VBH Valley Woods is a 58-bed 1 & 2 bedroom apartment complex with 3 residential buildings and 1 common area. This program is staffed 24 hours a day with mental health and case management services provided on-site. Safe Haven 1 & 2 – VBH Safe Haven is a 49-bed homeless transitional housing apartment complex for individuals living with mental illness. This program is staffed 24 hours a day with mental health and case management services provided on-site. VBH also offers community-based housing support. Rents are primarily covered by the clients. These housing programs include the following: · Valley Home Front – 8 apartments · Valley Crossroads – 20 apartments · Oquirrh Ridge West – 12 apartments · Oquirrh Ridge East – 12 apartments · Valley Horizons – 20 apartments for mentally ill 55 or older Residents of the above housing facilities are provided case management. In addition, independent living skills and vocational training are provided to residents, as applicable. Valley Oaks (opening Summer 2023) offers supervised cooperative living apartments for 30 residents with serious mental illness (SMI). Services include case management, medication management, daily living and life skills development, and 24-hour assistance. This program will provide housing for clients from multiple providers operating ACT teams. During FY24, DBHS anticipates to fund and contract for over 250 housing units through Housing Connect for individuals and families currently, or at-risk of being, homeless.The vast majority of the recipients of rental assistance through the Housing Connect contract have criminal justice involvement, a substance use disorder and/or mental illness. Funding under this contract is broken into 72 units for the State Hospital Diversion program, 55 units for the Project RIO Housing (master leased units for SMI clients), 58 units for HARP Housing (short and long term rental assistance), 22 units at the VOA Denver Apartments, 14 units at The Theodora, 25 units at the Central City Apartments, and 6 master lease units at First Step House's Fisher House (congregate site for SMI clients referred to housing

through their Mental Health Court participation). All partners referring to these programs are obligated to provide in-home case management for their clients in order to ensure housing stability. DBHS also partners with Housing Connect by providing in-kind matches for many federally subsidized housing programs.

Additionally, with the State Hospital Diversion Housing program, and in collaboration with DBHS/Optum, Housing Connect has developed agreements with Nephi Todd's, Odyssey House's Sunstone and Jasper boarding homes, and Oasis House to purchase housing for clients needing assistance as they discharge from the State Hospital, or as a measure to prevent decompensating mental health and inpatient hospitalization. The previously-named Evergreen boarding homes were closed in January 2022 for health and safety reasons. DBHS worked directly with Odyssey House and the property owners to renovate these buildings. During FY23 both buildings were rebranded as Sunstone and Jasper. They reopened with new operators (Odyssey House) and began accepting clients again. Clients at DBHS-supported boarding homes receive supervision, meals, housekeeping, and laundry services. To a smaller extent, the State Hospital Diversion program has leveraged housing placements or other resources (i.e., case management) at the following facilities as well: Grace Mary Manor, Gregson Apartments, Palmer Court, Kelly Benson, John Taylor House, Murray Apartments, and the Road Home. We continue to work with other partners and landlords to find additional housing units and to look for the development of new options including working with Housing Connect to access vouchers through the NED (non-elderly disabled) voucher program.

DBHS/Optum has also worked extensively to support the housing needs of unfunded individuals who cannot receive Medicaid coverage because of legal status or other impediments. Such individuals are commonly justice involved, SMI or otherwise utilizing Utah State Hospital (USH) and inpatient services. DBHS/Optum will work with VBH and other community partners to support their unique housing and treatment needs.

Additional Housing and Resources:
Optum's full-time Housing Support Specialist attends community meetings, supports providers and advocates for consumers experiencing homelessness. In addition, she offers guidance to providers who are providing intensive case management services to those who are newly housed.

Volunteers of America, Utah has opened two permanent supportive living facilities for clients with serious and persistent mental illness. Denver Apartments offers 22 units to clients who require supportive living services. This facility has a clubhouse for support with laundry, room for skills groups and is staffed 24/7 for assistance with physical and mental health needs. The Theodora is a fourteen bedroom boarding home, in addition to the 24/7 supportive services described above, clients receive three meals per day and snacks.

Intensive housing case management services are also offered with a multidisciplinary team at a less intensive model for homeless women who are living at the VOA operated Geraldine E. King Women's Resource Center. The team facilitates transitioning out of homelessness into apartments with continued supportive services to help the women maintain housing.

The VOA Homeless Youth Resource Center continues to operate in Salt Lake County and facilitates housing, educational and employment opportunities for homeless youth ages 15—22.

First Step House has plans to open 46 units of permanent supportive housing at 169 East 200 South, Salt Lake City, that will serve individuals with behavioral health conditions in FY25.

In May 2019, DBHS assumed management of the Sober Living Program that began as a pilot in FY19 spearheaded by state legislative leadership, the Department of Workforce Services, the Utah Office of Substance Use and Mental Health and Salt Lake County. Clients participating in residential treatment ready to step down into outpatient services, any Salt Lake County drug court, eligible participants from Volunteers of America (VOA) detox programming, or recent graduates of CATS are eligible for the Sober Living Program which originally offered up to 6 months of funding assistance at a contracted provider that is licensed as a recovery residence (or to a much smaller extent as a residential support provider). Additional need for sober housing from the Salt Lake County contracted network of providers is addressed on an as-needed basis. During FY21, DBHS provided program flexibility and relaxed protocols (allowing clients to return multiple times based on job loss, or allowing clients to stay longer than 6 months) due to the negative economic impacts of the pandemic. During FY22, this was further extended to allow clients to stay between 9 and 12 months when certain criteria were met. This same flexibility was afforded through March of 2023, but due to financial constraints, the ability to extend clients out to 9 to 12 months was rolled back beginning in April 2023. Clients will only be eligible for extensions beyond 6 months based on extenuating circumstances. This program sometimes serves MH clients with co-occurring SUD conditions.

Also during FY22, DBHS responded to an RFA for ARPA funds through OSUMH for additional recovery housing. This resulted in DBHS being awarded approximately $2.3M which was subcontracted to House of Hope (through the County's contract with Housing Connect) to purchase and renovate a large property in Salt Lake City, in an effort to create between 13 and 24 additional units of sober housing (depending on the makeup of staff and clients living on site) for women and women with children. This project serves a very specific niche, underserved population in Salt Lake County. They must have a primary SUD, but they also serve those who have a co-occuring MH issue. House of Hope held an official ribbon cutting for the program in March of 2023, and was granted its Health and Human Services license in April of 2023. The first clients will begin to be housed in May 2023. This program sometimes serves MH clients with co-occurring SUD conditions.

In FY24, DBHS anticipates providing approximately 900 clients with sober living vouchers. Due to funding and other resource constraints, the monthly program capacity is approximately 300 vouchers. During the majority of FY23, the program was housing on average 330 clients monthly, well above the budgeted capacity, by utilizing county reserve funds to cover this expense.

Indicate what assessment tools are used to determine criteria, level of care and outcomes for placement in treatment-based and/or supportive housing? Technical assistance is available through Pete Caldwell: pgcaldwell@utah.gov

A complete biopsychosocial assessment is completed by a LMHT and used to determine if a member demonstrates a clinical need for receiving supportive housing. All individuals referred into State Hospital Diversion, master lease units and boarding home placements (see information above on scattered site placements, Todd's Care Center, Evergreen, Oasis, Denver, Central City and The Theodora) housing units have been identified as SMI and their level of ability to independently function is taken into account. Ongoing assessment is required to warrant ongoing supportive living placement. For USH patients, an occupational therapy evaluation is requested to assess activities of daily living skills.

Children's Services (respite services) *Leah Colburn*

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please identify how this fits within your continuum of care. Include any planned changes in programming or funding.
DBHS/Optum contracts with Hopeful Beginnings, Project Connection and Summit Community Counseling to provide respite services. Respite is available for children and youth. This program provides planned respite for the purpose of allowing a period of relief for parents. Respite is used to help alleviate stress in the family, thereby increasing a parent's overall effectiveness. Respite care may be brief (for a couple hours) or extended for several hours, several days a week and may be provided in or out of the child's home. Overnight respite is only provided through DYS on a Single Case Agreement basis and it is limited to no longer than two weeks. The Family Support Center also offers a free Crisis Nursery 24/7 for families with children ages 0-11 in three locations in the Salt Lake Valley.
Please describe how you determine eligibility for respite services. How is the effectiveness of the service measured?
The youth must meet the criteria for this 1915(b)(3) service with SED status and eligibility for Traditional Medicaid. In addition, a licensed mental health therapist must prescribe respite services and include it in the treatment plan. Respite providers collaborate with the referring clinician regarding the member's presentation during respite outings. Since respite is not considered a therapeutic intervention, rather a supportive service, the goal which includes this service would be assessed during the treatment plan review.

9) Peer Support Services

Adult Services *Heather Rydalch*

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.
Providing and receiving peer support stands as an integral component of rehabilitation and recovery. DBHS/Optum is dedicated to the Peer Support Specialist Program and continues to work to expand the peer workforce in Salt Lake County. Peer Support Specialists are critical to the Salt Lake County Behavioral Health System and DBHS/Optum utilizes providers within DBHS/Optum's network of providers to provide this service. Optum continues to offer services through the Peer Navigator Program. Peer mentoring, support, advocacy, and skill building will be provided for these individuals through regular, individual contact over a period of time. The goal is to ease the transition of individuals being discharged from hospital settings back into community life, to significantly decrease the need for readmission to the hospital, and to significantly decrease the need for hospitalization by engaging people prior to entry into the inpatient facilities. Peer Support Specialists provide consumers with support and linkage to mental and physical health, and social services. Referrals are received from multiple sources including Utah State Hospital

for patients transitioning back into the community, provider agencies (e.g., VBH, HMHI, individual providers), and other systems.

Additionally, Pathways to Recovery are facilitated through Nephi Todd's boarding home for men, and Evergreen boarding home for women. Pathways to Recovery is also an evidenced-based, peer-facilitated program for those with mental illness which guides participants through a process of self-assessment, self-discovery and planning. It helps individuals set life goals and realize their dreams.

Optum has a Certified Peer Support Specialist who attends and participates in Mental Health Court. This peer specialist is involved in all court hearings, offers recommendations to the court and meets with clients of Mental Health Court as recommended by the team.

Describe how clients are identified for Peer Support Specialist services. How is the effectiveness of the services measured?

Referrals are made to the Optum Peer Support Specialists via providers, community stakeholders and internal Optum staff and committees. Optum educates our providers and expects them to identify when PSS services could be beneficial. If providers do not offer this service in-house, they refer the case to Optum. Peer services are expected to be prescribed in a treatment plan. Documentation needs to include a corresponding treatment goal, the services rendered, and clinical review of the member's progress toward that goal.
The effectiveness of services is measured through reporting by the CPSS offering services to members.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. *Describe how Family Peer Support Specialists will partner with other Department of Health & Human Services child serving agencies, including DCFS, DJJYS, DSPD, and HFW.* Include any planned changes in programming or funding.

Children/Youth Peer Support Services are provided primarily by Family Peer Support Specialists (FPSSs). DBHS is providing peer support offered to the parents and/or caregivers of children and youth receiving services. Salt Lake County Division of Youth Services (DYS) is the administrator of anchoring sites for FPSSs. Allies with Families is no longer in business. DYS has assumed the majority of the training, mentoring, data collection and reporting responsibilities, but not all of the responsibilities Allies with Families previously had. The State Office of Substance Use and Mental Health (OSUMH) provides the initial 40 hour FPSS certification training. Then throughout the year they provide the ongoing required monthly training to maintain FPSS certification. OSUMH also provides individual FPSS coaching upon request of the FPSS or the FPSS supervisor.

The FPSS program services are designed to provide family peer support services to parents and/or caregivers of children/youth with mental health, substance use and/or other complex needs. Generally, FPSSs have a family member with a mental illness giving them the lived experience necessary to have understanding and empathy for the families they work with. They also have experience and knowledge navigating various systems and agencies. They provide resource coordination, advocacy,

assistance with the 504 Special Needs Education plan and Individualized Education Plan (IEPs). The main goal of the program is to keep children at home with their families and in their community. This is achieved through support, education, skill building, and use of natural supports.

There are currently 6 FPSSs placed with 5 agencies throughout Salt Lake County, with 1 team lead position recently created. Negotiations are currently happening to place an FPSS in the Jordan School District for the coming school year. FPSSs are anchored at the following agencies or organizations, along with plans to expand during the next school year:

- 1 FTE Team Lead position created 1/2023 Salt Lake County Youth Services
- 1 FTEs Salt Lake County Division of Youth Services
- 1 FTE Granite School District
- 2 FTE State of Utah Division of Child and Family Services (DCFS)
- 1 FTE 3rd District Juvenile Court
- 1 FTE Family Support Center
- 1 FTE Jordan School District (currently in negotiation to start for the 2023/2024 school year)

Describe how clients are identified for Family Peer Support Specialist services. How is the effectiveness of the services measured?

Families/clients experiencing mental health, behavioral or substance abuse issues are identified by the various agencies within the Salt Lake County region as a family who could benefit from the services the FPSS program offers. Families experiencing barriers to services such as lack of understanding and/or navigation skills for systems such as child welfare, juvenile courts, and schools are identified and referred.

The continuum of care within the Salt Lake County region is structured in a way to support an appropriate referral. Any youth under the age of 24 still living at home with a behavioral health need, WITHOUT 2 arms of DHS systems involved, would be an appropriate referral. Peer support services are rendered to the parents of a youth under the age of 16 per Medicaid. No income verification or insurance coverage is required of the family to receive services. FPSSs take youth/children ages 3 years – 21 years but can make exceptions for clients still living at home up to age 24 years . This is a new criteria set forth in August 2022.

10) Consultation & Education Services

Adult Services ***Pam Bennett***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

Optum has a Recovery and Resiliency (R&R) team that consists of family support specialists and peer support specialists (adult services). This team provides education and consultation to consumers, consumer run organizations, their contracted providers, community partners and stakeholders, and centers of learning. They also file grievances and complaints from clients and submit them for resolution. The team members actively meet with clients where they receive services, promoting the recovery model and whole health. They work with the Optum Clinical Operations Team on all case staffings and utilization reviews. They also work with Salt Lake County's/Optum's network of providers to encourage the hiring and utilization of peer counselors to work on multi-disciplinary teams to provide

treatment.

This team conducts numerous trainings in the community, such as:
• Adult Mental Health First Aid (MHFA) trainings are scheduled during the current fiscal year.
• Youth Mental Health First Aid trainings scheduled during the current fiscal year.
• Dimensions Tobacco Free Trainings
• 39 people were trained and certified to become a Certified Peer Support Specialist

Additionally, two members of Optum's R&R team are certified to conduct Public Safety MHFA training for police officers in the community.

Other training topics presented by this team for community partners, provider trainings, or Optum staff include: Information on Suicide, Recovery, Peer Support, Power of Language, Wellness Recovery Action Plan, Certified Peer Support Specialist Training, Certified Peer Support Specialist Refresher Trainings, Recovery Training at the University of Utah and other community groups, Communication and Language, Trauma-Informed Care Panel at Generations, Discharge Planning, Peer Navigator Program, Optum's Grievance Process, Mental Health Courts, and CARE Court.

HMHI's Crisis Services partners with and supports the Salt Lake City Police Department in providing Crisis Intervention Team Trainings for law enforcement and correctional officers in Salt Lake County.

DBHS is deeply rooted in the community with many allied partners. Through these partnerships, DBHS and Optum provide consultation to multiple agencies and providers in the community regarding shared clients and concerns. Staff have frequent opportunities to educate the public through all forms of media, community fairs, and other venues.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

Optum has a Recovery and Resiliency team that consists of family support specialists and peer support specialists (adult services). This team provides education and consultation to consumers, consumer run organizations, their contracted providers, community partners and stakeholders, and centers of learning. They also file grievances and complaints from clients and submit them for resolution. The team members actively meet with clients where they receive services, promoting the recovery model and whole health. They work with the Optum Clinical Operations Team on all case staffings and utilization reviews.

They also work with Salt Lake County's/Optum's network of providers to encourage the hiring and utilization of peer counselors to work on multi-disciplinary teams to provide treatment.

In FY24, Optum will continue to:
• Provide QPR trainings with Optum, providers, and allied partners.
• Provide MHFA, YMFA and QPR trainings with Optum, providers, and allied partners.
• Provide training on the Recovery Model and recovery supports with APRN students at the University

of Utah School of Nursing.
• DBHS/Optum also coordinates and works closely with NAMI Utah and USARA in promoting and facilitating their services with our clients. DBHS is deeply rooted in the community with many allied partners. Through these partnerships, DBHS/Optum provide consultation to multiple agencies and providers in the community regarding shared clients and concerns. Staff have frequent opportunities to educate the public through all forms of media, community fairs, conferences, and other venues.

11) Services to Incarcerated Persons *Pam Bennett*

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider, and how you will coordinate with the jail to ensure service delivery is adequate. Include any planned changes in programming or funding.

Mental Health Services in Jail - The Salt Lake County Council, serving as the Local Mental Health Authority, appropriates funding annually for mental health services in the jail. This appropriation is made directly to, and managed by, the Salt Lake County Sheriff's Office.

The Salt Lake County Jail has two dedicated units that can address more severe mental health needs. One is a 17-bed unit for individuals who have been identified as high-risk for suicide, the other is a 48-bed unit for individuals with a mental health diagnosis that would benefit from not being with the general population.

The jail team provides mental health services, medication management, group therapy and crisis services for individuals in the general population. Jail mental health case managers coordinate services and releases for the severely mentally ill population, verify medications, obtain outside treatment records, conduct post-release planning, provide community resources, connect clients to in-reach services as available, and collaborate/communicate with community stakeholders such as community behavioral health providers,and the Legal Defenders Office social workers. Additionally, they participate in Mental Health Court staffings, Top 10 staffings, and the Metro Mental Health monthly roundtable. County appropriations fund medications, primary health care, and supportive services to persons in the jail who have serious mental illness. The Jail's healthcare services, including mental health services, have been awarded accreditation from the National Commission on Correctional Health Care (NCCHC).

This funding is not reported in our budget because the funding is allocated directly to the Jail from the County Council. DBHS has developed a strong partnership and relationship with our jail and has established a formal data sharing agreement. The jail has implemented their new electronic health record which allows them to better identify the individuals served in the jail and help with the transition of care for these individuals into the community. The jail is currently reporting collected data from the jail offender management system to DBHS for submission to DSAMH. There continues to be excellent collaboration with the jail and we will continue to collaborate with them on our Alternative to Incarceration programs (found in the Justice Services section).

State Competency Jail Restoration Program - This program is operated by the state, works to restore inmates to competency while awaiting a hospital bed, and works directly with the jail to coordinate and ensure delivery is adequate.

Community Response Team (CRT) – VBH
This VBH team works with SMI clients who are currently in jail, recent releases and also clients in the community who may be diverted from jail. CRT staff visit inmates prior to release to develop an APIC (Assess, Plan, Identify and Coordinate) Plan, a pre-release relationship with the inmate, assure medication continuity upon release, pre-determine eligibility for benefits and assist with transportation from the jail. The jail provides a list of SMI incarcerated individuals on a daily basis to this team.

The cost reflected on the MH budget report is the amount for the CRT case managers only. These case managers are not providing services that can be captured by SAMHIS.

Alternatives to Incarceration (ATI) Transport
This VBH program transports severely mentally ill inmates released from the jail at a specific time (avoiding nighttime releases) and transports them to a community-based treatment provider for assessment, continuity of medications and other services.

Social Services Position Housed in the Salt Lake Legal Defender Association's (LDA) Office
This position, funded through DBHS, connects individuals with SMI involved in the criminal justice system to community treatment, ATI Releases, referrals to Mental Health Court, etc. Additional social services positions are housed in the LDA's office, offering invaluable assistance in connecting large numbers of clients to treatment from the jail.

Top Ten - Once a month, DBHS facilitates a group that meets to staff frequently booked individuals with severe mental illness. Partners include the LDA, VBH, HMHI Crisis Programs, Jail Mental Health, DBHS, Optum, The Road Home, Volunteers of America, the SLC PD Community Connections Team, 4th Street Clinic, Criminal Justice Services, Division of Services for People with Disabilities (DSPD), and Odyssey House. Team goals are to:

- Ensure jail mental health is aware of an individual's diagnosis and medications prescribed in the community prior to arrest, and vice-versa, ensure community mental health programs are aware of an individual's diagnosis and medications prescribed in jail prior to release.
- Develop a pre-release relationship with the inmate prior to release whenever possible.
- Work to assertively engage the client in treatment upon release, address continuity of care/medications and transport if appropriate.
- Refer into appropriate programs (Mental Health Court, ACT Teams, dual-diagnosis residential programs, Jail Diversion Outreach Team, other outpatient services, DSPD services, housing, etc.).
- Communicate with the individual's attorney.
- Communicate with county supervising case managers, state AP&P officers or other private supervising agencies.
- Coordinate jail releases when appropriate.
- Support the client to resolve open court cases.
- Coordinate with medical providers when appropriate.
- Coordinate with other community providers (VA, private providers, etc.).
- Assist with housing, entitlements, and other needed supports.
- Address individuals as pre-contemplative rather than non-compliant when unable to engage them into services. That is, try, try again.

Additional IT support was provided through the Salt Lake County Mayor's Office of Criminal Justice

Initiatives, to provide real time information regarding bookings, charges, court cases, and other pertinent information.

Jail-based SUD services sometimes support the MH population. These would include:

Corrections Addictions Treatment Services (CATS) at Oxbow and Adult Detention Center Jails, South Salt Lake City: CATS is an addictions treatment therapeutic community based on an intensive outpatient level of care (9 - 19) hours per week of therapeutic and skill-based treatment services based on the therapeutic community model.

The program is operated within both the ADC and Oxbow Jails. The capacity for males is 152 beds (Oxbow) and 32 beds for females (ADC) based on an average length of stay of 3 months. The CATS program is also a direct referring partner for the Vivitrol Program and Salt Lake County Behavioral Health Services' housing programming. Upon completion of the CATS program, all inmates are eligible to apply for TAM Medicaid and be provided with a clinical referral into a county approved agency.

Currently, CATS includes a psycho-educational component (Prime for Life) for up to 1,500 inmates, plus a fuller continuum of treatment services with the inclusion of interim group services called Drug Offender Group Services (DOGS). The CATS, DOGS and Prime for Life programs are contracted through Odyssey House.

3 Year Plan:
Odyssey House is exploring a possible expansion of services into the Medium Security levels within the Salt Lake County jail, pending jail approval.

The DBHS Vivitrol program, which began as a pilot program in FY15 to provide Vivitrol to individuals leaving the CATS Program in the Jail, and into the community, continues to serve clients inside the Jail, as well as those engaging in SUD treatment, clients working towards treatment engagement, or those continuing services in the community. DBHS partners with the SLCo Jail Medical Team, Midtown Community Health Center, the Martindale Clinic, Utah Partners for Health, and the Utah Department of Corrections. Any Salt Lake County resident who meets income qualifications and is engaged in SUD treatment or continuing care services, as well as those working with case management teams with a goal of accessing ongoing treatment, are eligible to participate in the Vivitrol program. Our criminal justice partners, including CATS in the jail, the Department of Corrections Treatment Resource Centers (TRCs) and halfway houses, and Intensive Supervision Probation, constitute the bulk of our referrals. Those who attend regular case management appointments and remain engaged in treatment are eligible to receive monthly Vivitrol treatment at no additional charge to the client as long as they continue to meet income qualifications.

In 2019, federal grant dollars allowed for an expansion of MAT services in the jail. Qualifying program participants with an opioid or alcohol use disorder have access to MAT, SUD behavioral therapies, and coordinated referrals to community treatment services upon release. MAT Program medications may include methadone, buprenorphine or Naltrexone (Vivitrol). The MAT program provides a whole-patient approach to the treatment of substance use disorders and is clinically-driven with a focus on individualized patient care. Services are provided through the jail's health services staff and through a contract with Project Reality.

Qualifying participants have an opioid or alcohol use disorder and may include: individuals enrolled in an OTP in the community when booked; individuals undergoing supervised withdrawal; pregnant women; and individuals in the Naltrexone (Vivitrol) program. Admission guidelines are periodically reviewed and considered in an effort to cover additional populations with DBHS approval and as budgets allow. In FY22, the program was granted temporary approval to provide psychosocial

assessment and therapy absent medication, and at times medication absent therapy based on the ongoing struggle in maintaining licensed medical and behavioral health staff. Individuals with longer sentences or sentenced to prison are reviewed for taper of their medication.

Additionally, program participants identified as having an OUD are given information and education regarding the use of the Naloxone rescue kit, and an actual kit as supplies are available. Once supplies are exhausted, information and education regarding the use of the Naloxone rescue kit will be given, including where the client can obtain the kit.

Describe how clients are identified for services while incarcerated. How is the effectiveness of the services measured?

Mental health services receive referrals/requests from jail staff nurses and sworn staff (primarily), but all jail staff are able to refer a patient to mental health staff if they have concerns. A therapist will then assess the patient and provide services/referrals to a case management/psych provider for med management/therapy as clinically indicated. Assessments/interventions and the patient's response to treatment are documented.

Additionally, each unit is assigned a Pod therapist, who triages inmates daily. The therapist will ask the patient to complete a Sick Call Request. The therapist will respond to the request. A case manager will also meet to complete a Release of Information (ROI) for medication verification or clinical assessments. Other identification may come from community partners such as the Legal Defenders Office, Community Mental Health Centers, etc.

Additional clients are identified through behavioral health providers reaching out to the jail to facilitate continuity of care; through the jail reaching out to behavioral health providers in the community to gather information; through a monthly Top Ten Staffing; through communications with the 4th Street Clinic; LDA; Mental Health Court; Optum; Criminal Justice Services; and other stakeholders.

Peer reviews are completed as a means to validate the care they prescribe, patient feedback and CQI study information.

Describe the process used to engage clients who are transitioning out of incarceration.

Jail mental health case managers coordinate services and releases for the severely mentally ill population, verify medications, conduct post-release planning, provide community resources, connect clients to in-reach services as available, and collaborate/communicate with community stakeholders such as community behavioral health providers,and the Legal Defenders Office social workers. Additionally, they participate in Mental Health Court staffings, Top 10 staffings, and the Metro Mental Health monthly roundtable. Discharge planners also coordinate with the programs mentioned above, such as CRT, ATI Transport.

In addition to these, there are a number of other programs that work to engage inmates transitioning out of incarceration. Examples are release plans coordinated through Drug Courts, Mental Health Courts, CATS, Fourth Street Clinic, the Intensive Supervision Probation Program, and other providers.

In addition, the Jail MAT program coordinates connections to treatment providers upon release for clients involved in their programming. Staff have access to the UWITS electronic health record (for coordination with agencies utilizing the same health record) to assist them in coordination, and have

relationships with OTPs and other treatment providers outside of the Salt Lake County network. MH clients with a co-occurring SUD condition are sometimes served in this program.

Last, the Jail Resource Reentry Program is cited at the jail. It is voluntary and offers support to individuals as they transition back into the community to avoid recidivism and provide services to prevent them returning to the same circumstances that led to their arrest, helping to make the community safer. Salt Lake County Criminal Justice Services, the Salt Lake Legal Defenders Association and Valley Behavioral Health assist individuals to assist them in navigating the complexity of criminal justice and social services systems. Clients receive have access to email, phone calls and free Wi-Fi; phone charging stations; snacks, water, female personal hygiene products; SNAP/Medicaid enrollment; Department of Workforce Services (DWS) information; a safe place to wait for services; transport options (bus tokens, VOA van service, homeless van services); homeless housing referrals; donated clothing items are available on-site.

12) Outplacement

Adult Services ***Pam Bennett***

Describe the activities you propose to undertake over the three year period with outplacement funding, and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

DBHS/Optum provides one Clinical Care Coordinator and a Housing Support Specialist who are assigned full-time as a State Hospital Liaison to work directly with the Utah State Hospital (USH) teams to proactively facilitate and coordinate plans for consumers coming out of the USH. They are assisted by the Optum State Hospital Committee and the Optum Clinical Team as needed.

DBHS/Optum will continue to assist with independent living placements that offer wraparound supports such as an ACT Team. Housing options include but are not limited to: VBH housing; master lease units; Denver Apartments; programs which offer meals and supervision such as Nephi Todd's, Sunstone and Jasper (operated by Odyssey House) and Oasis; Fisher House and the Central City Apartments, both operated by First Step House.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake over the three year period with outplacement funding, and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

The Children's Outplacement Program (COP) and funding are managed by DBHS/Optum in a cooperative manner. DBHS/Optum staff sit on the Children's Continuity of Care committee. DBHS/Optum recommends children for consideration of State COPs assistance and recommends an appropriate array of services. Approved treatment services will be provided through the DBHS/Optum provider network. Approved ancillary services, such as mileage reimbursement, karate classes, therapeutic recreational activities, and those services provided for clients who are not funded by Medicaid will be paid for and/or provided to the client directly by DBHS.

The Optum representative meets with the Children's Continuity of Care meeting monthly at the Utah

State Hospital to present the requests for funding to get approval from the committee. Also, the Optum representative can ask for emergency outplacement funding approval from DBHS for cases that cannot wait for the monthly committee approval.

13) Unfunded Clients

Adult Services ***Pam Bennett***

Describe the activities you propose to undertake over the three year period and identify specific populations where services are and are not provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

The funding for the County's uninsured mental health clients is extremely limited and therefore Salt Lake County carefully prioritizes the funding to the below programs.

The Utah Department of Health (UDOH) subcontracts with four different organizations: AAU, Catholic Community Services, International Rescue Committee, and Utah Health and Human Rights to provide mental health services for refugees. These services include: the administration of the Refugee Health Screener (RHS-15) mental health screening tool; outreach and education to refugee health stakeholders about the mental health needs of refugees; outreach and education to refugee communities about mental health and available services; crisis services; and group therapy using traditional and non-traditional evidence-based methods. This interlocal agreement between DBHS and Health and Human Services (DHHS) was renewed in FY23.

Volunteers of America, Utah, operates the Homeless Mental Health Outreach Program centered at the main Salt Lake City Library on 400 South and 200 East. VOA staff members offer behavioral health support to patrons who request assistance. A housing and benefits coordinator is also available weekly to assist patrons. These services are optional and client centered/client directed. In addition, our team members offer training to library staff in understanding and responding appropriately to people with mental illness. Training is also available to other area libraries upon request. Outreach around the libraries has continued from that location as well. The team continues to have regular communication with library staff and responds to issues and questions that arise. In late FY22, VOA rebid for these services and was awarded a new treatment contract entering FY23. Additionally, VOA was awarded treatment funds for supported employment (see section 15, Client Employment) to operate their IPS program.

VBH provides direct services to a number of adult populations with the funds they receive. First, VBH provides adult mental health services in three different locations. Several of the programs are open in the evenings and weekends to further reduce schedule-related barriers for accessing services. Second, persons who are on community civil commitment have access to VBH's full continuum of adult, youth, and children's programs, services, and locations. Additionally, with the conversion of the AOT to a full fidelity ACT team described in 13), VBH can also enroll a limited number of unfunded individuals in ACT. These funds were awarded again to VBH during the treatment rebid, with services

funded beginning in FY23. In coordination with the Salt Lake County Division of Aging & Adult Services, VBH provides counseling at senior centers throughout the county. VBH was also awarded a a small portion of the unfunded mental health funds beginning in FY23 to address supported employment programs. Finally, VBH was awarded unfunded mental health funds to support uninsured clients in the
CORE residential treatment programs and any associated outpatient treatment.

First Step House also bid for unfunded mental health treatment funds and was awarded a contract beginning in FY23 to support their IPS supported employment program. See section 28) Client Employment for more information. They also received funding for case management for the SwitchPoint Program.

Odyssey House also bid for unfunded mental health treatment funds, and was awarded funding to support their residential mental health programs (two 16-bed facilities, one for SMI males, and the other for SMI females), and associated outpatient services for unfunded mental health clients beginning in FY23. Odyssey House also received unfunded mental health funding to support their Forensic ACT Team clients beginning in FY23.

Each agency with an ACT team applied for, and received, funding to supplement their ACT teams for the new contract cycle which began July 1, 2022. This funding extends the term of the contract and is intended to be used for individuals who do not qualify for Medicaid, and/or those who transition out of ACT and need continued assistance with treatment funding. Additionally, it can assist with expenses which Medicaid does not pay for, including housing support.

Civil Commitments: The County is responsible for the civil commitment court, and specifically, DBHS is responsible for the required sanity assessments by licensed professionals and various administrative costs to host the court at HMHI. These services are entirely funded with the County General Fund.

Please see section 20 for a description of the Unified Police Department (UPD) Mental Health Unit.

HMHI provides crisis services for Salt Lake County. These services are described under section 4.

Describe agency efforts to help unfunded adults become funded and address barriers to maintaining funding coverage.

Efforts to assist the uninsured population occur through a coordinated and concerted effort to enroll in Medicaid, CHIP, Marketplace Plans and Medicare.

Long before the expansions of Medicaid, DBHS began funding a Department of Workforce Services (DWS) Medicaid eligibility specialist, drawing down federal dollars as a match to assist DBHS' network of providers with enrollment into Medicaid. This effort included one FTE roaming between the jail, the provider network, and multiple Third District Court locations. During the pandemic, this assistance became remote. DWS awaits notification from Criminal Justice Services as to when the court will allow stakeholders to return to the courtroom setting. Additional DWS assistance is housed in one of the network's largest providers, Valley Behavioral Health (VBH).

Education, training and connections to Take Care Utah were made to the provider network beginning in 2014, as Marketplace Plans became an option to households earning more than 100% FPL. DBHS leadership also approached judges in the Third District Court to gain their permission to provide

enrollment space and internet access to Take Care Utah staff to assist with enrollment into Medicaid, Marketplace Plans and Medicare. The court was not amenable to this option at that time, but in 2017, with the advent of Targeted Adult Medicaid (TAM), embraced the idea. DBHS also approached the jail in considering a partnership with Take Care Utah during these early years. It was embraced in later years as you will see below. Multiple meetings were held with Take Care Utah sharing with them the touchpoints both within the DBHS network and the criminal justice system, to expand enrollment efforts. Throughout the years, more than 250 presentations were made by DBHS explaining the importance of expanding Medicaid, options through the Marketplace, and highlighted Take Care Utah and DWS Medicaid eligibility specialists (utilizing federal matching dollars). Presentations were also provided to organizations outside our network, to such agencies as UBHC, UAC, NACO and NACBHDD to promote enrollment throughout Utah and other states.

Numerous specialty enrollment efforts were initiated as TAM opened in November of 2017. This included but was not limited to collaborations with DWS and Take Care Utah to enroll in Drug Court and Mental Health Court settings; the expanded jail medication-assisted treatment (MAT) program; the Corrections Addiction Treatment Services (CATS) program; Legal Defender Association's (LDA) Office; and Criminal Justice Services (CJS). Some of this assistance became remote later on during the Pandemic.

Training was also held at DBHS with Adult Probation and Parole (AP&P) to assist them in their enrollment efforts (both upon release from prison and also in halfway houses), along with introductions to Take Care Utah, which later led to partnerships there.

In addition to specialty enrollment efforts put in place during the TAM expansion, two large eligibility and enrollment trainings were held by DBHS at the County Government Center to assist case managers within the county network of providers. Approximately 213 individuals from 20 organizations across the county registered or walked into these training sessions. The Utah Department of Health presented on the eligibility criteria, the Utah Department of Workforce Services presented on enrollment guidelines, and additional resources such as Take Care Utah were presented as options for clients as they transition from Medicaid into Marketplace Plans. Providers such as VOA eventually partnered directly with Take Care Utah (efforts expanded greatly once social detox became a Medicaid benefit).

While some of these efforts originate in adult populations, they often extend to household members (including children) as individuals begin the enrollment assistance process and request assistance for additional household members (for example, while attending an intake at Criminal Justice Services). Research has shown that Medicaid Expansion states have increased Medicaid enrollment for children. It is believed that as adults become aware of their eligibility, they pursue Medicaid enrollment assistance for children in the household as well. More specific enrollment assistance efforts for children and youth can be found in parts of the Area Plan where this is requested.

Additional presentations were made to the provider network as the state expanded to 100% FPL in April of 2019, and again as the state fully expanded to 138% FPL on January 1, 2020, to encourage and support enrollment in these new households.

DBHS has been planning for these enrollment touchpoints and educating providers since 2014 (the year Medicaid Expansion became an option for states), and saw the provider system respond quickly and nimbly with each new expansion.

Additionally, in 2020 outreach was made to Take Care Utah to advise them of legislative changes that would enable them to submit applications prior to release from jail (due to Utah becoming a suspension, rather than a termination state).

Enrollment assistance planning was also provided to other local authorities when they requested it.

To address COVID-19 responses and to reduce the spread of infection, DBHS worked with the State Medicaid Office to distribute PDF fillable forms for the TAM referral process, allowing the use of electronic signatures for those telecommuting [later sharing these statewide with Local Authority (LA) Directors].

Although some components of these enrollment efforts were curtailed due to COVID-19, such as in-court enrollment assistance, stakeholders will be working to resume them as soon as restrictions allow. For example, Criminal Justice Services Drug Court personnel stated they will notify us when stakeholders are allowed to return to court for this purpose. Providers were also immediately notified when the new administration opened up a new special enrollment period, and expanded eligibility to new populations, such as those who have received unemployment or those above 400% FPL.

In addition, in 2019, DBHS began working with the State Medicaid Office, the four Accountable Care Organizations (ACOs), and the Local Authorities from Weber, Davis, Utah and Washington Counties to support an integrated benefit for the Adult Medicaid Expansion Population. Numerous meetings were held with these stakeholders, and later with the Salt Lake County Provider Network. Through these meetings, the ACOs agreed to contract with the Salt Lake County essential provider network. As the integration effort neared implementation on January 1, 2020, we engaged our provider network with the ACOs to facilitate agreement on many of the needed next steps: guidelines for utilization management; billing requirements; and coordination of county funded services not covered by Medicaid. Since implementation, DBHS has worked diligently to support resolution of concerns identified by the provider network as they arise, and look forward to a successful integrated benefit. DBHS recognizes that an integrated physical and behavioral health benefit is in the best interest of the residents we serve.

Barriers to maintaining coverage:
One of the challenges to maintaining coverage can be seen as individuals transition between the various forms of Medicaid (due to the expansion of Medicaid). Real life examples include:

- Changes income (getting or losing a job)
- Changes in household size (gaining or losing custody of a child, marriage, divorce, etc.)
- Pregnant women giving birth, etc.

Fortunately, these challenges are often born by providers, and they have proven nimble to assist clients in maintaining coverage and switching payment streams on the backend, hopefully in a seamless way that is not stressful to clients.

In the fall of 2022, DBHS began assisting the Road Home's Homeless Resource Centers (HRCs) in developing collaborations with Take Care Utah to enroll clients in Medicaid or other health plans. Volunteers of America (VOA) HRC already had a process in place.

Today, Take Care Utah works in some capacity with around 100 organizations and sources of clients, many of which are individuals with behavioral health conditions. They enroll clients from many of these partner agencies, but the specific process takes different forms. At the jails and prison, for example, they are at multiple sites on a weekly basis. Others are less frequent. With others they have arranged a referral process so they get spreadsheets of uninsured folks from various organizations to do follow-up. They meet both in person and remotely depending on what works best for their partners.

During the Public Health Emergency (PHE), individuals were not allowed to be removed from Medicaid unless they moved out of state, requested to be removed, or passed away. Due to this temporary status, although some individuals could be sorted into different Medicaid plans as appropriate, they were not removed. Continuous enrollment has since been discontinued as a requirement of the PHE. As such, DWS began case reviews on March 1st, 2023, and are expecting the first case closures or

transfers to other Medicaid or Marketplace plans to initiate on April 30th, 2023. This effort is being referred to as the “unwinding”.

DBHS has been proactive during the preceding months, encouraging providers to assist clients in keeping their addresses current with DWS, responding to DWS inquiries, and to assist clients with any bumps along the way.

DBHS also hosted the State Medicaid Office (SMO) at one of their monthly provider meetings, to provide education on the “unwinding” and answer any questions they had.

Additionally, Optum and DBHS are working with their provider network to match a list provided by the SMO, with clients receiving services through them, to support individuals in remaining enrolled when possible, and to connect clients to Take Care Utah when needed, to assist with Marketplace Plan enrollment.

Additional ongoing training will be held during future monthly provider network meetings. DWS and the State Medicaid Office state they will also be working to transition clients no longer eligible into other Medicaid options or Marketplace Plans as able.

DBHS has also assisted in educating other local authorities on the unwinding and the need to assist clients.

Children's Services ***Leah Colburn***

Describe the activities you propose to undertake over the three year period and identify specific populations where services are and are not provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

The funding for the County's uninsured clients is extremely limited and therefore Salt Lake County carefully prioritizes the funding to the below programs.
Salt Lake County has prioritized anticipated funding as follows:

- Medication management
- Psychotherapy services
- Case management
- Skills development

The Utah Department of Health and Human Services (DHHS) subcontracts with four different organizations: the Refugee and Immigrant Center at Asian Association of Utah, Catholic Community Services, International Rescue Committee, and Utah Health and Human Rights to provide mental health services for refugees living in Salt Lake County. These services will include: the administration of the Refugee Health Screener (RHS-15) mental health screening tool; outreach and education to refugee health stakeholders about the mental health needs of refugees; outreach and education to refugee communities about mental health and available services; crisis services; and group therapy using traditional and non-traditional evidence-based methods.

Salt Lake County Division of Youth Services (DYS) provides direct services to individuals and their families. This may be in the form of individual or family therapy. Children and parents learn new skills to help process thoughts and feelings related to life events; manage and resolve distressing thoughts, feelings, and behaviors; and, enhance safety, growth, parenting skills, and family communication. DYS

incorporates Trauma-Focused Cognitive Behavioral Therapy if the client and/or family have been assessed as having traumatic life events.

DYS Afterschool Programs: Afterschool and summer Programs focusing on academic and enrichment support are offered at the following schools: Cyprus High School, Kearns Kennedy and Matheson Jr. Highs, South Kearns, Copper Hills, Magna, Pleasant Green, Millcreek, David Gourley and West Kearns Elementary Schools. Community School Coordinators are available to help connect families to resources at Kearns Jr.

On average 300 youth are served daily in the DYS after school programs. These services are not reflected in our budget.

Additionally, DYS Prevention provides programs to prevent or delay the onset of youth substance use by addressing local, data-informed risk and protective factors. DYS Prevention offers two programs for parents and three programs for youth. Guiding Good Choices and Staying Connected with Your Teen offer parents an opportunity to reduce the risk factors associated with teenage drug use and improve communication with their teens to strengthen family bonds. Mood Enhancement (ME) Time provides youth experiencing mild depressive symptoms with skills to manage their emotions and improve habitual thinking patterns and participation in enjoyable activities. The Body Project is a four-session group-based intervention that provides a forum for girls ages 15 and up to confront unrealistic appearance ideals and develop healthy body image and self-esteem. It has been shown to effectively reduce body dissatisfaction, negative mood, unhealthy dieting, and disordered eating. DYS also offers these four programs online and at various schools and community locations throughout Salt Lake County. However, DYS also offers these four programs at various schools and community locations throughout Salt Lake County. There are new classes for each program starting every month. Positive Action takes place at Matheson JHS and Cyprus HS in Magna alongside the Afterschool Program.

VBH provides direct services to three children/youth populations with the funds they receive. First, VBH provides direct services to uninsured youth/children's mental health in two locations. Second, VBH will be providing direct services to uninsured youth/children with substance use disorder in two locations.

Describe agency efforts to help unfunded youth and families become funded and address barriers to maintaining funding coverage.

Please see 13) Unfunded Clients - Adult Services, describing efforts to help unfunded adult clients become funded and address barriers as the efforts are highly similar, in Salt Lake County behavioral health services are delivered through a network model. Below are examples from seven providers of children's services, detailing the process that occurs within their programs to enroll children in Medicaid and other health plans.

The Children's Center Utah - Therapists refer parents to the Intake Coordinator for assistance with enrollment into Medicaid/CHIP. If children do not qualify for Medicaid the program works to find other resources to help with expenses. In cases where they do qualify, the Intake Coordinator has offered to fill out the application side-by-side with parents, but they most often choose to apply on their own through the website portal (very few choose actual paper applications to mail or fax in).

Valley Behavioral Health (VBH) – at ValleyWest, most children are already on Medicaid. In any of the programs (outpatient or day treatment), if a child loses or does not have Medicaid, they work with the VBH Medicaid Outreach Team to get their Medicaid instated or restored. Part of this team is a DBHS funded DWS Medicaid Eligibility Specialist. DBHS has also provided VBH information on partnering options with Take Care Utah to assist families if they wage out of Medicaid and require assistance enrolling in a Marketplace Plan.

Salt Lake County Youth Services – all clients complete a Medicaid eligibility questionnaire. Once the form is completed, and if the client is willing to apply for Medicaid, the client is then connected to the DWS Medicaid Eligibility Specialist funded and sited in DBHS. DBHS has provided updated information on the newly eligible populations (in case they are also able to assist in referring adult family members).

Primary Children's Safe and Healthy Families – this program is a specialty clinic at Primary Children's Hospital for pediatric victims of child abuse and other traumas. If a patient does not have insurance, they help connect them to the hospital's eligibility department, and also connect individuals to Take Care Utah as appropriate.

Odyssey House - during the admission process to Odyssey House, they screen all clients for Medicaid and complete enrollment paperwork for adults and children at that time. When Odyssey House has children join them in residence with their parents, they once again screen for eligibility and complete enrollment. In their youth outpatient programming, they screen at admission and monthly thereafter and support the family in applying for Medicaid when eligible.

Family Support Center – at the Life Start Village (LSV), many of the residents have come from substance use disorder treatment, and therefore their children have been enrolled. However, the director over LSV is vigilant in making sure the residents are able to receive all the services they qualify for. The clinical department also does not see many children who are not already enrolled if they qualify for Medicaid. In the rare cases that happens, they are connected to DWS to enroll. DBHS has provided education on additional resources through Take Care Utah, where enrollment assistance can be provided free of charge for Medicaid, CHIP, Medicare, and Marketplace Plans as a parent becomes employed and no longer eligible for Medicaid.

Project Connection – This program has found many children removed from private insurance due to job loss from COVID-19. They have also had many children, both in their outpatient clinic and in their school program who were private pay due to being unfunded or underfunded. They have mobilized their staff to check in with families and have provided steps to apply and enroll in Medicaid due to these issues. This is their standard process, but it has heightened due to recent circumstances.

14) First Episode Psychosis (FEP) Services ***Jessica Makin***

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

Volunteers of America offers First Episode Psychosis services in the form of a PREP (Prevention and Recovery from Early Psychosis) Team. This team is based on the CSC PREP treatment model and includes information from SAMHSA and EASA guidelines. Although housed at Cornerstone Counseling

Center, the team is mobile to flexibly meet the needs of clients in the community. PREP is a specialty care treatment model to provide services for individuals experiencing their first episode of psychosis. The five key areas of focus are case management, psychiatric medication, psychotherapy, family education/support and supported employment/ education. All services are provided directly by the VOA team. In addition this team will provide services to clients who are clinically at high risk for psychosis.
Describe how clients are identified for FEP services. How is the effectiveness of the services measured?
Clients will be identified through a broad range of community partnerships and referrals. Special care will be taken to ensure hospital systems, mental health care systems, schools, legal systems etc. have awareness and information about the new PREP team in Salt Lake County. A referral sheet will be accompanied by a completed PRIME screening and if the client is deemed appropriate, a SIPS (Structured Interview for Psychosis-risk Syndromes) assessment will follow. If the client is not deemed appropriate for PREP the client will be referred to a more appropriate treatment. FEP's effectiveness is measured using a state created quarterly assessment tool entitled Qualtrics Survey Software. In addition, VOA relies on ongoing assessment and client feedback.
Describe plans to ensure sustainability of FEP services. This includes: financial sustainability plans(e.g. billing and making changes to CMS to support billing) and sustainable practices to ensure fidelity to the CSC PREP treatment model. Describe process for tracking treatment outcomes. Technical assistance is available through Jessica Makin at jmakin@utah.gov
Special care will be taken to establish policies early in the program that strive to ensure fidelity based on the CSC PREP treatment model. Yearly fidelity measures will be scored and discussed with OSUMH. Financial sustainability will be addressed as we work to ensure that each client can obtain appropriate funding. Each encounter will then be billed. This will allow for steady payment to support the continuation of the program once grant funding decreases.

15) Client Employment

Sharon Cook

Increasing evidence exists to support the claim that competitive, integrated and meaningful employment is an essential part of the recovery process and is a key factor in supporting mental wellness. In the following spaces, please describe your efforts to increase client employment in accordance with Employment First 62A-15-105.2. Include any planned changes in programming or funding.
Competitive, integrated and meaningful employment in the community (including both adults and transition-aged youth).
Each ACT team has a Vocational Rehabilitation Specialist as part of the multidisciplinary team that works with clients to focus on education and employment goals. The Voc Rehab Specialist and the Team assists the client with resume building, interviewing skills, and employer engagement. The Voc Rehab Specialist conducts occupational assessments, and as the clients are progressing in their recovery, focuses more on employment goals. DBHS continues to partner with VOA on their Employment Services Program implemented to fidelity (utilizing the IPS model). In August of 2019, VOA received “Exemplary” fidelity for the program. Since the inception of the program, VOA has served 500 participants with 30% of the individuals maintaining continuous employment for 90 days or more. Additionally, 32% of the job starts have moved out of the

Employment Services Program and no longer receive services due to successful employment. In FY22, VOA bid for and was awarded DBHS contract funds to cover operations for this program beginning in FY23.

Alliance House continues to implement Individual Placements and Supports (IPS) with the support of the Division of Substance Use and Mental Health to pay for one staff salary and half of a supervisor's salary. Alliance House just recently went through our first fidelity review for IPS.
Alliance House has 10 members in IPS/Supported Employment. Alliance House has been able to reopen all of our Transitional Employment sites (many closed due to COVID), 14 members are employed part-time in Transitional Employment. Alliance House continues our partnership with the other sites and hopes to have more open during FY23. For FY22, 97 members were employed. In FY23, Alliance House has assisted 45 members in obtaining supported employment.

Referrals to Alliance House have increased with prospective members who are interested in employment. Alliance House currently provides education and employment dinners where members and staff can celebrate successful employment. These are held once a month.

First Step House also developed an Employment Services Program using the IPS Model. Launched in 2018, this program has connected with hundreds of businesses, partners, and potential employers in Salt Lake County. In the first quarter of FY23, FSH served 63 individuals. First Step House Employment Services Program actually targets primarily SUD clients in need of supported employment services, many of which are co-occurring mental health clients as well. During FY22, DBHS assisted in closing the funding gap between Medicaid billable services and the cost to operate the FSH program. FSH was awarded a service contract for FY23 with DBHS to cover operational costs.

The referral process for employment services and how clients who are referred to receive employment services are identified.

The ACT program evaluates a member's level of interest in participating in employment, volunteering, and/or education. The plan for the member is member driven and the Voc Rehab Specialist designed a plan that addresses the member's goals in this area.

The IPS programs are embedded in treatment facilities. As a part of the intake process, the client is asked their level of interest in seeking employment. Regardless of their progress in MH or SUD treatment, the employment specialists will work with the client to help them achieve their employment goal.

Collaborative employment efforts involving other community partners.

DBHS/Optum supports and collaborates with Utah State Division of Substance Abuse and Mental Health in the Peer Support Certification area and provided the CPSS training to community partners, including employees of USARA, VBH, and Odyssey House.

Employment of people with lived experience as staff through the Local Authority or subcontractors.

DBHS/Optum contracts directly with Alliance House, an International Accredited Clubhouse model program, in Salt Lake City to provide skills development programs for adults. The Alliance House's

objective is to help severely mentally ill individuals gain or recapture the ability to function in the community through meaningful work. The clubhouse incorporates several different work units, which are important in the maintenance of the clubhouse. Participation in these units gives members an opportunity to develop skills that foster their recovery and ultimately their reintegration into the community at large. The major focus of the program is transitional employment placements. The education unit has helped members obtain GEDs or high school diplomas, college education skills and support, and increased life skills. Though not all Alliance House members will go on to be employed as staff for a behavioral health provider, the Alliance House does prepare them to be able to work within the behavioral health system should they have this interest. It is anticipated that DBHS/Optum will continue to work with Alliance House moving forward.

Another important mechanism for employment of consumers as staff in Salt Lake County is the State of Utah Certified Peer Support Specialist (CPSS) program.

It is anticipated that during FY24, the use of CPSS will continue to be encouraged with our providers by offering presentations showing the benefits of including CPSS as part of an agency multidisciplinary team.

Evidence-Based Supported Employment.

See Alliance House above. Additionally, Alliance House works directly with DSAMH. Alliance House is implementing the IPS model and plans to meet fidelity in the next year. Clubhouse is an evidenced based model of rehabilitation. One section of Alliance House's standards is directly focused on employment. Alliance House has received full accreditation from Clubhouse International for meeting these standards. Goals which are currently being worked on include:

- 1805 Capital Campaign- demolishing their 9 unit housing property and rebuilding it to 16 units. These are deeply affordable housing for their members living in or at risk of homelessness.
- Average Daily Attendance- Increase average daily attendance. Currently a large percentage of their members are employed, preventing them from participating daily. They will partner with community referral streams to increase new referrals and new members in the Clubhouse.
- Staff retention- The board has approved performance based raises as well as an increase in starting wage to make their organization more competitive to individuals working in the mental health field.

Please note that Alliance House is scheduled to re-visit, update, and continue the strategic plan starting July 11, 2023.

DBHS continues to partner with VOA on their Employment Services Program implemented to fidelity (utilizing the IPS model). In August of 2019, VOA received "Exemplary" fidelity for the program. Since the inception of the program, VOA has served 500 participants with 30% of the individuals maintaining continuous employment for 90 days or more. Additionally, 32% of the job starts have moved out of the Employment Services Program and no longer receive services due to successful employment. In FY22, VOA bid for and was awarded DBHS contract funds to cover operations for this program beginning in FY23.

First Step House also developed an Employment Services Program using the IPS Model. Launched in 2018, this program has connected with hundreds of businesses, partners, and potential employers in Salt Lake County.. In FY22, FSH served 96 participants and 69% were employed within six months of receiving services.. Unique to this program, the First Step House Employment Services Program targets primarily SUD clients in need of supported employment services, many of which suffer from

co-occurring mental health disorders. During FY22, DBHS assisted in closing the funding gap between Medicaid billable services and the cost to operate the FSH program. FSH was awarded a service contract for FY23 with DBHS to cover operational costs.

16) Quality & Access Improvements

Identify process improvement activities over the next three years. Include any planned changes in programming or funding.

Please describe policies for improving cultural responsiveness across agency staff and in services, including "Eliminating Health Disparity Strategic Plan" goals with progress. Include efforts to document cultural background and linguistic preferences, incorporate cultural practice into treatment plans and service delivery, and the provision of services in preferred language (bilingual therapist or interpreter).

- See attached Quality and Improvements - VBH SLCo – Eliminating Health Disparities Goals and Action Plan
- See attached Quality and Improvements - Optum Cultural Responsiveness Plan

Service Capacity: Systemic approaches to increase access in programs for clients, workforce recruitment and retention, Medicaid and Non-Medicaid funded individuals, client flow through programming. Please describe how the end of the Public Health Emergency and subsequent unwinding is expected to impact the agency's services and funding.

Optum will continue to make referrals to the current ACT teams. Plans are being made to open a residential treatment facility for youth, another residential treatment program for males with MH, SUD and criminal justice issues and a subacute program for adults. Optum Bank and Optum Behavioral Health Services are working with different providers in SLCo to add housing for those meeting SMI criteria. Provider network expansion and retention will continue, even if the enrollment decreases due to the unwinding.

The services will not be impacted, other than providers will no longer be allowed to conduct therapy over the phone. Our Medicaid funding is expected to drop, since the dollars are paid per member. However, it is too early in the unwinding process to know the impact. Every effort is being made, working with State DHHS, to ensure Medicaid funding is sufficient to continue growing ACT census to match growing needs.

For those clients not funded by Medicaid, whether historically or due to the "unwinding", if they are already in treatment there should be no disruption to their treatment services. If they lose Medicaid and meet income and residency requirements, they will be put on Block Grant funding fairly seamlessly. However, for those who are not currently in treatment and need services who do not have Medicaid, regardless of the reason, DBHS will have to evaluate the capacity we have to serve balanced against how many additional people no longer have Medicaid and are in need of treatment financial support via the Block Grant funding. It is too early in the "unwinding" process to give any type of estimates, or even if the need will substantially increase.

The expansions of Medicaid in 2017 – 2020, brought an unprecedented opportunity to expand mental health and substance use disorder services for individuals suffering from behavioral health conditions. In Salt Lake County, this opportunity more than tripled the capacity of some services and led to "openings as needed" rather than long wait lists in certain areas such as residential treatment in substance use disorder (SUD) settings.

While the advent of these expansions was incredibly exciting, providing a payor for all those who fall under 133%FPL (and are documented), a new bottleneck emerged statewide, in the form of workforce capacity, that will take years to resolve.

Marry that with the severe impacts of COVID-19 beginning in 2020, we now find ourselves in a workforce crisis. Some providers have buildings and/or beds available for our residents with funding streams identified, but they go unused due to the lack of staff to serve these clients.

Due to COVID-19, providers had been seeing a lack of court referrals and admissions directly from the jail. While these numbers have improved to nearly pre-pandemic levels, they are still seeing an increase in admissions from hospitals, the streets, and shelters. These individuals require medical and medication stabilization, are often in acute withdrawal, etc., whereas individuals coming from the jail are generally more stable.

Although the shortfall in workforce capacity was identified and highlighted with stakeholders early on by Salt Lake County, and aggressive actions taken, the gap in the behavioral health workforce was too great to solve on its own. Thanks to advocacy from the Utah Substance Use and Mental Health Advisory Council and other stakeholders, numerous legislative actions have contributed to addressing this problem, yet substantial gaps still exist, as evidenced by the Utah State Hospital closing beds in 2022. The 2023 general session addressed this problem in a myriad of ways, including but not limited to, an increase in 175 university slots for those in the behavioral health field, and funding for the Workforce Loan Repayment Program (with approved sites matching 20% of the award). Additionally, rate increases were passed for social detox, 5 community mental health codes, and for the administration of methadone.

Statewide funding was also appropriated for additional Mobile Crisis Outreach Teams, Assertive Community Treatment Teams, and jail medication assisted treatment programs (in counties able to provide matching funds through Opioid Settlement dollars).

The passage of HB 32 during the 2020 general session, allowed for counties to apply for funding to develop and implement Receiving Centers. DBHS was awarded funding for a new non-refusal Receiving Center. SLCo transferred the property, and thanks to the Huntsman Mental Health Institute (HMHI) and additional partners and funding, a groundbreaking occurred May 2021. This program will serve Salt Lake County community members who are in psychiatric or substance use-related crisis; however, the new Receiving Center will accept any and all individuals including walk-ins, secure drop-offs, and referrals for assessment. As a non-refusal RC for police, firefighters, and EMS, many of these individuals will be low-level offenders cycling through the county jail, whose crimes are secondary to untreated or undertreated mental illness or substance use disorders. Others may be frequent patients in emergency departments throughout the Salt Lake Valley. These individuals will benefit from medical and psychiatric triage, clinical assessment, peer support, discharge planning, connection to community resources and partners, and referral to treatment programs such as inpatient care, medical care, and detox. Due to this facility not becoming operational until 2025, the Salt Lake County Council voted to dedicate $2.5M (ARPA funding) towards a temporary RC to act as a bridge until the new RC is built and operational. It will be a non-refusal center with the ability to expand to 12 chairs (increasing from 5 in the current facility).

During the Public Health Emergency (PHE), individuals were not allowed to be removed from Medicaid unless they moved out of state, requested to be removed, or passed away. Due to this temporary status, although some individuals could be sorted into different Medicaid plans as appropriate, they were not removed. Continuous enrollment has since been discontinued as a requirement of the PHE. As such, DWS began case reviews on March 1st, 2023, and are expecting the first case closures or transfers to other Medicaid or Marketplace plans to initiate on April 30th, 2023. This effort is being referred to as the “unwinding”.

DBHS has been proactive during the preceding months, encouraging providers to assist clients in keeping their addresses current with DWS, responding to DWS inquiries, and to assist clients with any bumps along the way.

DBHS also hosted the State Medicaid Office (SMO) at one of their monthly provider meetings, to provide education on the "unwinding", and answer any questions they had.

Additionally, Optum and DBHS are working with their provider network to match a list provided by the SMO, with clients receiving services through them, to support individuals in remaining enrolled when possible, and to connect clients to Take Care Utah when needed, to assist with Marketplace Plan enrollment.

An additional impact will be the gradual loss of the enhanced COVID-related Medicaid match (6.2%). This funding drops to:

- 5% in CY23 Q2
- 2.5% in CY23 Q3
- 1.5% in CY23 Q4, and
- Ends January 1, 2024.

The implementation of increased rates (social detox, administration of methadone, and 5 community mental health codes), new programs, the unknown shifts in membership due to the unwinding (in a prepaid health plan), and an ever increasing state Medicaid match rate, finds us in an unprecedented moment in time, making accurate estimates of numbers served and budgets nearly impossible.

Optum/DBHS continues to assess network gaps and needs based on Geomaps, feedback from members and providers, and community stakeholders. Optum holds multi-disciplinary meetings semi-monthly to review network needs and requests to join the Medicaid network for SLCo. As reported above, Optum/DBHS has added several MAT providers to our Medicaid network over the past 18 months. We understand that with the Medicaid "unwinding" there will be a shift in Medicaid eligibility and possible increased movement to non-Medicaid. Providers will be encouraged to work with members to assure continued eligibility when appropriate, and work with non-Medicaid funds when appropriate.

Describe how mental health needs and specialized services for people in Nursing Facilities are being met in your area.

Optum works with 3 agencies to provide services to Medicaid consumers in nursing facilities.
1. Valley Behavioral Health offers a program known as Specialized Rehabilitation Services (SRS*). This program provides mental health services, including medication management, to Medicaid consumers in nursing facilities. Referrals are made directly to VBH from the nursing facilities. Optum will also recommend a referral if Medicaid enrollees are identified as benefiting from this service.
2. Hopeful Beginnings offers medication management services in nursing homes.
3. For those who are receiving ACT services, ACT is willing to travel to wherever the member is residing within Salt Lake County, including nursing facilities.

Telehealth: How do you measure the quality of services provided by telehealth? Describe what programming telehealth is used in.

DBHS/Optum currently has over 100 providers utilizing telehealth platforms during the pandemic. The services on the authorization for telehealth mirror the in person (in clinic) services as pertinent. In regular communication with providers (by phone, in training, etc.). We have made providers aware that

all telehealth services must be HIPAA compliant.

All providers currently providing telehealth services have completed training on the following which will still apply if they attest and continue to provide telehealth services:
• Proper claim submission protocols
• Appropriate malpractice insurance for providing telehealth services

Telehealth services are included in treatment record reviews during monitoring visits of our providers. Optum and DBHS MH providers are required to use the OQ Measures tools, which are incorporated into this component of chart audits as well.

Describe how you are addressing maternal mental health in your community. Describe how you are addressing early childhood (0-5 years) mental health needs within your community. Describe how you are coordinating between maternal and early childhood mental health services. Technical assistance is available through Codie Thurgood: cthurgood@utah.gov

Reach Counseling offers specialized services for women during and after pregnancy. In addition, Children's Service Society offers specialized programming to address maternal mental health. Optum has notified providers of the opportunity for training and certification in this area and follows up with any provider who makes inquiries into providing these services.

We have two providers who serve children, ages 0 – 5. These include Valley Behavioral Health and The Children's Center. Valley Behavioral Health continues to offer a variety of services for youth and families from birth through early childhood. The Children's Center treats children as young as age two and will work with families to support achievement of developmental milestones at birth and beyond. They have a service titled Teleconsultation where other behavioral health providers can request consultation or attend webinars on Infant and Early Childhood topics at no cost to the providers.

Services for these youth focus on supporting parent's needs, psychoeducation around parenting and developmental stages of infants and early childhood, assessment and corresponding treatment as indicated.

Describe how you are addressing services for transition-age youth (TAY) (age 16-25) in your community. Describe how you are coordinating between child and adult serving programs to ensure continuity of care for TAY. Describe how you are incorporating meaningful feedback from TAY to improve services. Technical assistance is available through Jessica Makin, jmakin@utah.gov, and Theo Schwartz, aschwartz@utah.gov

When considering providers for our network, those who work with TAY are prioritized. Currently, the VOA YESS and the Youth Services Milestones programs serve this population. In addition, VOA has a program called PREP that serves members aged 16-26 who are experiencing a first episode of psychosis, while Hopeful Beginnings offers an outpatient DBT group. It is expected that youth service providers both communicate with and share clinical record information (with ROI) with the adult service provider when services transition between providers. In reality, most of our providers work with both adults and youth and continue to see the members through this TAY time. If the youth is coming from DCFS or DJJS, we are hopeful the provider will share the information with our adult services provider and encourage our providers to seek this information. (Some of these youth providers for DHHS custody youth are not Optum providers.) The Optum Youth Care Coordinator refers TAY to providers who offer services to adolescents and adults. When job support is needed, therapists are referred to DWS. When a specific need arises, the Optum Care Coordinators collaborate on resources and

referrals. Discharge planning throughout treatment is the focus of the Optum mandatory provider training this year. The trainers will specifically address the unique needs of TAY and available resources in the network and community.

Other Quality and Access Improvement Projects (not included above)

As outlined in the QAPIP submitted to DHHS Medicaid on February 1, 2023, the following projects are underway.

1. Development of a new PIP focusing on efforts to improve FUH rates. The preliminary submission has been approved by DBHS and will be sent to HSAG for feedback in April 2023. This will be a three-year project, if approved.
2. Increase youth engagement in follow-up care after hospitalization 60 days after discharge. Engagement includes the member receiving at least one treatment service and as endorsed by the outpatient provider.
3. Improve community tenure and reduce future inpatient lengths of stay for identified members: There is currently an effort to address over and under-utilization of specifically identified members with extremely complex behavioral health issues. The data are being reviewed to determine which members will be identified and what interventions will be implemented to support the population. A goal and measure will be developed upon determination of the process. The work plan will be updated at that time.
4. Validate case manager and CPSS/FPSS certifications: 98% of all case manager and CPSS/FPSS certifications, as submitted by providers, will be validated through the LookUp Verification Tool or through DHHS personnel.
5. Verify CM/CPSS/FPSS authorization to provide services: In 11 out of 12 months, a CPT code report will be run to verify individuals rendering CM and CPSS/FPSS services are authorized to do so. 100% of non-compliant services billed will be reported to Quality and Compliance for further action.
6. Ensure Live and Work Well Online Directory Accuracy: 25% of providers profiles in LAWW will be reviewed quarterly to ensure accuracy of information. 2023 will be used as a year to develop baseline data.
7. For all clients in OQ® measures increase the percent of unduplicated clients participating to greater than or equal to 50% for adults and youth. Adult Mental Health baseline: 48.6% Youth Mental Health baseline: 42.1%

17) Integrated Care

Pete Caldwell

Describe your partnerships with local Health Departments, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers.

Providers within the SLCo network have taken great steps towards integrating physical health and behavioral health services, and include access by individuals with co-occurring mental health and SUD conditions. Please find examples below of integrated efforts within their programs:

Odyssey House (OH)
Odyssey House operates the Martindale Clinic, an integrated primary care/behavioral health clinic focused on serving individuals with behavioral health issues and their families. Within the clinic, they provide typical family practice medical services and procedures, such as chronic care management, labs, wound care, diabetes management, blood pressure management, etc.; MAT prescribing and

administration; mental health medication prescribing; women's health and family planning services and procedures; and HEP C treatment.

The Martindale Clinic is also a syringe exchange site and facilitates providing clean syringes, fentanyl test strips, disease prevention education, and recovery access information to current injecting users.

Additionally, Martindale providers in conjunction with Soap to Hope, provide weekly street-based medical care to sex workers and homeless individuals, typically treating wounds, STDs, MAT, among others. These individuals are typically resistant to coming into a traditional medical setting because of fear of going to jail or getting in trouble with their pimp, so they are going to them and having real success.

Within BH programs, BH and medical staff work closely together to address mental health, physical health, and MAT needs for all clients. As an example, in residential settings, Odyssey House serves PICC (Peripherally Inserted Central Catheter) patients from all the hospital systems. These clients have an IV line that runs directly to the heart to deliver high dose antibiotics over a period of ~6 weeks. The individuals they serve in this program have an infection from IV drug use that has infected the heart. Often these individuals have heart valves that have been replaced because of the infection, and require this antibiotic regimen in order to salvage the donated valve and the rest of the heart. They are at high risk for overdose and death, because they have an open port directly to their heart and are at risk of using that port to use drugs. Consequently, prior to this program, hospitals would have ordinarily kept these patients in the hospital because of that overdose risk. Through this program, they can be managed safely at a lower level of care and have better outcomes. Intermountain and their lead infectious disease doctor approached Odyssey House with this project a number of years ago. The University of Utah followed a couple of years later and now SL Regional, St. Marks, and other hospital systems across the state have been referring in, seeing patients from across the state.

First Step House (FSH)
The First Step House Medical Services Department includes a Medical Clinic and Nursing Services. This program provides medical care and preventive health services to clients in their residential SUD treatment program.

The FSH Medical Clinic, staffed by an APRN and registered nurse, is located at 434 South 500 East in downtown Salt Lake City. The FSH medical clinic provides a routine medical visit to new residential treatment clients at intake. This includes a review of health history and medications, preventive screening and services, and identification of acute medical and psychiatric concerns. Clinic staff can address a client's immediate medical needs, beginning treatment in the clinic or referring out for treatment. An in-house psychiatric nurse also provides consultations for new clients with acute psychiatric needs. The medical clinic includes an onsite immunization program and an onsite lab. The clinic offers seasonal influenza vaccines and year-round COVID-19 vaccines. The clinic also screens for sexually transmitted infections, orders Hepatitis A and B vaccines as needed, and provides Hepatitis C treatment.

The FSH Nursing Services Department, staffed by two registered nurses and four medication technicians, provides nurse care, care management, and medication management to three residential treatment programs. Nursing staff work with clients during medical orientation to establish care with a primary care provider if they do not already have one. The admissions process for new clients also requires a comprehensive medical orientation class during their two-week orientation before residential treatment. Nursing staff teach about medication transfers and guidelines for use, immunization

education, how and why to find a primary care provider, COVID-19, and other health and safety precautions. As needed, nurses make referrals to partner providers such as 4th Street Clinic, UofU School of Dentistry, Salt Lake VA Medical Center, Martindale Clinic, and others.

They also have a Joint Commission accredited UA lab (and bill it on the PH side of Medicaid).

Valley Behavioral Health (VBH)

- Valley launched the integrated care clinic at the North Valley building in early 2022 and closed the program in December 2022.
  - Valley is currently negotiating with a provider in the community to reopen the clinic in 2024 and provide on-site services at the North Valley building.
  - Approximately 800 patients affected by the closing were referred and connected to primary care providers in the community.
- Valley continues to provide integrated on-site and telehealth primary care services to our residential substance use treatment programs.
- Valley launched the chronic care management program in 2021 and closed it in 2022. We plan to reopen this program through the future primary care community provider plan discussed above.
- The on-site integrated care clinic for Valley West serving youth, families, and children was never opened and the provision of these services will be part of the community primary provider plan discussed above.

Clinical Consultants

Clinical Consultants developed a Family Primary Care practice within their building in West Jordan. They have two medical exam rooms and three employees currently delivering services. This includes a 20-hour/week DO (Doctor of Osteopathic Medicine), and two-family practice nurse practitioners. Clinical Consultants is one of the Salt Lake County network providers of MAT services.

By the end of FY 21, they began to offer physical exams, preventative health, primary care, routine medical care, STD screenings, vaccines, and urgent illness care (in addition to MAT). In addition to serving their behavioral health clients, they have opened access to the general public.

In February of 2022 Clinical Consultants began to provide the local community with free COVID-19 testing. In April 2022, they completed an internship agreement for placement of APRN Interns. They have been approved as panel providers for medical networks with Healthy U and have applications pending with HealthChoice, Molina and SelectHealth. They are presently interviewing Medical Assistants for immediate full-time hire. Their prescribers are now set up with a medical software and e-script system. They continue to deliver the services with the above staff.

As of November 2023, they opened a Toxicology Lab in West Jordan. This lab holds a moderate level complexity certification.

Clinical Consultants has completed Utah Medicaid credentialing for integrated care. They have become approved providers for Steward and Health Choice, and are in the final contracting phase with Healthy U.

Volunteers of America (VOA)

Volunteers of America, Utah is dedicated to providing integrated primary and behavioral health care. They partner with Fourth Street Clinic to provide onsite triage and medical care at their Detoxification facilities and Homeless Resource Centers. Their outpatient clinics partner with Midtown Community

Health Center.

VOA has a medical assistant to triage client needs, coordinate care, and make the referral to primary care services seamless. For several years they have been a recipient of the Utah State Primary Care Grant which provides funding to pay for the primary care needs of clients who are unfunded.

Wasatch Homeless Health Care Inc. dba. Fourth Street Clinic

Fourth Street Clinic is committed to providing integrated health care services for those in our community that are experiencing homelessness. Through offering high quality medical, dental, behavioral and supportive health care services, including an onsite pharmacy, unsheltered individuals have access to essential treatment and care. Through low barrier, integrated health care, Fourth Street Clinic is a partner in ending homelessness, promoting community health, and achieving across-the-board health care savings. Fourth Street Clinic's integrated health team provides psychotherapy, behavioral health counseling, psychiatric evaluation and management, health and wellness, primary care provider collaboration and substance use disorder assessment, including Medication Assisted Treatment, and treatment referrals.

Optum is in the process of credentialing Red Tractor Family Medicine and Psychiatry, Families First Pediatrics, and Wasatch Pediatrics for integrated services.

Copa Health is finalizing an integrated clinic in Murray, Utah to work with all ACOs, TAM, and Optum.

Salt Lake County Vivitrol Program
Strong partnerships have been developed with Midtown Community Health Center in South Salt Lake, Odyssey House's Martindale Clinic, and Utah Partners for Health (UPFH) in West Jordan. Not only are clients referred to these clinics for their Vivitrol screenings and injections, clients are also offered access to primary care services through these same encounters. At Midtown and UPFH, with so many complicating health factors often arising during Vivitrol engagement, DBHS, in coordination with DSAMH, agreed to fund an enhanced office visit cost, to assist with covering the costs of other routine screens that may be necessary during a client's visit with medical professionals. In turn, the clinics provide the full spectrum of physical health care for Vivitrol clients as they actively attend their appointments. At Martindale, clients are also offered access to primary healthcare. All partner clinics accept Medicaid and private insurance as well.

In addition to the efforts mentioned above, Optum meets and collaborates weekly with the four Accountable Care Organizations (ACOs) to staff complex cases, coordinate care for Civil Commitment Court, facilitate aftercare post IP Detox, make case management referrals, and identify medical and BH Resources and inform the ACOs of BH IP stays. Optum also provides information about the planned aftercare and discharge medications. This collaboration results in improved engagement and access for our most vulnerable clients. The ACOs use this information to ensure follow-up with discharge services and support as needed.

Describe your efforts to integrate care and ensure that children, youth and adults have both their physical and behavioral health needs met, including training, screening and treatment and recovery support (see Office Directives Section E.viii). Identify what you see as the primary barriers to implementing integrated care at your agency and your efforts to overcome those barriers. Please also describe how you will provide education and referrals to individuals

regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).

All contracted vendors are required to have relationships with primary care systems. Four primary care providers who are excellent partners are: the Fourth Street Clinic for the homeless population, Odyssey House's Martindale Clinic, Utah Partners for Health, and Midtown Community Health Center located on State Street in Salt Lake City. In addition, Intermountain Healthcare provides extensive charity care for County clients.

The Division currently contracts with Fourth Street Clinic for behavioral health assessments for uninsured homeless clients. Our other partner clinics, Midtown Community Health Center, Martindale Health Clinic and Utah Partners for Health administer Vivitrol to clients who are opioid or alcohol dependent. We continually seek out opportunities to increase the availability of integrated physical and behavioral health care to our clients through our partnerships with primary care providers. DBHS now funds mental health treatment for some Vivitrol clients at Utah Partners for Health, so that they may receive their MAT and therapeutic services at the same clinic. Additionally, Martindale Clinic offers physical health services to RSS clients.

The DBHS/Optum treatment network is committed to addressing co-occurring disorders. For this reason, all SUD providers within the network meet the definition of dual diagnosis capable by ASAM standards. In addition, we contract with three SUD providers (VBH, VOA and Odyssey House) to provide ASAM dual diagnosis enhanced services. VBH provides our largest service delivery for dual diagnosed individuals. They have multiple locations, serving individuals with co-occurring psychiatric and substance use related disorders. VBH provides treatment to these individuals at all levels of care, including having a residential facility for dual diagnosed adult males (Co-Occurring Residential and Empowerment, CORE Program) and females (CORE 2). Additionally, AAU expanded their services to become a dual diagnosis enhanced program. In FY21, Odyssey House opened a residential program for women who have co-occurring disorders and are justice involved. In FY23 Odyssey House opened a residential program for men who have co-occurring disorders.

Optum continues to be invested in our relationships with the ACOs, who are very responsive to collaboration and information requests. The ACOs are notified of all inpatient stays. Medical issues identified during utilization management reviews are forwarded to the Care Coordination team for outreach to the medical plan to identify services, case management programs, resources, history, and direction to address medical issues. Members from the care coordination team attend all ACT meetings and facilitate connection with the medical plans when medical issues are a concern. The ACOs routinely contact the Care Coordination team to identify resources for behavioral health and SUD services which support medical interventions related to chronic illness, pregnancy, and discharge from IP detox.

Describe your efforts to incorporate wellness and wellness education into treatment plans for children, youth and adults. Please consider social determinants of health in your response.

Treatment plans are to include the multiple methods, clinical and non-clinical, which are used to help members achieve SMART objectives and member driven goals. Please see the Quality Improvement section below.

Quality Improvement: What education does your staff receive regarding health and wellness for client care including children, youth and adults?

For the Optum network, during the recent mandatory provider training focused on comprehensive assessments, clinicians offered guidance on the inclusion of the medical histories of individuals and their families. Providers are to consider the member's culture and living conditions which may also influence their physical, social, emotional and spiritual wellbeing. Providers are expected to request a release of information to collaborate with the individual's primary care physician, behavioral health prescriber and other key medical and behavioral health providers to encourage coordinated care. Provider policies and procedures, as well as treatment records, are monitored to ensure assessment and coordination of treatment are considered for all who receive treatment. Providers within the Optum SLCo Network may also offer specific training for the clinicians and other service providers within their facilities/agencies/groups. Optum and SLCo refer treatment providers and members to Take Care Utah and care coordinators through the member's ACO to obtain links to a PCP and other supports for medical care and maintenance. Within DBHS, while we do not provide any direct services to any population, staff are encouraged to attend various trainings that focus on client care. These include, but are not limited to Generations, the OSUMH Fall Conference on Substance Use Disorders, and Critical Issues.
Describe your plan to reduce tobacco and nicotine use in SFY 2023, and how you will maintain a *nicotine free environment* as a direct service or subcontracting agency. For ongoing engagement, it is recommended to use an evidence-based nicotine dependence tool such as the Fagerstrom scale. SUD Target= reduce tobacco and nicotine use by 4.8%.
DBHS/Optum continues to educate providers on the mandate to diagnose and provide treatment for nicotine addiction as a healthcare issue. Screening for use and abuse with referrals to smoking cessation supports continues to be addressed at provider meetings and trainings for MH and SUD treatment providers. Clinicians are reminded of the health implications of smoking for our clients, the need to ask clients if they are interested in cessation services, and the need for proper documentation of these efforts. Except for the very small providers, all providers have some level of cessation services, from the basic referring to a quitline (and helping the client access that) to formal classes. In addition, for those who do want to quit tobacco, CBT is used, and MI for those who have not committed yet to quitting. Due to the popularity of previously non-traditional ways to use nicotine, the providers are also being educated to ensure that any type of nicotine delivery system is addressed with the client. Salt Lake County/Optum has also incorporated a review of nicotine-free environment initiatives during audits providing a forum for another conversation about the importance of offering cessation services to clients. The Optum Recovery & Resiliency Team has incorporated education about tobacco cessation in their CPSS trainings. DBHS and Optum continue to offer these training sessions each fiscal year, and will continue to do so.
Describe your efforts to provide mental health services for individuals with co-occurring mental health and intellectual/developmental disabilities. Please identify an agency liaison for OSUMH to contact for IDD/MH program work.
Optum has identified providers who work with co-occurring diagnoses, and will work with the ACOs when associated medical conditions are identified where physical therapy or occupational therapy may be needed. Optum keeps its ACO contact list updated. Sandy Meyer is the IDD/MH liaison for Optum.

18) Mental Health Early Intervention (EIM) Funds
Please complete each section as it pertains to MHEI funding utilization.

School Based Behavioral Health: Describe the School-Based Behavioral Health activities or other OSUMH approved activity your agency proposes to undertake with MHEI funding over the three year period. Please describe how you intend to support family involvement in treatment. For each service, identify whether you will provide services directly or through a contracted provider. Please include: any partnerships related to 2019 HB373 funding and any telehealth related services provided in school settings. Include any planned changes in programming or funding. Please email Leah Colburn lacolburn@utah.gov a list of your FY24 school locations.
Currently, Odyssey House is DBHS' sole contracted provider for utilization of MHEI funding for school-based treatment. Odyssey House provides individual and family therapy, as well as case management services to those funded with MHEI dollars and Optum Salt Lake County Medicaid eligible youth. Families are encouraged to participate with their children in treatment; however, this can be difficult due to the parents oftentimes not having much, or any, leave time from work, and some also work multiple jobs. However, if circumstances permit it then parents are welcome and encouraged to participate. Odyssey House focuses on partnering with school leadership and personnel to help youth access much needed resources and accomplish therapeutic objectives.
Please describe how your agency plans to collect data including MHEI required data points and YOQ outcomes in your school programs. Identify who the MHEI Quarterly Reporting should be sent to, including their email.
DBHS will continue to use the Mental Health Early Intervention Data & Outcomes Report form which has been provided by DSAMH. Specifically for the school-based programs, data for total clients served, number of schools and school districts served, and the YOQ.
Family Peer Support: Describe the Family Peer Support activities your agency proposes to undertake with MHEI funding over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. For those not using MHEI funding for this service, please indicate "N/A" in the box below.
Family Peer Support Specialists (FPSSs): These facilitators, who are specially trained family members, work to develop a formalized, family-driven and child-centered public mental health system in the state of Utah. At no charge to families, FPSSs provide referrals to local resources; advocacy for culturally appropriate services; links to information and support groups. These services encourage increased family involvement at the service delivery, administration and policy levels, which help lead to improved outcomes for families and communities. The FPSS program services are designed to provide family peer support services to parents and/or caregivers of children/youth with mental health, substance use and/or other complex needs. Generally, FPSSs have a family member with a mental illness giving them the lived experience necessary to have understanding and empathy for the families they work with. They also have experience and knowledge navigating various systems and agencies. They provide resource coordination, advocacy, assistance with the 504 Special Needs Education plan and Individualized Education Plan (IEPs). The main goal of the program is to keep children at home with their families and in their community. This is achieved through support, education, skill building, and use of natural supports. There are currently 6 FPSSs placed with 6 agencies throughout Salt Lake County, with 1 team lead position recently created. Negotiations are currently happening to place an FPSS in the Jordan School

School Based Behavioral Health: Describe the School-Based Behavioral Health activities or other OSUMH approved activity your agency proposes to undertake with MHEI funding over the three year period. Please describe how you intend to support family involvement in treatment. For each service, identify whether you will provide services directly or through a contracted provider. Please include: any partnerships related to 2019 HB373 funding and any telehealth related services provided in school settings. Include any planned changes in programming or funding. Please email Leah Colburn lacolburn@utah.gov a list of your FY24 school locations.
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Please describe how your agency plans to collect data including MHEI required data points and YOQ outcomes in your school programs. Identify who the MHEI Quarterly Reporting should be sent to, including their email.
DBHS will continue to use the Mental Health Early Intervention Data & Outcomes Report form which has been provided by DSAMH. Specifically for the school-based programs, data for total clients served, number of schools and school districts served, and the YOQ.
District for the coming school year. FPSSs are anchored at the following agencies or organizations, along with plans to expand during the next school year: • 1 FTE Team Lead position created 1/2023 Salt Lake County Youth Services • 1 FTEs Salt Lake County Division of Youth Services • 1 FTE Granite School District • 2 FTE State of Utah Division of Child and Family Services (DCFS) • 1 FTE 3rd District Juvenile Court • 1 FTE Family Support Center • 1 FTE Jordan School District (currently in negotiation to start for the 2023/2024 school year)
Mobile Crisis Team: Describe the *Mobile Crisis Team* activities your agency proposes to undertake with MHEI funding over the three year period and identify where services are provided. Include any planned changes in programming or funding. For those not using MHEI funding for this service, please indicate "N/A" in the box below.
The HMHI MCOT is an interdisciplinary team of mental health professionals, including Peers, who provide a combination of crisis services including crisis intervention, psychiatric emergency care, urgent care, and crisis follow-up for residents of the Salt Lake community 24 hours a day, 7 days a week, 365 days per year. The team is committed to responding within 30 minutes to law enforcement requests and within 60 minutes to community response. The staff assesses the situation and makes a determination regarding disposition using all the resources available to provide the best outcome possible using the least restrictive alternatives. The Youth MCOT is flexible, multi-faceted, and immediately accessible to families, children and adolescents at risk for hospitalization or out-of-home placement. They work closely with community

School Based Behavioral Health: Describe the School-Based Behavioral Health activities or other OSUMH approved activity your agency proposes to undertake with MHEI funding over the three year period. Please describe how you intend to support family involvement in treatment. For each service, identify whether you will provide services directly or through a contracted provider. Please include: any partnerships related to 2019 HB373 funding and any telehealth related services provided in school settings. Include any planned changes in programming or funding. Please email Leah Colburn lacolburn@utah.gov a list of your FY24 school locations.
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Please describe how your agency plans to collect data including MHEI required data points and YOQ outcomes in your school programs. Identify who the MHEI Quarterly Reporting should be sent to, including their email.
DBHS will continue to use the Mental Health Early Intervention Data & Outcomes Report form which has been provided by DSAMH. Specifically for the school-based programs, data for total clients served, number of schools and school districts served, and the YOQ.
partners who specialize in child and family issues including DYS and Hopeful Beginnings. All staff are state certified Designated Examiners who can evaluate and initiate commitment procedures for those IPS under the age of 18. Please see Section 4) for further detail.

19) Suicide Prevention, Intervention & Postvention — Carol Ruddell

Identify, define and describe all current strategies, programs and activities in place in suicide prevention, intervention and postvention. Strategies and programs should be evidence-based and alight with the Utah State Suicide Prevention Plan. For intervention/treatment, describe your policies and procedures for suicide screening, risk assessment, and safety planning as well as suicide specific treatment and follow up/care transition services. Describe how clients are identified for suicide specific services. How is the effectiveness of the services measured? Include the evaluation of the activities and their effectiveness on a program and community level. If available, please attach the localized agency suicide prevention plan or link to plan.
Providers within the DBHS/Optum network are mandated to provide a systematic approach in their efforts with suicide follow-up by administering the C-SSRS/Suicide Risk Assessment upon intake and admission. If a client initially screens negative for suicide but later suicidal risk is suspected by the clinician or other staff member during the course of treatment, a C-SSRS/Suicide Risk Assessment will be re-administered. Safety plans are created and updated when clients demonstrate an affirmative response to question #2 or to subsequent questions on the C-SSRS.

Safety plans are also used as a tool to assist members with other safety issues or to improve their ability to manage the symptoms of their mental illness. DBHS/Optum adheres to a Sentinel Events policy and procedure to investigate serious suicide attempts requiring hospitalization while members are receiving treatment and when members complete suicide during or shortly after completing suicide. Each of these reported incidents are reviewed to determine if any quality of care issues exist and to partner with the provider to improve treatment for all members. Most of our providers have submitted verification of completed Counseling on Access to Lethal Means (CALM).

In partnership with the DHHS Suicide Prevention Program Administrator, Optum facilitated two Postvention trainings for approximately 80 Optum Network rendering providers in April 2023. We continue to work with Allison Foust with an upcoming training this fall for agency leaders to assess their practice for postvention preparedness, with hands-on activities to begin creating or updating their current postvention plan. Finally, Allison is developing a postvention training specifically for solo providers, as their internal resources are limited and will benefit from other treatment providers, community supports, Optum and DBHS. Optum has also contacted Brianne Silcox and Alyssa Burnham, the grant related suicide prevention specialists in the SLCo Health Department, to relay our efforts to prepare providers to respond when a peer, co-worker, or individual in their practice dies by suicide.

Identify at least one staff member with suicide prevention responsibilities trained in the following OSUMH Suicide Prevention programs. If a staff member has not yet been identified, describe the plan to ensure a staff member is trained in the following:

1. **Suicide Prevention 101 Training**
2. **Safe & 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)**

Optum R&R Team is certified to present QPR and MHFA, and offers training in Salt Lake County which is available to in-network providers and the greater community. In FY23, Optum will create a plan to ensure training for the other two OSUMH programs are made available to providers in Salt Lake County.

Describe all current strategies in place in suicide postvention including any grief supports. Describe your plan to 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 Utah Suicide Coalition for Suicide Prevention Community Postvention Toolkit. Identify existing partners and intended partners for postvention planning. If available, please attach a localized suicide postvention plan for the agency and/or broader local community or link to plan.

Suicide Loss survivors may seek support and referrals from the Optum Recovery & Resiliency Team who can help to identify local grief support and suicide survivor groups. These include, but are not limited to, The Sharing Place, Bradley Center, Caring Connections and NAMI.
Optum has developed the following postvention plan:

- Identify and partner with providers within the Optum Network who are immediately able to offer support and engage with suicide loss survivors.
- Educate and build relationships among those systems who will interact with bereaved people to

enable a coordinated community response.
● Work with those affected by the suicide death to aid mourning in ways that avoid increasing the risk of contagion.
● Seek support and referrals from the Optum Recovery & Resiliency Team as described above.

For Local Authorities participating in the Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant Program or the Project AWARE grant, summarize your implementation plans for implementing skill based programming, gatekeeper training, community or school based screening activities, and crisis follow up services after inpatient or emergency department visits. (note: this can be done in the box below, or by linking/attaching your most current report).

For those not participating in either of these grant programs, please indicate "N/A" in the box below.

N/A

For Local Authorities participating in the Comprehensive Suicide Prevention grants describe your implementation plans for primary prevention programs, suicide intervention supports including gatekeeper training, and community postvention planning. (note: this can be done in the box below, or by linking/attaching your most current report).

If any of the following project deliverables are currently available, please link them here or attach them to your submission.

1. **By year 2, funding recipients shall submit a written comprehensive suicide prevention plan that is in alignment with the Utah Suicide Prevention State Plan and by year 2, funding recipients shall submit a written postvention response plan and communication protocol for their organization.**
2. **By year 3 funding recipients shall submit a written community postvention response plan.**

For those not participating in this project, please indicate, "N/A" below.

N/A

20) Justice Treatment Services (Justice Involved) *Thom Dunford*

What is the continuum of services you offer for justice-involved clients and how do you address reducing criminal risk factors?

DBHS Alternatives to Incarceration Program Initiatives

Project RIO (Right Person In/Right Person Out) began in 2006 when the Salt Lake County Criminal Justice and Mental Health Systems concurred with Munetz and Griffin, that in the ideal case, persons with mental illness would have the same rate of contact with the criminal justice system as does any other person. Systemic improvements were implemented that involved all five of the "sequential intercepts" in which persons with behavioral health conditions contact the criminal justice system, with the goal of diverting persons who have mental illness or substance use disorders and who are non-dangerous offenders from inappropriate incarceration. These programs supported an already active CIT program and Mental Health Court, and were the product of a rich collaboration of numerous

agencies. Below please find an array of federal, state, and county funded programs that exist today. Programs supported in varying degrees by JRI funds have a **red*** next to them and more detailed program descriptions.

Sequential Intercept #1 - Law Enforcement & Emergency Services

● **Crisis Line & Warm Line** - The HMHI Crisis Line, in affiliation with the National Suicide Prevention Lifeline, is in operation 24/7, 365 days of the year, acts as the front door to the HMHI Crisis System, and is staffed by experienced certified crisis workers. The Crisis Line team coordinates Mobile Crisis Outreach Teams as needed. The Warm Line is a peer-run phone line staffed by individuals in recovery. Peer operators are trained to attentively and empathically listen to anonymous callers, offer compassion and validation, and assist callers in connecting with their own internal resources, strengths, and direction.

● **Mobile Crisis Outreach Teams (MCOT)** - HMHI interdisciplinary teams of mental health professionals (a licensed mental health practitioner and peer support specialist) who provide face-to-face crisis resolution services for individuals in Salt Lake County who are experiencing or at-risk of a mental health crisis, and who require mental health intervention. MCOT staff often provide law enforcement with alternatives to incarceration or hospitalization when responding to patients in crisis, allowing the individual to remain in the least restrictive setting. These teams serve both adults and youth, 24/7 throughout the county.

● **Receiving Center (RC)** - An HMHI short stay facility (up to 23 hours) designed as an additional point of entry into the Salt Lake County crisis response system for assessment and appropriate treatment of adult individuals experiencing a behavioral health crisis. Clients may receive assessments, medications and other support. It may be used by law enforcement officers, EMS personnel and others as a receiving facility for individuals who are brought there voluntarily or on an involuntary hold. The RC is an innovative program that provides a secure crisis center featuring the “Living Room” model, which includes peer support staff as well as clinical staff. The goal of the center is to reduce unnecessary or inappropriate utilizations of ER visits, inpatient admissions, or incarceration by providing a safe, supportive and welcoming environment that treats each person as a “guest” while providing the critical time people need to work through their crisis.

Although progressive for its time upon opening in 2012, the Receiving Center is currently underutilized by law enforcement and emergency services due to a combination of issues. Physical set-up of the current space and gaps in funding for robust medical care have led the majority of law enforcement cases to be sent through emergency rooms for medical clearance which is a significant barrier to utilization. The geographical location is also not central to the jurisdictions most in need of the service, taking law enforcement serving those areas off the streets for longer than is practical. Care in this setting has been impacted in 2021 and 2022 due to the COVID-19 pandemic due to the living room model, which presents significant challenges to communal care without risk of community outbreak. This led to some delays in acceptance and periodic reduction in bed capacity.

DBHS was awarded funding for a new non-refusal Receiving Center, and thanks to additional partners and funding, a groundbreaking occurred in May 2021. This program will serve Salt

Lake County community members who are in psychiatric or substance use-related crisis from a central, accessible location in South Salt Lake. The new Receiving Center (RC) has been designed and funded to operate as a true non-refusal facility that will accept any and all individuals including community walk-ins, secure drop-offs from police, fire & EMS, and referrals for assessment. As a non-refusal RC for police, firefighters, and EMS, many of these individuals will be low-level offenders cycling through the county jail, whose crimes are secondary to untreated or undertreated mental illness or substance use disorders. Others may be frequent patients in emergency departments throughout the Salt Lake Valley. These individuals will benefit from medical and psychiatric triage, clinical assessment, peer support, discharge planning, connection to community resources and partners, and referral to treatment programs such as inpatient care, medical care, and detox.

Due to this facility not becoming operational until 2025, the Salt Lake County Council voted to dedicate $2.5M (ARPA funding) towards a temporary RC to act as a bridge until the new RC is built and operational. It will be a non-refusal center with the ability to expand to 12 chairs (increasing from 5 in the current facility).

● **Volunteers of America Detox Centers** *

These programs partner with multiple law enforcement agencies to offer individuals who have been picked up for public intoxication an alternative to jail and a safe environment focused on recovery. Officers can call for bed availability, van pick-up hours and availability. To meet the criteria for the Jail Diversion Program, clients must be intoxicated, non-combative, medically stable and willing to go to the detox center.

DBHS contracts to provide social detoxification services in multiple sites within the county. These sites are:

Volunteers of America Men's Adult Detoxification Center: This social model residential detoxification and withdrawal management program provides 80 beds for men 18 and older in need of detoxification & withdrawal management services. This facility is located at 252 W. Brooklyn Ave. Salt Lake City, UT, 84101.

Volunteers of America Center for Women and Children: This social model residential detoxification and withdrawal management program provides 32 beds for homeless and low-income women, 18 years and older, in need of detoxification and withdrawal management services. In addition, women may bring their children age 10 and under into the program. This mitigates a barrier many women face when they do not have safe alternative childcare. In addition, clients have access to an outdoor area and onsite garden. It is located at 697 W 4170 S, Murray, UT, 84123.

Both programs offer a trauma-informed environment wherein clients can receive help managing intoxication and withdrawal symptoms and decide the next steps in their recovery journey. Clients may stay at these facilities for up to 30 days as they work with their case manager to link to behavioral health services. These services include connection to essential substance use treatment, Medicaid enrollment, primary care referral, assistance with legal issues, reconnecting with family, etc.

While in residence, clients can also access medication-assisted treatment (MAT) through our community partnerships, a critical service we provide. Peer support services, in-house 12-step recovery meetings, connections to the Salt Lake County recovery community, and harm reduction services are also available. In addition, qualifying clients interested in substance use disorder treatment can often transfer directly to treatment and receive a full ASAM-driven biopsychosocial assessment and referral

to an appropriate treatment program.

By the end of 2023 they will be moving locations to 1875 S Redwood Road and expanding their beds by 50.

● **Unified Police Department (UPD) Mental Health Unit (MHU)** *

Supported with JRI funding, a licensed mental health therapist is housed within the UPD offices, co-responds with law enforcement to mental health crises within the community, and provides individualized follow-up. The UPD Mental Health Unit serves the cities of Kearns, Magna, Holladay, Millcreek, Midvale, Canyons, Copperton, Cottonwood Heights, Draper, Sandy, Murray, South Salt Lake, Brighton and White City, and also provides additional assistance to other law enforcement agencies throughout the county upon request to: Salt Lake City, UTA, Bluffdale, South Jordan, West Jordan, Herriman and West Valley City.
The objectives of the Mental Health Unit are to:

- Assist with the de-escalation of volatile situations, reducing the potential for violence during police contacts
- Provide mental health consumers and their families with linkages to services and supports
- Serve consumers in the least restrictive setting, diverting from jail and hospitalization as appropriate
- Reduce repeated law enforcement responses to the same location, and
- Free up patrol officers to respond to other calls.

The Mental Health Unit is a partnership of law enforcement agencies in Salt Lake County. Currently there are 12 MHU officers and one mental health therapist that respond to calls throughout the county.

This effort enjoys a commitment to problem solving and a fruitful collaboration between law enforcement, DBHS, HMHI, and the greater community of Salt Lake County.

Sequential Intercept #2 – Jail

● **Jail Behavioral Health Services** * - Mental health and substance use disorder (SUD) services are provided to inmates of the SLCo Jail. More detailed program descriptions may be found in the incarcerated individuals section above.

Mental Health services are funded through a direct appropriation from the County Council to the SLCo Sheriff's Office. In addition to providing mental health services and medication management, jail mental health case managers coordinate services and releases for the severely mentally ill population. This includes such things as verifying medications, obtaining outside treatment records, post-release planning, providing community resources, connecting clients to in-reach services as available, collaborating/communicating with community stakeholders such as community behavioral health providers, the Legal Defenders Office social workers, and participating in Mental Health Court staffings, Top 10 staffings, and the Metro Mental Health monthly roundtable.

The Salt Lake County Jail has two dedicated units that can address more severe mental health

needs – a 17-bed unit for individuals who have been identified as high risk for suicide and a 48-bed unit for individuals with a mental health diagnosis that would benefit from not being with the general population. In addition to these, the jail team provides group therapy and crisis services for individuals in the general population.

DBHS funds the SUD services in the jail, including:
Corrections Addictions Treatment Services (CATS) at Oxbow and Adult Detention Center Jails, South Salt Lake City: CATS is an addictions treatment therapeutic community based on an intensive outpatient level of care (9 - 19) hours per week of therapeutic and skill-based treatment services based on the therapeutic community model.

The program is operated within both the ADC and Oxbow Jails. The capacity for males is 152 beds (Oxbow) and 32 beds for females (ADC) based on an average length of stay of 3 months. The CATS program is also a direct referring partner for the Vivitrol Program and Salt Lake County Behavioral Health Services' housing programming. Upon completion of the CATS program, all inmates are eligible to apply for TAM Medicaid and be provided with a clinical referral into a county approved agency.

Currently, CATS includes a psycho-educational component (Prime for Life) for up to 1,500 inmates, plus a fuller continuum of treatment services with the inclusion of interim group services called Drug Offender Group Services (DOGS). The CATS, DOGS and Prime for Life programs are contracted through Odyssey House.

These programs are available to MH clients with co-occurring SUD conditions.

3 Year Plan:
Odyssey House is exploring a possible expansion of services into the Medium Security levels within the Salt Lake County jail, pending approval.

Jail Medication-Assisted Treatment Program - Qualifying program participants with opioid or alcohol use disorders have access to medication-assisted treatment, substance use disorder behavioral therapies, and coordinated referrals to community treatment services upon release. MAT program medications may include methadone, buprenorphine or Naltrexone. The MAT program provides a whole-patient approach to the treatment of substance use disorders and is clinically-driven with a focus on individualized patient care. Services are provided through the jail's health services staff and through a contract with Project Reality. Naloxone kits are provided to qualifying participants upon release (as supplies last).

- **State Competency Jail Restoration Program -** This program is operated by the state and works to restore inmates to competency while awaiting a hospital bed.

- **Community Response Team (CRT)** * - This Valley Behavioral Health (VBH) team works with severely mentally ill (SMI) clients who are currently in jail, recent releases and also clients in the community who may be diverted from jail. CRT staff visit inmates prior to release to develop an APIC (Assess, Plan, Identify and Coordinate) Plan, a pre-release relationship with the inmate, assure medication continuity upon release, pre-determine eligibility for benefits and assist with transportation from the jail.

● **Salt Lake County Criminal Justice Services Pretrial Services** - This is a risk-based service to release individuals from jail while awaiting a court hearing. Utilizing the least restrictive conditions possible, Pretrial:

- Provides a non-financial release from jail and case management or tracking through case disposition.
- Provides information about upcoming court dates
- Utilizes evidence-based assessments and tools to identify appropriate resources and create case plans to help reduce barriers to success. Assessments used include Public Safety Assessment (PSA) and the Gender Informed Needs Assessment (GINA).
- Assists in connecting individuals to treatment.

● **County Pre-file Intervention Program (CPIP) -** This is a pre-filing diversion program that targets people who have been arrested for minor, non-violent crimes. Instead of filing criminal charges against them, prosecutors connect them to case workers who help them with required classes or other resources they might need. It is a voluntary program. People accused of violent crimes or domestic violence are not eligible. Participants stay out of the criminal justice system entirely if they complete the requirements and don't commit any new crimes while in the program, which lasts between four and six months.

Sequential Intercept #3 – Courts

● **Mental Health Courts** - Mental Health Court is a collaboration between criminal justice and mental health agencies in Salt Lake County. The Mental Health Court provides case management, treatment services, and community supervision for the purpose of improving the mental health and well-being of participants, protecting public safety, reducing recidivism, and improving access to mental health resources. Every participant who is accepted into MHC has completed a criminogenic risk assessment which providers have access to and can use as a means of targeting client specific areas of risk. Providers provide interventions at the individual, group and case management level to target areas of risk as well. DBHS funds coordination of care, treatment services and housing programs for this population

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● **Family Recovery Court** - The mission of the Family Recovery Court is to treat individuals with substance use disorders through an intense and concentrated program to preserve families and protect children. This is achieved through court-based collaboration and an integrated service delivery system for the parents of children who have come to the attention of the court on matters of abuse and neglect. A drug court team, including the Judge, Guardian Ad Litem, Assistant Attorney General, parent defense counsel, DCFS drug court specialist, HMHI Assessment and Referral specialist, case managers, and the court's drug court coordinator, collaborate to monitor compliance with treatment and court-ordered requirements. DBHS funds services and care coordination for this population.

● **Drug Court** - The establishment of drug courts in the State of Utah is part of an ongoing effort to increase public safety by supporting recovery. Judges observed the same offenders appear in their courts time and time again, and it became evident traditional methods of working with individuals with a substance use disorder, such as strict probation or mandatory imprisonment, did not address the fundamental problem of addiction. Drug Court teams work through a close collaboration between the court system, supervising agencies and treatment providers. DBHS funds services and care coordination for this population.

● **Social Services Position Housed in the Legal Defenders Office** - this position, funded through DBHS, coordinates connecting individuals with severe mental illness involved in the criminal justice system to community treatment, Alternatives to Incarceration (ATI) Releases, referrals to Mental Health Court, etc. Additional social services positions are housed in the legal defenders' office, offering invaluable assistance in connecting large numbers of clients to treatment.

● **Case Resolution Coordinator** - An attorney funded through Salt Lake County, housed in the Legal Defenders Office, that helps individuals with behavioral health conditions resolve multiple court cases throughout the valley (in coordination with other court orders). Through close coordination of treatment and judicial oversight, individuals are diverted from incarceration, avoiding changes or lapses in their medications, loss of housing and associated emergency room visits or hospitalizations.

Sequential Intercept #4 – Reentry

● **Top Ten** - Once a month, DBHS facilitates a group that meets to staff frequently booked individuals with severe mental illness. Partners include the Legal Defender's Association (LDA), Valley Behavioral Health, HMHI Crisis Programs, Jail Mental Health, DBHS, Optum, The Road Home, Volunteers of America, the SLC PD Community Connections Center, 4th Street Clinic, Criminal Justice Services, Division of Services for People with Disabilities (DSPD), and Odyssey House. Team goals are to:

- ○ Ensure jail mental health is aware of an individual's diagnosis and medications prescribed in the community prior to arrest, and vice-versa, ensure community mental health programs are aware of an individual's diagnosis and medications prescribed in jail prior to release.
- ○ Develop a pre-release relationship with the inmate prior to release whenever possible.
- ○ Work to assertively engage the client in treatment upon release, address continuity of care/medications and transport if appropriate.
- ○ Refer into appropriate programs (Mental Health Court, ACT Teams, dual-diagnosis residential programs, Jail Diversion Outreach Team, other outpatient services, housing, DSPD services, etc.).
- ○ Communicate with the individual's attorney.
- ○ Communicate with county supervising case managers, state AP&P officers or other private supervising agencies.
- ○ Coordinate jail releases when appropriate.
- ○ Support the client to resolve open court cases.
- ○ Coordinate with medical providers when appropriate.
- ○ Coordinate with other community providers (VA, private providers, etc.).
- ○ Assist with housing, entitlements, and other needed supports.
- ○ Address individuals as pre-contemplative rather than non-compliant when unable to engage them into services. That is, try, try again.

Additional IT support is provided by the Salt Lake County Mayor's Office of Criminal Justice Initiatives, providing real time information regarding bookings, charges, court cases, and other pertinent information.

● **Jail Diversion Outreach Team (JDOT)** * - This VBH assertive community treatment "like" team

is a multidisciplinary team that assists severely mentally ill individuals that are frequent recidivists in the county jail.

● **CORE (Co-occurring, Re-Entry & Empowerment)** * - VBH CORE 1 and CORE 2, offer services to adult male and female individuals suffering from co-occurring disorders including substance use disorders and serious mental illness. These 16-bed residential facilities are designed to provide wraparound services both on-site and in the community, integrating mental health and substance use disorder treatment and focusing on medium/high risk and medium/high need individuals with supportive housing attached upon discharge. These programs were implemented due to community requests and have demonstrated impressive outcomes over the years with the ultimate goal of successful reentry and a reduction in jail recidivism.

DBHS utilizes multiple funding streams, including JRI, for the VBH CORE 1 & 2 programs.

A 2020 report found a 78.6% reduction in criminal recidivism for CORE 1 (men) and a 92.5% reduction for CORE 2 (women), when comparing 3 years prior to 3 years post program admission.

JRI dollars also support housing for the CORE programs and Jail Diversion Outreach Team clients. DBHS contracts for these housing resources through Housing Connect, and are generally master leased units. Valley Behavioral Health provides mental health and substance use disorder services and in-home case management visits throughout the client's residency in these units.

● **Odyssey House Women's MH Residential Program -** This 16-bed facility is a dual-diagnosis residential facility for women, providing mental health stabilization services and medication management to women with primary mental health diagnoses. Due to high demand from Mental Health Court and other stakeholders, this new program was brought online in 2020.

● **Odyssey House Men's MH Residential Program -** This 16-bed facility opened on April 27, 2022, and is a dual-diagnosis residential facility for men, providing mental health stabilization services and medication management to women with primary mental health diagnoses. Due to high demand from Mental Health Court and other stakeholders, this new program was brought online.

● **ATI Transport** * - This VBH program transports severely mentally ill inmates released from the jail at a specific time (avoiding nighttime releases) and transports them to a community-based treatment provider for assessment and services.

● **DORA** * - A collaboration between Adult Probation and Parole, the court system and behavioral health service providers utilizing smarter sentencing guidelines for better treatment outcomes.

● **The Fourth Street Clinic** - Collaborates with the jail health system to help provide continuity of care for individuals who are registered patients at Fourth Street Clinic, supporting these patients to continue the medications and treatment they were receiving prior to incarceration. Staff at FSC are also able to coordinate with the jail health system to help provide continuity of care when individuals experiencing homelessness are released from jail and want to re-establish care with the clinic.

● **DWS Medicaid Eligibility Specialists** - DBHS funds a Medicaid Eligibility Specialist to assist with enrollment into Medicaid. Prior to the pandemic, this was a mobile position, visiting various locations such as the jail, court settings and Criminal Justice Services. Currently these services are provided remotely. Another DWS Medicaid Eligibility Specialist is embedded within the largest behavioral health provider.

● **Navigator and Certified Application Counselor Assistance** - DBHS providers, the jail, Criminal Justice Services, the Legal Defenders Association, Homeless Resource Centers, state corrections programs, and others, collaborate with navigators and certified application counselors to enroll individuals in Marketplace Plans, Medicaid and other health plan options, through Take Care Utah. Prior to the pandemic, these services were provided at many different locations, including court settings, the jail, provider locations, pretrial and probation settings. Currently they are a blend of in-person, and remote services. DBHS worked aggressively throughout the years to develop a coordinated response to enrollment efforts within the criminal justice and behavioral health populations.

● **Gap Funding** * - DBHS provides gap funding to assist with medications and treatment for uninsured severely mentally ill individuals being released from jail.

● **Jail Resource Reentry Program -** is voluntary and offers support to individuals as they transition back into the community to avoid recidivism and provide services to prevent them returning to the same circumstances that led to their arrest, helping to make the community safer. Salt Lake County Criminal Justice Services, the Salt Lake Legal Defenders Association and Valley Behavioral Health assist individuals to assist them in navigating the complexity of criminal justice and social services systems. Clients receive have access to email, phone calls and free Wi-Fi; phone charging stations; snacks, water, female personal hygiene products; SNAP/Medicaid enrollment; Department of Workforce Services (DWS) information; a safe place to wait for services; transport options (bus tokens, VOA van service, homeless van services); homeless housing referrals; donated clothing items are available on-site.

Sequential Intercept #5 – Community

● **VOA & VBH Assertive Community Treatment (ACT) Teams & Odyssey House (OH) Forensic ACT Team** - Salt Lake County/Optum has contracted with VOA, VBH and OH to implement Assertive Community Treatment (ACT) Team service delivery models for Salt Lake County residents. The teams provide intensive home and community-based services. The ACT Teams offer a "hospital without walls" by a multidisciplinary team. The emphasis is to provide support to those who are high utilizers of services and to offer stabilization within the community. The programs are implemented to fidelity to the evidence-based model as outlined by SAMHSA. DBHS also funds housing for these programs. A large portion of these individuals are justice-involved.

● **Housing Programs** * – DBHS funds multiple housing first initiatives for individuals involved in the justice system. Some serve individuals with severe mental illness, while others are tailored towards supporting individuals with primary SUD conditions. These programs are a combination of scattered units throughout the valley, boarding homes, rental assistance vouchers, sober living homes, and partnerships on tax credit housing projects where DBHS

funds Medicaid supportive living rates, rental subsidies, and even some capital expenses.

In addition to the above, there are many housing programs through other funding streams that DBHS partners with and in some cases funds in-kind behavioral health services for, to assist in meeting HUD funding requirements.

JRI funding is used for a portion of these housing programs.

● **Intensive Supervision Probation (ISP) Program** * - DBHS continues to partner with the Sheriff's Office and CJS on the ISP program. This program targets high-risk, high-need (SUD) individuals sentenced to county probation at CJS. Clients are evaluated using the LS/CMI risk tool, along with an ASAM assessment to determine appropriate level of supervision and care. They are supervised in the community by deputies from the Sheriff's Office and receive intensive case management services through CJS. DBHS continues to provide dedicated assessment staff working in coordination with the deputies and case managers, as well as prioritized access to treatment services for the uninsured and underinsured populations. Through this model there has been an increase in the number of clients who present for an assessment and treatment, reductions in the wait times associated with accessing treatment, and lower attrition rates when compared to the overall system. Through the expansion and evolution of the program, Recovery Support Services (case managed at DBHS), access to evidence-based MAT (case managed at DBHS and offered through a network of providers), and peer-led recovery coaching (through a contract with USARA) are accessible to ISP participants. Between 2015 and 2021, over 60% of all clients have been referred due to drug-related offenses and over 99% have struggled from moderate or greater SUD. Additionally, over 32% of all clients have identified opiates as a primary substance of abuse (26.9% of all males and 35.7% of all females).

In March 2016 this program was presented to the County Council and received unanimous support for an increase in ongoing county funds ($2.3 million overall, $790,000 for community treatment) to grow the program. County funds for this program are not included in this budget narrative. After successful implementation, ISP received several accolades for the innovative strategies employed to stop the revolving door of recidivism in Salt Lake County, including: the 2016 National Association of Counties (NACo) Achievement Award; was selected to present at the national 2016 American Probation and Parole Association Conference in Cleveland; the 2017 Salt Lake County Sheriff's Office Distinguished Unit award; and, was recognized by the Honorary Colonels of Salt Lake in 2018.

An additional $1.4M was awarded to ISP in July 2017 from the Justice Reinvestment Committee (JRC funds cut in FY20). Leveraging these funds, ISP was able to fund a third licensed mental health therapist (has since reduced back to two, and then back down to one based on pandemic shifts and demand) to provide additional clinical assessments. The program also was able to expand treatment capacity, funding an active caseload of 280 clients, up from the original program capacity of 180 clients. By utilizing county funds, ISP was able to expand supervision and case management capacity as well (hiring 2 additional case managers and 3 Sheriff's Office deputies).

In a 2021 evaluation, 406 clients were admitted into the ISP program during a 12 month period (January 2020 – December 2020). Since the program's inception 320 individuals have graduated, and multiple successful outcomes documented: 75.4% of all clients referred into ISP have been assessed for treatment. Looking at a snapshot of the program in March of FY20, 73.1% of all open clients remain

actively engaged in treatment. Graduates of the program enjoy a 34% reduction in risk scores. Successful clients saw an 86% reduction in new-charge bookings (comparing one year prior to one year post-program intake); revoked clients showed a 59.2% reduction; with the total population showing a 71.6% reduction.

FY20 was a time of transition for this program due to the elimination of JRC funding. While the number of uninsured and underinsured individuals post-Medicaid Expansion is unknown, it was our intention to maintain current levels of programming throughout this time by transitioning from JRC funding to Medicaid funding. Every effort was made to enroll participants into Medicaid. In addition to specialty enrollment efforts put in place during the Targeted Adult Medicaid (TAM) expansion, two large eligibility and enrollment training sessions were held at the County Government Center. Approximately 213 individuals from 20 organizations across the county registered or walked into these trainings. The Utah Department of Health presented on the eligibility criteria, the Utah Department of Workforce Services presented on enrollment guidelines, and additional resources such as Take Care Utah were presented as options for clients as they transition from Medicaid into Marketplace Plans. DBHS requires providers to utilize Medicaid prior to accessing public dollars and audits to adherence to this process. It is important to keep in mind that DBHS will no longer be able to monitor data for this program in the same way, as the new Medicaid Expansion and Targeted Adult Medicaid dollars do not flow through this agency, and as such, will not have access to a complete data set.

During FY21, due in large part to TAM and the Adult Medicaid Expansion occurring over the prior two years, a large portion of treatment funds were no longer needed for this program. The participating treatment providers assisted with a seamless transition in funding source to Medicaid without service interruption to the clients. With the Medicaid expansions being open to other providers outside of the DBHS network, additional providers have begun to serve ISP clients as well. JRI funds continue however to play a large role in funding the correctional staff and other ancillary, non-Medicaid funded services such as UA testing, RSS services and recovery coaching through USARA.

● **Mental Health Court Housing** – beginning in FY22, mental health court housing units (2 master leased units and 6 units at First Step House's Fisher House) transferred from Salt Lake County Criminal Justice Services to DBHS.

● **Rep Payee Services** - a supportive service to individuals in need of assistance in managing their finances. Many individuals with severe and persistent mental illness, cycling through the criminal justice system, benefit from this type of service.

● **Supported Employment Programs** – multiple Salt Lake County network providers operate successful employment assistance programs for justice-involved populations.

● **USARA (Utah Support Advocates for Recovery Awareness)** - DBHS assists with funding for this program. This organization provides peer recovery support services, delivered by peer recovery coaches, a non-clinical support that brings the lived experience of recovery along with training and supervision to assist individuals in initiating and/or maintaining recovery. They also provide support groups for families and friends who are concerned about someone with a substance use disorder.

This program has targeted efforts for justice-involved populations such as the Intensive Supervision Probation Program, Family Recovery Court, and others.

● **Medication-Assisted Treatment Programs** - In recent years, DBHS utilized federal dollars to expand medication-assisted treatment access within the community. Salt Lake County had six out of the top ten hotspots identified within the state for opioid related emergency room visits and overdose deaths. In an effort to address these hotspots, capacity in the existing Project Reality location was increased, and two new clinics were opened in other areas of the county.

One of the new clinics is located in West Jordan, through Clinical Consultants, the other is located in Murray, through Project Reality. Federal grant dollars are utilized to maintain these clinics. Additionally, Discovery House, Tranquility Place, BayMark have been added to our network of providers.

● **Community Mental Health and SUD programs** - there are many other mental health or substance use disorder treatment programs, in all levels of care, that serve the criminal justice population. Medicaid expansion has enabled an unprecedented expansion of these services.

As an example, ~170 SUD residential beds existed in 2016, and currently exceeds 600, more than tripling capacity within the Salt Lake County network. Additional services have expanded outside this network as well.

Criminogenic Screening and Assessment Tools
In Salt Lake County, services are provided through a network of public and private providers within the community. The criminogenic screening and assessment tools utilized by these programs may be varied. The Intensive Supervision Probation Program for example employs the LS/CMI with each program participant, while the University of Utah Assessment and Referral Services utilizes the RANT. Unfortunately, even though Salt Lake County Criminal Justice Services and Adult Probation and Parole complete the LS/CMI with participants, the full results are not shared with providers within our system (based on proprietary concerns) requiring duplication within the network.

Strategies used with low and high risk offenders
All clients are screened for criminogenic risk using validated, JRI-recommended tools (either the LS/CMI, the LSI, or the RANT) depending on the agency. Based on capacity at each agency, and the ability to stratify residential and outpatient programs by risk, clients are separated into the most appropriate setting. For example, Odyssey House places all 'intense' and 'very high' risk clients at their Millcreek campus. All 'high' clients go to the Downtown facility. All moderate clients attend Lighthouse, and all 'moderate-low' clients attend the Meadowbrook facility. Because of the size of the programs at Odyssey House, they would not have low-risk clients in service with high-risk clients. For the outpatient side of services, OH places all lower risk clients in the weekend IOP/OP Expedition Program. Not as much flexibility exists for outpatient. Other agencies do not have as much flexibility because of the size of their programs and other financial constraints. First Step House for instance does not serve many, if any, low-risk clients. They do have some higher and intense risk programs that will serve only clients scoring in the 25+ range of the LS/CMI (REACH Program). Lower risk clients at FSH are typically referred to other programs for services, where they can receive differentiated services based on their lower risk scores. In our criminal justice programs (such as the ISP Program), many different EBPs are utilized to work with lower risk (all clients are at least a 20 on the LS/CMI) clients. These include EPICS (Effective Practices in Community Supervision), BITS (Brief Intervention Tools), Seeking Safety, and risk-based case planning based on the Risk, Needs, Responsivity (RNR) model.

Describe how clients are identified as justice involved clients
There are many ways that a client can be identified as a justice-involved person. ● Some clients may be referred by a criminal justice partner, such as: ○ The courts ○ Legal defender ○ District attorney ○ Criminal justice services ○ Law enforcement ○ Adult Probation & Parole ○ Jail or Prison ○ Halfway House, and others. ● Some clients may self-report an active court case. ○ This can occur prior to sentencing (with no court-ordered treatment or with a sentence that did not include an order to treatment). ● Some clients may self-report interactions with law enforcement. ○ This can occur without a case being filed in court or any court-ordered treatment. ● Some clients may have a recent history and pattern of justice involvement, with multiple cases closed (none open), but cycling through the criminal justice system. A good example of this would be a Forensic ACT client, with 52 previous bookings, still using illegal substances, off his/her medications, and homeless.

How do you measure effectiveness and outcomes for justice involved clients?
Correctional Program Checklist (CPC) - The CPC is a tool developed to assess correctional intervention programs and is used to ascertain how closely those programs meet known principles of effective intervention. Several studies conducted by the University of Cincinnati-of both adult and juvenile programs-were used to develop and validate the indicators on the CPC. These studies found strong correlations with outcome between overall scores, domain areas, and individual items. The CPC is divided into two basic areas: CAPACITY and CONTENT. The CAPACITY area is designed to measure whether a correctional program has the capability to deliver evidence-based interventions and services for offenders. There are three domains in the capacity area including: (1) Leadership and Development; (2) Staff; and (3) Quality Assurance. The CONTENT area focuses on the substantive domains of: (1) Offender Assessment; and (2) Treatment Characteristics. This area evaluates the extent to which the program meets the principles of risk, need, responsivity, and treatment. There are a total of 77 indicators, worth up to 83 total points. Each area and all domains are scored and rated as either "HIGHLY EFFECTIVE"; "EFFECTIVE"; "NEEDS IMPROVEMENT": or "INEFFECTIVE". As a network system, multiple agencies within the DBHS network have worked with the CPC to assess, and then implement strategies to improve their services, in particular around individuals with current or past justice involvement. In recent years, First Step House and Odyssey House have worked extensively with the CPC, among other agencies. DBHS has developed multiple outcome measures that vary from program to program. Please reference the attached compilation of reporting metrics and sections in this narrative above for some examples. Data DBHS has collected in the past include hospital diversion rates, treatment engagement, graduation rates, reductions in Risk Scores, positive drug testing rates, number of bed nights funded for individuals in permanent supportive housing, changes in census in co-occurring residential programs, changes in ACT Team census numbers and NOMS data such as employment, housing and "frequency of use" changes. New outcome measures for ACT teams were developed in FY22 and continue to be monitored on baselines and targets established in FY23. DBHS has also tracked reductions in jail recidivism for certain cohorts through a data sharing agreement with the Salt

Lake County Jail.

Although Medicaid expansion has been a huge benefit to the behavioral health population we serve, it is important to understand that since November 2017 (the implementation of TAM), April 2019 (the Medicaid Expansion to 100% FPL), and finally January 2020 (expanding up to 138% FPL), DBHS lost the ability to track many of the metrics above for a large portion of these programs.

Significant anomalies may occur in data and outcome metrics for FY21 and forward due to COVID responses both within the treatment system and within our county jail.

Identify training and/or technical assistance needs.

None presently

Identify a quality improvement goal to better serve justice-involved clients.

Although progressive for its time in 2012, the Receiving Center (RC), is currently underutilized by law enforcement and emergency services. Though it is set up to receive referrals from law enforcement, these referrals have decreased over the years due to the requirement that clients routinely need to go to the emergency room first to be medically cleared. Though that was not a requirement when the existing Receiving Center initially began, this became a necessity due to a combination of medical liability concerns, physical setup of the Receiving Center space, and inability to fund the correct staffing model to operate as a "no wrong door" facility. This, plus the location of the facility, is a discouragement to law enforcement since it takes them off the streets for extended periods of time.

Our goal is to open a new centrally located, non-refusal Receiving Center. DBHS was awarded funding for a new non-refusal Receiving Center, SLCo transferred the property, and thanks to HMHI and additional partners and funding, a groundbreaking occurred in May, 2021. This program will serve Salt Lake County community members who are in psychiatric or substance use-related crisis; however, the new Receiving Center will accept any and all individuals including walk-ins, secure drop-offs, and referrals for assessment. As a non-refusal RC for police, firefighters, and EMS, many of these individuals will be low-level offenders cycling through the county jail, whose crimes are secondary to untreated or undertreated mental illness or substance use disorders. Others may be frequent patients in emergency departments throughout the Salt Lake Valley. These individuals will benefit from medical and psychiatric triage, clinical assessment, peer support, discharge planning, connection to community resources and partners, and referral to treatment programs such as inpatient care, medical care, and Detox.

Due to this facility not becoming operational until 2025, the Salt Lake County Council voted to dedicate $2.5M (ARPA funding) towards a temporary RC to act as a bridge until the new RC is built and operational. It will be a non-refusal center with the ability to expand to 12 chairs (increasing from 5 in the current facility).

Identify the efforts that are being taken to work as a community stakeholder partner with local jails, AP&P offices, Justice Certified agencies, and others that were identified in your original implementation committee plan.

DBHS recognizes Justice Reinvestment Initiative (JRI) Programming as a countywide initiative affecting multiple stakeholders including law enforcement, the county jail, courts, criminal justice services, legal defender's office and district attorney's office. As a result, when implementing a JRI strategy DBHS was

committed to broad support of county stakeholders, including approval from the following Criminal Justice Advisory Council stakeholders prior to implementing programming with JRI community-based treatment funding:

Mayor Jenny Wilson	Salt Lake County Mayor
Sheriff Rosie Rivera	Salt Lake County Sheriff's Office
Hon. Brendan McCullagh Judge	West Valley City Justice Court
Jean Hill	CJAC Coordinator
Honorable Jojo Liu Judge	Salt Lake City Justice Court
Jim Bradley	Salt Lake County Council
Dave Alvord	Salt Lake County Council
Jack Carruth	Chief of Police, South Salt Lake City
Karen Crompton	Director Salt Lake County Human Services
Sim Gill	District Attorney, Salt Lake County
Kele Griffone	Director, Criminal Justice Services
Representative Jim Dunnigan	Utah House of Representatives
Senator Stephanie Pitcher	Utah State Senate
Matt Dumont	Chief, Salt Lake County Sheriff's Office
Rich Mauro	Executive Director, Salt Lake Legal Defenders Association
Kim Brock	Third District Court Executive
Jim Peters	State Justice Court Administrator
Honorable Mark Kouris	Presiding Judge, Third District Court
Honorable Susan Eisenman	Third District Juvenile Court
Aimee Griffiths	AP&P Region Chief
Andrew Johnston	Salt Lake City Homeless Policy and Outreach
Tiffany King	Crime Victim Advocate
Jason Marzuran	Chief, Unified Police Department, LEADS Chair
Wayne Niederhauser	Office of Homeless Services
Jeff Silvestrini	Mayor, Millcreek City
Tim Whalen	Director, Salt Lake County Behavioral Health Services
Pamela Vickrey	Utah Juvenile Defender Attorneys, Executive Director
Scott Fisher	Salt Lake City Municipal Prosecutor
Luna Banuri	Chair, SL County Council on Diversity Affairs, Subcommittee on Criminal Justice & Law Enforcement

Additional stakeholders that participated in implementing these programs included: The University of Utah Assessment and Referral Services, Odyssey House, First Step House, Valley Behavioral Health, Clinical Consultants, Project Reality, Volunteers of America, House of Hope, the University of Utah Neuropsychiatric Institute and the Salt Lake City Police Department Social Work Program.

DBHS is a member of the Criminal Justice Advisory Council, where ongoing systemic needs are addressed monthly, coordinated and planned for. One example is the new Receiving Center. This item will be periodically addressed on the agenda to provide updates and receive feedback from stakeholders.

Identify efforts being taken to work as a community stakeholder for children and youth who are justice involved with local DCFS, JJYS, Juvenile Courts, and other agencies.

Examples of services to these populations include:

Volunteers of America, Utah's Treatment Services Division (Cornerstone Counseling Center/Family Counseling Center - VOA/CCC/FCC) - has several programs to assist children and youth who are justice-involved with local DCFS, DJJS, Juvenile Courts, etc. Both CCC and FCC provide direct mental health services based on the client-centered biopsychosocial assessment. Services are provided by Licensed Mental Health Therapists as well as therapists working towards full licensure and Advanced Practice Registered Nurses (APRNs). Medication management services are provided for youth aged 16 years and older. Other available services include individual therapy (including play therapy) for children four years and older, group therapy as indicated by current census, and family therapy. Additionally, CCC provides Parent Child Interaction Therapy (PCIT), an evidence-based practice, for children aged two and a half up to seven years old.

Odyssey House - Their adolescent continuum serves JJS and DCFS youth and works closely with JJYS and DCFS workers to coordinate care. Their school-based behavioral health services work with JJYS and DCFS youth K-12 schools in every district in the county. The Youth Afterschool Program was developed in partnership with JJYS and demonstrates significant recidivism reductions. Finally, their Parents with Children Program works with DCFS custody youth to re-unify them with their parents while concurrently providing mental health and developmental services.

Salt Lake County Division of Youth Services-Juvenile Receiving Center (JRC) - This program offers screening, evaluation and referral services to youth, families and law enforcement 24/7. Services are for youth ages 8 to 17 who need a crisis timeout, are runaway, homeless, ungovernable youth or youth who have committed minor offenses. Youth may come to the facility on their own, with parents or police may bring in youth who have committed a status offense or delinquent act that does not meet Detention Admission Guidelines. This may include but not limited to running away from home, truancy, substance use, curfew violation or acting beyond the control of the youth's parents. No appointment is needed to access the Juvenile Receiving Center services including individual or family crisis counseling. Serving two locations: Salt Lake and West Jordan. The Salt Lake location operates 24/7, the West Jordan office operates 8am - 8pm Monday through Friday.

Please also refer to the Drug Court section of the SUD Narrative for additional information on support to the Juvenile Drug Court and Family Recovery Court.

21) Specialty Services *Pete Caldwell*

If you receive funding for a speciality service outlined in the Division Directives (Operation Rio Grande, SafetyNet, PATH, Behavioral Health Home, Autism Preschools), please list your approach to services, how individuals are identified for the services and how you will measure the effectiveness of the services. Include any planned changes in programming or funding. <u>If not applicable, enter NA.</u>

The ORG funding had been used for VBH's ACOT team. Historically, VBH had offered an Assertive Community Outreach Team (ACOT) for adult clients with SPMI/SMI. The ACOT subscribed to an Assertive Community Treatment Team approach with services to promote a client's growth and recovery and to enhance the quality of their personal, family, and community life. The ACOT primarily provided case management services to Medicaid and non-Medicaid clientele. However, toward the end

of FY21, VBH took the necessary steps to convert the ACOT to a SAMHSA full fidelity ACT team. Though VBH will serve any person who meets criteria, they specialize in those with criminal justice involvement. Most of those who were already clients of ACOT transitioned into the new ACT team when the ACT team was first organized.

As of this writing, the VBH ACT team is not at full capacity. However, when at capacity, this team will serve approximately 100 members needing these community-based services. VBH will follow the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures will be completed by VBH and reported to Optum. Depending upon the measure, evaluation will be completed weekly or monthly. Outcome measures include increase in community tenure including housing stability and employment/volunteering involvement while simultaneously reviewing reduction of inpatient admissions.

The Projects for Assistance in Transition from Homelessness (PATH) program funds community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services for seriously mentally ill individuals. PATH funds are used for those who are literally homeless or at imminent risk of becoming homeless. Priorities for services should be for those who are literally homeless.

Safe Haven 1 Transitional Housing program has 25 units for SMI clients who have been homeless for at least three of the previous six months. Residents of Safe Haven 1 are able to maintain their status of homelessness, so they can continue to qualify for permanent housing.

Safe Haven 2 has 24 permanent housing units for those individuals challenged by a history of chronic homelessness, mental health and substance abuse issues. They are assisted with apartment living/home maintenance, medication management, benefit management, skills development, socialization and peer support services.

Client Requirements:
- The client must be homeless.
- The client must carry a diagnosis of Mental Health disability.

Treatment Process:
Once Outreach and Enrollment is completed, the Contractor shall provide the following PATH Treatment services as needed:

1. Screening and Diagnostic Treatment Services
2. Habilitation and Rehabilitation Services
3. Community Mental Health Center Services
    1. Provide or refer the PATH eligible clients to the following services as necessary:
        1. Mental health diagnosis;
        2. Evaluation of treatment needs;
        3. Mental health treatment;
        4. Medication management; and
        5. Psychosocial rehabilitation services
    2. Ensure that providers of referred services meet the same qualifications required of the Contractor for the applicable services and all other contract requirements.

4. Substance use treatment: The Contractor shall provide or refer for preventive, diagnostic, and other services and supports for people who have a psychological and/or physical dependence on one or more substances.
5. Case Management: The Contractor shall provide case management services that includes advocacy, communication, and resource management that are used to design and implement a wellness plan specific to a PATH-enrolled individual's recovery needs as follows:

1. Developing and implementing a service plan for the provision of community mental health services, and reviewing such plan not less than once every 90 days;
2. Assisting the PATH eligible client in obtaining and coordinating social and maintenance services including services related to daily living activities, transportation, prevocational-vocational training and housing;
3. Arrange with medical and dental providers to provide services to the PATH eligible clients.
4. Assisting the PATH eligible clients in applying for and obtaining income support services, such as, food stamps, housing assistance, and supplemental security income benefits, other public entitlements and medical insurance; and
5. Referring PATH eligible clients to other appropriate agencies and representative payee services in accordance with Section 1631 (a) (2) of the Social Security Act.

6. Residential supportive services: Contractor shall provide services that help PATH-enrolled individuals practice the skills necessary to maintain residence in the least restrictive community-based setting possible. The Contractor shall provide these services, refer and arrange for these services for PATH eligible clients in residential settings. The Contractor shall *not* provide or refer clients for services that are funded under: 1) the transition housing demonstration program of the Housing and Urban Development (HUD) pursuant to section the supportive housing demonstration program established in subtitle C, Title V of the Stewart B. McKinney Homeless Assistance Act.
7. Referral Services: The Contractor shall refer PATH eligible clients and facilitate or arrange access to, and referral for, primary health services, job training, and educational services as follows:

1. Community mental health referral
2. Substance use treatment referral
3. Primary health/dental care referral
4. Job training referral
5. Employment assistance referral
6. Educational services referral
7. Income assistance referral
8. Medical insurance referral
9. Housing services referral
10. Temporary housing referral
11. Permanent housing referral

8. Housing Services
9. Transition to Mainstream: Assist PATH eligible clients to make a formal change from PATH to housing and services funded through other programs such as Section 8, Medicaid, Public Health, Mental Health / Substance Abuse Block Grant.

22) Disaster Preparedness and Response ***Nichole Cunha***

Outline your plans for the next three years to:
Identify a staff person responsible for disaster preparedness and response coordination. This individual shall coordinate with DHHS staff on disaster preparedness and recovery planning, attending to

community disaster preparedness and response coalitions such as Regional Healthcare Coordinating Councils, Local Emergency Preparedness Committees (ESF8), and engage with DHHS in a basic needs assessment of unmet behavioral health disaster needs in their communities. In addition, please detail plans for community engagement, to include partnership with local councils and preparedness committees as well as plans for the next three years for staff and leadership on disaster preparedness (to include training on both internal disaster planning and external disaster preparedness and response training). Please detail what areas your agency intends to focus on with training efforts and timeline for completing training.
Nancy Kessel is our identified staff who is responsible for our emergency plan. Salt Lake County is currently working with a consulting firm to re-design the emergency plans. We are unsure of where this project is headed and what it will entail. We will be reviewing our plan annually and making sure that staff and leadership are aware of what is included in the plan.

23) Required attachments

- **List of evidence-based practices provided to fidelity and include the fidelity measures. Please see Form A Attachment A.**
- **Disaster Preparedness and Recovery Plan to coordinate with state, regional, and local partners in Disaster Preparedness Planning and Supporting Disaster Behavioral Health Response.**
- **A list of metrics used by your agency to evaluate client outcomes and quality of care. Please see Form A Attachment B.**
- **A list of partnership groups and community efforts (ie. Multi-Agency Coordinating Committees, Regional Advisory Councils, High Fidelity Wraparound teams, Local Interagency Councils, Local Recovery Community, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts including Mental Health Court, Regional Healthcare Coalitions, Local Homeless Councils, State and Local government agencies, and other partnership groups relevant in individual communities)**