GOVERNANCE & OVERSIGHT NARRATIVE

Local Authority: Salt Lake County Behavioral Health (DBHS)

Instructions:

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

1) Access & Eligibility for Mental Health and/or Substance Abuse Clients

Who is eligible to receive mental health services within your catchment area? What services (are there different services available depending on funding)?
All residents of Salt Lake County are eligible for services regardless of their ability to pay. We do expect residents with insurance, adequate wages, or other forms of payment to pay for as much of their care as possible but payment is based on our Local Authority approved sliding fee schedules. The fee schedule aligns DBHS's fee policy with federal poverty guidelines related to the Affordable Care Act. Public funds, by contract language, are the payer of last resort. We consider insurance and other non-public funds to be third-party liability (TPL) payments and require Optum as well as other network providers to maximize TPL payments. All ASAM (American Society of Addiction Medicine) levels of care (LOC), from ASAM .5 to ASAM 3.5, and all mental health (MH) LOCs, from standard outpatient to acute hospitalization, are available to any qualifying Salt Lake County resident. To qualify for DBHS funded services clients must meet a residency requirement and receive an ASAM or MH assessment to determine the appropriate level of care. For someone who is experiencing homelessness, residency requirements are waived. Within the Medicaid program, we maintain and adhere to Medicaid Access standards. Access for the Non-Medicaid population is challenging as funding limits availability. However, we do provide Substance Use Disorder (SUD) interim groups for individuals who are awaiting enrollment in a program. DBHS will submit their annual PMHP Financial Report (Medicaid Cost Report) to DSAMH annually within 15 days of finalizing the report with the Department of Health Division of Medicaid Financing.
Who is eligible to receive substance abuse services within your catchment area? What services (are there different services available depending on funding)? Identify how you manage wait lists. How do you ensure priority populations get served?
Same response as above for the first two questions. Regarding wait lists, there are no wait lists for Medicaid clientele due to the timely access standards required by Medicaid. However, this is only possible due to funding being available on-demand for Medicaid clientele. For those clients who are unfunded (i.e., Block Grant funding) each contracted provider must maintain their own wait list. The contracted providers have a person(s) designated for intakes. This individual maintains the waiting list. Most providers require clients to call in each day/week (program specific) to check-in, express their continued interest in SUD treatment, and will be told at that time if they can now be admitted or if their place on the wait list has changed. Approximate dates are given for when the client may expect admission, but these can vary greatly due to the nature of those in SUD treatment and the course of treatment. The Federal priority populations, along with the required timelines for accessing treatment, are in every provider's contract. These priorities are reviewed during the annual monitoring visit. Additionally, when a client contacts Assessment and Referral Services (ARS) for an assessment, the questions relating to the priority requirements are asked. Similarly, when a client contacts a provider directly for an assessment, the Federal priority questions are asked. Should anyone meet the Federal priorities, their admission and assessment are prioritized according to the required timelines. While on the wait list, any given client can attend interim groups offered through ARS six days a week. These are

free of charge. Additionally, a few providers also have interim groups which the clients may attend, free of charge.

What are the criteria used to determine who is eligible for a public subsidy?

As described above, we expect clients who either have the ability to pay or have adequate insurance to pay for as much of their treatment as possible. However, for the underinsured and uninsured client proof of income must be provided. When determining the appropriate fee for services, providers are encouraged to take into account other financial responsibilities the client has such as mortgage or rent, paying of fines, child support, etc., which demonstrate they are a contributing member of society and working toward recovery. For those who are indigent a history is obtained which shows the need for treatment and the lack of ability to pay for treatment. All providers are educated that the lack of ability to pay for treatment cannot be a barrier to treatment. The sliding fee scale applies to anyone who enters treatment under a public subsidy.

How is this amount of public subsidy determined?

In general, the amount of public subsidy is dependent on the appropriation amount by the legislature, the SLCo Council, and other grant/transfer funds available through the DSAMH. Amounts are also dependent on the intent of the funding – for instance the prevention set-aside cannot be used for MH services, the early intervention funds cannot be used for SUD treatment, etc.

Treatment is not just one service but a comprehensive list of services and an entire treatment episode can range from several hundred dollars to several thousand, depending on the need and the length of stay in treatment. Instead of how much of a public subsidy a person will receive, it is based on how much a person can pay.

For the underinsured and uninsured client, proof of income must be provided. In addition to this, providers are encouraged to take into account other responsibilities the client has such as mortgage or rent, paying of fines, child support, and other things for which they are showing that they are a contributing member of society and working toward recovery. For those who are indigent, a history is obtained that shows the need for treatment and the lack of ability to pay for treatment. Based on this information all providers are required by contract to have a sliding fee agreement in every client's file. All providers are educated that the lack of ability to pay for treatment cannot be a barrier to treatment.

How is information about eligibility and fees communicated to prospective clients?

All residents of Salt Lake County that need behavioral health services are eligible to receive them based on appropriations. All network providers are required via contract to apply the DBHS's approved sliding fee schedule, or otherwise approved sliding fee schedule, and explain it adequately to all those Salt Lake County residents seeking care.

When a client first calls for an appointment, ideally the provider will inform the client of eligibility requirements, ask about Salt Lake County residency, and inform the client of required documents that he or she needs to bring to the intake. When a client first comes in for an intake, eligibility and fee criteria are communicated to the client in further detail. Providing the client has brought all the required documents, they can be immediately informed of eligibility and, if they qualify, what their financial responsibility is going to be.

Are you a National Health Service Core (NHSC) provider? YES/NO
In areas designated as a Health Professional Shortage Areas (HPSA) describe programmatic implications, participation in National Health Services Corp (NHSC) and processes to maintain eligibility.

DBHS is not an NHSC provider. Additionally, DBHS is not advised when any particular area is designated as HPSA.

2) Subcontractor Monitoring

The DHS Contract with Mental Health/Substance Abuse Local Authority states: When the Local Authority subcontracts, the Local Authority shall at a minimum:

(1) Conduct at least one annual monitoring review of each subcontractor. The Local Authority shall specify in its Area Plan how it will monitor their subcontracts.

Describe how monitoring will be conducted, what items will be monitored and how required documentation will be kept up-to-date for active subcontractors.
All contracted network providers are monitored at least once per year. DBHS staff conduct regular on-site monitoring, electronic monitoring through our EHR, and spot check monitoring as needed for all vendors who are directly contracted with DBHS. This includes our SUD vendors and also our MH vendors who received non-Medicaid monies. Optum monitors its 150+ network providers at least once during the contract cycle. High volume audits are completed on all large providers annually. DBHS monitors/audits Optum at least once per year, but more often if needed. Additionally, the consistent, ongoing reviews and re-authorizations required by contract of any ASAM LOC higher than ASAM 1.0 and any MH contract where the client receives five or more hours a week of treatment immediately alerts us when any issues are identified. A complete list of monitoring tools for SUD items and for MH services is available upon request. All documentation is contained in UWITS or Optum's EHR, Netsmart, or other EHR approved by DBHS. All contracted network providers are required by contract to keep documentation up-to-date and accurate. DBHS requires, through contract language with providers, that the treatment plan and ASAM assessment and mental health assessment be kept current. DBHS determines compliance with this during their annual monitoring visits. For providers that directly contract with DBHS to provide non-Medicaid services, DBHS maintains current copies of insurance certificates, Division of Office of Licensing licenses, and conflict of interest forms in the contractor's file. Optum is responsible for maintaining this documentation for their contracted Medicaid providers. DBHS verifies this during their annual monitoring visit of Optum. For DBHS' audit of our contracted managed care organization (MCO), Optum, an audit is completed annually. There are two parts to the audit, clinical/administrative and financial. For the clinical/administrative audit, that begins in the early spring and is concluded by June 30 of each year. The final report is issued by September 30 of each year. The reason for this timing is to give providers an opportunity to become familiar with any new requirements and implement them in a meaningful manner. Additionally Medicaid's audit of our MCO for the previous calendar year is in July or August each year (varies year by year). There are some things which Medicaid measures which exceed the scope of our audit and we believe it crucial to add their findings into our audit report for a comprehensive review. We receive Optum's response no later than October 31.Therefore, DSAMH can expect to receive the clinical/administrative report no later than November 15 of each year. For the financial audit, we consider that concluded once Medicaid has completed their financial audit. This is done in order to add validity to our audit and demonstrate that an agency independent of DBHS concurs with our findings. We receive the Medicaid audit report sometime in June and issue our final report by July 31 of each year. We receive Optum's response no later than August 31. Therefore, DSAMH can expect to receive the financial audit report no later than September15 of each year.

FORM A - MENTAL HEALTH BUDGET NARRATIVE

Local Authority: Salt Lake County Behavioral Health (DBHS)

Instructions:

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

1) Adult Inpatient

Form A1 - FY21 Amount Budgeted:	**$7,193,368**	**Form A1 - FY21 Projected clients Served:**	**350**
Form A1 - Amount budgeted in FY20 Area Plan	**$5,213,737**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**350**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$6,299,462**		**342**

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.

For Medicaid clientele, DBHS's/Optum's Network consists of contracts with the University Neuropsychiatric Institute (UNI), Jordan Valley West (formerly known as Pioneer Valley Hospital),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.

For those who are unfunded, DBHS has contracted with UNI 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 preauthorization. This is due to the fact that the money for unfunded hospitalization is limited and UNI 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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes

Describe any significant programmatic changes from the previous year.

No significant changes

2) Children/Youth Inpatient

Form A1 - FY21 Amount Budgeted:	**$4,442,941**	**Form A1 - FY21 Projected clients Served:**	**264**
Form A1 - Amount	**$4,449,741**	**Form A1 - Projected Clients**	**270**

budgeted in FY20 Area Plan		**Served in FY20 Area Plan**	
Form A1 - Actual FY19 Expenditures Reported by Locals	**$3,955,752**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**279**
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.			
DBHS/Optum Network consists of contracts with UNI 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 UNI be at capacity, DBHS/Optum has the ability to implement a single case agreement (SCA) with any willing provider.			
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).			
No significant Changes			
Describe any significant programmatic changes from the previous year.			
No significant changes			

3) Adult Residential Care

Form A1 - FY21 Amount Budgeted:	**$8,354,042**	**Form A1 - FY21 Projected clients Served:**	**1,421**
Form A1 - Amount budgeted in FY20 Area Plan	**$7,503,688**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**750**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$5,941,035**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**1,312**
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.			
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. Recovery Innovations International (RI) will be adding a 16-bed residential facility for mentally ill adult male clients who also have substance use disorder (SUD) treatment needs and are involved in criminal justice services. Treatment will have focus on behavioral health issues and criminogenic risk factors.			

Summit Subacute – Highland Ridge Hospital operates a 10-bed, short-term residential and inpatient diversion program for male and female adults with acute mental health (MH) needs.

Odyssey House will be adding a 16-bed residential facility for mentally ill adult clients who also have substance use disorder (SUD) treatment needs and are involved in criminal justice services. Treatment will have focus on behavioral health issues and criminogenic risk factors.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

The projected FY21 increase from FY19 actuals in the budgeted amount and clients served are due to the VOA Denver Apartments project which occurred during the second quarter of FY20 and the pending FSH Central City Apartments project that has a target date of opening on July 25, 2020. Though both of these projects are strictly housing (i.e., not residential treatment) they are or will be billing supportive living and therefore are captured under this section the same as VBH's CORE programs and the Summit Subacute unit (who also bill supportive living for their facilities).

Describe any significant programmatic changes from the previous year.

No significant changes.

4) Children/Youth Residential Care

Form A1 - FY21 Amount Budgeted:	**$290,480**	**Form A1 - FY21 Projected clients Served:**	**75**
Form A1 - Amount budgeted in FY20 Area Plan	**$758,674**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**68**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$240,153**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**71**

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. Please identify any significant service gaps related to residential services for youth.

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.

FAST Program – DYS
The FAST program was developed through a collaborative effort between Optum and DYS for Medicaid youth ages 8-17. The FAST program allows youth to have supportive family-based services to keep children in their homes during times of mental health crisis including a suicide attempt and suicidal ideation. Generally, youth admitted to the program stay at Youth Services during the week and go home on the weekends.

The voluntary 30-day Medicaid acute care step-down and diversion program is centered around individual needs of youth and family, specifically focusing on family therapy at least once per week, individual therapy for the youth client twice per week, psychotherapy and life-skill groups, and school. Home visits are determined clinically every week to apply learned skills and assess barriers to stabilization and successful reunification.

New Beginnings
New Beginnings is a 16-bed residential facility for adolescent boys and girls, Located on a large campus in West Jordan, the youth have access to school services along with therapeutic services, including medication management.

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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

The greater than 15% increase in the budgeted amount compared to FY19 actuals is due to an increased amount of youth being served in residential treatment. Though the increase in numbers served is less than 15%, the cost of residential is such that this should equate to a greater than 15% increase in costs.

Describe any significant programmatic changes from the previous year.

No significant changes

5) Adult Outpatient Care

Form A1 - FY21 Amount Budgeted:	**$11,184,042**	**Form A1 - FY21 Projected clients Served:**	**8,172**
Form A1 - Amount budgeted in FY20 Area Plan	**$10,498,237**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**8,200**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$9,908,657**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**7,698**

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.

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 (AAU). 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.

Jordan West Valley Outpatient treatment continues to emphasize DBT (Dialectical Behavioral Therapy) and trauma-focused care to help individuals and families stabilize and return to functioning in the community.

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) Team 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.
Recovery Innovations International (RI) is developing a Forensic ACT Team. The Forensic ACT Team will serve 100 Salt Lake County residents with criminal justice involvement.

Describe community based services for high acuity patients including Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment services. 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 team follows the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures is completed by VOA and reported to Optum. Dependent 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.

Recovery Innovations International (RI) Forensic ACT (Anticipated start date, June 2020)
While the Forensic ACT team follows the same service delivery approach as ACT, this team maintains an increased focus on criminogenic risk factors. For consumers with the most challenging and persistent problems, Forensic 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 Forensic ACT program takes a team approach to provide the treatment and services that members need. The RI Forensic ACT team follows the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures will be completed by RI and reported to Optum. Dependent upon the measure, evaluation will be completed weekly or monthly. DBHS will conduct 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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

Please see the new RI Forensic ACT program described above anticipated for FY21.

Describe programmatic approach for serving individuals in the least restrictive level of care who are civilly committed.

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.

6) Children/Youth Outpatient Care

Form A1 - FY21 Amount Budgeted:	**$11,228,192**	**Form A1 - FY21 Projected clients Served:**	**5,755**

Form A1 - Amount budgeted in FY20 Area Plan	**$15,399,863**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**5,800**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$9,908,657**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**7,698**

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.

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 Resource Facilitation, 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.

Valley Behavioral Health
VBH offers outpatient and medication management services for youth. Services offered are Intensive Outpatient (ACES - Acute Children's Extended Services), for elementary aged youth, and AIM (Adolescents in Motion) for adolescents with primary mental health diagnoses. Also available is a DBT specific program and KIDS (Kids Intensive Day Services), which specializes in day treatment services.

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.

The following programs are offered through Salt Lake County Division of Youth Services (DYS):
Counseling services include immediate crisis counseling for youth and families, as well as a short-term 60-day brief intervention model, 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.

DBHS/Optum have added Foundations to our Medicaid network which focuses on in-home and in-clinic services working with youth and families with severe conduct, oppositional and other externalizing disorders.

Reach Counseling has also been added by DBHS/Optum to work with children and families with various issues. Reach Counseling has several clinicians certified in working with Perinatal Mood Disorders including postpartum depression.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

Please see the above additions of Foundations and Reach Counseling as providers.

7) Adult 24-Hour Crisis Care

Form A1 - FY21 Amount Budgeted:	**$6,067,368**	**Form A1 - FY21 Projected clients Served:**	**470**
Form A1 - Amount budgeted in FY20 Area Plan	**$3,150,676**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**550**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$5,095,918**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**265**

Describe 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 criminal justice system. Identify what crisis services are provided and where services are provided. 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.

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, 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 – UNI
The UNI 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, 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 response. At the time of this writing the average law enforcement response time was 19 minutes and the average community response time was 20

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 FY19, 89.0% of those receiving an outreach visit were diverted from inpatient and emergency room visits. This was a decrease from the previous year. The UNI MCOT averages almost 274 contacts per month, a decrease of 108 contacts per month. Of the 274 contacts, an average of 195 result in a direct outreach by the MCOT team. In FY19, we initiated a collaborative effort with Fourth Street Clinic in serving the Rio Grande Community's crisis needs. This includes curbside consultation to Fourth Street Clinic staff members.

Summit Subacute – Highland Ridge Hospital
The Summit Subacute (operating 24/7 365 days a year) diverts people from inpatient services who are experiencing acute mental health distress. Individuals are referred by emergency departments, ACT Team, UNI Receiving Center, and Optum Care Advocates. This program stabilizes those who do not meet inpatient criteria, but need more than 23 hours of support. Services include individual therapy, family therapy, group therapy, medication management, and case management to help transition to community-based providers.

During FY19, there were a total of 253 admissions with average length of stay during this time period of 8.8 days, for a total of 2,229 bed days.

Receiving Center – UNI
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. The center receives an average of 138 consumer visits per month. Of these, only 11.0% continued on to inpatient stays, no one was diverted to the County jail (for FY20), with 57% returning to their home or family.

Crisis Line – UNI
The crisis line is a phone line answered by licensed mental health therapists. Clinicians will 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 not truly a crisis, staff can also immediately connect the caller with the Warm Line (see below). During FY20, through March, the crisis line has received an average of 3323 calls per month. A decrease of 45 from the average during the same time in FY19.

Warm Line – UNI
The warm line is a confidential anonymous phone line answered by Peer Support Specialists professionally trained to provide support to callers. Staff is 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 FY20, through March, the warm line has received an average of 2048 calls per month. An increase of 373 from the average during the same time in FY19.

Description of the additional adult crisis services funded through JRI (UNI/UPD Pilot) can be found under 34) Justice Reinvestment Initiative.

Describe the current process or planning to develop tracking and protocols for all adults who have been civilly committed and those placed on an assisted outpatient treatment court order to their local authority.

Optum is responsible for tracking any civilly committed individual and those placed on an assisted outpatient treatment court order, regardless of funding source. The process is as follows:

The total number of adults under commitment in Salt Lake County exceeds 300 individuals at any given time. DBHS/Optum works closely with the Court on tracking and determining the ongoing mental health services that are being provided to the committed persons with Medicaid only. DBHS/Optum receives an update from the civil commitment court clerk regarding upcoming hearings, transfers and terminations. Information for where the client is receiving treatment services is typically within these updates. DBHS/Optum will reach out to the listed provider to confirm that the client is receiving services and to request that they update the court, in time for the next hearing. DBHS/Optum educates their provider network to help them understand the commitment process, and how best to report back to the court, to advocate for their clients. Most committed individuals are placed with providers who

offer case management and outreach. When a committed person stops engaging with treatment, their name is flagged within the mobile crisis outreach system to let them know that it is possible the individual will need outreach to get back into treatment/services. The current commitment process is considered “voluntary” and requires that the individual is willing to engage and accept services/treatment.

Planning and discussion will continue this year around the implementation of SB 39 and court ordered assisted outpatient treatment requirements. If necessary, DBHS and Optum will modify and/or implement whatever is necessary to be compliant with the regulation.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

The greater than 15% increase in the budgeted amount compared to FY19 actuals is due to adding an additional MCOT which is stationed at Fourth Street Clinic. This MCOT is also operated by UNI. The increase in costs and clients served reflect a full year of services with this additional team.

Describe any significant programmatic changes from the previous year.

No significant changes.

8) Children/Youth 24-Hour Crisis Care

Form A1 - FY21 Amount Budgeted:	**$1,494,323**	**Form A1 - FY21 Projected clients Served:**	**92**
Form A1 - Amount budgeted in FY20 Area Plan	**$1,008,091**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**120**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$1,331,125**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**83**

Describe 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 criminal justice system. Identify what crisis services are provided and where services are provided. Include if you provide SMR 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.

For a 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 FAST and FASTer programs, case management, psychotropic medications and, when necessary, access to acute inpatient hospitalization.

Mobile Crisis Outreach Teams
The UNI 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, 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 response. At the time of this writing the average law enforcement response time was 19 minutes and the average community response time was 20 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 FY19, 87.0% of those receiving an outreach visit were diverted from inpatient and emergency room visits. The UNI MCOT averages 104 youth contacts per month, of which an average of 88 result in a direct outreach by the MCOT team.

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 are runaway, homeless and ungovernable youth or youth who have committed minor offenses. 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.

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. 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 (UNI/UPD Pilot) can be found under 34) Justice Reinvestment Initiative.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

No significant changes.

9) Adult Psychotropic Medication Management

Form A1 - FY21 Amount Budgeted:	**$2,387,197**	**Form A1 - FY21 Projected clients Served:**	**4,778**

Form A1 - Amount budgeted in FY20 Area Plan	**$2,660,493**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**5,050**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$2,171,479**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**4,746**

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. Please list any specific work related to medication management during transition from providers.

Medication management services are offered by multiple providers throughout the county to include outpatient clinics, nursing homes, and via telehealth. Prescribers on the ACT Team 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 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 for FY21.

Summit Community Counseling has added 4 hours per week of prescriber services through telehealth. The goal is to be able to reach out to any member they serve in Salt Lake County with this service.

DBHS/Optum have also added Summer Anderson, APRN as an independent practitioner to the network. Summer is able to work in conjunction with some of our other network providers to add medication management/prescriptive services for members.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

No significant changes.

10) Children/Youth Psychotropic Medication Management

Form A1 - FY21 Amount Budgeted:	**$502,947**	**Form A1 - FY21 Projected clients Served:**	**1,057**
Form A1 - Amount budgeted in FY20 Area Plan	**$507,700**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**1,300**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$445,048**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**1,038**

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. Please list any specific work related to medication management during transition from providers.

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, RISE Behavioral Health, and others have delivered medication management to children and adolescents in FY20 and will continue into FY20. 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 may provide supportive interventions.

DBHS/Optum will continue to seek out prescribers in the community for FY20.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

No significant changes.

11) Adult Psychoeducation Services & Psychosocial Rehabilitation

Form A1 - FY21 Amount Budgeted:	**$1,480,787**	**Form A1 - FY21 Projected clients Served:**	**1,180**
Form A1 - Amount budgeted in FY20 Area Plan	**$1,938,057**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**1,350**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$1,369,775**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**1,135**

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.

DBHS/Optum contracts directly with Alliance House, an International Certified 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 severe and persistent mental illness (SPMI) 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 27) 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, Youth Empowerment Services, Summit Community Counseling, and others.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.
Describe any significant programmatic changes from the previous year.
No significant changes.

12) Children/Youth Psychoeducation Services & Psychosocial Rehabilitation

Form A1 - FY21 Amount Budgeted:	**$6,589,849**	**Form A1 - FY21 Projected clients Served:**	**862**
Form A1 - Amount budgeted in FY20 Area Plan	**$6,124,560**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**875**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$5,766,145**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**840**

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.

DBHS/Optum contracts with VBH to provide skills development programs for youth and children. They include:

The Community Based Treatment Unit (CBTU), a school-based mental health intervention program, provides community-based comprehensive mental health programs in a highly structured therapeutic classroom, in partnership with local school districts for children and youth requiring highly structured therapeutic academic settings to succeed and prevent more restrictive placements. CBTU programs include on-site mental health therapists, behavioral specialists, and counselors who support children in accessing academics, succeeding in schools, and developing healthy social emotional skills to succeed across settings. The model engages case management, individual and family therapy, and psychosocial rehabilitation skills development. Two classrooms are available in Salt Lake School District at Beacon Heights Elementary, and two classrooms are available in Granite School District at Robert Frost Elementary.

School-based Early Intervention Services
These services consist of therapy, case management, and parent/teacher consultation and training. Please see section 32 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. The KIDS program has a capacity of 36 clients.

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.

AIM Day Treatment is a day program option for youth struggling with behavioral health issues across multiple settings (i.e. home and school). The program can serve up to 24 adolescents. 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, Utah House, and others.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

Additional districts and schools were added to the list of those partnering with DBHS and Optum providers for school-based treatment. This is outlined in #32.

13) Adult Case Management

Form A1 - FY21 Amount Budgeted:	**$4,694,082**	**Form A1 - FY21 Projected clients Served:**	**2,908**
Form A1 - Amount budgeted in FY20 Area Plan	**$4,850,903**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**2,850**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$4,090,376**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**2,744**

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. Please include how you ensure each case management provider is certified to provide these services.

Targeted Case Management (TCM) is provided to clients with SPMI and 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 Care Navigator to coordinate case management services for clients who need housing and/or supports to stay housed. Optum has three providers who offer intensive, targeted case management for our clients: Silverado Counseling, 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 also offers an Assertive Outreach Team (AOT) for adult clients with SPMI. The AOT subscribes 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 AOT primarily provides case management services to Medicaid and non-Medicaid clientele.

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.

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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

Project Connection is a new program which provides individual, couples and family counseling and specializes in acute trauma; developmental trauma; attachment; adoption; emotional regulation; relationship conflicts; parent/child conflicts; motivation; grief & loss; depression; anxiety; shame and identity issues; and, LGBTQA issues. Additionally, Project Connection has implemented an evidenced-based program known as Critical Time Intervention (CTI). CTI is an empirically supported, time-limited case management model designed to improve outcomes and decrease recidivism for people with mental illness following discharge from hospitals and inpatient mental health facilities. The CTI Team provides person- centered case management services over a 9-month, 3 phase timeline with a goal to increase participant's access to resources and help them connect to the community in meaningful ways.

14) Children/Youth Case Management

Form A1 - FY21 Amount Budgeted:	**$300,029**	**Form A1 - FY21 Projected clients Served:**	**1,009**
Form A1 - Amount budgeted in FY20 Area Plan	**$284,228**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**1,090**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$275,616**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**899**

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. Please include how you ensure each case management provider is certified to provide these services.

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 meeting seriously emotionally disturbed (SED) criteria and 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: This program provides transitional living to 18 up to 22 year olds who are experiencing homelessness. 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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes compared to FY19 actual report..

Describe any significant programmatic changes from the previous year.

No significant changes

15) Adult Community Supports (housing services)

Form A1 - FY21 Amount Budgeted:	**$1,222,263**	**Form A1 - FY21 Projected clients Served:**	**361**
Form A1 - Amount budgeted in FY20 Area Plan	**$1,004,559**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**400**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$852,658**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**13**

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.

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 48-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.

DBHS currently funds and contracts for 184 additional housing units through Housing Connect (formerly the Housing Authority of the County of Salt Lake) for individuals and families currently, or at-risk of being, homeless. The vast majority of the recipients of rental assistance through this contract have criminal justice involvement, a substance use disorder and/or mental illness. Funding under this contract is broken into 60 units for the State Hospital/VOA ACT Housing, 53 units for the Project RIO (Core 1, JDOT and CORE 2) Housing, 49 units for HARP Housing (short and long term rental assistance), and new to FY20, 22 units at the VOA Denver Apartments (see more below on this tax credit project completed in FY20). The 18 Milestone/CAF (Children Aging out of Foster care) Housing program units were shifted to Salt Lake County Division of Youth Services to administer during FY20. All partners referring into 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 match for many federally-subsidized housing programs.

Additionally, with the State Hospital/VOA ACT Housing program, and in collaboration with DBHS/Optum, Housing Connect has developed agreements with Nephi Todd's, Evergreen Place and Oasis House to purchase housing for clients needing assistance as they discharge from the State Hospital. These clients receive supervision, meals, housekeeping, and laundry services. To a smaller extent, this program has leveraged housing placements or other resources (i.e., case management) at the following facilities as well: Mary Grace 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. Often DBHS/Optum will work with VBH and other community partners to support their unique housing and treatment needs.

DBHS/Optum continues to work with community partners on two low income tax credit projects. The first project, the Denver Apartments, is a partnership between DBHS, Optum, Housing Connect, and GIV Group. In 2018 VOA was awarded tax credits to fund housing for 22 VOA ACT Team participants, while supporting wraparound services through the ACT Team. The project was greatly supported by the Salt Lake County Council through a $400,000 capital investment, and was opened November 1, 2019. The second project, the Central City Apartments (originally named the Fifth East Apartments), is a partnership between DBHS, Optum, First Step House, Blue Line Development, Housing Connect and the Salt Lake City Housing Authority, to develop 75 units of housing for the severely and persistently mentally ill population. This tax credit project will target individuals exiting the USH, often with co-occurring substance use disorders, as well as those who are frequent utilizers of inpatient services. The project officially broke ground on March 1, 2019, and is scheduled to begin housing clients in July 2020.

Additional Housing and Resources:

Optum's full-time Housing Navigator 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.

The VOA Homeless Youth Resource Center continues to operate in Salt Lake County, and has opened Maud's Cafe as an employment training program for these young people.

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 State Division of Substance Abuse and Mental Health and Salt Lake County. Clients participating in residential treatment ready to step down into outpatient services, the Utah Highway Patrol Frequent Utilizer Program, any Salt Lake County drug court, the Volunteers of America (VOA) Journey program, or recent graduates of CATS will be eligible for the Sober Living Program which offers up to 6 months of funding assistance at a contracted provider that is licensed as a recovery residence. Additional need for sober housing from the Salt Lake County contracted network of providers will be addressed on an as-needed basis. During FY21, DBHS is anticipated to provide approximately 700 clients with sober living vouchers. Due to funding and other resource constraints, the monthly program capacity is approximately 275 vouchers.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

The additional clients served are due to the opening of the Denver Apartments (through VOA in FY20), the Central City Apartments (through First Step House in FY21), additional USH outplacement housing, and additional housing units being provided to the new RI residential program. Additional costs are due to the associated housing subsidies required for all the above-mentioned new housing placements being funded.

Describe any significant programmatic changes from the previous year.

In FY21, Nephi Todd will continue rehabbing the former Green Gables facility he purchased in FY20 to offer more quality units available to DBHS and Optum for clients completing residential mental health programs or those exiting the State Hospital.

In FY21, DBHS/Optum will continue funding housing support [clinical services delivered on-site (including supportive living and case management), and the housing subsidy] for clients in the new Denver Apartments, and will begin supporting these same services at First Step House's new 75 unit Central City Apartment development (slated to open in late July 2020). As RI begins to offer services through the new residential program in FY21, DBHS will also contract for up to 16 additional housing units in the community through master-leased apartments or congregate living sites to provide support for this program.

16) Children/Youth Community Supports (respite services)

Form A1 - FY21 Amount Budgeted:	**$1,388,081**	**Form A1 - FY21 Projected clients Served:**	**402**
Form A1 - Amount budgeted in FY20 Area Plan	**$1,105,557**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**250**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$1,012,716**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**260**

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. Please identify how this fits within your continuum of care.

DBHS/Optum contracts with DYS, Hopeful Beginnings 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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

The greater than 15% increase in the budgeted amount compared to FY19 actuals is due to Hopeful Beginnings continually expanding their ability to provide an increased number of respite services. Though the increase in numbers served is less than 15%, the cost of respite is such that this should equate to a greater than 15% increase in costs.

Describe any significant programmatic changes from the previous year.

Currently, Optum has a new provider in the credentialing process which would increase the opportunities for psychosocial rehabilitative services, targeted case management and respite services with an emphasis on post-adopt youth. This agency also has experience supporting youth who are court involved and require after hours support.

17) Adult Peer Support Services

Form A1 - FY21 Amount Budgeted:	**$789,932**	**Form A1 - FY21 Projected clients Served:**	**1,274**
Form A1 - Amount budgeted in FY20 Area Plan	**$507,841**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**1,300**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$693,406**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**1,312**

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.

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. For a few hours each week, services are offered at the dedicated site of Jordan West Valley Outpatient Services. Additionally, Pathways to Recovery are facilitated at Highland Ridge Summit Subacute Unit, 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. Referrals are also received from multiple sources including Utah State Hospital for patients transitioning back into the community, provider agencies such as VBH, UNI, individual providers, and other systems such as Mental Health Court.

Peer mentoring, support, advocacy, and skill building will be provided for these individuals through regular

individual contact over a period of time with the goal of easing 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 health, physical health and social services.
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).
No significant changes compared to FY19 actual report..
How is adult peer support supervision provided? Who provides the supervision? What training do supervisors receive?
Per Utah Medicaid, Rehabilitative Mental Health and Substance Use Disorder Services directives, certified peer support specialists are under the supervision of a licensed mental health therapist , or a licensed ASUDC or SUDC when peer support services are provided to individuals with an SUD. Supervisors are expected to follow these guidelines offering ongoing weekly individual and/or group supervision to the Certified Peer Support specialist they supervise. All providers are encouraged to attend the Supervision training offered through the State of Utah Division of Substance Abuse and Mental Health (DSAMH). Additionally, Optum Recovery and Resiliency can provide technical assistance to In-Network providers with Toolkits for Providers. The Tool Kit addresses misconceptions about using peers in services delivery and includes information on how to bill Medicaid, gives examples of job descriptions and provides information on supervision.
Describe any significant programmatic changes from the previous year.
No significant changes.

18) Children/Youth Peer Support Services

Form A1 - FY21 Amount Budgeted:	**$738,433**	**Form A1 - FY21 Projected clients Served:**	**155**
Form A1 - Amount budgeted in FY20 Area Plan	**$731,009**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**200**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$532,614**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**132**

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.
Children/Youth Peer Support Services are provided primarily by Family Resource Facilitators (FRFs). 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 FRFs. Training, mentoring, data collection and reporting is the responsibility of Allies with Families. The FRF program services are designed to provide family peer support services to parents and/or caregivers of children/youth with complex needs. Generally, FRFs have a family member with a mental illness giving them their 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), and wraparound to fidelity. 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 11 FRFs placed with 8 agencies throughout Salt Lake County. Presently FRFs are anchored at the following agencies or organizations:
• 2 FTEs Salt Lake County Division of Youth Services
• 1 FTE Utah Division of Juvenile Justice Services
• 1 FTE The Children's Center
• 1 FTE Granite School District
• 1 FTE Allies with Families
• 3 FTE State of Utah Division of Child and Family Services (DCFS)
• 1 FTE 3rd District Juvenile Court
• 1 FTE Family Support Center

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

The expected increase in costs compared to FY19 actual budget and clients served compared to FY19 actual number of clients served is due to DYS expanding their FRF services during FY20.

How is Family Resource Facilitator (FRF) peer support supervision provided? Who provides the supervision? What training do supervisors receive?

Supervision of the FRFs is two-fold. The FRF Coordinator at DYS oversees all programmatic and personnel issues for all 10 FRFs. In addition, the FRFs placed at various site locations also report to a site supervisor. This person is available for any immediate questions or concerns an FRF may have in the course of working with families referred through site staffings. Site supervision of the FRF takes place as needed and involves the DYS FRF Coordinator, the site supervisor, the mentor, and the FRF. The on-site supervisor can contact the DYS FRF coordinator at any time to discuss any problems or issues involving the FRF. The mentor can also provide input.

Describe any significant programmatic changes from the previous year.

No significant changes.

19) Adult Consultation & Education Services

Form A1 - FY21 Amount Budgeted:	**$1,137,067**		
Form A1 - Amount budgeted in FY20 Area Plan	**$1,131,627**		
Form A1 - Actual FY19 Expenditures Reported by Locals	**$1,042,285**		

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.

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. In FY20:
• 71 people in the community were certified in Mental Health First Aid (MHFA) with more trainings scheduled during the current fiscal year.
• Youth Mental Health First Aid trainings scheduled during the current fiscal year.
• 10 people participated in suicide prevention training, QPR training (Question, Persuade, Refer), during the past year, with more trainings to be scheduled in the coming fiscal year.

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, Recovery Training at the University of Utah and other community groups, Communication and Language, Peer Support through the Life Span at Generations, Discharge Planning, Peer Navigator Program, Optum's Grievance Process, CARE Court.

UNI'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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

No significant changes.

20) Children/Youth Consultation & Education Services

Form A1 - FY21 Amount Budgeted:	**$269,389**		
Form A1 - Amount budgeted in FY20 Area Plan	**$274,824**		
Form A1 - Actual FY19 Expenditures Reported by Locals	**$253,127**		

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.

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 FY20, 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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes compared to FY19 actual report.

Describe any significant programmatic changes from the previous year.

No significant changes.

21) Services to Incarcerated Persons

Form A1 - FY21 Amount Budgeted:	**$153,424**	**Form A1 - FY21 Projected clients Served:**	**1,002**
Form A1 - Amount budgeted in FY20 Area Plan	**$158,542**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**340**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$174,999**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**1,017**

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.

Salt Lake County has developed a nationally recognized sequential intercept model that can be shared with DSAMH upon request.

Community Response Team (CRT) – VBH
Provides immediate, short-term response to the Metro Jail when an inmate is being diverted from jail, or is being discharged from the jail, and has been identified as SMI. When an inmate is identified who has an assessed SPMI condition and is identified on the discharge plan as transitioning to community services, VBH will provide in-reach to the inmate to establish relationships and develop a discharge plan to enhance the likelihood of successful re-entry. 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.

Mental Health – Alternatives to Incarceration (ATI) Transportation

ATI transport is available for all mental health providers paneled with Optum. The CRT program has been further enhanced in coordination with VBH's CORE and CORE 2 residential programs. VBH is notified by the Metro Jail when a SMI inmate is to be released and transport is arranged for the inmate directly to VBH services. This service helps ensure SMI inmates are released during business hours (avoiding nighttime releases) through a court order, immediately engaged in community services and the appropriate medication therapy goes uninterrupted.

Social Services Position Housed in the Legal Defenders Office - this position, funded through DBHS, connects individuals with serious 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 from the jail.

Top Ten—Once a month this group meets to staff the most frequently booked individuals with serious mental illness. Partners include the Legal Defender's Office (LDA), Valley Behavioral Health, Criminal Justice Services (CJS), UNI Crisis Programs, Jail Mental Health, DBHS, Optum, The Road Home as a liaison with the Homeless Resource Centers, Volunteers of America, the Community Connections Center, and Fourth Street Clinic. Team goals are to:

- ensure jail mental health is aware of diagnosis and medications prescribed in the community prior to arrest, and vice-versa, ensure community mental health programs are aware 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, CORE, JDOT, Other Outpatient, RIO Housing, etc.);
- communicate with the individual's attorney;
- communicate with county supervising case managers, state AP&P officers or other private supervising agency;
- coordinate jail releases when appropriate (LDA or CJS);
- 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; and,
- address individuals as pre-contemplative rather than non-compliant when unable to engage them into services. That is, try, try again.

Mental Health Services in Jail - The Salt Lake County Council, serving as the Local Mental Health Authority, appropriates approximately $2,000,000 annually for mental health services in the jail. This appropriation is made directly to the Salt Lake County Sheriff's Office. The Salt Lake County Sheriff's Office has incorporated a mixed model of Mental Health Care. The healthcare services, including mental health services, have been awarded accreditation from the National Commission on Correctional Health Care (NCCHC). Additional county funds are used to fund medications, primary health care, and supportive services to persons in the jail who have serious mental illness. 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. 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, including: CRT, CORE, CORE 2, JDOT, ATI Transport and VBH Forensics.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes compared to FY19 actual report.

Describe any significant programmatic changes from the previous year.
No significant changes.

22) Adult Outplacement

Form A1 - FY21 Amount Budgeted:	**$1,305,771**	**Form A1 - FY21 Projected clients Served:**	**101**
Form A1 - Amount budgeted in FY20 Area Plan	**$996,292**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**85**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$1,202,206**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**97**

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.
DBHS/Optum provides a Clinical Care Advocate who is 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, including a housing coordinator. 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, Evergreen and Oasis; and new to FY21 the Central City Apartments operated by First Step House
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).
No significant changes compared to FY19 actual report.
Describe any significant programmatic changes from the previous year.
In FY21, the 75 unit Central City Apartments operated by First Step House will begin housing SMI clients.

23) Children/Youth Outplacement

Form A1 - FY21 Amount Budgeted:	**$**	**Form A1 - FY21 Projected clients Served:**	
Form A1 - Amount budgeted in FY20 Area Plan	**$**	**Form A1 - Projected Clients Served in FY20 Area Plan**	
Form A1 - Actual FY19 Expenditures Reported by Locals	**$**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	

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.

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 Outplacement Committee monthly at the Children's Continuity of Care meeting 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.

DBHS/Optum meets twice a month with the Division of Youth Services and Hopeful Beginnings, to address the needs and better coordinate care for children and youth and their families with complex needs.

Describe any significant programmatic changes from the previous year.

No significant changes.

24) Unfunded Adult Clients

Form A1 - FY21 Amount Budgeted:	**5,799,817**	**Form A1 - FY21 Projected clients Served:**	**4,243**
Form A1 - Amount budgeted in FY20 Area Plan	**$4,813,638**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**4,050**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$6,356,577**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**4,070**

Describe the activities you propose to undertake 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.

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.

Volunteers of America/Cornerstone Counseling Center (VOA/CCC) has several programs to assist the unfunded population. The Uninsured Mental Health Clinic provides direct mental health services based on the client-centered biopsychosocial assessment. Services are provided by Licensed Mental Health Therapists and an Advanced Practice Registered Nurse (APRN). The Whole Health Clinic is a medical clinic providing direct physical health care services. This clinic works in tandem with the Uninsured Mental Health Clinic so that clients can have physical care and behavioral health co-located in the same clinic. The Homeless Mental Health Outreach Program is 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.

VBH provides direct services to two 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.

UNI provides crisis services for Salt Lake County. These services are described under section 1g.

Describe efforts to help unfunded adults become funded.

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

Long before expansions of Medicaid, DBHS began funding the Department of Workforce Services (DWS) Medicaid eligibility specialists, drawing down federal dollars as match to assist the county's network of providers with enrollment into Medicaid. Education, trainings and connections to Take Care Utah were made in 2014, as Marketplace Plans became an option to individuals earning more than 100% FPL.

Numerous specialty enrollment efforts were initiated as TAM opened in November of 2017. This includes but is not limited to collaborations with DWS and Take Care Utah to enroll in Drug Court and Mental Health Court settings; the newly implemented Jail MAT program; the CATS (Corrections Addiction Treatment Services) program; Legal Defender's Office; and Criminal Justice Services. Trainings were also held with AP&P to assist them in their enrollment efforts. In addition to specialty enrollment efforts put in place during the TAM expansion, two large eligibility and enrollment trainings were held 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 in to 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.

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 1st 2020, to encourage and support enrollment in these new populations. More recently, 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. 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.

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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.
No significant changes.

25) Unfunded Children/Youth Clients

Form A1 - FY21 Amount Budgeted:	**$1,837,972**	**Form A1 - FY21 Projected clients Served:**	**900**
Form A1 - Amount budgeted in FY20 Area Plan	**$1,508,342**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**850**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$1,444,241**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**830**

Describe the activities you propose to undertake 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.

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 (UDOH) 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.

VBH provides direct services to two children/youth populations with the funds they receive. First, VBH's provides direct services to uninsured youth/children's mental health in two locations (not including the below mentioned school-based services). Second, VBH has a school-based mental health program in 7 different schools, within five school districts.

Describe efforts to help unfunded youth and families become funded.

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

Long before expansions of Medicaid, DBHS began funding Department of Workforce Services (DWS) Medicaid eligibility specialists, drawing down federal dollars as match to assist the county's network of providers with enrollment into Medicaid. Education, trainings and connections to Take Care Utah were made in 2014, as Marketplace Plans became an option to households earning more than 100% FPL.

Numerous specialty enrollment efforts were initiated as TAM opened in November of 2017. This includes but is not limited to collaborations with DWS and Take Care Utah to enroll in Drug Court and Mental Health Court settings; the newly implemented Jail MAT program; the CATS (Corrections Addiction Treatment Services) program; Legal Defender's Office; and Criminal Justice Services. Trainings were also held with AP&P to assist them in their enrollment efforts. In addition to specialty enrollment efforts put in place during the TAM expansion, two large eligibility and enrollment trainings were held 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 in to 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. 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. Research has shown that Medicaid Expansion states have increased Medicaid enrollment for children as well. It is believed that as adults become aware of their eligibility, they pursue Medicaid enrollment assistance for children in the household as well.

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 1st 2020, to encourage and support enrollment in these new households. More recently, 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. 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.

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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes.

Describe any significant programmatic changes from the previous year.

No significant changes.

26) Other non-mandated Services

Form A1 - FY21 Amount Budgeted:	**$1,107,819**	**Form A1 - FY21 Projected clients Served:**	**684**
Form A1 - Amount budgeted in FY20 Area Plan	**$1,036,917**	**Form A1 - Projected Clients Served in FY20 Area Plan**	**580**
Form A1 - Actual FY19 Expenditures Reported by Locals	**$1,006,327**	**Form A1 - Actual FY19 Clients Serviced as Reported by Locals**	**722**

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.

DYS Afterschool Programs: Afterschool Programs focusing on academic and enrichment support are offered at the following schools: Cyprus High School; Kearns Kennedy and Matheson Jr Highs; South Kearns, Elk Run, Lake Ridge, Copper Hills, Magna, Pleasant Green, Millcreek, David Gourley and West Kearns Elementary Schools. 2019 Summer programs are offered at Kearns, Kennedy and Matheson Jr Highs and South Kearns and Elk Run Elementary. Community School Coordinators are available to help connect families to resources at Kearns Jr.

On average 600 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. DYS Prevention also works with the DYS Afterschool Program to facilitate Positive Action, as well as co-leads a Gender-Sexuality Alliance (GSA), PRISM, on DYS campus. DYS hosts cycles of ME Time, Staying Connected, and Guiding Good Choices at Youth Services in South Salt Lake and ME Time at Youth Services in West Jordan. However, DYS also offers these three 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. Our GSA operates weekly at Youth Services in South Salt Lake.

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 UNI. These services are entirely funded with County General Fund.

Please see section 34 for a description of the Unified Police Department (UPD) UNI.

In January 2019, VOA began housing a Licensed Mental health Therapist (LMHT) with the Department of Public Safety (DPS) to assist with the Rio Grande region in downtown Salt Lake City. The position is funded by DPS. The purpose of the program is to improve outcomes for about 20 individuals with a high number of arrests and police contacts, who DPS believes are in need of treatment, housing, or other services, and motivated to change in order to decrease arrests and improve outcomes for these individuals. The VOA LMHT endeavors to prevent unnecessary incarceration and/or hospitalization of persons with mental illness or addiction by directing individuals, based on medical necessity, to care in the least restrictive environment through a coordinated and comprehensive system-wide approach. This was the same model utilized with the UPD/UNI program explained in section 34.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Increase in funding is for UPD UNI and Public Safety worker VOA programs

Describe any significant programmatic changes from the previous year.

No significant changes.

27) Client Employment

Increasing evidence exists to support the claim that competitive 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

Competitive employment in the community (include both adults and transition aged youth).
The 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 assist 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/Optum 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 255 participants with 23% of the individuals maintaining continuous employment for 90 days or more. Additionally, 35% of the job starts (79 total to date) have moved out of the Employment Services Program and no longer receive services due to successful employment. Alliance House is working on training all staff on the Individual Placement and Support (IPS) Supported Employment Program. Alliance House has 17 members in IPS/Supported Employment. Alliance House has 8 Transitional Employment sites where 11 members are employed part-time. For the FY19, 87 members were employed. In FY20, Alliance House has assisted 5 members in obtaining transitional employment and 5 members to obtain 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.
Collaborative 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 USARA employees in FY20.
Employment of people with lived experience as staff.
DBHS/Optum contracts directly with Alliance House, an International Certified 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 through FY20. 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 FY20, the use of CPSS will continue to grow throughout the network.
Evidence-Based Supported Employment.
See Alliance House above. Additionally, Alliance House works directly with DSAMH. Alliance House meets fidelity for Supported Employment of the IPS model with the Clubhouse Model and for Alliance House to serve as a training agency to train other Clubhouses in Utah on the Supported Employment model. This aligns well with the Clubhouse International standards. 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.

Originally in FY19, DBHS implemented a contractual performance goal (PG) with Optum to develop an IPS program with an additional provider. VOA was chosen as the partner, and both agencies worked to grow the new program according to the goals outlined in the PG. In FY20, the PG was enhanced to require the selected provider to achieve good program fidelity, and to apply to become a Community Rehabilitation Provider (CRP) in order to receive Milestone payments to supplement the program costs. To date, the IPS Program has been very successful in meeting targets.The program is staffed with one supervisor and four employment specialists, all of which carried a full client caseload in FY20 (equating to 84 clients served at a given time). Also during FY20, DSAMH performed the initial fidelity review (August 2019), wherein the program received "Exemplary" fidelity. The program will be applying for additional federal SAMHSA grant dollars through DSAMH specifically aimed at sustaining Supported Employment programs as they establish a program foundation and develop the ability to provide Medicaid-reimbursable services. In FY21, DBHS/Optum will continue to financially support the program, while monitoring its growth and progress.

28) Quality & Access Improvements

Identify process improvement activities including implementation and training of:

Describe access and quality improvements

For DBHS/Optum, Quality Assessment and Performance Improvement (QAPI) is a central tenet in the way it conducts all aspects of its operations. It continually monitors multiple areas of its performance; its impact on consumers, youth and families and on providers; and constantly looks for ways to improve. The core goals of its QAPI Plan are straightforward: greater levels of recovery and improved resiliency for consumers, youth and families. To achieve these goals, Salt Lake County/Optum has structured a comprehensive QAPI Plan that provides the framework for continuous monitoring and evaluation of all aspects of mental healthcare delivery and service.

On December of 2019, Optum adopted a new clinical criteria review guideline, the LOCUS, and on January 31, 2020, two additional guidelines, CASII and ESCII:

1) **Level of Care Utilization System (LOCUS)** – a standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions **for adults**.
2) **Child and Adolescent Service Intensity Instrument (CASII)** – a standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry (AACAP) used to make medical necessity determinations and to provide level of service intensity **for children and adolescents ages 6-18**.
3) **Early Childhood Service Intensity Instrument (ECSII)** – a standardized assessment tool developed by the AACAP used to make medical necessity determinations and to provide level of service intensity **for children ages 0-5.**

The change in guidelines allows the opportunity to create a common language between providers. Additionally, the tool is divided into six dimensions which provide a more holistic view of acuity and chronicity of behavioral condition, thereby promoting more appropriate care for patients.

In collaboration with DBHS, Optum hired a licensed clinician in April 2020 to provide clinical support of the two 3rd district mental health courts. This person will help integrate new providers and treatment options into the court process to help ensure mental health courts are recertified. In November, 2019, Marc Gunderson (Optum BH/Medical Integration Specialist) became a temporary part of the court team to help identify barriers and provide clinical support to Medicaid members.

Identify process improvement activities - Implementation

The QAPI program promotes continuous quality improvement and recovery & resiliency in the following ways:
• Communication: With consumers, youth, families, providers and other stakeholders, is essential to understand the current and developing needs in the system. Salt Lake County/Optum seeks to empower individuals and families to live in their communities with health and wellness, dignity, security, and hope.
• Performance measurement: The focus on indicators of recovery and resiliency in addition to monitoring clinical and administrative oversight functions leads to interventions to improve quality in these areas. These performance measures are further demonstrated by specific metrics outlined in the QAPI Work Plan.
• Consumer and Family Involvement in Planning and Goal Setting: Consumers and family members (as

appropriate) are involved in the development of recovery and resiliency goals. Consumer and family involvement is monitored through audits of clinical records and feedback from consumers and family members through a variety of communication avenues.
• Systems are improved through Performance Improvement Projects (PIP): DBHS/Optum have designed a PIP in an effort to increase the use of Medication Assisted Treatment (MAT) services for those with Opioid Use Disorder (OUD), by training Peer Recovery Coaches (PRC) on the MAT facts, benefits and motivational techniques.
• The Cultural Responsiveness Representatives from providers and community partners collaborate on methods to improve cultural responsiveness within the DBHS/Optum network of providers. Annual training is offered and attendees are noted in the Optum Provider Directory.

Identify process improvement activities - Training and Supervision of Evidence Based Practices. Describe the process you use to ensure fidelity.

In addition to the processes outlined in the QAPI plan, DBHS/Optum utilizes national benchmarks and best practices, managing inpatient records to ensure care provided adheres to established and validated clinical guidelines, medical necessity reviews, and recovery and resiliency training to ensure a focus on evidence-based practices. All contracted providers are mandated to conduct supervision for EBP and it is the responsibility of each individual agency to meet fidelity requirements. This is verified during each annual monitoring visit. All of the practices listed below are recognized by SAMHSA and are offered in the DBHS/Optum Network..
• Assertive Community Treatment (ACT)
• Trauma Focused Cognitive Behavior Therapy (TF-CBT)
• Dialectical Behavior Therapy (DBT)
• Motivational Interviewing (MI)
• Cognitive Behavior Therapy (CBT)
• Eye Movement Desensitization and Reprocessing (EMDR)
• OQ Measures
• Behavior Therapy
• Integrated Dual Disorders Treatment
• Exposure Therapy for PTSD
• Seeking Safety
• Double Trouble in Recovery
• Mental Health First Aid
• Wellness Recovery Action Plan (WRAP)
• QPR Gatekeeper Training for Suicide Prevention
• Interpersonal Therapy (IPT)
• Medication Assisted Treatment (MAT)
• Moral Reconation Therapy (MRT)

Identify process improvement activities - Outcome Based Practices. Identify the metrics used by your agency to evaluate client outcomes and quality of care.

DBHS/Optum will continue to require the use of OQ/YOQ questionnaires and additional resources available through the OQ Analyst to enhance outcome-based practices. Annual beginner and advanced trainings with CEUs are provided to clinical staff to help them understand the foundations of practice based evidence and how to incorporate the Clinician Reports into treatment planning. Optum monitors pre and post community tenure for members enrolled in VOA ACT. Beginning FY20, USH days of service were incorporated into this analysis. DBHS and Optum, collectively and independently, complete quality audits of treatment records to ensure DSAMH mandates are implemented in treatment and documentation supports the member's diagnoses, level of care and services rendered. Those who do not are required to complete a corrective action plan to fulfill the requirements.

DBHS has developed multiple outcome measures for various programs. In addition to reductions in Risk Scores, and NOMS data such as employment, housing and "frequency of use" changes, DBHS tracks reductions in jail recidivism. This was accomplished by finalizing a data sharing agreement with the Salt Lake County Jail; through the hiring of a data analyst; then matching program cohorts with jail data to analyze reductions in new-charge bookings in the Salt Lake County Jail. Prior to release the methodology is shared with the Sheriff's Office to gain their validation and approval for release.

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

Identify process improvement activities - Increased service capacity

The VOA ACT Team has a capacity of 100 clients and offers the program to fidelity. VOA will begin a second ACT team of at least 50 clients during FY21. DBHS and Optum will continue to monitor adherence to these standards with the addition of the new Medicaid code.

Optum has completed a geo-map to identify providers relative to the location of Medicaid consumers in Salt Lake County. This information is used to detect needs within the network. Providers who can fulfill specific service areas, levels of care, requested service hours and treatment for specific diagnoses may be added to the network.

DBHS/Optum is collaborating with Housing Connect (formerly the Housing Authority of the County of Salt Lake) to increase the number of housing opportunities for consumers who meet SMI criteria and to engage these consumers in treatment methods other than traditional office based care. In FY20, this included expansion of housing options for the VOA ACT Team through the Denver Apartments (22 units for SMI clients). In FY21, an additional 75 units will come online through the Central City Apartments, operated by First Step House (anticipated completion date in late July 2020). As RI begins to offer services through the new residential program, DBHS will also contract for up to 16 additional housing units in the community through master-leased apartments or congregate living sites to provide support for this program.

Guardian & Conservator Services (GCS) is contracted to provide personal services to consumers who are living with mental illness and meet SPMI criteria. These services are offered to help individuals with basic living needs and to increase community tenure. With clinical staff involved, those who may need to engage in therapeutic services may be identified sooner.

In order to address the need for some of the most in-demand services, DBHS is planning to add the following services in FY21.

1) Recovery Innovations International (RI) will be adding a 16-bed residential facility for mentally ill adult male clients who also have substance use disorder (SUD) treatment needs and are involved in criminal justice services. Treatment will have focus on behavioral health issues and criminogenic risk factors.

2) Recovery Innovations International (RI) Forensic ACT (Anticipated start date, June 2020)
While the Forensic ACT team follows the same service delivery approach as ACT, this team maintains an increased focus on criminogenic risk factors. For consumers with the most challenging and persistent problems, Forensic 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 Forensic ACT program takes a team approach to provide the treatment and services that members need. The RI Forensic ACT team follows the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures will be completed by RI and reported to Optum. Dependent upon the measure, evaluation will be completed weekly or monthly. DBHS will conduct 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.

3) The passage of HB 32 allows for counties to apply for funding to develop and implement Receiving Centers. It does not allow for this funding to be used for the acquisition of land. DBHS is actively engaged in developing partnerships to implement a non-refusal receiving center in Salt Lake County and preparing to apply for this funding.

4) Odyssey House will be adding a 16-bed residential facility for mentally ill adult clients who also have substance use disorder (SUD) treatment needs and are involved in criminal justice services. Treatment will have focus on behavioral health issues and criminogenic risk factors.

Identify process improvement activities - Increased Access for Medicaid & Non-Medicaid Funded Individuals

Beginning in July, 2019, a process was implemented for the Optum clinical team to identify hospital discharge situations where inadequate disposition planning took place. A workflow was developed to refer those cases to the

Optum BH/Medical Integration Specialist to work with hospitals or make outreach to members to connect them with providers. The Optum Care Coordination team will experience growth in the coming months.

Identify process improvement activities - Efforts to respond to community input/need

Optum continually assesses the needs of the community. Optum has introduced their network to Take Care Utah through the Utah Health Policy Project to assist Salt Lake County residents with applications for insurance. Providers recognize some of those they serve lose Medicaid eligibility and are unsure of the reason and/or how to address the issue. Through these partnerships, adults and youth living with mental health and/or substance use disorders have received one-on-one support to apply for all types of insurance, including Traditional, Non-Traditional and Targeted Adult Medicaid. Also, an Optum Quality Assurance and Performance Improvement (QAPI) Committee Member, who represents families of those living with behavioral health issues, has linked Mental Health Court to Take Care Utah for assistance with insurance applications.

Optum's Community and Housing Care Manager participates in several committees and groups to collaborate on supporting Utah's homeless. The Community Triage Group (CTG) is comprised of community partnering agencies who meet weekly to prioritize homeless individuals for housing vouchers. Community stakeholders from various agencies gather monthly as the Salt Lake County Coalition to End Homelessness to discuss the direction of initiatives and to problem solve associated issues impacting the County. Other community partners conduct meetings within their agencies to address how to support those who are frequently using high level services, such as crisis response. The Community and Housing Care Manager lends her knowledge of behavioral health services to these groups as well.

In 2018, there was a noted significant year over year increase in Utah State Hospital (USH) admissions to civil beds for a total of 37. However, in 2019, admissions to civil beds decreased to 28 with an equal number of discharges, 28. The Optum USH Liaison works with USH consumers, USH treatment team members, the Optum Utah State Hospital Committee, and Salt Lake County service providers to arrange housing, behavioral and physical health care to transition to community based living and care. Additionally, during this past year there has been an adjustment in the SLCo Liaison support for USH. Optum currently has identified two individuals who spend the majority of their time focusing on admissions and discharges from USH.

Identify process improvement activities - Coalition Development

DBHS/Optum works closely with the three inpatient facilities in the network, community providers and DBHS, meeting weekly to coordinate the care for consumers. In addition, DBHS/Optum led a coordinated service effort to outline processes and contacts to improve communication and services.

Describe how mental health needs 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 Assertive Community Treatment (ACT) services, ACT is willing to travel to wherever the member is residing within Salt Lake County, including nursing facilities.

Describe how you are utilizing telehealth based services in your area.

DBHS/Optum SLCo has four providers who are approved and are currently providing Telehealth services. While no specific telehealth system is required for our providers, they submit an attestation confirming that the videoconferencing technology is compliant with HIPAA requirements and meets current American Telemedicine Association minimum standards. In addition, the following requirements must be met to perform telehealth services:
• HIPAA and bandwidth requirements
• Compliance with applicable laws, rules, regulations, and state requirements to provide telehealth services along with coding requirements and documented protocols
• Standards for appropriate, private and secure room/environment

• Secure documentation rules in accordance with HIPAA
• Protocols to assure equipment functions properly with a backup plan in case of failure
• Licensing standards for the state
• Proper claim submission protocols
• Appropriate malpractice insurance for providing telehealth services

The following discrete services for substance abuse and mental health treatment are included: assessment, individual therapy, family therapy, nursing assessment, medication management, crisis psychotherapy and skills related services among other service codes.

Please note, the above is the protocol for telehealth approval under normal operating circumstances. It does not take into account the current COVID-19 State of Emergency and that all providers have been granted the ability to do telehealth in accordance with the most recent guidance by the various governing bodies.

Describe how you are addressing maternal and early childhood (0-5 years) mental health needs within your community.

Reach Counseling offers specialized services for women during and after pregnancy. In addition, Optum SLCo is in the process of adding Children's Service Society to our provider network who also offers specialized programming to address maternal mental health.

Describe (or attach) your policies for improving cultural responsiveness in services.

The Cultural Responsiveness Committee meets quarterly and has a cultural competence plan that helps guide the committee. The committee is chaired by our provider relations advocate and co-chaired by a representative from DBHS. The committee meets quarterly and is comprised of various providers in the network and community stakeholders. A new committee was formed in FY19 and focused on identifying training needs within the network to better recognize the diverse needs of our members. The committee offers training with CEUs to establish a foundation for cultural responsiveness. DBHS/ Optum is committed to offering annual trainings to enhance our ability to meet the diverse needs of the Medicaid mental health population.

Identify a staff member responsible to collaborate with DSAMH to conduct health disparity and youth-in-transition needs assessments/gap analysis during 2020-2021.

Optum SLCo Senior Care Advocate, Mark Schull has been selected for this role.

Other Quality and Access Improvements (not included above)

All quality and access improvements have been described above.

29) Integrated Care

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

Optum continues to collaborate with the four ACOs with frequent PRN contact. Optum frequently works with the ACOs on finding/researching providers and supplying information to help all providers to work with members more effectively.

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 arose, 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.

The following partnerships have been developed with the following Federally Qualified Health Centers and primary care organizations:
Fourth Street Clinic – Helps homeless Utahns improve their health and quality of life by providing high quality integrated care and health support services. For many homeless Utahns, this is their first and only chance at a diagnosis and ongoing treatment. By increasing homeless Utahns' access to both primary and behavioral health care, Fourth Street Clinic has become a major partner in ending homelessness, promoting community health, and achieving across- the-board health care savings. Fourth Street Clinic provides psychotherapy, psychological counseling, psychiatric evaluation and management, family and couples therapy, health and wellness, primary care provider collaboration and substance use disorder assessment and treatment referrals.

Odyssey House – Martindale Clinic - Odyssey House operates its Martindale Clinic in order to bring a multidisciplinary approach to addressing addiction and mental illness. The Martindale Clinic provides medical, psychiatric and behavioral health professionals within one fully-integrated setting.

Additionally, through the 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, 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, Midtown provides the full spectrum of physical health care for Vivitrol clients as they actively attend to their appointments. At Martindale and UPFH, clients are also offered access to primary healthcare. All partner clinics accept Medicaid and private insurance as well.

Describe your efforts to integrate care and ensure that clients have their physical, mental and substance use disorder needs met, including screening and treatment and recovery support.

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.

The Optum Clinical Operation Team coordinates with providers in our network to help clients find the best treatment programs available that are suited to their individual needs. Our Clinical Operation Team works with a variety of community partners to coordinate care. The Optum Clinical Operations Team currently has one Care Advocate who specializes in working with the ACOs to coordinate mental health care, substance use disorder treatment and health care for clients who are in need. The partnership between the ACOs and Optum has led to improved coordination of services offered and real time discussions regarding the management of challenging individuals.

Describe your efforts to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).

During the past year, Optum network trainings have continued to include a focus on the importance of the physical health assessment components as well as coordinating with PCPs as needed for their services.

Optum Care Advocates collaborate with the respective ACOs on a case-by-case basis when it is noted that the consumer's medical needs, such as HIV, AIDS, Diabetes and Pregnancy, are a component of their mental illness and/or a part of their recovery. Each ACO has an identified person that is our contact point. The ACO then staffs the case and Optum will be contacted in return with their recommendation and/or plan to help address the medical status. Optum then coordinates with the treating mental health provider what the medical plan is and who to coordinate with for their collaborative care. In some cases Optum has been able to proactively access health care services for consumers coming out of USH, so that medical support is available upon immediate return to the community. This process is fluid and responsive on an as needed basis in order to meet consumer needs.

Recovery Plus: Describe your plan to reduce tobacco and nicotine use in SFY 2021, and how you will maintain a *tobacco free environment*. SUD Target= reduce tobacco and nicotine use by 5%.

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.

Describe your efforts to provide integrated care for individuals with co-occurring mental health and autism and other intellectual/developmental disorders.

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.

30) Children/Youth Mental Health Early Intervention

Describe the *Family Resource Facilitation (Family Peer Support)* activities you propose to undertake and identify where services are provided. *Describe how you intend to partner with other Department of Human Services child serving agencies, including DCFS, DJJS, DSPD, and SOC.* For each service, identify whether you will provide services directly or through a contracted provider.

Family Resource Facilitators (FRF): 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, FRFs provide referrals to local resources; advocacy for culturally appropriate services; links to information and support groups; and family wraparound facilitation. 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 FRF program services are designed to provide family peer support services to parents and/or caregivers of children/youth with complex needs. Generally, FRFs have a family member with a mental illness giving them their

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), and wraparound to fidelity. 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 11 FRFs placed with 8 agencies throughout Salt Lake County.

Presently FRFs are anchored at the following agencies or organizations:
• 2 FTEs Salt Lake County Division of Youth Services
• 1 FTE Utah Division of Juvenile Justice Services
• 1 FTE The Children's Center
• 1 FTE Granite School District
• 1 FTE Allies with Families
• 3 FTE State of Utah Division of Child and Family Services (DCFS)
• 1 FTE 3rd District Juvenile Court
• 1 FTE Family Support Center

Include expected increases or decreases from the previous year and explain any variance over 15%.

No significant changes.

Describe any significant programmatic changes from the previous year.

No significant changes.

Do you agree to abide by the Mental Health Early Intervention Family Resource Facilitation Agreement? YES/NO

Yes

31) Children/Youth Mental Health Early Intervention

Describe the *Mobile Crisis Team* activities you propose to undertake and identify where services are provided. *Please note the hours of operation.* For each service, identify whether you will provide services directly or through a contracted provider.

The UNI MCOT is an interdisciplinary team of mental health professionals, including FRFs, 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. At the time of this writing the average law enforcement response time was 19 minutes and the average community response time was 20 minutes. 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 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 under the age of 18.

Include expected increases or decreases from the previous year and explain any variance over 15%.

We are projecting a 28% increase in MCOT services to youth funded by Medicaid.

Describe any significant programmatic changes from the previous year.

No significant changes.

Describe outcomes that you will gather and report on. Include expected increases or decreases from the previous year and explain any variance over 15%.

In additional to the total number of youth contacts and outreaches, DBHS collects the following outcomes:
• Number of contacts/outreaches that avoided out-of-home placement;
• Number of contacts/outreaches avoided legal involvement;
• Number of individuals that received assistance when they were in danger of harming themselves or others; and
• Number of police calls avoided.

No expected increases.

32) Children/Youth Mental Health Early Intervention

Describe the School-Based Behavioral Health activities you propose to undertake and 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.

VBH Prevention Programs: These school-based early intervention programs give children, adolescents and their families access to a licensed clinical social worker, medication prescriber, case manager, and a peer worker, all of whom provide behavioral health services in familiar school and community surroundings to help eliminate the stigma associated with receiving such services. The program also offers referrals to a primary care physician to address any co-morbid physical conditions and promote a whole-health approach to care delivery.

Hopeful Beginnings: Licensed Mental Health Therapists (LMHT) work in schools and homes and provide individual and family therapy, as well as targeted case management services to Optum Salt Lake County Medicaid eligible youth. This agency offers a sliding scale fee to non-Medicaid children at the same schools for the same services. They focus on partnering with school leadership and personnel to help youth access much needed resources and accomplish therapeutic objectives.

Project Connections and Odyssey House implement their school-based services during FY20 (Medicaid only) which are similar in their delivery of services to VBH and Hopeful Beginnings.

Include expected increases or decreases from the previous year and explain any variance over 15%.

At the School Districts' request, DBHS has increased school based behavioral health services and funding. We are projecting a 38% increase.

Describe any significant programmatic changes from the previous year and include a list of the schools where you plan to provide services. (Please e-mail Leah Colburn lacolburn@utah.gov a list of your current school locations.)

Only the schools which VBH is in serve those with Medicaid and the unfunded (Early Intervention dollars). The other agencies serve only Medicaid clients.

The following are schools that VBH is currently in, divided by school district.

Salt Lake City School District
Glendale Middle School
Newman Elementary
Rose Park Elementary

Canyons School District

Midvale Middle

Granite School District
Copper Hills Elementary
Hunter High School
Kearns' Jr. High

The following are schools that Hopeful Beginnings is currently in, divided by school district.

Canyons School District
Midvale Elementary
Copperview Elementary
Sandy Elementary
East Midvale Elementary
Bellview Elementary
Peruvian Park Elementary
East Sandy Elementary
Bridges Transitional Program
Mt. Jordan Middle School
Hillcrest High School
Alta High School
Jordan High School

Murray School District
McMillan Elementary
Viewmont Elementary
Grant Elementary
Liberty Elementary
Parkside Elementary
Hillcrest Jr. High
Murray High School

Jordan School District
Herriman High School (only funded through Jordan School District – services may be off-site)

Charter Schools
Pacific Heritage
East Hollywood High School

The following are schools that Project Connections is currently in, divided by school district.

Canyons School District
Oak Hollow Elementary
Willow Springs Elementary
Draper Park Middle School
Indian Hills Middle School
Corner Canyon High School

Charter Schools
Itineris Early College High School

The following are schools that Odyssey House is currently in, divided by school district.

Salt Lake School District
Backman Elementary
Diamond Ridge Elementary
Horizonte High School
Wasatch Elementary

Charter Schools:

School for the Performing Arts (SPA)

Describe outcomes that you will gather and report on.

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, YOQ, and other indicators such as Office Disciplinary Referral, and grade point average will be reported.

33) Suicide Prevention, Intervention & Postvention

Describe the current services in place in suicide prevention, intervention and postvention. Please include a link or attach your localized suicide prevention plan for the agency or broader local community.

Optum's Recovery and Resiliency team have provided the following trainings in collaboration with other stakeholders and community partners.
• 71 people in the community were certified in Mental Health First Aid (MHFA) with more trainings scheduled during the current fiscal year.
• Youth Mental Health First Aid trainings scheduled during the current fiscal year.
• 10 people participated in suicide prevention training, QPR training (Question, Persuade, Refer), during the past year, with more trainings to be scheduled in the coming fiscal year. the current fiscal year.

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

Regarding efforts on expansion/improvement of suicide specific treatment which is non-crisis, the Optum Recovery and Resiliency Team continues to provide QPR Trainings (Question, Persuade and Refer) in the community to assist with recognition of people experiencing suicidal ideation and how to link people in need to services. Though the Performance Improvement Project (PIP) which utilized the Columbia Suicide Severity Rating Scale (C-SSRS) to help identify those with suicidal ideations has ended, Salt Lake County continues to mandate by contract use of the C-SSRS to increase comprehensive assessment of suicide risk and the use of individualized safety plans, with access to the crisis continuum if needed.

In addition to the above, the clinical operations/care advocacy teams' manage/pre-certify IP acute admissions and concurrent reviews which are post ED, coordinating stabilization and safety. An Optum Care Coordination Specialist assists hospitals to coordinate and work with the provider Network to align ongoing services including follow-up after hospitalization (FUH). An additional measure required by Medicaid is to track all those who have been hospitalized for how soon the consumer has their first behavioral health appointment post-discharge. For the year ending December 31, 2018, Optum demonstrated that 43.87% attended an appointment within seven days post-discharge and an additional 17.7% attended an appointment within 30 days, for a total of 61.57% attending an appointment post-charge from a hospital.

If a consumer is not admitted and there is a clear mental health presentation Optum will refer and follow-up with Network provider (existing or new). The level of care can be routine OP or more intensive services such as VOA's ACT or VBH's AOT. If the ED presented or notified Optum of the presentation we would always recommend the appropriate level of care and follow up.

Optum attends the Salt Lake Suicide Prevention Coalition meeting. Additionally, Optum's Recovery and Resiliency (R&R) Team has been participating in the DSAMH Peer Support Conference Planning and DSAMH Utah Behavioral Health Planning and Advisory Council as well as the USARA Advisory Council. The R&R Team frequently meets with providers for the purpose of collaboration and coordination of care. For example: the ACO Learning Collaborative, Clinical Review meeting with VBH, Field Care Advocacy Meetings at UNI, VOA ACT Team Meeting, Fast/Faster Meetings with DYS. Additionally, a member of the R&R Team chairs the Community Advisory Committee, and participates in the Cultural Responsiveness Committee, the Salt Lake Suicide Prevention Coalition, the Utah Behavioral Health Planning Committee, the Peer Conference Planning Committee, the USARA Recovery Day Planning Committee, the Well Champ Network Committee, the USH Committee, and has sat in on some of the Shelter the Homeless Committee meetings.

Regarding postvention efforts, Optum Care Advocates are licensed mental health therapists who notify outpatient providers, as well as the consumer's care manager through their ACO, of any Optum member who is admitted for inpatient psychiatric treatment. The providers are encouraged to collaborate with the inpatient team and to collaborate on discharge planning when appropriate. During outpatient provider audits, members of the Optum Quality Assurance and Performance Improvement Team address care collaboration with inpatient providers as needed. In FY20, Optum added three more care advocates dedicated to case collaboration and assisting with transitions in care for consumers with more complex circumstances. This support will be available for all levels of care, not just transitions out of inpatient care.

Describe progress of your implementation plan for comprehensive suicide prevention quality improvement. Please specifically outline your plan to increase same day safety plans that include counseling on access to lethal means as well as your plan to train staff in CALM.

Although the DSAMH PIP focusing on suicide prevention and safety planning ended in 2018, DBHS has continued to require providers use the C-SSRS to screen for suicidal ideation upon admission and any other time an individual 5 years or older demonstrates suicide risk. Providers are required to create safety plans with those who answer yes to question #2 or any subsequent question. DBHS and Optum SLCo audit for these components during quality treatment record reviews. During 2020, all Optum SLCo providers will be required to complete CALM training and present a certificate of completion. Screening for suicidal ideation and access to lethal means will be incorporated into all clinician trainings offered in FY21, where appropriate.

Describe your plan for coordination with Local Health Departments to identify roles and support implementation of a community postvention plan in alignment with the state Community Postvention Toolkit.

Our Clinical Operations Team coordinates care with our crisis programs and community providers to help our clients access the care they need. The Optum clinical team participates in the Salt Lake County Zero Suicide Collaboration and is constantly updating our providers on any new information via our Optum Network eBlast system. The team collaborates closely with Primary Children's Medical Center's Suicide Prevention Coordinator.

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 array of services includes telephone crisis-line services, warm-line services, MCOT, close coordination with the Salt Lake Police Department CIT program, a receiving center, case management, psychotropic medications and, when necessary, access to acute inpatient hospitalization.

For a 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, case management, psychotropic medications and, when necessary, access to acute inpatient hospitalization.

34) Justice Reinvestment Initiative

Identify the members of your local JRI implementation Team.

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:

Chair, Sheriff Rosie Rivera Salt Lake County Sheriff's Office

Vice Chair, Mayor Jenny Wilson	Salt Lake County Mayor
Hon. Brendan McCullaugh	Judge, West Valley City Justice Court
Jojo Liu	CJAC Coordinator
Honorable John Baxter	Judge, Salt Lake City Justice Court
Jim Bradley	Salt Lake County Council
Mike Brown	Chief of Police, Salt Lake City Police Department
Max Burdick	Salt Lake County Council
Craig Burnett	Chief of Police, Murray City, LEADS Chair
Jack Carruth	Chief of Police, South Salt Lake City
Mike Haddon	Director, Utah State Department of Corrections
Karen Crompton	Director, Salt Lake County Human Services
Sim Gill	District Attorney, Salt Lake County
Kele Griffone	Director, Criminal Justice Services
Representative Eric Hutchings	Utah House of Representatives
Senator Karen Mayne	Utah State Senate
Matt Dumont	Chief, Salt Lake County Sheriff's Office
Rich Mauro	Executive Director, Salt Lake Legal Defenders Association
Peyton Smith	Third District Court Administrator's Office
Jim Peters	State Justice Court Administrator
Honorable Mark Kouris	Presiding Judge, Third District Court
Jeff Silvestrini	Mayor, Millcreek City
Tim Whalen	Director, Salt Lake County Behavioral Health Services
Catie Cartisano	Individual with Lived Experience in the Criminal Justice System
Pamela Vickrey	Utah Juvenile Defender Attorneys, Executive Director
Scott Fisher	Salt Lake City Municipal Prosecutor

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.

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 tool 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..

Describe the evidence-based mental health screening, assessment, prevention, treatment, and recovery support services you intend to implement including addressing criminal risk factors.

Justice Reinvestment Initiative
Salt Lake County formerly received Justice Reinvestment Initiative (JRI) dollars through two funding streams, the FY16 formula-based dollars and the FY18 competitive application-based dollars. In FY20, the competitive application-based dollars commonly referred to as JRC, were cut.

Formula-based Funding
Originally in 2016, utilizing the formula-based funding as seed dollars, the Intensive Supervision Probation (ISP) Program, CORE 2 and a Prosecutorial Pre-Diversion Program (Operation Diversion) were implemented. Operation Diversion ended treatment referrals July 1st, 2017 as funding for this program ended. ISP and CORE 2 remain in operation. Additional funding sources for these programs included County General Fund, Federal Medicaid dollars, City dollars, and one-time CCJJ grant dollars.

Application-based Funding
Based on the application-based funds originally awarded in FY18 and then later cut in FY20, ISP was expanded, additional Drug Court residential capacity was funded, and the Unified Police Department (UPD)/University of Utah Neuropsychiatric Institute (UNI) Program was started, co-locating a licensed mental health professional with a UPD officer to respond to mental health crises in the community. All programs are still operational as described below.

Justice Reinvestment Initiative Programs

Intensive Supervision Probation Program
DBHS will continue to partner with the Sheriff's Office and CJS on the ISP program. This program targets high-risk 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 will continue to provide two dedicated assessment workers who are seated at CJS with the officers 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) were introduced to ISP. Since the inception of ISP in 2015, 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 30% 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 Colonel's 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 professional (since reduced back to two) 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 an April 2020 evaluation 470 clients were found to have engaged in programming during a 12 month period (April 2019 – March 2020). Since the program's inception 265 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 is our intention to maintain current levels of programming throughout this time by transitioning from JRC funding to Medicaid funding. Every effort is being 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 trainings were held at the County Government Center. Approximately 213 individuals from 20 organizations across the county registered or walked in to 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 last two years, a large portion of treatment funds are no longer needed for this program (JRC). 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.

Please refer to the attached ISP report for the most recent outcomes and demographic information.

Drug Court Treatment Expansion
Beginning July 1st, 2017 through JRC dollars, an additional $500,000 was made available to Drug Court utilizing a fund code that accelerated access to treatment slots. Historically, the waiting list for Drug Court participants to admit to a residential program was long, creating frustration with the court and teams, and was the impetus in prioritizing dollars for this population. During this same year, the Utah Department of Health implemented the Targeted Adult Medicaid (TAM) program providing new Medicaid funding for non-parenting Drug Court participants earning less than 5% of the FPL. These new funding streams enabled Salt Lake County providers to grow in a very large way, more than doubling the residential treatment capacity in the county (residential beds increased from approximately 170 beds in 2016 to 440 beds).

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 was unknown, levels of programming were maintained 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 trainings were held at the County Government Center. Approximately 213 individuals from 20 organizations across the county registered or walked in to 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 this data 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.

FY21

Due to the elimination of JRC funding, and the success of maintaining levels of programing through TAM and Adult Medicaid Expansion (up to 100% FPL April 2019, and up to 138% FPL January 2020), with the exception of some small gaps being filled when needed, this program no longer relies on JRI funding. Through these Medicaid expansions, by the end of FY20, it is anticipated that the Salt Lake County network of contracted providers will have grown the SUD residential capacity from 170 beds in 2016 to ~700 beds. Additional capacity outside of this network also increased through other providers throughout the county. Very specialized Medicaid enrollment efforts and trainings continue, including a rapid response in April 2020 providing our network with PDF fillable forms for the TAM referral process to support telecommuting and COVID-19 risk of infection. DBHS also continues to work closely with the ACOs to support the integrated expansion population by engaging them with providers to problem solve, and to assist with non-Medicaid reimbursable services through the DBHS network.

CORE 1 & 2

Initially, DBHS utilized JRI dollars as seed dollars to implement CORE 2. DBHS now utilizes multiple funding streams, including JRI, for the VBH CORE 1 & 2 programs. These 16 bed residential facilities, one for men and one for women, serve individuals with co-occurring serious mental illness and substance use disorders. They 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 offenders 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 criminal recidivism.

A January 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.

UPD/UNI Mental Health Unit Program

With JRC application-based dollars DBHS worked with program stakeholders to implement the Mental Health Unit within the Unified Police Department (UPD) in July 2017. After finalizing contracts and MOU's, and assigning a licensed clinician employed by UNI, the program became operational in November of that year (with JRC dollars supporting the cost of one clinician). JRI funding now supports this program, due to the discontinuation of JRC dollars.

Through this program, 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. This program serves the cities of Taylorsville, Kearns, Magna, Riverton, Holladay, Millcreek, Midvale, Canyons, Copperton, and White 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.

Through additional county dollars, the Mental Health Unit is made up of one sergeant, one detective, and nine secondary officers in each precinct that work with the unit one to two days a month. The unit also utilizes interns from the University of Utah in assembling the program database.

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

The program enjoys an average diversion from medical or psychiatric hospitalization rate of 95.1%. Through the first eight months of FY20 (July 2019 through February 2020), the program has made 529 outreaches.

Budget:
JRI programs serve individuals with both mental health and substance use disorders. Budgets for these programs are separated appropriately between the MH and SUD Area Plans.

Identify your outcome measures.

DBHS has developed multiple outcome measures for the programs listed above. Please reference the sections above and attached ISP report for these outcomes and demographics. In addition to reductions in Risk Scores, and NOMS data such as employment, housing and "frequency of use" changes, DBHS tracks reductions in jail recidivism. This was accomplished by finalizing a data sharing agreement with the Salt Lake County Jail; through the hiring of a data analyst; then matching program cohorts with jail data to analyze reductions in new-charge bookings in the Salt Lake County Jail. Prior to release the methodology is shared with the Sheriff's Office to gain their validation and approval for release. 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.

35) Disaster Preparedness and Recovery Plan

Please attach or input your disaster preparedness and recovery plan for programs that provide prevention, treatment and recovery support for mental illness and substance use programs.

Optum has developed a proprietary Business Continuity Plan (BCP). This document is updated annually and is designed to evaluate all business functions and develop appropriate plans so that all needs of the community and providers can be maintained. The plan is flexible enough to accommodate a wide range of potential impacts. The BCP is reviewed annually with DBHS and is also available to review onsite at the Optum offices as per request.

DBHS has uploaded our Continuity of Operations Plan (COOP) plan and our Pandemic COOP. Additionally, we require by contract that each provider have their own COOP (aka Disaster and Preparedness and Recovery Plan), personalized to their facility(ies). We review the providers' COOPs during the annual audit process.

FORM B - SUBSTANCE USE DISORDER TREATMENT BUDGET NARRATIVE

Local Authority: Salt Lake County Behavioral Health (DBHS)

Instructions:

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

1) Screening and Assessment Only

Form B - FY21 Amount Budgeted:	**$951,891**	**Form B - FY21 Projected clients Served:**	**2,244**
Form B - Amount Budgeted in FY20 Area Plan	**$1,079,029**	**Form B - Projected Clients Served in FY20 Area Plan**	**2,300**
Form B - Actual FY19 Expenditures Reported by Locals	**$1,183,307**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**2,908**

Describe activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers.

Salt Lake County Division of Behavioral Health Services (DBHS) practices the philosophy that there is "no wrong door to treatment." What this means is that though we do contract with The University of Utah's Assessment and Referral Services/Interim Group Services (ARS/IGS) for substance use disorder (SUD) assessments, any of DBHS' ten SUD contracted treatment providers may conduct the assessment and refer into services.

DBHS/Optum Contracted Providers

University of Utah Assessment and Referral Services/Interim Group Services (ARS/IGS) - Screening and Assessment only

All other providers who provide screening and assessment, and also various levels of treatment:
Ascendant Behavioral Health
Asian Association of Utah Refugee & Immigrant Center
Clinical Consultants
Division of Youth Services (DYS) - Salt Lake County
First Step House
House of Hope
Odyssey House
Project Reality
Valley Behavioral Health (VBH)
Volunteers of America/Cornerstone Counseling Center(VOA/CCC)/Family Counseling Center

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Decrease in funding and clients served due to State cuts and as a result of the County no longer reporting TAM

TEDS to the State.

Describe any significant programmatic changes from the previous year.

Ascendant Behavioral Health has been added to Optum's network as both a Substance Use and Mental Health provider. They have the capability of providing outpatient and intensive outpatient services for members with substance use disorders. In addition, they provide medication evaluation and management as well as Medication Assisted Treatment.

Describe forensic (performed for the court) substance use disorder screening and assessment services for adults/ youth? Please describe how individuals schedule this activity, list any fees assessed and provide a summary of the clinical process used.

DBHS provides behavioral health services through a network model of public and private providers throughout the community. Providers within this system provide court mandated substance use disorder screening and assessment for adults/youth. The process for scheduling, fees and the clinical process used varies by provider, and negotiated through contract. For example, one large provider of assessments and referrals is ARS. It is common for those who have been court-ordered to obtain a substance use disorder screening and assessment through ARS. ARS has a history of providing many court-ordered assessments and therefore know exactly what judges are looking for. Their assessments include a background criminal investigation (BCI - staff have terminal access), the Risk and Need Triage (RANT), and a face-to-face interview to complete diagnosis and make an American Society of Addiction Medicine (ASAM) recommended placement.

2) Detoxification Services (ASAM IV-D, III.7-D, III.2-D, I-D or II-D)

Form B - FY21 Amount Budgeted:	**$1,547,989**	**Form B - FY21 Projected clients Served:**	**2,500**
Form B - Amount Budgeted in FY20 Area Plan	**$1,460,920**	**Form B - Projected Clients Served in FY20 Area Plan**	**2,300**
Form B - Actual FY19 Expenditures Reported by Locals	**$3,268,371**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**2,441**

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers.

DBHS contracts to provide social detoxification services for youth and adults, including women and mothers with dependent children, in multiple sites within the county. These sites are:

1. Volunteers of America Men's Adult Detoxification Center: This center provides an 83 bed, social model residential detoxification center for men 18 and older in need of detoxification & withdrawal management services. It is a social model detox program that focuses on creating a safe and trauma informed environment where clients can manage their intoxication and withdrawal symptoms to prepare them for long term recovery.

   Clients are able to stay at this facility for up to 14 days and receive 3 meals a day, case management services, access to Medication Assisted Treatment (MAT), Seeking Safety groups, peer support meetings, and 12 Step meetings. Qualifying clients who are interested in treatment for substance use disorder will be able to receive an assessment to determine the level of treatment required and a referral into that level of treatment. This facility is located at 252 W. Brooklyn Ave. Salt Lake City, UT, 84101.

2. Volunteers of America Center for Women and Children: provides a 32 bed, social model residential detoxification center for homeless and low-income women and children. It is a social model detoxification facility which provides a safe place to stay for women withdrawing from use of alcohol or drugs. Women may stay at this residential facility for up to 2 weeks.

   During their stay, women will have the opportunity to meet with a case manager to discuss their eligibility for substance use treatment, as well as get connected to other needed resources. Women may bring children under the age of 10 years old.
   Clients receive 3 meals a day, access to an outdoor area, and can attend supportive programming activities, including recovery-focused support groups and working in the onsite garden. It is located at 697 W 4170 S, Murray, UT, 84123.

3. Salt Lake County's Division of Youth Services (DYS) program located in South Salt Lake provides detoxification services on an "as needed" basis for adolescents.

DBHS provides access to dedicated law enforcement jail diversion detox beds at VOA. Also included in the figures above are 18 new detox beds added in FY19 to support clients involved in Operation Rio Grande.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Large reduction in funding due to State funding cuts. Immaterial change in client count due to the new Medicaid detox pilot more than covering the cut. The TEDS are fully reported to the State because Salt Lake County is responsible for the match for this pilot program no matter the type (i.e., Legacy, TAM, or Expansion) but only the Medicaid match is reported in the budget as the Medicaid funds are paid by DOH directly to VOA.

Describe any significant programmatic changes from the previous year.

No significant programmatic changes

If this service is not provided by the Local Authority, where are individuals accessing this level of care when needed? Who in your community provides this service? How is the service paid for?

N/A

3) Residential Treatment Services: (ASAM III.7, III.5, III.3, III.1)

Form B - FY21 Amount Budgeted:	**$7,039,953**	**Form B - FY21 Projected clients Served:**	**1,002**
Form B - Amount Budgeted in FY20 Area Plan	**$9,345,507**	**Form B - Projected Clients Served in FY20 Area Plan**	**1,100**
Form B - Actual FY19 Expenditures Reported by Locals	**$7,549,976**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**1,342**

Describe the activities you propose and identify where services will be provided. Identify whether you will provide services directly or through a contracted provider. Please list all contracted providers and identify the population served (Men, Women, Youth).

DBHS and Optum currently contract with four residential treatment providers for ASAM 3.1, 3.3, and/or 3.5

services. A process of pre-authorization and utilization review is in place in order to utilize residential services appropriately. The following agencies perform this pre-authorization function:

• Optum for Medicaid clients;
• ARS for Drug Offender Reform Act (DORA), ISP (Intensive Supervision Probation), and juvenile drug court clients; and
• DBHS for all other adults and youth, as well as Family Recovery Court.

Contracted Providers and the associated ASAM level of care (LOC) they provide:

First Step House – Men only; 3.1, 3.3, 3.5

House of Hope – Women; Children with Parents 3.5

Odyssey House – Adult, Youth, and Children with Parents 3.1 and 3.5;
Adult, Children with Parents 3.3

Valley Behavioral Health – Adult, Children with Parents 3.5

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Material reduction in clients served due to the combination of State cuts and as a result of the County no longer reporting TAM TEDS to the State.

Describe any significant programmatic changes from the previous year.

Through the expansion of Targeted Adult Medicaid (TAM) and the Adult Medicaid Expansion (AME), DBHS has seen a dramatic increase in access to SUD residential treatment beds and other services. For example, in 2016 there were approximately 170 SUD residential beds. By the end of FY20, this number is anticipated to be ~700 beds. The primary funding source is the Targeted Adult Medicaid and Adult Medicaid Expansion, not included in the budget due to it going directly to our provider network.

4) Opioid Treatment Program (OTP-Methadone)

Form B - FY21 Amount Budgeted:	**$2,318,614**	**Form B - FY21 Projected clients Served:**	**1,332**
Form B - Amount Budgeted in FY20 Area Plan	**$1,326,536**	**Form B - Projected Clients Served in FY20 Area Plan**	**800**
Form B - Actual FY19 Expenditures Reported by Locals	**$1,980,769**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**1,137**

Describe the activities you propose and identify where services will be provided. Identify whether you will provide services directly or through a contracted provider. Please list all contracted providers and summarize the services they will provide for the local authority.

For individuals who are not eligible for Medicaid, DBHS contracts with one provider, Project Reality, to deliver this service. Project Reality has two locations in Salt Lake County, one in their historical location of SLC and a second office in Murray. Project Reality provides ASAM 1.0 LOC services. This can include medication management, individual therapy, group therapy, and case management. Additionally, Project Reality does provide daily off-site dosing at the VOA/CCC Detox and other providers as needed. Medicaid clients also have the option of receiving opioid treatment and withdrawal services at the Fourth Street Clinic.

Also see sections 10 and 11, which include methadone services provided through STR/SOR funding.

Justify any expected increase or decrease in funding and/or any expected increase or decrease

in the number of individuals served (15% or greater change).
Projected client counts and spend are materially increasing in FY21 as compared to actual FY19 due to the expanded Project Reality MAT programming that was started with SOR in FY19 and fully ramped up in FY21. Even though we are only projecting SOR through Sept 30, 2020 at this point in the budget, we have projected utilizing reserves to maintain the new MAT programming through at least the end of FY21.
Describe any significant programmatic changes from the previous year.
No significant changes

5) Office-based Opioid Treatment -(Vivitrol, Naltrexone, Buprenorphine)

Form B - FY21 Amount Budgeted:	**$1,874,332**	**Form B - FY21 Projected clients Served:**	**1,100**
Form B - Amount Budgeted in FY20 Area Plan	**$1,384,441**	**Form B - Projected Clients Served in FY20 Area Plan**	**400**
Form B - Actual FY19 Expenditures Reported by Locals	**$993,499**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**778**

Describe activities you propose to ensure access to Buprenorphine and Naltrexone (including vivitrol) and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers.

DBHS continues to provide access to Vivitrol for clients actively engaged in SUD treatment. 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 to provide medical care and Vivitrol injections to participating clients. Referrals can come from any DBHS network provider, through CATS in the Jail, the Department of Corrections Treatment Resource Centers (TRCs) and halfway houses, through community health centers, or through Intensive Supervision Probation. 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. Please refer to the area plan attachments for a Vivitrol Program report detailing reductions in new charge jail bookings, jail length of stay and other pertinent outcomes.

In addition, SOR dollars have allowed an expansion of MAT services in the jail. Qualifying program participants with opioid use disorders (OUD) have access to MAT, substance use disorder behavioral therapies, and coordinated referrals to community treatment services upon release. MAT Program medications 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.

Qualifying participants have an OUD 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 may be expanded to cover additional OUD populations with DBHS approval and as budgets allow. Individuals with longer sentences or sentenced to prison are reviewed for taper of their medication.

Additionally, program participants identified as having an OUD shall be given information and education regarding the use of the Naloxone rescue kit, and an actual kit as supplies last. 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. Through the first eight months of programming, over 200 kits have been distributed to clients leaving the jail after participation in the Jail MAT Program.

DBHS has contracted with Clinical Consultants to further expand the availability of Buprenorphine and Naltrexone and other office-based MAT services to county residents eligible for federal STR/SOR funding. DBHS has made consistent efforts to coordinate with the STR/SOR OTPs to transfer over any clients who are eligible to utilize STR/SOR funds.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Projected client counts and spend are materially increasing in FY21 as compared to actual FY19 due to the new Clinical Consultants and Jail MAT programs that were started with SOR in FY19 and fully ramped up in FY21. Even though we are only projecting SOR through Sept 30, 2020 at this point, we have projected utilizing reserves to maintain the new MAT programs through at least the end of FY21.

Describe any significant programmatic changes from the previous year.

DBHS/Optum have collaborated on a PIP which is focused on increasing the use of MAT to treat OUD. Trainings for Peer Recovery Coaches (PRC) will be offered to provide information and tools related to MAT facts, benefits and motivational techniques. In addition, mid-year coaching will be provided to offer support to PRC and to problem-solve barriers to incorporating MAT into recovery plans.

6) Outpatient (Non-methadone – ASAM I)

Form B - FY21 Amount Budgeted:	**$3,873,891**	**Form B - FY21 Projected clients Served:**	**3,240**
Form B - Amount Budgeted in FY20 Area Plan	**$3,770,828**	**Form B - Projected Clients Served in FY20 Area Plan**	**3,300**
Form B - Actual FY19 Expenditures Reported by Locals	**$3,825,519**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**3,471**

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers.

DBHS and Optum contract with 10 agencies to provide the full continuum of outpatient ASAM LOCs. These programs provide services for youth, women, mothers and fathers with dependent children, and general adult patients, in multiple sites across Salt Lake County. Psychiatric medication evaluation services are provided by VOA/Family Counseling Center (FCC), Odyssey House, and VOA/CCC, for all levels of care, and can be accessed by any client currently served.

Contracted Providers:
Asian Association of Utah Refugee & Immigrant Center – Adult; Youth
Ascendant Behavioral Health - Adult; Youth
Clinical Consultants – Adult
First Step House – Adult
House of Hope – Women; Children with Parents
Odyssey House – Adult; Youth; Children with Parents
Project Reality – Adult
Salt Lake County Division of Youth Services – Youth
Valley Behavioral Health – Adult; Children with Parents
Volunteers of America / Cornerstone Counseling/Family Counseling Center – Adult; Youth; Children with Parents

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).
No significant change as compared to FY19 actuals.
Describe any significant programmatic changes from the previous year.
As mentioned in Item #1, Ascendant was added to the Optum Network for Medicaid members only. They provide substance use and dual diagnosis services for both adolescents and adults.

7) Intensive Outpatient (ASAM II.5 or II.1)

Form B - FY21 Amount Budgeted:	**$4,472,869**	**Form B - FY21 Projected clients Served:**	**1,869**
Form B - Amount Budgeted in FY20 Area Plan	**$4,432,124**	**Form B - Projected Clients Served in FY20 Area Plan**	**2,000**
Form B - Actual FY19 Expenditures Reported by Locals	**$4,462,738**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**1,968**

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers.
DBHS and Optum contracts with 7 agencies to provide ASAM 2.1 and/or 2.5 for youth, women, mothers with dependent children, and general adult patients in multiple sites across Salt Lake County. Psychiatric medication evaluation services are provided by VOA/FCC, Odyssey House, and VOA/CCC for all levels of care and can be accessed by any client currently served. <u>Contracted Providers:</u> Clinical Consultants – Adult 2.1 First Step House – Adult 2.5, 2.1 House of Hope – Women; Children with Parents 2.1, 2.5 Odyssey House – Adult; Youth; Children with Parents 2.1, 2.5 Salt Lake County Division of Youth Services – Youth 2.1, 2.5 Valley Behavioral Health – Adult 2.1, 2.5; Children with Parents 2.1 Volunteers of America / Cornerstone Counseling – Adult; Youth; Children with Parents 2.1 Adult; Children with Parents 2.5
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).
No significant change as compared to FY19 actuals.
Describe any significant programmatic changes from the previous year.
Ascendant Behavioral Health has been added to Optum's network as both a Substance Use and Mental Health provider. They have the capability of providing outpatient and intensive outpatient services for members with substance use disorders. In addition, they provide medication evaluation and management as well as Medication Assisted Treatment.

8) Recovery Support Services

Form B - FY21 Amount Budgeted:	**$4,462,057**	**Form B - FY21 Projected clients Served:**	**1,516**
Form B - Amount Budgeted in FY20 Area Plan	**$3,707,244**	**Form B - Projected Clients Served in FY20 Area Plan**	**2,100**
Form B - Actual FY19 Expenditures Reported by Locals	**$4,578,675**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**1,556**

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers. For a list of RSS services, please refer to the following link: https://dsamh.utah.gov/pdf/ATR/FY21 RSS Manual.pdf

DBHS operates the Parole Access to Recovery (PATR) and Intensive Supervision Probation Recovery Support Services (RSS) programs to provide clients with services that support their ongoing recovery. DBHS contracts with providers to offer services that typically are not part of SUD treatment but that increase the likelihood the client will experience long-term recovery. Common services provided by the PATR and RSS programs are housing assistance, medical and dental services, outpatient treatment, transportation assistance and employment assistance. DBHS and contracted providers actively support USARA's (Utah Support Advocates for Recovery Awareness) efforts to advocate for recovery awareness. DBHS supports the Recovery Oriented Systems of Care initiative.

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 State Division of Substance Abuse and Mental Health and Salt Lake County. Clients participating in residential treatment ready to step down into outpatient services, the Utah Highway Patrol Frequent Utilizer Program, any Salt Lake County drug court, the Volunteers of America (VOA) Journey program, or recent graduates of CATS will be eligible for the Sober Living Program which offers up to 6 months of funding assistance at a contracted provider that is licensed as a recovery residence. Additional need for sober housing from the Salt Lake County contracted network of providers will be addressed on an as-needed basis. During FY21, DBHS is anticipated to provide approximately 700 clients with sober living vouchers. Due to funding and other resource constraints, the monthly program capacity is approximately 275 vouchers.

DBHS currently funds and contracts for 184 additional housing units through Housing Connect (formerly the Housing Authority of the County of Salt Lake) for individuals and families currently, or at-risk of being, homeless. The vast majority of the recipients of rental assistance through this contract have criminal justice involvement, a substance use disorder and/or mental illness. Funding under this contract is broken into 60 units for the State Hospital/VOA ACT Housing, 53 units for the Project RIO (Core 1, JDOT and CORE 2) Housing, 49 units for HARP Housing (short and long term rental assistance), and new to FY20, 22 units at the VOA Denver Apartments (see more below on this tax credit project completed in FY20). The 18 Milestone/CAF (Children Aging out of Foster care) Housing program units were shifted to Salt Lake County Division of Youth Services to administer during FY20. All partners referring into 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 match for many federally-subsidized housing programs. The budget for these programs is addressed in the MH area plan.

DBHS/Optum continues to work with community partners on two low income tax credit projects. The first project, the Denver Apartments, is a partnership between DBHS, Optum, Housing Connect, and GIV Group. In 2018 VOA was awarded tax credits to fund housing for 22 VOA ACT Team participants, while supporting wraparound services through the ACT Team. The project was greatly supported by the Salt Lake County Council through a $400,000 capital investment, and was opened November 1, 2019. The second project, the Central City

Apartments (originally named the Fifth East Apartments), is a partnership between DBHS, Optum, First Step House, Blue Line Development, Housing Connect and the Salt Lake City Housing Authority, to develop 75 units of housing for the severely and persistently mentally ill population. This tax credit project will target individuals exiting the USH, often with co-occurring substance use disorders, as well as those who are frequent utilizers of inpatient services. The project officially broke ground on March 1, 2019, and is scheduled to begin housing clients in July 2020.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant change as compared to FY19 actuals.

Describe any significant programmatic changes from the previous year.

In FY21, DBHS will begin housing support (clinical services delivered onsite [including supportive living and case management], and the housing subsidy) for clients in First Step House's new 75 unit Central City Apartment development (slated to open in late July 2020). As RI begins to offer services through the new residential program in FY21, DBHS will also contract for up to 16 additional housing units in the community through master-leased apartments or congregate living sites to provide support for this program.

Do you provide access to a licensed recovery residence? Is it for men, women or both? Do you provide directly or through a contracted provider? Are there provisions of MAT use in the sober living facilities? What plans do you have for 2021 to increase access to licensed sober living for clients?

Both male and female clients identified through the previously-described referral pathways are eligible for the Sober Living Program to obtain a voucher for up to 6 months of housing with one of our 16 contracted recovery residence providers. All Salt Lake County contracted recovery residences support medically-necessary MAT either through on-site monitoring or off-site dosing/prescribing through licensed clinics. Clients participating in PATR can obtain assistance up to $800 for rent, either at a contracted recovery residence provider, or any community rental property that is approved by their Parole Officer. PATR and RSS case managers also maintain relationships with various local property managers that rent to people with a felony on their record.

In FY21, DBHS will continue to monitor the demand for expanded access to recovery residences. As demand is identified, DBHS will engage with interested providers to develop and contract for additional capacity in the community, within the funding constraints given. Currently, there is very little wait time for sober living placements, and the capacity is adequate for the demand we are experiencing, as well as the available funding.

What employment, life skill and/or educational service do you provide for SUD clients?

RSS clients can access Prime for Life classes through our contracted provider, Odyssey House. Clients can also receive assistance through our RSS programs with paying for tuition and books when they are enrolled in an education program. DBHS also offers RSS clients assistance with items needed to maintain employment, such as tools and clothes. Additional requests for employment, education and life skills needs are evaluated based on their congruence with approved services as outlined in the RSS Manual.

For recovery residence participants, they are required to participate in budgeting and credit courses through AAA Fair Credit in order to qualify for extensions in their housing vouchers (anything longer than the three months, and up to six months). This support serves to improve financial sustainability for the clients, as well as to increase client capacity to be able to pay down any state debts and to work towards funding their own housing upon completion of the housing subsidy offered through this program.

Is continuing care offered to clients? If so, identify whether you will provide services directly, through a contracted provider, or referred to another Local Authority.

Continuing Care is available at RSS contracted agencies that have an outpatient license. Clients can utilize their RSS funds to cover Continuing Care. Many clients receive continuing care services at no cost through USARA.

If you accepted and are using SAPT block grant funds for Recovery Residences, please list how many licensed community partners you are contracted with and your plan for the next year to contract with additional partners.
DBHS received additional SAPT block grant funds for recovery residences in FY20 and FY21. These funds were utilized in FY20 to continue contracting with the 16 providers currently providing housing to Salt Lake County clients. In FY21, these funds will continue to be used for sober living voucher subsidy for clients in need at the 16 current contracted providers. Should demand and additional funding increase, DBHS will work to generate additional capacity first through the SUD network of treatment providers, and then to the general recovery residence community of providers. Many agencies within the SUD network and beyond the DBHS network expressed interest in expanding services or adding recovery residences to their portfolios of services offered.

9) Peer Support Services-Substance Use Disorder

Form B - FY21 Amount Budgeted:	**$15,000**	**Form B - FY21 Projected clients Served:**	**170**
Form B - Amount Budgeted in FY20 Area Plan	**$16,000**	**Form B - Projected Clients Served in FY20 Area Plan**	**150**
Form B - Actual FY19 Expenditures Reported by Locals	**N/A**	**Form B - Actual FY19 Clients Serviced as Reported by Locals**	**N/A**

Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider.
Providing and receiving peer support stands as an integral component of rehabilitation and recovery. Salt Lake County and Optum are dedicated to the Peer Support Specialist Program and work to expand the peer workforce in Salt Lake County. Certified Peer Support Specialists are currently employed at Valley Behavioral Health, First Step House, Odyssey House, House of Hope, Volunteers of America, Silverado Counseling services, University of Utah Warm Line and Mobile Crisis Outreach Team, and most recently, Psychiatric and Behavioral Solutions. Peer Support Specialists provide consumers with linkage to support services for SUD issues, mental health, physical health and social services. This service promotes the recovery model and provides tools for coping with and recovering from a substance use disorder.
How is peer support supervision provided? Who provides the supervision? What training do supervisors receive?
Per Utah Medicaid, Rehabilitative Mental Health and Substance Use Disorder Services directives, certified peer support specialists are under the supervision of a licensed mental health therapist, or a licensed ASUDC or SUDC when peer support services are provided to individuals with an SUD. Supervisors are expected to follow these guidelines offering ongoing weekly individual and/or group supervision to the Certified Peer Support specialist they supervise. All providers are encouraged to attend the Supervision training offered through the State of Utah Division of Substance Abuse and Mental Health (DSAMH). Additionally, Optum SLCO Recovery and Resiliency can provide technical assistance to In-Network providers with Toolkits for Providers. The Tool Kit addresses misconceptions about using peers in services delivery and includes information on how to bill Medicaid, gives examples of job descriptions and provides information on supervision.
Describe any significant programmatic changes from the previous year.

No significant change as compared to FY19 actuals. However, as mentioned in Item #5, training and support will be provided for CPSS/PRC in an effort to increase awareness of MAT, the benefits and methods to motivate members to consider MAT as part of their recovery plan.

10) Quality & Access Improvements

Identify process improvement activities including implementation and training of:

Describe how you will increase access to treatment services. Is there a waiting list for certain levels of care? What services are available to individuals who may be on a wait list?

Through the expansion of Targeted Adult Medicaid (TAM) and the Adult Medicaid Expansion (AME), DBHS has seen a dramatic increase in access to SUD residential treatment beds and other services. For example, in 2016 there were approximately 170 SUD residential beds. By the end of FY 20, this number is anticipated to be ~700 beds. The primary funding source is TAM and AME Adult Medicaid Expansion, not included in the budget due to it going directly to our provider network. Key to further expansions will be workforce capacity. DBHS looks forward to the implementation of bills passed during the 2020 general session to begin addressing this gap.

Furthermore, Medicaid resources like TAM and AME have allowed our providers to increase services, but we are not payers for these services and Federal privacy law does not allow us to collect or report them so we no longer are able to state the amount by which they have increased.

The passage of HB 32 allows for counties to apply for funding to develop and implement Receiving Centers. It does not allow for this funding to be used for the acquisition of land. DBHS is actively engaged in developing partnerships to implement a non-refusal receiving center in Salt Lake County and preparing to apply for this funding.

There is a waiting list for residential LOCs for those who do not have some form of Medicaid. DBHS/Optum has strongly encouraged all providers to offer lower level SUD services until an opening is available when any given client is on a waiting list for higher levels of care (ASAM 2.1 – 3.5). Additionally, Interim Group Services (IGS) through the University of Utah are offered for individuals awaiting treatment. if SUD contracted providers are unable to complete initial evaluations for adults, consumers are referred to ARS for interim groups until their initial evaluation date.

Describe your efforts to market or promote the services you provide.

DBHS strives to ensure that community stakeholders are aware of the services DBHS provides and how to access them. A primary way DBHS ensures this awareness is by regular attendance at community stakeholder meetings. Some of the meetings DBHS representatives attend are: the Granite School District Mental Health Consortium, the Mental Health Court Advisory Committee, the Salt Lake Juvenile Court Multi-Agency Staffings, the Salt Lake Regional Advisory Committee, the Salt Lake City School District Mental Health Roundtable, the Utah State Child Welfare Improvement Council, The Utah Youth Initiative, and the DSAMH ATR Steering Committee.

Additionally, staff at DBHS provide regular trainings and educational opportunities to providers and community stakeholders regarding services offered and DBHS programs administered. Such opportunities include but are not limited to trainings held for the courts, Criminal Justice Services, the Legal Defenders Association, the Salt Lake County Jail, and the Criminal Justice Advisory Council.

In April 2020, Optum will again offer basic substance use disorder training to mental health providers within the network. Providers will learn how to screen for substance use and a possible SUD. In addition, resources within the network for ASAM assessments, all levels of treatment and community supports will be provided. CEUs have been requested from NASW for the training.

What EBPs do you provide? Describe the process you use to ensure fidelity?

All of the practices listed below are recognized by SAMHSA and are offered in the DBHS/Optum SLCo Network.
- Assertive Community Treatment (ACT)
- Trauma Focused Cognitive Behavior Therapy (TF-CBT)

• Dialectical Behavior Therapy (DBT)
• Motivational Interviewing (MI)
• Cognitive Behavior Therapy (CBT)
• Eye Movement Desensitization and Reprocessing (EMDR)
• IPS Supported Employment
• Family Psychoeducation
• Supported Housing
• Consumer Operated Services
• Critical Time Intervention
• Parent Child Interaction Therapy
• Behavior Therapy
• Integrated Dual Disorders Treatment
• Exposure Therapy for PTSD
• Seeking Safety
• Double Trouble in Recovery
• Mental Health First Aid
• Wellness Recovery Action Plan (WRAP)
• QPR Gatekeeper Training for Suicide Prevention
• Interpersonal Therapy (IPT)
• Medication Assisted Treatment (MAT)
• Moral Reconation Therapy (MRT)

All contracted providers are mandated to conduct supervision for EBP and it is the responsibility of each individual agency to meet fidelity requirements. This is verified during each annual monitoring visit. In addition to the regular reviews and re-authorizations described below in the quality of care section, the quality assurance team provides oversight and ongoing consultation and training to the network of providers based on the annual contract compliance/improvement audits. Trainings are focused on the use of individualized, client-centered services; development of standardized assessment and treatment planning tools; the utilization of ASAM patient placement criteria; continued stay criteria; utilization review; and more rigorous quality assurance/improvement, fiscal and administrative oversight requirements.

Additionally, ongoing training is provided to help educate and inform all providers on the ASAM criteria and manual.

Describe your plan to improve the quality of care.

DBHS has created a system whereby all ASAM LOCs greater than 1.0 must seek preauthorization and be reviewed based on the standards set forth by DSAMH and Medicaid. This entails the primary clinician completing a treatment plan update with a corresponding progress note. The clinician then notifies DBHS via a universal mailbox established for this purpose that a given file is ready for review. Each request is handled on a case-by-case basis. Should a client meet criteria to continue at the current level, a reauthorization is granted according to pre-established standards set by DSAMH and Medicaid. If DBHS disagrees with the request to continue at the current LOC, then a plan is established by the agency to place the client in the most appropriate LOC according to the most recent ASAM assessment within the treatment plan review. No client is immediately discharged. Should a client be assessed as needing a higher LOC, a similar process is required.

Through the above, the quality of care is monitored consistently. DBHS requires all providers to notify the Division when any new or ongoing authorization is needed. At that time, a Quality Assurance (QA) Coordinator will review the most recent treatment plan/ASAM update for medical necessity. These requests are not automatically approved. If medical necessity is met, then the authorization is granted. If not, then a plan is developed to transition the client to the next appropriate level of care according to the most recent ASAM assessment. DBHS receives multiple requests every day for authorizations and this is a significant part of the responsibility of the QA Coordinators. In addition to this, every provider is audited each year. This involves pulling a random sample of files and thoroughly reviewing each file. A report is issued wherein clinical, administrative, and financial concerns are addressed. If necessary, a corrective action plan is requested within specified time frames.

Optum, ARS/IGS and DBHS have developed similar preauthorization processes in order to reduce confusion with providers. The overall medical necessity expectations and licensure of those reviewing the request are the same. Slight procedural variations are present such as how authorizations are communicated.

DBHS and Optum continue to support providers in their use of evidenced-based practices; however, the individual providers have the responsibility of obtaining training for evidence-based practices. All current providers have to provide evidenced-based practices, including the supervision required by the EBP, by contract. DBHS and Optum have seen increased use of EBPs by providers including increased use of Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Solution-focused Therapy, Trauma Awareness Focused Therapy, Strengthening Families, and gender specific treatments.

Identify the metrics used by your agency to evaluate substance use disorder client outcomes and quality.

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".

DBHS has developed multiple outcome measures for various programs. Reports and presentations highlighting these outcomes are attached for the Sober Living Program, Medication Assisted Treatment Program, and Intensive Supervision Probation Program. In addition to reductions in Risk Scores, and NOMS data such as employment, housing and “frequency of use” changes, DBHS tracks reductions in jail recidivism. This was accomplished by finalizing a data sharing agreement with the Salt Lake County Jail; through the hiring of a data analyst; then matching program cohorts with jail data to analyze reductions in new-charge bookings in the Salt Lake County Jail. Prior to release the methodology is shared with the Sheriff’s Office to gain their validation and approval for release.

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

DBHS is also appreciative of the quality monitoring that occurs as a part of Utah’s Justice Reinvestment Initiative. Through this initiative the Division of Substance Abuse and Mental Health (DSAMH) is responsible for providing certification of behavioral health treatment programs in the state of Utah. The standards are mandatory for treatment providers who serve individuals that are incarcerated, or required to participate in treatment by a court, or the Board of Pardons and Parole. Utah Administrative Code, Rule 523-4 details how DSAMH will carry out the duties and obligations required per the JRI legislation. DSAMH periodically monitors the performance of each provider to determine if they are in compliance with the requirements of the rules.

During the site monitoring visit, the reviewer focuses the evaluation on:

- The agency’s use of criminogenic, substance use and mental health disorder screening and assessments
- The agency’s ability to triage clients based on criminogenic risk
- UAs
- Evidence-based practices that are used to treat criminogenic risk factors and substance use and mental health disorders, and
- Treatment plan goals are linked to a criminogenic need; the agency’s use of MAT and the number of staff that are certified in the use of the EBPs that require certification; and recovery supports and after care services.

A link to the state’s site monitoring report template may be found at:
https://drive.google.com/file/d/0B8IDp-QgjBuKN0FMUTFHdDZMMjZ5Z0ZXd2hsRF9IU0JzR1ZN/view

11) Services to Persons Incarcerated in a County Jail or Other Correctional Facility

Describe the activities you propose and identify where services will be 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.

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 a day treatment level of care (20 hours per week of treatment services with additional services included based on the therapeutic community model). The program is operated within both the ADC and Oxbow Jails. The capacity for males is 120 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.

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 and DOGS programs are contracted through Odyssey House.

DBHS operates many additional programs aimed at diverting individuals from the county jail by providing services prior to arrest; while incarcerated in order to reduce their time of incarceration; and through transition services for incarcerated individuals as they are released from jail. These services are funded entirely with State and County funds. Please refer to Salt Lake County's Sequential Intercept Model and ATI Fact Sheet attached for program descriptions and contracted providers.

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 or continuing care 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. In FY21, DBHS will continue working with the State Department of Corrections to expand access to injections behind the walls of the prison, as well as coordination and injections in the community following release. Any Salt Lake County resident engaged in SUD treatment or continuing care services is 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. Please refer to the area plan attachments for a Medication Assisted Treatment (MAT) report detailing reductions in new charge jail bookings and other pertinent outcomes.

In addition, SOR dollars have allowed an expansion of MAT services in the jail. Qualifying program participants with an OUD 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. 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 OUD 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 may be expanded to cover additional OUD populations as budgets allow. 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 last. 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. Through the first eight months of programming, over 200 kits have been distributed to clients leaving the jail after participation in the Jail MAT Program.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

There is an increase due to the implementation of a new SOR funded MAT program which occurred at the end of FY19 that will be fully ramped up in FY21.

Describe any significant programmatic changes from the previous year.

SOR dollars have allowed an expansion of MAT services in the jail (described in section 1 above).

Describe current and planned activities to assist individuals who may be experiencing withdrawal (including distribution of Naloxone) while incarcerated or any efforts to use Medication-assisted treatment within a county jail or Prison. Identify all FDA approved medications currently provided within the jail(s).

The Salt Lake County Jail has an intoxication and withdrawal policy to ensure safe and effective drug and alcohol withdrawal and clinical management of patients in withdrawal. A program of medical detoxification will be initiated for each patient incarcerated in the jails who is physically and/or psychologically dependent on the following: alcohol, opiates, stimulants, sedative, hypnotic or hallucinogenic drugs.

Health Services within the jail is responsible to provide procedures for the clinical management of these patients. The protocols for intoxication and detoxification are approved by the responsible physician, are current and are consistent with nationally accepted treatment guidelines. Medical detoxification is performed at the jail under medical supervision or at a local hospital depending on the severity of symptoms.

Patients are screened by a registered nurse and mental health professional for drug and alcohol abuse or dependence, in processing at the nurses pre-screen, and during the comprehensive nurse and mental health screenings.

These screenings will include a detailed history of the type of drug; duration of use; frequency of use; approximate dose; last dose; history of prior withdrawal; history of prior treatment for withdrawal; and current signs or symptoms of withdrawal.

All patients found to be withdrawing from a physiologically addicting drug will be treated in accordance with recommended medical practice. Treatment will be determined by the individual needs of the patient as well as the type and severity of the drug withdrawal. Patients at risk for progression to more severe levels of withdrawal are transferred to the Acute Medical, Acute Mental Health, or Sub-Acute Mental Health units, or to an outside medical provider for observation, treatment and stabilization.

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 or continuing care 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. In FY21, DBHS will continue working with the State Department of Corrections to expand access to injections behind the walls of the prison, as well as coordination and injections in the community following release. Any Salt Lake County resident engaged in SUD treatment or continuing care services is 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. Please refer to the area plan attachments for a Medication Assisted Treatment (MAT) report detailing reductions in new charge jail bookings and other pertinent outcomes.

In addition, SOR dollars have allowed an expansion of MAT services in the jail. Qualifying program participants with an OUD 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. 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 OUD 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 may be expanded to cover additional OUD populations as budgets allow. 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 last. 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. Through the first eight months of programming, over 200 kits have been distributed to clients leaving the jail after participation in the Jail MAT Program.

The SAPT block grant regulations limit SAPT expenditures for the purpose of providing treatment services in penal or correctional institutions of the State. Please identify whether your County plans to expend SAPT block grant dollars in penal or correctional institutions of the State.

DBHS does not spend any SAPT funds on jail-based programming. The division utilizes County funds, SOR Grant dollars, and other State funds for these programs.

12) Integrated Care

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

Optum and each of the four ACO's meet on an as needed basis to hold staffings of high utilizing clients. These meetings result in improved coordination for our most vulnerable clients. The ACOs continue to be notified by Optum clinical team of an inpatient psychiatric admission for their members. They are also notified of the discharge and the discharge medications that the member is prescribed. The ACOs use this information to ensure follow-up with discharge services and support as needed.

Two of DBHS'/Optum's providers offer integrated physical and behavioral health services, Odyssey House and Fourth Street Clinic. Additional coordination between behavioral health providers and physical health providers occur. One example is a collaboration between the Midtown Community Health Center and multiple behavioral health providers through the Vivitrol Program.

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.

Additionally, through the 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, 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, Midtown provides the full spectrum of physical health care for Vivitrol clients as they actively attend their appointments. At Martindale and UPFH, clients are also offered access to primary healthcare. All partner clinics accept Medicaid and private insurance as well.

Describe efforts to integrate clinical care to ensure individuals physical, mental health and substance use disorder needs are met.

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.

Describe your efforts to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy,Nicotine).

Optum Care Advocates continue to collaborate with the respective ACOs on a case-by-case basis when it is noted that the consumer's medical needs, such as HIV, AIDS, Diabetes and Pregnancy, are a component of their SUD treatment and/or a part of their recovery. Each ACO has an identified person that is our contact point. The ACO then staffs the case and Optum will be contacted in return with their recommendation and/or plan to help address the medical status. Optum then coordinates with the treating provider what the medical plan is and who to coordinate with for their collaborative care. In some cases Optum has been able to proactively access health care services for consumers coming out of USH, so that medical support is available upon immediate return to the community. This process is fluid and responsive on an as-needed basis in order to be flexible in meeting consumer needs

Describe your plan to reduce tobacco and nicotine use in SFY 2021, and how you will maintain a tobacco free environment at direct service agencies and subcontracting agencies. SUD Target= reduce nicotine use to 4.8 in 2021 in TEDs.

DBHS and Optum continue to educate providers on the mandate to diagnose and provide treatment for nicotine addiction as a healthcare issue. Screening for nicotine use and abuse with referrals to smoking cessation supports continues to be addressed at provider meetings and trainings. 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. Due to the popularity of previously non-traditional ways to use nicotine, the providers are also educated to ensure that any type of nicotine delivery system is addressed with the client. DBHS and Optum have 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.

13) Women's Treatment (WTA and WTX)

Form B - FY21 Amount Budgeted:	**$10,850,166**		
Form B - Amount Budgeted in FY20 Area Plan	**$11,659,411**		
Form B - Actual FY19 Expenditures Reported by Locals	**$11,705,599**		

Describe the evidence-based services provided for women including gender-specific substance use disorder treatment and other therapeutic interventions that address issues of trauma, relationships, sexual and physical abuse, vocational skills, networking, and parenting.

DBHS and Optum contract to provide women's treatment with eight providers located throughout the County. Providers include House of Hope, Odyssey House, VBH, VOA/Cornerstone, Midtown, Clinical Consultants, Martindale Clinic, and Project Reality. Services include 5 outpatient sites, 4 intensive-outpatient sites, 3 day treatment sites, 3 residential sites, 1 site for social detox, and 6 locations for MAT services.

Additionally, DBHS and Optum contract to provide gender specific treatment for parenting and/or pregnant women and accompanying children with five providers located throughout the County. Providers include House of Hope, Odyssey House, VBH, VOA/Cornerstone, and Project Reality. Services include 5 outpatient sites, 4 intensive-outpatient sites, 3 day treatment sites, 3 residential sites, 1 site for social detox, and 6 locations for MAT services.

Some of the specific, specialized services provided to women include:

• Women on Methadone can receive treatment at House of Hope, VBH, and Odyssey House while pregnant. VBH and House of Hope will work with women after the birth to taper to an appropriate dose and then continue treatment. Odyssey House asks that the women taper off methadone after the birth of the baby.
• Project Reality is currently providing multiple services for women and pregnant women. The agency partners with obstetricians and high risk pregnancy obstetric services all over Salt Lake County. Project Reality has developed specific collaborations with SUPeRAD at the University of Utah and Intermountain Medical Centers to support success for pregnant women with opioid use disorders and their infants after delivery. Project Reality delivers OTP medication to the 'rooming in' program at the University of Utah Medical Center to support mothers caring for infants who stay in the hospital. Women, in general, are offered specialized women's groups that rotate topics to address a number of specific women's issues. Project Reality also provide referrals to women's specific programs such as House of Hope, Odyssey House women's and children program, and YWCA; provide parenting classes for families with children; and offer options for childcare during their therapy session such as bringing young children to session or offering temporary emergency childcare, if needed, during the session if available. Project Reality also has a women's resource room dedicated to offering different types of information for resources specific for women, supplies for emergencies with children such as diapers, and toys to keep children occupied in the room while women are in their therapy sessions in the same room.

Describe the therapeutic interventions for children of clients in treatment that addresses their developmental needs, their potential for substance use disorders, and their issues of sexual and physical abuse and neglect. Describe collaborative efforts with DCFS for women with children at risk of, or in state custody.

Children of families receiving substance use disorder treatment receive therapeutic/developmental services during the day while their parents are attending group/individual therapy sessions. These services include assessment, individual and family therapy, practicing pro-social and health behaviors. For children in the transition program they are eligible to continue receiving services while their parents work and move into permanent or transitional housing.

All programs also coordinate care with DCFS and CPS assisting mothers to meet service plan goals, arrange visitation as allowed by the court or family agreement, and contingency plans for emergencies.

Describe the case management, child care and transportation services available for women to ensure they have access to the services you provide.

The parent and children programs provide case management assistance with obtaining children's records such as birth certificates and social security cards, obtaining Medicaid or other financial supports, and monitoring court dates. Efforts are made to set up educational, mental health, and/or developmental referrals for current and future assistance. Case management services also involve working with families to manage financial assistance already in place.

Childcare includes services provided directly to children without parents present such as maintaining daily routines, assisting with activities of daily living, or engaging in recreational activities.

Transportation includes child and family appointments outside of the program, attending court, or other events necessary to healthy family functioning.

Describe any significant programmatic changes from the previous year.
No significant change as compared to FY19 actuals

Residential Women & Children's Treatment (WTX) (Salt Lake, Weber, Utah Co & Southwest Only)

Identify the need for continued WTX funding in light of Medicaid expansion and Targeted Adult Medicaid.
DBHS uses the WTX funds to support the VBH Phoenix Women and Children program, which is available to serve clients statewide. Though most of the clients DBHS serves at the Phoenix Women and Children program are now Medicaid eligible, Medicaid does not cover the room and board expense. The total room and board expense alone is projected to be $280,000 in FY21 and that does not include those rare situations when a client is not Medicaid eligible. **Though DBHS currently utilizes the funds to support VBH's Phoenix program, we would prefer that these funds be shifted from residential women and children treatment to support USARA in their statewide efforts. Medicaid now covers almost all of the women and children service needs while USARA's outreach programs struggle for adequate, ongoing funding. DBHS would support this funding being redirected to go directly from the State to USARA and further ask that the State consider redirecting all of these WTX funds for this purpose. Perhaps this could be done as the SOR funds that currently support USARA programming begin to sunset. This would not harm the VBH Phoenix program as DBHS would continue to reimburse their room and board expense.**
Please describe the proposed use of the WTX funds
The $210,000 would primarily be used to cover the room and board expense of the Valley Phoenix program.
Describe the strategy to ensure that services provided meet a statewide need, including access from other substance abuse authorities
The $210,000 would primarily be used to cover the room and board expense of the Valley Phoenix program.
Submit a comprehensive budget that identifies all projected revenue and expense for this program by email to: bkelsey@utah.gov
Submitted on 4/21/20

14) Adolescent (Youth) Treatment

Form B - FY21 Amount Budgeted:	**$1,769,647**		
Form B - Amount Budgeted in FY20 Area Plan	**$1,959,834**		
Form B - Actual FY19 Expenditures Reported by Locals	**$1,643,630**		
Describe the evidence-based services provided for adolescents and families. Please identify the ASAM levels of care available for youth. Identify your plan for incorporating the 10 Key Elements of Quality Adolescent SUD Treatment: (1) Screening / Assessment (2) Attention to			

Mental Health (3) Comprehensive Treatment (4) Developmentally Informed Programming (5) Family Involvement (6) Engage and Retain Clients (7) Staff Qualifications / Training (8) Continuing Care / Recovery Support (9) Person-First Treatment (10) Program Evaluation. Address goals to improve one to two areas from the 10 Key Elements of Quality SUD Treatment for the Performance Improvement Plan.

DBHS and Optum contract to provide treatment for adolescents through four providers located throughout the County. Providers include Odyssey House, Youth Services, VOA/Cornerstone/Family Counseling Center, and Asian Association. Services include 8 outpatient sites, 3 intensive-outpatient sites, 2 day treatment sites, 1 residential site, and 1 site for social detox. Medical detox is available to youth needing this service as well.

Some of the evidence-based practices employed by our providers are:
• Multifamily Psychoeducation Group (MFG)
• Trauma Focused Cognitive Behavior Therapy
• Dialectical Behavior Therapy
• Motivational Interviewing
• Cognitive Behavior Therapy
• Behavior Therapy
• Integrated Dual Disorders Treatment
• Seeking Safety
• Wellness Recovery Action Plan (WRAP)

Additionally, some of the specific specialized services provided to adolescents include:
• A “Young Adult” program with Volunteers of America to deliver services to individuals age 17 to 23 to further support their transition into adulthood.
• Gender specific treatment.

In order to incorporate the ten key elements of quality adolescent treatment, DBHS will have this as a discussion item during the monthly PSCC meetings. Additionally, DBHS and Optum have a robust monitoring system (see "Governance and Oversight Narrative", section 2 for more detail). DBHS and Optum will incorporate the key elements of quality adolescent treatment into the monitoring tools. This includes providing immediate feedback and training to the providers as problems are identified.

Also, Salt Lake County Division of Youth Services (DYS) has clinical outpatient, 2.1 and 2.5 SUD treatment options for adolescents. The outpatient portion is conducted by licensed mental health therapists. DYS has free groups open to any teen 13-17 in Salt Lake County without cost, even if the teen has been screened and treatment is not indicated. These services incorporate all types of discussions inclusive of “depressive symptoms,” managing moods, anger and stress management, problem solving plus parenting classes. There are components of SUD discussions in all of the above.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes as compared to 2019 actuals.

Please identify your primary referral sources for youth. Also identify the efforts you have made market services to youth, families and other community partners.

Optum Salt Lake County receives referrals for youth from a variety of sources including: families, juvenile drug court, school districts, inpatient facilities, other treatment agencies that do not typically offer specialty SUD treatment services, Multi-Agency Staffing, and System of Care. To ensure that the Salt Lake County community stakeholders continue to remain aware of the SUD resources available, Optum has met with several agencies including, but not limited to, juvenile court/probation officers and school district meetings. Additionally, Optum has offered trainings to Mental Health providers regarding SUD related topics. During these trainings, providers are reminded of the SUD resources available through the Optum Network. Optum’s Clinical Operations team also offers referrals to families who may call in requesting information on SUD resources available for their child.

Describe collaborative efforts with other state child serving agencies (DCFS, DJJS, SOC, DSPD,

Juvenile Court) and any significant programmatic changes from the previous year.
Each agency providing treatment collaborates closely with other State agencies serving children and youth to ensure that needs are being met. Both DBHS and Optum monitor these efforts and request that providers document their efforts at collaboration in the client plan. DBHS and Optum participate in the weekly Multi-Agency Staffing (MAS). This staffing also includes representatives from Juvenile Court, Granite School District, and other treatment providers including SUD.

15) Drug Court

Form B - FY21 Amount Budgeted: Felony	**$210,577**	**Form B - FY20 Amount Budgeted: Felony**	**$343,391**
Form B - FY21 Amount Budgeted: Family Dep.	**$879,202**	**Form B - FY20 Amount Budgeted: Family Dep.**	**$1,206,571**
Form B - FY21 Amount Budgeted: Juvenile	**$241,474**	**Form B - FY20 Amount Budgeted: Juvenile**	**$363,111**
Form B - FY21 Recovery Support Budgeted	**$2,931,514**	**Form B - FY20 Recovery Support Budgeted**	**$3,264,061**

Describe the Drug Court eligibility criteria for each type of specialty court (Adult, Family, Juvenile Drug Courts, etc). Please provide an estimate of how many individuals will be served in each certified drug court in your area.
Adult Drug Court clients are required to screen high risk based on the LS/CMI assessment to be eligible for the Adult Drug Court program. Potential clients are identified by the Legal Defenders Association and are referred to the District Attorney (DA) who screens based on criteria. The DA then refers clients to CJS for the LS/CMI. CJS also arranges for an assessment to be conducted by ARS/IGS. Upon completion of both the assessment and LS/CMI, CJS sends the LS/CMI results and treatment level recommendation back to the DA to make final determination of program appropriateness. Once this process is complete, clients who are eligible are pled into the program. CJS supports adherence to Best Practices and recommends a maximum of 125 clients per court. All four Drug Court programs are close to capacity; client count is controlled by the DA and the Judge. We anticipate maintaining the 125 client maximum in all our courts. There are currently 448 total participants. Family Recovery Court (FRC): Clients participating in the FRC program must meet the eligibility criteria of being high risk and high need. DBHS works closely with the Third District Court and DCFS to identify clients that may be eligible for the FRC program. FRC is using the ASAM assessment to assess the needs of clients and then working with DCFS to determine if an individual is high risk. Indicators of high risk would include multiple episodes of DCFS involvement, reunification, and failure to succeed at a higher level of care. Additionally, clients assessed at ARS rather than at DBHS receive a RANT. There are four Family Recovery Courts in the Salt Lake Valley. The amount of participants served in each Family Recovery Court is an average of 25 parents and approximately 200 participants collectively per year. Juvenile Drug Court (JDC): Clients participating in the JDC program must meet the eligibility criteria of being high risk and high need. DBHS works closely with the Third District Juvenile Court to identify clients that may be eligible for the program. The JDC program uses the Pre-Screen Risk Assessment and Protective and Risk Assessment to identify high risk/high need clients. Additionally, all JDC clients receive an ASAM assessment to determine the appropriate level of care for treatment. There are two Juvenile Drug Courts in the Salt Lake Valley. The amount for participants served is an average of 16 youth and approximately 25 participants per calendar year.
Describe Specialty Court treatment services. Identify the services you will provide directly or through a contracted provider for each type of court (Adult, Family, Juvenile Specialty Courts, DUI). How will you engage and assist individuals with Medicaid enrollment throughout their episode of care.

Adult Drug Court (DC) clients receive SUD treatment through SLCo contracted providers (ASAM 1.0, 2.1, 3.1, 3.3 and 3.5). In January of 2019, CJS discontinued providing SUD treatment and conducting ASAM assessments; therapists transitioned to providing clinical case management services and bridging any treatment service gap with internal therapeutic based classes including Seeking Safety and MRT. Additionally, clients receive case management supervision services and cognitive based journaling classes while in Drug Court through CJS.

During initial court orientation, clients complete an application for Medicaid/TAM; if the client is incarcerated, the case manager sends the referral to UHPP upon his/her release. If the client's paperwork was not completed or they need to reapply, the case manager refers the client to a Medicaid enrollment specialist. Clinical Case Managers monitor treatment and funding/Medicaid eligibility in collaboration with the treatment provider.

CJS uses several evidence-based curriculums with drug court clients including Seeking Safety, Moral Reconation Therapy (MRT), and Courage to Change. All staff who provide these curriculums were trained and certified by qualified trainers and receive regular boosters via webinars, DVDs, etc.

Family Recovery Court: Clients have access to DBHS' full network of contracted providers for treatment and case management services. Additionally, DBHS employs an assessment worker to conduct initial assessments and serve as a liaison between treatment providers and the Court. Clients are assisted with Medicaid enrollment in multiple touchpoints.

Juvenile Drug Court: Clients have access to DBHS' full network of contracted youth providers for treatment and case management services. Third District Juvenile Court staff will receive training to assist participants and collaborate with the DBHS liaison.

Describe the MAT services available to Specialty Court participants. Will services be provided directly or by a contracted provider (list contracted providers).

All adult Drug Court clients are eligible to participate in the County's MAT services. All services are contracted out. These include methadone or suboxone through Project Reality and the Vivitrol Program. The injections for the Vivitrol Program are administered via Odyssey House's Martindale clinic, within the county jail, at Utah Partners for Health, or Midtown Community Health Center. Clinical Consultants also offers Suboxone and Vivitrol through their outpatient MAT clinic. Agencies who do not have direct MAT services are able to refer clients to the previously listed service providers. Vivitrol services are described under the RSS Section. CJS also has a dedicated MAT case manager providing additional case management to clients currently utilizing MAT services in the community who need additional help navigating these services.

Through the years, FRC has continued to expand MAT services. Clients may engage MAT support from the moment they express interest. FRC partners with community clinics that offer methadone, Suboxone and Vivitrol based on client preference and clinical recommendations. FRC is supportive of participants seeking MAT through a licensed private provider as well.

Describe your drug testing services for each type of court including testing on weekends and holidays for each court. Identify whether these services will be provided services directly or through a contracted provider. (Adult, Family, Juvenile Specialty Courts, etc).

Adult Drug Court contracts with Averhealth for drug testing. Averhealth uses current research and complies with the national standards for drug testing techniques. Averhealth can provide a breadth of drug testing. Every client is given a five or eight panel drug test, and usually given a random specialty test to determine if cross addiction is occurring. Averhealth provides observed sample collection, temperature readings, and checks for creatinine and specific gravity to detect adulterated samples. Clients who are receiving ASAM 3.1 and above are usually drug tested at the facility where treatment is being provided. In some cases, if the provider does not have the resources for drug testing or is not able to provide the frequency of 2-3 times per week, including weekends and holidays, the client will be sent to Averhealth to test. Averhealth provides random testing to our clients 6 days a week including Monday through Friday, on Saturday or Sunday and on at least three federal holidays. In order to better serve the client, Averhealth also provides confirmation tests to better determine the client's use and which specific drug was used.

Family Recovery Court and Juvenile Drug Court clients are tested randomly twice a week, including weekends and holidays, by the treatment provider they are being served through. In addition, FRC funds are used to pay for a contracted agency (Averhealth) to drug test participants on a random basis, twice a week, including weekends and holidays. FRC participants are not charged a fee for drug testing. Participants drug testing through Averhealth are given a five panel drug test, which includes a breathalyzer. Additionally, they provide observed sample collection, temperature readings, and checks for creatinine and specific gravity to detect adulterated samples. Participants who are receiving ASAM 3.1 and above are drug tested at the facility where treatment is being provided. In some cases if the provider does not have the resources for specific drug testing, or is not able to provide the frequency of 2-3 times per week, including weekends and holidays, the participant will be sent to Averhealth to drug test.

List all drug court fees assessed to the client in addition to treatment sliding scale fees for each type of court (Adult, Family, Juvenile Specialty Courts, etc).

Adult Drug Court: There are no fees associated with Drug court. Clients are only responsible to pay any restitution associated with their case. Outside of residential treatment, clients may be asked to pay by their individual treatment providers/sober living program depending on individual circumstances. If the treatment provider is within the Salt Lake County DBHS network, they will be assessed for payment based on the DBHS sliding scale fee schedule. Clients also pay for their own tests through Averhealth, but CJS can provide fee waivers on a case-by-case basis.

Family Recovery Court and Juvenile Drug Court: There are no fees associated with participation in FRC or JDC. In regards to accessing treatment, when FRC and JDC participants engage in treatment, these expenses are generally covered by Medicaid. In cases where the participant does not have Medicaid and the treatment provider is within the Salt Lake County DBHS network, they will be assessed for payment based on the DBHS sliding scale fee schedule.

Describe any significant programmatic changes from the previous year (Adult, Family, Juvenile Specialty Courts, etc).

Just prior to January 2019, CJS discontinued providing direct therapy and conducting ASAM assessments and the role of the CJS therapist transitioned to Clinical Case Management in a brokerage model as supported by Best Practices. In a collaborative effort with Assessment and Referral Services/Interim Group Services (ARS/IGS), ARS/IGS clinicians are now conducting all ASAM assessments and clients are referred to community treatment providers for all levels of care. CJS clinical case managers continue to help bridge any treatment gap by providing drug court clients with Seeking Safety, MRT and other EBP classes as deemed appropriate.

Family Recovery Court (FRC) was selected to work with the Office of Juvenile Justice and Delinquency Prevention and granted technical assistance through Children and Family Futures to improve outcomes for children and families by implementing best practice strategies. The technical assistance has identified four areas that FRC has incorporated in a two year Action Plan that includes 1) Expedite and simplify the referral and assessment process, 2) Strengthen the FRC by creating a three-tiered governance structure, 3) Drive ongoing program improvement through data-informed decision making and 4) Shift towards a family centered approach. With the assistance of DBHS, a Case Manager position was created and in January 2019 the position was filled. In addition, service assignments for each FRC participant were added in the court's data system. Outcomes regarding date of entry, discharge and treatment provider will be available for each participant dating back to 2015. This year FRC has connected with the University of Utah Intern Program. A continuing special project is the implementation of a web-based program survey for participants as a means to monitor service delivery and gauge effectiveness.

In addition, USARA has partnered with FRC and implemented a Peer Recovery Coach Program in each courtroom.

Describe the Recovery Support Services you have available for Drug Court clients (RSS services as outlined in the RSS manual).

CJS refers clients to USARA to provide support for those in recovery. USARA offers clients a network for building strong and mutually supportive relationships within their communities. All their services are strengths-based to promote and encourage recovery. USARA also provides additional resources for the whole family as well as

activities to keep individuals engaged. In addition, clients are provided with information regarding other local support groups that are responsive to their individual needs, such as AA and NA services.

In FRC, treatment provider aftercare and support groups are offered to participants. More recently, FRC has added client support through USARA. Peer Recovery Coaches are specifically assigned to FRC. USARA peer specialists are available in all the courts to meet with clients and answer questions. Participants are further encouraged to engage with USARA during their off hours from treatment to help with the transition to community living by attending social activities sponsored by USARA. This program has family nights and offers numerous sober activities for people in recovery throughout the year. Participants can also engage in AA and NA groups based on their preference.

The Juvenile Drug Court implemented a youth Recovery Support Group that meets the first Thursday of every month. The youth, parents and siblings are invited. The judge and team members also attend. Dinner is provided and guest speakers are arranged. Also, JDC has implemented the SASSI as a screener for youth. Thirty youth have been screened as of the July 2019 implementation date.

16) Justice Reinvestment Initiative (Justice Involved)

Form B - FY21 Amount Budgeted:	**$542,824**	**Form B - FY20 Amount Budgeted:**	**$814,567**

Describe the process used to identify criminogenic risk? Who screens individuals? What instruments/tools are used? How is this information communicated?

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:

Chair, Sheriff Rosie Rivera	Salt Lake County Sheriff's Office
Vice Chair, Mayor Jenny Wilson	Salt Lake County Mayor
Hon. Brendan McCullaugh	Judge, West Valley City Justice Court
Jojo Liu	CJAC Coordinator
Honorable John Baxter	Judge, Salt Lake City Justice Court
Jim Bradley	Salt Lake County Council
Mike Brown	Chief of Police, Salt Lake City Police Department
Max Burdick	Salt Lake County Council
Craig Burnett	Chief of Police, Murray City, LEADS Chair
Jack Carruth	Chief of Police, South Salt Lake City
Mike Haddon	Director, Utah State Department of Corrections
Karen Crompton	Director, Salt Lake County Human Services
Sim Gill	District Attorney, Salt Lake County
Kele Griffone	Director, Criminal Justice Services
Representative Eric Hutchings	Utah House of Representatives
Senator Karen Mayne	Utah State Senate
Matt Dumont	Chief, Salt Lake County Sheriff's Office
Rich Mauro	Executive Director, Salt Lake Legal Defenders Association
Peyton Smith	Third District Court Administrator's Office
Jim Peters	State Justice Court Administrator
Honorable Mark Kouris	Presiding Judge, Third District Court
Jeff Silvestrini	Mayor, Millcreek City
Tim Whalen	Director, Salt Lake County Behavioral Health Services
Catie Cartisano	Individual with Lived Experience in the Criminal Justice System
Pamela Vickrey	Utah Juvenile Defender Attorneys, Executive Director
Scott Fisher	Salt Lake City Municipal Prosecutor

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.

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 tool 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.

Describe the strategies used to reduce criminogenic risk. Identify strategies used with low risk offenders. Identify the strategies used with high risk offenders.

Justice Reinvestment Initiative
Salt Lake County formerly received Justice Reinvestment Initiative (JRI) dollars through two funding streams, the FY16 formula-based dollars and the FY18 competitive application-based dollars. In FY20, the competitive application-based dollars commonly referred to as JRC, were cut.

Formula-based Funding
Originally in 2016, utilizing the formula-based funding as seed dollars, the Intensive Supervision Probation (ISP) Program, CORE 2 and a Prosecutorial Pre-Diversion Program (Operation Diversion) were implemented. Operation Diversion ended treatment referrals July 1st, 2017 as funding for this program ended. ISP and CORE 2 remain in operation. Additional funding sources for these programs included County General Fund, Federal Medicaid dollars, City dollars, and one-time CCJJ grant dollars.

Application-based Funding
Based on the application-based funds originally awarded in FY18 and then later cut in FY20, ISP was expanded, additional Drug Court residential capacity was funded, and the Unified Police Department (UPD)/University of Utah Neuropsychiatric Institute (UNI) Program was started, co-locating a licensed mental health professional with a UPD officer to respond to mental health crises in the community. All programs are still operational as described below.

Justice Reinvestment Initiative Programs

Intensive Supervision Probation Program
DBHS will continue to partner with the Sheriff's Office and CJS on the ISP program. This program targets high-risk 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 will continue to provide two dedicated assessment workers who are seated at CJS with the officers 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) were introduced to ISP. Since the inception of ISP in 2015, 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 30% 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 Colonel's 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 professional (since reduced back to two) 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 an April 2020 evaluation 470 clients were found to have engaged in programming during a 12 month period (April 2019 – March 2020). Since the program's inception 265 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 is our intention to maintain current levels of programming throughout this time by transitioning from JRC funding to Medicaid funding. Every effort is being 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 trainings were held at the County Government Center. Approximately 213 individuals from 20 organizations across the county registered or walked in to 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 last two years, a large portion of treatment funds are no longer needed for this program (JRC). 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.

Please refer to the attached ISP report for the most recent outcomes and demographic information.

Drug Court Treatment Expansion
Beginning July 1st, 2017 through JRC dollars, an additional $500,000 was made available to Drug Court utilizing a fund code that accelerated access to treatment slots. Historically, the waiting list for Drug Court participants to admit to a residential program was long, creating frustration with the court and teams, and was the impetus in prioritizing dollars for this population. During this same year, the Utah Department of Health implemented the Targeted Adult Medicaid (TAM) program providing new Medicaid funding for non-parenting Drug Court participants earning less than 5% of the FPL. These new funding streams enabled Salt Lake County providers to grow in a very large way, more than doubling the residential treatment capacity in the county (residential beds increased from approximately 170 beds in 2016 to 440 beds).

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 was unknown, levels of programming were maintained 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 trainings were held at the County Government Center. Approximately 213 individuals from 20 organizations across the county registered or walked in to 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 this data 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.

FY21

Due to the elimination of JRC funding, and the success of maintaining levels of programing through TAM and Adult Medicaid Expansion (up to 100% FPL April 2019, and up to 138% FPL January 2020), with the exception of some small gaps being filled when needed, this program no longer relies on JRI funding. Through these Medicaid expansions, by the end of FY20, it is anticipated that the Salt Lake County network of contracted providers will have grown the SUD residential capacity from 170 beds in 2016 to ~700 beds. Additional capacity outside of this network also increased through other providers throughout the county. Very specialized Medicaid enrollment efforts and trainings continue, including a rapid response in April 2020 providing our network with PDF fillable forms for the TAM referral process to support telecommuting and COVID-19 risk of infection. DBHS also continues to work closely with the ACOs to support the integrated expansion population by engaging them with providers to problem solve, and to assist with non-Medicaid reimbursable services through the DBHS network.

CORE 1 & 2

Initially, DBHS utilized JRI dollars as seed dollars to implement CORE 2. DBHS now utilizes multiple funding streams, including JRI, for the VBH CORE 1 & 2 programs. These 16 bed residential facilities, one for men and one for women, serve individuals with co-occurring serious mental illness and substance use disorders. They 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 offenders 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 criminal recidivism.

A January 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.

UPD/UNI Mental Health Unit Program

With JRC application-based dollars DBHS worked with program stakeholders to implement the Mental Health Unit within the Unified Police Department (UPD) in July 2017. After finalizing contracts and MOU's, and assigning a licensed clinician employed by UNI, the program became operational in November of that year (with JRC dollars supporting the cost of one clinician). JRI funding now supports this program, due to the discontinuation of JRC dollars.

Through this program, 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. This program serves the cities of Taylorsville, Kearns, Magna, Riverton, Holladay, Millcreek, Midvale, Canyons, Copperton, and White 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.

Through additional county dollars, the Mental Health Unit is made up of one sergeant, one detective, and nine secondary officers in each precinct that work with the unit one to two days a month. The unit also utilizes interns from the University of Utah in assembling the program database.

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

The program enjoys an average diversion from medical or psychiatric hospitalization rate of 95.1%. Through the first eight months of FY20 (July 2019 through February 2020), the program has made 529 outreaches.

Outcome Measures

DBHS has developed multiple outcome measures for the programs listed above. Please reference the sections above and attached ISP report for these outcomes and demographics. In addition to reductions in Risk Scores, and NOMS data such as employment, housing and "frequency of use" changes, DBHS tracks reductions in jail recidivism. This was accomplished by finalizing a data sharing agreement with the Salt Lake County Jail; through the hiring of a data analyst; then matching program cohorts with jail data to analyze reductions in new-charge bookings in the Salt Lake County Jail. Prior to release the methodology is shared with the Sheriff's Office to gain their validation and approval for release. 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.

Budget:
JRI programs serve individuals with both mental health and substance use disorders. Budgets for these programs are separated appropriately between the MH and SUD Area Plans.

Identify training and/or technical assistance needs.

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. Technical assistance from DSAMH on how to reduce the duplication of efforts would be greatly appreciated.

Additionally, 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 and others. Many stakeholders and funders regularly request and sometimes require data that we can no longer access. Support from DSAMH in this area would also be greatly appreciated.

FORM C - SUBSTANCE USE PREVENTION NARRATIVE

With the intention of helping every community in Utah to establish sustainable Community Centered Evidence Based Prevention efforts, fill in the following table per the instructions below.

Not every community will be at optimal readiness nor hold highest priority. This chart is designed to help you articulate current prevention activities and successes as well as current barriers and challenges. Please work with your Regional Director if you have questions about how to best report on your communities.

List every community in your area defined by one of the following:
1. serving one of the 99 Small Areas within Utah
2. serving the communities that feed into a common high school
3. any other definition of community with DSAMH approval.

*All "zero" or "no priority" communities may be listed in one row

Community	**Coalition Readiness** Community Readiness 1-9 **This column is OPTIONAL for FY2021 Area Planning ***Unofficial readiness Score*** conducting an official readiness assessment with Bach Harrison this year.	**List of Programs provided**	**Notes**	**Priority** A B C	**Evidence Based Operating System (e.g. CTC, CADCA, PROSPER)**	**Links to community strategic plan**
Central 9th	8	CTC	KLO done,	A	Coordinator is working with CTC coach and is familiar with CTC	n/a
Evidence2Success Kearns Community Coalition	9	CTC	In year 3 of DFC. Been functioning as a CTC for 4.5	A	Coordinator has completed CTC TOF and coalition has completed the	https://www.kearnse2s.org/

			years.		CADCA academy	
Magna	9	CTC	KLO completed and priorities have been set.	A	Coordinator has completed CTC TOF	n/a
Murray	7	None	Was learning about CTC and trying to decide which direction to go.	A	Was on track to use CTC but then a new coordinator was hired by the school district.	n/a
Midvale	6	None	Community coalition focusing on student health in local schools.	B	None	n/a
South Salt Lake	7	None	Focuses on neighborhood development as a whole.	A	Neighborhood Centers Model	http://www.southsaltlakecity.com/department-listings/promise-ssl
West Valley City	5	None	Talks of getting a coalition started are happening.	B	None	n/a
Draper	6	None	Old CTC	C	Used to use CTC. Has since disbanded	n/a
West Jordan	7	None	Community coalition mostly focusing on physical health.	B	None	n/a
South Jordan	7	None	Community coalition mostly focusing on mental health resources.	B	None	n/a
Riverton/Bluffdale	7	None	Community Coalition mostly focusing on sucicide prevention.	B	None	n/a

Sandy	6	None	Has money for mini-grants for health initiatives in the community.	B	None	n/a
Holladay	6	None	Community health coalition focusing on physical health.	B	None	n/a
Herriman	7	None	Community coalition focusing on suicide prevention and mental health.	B	None	n/a
Glendale	7	None	Currently in the planning phase. Working with UNP to outline a systems map of the strengths and challenges facing the community.	B	None- has elements of SPF in the process. Community driven.	n/a
Millcreek	5	Promise Millcreek	Community Coalition working to address barriers to education, health and safety, and economic well being.	C	None	https://millcreek.us/221/Promise-Program
Daybreak	4	None	There has been some discussion about breaking off from South Jordan to form own coalition.	C	None	n/a
Avenues	1	None	No expressed community interest and not a high need area at this time.	C	None	n/a

Foothill/East Bench	1	None	No expressed community interest and not a high need area at this time.	C	None	n/a
Southeast Liberty	1	None	Some of Southeast Liberty will be encompassed in the central 9th coalition.	C	None	n/a
Sugarhouse	1	None	No expressed community interest and not a high need area at this time.	C	None	n/a
Rose Park	1	None	No expressed community interest and gets served by coalitions sounding this small area.	C	None	n/a
Cottonwood	1	None	No expressed community interest and not a high need area at this time.	C	None	n/a
Taylorsville	1	None	No expressed community interest.	C	None	n/a

Priority Key

A: LA supports and has prioritized the community coalition; readiness issues have been addressed, capacity has been sufficiently built to move to next steps (define next steps, i.e. “planning and implementation phases”of Community Centered Evidence Based Prevention.

B: Community is prioritized for capacity building efforts/addressing community readiness issues.

C: Not a priority at this time. Please explain in Notes.

Area Narrative

For each community identified in the table above, please outline strategic steps the Local Authority is planning to do to improve Community Centered Evidence Based Prevention.

We are currently working with Bach Harrison to conduct a substance misuse needs assessment for all of Salt Lake County. This assessment will evaluate current programming and identify gaps in services both within and outside of the SLCoHD.

Community: Central 9th
Central 9th is a new CTC Coalition in the downtown area around 900 S. SLCoHD funds this CTC. Because this coalition is up and coming; SLCoHD is providing technical assistance to the coalition to ensure its start up is a success. Currently two SLCoHD staff sit on the coalition and assist where needed.

Community: Evidence2Success Kearns Community Coalition
Kearns E2S is a CTC in Kearns that has been up and running for 4.5 years. SLCoHD houses the coordinator for the coalition and serves as the fiscal agent for the coalition managing budgets and grant reporting.

Community: Magna
Magna is a new CTC Coalition in Magna. SLCoHD funds this CTC. Because this coalition is up and coming; SLCoHD is providing technical assistance to the coalition to ensure its start up is a success. Currently two SLCoHD staff sit on the coalition and assist where needed. The coalition coordinator is employed through Salt Lake County Youth Services.

Community: Murray
Murray is a coalition in Murray run by the Murray City School District. SLCoHD provides technical assistance to this coalition. Currently two SLCoHD staff serve on the coalition. Historically SLCoHD was helping Murray move towards a CTC model but staff turn over at Murray City School District has made growth slow. SLCoHD is still encouraging Murray to move toward an evidence based coalition model.

Community: Midvale
Midvale is a coalition in Midvale run by Canyons School district with legislative funding. This coalition aims to improve student outcomes. SLCoHD has recently become involved with this coalition and is currently working on building rapport.

Community: South Salt Lake
South Salt Lake is a coalition in South Salt Lake run by Promise. Promise aims to improve economic outcomes in South Salt Lake through a variety of means (including SUD Prevention). SLCoHD currently serves on the coalition.

Community: West Valley City
West Valley City wants to start a community coalition and is currently looking for partners and key leaders. There is a lot of interest by the local government. SLCoHD will serve as a key leader to this coalition and assist with the start up.

Community: Draper

Draper had a CTC Coalition in the past. This coalition has since disbanded and is no longer a priority due to lack of community interest.

Community: West Jordan
West Jordan currently has a Healthy Communities Coalition focusing on physical health. The SLCoHD Coalitions Team helps run this coalition. SLCoHD is currently encouraging this coalition to move towards an evidence based model.

Community: South Jordan
South Jordan currently has a Healthy Communities Coalition focusing on mental and physical health. The SLCoHD Coalitions Team helps run this coalition. SLCoHD is currently encouraging this coalition to move towards an evidence based model.

Community: Riverton/Bluffdale
Riverton/Bluffdale currently has a Healthy Communities Coalition focusing on suicide prevention. The SLCoHD Coalitions Team helps run this coalition and assists with QPR trainings. SLCoHD is currently encouraging this coalition to move towards an evidence based model and expanding to more than suicide prevention.

Community: Sandy
Sandy has a Healthy Communities Coalition that mostly serves as a board in order to give out mini-grants for health initiatives in Sandy. This coalition is not a priority for SLCoHD at this time but SLCoHD is an active member of the coalition.

Community: Hollady
Holliday currently has a Healthy Communities Coalition focusing on physical health. The SLCoHD Coalitions Team helps run this coalition. SLCoHD is currently encouraging this coalition to move towards an evidence based model.

Community: Herriman
Herriman currently has a Healthy Communities Coalition focusing on suicide prevention and mental health. The SLCoHD Coalitions Team helps run this coalition and assists with QPR trainings and other TA as needed. SLCoHD is currently encouraging this coalition to move towards an evidence based model and expanding to more than suicide prevention.

Community: Glendale
Glendale is currently in the planning phase. SLCoHD is working with University Neighborhood Partners to outline a systems map of strengths and challenges in the community. SLCoHD is the lead partner in this initiative.

Community: Millcreek
Millcreek currently has a Promise Coalition. This coalition works on addressing barriers to education, health and safety, and economic well being. SLCoHD currently serves on this

coalition and provides assistance as needed but this coalition is well established and not a priority for SLCoHD at this time.

Community: Daybreak
Daybreak is currently part of the South Jordan Healthy Community (see above).

Community: Avenues
The Avenues area in downtown SLC doesn't have a coalition at this time. This area does not have expressed community interest or high rates of problem behavior. Because of this it is not a priority for SLCoHD at this time.

Community: Foothill/East Bench
Foothill/East Bench area in SLC doesn't have a coalition at this time. This area does not have expressed community interest or high rates of problem behavior. Because of this it is not a priority for SLCoHD at this time.

Community: Southeast Liberty
Southeast Liberty in SLC will most likely be encompassed within the Central 9th Coalition.

Community: Sugarhouse
Sugarhouse in SLC doesn't have a coalition at this time. This area does not have expressed community interest or high rates of problem behavior. Because of this it is not a priority for SLCoHD at this time.

Community: Rose Park
Rosepark in SLC doesn't have a coalition at this time. This area does not have expressed community interest and is served by surrounding coalitions as the area is quite small.

Community: Cottonwood
Cottonwood in SLC doesn't have a coalition at this time. This area does not have expressed community interest or high rates of problem behavior. Because of this it is not a priority for SLCoHD at this time.

Community: Taylorsville
Taylorsville currently doesn't have a coalition and lacks community interest. However, this area does have increased rates and SLCoHD is currently partnering with their Cultural Competency Coalition to explore future partnerships.

Create a Logic Model for each program or strategy funded by Block Grant Dollars, PFS, SOR, SPF Rx or State General Funds.

Program Name	Cost of Program	Evidence Based: Yes or No
RIC-AAU Mentoring Program	Block Grant Funds: $65,000 State General Funds: Discretionary Funds: Total: $65,000	Yes

Agency/Coalition	Tier Level:
The Refugee and Immigrant Center: Asian Association of Utah	Effective and Promising Crime Solutions

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Reduce past 30 day drug, alcohol, tobacco, and marijuana use for refugee and immigrant youth under the age 21	Risk Factors: - Low Commitment to School - School Failure - Attitudes Favorable to Antisocial Behavior -Perceived risk of drug use Protective Factors: - Rewards for Prosocial Involvement	Refugee and immigrant youth under the age 21 living in Salt Lake County	Evidence base Mentoring program	Improvement in prosocial scores in the SDQ questionnaire among 80% of participants; 3% improvement in GPA and school attendance cumulatively in all program participants	Reduce past 30 day drug, alcohol, tobacco, and marijuana use for youth under the age 21 as measured on the SHARP Survey
Measures & Sources	2019 SHARP data; Strengths and	Strength and Difficulties Questionnaire (SDQ)	Intake forms and quarterly administrati	Quarterly SDQ Questionnaire administ	SDQ testing; Quarterly Report Cards/School Attendance	2023 SHARP Testing

	Difficulties Questionnaires		on of the SDQ	rations; Quarterly School Report Cards		

Program Name	Cost of Program	Evidence Based: Yes or No
STEP Parenting Program	Block Grant Funds: $49,000 State General Funds: Discretionary Funds: Total: $49,000	Yes

Agency/Coalition	Tier Level:

Asian Association of Utah	First Clearinghouse Pew

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Indicated		Short	Long
Logic	Prevent ATOD use and increase Family Attachment	Risk Factors: - Parental Attitudes Favorable to Antisocial Behavior Protective Factor: - Family Attachment	Parents of refugee or immigrant youth aged 5-18	STEP Evidence Based Curriculum	Increase Family Attachment in 80% of program participates	Reduce 30-day alcohol use by individuals under the age of 21 by 2% from 2017 – 2025 SHARP Surveys
Measures & Sources	STEP Curriculum; STEP assessments	- 2017 SHARP Assessment - STEP Assessments	Registration Forms/Roll Sheets/Program Logs	STEP Assessments	STEP Assessment Data	SHARP 2025 Data

Program Name	Cost of Program	Evidence Based: Yes or No
One-to-One Mentoring for Counselor-Referred Youth	Block Grant Funds: $34,000 State General Funds: Discretionary Funds: Total: $34,000	Yes

Agency/Coalition	Tier Level:
Big Brothers Big Sisters of Utah	Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Indicated		Short	Long

Logic	Reduce attitudes favorable to antisocial behavior (Parent and Individual) Increased Commitment to School Reduce Underage Alcohol use (past 30 days) Reduce misuse of prescription medication	Favorable attitudes (parent and individual) toward antisocial behaviors Perceived Risk of Drug Use Low Commitment to School Rewards for Prosocial Involvement (Family) Family Attachment Rewards for Prosocial Involvement (Community)	**Indicated:** (56) 28 Youth ages 6-17 matched with 28 volunteer mentors in Salt Lake County One-to-one Big Brothers Big Sisters Mentoring Programs	Youth will meet with their mentor 2-4 times per month for a minimum of 12 months with a mentor in Big Brothers Big Sisters of Utah mentoring programs BBBSU professional staff will work with each child, parent/guardian, and volunteer mentor to develop individualized support plans for each child (BBBSU Youth Outcome Development Plan- YODP) BBBSU professional staff will maintain monthly (or more frequent, if needed) contact with all first year program participants and at least quarterly contact with all continuing participants to ensure continuous individualized support to achieve positive youth outcomes	8th grade youth reporting attitudes favorable to antisocial behaviors will decrease from 27.3% in 2017 to 26% by 2021 8th grade youth reporting a perceived risk of drug use will decrease from 34.9 in 2017 to 32 by 2021 8th grade youth reporting a lack of commitment to school will decrease from 46.3% in 2017 to 44% by 2021 8th grade youth reporting perceived opportunities for prosocial involvement will increase from 60.3% in 2017 to 62% by 2021 8th grade youth reporting positive family attachment will increase from 71.3% in 2017 to 72% by 2021 8th grade youth reporting perceived rewards for prosocial involvement (Community) will increase from 58.4% in 2017 to 60% by 2021	Reduce attitudes favorable to antisocial behavior in 10th grade youth from 33.4% to 30% by 2027 Increase commitment to school in 10th grade youth from 44.5% to 49% by 2027 Reduce underage alcohol use past 30 days 10th grade students from 11.8% to 9% by 2027 Reduce misuse of prescription drugs or narcotics in 12th grade students from 5.1% in 2017 to 4% in 2027

Measures & Sources	2017 SHARP data	-2017 SHARP data -Hawkins & Catalano Risk & Protective Factors -Public/Private Ventures Study: "Making a Difference, An impact study of Big Brothers Big Sisters" -Search Institute's 40 Developmental Assets	Participant Records managed through BBBSU's program database- MatchForce	Case Management Records and resulting data from BBBSU's program database- MatchForce	SHARP data- Baseline from 2017 SHARP BBBSU's Youth and Child Outcomes Surveys (includes baseline & annual follow-up surveys) BBBSU's Strength of Relationship Survey (conducted annually)	SHARP data- Baseline from 2017 SHARP

Program Name	Cost of Program	Evidence Based: Yes or No
One-to-One Mentoring for Refugee Youth	Block Grant Funds: $24,385 State General Funds: Discretionary Funds: Total: $24,385	Yes

Agency/Coalition	Tier Level:
Big Brothers Big Sisters of Utah	Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Reduce attitudes favorable to antisocial behavior (Parent and Individual) Increased Commitment to School Reduce Underage Alcohol use (past 30 days) Reduce misuse of prescription medication	Favorable attitudes (parent and individual) toward antisocial behaviors Perceived Risk of Drug Use Low Commitment to School Rewards for Prosocial Involvement (Family) Family Attachment Rewards for Prosocial Involvement (Community)	**Selective:** (60) 30 Refugee Youth ages 6-17 matched with 30 volunteer mentors in Salt Lake County One-to-one Big Brothers Big Sisters Community Based Mentoring Program	Youth will meet with their mentor 2-4 times per month for a minimum of 12 months with a mentor in Big Brothers Big Sisters of Utah mentoring programs BBBSU professional staff will work with each child, parent/guardian, and volunteer mentor to develop individualized support plans for each child (BBBSU Youth Outcome Development Plan- YODP) BBBSU professional staff will maintain monthly (or more frequent, if needed) contact with all first year program participants and at least quarterly contact with all continuing participants to ensure continuous individualized support to achieve positive youth outcomes BBBSU staff will work with other Refugee service providers to	8th grade youth reporting attitudes favorable to antisocial behaviors will decrease from 27.3% in 2017 to 26% by 2021 8th grade youth reporting a perceived risk of drug use will decrease from 34.9 in 2017 to 32 by 2021 8th grade youth reporting a lack of commitment to school will decrease from 46.3% in 2017 to 44% by 2021 8th grade youth reporting perceived opportunities for prosocial involvement will increase from 60.3% in 2017 to 62% by 2021 8th grade youth reporting positive family attachment will increase from 71.3%	1. Reduce attitudes favorable to antisocial behavior in 10th grade youth from 33.4% to 30% by 2027 2. Increase commitment to school in 10th grade youth from 44.5% to 49% by 2027 3. Reduce underage alcohol use past 30 days 10th grade students from 11.8% to 9% by 2027 Reduce misuse of prescription drugs or narcotics in 12th grade students from 5.1% in 2017 to 4% in 2027

				insure that communications with Parents and Guardians can be translated, and that referrals for other needed services can be made.	in 2017 to 72% by 2021 8th grade youth reporting perceived rewards for prosocial involvement (Community) will increase from 58.4% in 2017 to 60% by 2021	

Measures & Sources	2017 SHARP data	-2017 SHARP data -Hawkins & Catalano Risk & Protective Factors -Public/Private Ventures Study: "Making a Difference, An impact study of Big Brothers Big Sisters" -Search Institute's 40 Developmental Assets	Participant Records managed through BBBSU's program database-MatchForce	Case Management Records and resulting data from BBBSU's program database-MatchForce	SHARP data-Baseline from 2017 SHARP BBBSU's Youth and Child Outcomes Surveys (includes baseline & annual follow-up surveys) BBBSU's Strength of Relationship Survey (conducted annually)	SHARP data-Baseline from 2017 SHARP

Program Name	Cost of Program	Evidence Based: Yes or No
Protecting You/Protecting Me (ages 6–12) and Keepin' it REAL (ages 12–18).	Block Grant Funds: $49,915 State General Funds: Discretionary Funds:	Yes

Total: $49,915

Agency/Coalition	Tier Level:
Boys and Girls Club	Promising California Evidence Based Clearinghouse

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Reduce underage drinking, cigarette, and marijuana use. Reduce underage drinking, cigarette, and marijuana use among Hispanic and Black youth.	Early Initiation of Drug Use Perceived Risk of Drug Use	School age youth, ages 13 – 18, who are members, or recruited as members, of Salt Lake City Boys & Girls Clubs. School age youth, ages 6 – 12, who are members, or recruited as members, of Salt Lake City Boys & Girls Clubs.	"Keepin' it REAL"@ 60 min – 1x per week for 10 weeks, 2x per year, @ 3 Boys & Girls Club sites (Capitol West, Lied, and Sugar House) "Protecting You, Protecting Me" @ 60 min – 1x per week for 8 weeks, 2x per year @ 3 Boys & Girls Club sites (Capitol West, Lied and Sugar House)	Percent reporting Early Initiation of Drug Use will decrease from 20% in 2013 to 15% in 2017, all races; 33% to 28%, Hispanic; 20% to 15%, Black. Percent reporting Perceived Risk of Drug Use will decrease from 37% in 2013 to 32% in 2017, all races; 50% to 45%, Hispanic; 52% to 47%, Black.	Underage drinking will decrease from 26% LTU in 2013 to 21% LTU in 2019, all races; 38% to 32%, Hispanic; 26% to 21%, Black. Underage cigarette use will decrease from 15% LTU in 2013 to 10% LTU in 2019, all races; 22% to 17%, Hispanic; 17% to 12% Black. Underage marijuana use will decrease from 18% LTU in 2013 to 13% LTU in 2019, all races; 27% to 22% Hispanic, 20% to 15%, Black.
Measures & Sources	2013 SHARP Survey	2013 SHARP Survey	Boys & Girls Club membership forms. Attendance data in electronic	Attendance records	2017 SHARP Survey	2019 SHARP Survey

			membership database.		

Program Name	Cost of Program	Evidence Based: Yes or No
Nuevo Dia	Block Grant Funds: $57,875 State General Funds: Discretionary Funds: Total: $57,875	Yes

Agency/Coalition	Tier Level:
Centro de la Familia de Utah	Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Prevent child's alcohol and drug use.	Lack of parent involvement	Thirty 9-12-year-old Latinx Boys and Girls and their mothers within the Salt Lake School District @ Mountain View Elementary	Strengthening Families Curriculum @ Mountain View Elem., 18 classes per cohort	Youth and parents complete the program and gain knowledge of the effects of ATOD. Parents in particular learn of the influence of	Youth become competent and able to make good judgments about behavior and coping with social situations more appropriately. This provides them with skills to avoid adverse

					involvement in their children's lives.	behavior with alcohol and drugs.
Measures & Sources	2009 SHARP Survey	2009 SHARP Survey	Attendance Records Program Logs	Pre/Post Tests Home visits Weekly calls Home-work Weekly staff meetings Case management	2015 SHARP Survey	2019 SHARP Survey

Program Name	Cost of Program	Evidence Based: Yes or No

Grandfamilies (GF) Kinship Care	Block Grant Funds: $38,150 State General Funds: Discretionary Funds: Total: $38,150	Yes

Agency/Coalition	Tier Level:
Children's Service Society (CSS)	3

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Prevention of substance and alcohol use in the second generation	Parental Attitudes Favorable to Antisocial Behavior Attitudes Favorable to Anti-Social Behavior Perceived Risk of Drug Use Low Commitment to School Family Attachment Interactions with Pro Social Peers	Kinship Caregivers and the children/adolescents of relatives they are raising	Intake/Global Assessment 4-8 Series of 10-wk sessions, 90 minutes each GF Kinship Caregivers Group 4-8 Series of 10 wk sessions 90 minutes each GF Children's Groups 4-8 Series of 10-wk sessions of 90 minutes each GF Adolescent Groups Monthly Friend 2 Friend prosocial activities,12 @ 90 min	75% of participants will report children are safer, free of impact from parental attitudes favorable to antisocial behaviors 60 % of participants will report improvement in family attachment and functioning Groups Participants will report at or above the state average for the 5 Protective Factors 70% of children and adolescents will report an understanding and use of healthy coping skills 60% of children and adolescents will report an understanding of substance use and it's harmful effects on their physical and mental health 80% of Families attending F2F will report that the activities provide opportunities for pro social interactions and family bonding	Reported 30 day use of alcohol in 10th graders in SL County will decrease from 10 % in 2017to 8 % in 2021 Reported 30 day use of Marijuana in 10th graders in SL County will decrease from 8% in 2017 to 6% 2021 Lifetime Misuse of prescription drugs in 10th graders will drop from 8% in 2017 to 6% in 2021
Measures & Sources	SHARP SURVEY 2017	GF Global Assessment Protective Factors Survey	Attendance Records	Attendance Records	GF Global Assessment Protective Factors Survey	SHARP SURVEY 2021

		Relatives as Parents Survey Children's Group Pre/ Post Evaluation Adolescent Group Pre/Post Evaluation Friend 2 Friend Survey		Relatives as Parents Survey Children's Group Pre/Post Evaluation Adolescent Group Pre/Post Evaluation Friend 2 Friend Survey	

Name	Program	e Based: Yes or No
ce Abuse Prevention Program- Peer Assistance and hip (PAAL)	rant Funds: $35,737 eneral Funds: onary Funds:	
	35,737	

Coalition	el:
South Salt Lake	iewed

			Population: U/S/I	es	Outcomes	
			Selective			

	articipant Families are in their child's nd civic ce uth demonstrate y, motional ence APP program ll demonstrate/ that they have ge regarding risk arm from drug uth are making s toward academic cy	tal Attitudes le to Anti- ehavior, y ent, rds for Pro- volvement s favorable to al behavior ed risk of e nmitment to	Families of 890 K-8 th participants in 9 centers across the South Salt Lake of neighborhood and after- school s. SSL youth nts in 9 selected across the Promise alt Lake system of rhood centers and hool programs SSL youth nts in 9 selected across the Promise alt Lake system of rhood centers and hool programs SSL youth nts in 9 selected across the Promise alt Lake system of rhood centers and hool programs	uardian attendance rences, school parents/families r at afterschool , parents/families programming that s higher levels of ng rogram @ 9 centers in SSL. 60 min lessons & ng activities x 9 centers x 40 9 selected centers Program 60 min & supporting s 1x/week x 9 x 40 weeks, ation in regular fitness, dance, ecreation high quality ic tutoring, STEM n, experiential n, summer ming, literacy s	parents ting ting increase in nent decrease of -3 (at left) by 2% uth reporting s favorable to al behavior will e from 28.6% in 2021 ave accurate ion regarding ences of drug e in attendance. te of SSL schools 80% of youth progress toward cy in Lang arts & reater than 1 year per year)	tal Attitudes e to anti-social will decrease 6% (2017) by 2021 APP youth nts will trate resiliency, ate social rs as shown by e in SSL youth te ubstance Abuse will decrease over uth will experience ase in school nent as trated by e in failing and dropouts, e in % students on graduation
es &	oles and nce records for nent/interest ourses. Surveys g questions re: al behavior	Family h Project ment- parent ment, PSSL Survey	te Coordinator e: opportunities for ngagement, ring, interest-based s	rolls, Family Anecdotal Records, session rolls, er Attendance	urveys and pre t-tests adapted for	e in Factors 1-3 17 SHARP as ed to 2021 for SSL report

	iaison Reports 2019 youth Teacher Survey outh survey- re: th relationships, post test specific s, ata for each SSL	ily program eports necdotal office HARP report SSL s 40.2% of th are at risk erception g harms from e HARP research for	nce records /CTC Risk and ve Factors Survey nce records /CTC Risk and ve Factors Parent nce records /CTC Risk and ve Factors Parent	tivity Reports, nce Records, Action Pre and ts nce Records ation, pre and post nce Records, pre t tests, DIBELS shrink in ESL gap & ic risk	HARP (Baseline), ark: 5% reported 2021 & CTC R&P 2017 (Baseline) ark: % reported in HARP Survey e in risk of ment to school 17 Sharp e) compared to	HARP as ed to 2021 & 2023 disaggregated r SSL, SSL Youth te HARP as ed to 2021, 2023 for SSL Youth HARP as ed to 2021 & 2023 for Commitment l + higher grad SSL

SHARP, as the 2019 SHARP will have already been administered by the time of program initiation. Factors represented in this logic model align with priority risk factors in SSL as outlined in Section 2 of narrative.

Program Name	Cost of Program	Evidence Based: Yes or No
Substance Abuse Prevention Program- Positive Action	Block Grant Funds: $35,737 State General Funds: Discretionary Funds: Total: $35,737	Yes

Agency/Coalition	Tier Level:
Promise South Salt Lake	Model Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	SAPP Participant Parents/Families are engaged in their child's school and civic experience SSL Youth demonstrate resiliency, social/emotional competence PSSL-SAPP program youth will demonstrate/ respond that they have knowledge regarding risk and/or harm from drug use. SSL Youth are making progress toward academic proficiency	1. Parental Attitudes Favorable to Anti-social behavior, 2. Family Attachment, 3. Rewards for Pro-social involvement Attitudes favorable to antisocial behavior Perceived risk of drug use Low commitment to school	Parents/Families of 890 K-8 SSL youth participants in 9 selected centers across the Promise South Salt Lake system of neighborhood centers and after-school programs. 890 K-8 SSL youth participants in 9 selected centers across the Promise South Salt Lake system of neighborhood centers and after-school programs 890 K-8 SSL youth participants in 9 selected centers across the Promise South Salt Lake system of neighborhood centers and after-school programs 890 K-8 SSL youth participants in 9 selected centers across the Promise South Salt Lake system of neighborhood centers and after-school programs	Parent/guardian attendance at conferences, school events; parents/families volunteer at afterschool program, parents/families access programming that supports higher levels of functioning Positive Action Program @ 9 selected centers in SSL. Program 60 min lessons & supporting activities 1x/week x 9 centers x 40 weeks Positive Action Program @ 9 selected centers in SSL. Program 60 min lessons & supporting activities 1x/week x 9 centers x 40 weeks, Participation in regular physical fitness, dance, sports/recreation Deliver high quality academic tutoring, STEM education, experiential education,	# and % parents participating % reporting increase in involvement activity/decrease of factors 1-3 (at left) by 2% per year % of youth reporting Attitudes favorable to antisocial behavior will decrease from 28.6% in 2017 to 23% in 2021 Youth have accurate information regarding consequences of drug use. Increase in attendance. Aggregate of SSL schools will show 80% of youth making progress toward proficiency in Lang arts & math (Greater than 1 year growth per year)	% Parental Attitudes favorable to anti-social behavior will decrease from 25.6% (2017) to 20% by 2021 PSSL-SAPP youth participants will demonstrate resiliency, appropriate social behaviors as shown by decrease in SSL youth crime rate Youth Substance Abuse overall will decrease over time. SSL youth will experience an increase in school commitment as demonstrated by decrease in failing classes and dropouts, increase in % students on track for graduation

				summer programming, literacy initiatives		

Measures & Sources	Parent roles and attendance records for engagement/interest based courses. Surveys including questions re: pro-social behavior Family Liaison Reports 2018 & 2019 youth survey, Teacher Survey PSSL youth survey- re: staff/youth relationships, Pre and post test specific to harms, USBE data for each SSL School	Harvard Family Research Project endorsement - parent engagement, PSSL Parent Survey Positive Action daily program activity reports (ETO), anecdotal records, office referrals 2017 SHARP report data for SSL indicates 40.2% of SSL youth are at risk of misperception regarding harms from drug use 2013 SHARP NREPP research for program	PSSL Site Coordinator reports re: opportunities for family engagement, volunteering, interest-based sessions Attendance records Program/CTC Risk and Protective Factors Survey Attendance records Program/CTC Risk and Protective Factors Parent Survey Attendance records Program/CTC Risk and Protective Factors Parent Survey	Program rolls, Family Liaison Anecdotal Records, Partner session rolls, Volunteer Attendance records Daily Activity Reports, Attendance Records, Positive Action Pre and post-tests Attendance Records Participation, pre and post tests Attendance Records, pre and post tests, DIBELS scores, shrink in ESL gap & academic risk	Parent surveys and pre and post-tests adapted for 2017 SHARP (Baseline), Benchmark: 5% reported in 2019, 2021 & CTC R&P Survey 40.2% in 2017 (Baseline) SHARP Benchmark: % reported in 2021 SHARP Survey Decrease in risk of commitment to school from 2017 Sharp (baseline) compared to 2021	Decrease in Factors 1-3 from 2017 SHARP as compared to 2021 SHARP for SSL report 2017 SHARP as compared to 2021 & 2023 SHARP disaggregated report for SSL, SSL Youth crime rate 2017 SHARP as compared to 2021, 2023 SHARP for SSL Youth 2017 SHARP as compared to 2021 & 2023 SHARP for Commitment to school + higher grad rates in SSL

Program Name	Cost of Program	Evidence Based: Yes or No
Substance Abuse Prevention Classroom	Block Grant Funds: $50,000 State General Funds: Discretionary Funds: Total: $50,000	Yes

Agency/Coalition	Tier Level:
Granite School District	Model+ and Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Indicated		Short	Long

Logic	Reduce 30 day use of ATOD by 25% for students who are in the programs for at least 30 days. Reduction of individual risk factors (attitudes favorable to antisocial behavior, ATOD, academic failure, low school/neighborhood attachment. Reduce the recidivism rate by 5% over three years. The current rate is 13% Reduce Family Risk Factors (attitudes favorable to antisocial behavior and perceived risk to ATOD).	ATOD Use. Use of ATOD. Academic failure, low school/neighborhood attachment. Referred to the District for an ATOD Violation. Placement in SAPC Classroom. Referred to the District for ATOD Violations. Placement in the SAPC Classroom.	Students in 10th grade in Granite School District who violate the GSD Safe and Drug Free policy and are placed into the program for at least thirty and no more than 180 days. Students in 10th grade in Granite School District who violate the GSD Safe and Drug Free school policy and are placed into the SA Classroom for at least thirty days and no more than one hundred eighty days. Students in 10th grade in	Educate all students in the SAPC Classroom regarding the research regarding short and long-term physical, mental, and emotional effects of ATOD. In receiving appropriate instruction and skill building support, students will reduce their identified risk factors and increase the desired protective factors. Students in the SAPC Classroom will be tracked over time to measure recidivism. Students and their parents will	Reduce 20 day use of ATOD for students who are in the program for at least 30 days. Reduction of individual risk factors (attitudes favorable to anti-social behavior, perceived risk of us of ATOD, academic failure, and low school/neighborhood attachment among the identified population. Reduce recidivism rate by 1-2% each year. Students and their parents who participate in the SAPC will demonstrate reduced	Reduce 30-day use of alcohol/e-cigarette/ marijuana for students who are in the program for at least 30 days. Students who have completed the Substance Abuse Classroom demonstrate increased protective factors including pro-social behaviors, improved academic achievement. Reduce recidivism by 5% over three years. Students and their families who

			Granite School District who violate the GSD Safe and Drug Free School Policy and are placed into the SAPC classroom for at least 30 days and no more than 180 days. Students in 10th grade in Granite School District who violate the GSD Safe and Drug Free School policy and are placed in the SAPC Classroom for at least 30 days and no more than 180 days.	have a reduction in risk factors when they are given relevant and accurate research based information regarding the real risks of ATOD use and are given appropriate support and skills training through the Strengthening Families Program.	family risk factors (attitudes favorable to antisocial behavior and risk of ATOD.	successfully complete the SAPC Classroom will reduce family risk factors (attitudes favorable to antisocial behavior and perceived risk of ATOD).

Measures & Sources	SASSI, SHARP Survey, Student Questionnaire. SASSI, SHARP Survey, Pre-Post Tests. District Drug & Alcohol Referrals for last three years. SHARP Survey, SASSI.	District Referrals for ATOD Use. District Placement Records District Referrals. Grades & Attendance. Anti-Social Behavior. Self, Parent, School Reports. District Referral Records for ATOD Violation. Attendance records.	Attendance Records. District Referrals for students who have violated the Drug & Alcohol Policies. Placement hearing records. ATOD Referrals and attendance records. ATOD Referrals and attendance records.	Lifeskills Training (LST), SASSI, SHARP Survey, Pre/Post Tests. Lifeskills Training Strengthening Families. Grades, Attendance, Counselor Logs. SHARP Survey, SASSI, use of SFP.	SASSI, LST, SHARP Survey, Pre/Post Tests. SASSI, SHARP Survey, Pre-Post Tests. District Referrals data SHARP Survey, SASSI, use of SFP	SASSI, LST, SHARP Survey, Pre/Post Tests. SASSI, SHARP Survey, Pre-Post Tests. Reduction in Recidivism Rate. District Referrals data SHARP Survey, SASSI, use of SFP

Program Name	Cost of Program	Evidence Based: Yes or No

Magna Coalition CTC creation	Block Grant Funds: $88,000 State General Funds: Discretionary Funds: Total: $88,000	Yes

Agency/Coalition	Tier Level:
Magna Coalition	Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long
Logic	Creation of a CTC coalition to address youth substance use prevention in Magna	Poor family management Low attachment to school and community	Families and youth ages 8-18 in Magna	Creation of a CTC coalition to provide sustainable, programs and services in Magna	CTC coalition will be funded and coordinator hired and steps 1 -3 begun.	Coalition will be in a place to apply for DFc funding by 2020.
Measures & Sources	2017 SHARP Survey of Magna United Partners	2017 SHARP	Magna United Partners	Following the CTC program	Training of coalition and Hiring of coordinator	Beginning Programming and application for DFC funding

Program Name	Cost of Program	Evidence Based: Yes or No
Communities Empowering Parents	Block Grant Funds: $69,505 State General Funds: Discretionary Funds: Total: $69,505	Yes

Agency/Coalition	Tier Level:
Project Reality	EBW Tier 4

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Reduce 30 day use of: 1. Alcohol 2. Tobacco 3. Marijuana Among youth ages 12 and older	Risk Factors 1. Poor family management (PFM) 2. High levels of family conflicts 3. Interaction with antisocial peers 4. Parental attitudes favorable to anti-social behavior 5. Adolescents attitudes favorable to anti-social behavior 6. Low commitment to school 7. Low perceived risk of drug use Protective Factors 8. Rewards for prosocial involvement 9. Opportunitie	-Parents and primary caretakers of elementary and adolescent aged children (2- 17 years old) in Salt Lake County -Selective at risk multicultural families from Salt Lake County	20 hours of interactive, parenting classes using Communities Empowering Parents Curriculum (site coordinators choose one of the following options) 2.5 hours, 1X wk. for 8 weeks or 2 hours, 1X week for 10 weeks Held in community sites and public schools in Salt Lake County -Concurrent classes for all members of the family: - Parents - Adolescents - Elementary age - Pre-school age	Among youth ages 12 and older: 1. Percent reporting PFM will decrease from 30% in 2017 to 25% in 2019 2. Percent reporting family conflicts will decrease from 30% in 2017 to 28% in 2019 3. Percent reporting Interaction with antisocial peers will decrease from 20% in 2017 to 18% in 2019 4. Percent reporting Parental attitudes favorable to anti-social behavior will decrease from 36% in 2017 to 34% in 2019 5. Percent reporting Attitudes favorable to anti-social behavior will decrease from 32% in 2017 to 31% in 2019 6. Percent reporting low commitment to school will decrease from 45% in 2017 to 44% in 2019 7. Percent reporting low perceived risk of drug use will decrease from	Among youth ages 12 and older: 1. Underage drinking, 30 day use, will decrease from 12% in 2017 to 8% by 2021 2. Underage cigarette smoking, 30 day use, will decrease from 4% in 2017 to 3% by 2021 Underage vaping/ e-cigarette 30 day use will decrease from 14% in 2017 to 11% in 2021 3. Marijuana use, 30 day use, will decrease from12% in 2017 to 9% in 2021

		s for prosocial involvement 10. Family attachment			41% in 2017 to 40% in 2019 8.Percent reporting Rewards for prosocial involvement will increase from 58% in 2017 to 61% in 2019 9. Percent reporting Opportunities for prosocial involvement will increase from 67% in 2017 to 68% in 2019 10. Percent reporting family attachment will increase from 67% in 2017 to 69% in 2019	

Measures & Sources	2017 SHARP Survey	CEP Pre/Post Test for parent class participants Program and Attendance Records Program participant self-report	Program and Attendance Records	Program and attendance Records	2019 SHARP Survey Program attendance records CEP Pre/Post-Test for parent class participants Behavior Rating Scales Program participant self-report	Program participant self-report 2021 SHARP Survey

Program Name	Cost of Program	Evidence Based: Yes or No
Insight	Block Grant Funds: $49,200 State General Funds: Discretionary Funds: Total: $49,200	Yes

Agency/Coalition	Tier Level:

Salt Lake City School District	Peer reviewed

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Reduce underage drinking Reduce underage e-cigarette use Reduce youth marijuana use	Opportunities and rewards for prosocial involvement Rebelliousness Favorable attitudes towards antisocial behavior and drug use Perceived risk of drug use Early antisocial behavior and drug use Low commitment to school Poor family management	Salt Lake City School District parents and youth in 4th through 12th grades referred for a first-time alcohol or drug-related offense or serious behavior incident at school. Salt Lake City School District expects to serve 120 unduplicated youth and parents.	The Insight program is a 4-session substance abuse prevention program implemented for district youth and parents at Horizonte Instruction and Training Center. Two hour sessions are held weekly on Tuesday evenings from 6 to 8 PM during the school year.	Rewards for prosocial involvement will increase from 62.8% in 2017 to 65.8% in 2021 Rebelliousness will decrease from 30.8% in 2017 to 27.8% in 2021. Favorable attitudes towards drug use will decrease from 30.6% in 2017 to 27.6% in 2021 Parental attitudes favorable to drug use will decrease from 17.9% in 2017 to 14.9% in 2021. Perceived risk of drug use will increase from 48.8% in 2017 to 51.8% in 2021 Early antisocial behaviors will decrease from 25.2% in 2017 to 22.2% in 2021. Low commitment to school will decrease from 44.7% in 2017 to 41.7% in 2021 Poor family management will decrease from 38.5% in 2017 to 35.5% in 2021	Past 30-day alcohol use by minors will decrease from 11.8% in 2017 to 8.8% in 2023 Past 30-day e-cigarette use by minors will decrease from 8.4% in 2017 to 5.4% in 2023 Past 30-day marijuana use by minors will decrease from 11.8% in 2017 to 8.8% in 2023
Measures & Sources	2017 (SHARP) Survey	2017 SHARP Survey	Service Rolls; Internal Tracking Spreadsheet	Service Rolls; Internal Tracking Spreadsheet ; Session Fidelity Tools	Participant Pre/Posttest; Participant Feedback Surveys; 2021 SHARP Survey	2023 SHARP Survey

Program Name	Cost of Program	Evidence Based: Yes or No
Self-Management Programs	Block Grant Funds: $28,613 State General Funds: Discretionary Funds: Total: $28,613	Yes

Agency/Coalition	Tier Level:
Salt Lake County Aging & Adult Services	CDC from peer-reviewed publications

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Reduce misuse of prescription drugs among older adults	Rewards for prosocial involvement	Persons 60 years of age and older in Salt Lake County	Self-management programs including: Chronic Disease Self-Management, Chronic Pain Selfmanagement, Diabetes SelfManagement and Tomando Control de su Salud conducted in senior centers, 6 weeks; 1x week, 2.5 hours	Percent reporting on change in knowledge of perceived risk will improve by 5% from baseline	Reduce the rate of ED visits due to drug poisonings for people 55 - 85+ from 9.8 to 7.8 per 10,000 population by 2025
Measures & Sources	2014 IBIS	SLCOAA Pre/ post tests	Participant Information Forms	Attendance Records	SLCoAA Pre/ Post Tests	2025 IBIS

Program Name	Cost of Program	Evidence Based: Yes or No
The Blues Program/ME Time	Block Grant Funds: $45,000 State General Funds: Discretionary Funds: Total: $45,000	Yes

Agency/Coalition	Tier Level:
Salt Lake County Division of Youth Services	Model Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Reduce all grades 30 day and lifetime alcohol, tobacco, and marijuana use	- Depressive Symptoms	Selective- High School Students; youth age 14-17	10 cycles of the 6 session Blues Program curriculum Each session is 60 minutes	-increased coping skills -increased positive social activity -increased physical activity -decreased depressive symptoms	All grades Underage drinking will decrease to 8.5% last 30 day, and 22.2% for lifetime use. All grades marijuana use decrease to 6% last 30 day and 15% life time use. reduction in teen and adult suicide rates reduction in depressive symptoms
Measures & Sources	2017 SHARP	2017 SHARP	Attendance Rosters, Intake Paperwork, Participant Program Evaluations	Attendance Rosters, Developer Fidelity Evaluations, Facilitator Fidelity Evaluations	2021 SHARP; participant outcome surveys: last session and 6 month	2021 SHARP

Program Name	Cost of Program	Evidence Based: Yes or No
Genders and Sexuality Alliance (GSA/PRISM Club)	Block Grant Funds: $12,061 State General Funds: Discretionary Funds: Total: $12,061	Yes

Agency/Coalition	Tier Level:
Salt Lake County Division of Youth Services	Peer reviewed

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Reduce all grades 30 day and lifetime alcohol, tobacco, and marijuana use	- Low commitment to school - association with anti-social peers - low perceived risk of substance use -depressive symptoms	Selective- 12-18 year olds	- two weekly GSA club meetings - Each session is 90 minutes	- increased self-esteem -decreased depressive symptoms -increased connection to prosocial peers	All grades Underage drinking will decrease to 8.5% last 30 day, and 22.2% for lifetime use. All grades marijuana use decrease to 6% last 30 day and 15% life time use.

Measures & Sources	2017 SHARP	2017 SHARP	Attendance Rosters, Participant Program Evaluations	Attendance Rosters, Fidelity Evaluations	2021 SHARP; participant outcome surveys	2021 SHARP

Program Name	Cost of Program	Evidence Based: Yes or No
Guiding Good Choices- Kearns	Block Grant Funds: $56,500 State General Funds: Discretionary Funds: Total: $56,500	Yes

Agency/Coalition	Tier Level:
Salt Lake County Division of Youth Services	Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long
Logic	Reduce all grades 30 day and lifetime alcohol, tobacco, and marijuana use	-Parental attitudes favorable toward antisocial behavior - Poor family management - Family Conflict - Youth attitudes favorable to ATOD -Bonding to Family	Universal- Caregivers of Youth 9-14 years old who live, work, or play in Kearns	12 cycles of the five session program: Guiding Good Choices. Each session is 120 minutes, with an added 30 minutes for dinner.	70% of families to graduate the program 70% complete the weekly homework assignment of holding a family meeting at least two times. 70% of families to rate the meetings as going well.	All grades Underage drinking will decrease to 8.5% last 30 day, and 22.2% for lifetime use. All grades marijuana use decrease to 6% last 30 day and 15% life time use.
Measures & Sources	2017 SHARP	2017 SHARP	Attendance Rosters, Intake Paperwork, Participant Program Evaluations	Attendance Rosters, Observer Fidelity Evaluations, Facilitator Fidelity Evaluations	2021 SHARP	2021 SHARP

Program Name	Cost of Program	Evidence Based: Yes or No
Cyprus After School Program (Positive Action Curriculum)	Block Grant Funds: $33,500 State General Funds: Discretionary Funds:	Yes
	Total: $33,500	

Agency/Coalition	Tier Level:
Salt Lake County Division of Youth Services	Model Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long

Logic	Reduce all grades 30 day and lifetime alcohol, tobacco, and marijuana use	- Low commitment to school	Universal- High School Students; grade 9-12	- 15 hours of After-School Program weekly during the school year -1 cycle of the 132 session Positive Action Curriculum Each session is 20 minutes	-increased attendance at school -increased completion of school assignments	All grades Underage drinking will decrease to 8.5% last 30 day, and 22.2% for lifetime use. All grades marijuana use decrease to 6% last 30 day and 15% life time use.
Measures & Sources	2017 SHARP	2017 SHARP	Attendance Rosters, Intake Paperwork, Participant Program Evaluations	Attendance Rosters, Developer Fidelity Evaluations,	2021 SHARP; participant outcome surveys	2021 SHARP

Program Name	Cost of Program	Evidence Based: Yes or No
Matheson Jr. High After School Program (Positive Action Curriculum)	Block Grant Funds: $33,500 State General Funds: Discretionary Funds: Total: $33,500	Yes

Agency/Coalition	Tier Level:
Salt Lake County Division of Youth Services	Model Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long
Logic	Reduce all grades 30 day and lifetime alcohol, tobacco, and marijuana use	- Low commitment to school	Universal- Jr. High Students; youth in 7th and 8th grade	- 15 hours of After-School Program weekly during the school year -2 cycles of the 82 session Positive Action Curriculum Each session is 20 minutes	-increased attendance at school -increased completion of school assignments	All grades Underage drinking will decrease to 8.5% last 30 day, and 22.2% for lifetime use. All grades marijuana use decrease to 6% last 30 day and 15% life time use.
Measures & Sources	2017 SHARP	2017 SHARP	Attendance Rosters, Intake Paperwork,	Attendance Rosters, Developer Fidelity Evaluations,	2021 SHARP; participant outcome surveys	2021 SHARP

			Participant Program Evaluations		

Program Name	Cost of Program	Evidence Based: Yes or No
Staying Connected with Your Teen	Block Grant Funds: $39,500 State General Funds: Discretionary Funds: Total: $39,500	Yes

Agency/Coalition	Tier Level:
Salt Lake County Division of Youth Services	Promising Crime Solutions

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long
Logic	Reduce all grades 30 day and lifetime alcohol, tobacco, and marijuana use	-Parental attitudes favorable toward antisocial behavior - Poor family management - Family Conflict -Bonding to Family	Universal- Caregivers of Youth 12-17 years old who live, work, or play in Salt Lake County	8 cycles of the five session program: Staying Connected with Your Teen Each session is 120 minutes, with an added 30 minutes for dinner.	70% of families to graduate the program 70% complete the weekly homework assignment (family meeting) at least two times. 70% rate the meetings as going well.	All grades Underage drinking will decrease to 8.5% last 30 day, and 22.2% for lifetime use. All grades marijuana use decrease to 6% last 30 day and 15% life time use.
Measures & Sources	2017 SHARP	2017 SHARP	Attendance Rosters, Intake Paperwork, Participant Program Evaluations	Attendance Rosters, Observer Fidelity Evaluations, Facilitator Fidelity Evaluations	2021 SHARP	2021 SHARP

Program Name	Cost of Program	Evidence Based: Yes or No
YouthWorks	Block Grant Funds: $100,000 State General Funds: Discretionary Funds: Total: $100,000	Yes

Agency/Coalition	Tier Level:
NeighborWorks Salt Lake	Promising California Evidence Based Clearinghouse

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Reduce use of alcohol, tobacco, and other drugs	Risk Factors to reduce: 1. Attitudes Favorable to Antisocial Behavior (Peer Individual Domain) 2. Perceived Risk of Drug Use (Peer Individual Domain) 3. Low Commitment to School (School Domain) Protective Factors to strengthen: 1. Rewards for Prosocial Involvement (Community Domain) 2. Interaction with Prosocial Peer (PeerIndividual Domain)	Salt Lake County youth enrolled in high school between the ages of 14 - 18 years old with low to medium risk factors and/or high to medium protective factors.	1.Provide 9- to 12-week sessions with 15 hours of employment training and 5 hours of social skills per Monday – Thursday work week 2.Implement the keepin' it REAL curriculum to fidelity 3.Offer a bi-weekly “scholarship” stipend and school elective credit 4.Monitor daily school attendance, grades, and participation upon hire and throughout employment. Require and collect daily school attendance and biweekly completion of school progress report in order to continue employment and receive stipend checks. 5.Create, implement, evaluate, and revise personal success plans 6.Provide a daily positive peer and adult relationship building environment at work through daily briefing, goal setting, positive pro-social role modeling, experiential team learning experiences, goal accomplishment self-ratings, and debriefing 7.Provide weekly social skills training through prosocial and educational activities, and community service learning projects 8.Host program graduation ceremony	School commitment increases by 10%. Sense of belonging increases by 15%. Attitudes favorable to alcohol, tobacco, & other drugs use decreases by 10%. Perceived risk of alcohol, tobacco, & other drugs use increases by 10%. Intentions to use alcohol, tobacco, & other drugs use decreases by 10%. Resistance strategies to use alcohol, cigarettes, vape, marijuana, & other drugs increases by 20%.	Decreased use of alcohol, tobacco, and other drugs among high school youth by 10% by 2023.
Measures & Sources	2017 SHARP	YASI YouthWorks Pre-Survey	YASI Intake Forms Interview Report Attendance Records Academic Transcript	Attendance Records School Records Progress Reports Success Plans keepin' it REAL Classwork and Homework Completion	YouthWorks PostSurvey Exit Interview	2023 SHARP

Program Name	Cost of Program	Evidence Based: Yes or No
Salt Lake City CTC	Block Grant Funds: $90,000 State General Funds: Discretionary Funds: Total: $90,000	Yes

Agency/Coalition	Tier Level:
Spy Hop Productions	Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long
Logic	Reduce substance use and misuse by implementing an effective CTC in Downtown Salt Lake Cit	Attitudes favorable to drug use Poor family management Rewards for prosocial involvement (community) Parental attitudes favorable to drug use Low neighborhood attachment	Target population to be determined through the CTC process. The Salt Lake City CTC will seek to have 15 active participants	1. Get Started Communities get ready to introduce CTC. 2. Get Organized Communities form a board or work within an existing coalition. 3. Develop a Community Profile Communities assess community risks and strengths—and identify existing resources 4. Create a Community Action Plan The community board creates a plan for prevention work in their community 5. Implement & Evaluate	Decrease attitudes favorable to drug use from 23% in 2017 to 21% in 2021 Decrease poor family management from 32.3% in 2017 to 30% in 2021 Increase rewards for prosocial involvement (community) from 51.9% in 2017 to 53% in 2021 Decrease parental attitudes favorable to drug use from 14.2% in 2017 to 12% in 2021	Reduce substance use and misuse by implementing an effective CTC in Downtown Salt Lake City

					Decrease low neighborhood attachment from 36.9% in 2017 to 34% in 2021	
Measures & Sources	SHARP 2017	SHARP 2017	Meeting Minutes Attendance Records CTC Community Profile	CTC Youth Survey	SHARP 2021	SHARP 2025

Program Name	Cost of Program	Evidence Based: Yes or No

Spy Hop Prevention Program	Block Grant Funds: $29,805 State General Funds: Discretionary Funds: Total: $29,805	Yes

Agency/Coalition	Tier Level:
Spy Hop Productions	2

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Preventing prescription drug misuse among 10th and 12th graders in Salt Lake County	RF1: Attitudes favorable to antisocial behavior & drug use RF2: Perceived risk of drug use PF1: Opportunities for prosocial involvement PF2: Rewards for prosocial involvement in community	140 Salt Lake County youth ages 14-20 who: 1) Live in low-income neighborhoods 2) Have peers who engage in substance misuse; 3) Have limited access to quality after-school programming; 4) Have limited access to technology; and, Exhibit rebelliousness	Scaffolded media arts workshops (4-10 hrs/wk, between 4 and 13 months; 160-600hrs/yr) Mentor based, inquiry based, and project based pedagogy Positive Youth Development	Reduce 30-day prescription drug misuse among 10th graders in Salt Lake County from 1.2% to 1.0%. Reduce 30-day prescription drug misuse among 12th graders in Salt Lake County from 1.1% to .09%.	Reduce 30-day prescription drug misuse among 10th graders in Salt Lake County from 1.2% to .09%. Reduce 30-day prescription drug misuse among 12th graders in Salt Lake County from 1.1% to .08%.

Measures & Sources	Pre and Post SEL Survey Salt Lake County SHARP data	Pre and Post SEL Survey Attendance Records	Registration Intake Forms	Attendance Records Pre and Post SEL Survey Rubrics Student Surveys Student Journals Class observations	Pre and Post SEL Survey Attendance Records SHARP data	Pre and Post SEL Survey Follow-up Survey SHARP data

Program Name	Cost of Program	Evidence Based: Yes or No
Parents as Teachers Program	Block Grant Funds: $143,109 State General Funds: Discretionary Funds:	Yes
	Total: $143,109	

Agency/Coalition	Tier Level:
The Housing Authority of the County of Salt Lake	Promising California Evidence Based Clearinghouse

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Reduce the risk for future substance abuse among children 0-5 receiving housing subsidy through the Housing Authority of the County of Salt Lake	*Family Attachment *Rewards for prosocial involvement in the family *Rewards for prosocial involvement in the community *Commitment to school *Academic failure	100 children ages 0-5 and their families that are receiving housing subsidy through the Housing Authority of the County of Salt Lake	Parents as Teachers Program: Personal Visits Personal home visits conducted for a minimum of one hour on a monthly, bi-weekly or weekly basis Screenings Developmental and Health, Hearing, and Vision screenings are conducted within 90 days on enrollment and annually thereafter Group Connections Monthly, on-site for 2 hours Resource Connection As needed, a minimum of 1 resource connection per year per family	Percentage of families measuring as having strong relationships with their children will increase from 72% to 85% in FY 2020 Percentage reporting increase in rewards for prosocial involvement in the family will increase from 71% to 85% in FY 2020 Percentage reporting increase in rewards for prosocial involvement in the community will increase from 80% to 90% in FY 2020 Percentage of children enrolled in an early education program will increase from 82% to 85% in FY 2020 Percentage of children screened for	HACSL youth alcohol use will decrease from 13% LTU in 2017 to 5% LTU in 2035 HACSL youth e-cigarette use will decrease from 16% LTU in 2017 to 5% LTU in 2035

					developmental and health delays will increase from 71% to 80% in FY 2020	
	2035 SHARP	SHARP			PAT Pre/Post	2035 SHARP

Measures & Sources		PAT Pre/Post Assessments Satisfaction Surveys	Enrollment Records Demographic Tracking Forms	Demographic Tracking Forms PAT Pre/Post Assessments Group Connection Activity Log PAT Service Report	Assessments Satisfaction Surveys Early Education Tracking Form PAT Service Report	

Program Name	Cost of Program	Evidence Based: Yes or No
SPORT© Program	Block Grant Funds: $17,224.50 State General Funds: Discretionary Funds: Total: $17,224.50	Yes

Agency/Coalition	Tier Level:
Neighborhood Action Coalition at the University of Utah	Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Reduce substance abuse among Midvale City's youth	1. Early initiation of drug use 2. Attitudes favorable to drug use 3. low commitment to school 4. rewards for antisocial behavior 5. interaction with antisocial peers --- 1. Increase frequency of moderate physical activity 2. Increase frequency of vigorous physical activity 3. Increase knowledge of healthy stress management techniques 4. Increase parent-youth communication about health behavior 5. interaction with prosocial peers 6. opportunities for prosocial involvement 7. rewards for prosocial	200 Midvale youth 12-18 years at the *Boys and Girls Club of Midvale*, *Midvale Middle School and Community Building Community* center	SPORT Curriculum and physical activity program: promotes an active lifestyle, positive images, and achieving goals, along with activities designed by Exercise and Sport Science Professionals; 126 hours of instruction delivered approximately 2-4 times a week for 42 weeks. If the youth increase frequency of moderate physical activity, their knowledge of healthy behaviors will increase, when healthy behavior increase, youth will have more skills to resist using ATODs.	1. Decrease risk factor early initiation of drug use from 24% to 22% by 2021 2. Decrease number of youth who have favorable attitudes toward drug use from 28% – 25% by 2021 3. Decrease low commitment to school from 48% to 44% by 2021 4. Decrease rewards for antisocial behavior from 29% to 27% by 2021 5. Decrease interaction with antisocial peers from 22% to 20% by 2021 --- 1. Increased levels of moderate physical activity based on individual pre- test levels. 2. Higher levels of vigorous activity based on individual pre- test levels.	Reduction of substance abuse among Midvale City's youth: 1. Decrease alcohol use in past 30-days from 10.2% to 8.0% in the next 10 years 2. Decrease marijuana use in past 30-days from 13.8% to 9.8% in the next 10 years 3. Decrease binge drinking (5 or more drinks in a row in past 2 weeks) from 5.8% to 4.2% in the next 10 years 4. Decrease "been drunk or high at school in the past year) from 14% to 11.7% in the next 10 years 5. Decrease e-cigarette use in past 30-days

		involvement (family) 8. rewards for prosocial involvement (community)			3. Increase knowledge of healthy stress management techniques based on individual pre-test levels. 4. Increase parent-youth communication about health behavior based on individual pre-test levels. 5. Increase interaction with prosocial peers from 45% to 52% by 2021 6. Increase opportunities for prosocial involvement	from 12% to 9% in the next 10 years 6. Decrease prescription drug abuse in past 30 days from 4.6% to 3% in the next 10 years.

					from 69% to 71% by 2021. 7. Increase rewards for prosocial involvement (family) from 58% to 61% by 2021 8. Increase rewards for prosocial involvement (community) from 45% to 49% by 2021	

Measures & Sources	SHARP Data	SHARP Data	Attendance Sheets	Staff Reports Curriculum checklist/lesson plans Worksheet completion checklist Pre-Post tests provided in SPORT curriculum Follow-up phone calls with parents	Completion of Fitness Feedback Sheet Pre- and Post-consultation interviews/surveys SHARP Survey	SHARP Data

Program Name	Cost of Program	Evidence Based: Yes or No
Lifeskills Training	Block Grant Funds: $17,224.50 State General Funds: Discretionary Funds:	Yes
	Total: $17,224.50	

Agency/Coalition			Tier Level:			
Neighborhood Action Coalition at the University of Utah			Model+ Blueprints			
	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Reduce substance abuse among Midvale City's youth	1. Early initiation of drug use 2. Attitudes favorable to drug use 3. low commitment to school 4. rewards for antisocial behavior 5. interaction with antisocial peers --- 1. Improved healthy beliefs and standards regarding ATOD use. 2. Possess and use appropriate social skills. 3. interaction with prosocial peers 4. opportunities for prosocial involvement 5. rewards for prosocial involvement (family) rewards for prosocial involvement (community)	2190 students ages 12-17 years old, attending Midvale Middle School or Hillcrest High School or other organizations in Midvale.	LifeSkills Training curriculum: Age-appropriate, best practice (science-based) prevention programs utilizing social, developmental, communication, refusal, and life skills for healthy living. By providing one presentation per healthy lifestyles class per semester (approx. 60 per year) students will increase their knowledge of healthy behaviors and ATOD use, as well as learn appropriate social skills, in turn, decreasing substance use.	1. Decrease risk factor early initiation of drug use from 24% to 22% by 2021 2. Decrease number of youth who have favorable attitudes toward drug use from 28% – 25% by 2021 3. Decrease low commitment to school from 48% to 44% by 2021 4. Decrease rewards for antisocial behavior from 29% to 27% by 2021 5. Decrease interaction with antisocial peers from 22% to 20% by 2021 --- 1. Improve health beliefs and perceptions of ATOD use based on pre/post score differentials. 2. Improve knowledge of social skills and refusal skills based on pre/post test differentials. 3. Increase interaction with prosocial peers	Reduction of substance abuse among Midvale City's youth: 1. Decrease alcohol use in past 30- days from 10.2% to 8.0% in the next 10 years 2. Decrease marijuana use in past 30-days from 13.8% to 9.8% in the next 10 years 3. Decrease binge drinking (5 or more drinks in a row in past 2 weeks) from 5.8% to 4.2% in the next 10 years 4. Decrease "been drunk or high at school in the past year) from 14% to 11.7% in the next 10 years 5. Decrease e-cigarette use in past 30-days from 12% to 9% in the next 10 years 6. Decrease prescription drug abuse in past 30 days from 4.6% to 3% in the next 10 years.

					from 45% to 52% by 2021 4. Increase opportunities for prosocial involvement from 69% to 71% by 2021. 5. Increase rewards for prosocial involvement (family) from 58% to 61% by 2021 6. Increase rewards for prosocial involvement (community) from 45% to 49% by 2021.	

Measures & Sources	SHARP Data	SHARP Data	Staff Reports Attendance Sheets	LifeSkills curriculum checklist Staff Reports	Pre and post tests	SHARP Data

Program Name	Cost of Program	Evidence Based: Yes or No
Strengthening Families	Block Grant Funds: $12,875 State General Funds: Discretionary Funds:	Yes
	Total: $12,875	

Agency/Coalition	Tier Level:

Urban Indian Center of Salt Lake (Sacred Paths Youth Services)			Promising Blueprints			
	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long
Logic	Reduce lifetime underage drinking and commercial tobacco misuse	Early initiation of alcohol use Opportunities for Prosocial Involvement	American Indian and Alaska Native Youth ages 6-18 living in Salt Lake County	Strengthening Families Program	Reduce early initiation of alcohol from 2020 to 2022 Increase opportunities for Prosocial Involvement from 2020-2022	Reduce Underage Drinking from 20.5% to 15% by 2023 (be reduced by 5% by 2021. Reduce E-cigarette use from 24.6% to 20% by 2023 and 5% by 2021
Measures & Sources	Sharp Survey 2017	Sharp Survey 2017	Program Logs and Attendance Records UICSL Reports to Indian Health Services	Program Logs and Attendance Records UICSL Reports to Indian Health Services Strengthening Families Program Curriculum	2017, 2019, 2021, and 2023 SHARP Surveys UICSL Focus Groups and surveys	2017, 2019,2021, and 2023 SHARP Surveys UICSL Focus Groups and surveys

Program Name	Cost of Program	Evidence Based: Yes or No
All Stars	Block Grant Funds: $41,000 State General Funds: Discretionary Funds: Total: $41,000	Yes

Agency/Coalition	Tier Level:
Volunteers of America, Utah	National Registry

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long

Logic	Reduce underage drinking Reduce underage e-cigarette use Reduce youth marijuana use	Opportunities and rewards for prosocial involvement Perceived risk of drug use Favorable attitudes towards drug use Intentions to use drugs Low commitment to school	Salt Lake County students in 6th, 7th, 8th, and 9th grade classrooms and afterschool programs. VOA expects to serve 675 youth in 27 classrooms.	The All Stars program is a 13-session substance abuse prevention curriculum implemented in ten Salt Lake County schools. Weekly 45-minute sessions are held in the classroom during the regular school day or in an afterschool program.	Rewards for prosocial involvement will increase from 63.7% in 2017 to 66.7% in 2021 Perceived risk of drug use will increase from 40.4% in 2017 to 37.4% in 2021 Favorable attitudes towards drug use will decrease from 23% in 2017 to 20% in 2021 Intentions to use will decrease from 29.9% in 2017 to 26.9% in 2021 Low commitment to school will decrease from 45% in 2017 to	Past 30-day alcohol use by minors will decrease from 9.1% in 2017 to 6.1% in 2023 Past 30-day e-cigarette use by minors will decrease from 10.5% in 2017 to 7.5% in 2023 Past 30-day marijuana use by minors will decrease from 9.2% in 2017 to 6.2% in 2023

					42% in 2021	
Measures & Sources	2017 Student Health and Risk Prevention (SHARP) Survey	2017 SHARP Survey	Service Roll; Staff Assignment Spreadsheet; MMDS Internal Tracking Spreadsheet	Service Roll; Staff Assignment Spreadsheet; MMDS Internal Tracking Spreadsheet; Session Fidelity Tools	Participant Pre/Posttest; Teacher Feedback Survey; 2021 SHARP Survey	2023 SHARP Survey

Program Name	Cost of Program	Evidence Based: Yes or No
Curriculum Based Support Group (Voices)	Block Grant Funds: $103,664 State General Funds: Discretionary Funds: Total: $104,664	Yes

Agency/Coalition	Tier Level:
Volunteers of America, Utah	CDC- Peer reviewed

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Reduce underage drinking Reduce underage e-cigarette use Reduce youth marijuana use	Opportunities and rewards for prosocial involvement Favorable attitudes towards antisocial behavior and drug use Interactions with antisocial peers Perceived risk of drug use Early antisocial behavior and drug use Low commitment to school	Salt Lake County youth ages 10 to 17 living in high-risk neighborhoods. Youth are referred for participation by classroom teachers, school counselors, after school program coordinators, community center coordinators, and housing site managers based on identifiable risk factors. VOA expects to serve 468 youth at 15 sites.	The Curriculum Based Support Group (Voices) program is a 10-session substance abuse prevention curriculum implemented in small groups at schools, after school programs, community centers, and housing sites. Sessions are weekly or bi-weekly and are typically 45 minutes to an hour.	Rewards for prosocial involvement will increase from 63.7% in 2017 to 66.7% in 2021 Favorable attitudes towards drug use will decrease from 23% in 2017 to 20% in 2021 Perceived risk of drug use will increase from 40.4% in 2017 to 37.4% in 2021 Early antisocial behaviors will decrease from 24.9% in 2017 to 21.9% in 2021 Low commitment to school will decrease from 45%	Past 30-day alcohol use by minors will decrease from 9.1% in 2017 to 6.1% in 2023 Past 30-day e-cigarette use by minors will decrease from 10.5% in 2017 to 7.5% in 2023 Past 30-day marijuana use by minors will decrease from 9.2% in 2017 to 6.2% in 2023

					in 2017 to 42% in 2021	
Measures & Sources	2017 Student Health and Risk Prevention (SHARP) Survey	2017 SHARP Survey	Service Roll; Staff Assignment Spreadsheet; MMDS Internal Tracking Spreadsheet	Service Roll; Staff Assignment Spreadsheet; MMDS Internal Tracking Spreadsheet; Session Fidelity Tools	Participant Pre/Posttest; Feedback Survey;	2023 SHARP Survey

					2021 SHARP Survey	

Program Name	Cost of Program	Evidence Based: Yes or No
Guiding Good Choices	Block Grant Funds: $26,344 State General Funds: Discretionary Funds: Total: $26,344	Yes

Agency/Coalition	Tier Level:
Volunteers of America, Utah	Promising Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long

Logic	Reduce underage drinking Reduce underage e-cigarette use Reduce youth marijuana use	Poor family management Family conflict Attitudes favorable towards drug use Family attachment Opportunities and rewards for prosocial involvement Early initiation of antisocial behavior and drug use	Parents of Salt Lake County youth ages 8 to 14 living in high-risk neighborhoods. Families are referred for participation by school counselors, community center coordinators, and housing site managers based on identifiable risk factors. VOA expects to sever 20 families at 3 sites.	The Guiding Good Choices program is a 5-session substance abuse prevention curriculum for parents implemented in a multi-family group at Midvale CBC and other school and community sites. Weekly 2-hour sessions are held in the evening. Youth have the opportunity to participate in the Curriculum Based Support Group (Voices) program concurrent to the parent program.	Poor family management will decrease from 32.3% in 2017 to 29.3% in 2021 Family conflict will decrease from 31.3% in 2017 to 28.3% in 2021 Parental attitudes favorable to drug use will decrease from 14.2% in 2017 to 11.2% in 2021 Youth attitudes favorable to drug use will decrease from 23% in 2017 to 20% in 2021 Family attachment will increase from 67.8% in 2017 to 70.8% in 2021	Past 30-day alcohol use by minors will decrease from 9.1% in 2017 to 6.1% in 2023 Past 30-day e-cigarette use by minors will decrease from 10.5% in 2017 to 7.5% in 2023 Past 30-day marijuana use by minors will decrease from 9.2% in 2017 to 6.2% in 2023

					Rewards for prosocial involvement will increase from 63.7% in 2017 to 66.7% in 2021 Early antisocial behaviors will decrease from 24.9% in 2017 to 21.9% in 2021	

Measures & Sources	2017 Student Health and Risk Prevention (SHARP) Survey	2017 SHARP Survey	Service Roll; Staff Assignment Spreadsheet; MMDS Internal Tracking Spreadsheet	Service Roll; Staff Assignment Spreadsheet; MMDS Internal Tracking Spreadsheet; Session Fidelity Tool	Participant Pre/Posttest; Participant Feedback Survey; 2021 SHARP Survey	2023 SHARP Survey

Program Name	Cost of Program	Evidence Based: Yes or No
Life Skills Training Booster & Prescription Drug Misuse Module	Block Grant Funds: $18,000 State General Funds: Discretionary Funds: Total: $18,000	Yes

Agency/Coalition	Tier Level:
Volunteers of America, Utah	Model+ Blueprints

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Universal		Short	Long

Logic	Reduce underage drinking Reduce underage e-cigarette use Reduce youth marijuana use Reduce youth prescription drug misuse	Opportunities and rewards for prosocial involvement Perceived risk of drug use Favorable attitudes towards drug use Intentions to use drugs Low commitment to school	Salt Lake County students in 7th, 8th, 9th, and 10th grade classrooms and afterschool programs. VOA expects serve 450 youth in 18 classrooms.	The Life Skills Training Booster & Prescription Drug Misuse Module is an 8-session substance abuse prevention curriculum implemented at Hillcrest Junior High, Riverview Junior High, and Northwest Middle Schools. Weekly 45-minutes sessions are held in the classroom as part of the regular school day.	Rewards for prosocial involvement will increase from 63.7% in 2017 to 66.7% in 2021 Perceived risk of drug use will increase from 40.4% in 2017 to 37.4% in 2021 Favorable attitudes towards drug use will decrease from 23% in 2017 to 20% in 2021 Intentions to use will decrease from 29.9% in 2017 to 26.9% in 2021 Low commitment to school will decrease	Past 30-day alcohol use by minors will decrease from 9.1% in 2017 to 6.1% in 2023 Past 30-day e-cigarette use by minors will decrease from 10.5% in 2017 to 7.5% in 2023 Past 30-day marijuana use by minors will decrease from 9.2% in 2017 to 6.2% in 2023 Past 30-day prescription drug misuse by minors will decrease from 7.5% in 2017 to 4.5% in 2023

					from 45% in 2017 to 42% in 2021	
Measures & Sources	2017 Student Health and Risk Prevention (SHARP) Survey	2017 SHARP Survey	Service Roll; Staff Assignment Spreadsheet;	Service Roll; Staff Assignment Spreadsheet; MMDS Internal Tracking Spreadsheet; Session Fidelity Tools	Participant Pre/Posttest; Teacher Feedback Survey;	2023 SHARP Survey

			MMDS Internal Tracking Spreadsheet		2021 SHARP Survey	

Program Name	Cost of Program	Evidence Based: Yes or No
Living Skills	Block Grant Funds: $77,083 State General Funds: Discretionary Funds:	Yes
	Total: $77,083	

Agency/Coalition	Tier Level:
Volunteers of America, Utah	Peer reviewed

	Goal	Factors	Focus Population: U/S/I	Strategies	Outcomes	
			Selective		Short	Long

Logic	Reduce underage drinking Reduce underage e-cigarette use Reduce youth marijuana use	Opportunities and rewards for prosocial involvement Rebelliousness Early antisocial behavior Favorable attitudes towards antisocial behavior Interaction with antisocial peers Low commitment to school	Salt Lake County youth ages 6 to 11 living in high-risk neighborhoods. Youth are referred for participation by classroom teachers, school counselors, after school program coordinators, community center coordinators, and housing site managers based on identifiable risk factors. 348 youth served at 19 sites.	The Living Skills program is a 10-session prevention curriculum implemented in small groups at schools, after school programs, community centers, and housing sites. Sessions are weekly or bi-weekly and are typically 45 minutes to an hour.	Rewards for prosocial involvement will increase from 63.7% in 2017 to 66.7% in 2021. Rebelliousness will decrease from 25.1% in 2017 to 22.1% in 2021. Early antisocial behaviors will decrease from 24.9% in 2017 to 21.9% in 2021 Favorable attitudes towards drug use will decrease from 23% in 2017 to 20% in 2021 Interactions with antisocia	Past 30-day alcohol use by minors will decrease from 9.1% in 2017 to 6.1% in 2023 Past 30-day e-cigarette use by minors will decrease from 10.5% in 2017 to 7.5% in 2023 Past 30-day marijuana use by minors will decrease from 9.2%

					l peers will decrease from 20.4% in 2017 to 17.4% in 2021. Low commitment to school will decrease from 45% in 2017 to 42% in 2021	in 2017 to 6.2% in 2023
Measures & Sources	2017 Student Health and	2017 SHARP Survey	Service Roll; Staff Assignment Spreadsheet; MMDS Internal Tracking Spreadsheet	Service Roll; Staff Assignment Spreadsheet;	Teacher Feedback Survey;	2023 SHARP Survey

	Risk Prevention (SHARP) Survey			MMDS Internal Tracking Spreadsheet; Session Fidelity Tools	2021 SHARP Survey	

FY21 Mental Health Area Plan & Budget

Local Authority: Salt Lake County

Form A

	State General Fund			County Funds									
FY2021 Mental Health Revenue	State General Fund	State General Fund used for Medicaid Match	$2.7 million Unfunded	NOTused for Medicaid Match	Used for Medicaid Match	Net Medicaid	Mental Health Block Grant (Formula)	10% Set Aside Federal - Early Intervention	Other State/Federal	Third Party Collections	Client Collections (eg, co-pays, private pay, fees)	Other Revenue	TOTAL FY2021 Revenue
JRI/JRC	$1,000,000			$200,000									$1,200,000
Local Treatment Services	$1,670,950	$12,406,364	$352,547	$3,455,728	$6,888,376	$46,705,260	$828,564		$130,000	$803,580			$73,241,369
FY2021 Mental Health Revenue by Source	$2,670,950	$12,406,364	$352,547	$3,655,728	$6,888,376	$46,705,260	$828,564	$0	$130,000	$803,580	$0	$0	$74,441,369

	State General Fund			County Funds											
FY2021 Mental Health Expenditures Budget	State General Fund	State General Fund used for Medicaid Match	$2.7 million Unfunded	NOTused for Medicaid Match	Used for Medicaid Match	Net Medicaid	Mental Health Block Grant (Formula)	10% Set Aside Federal - Early Intervention	Other State/Federal	Third Party Collections	Client Collections (eg, co-pays, private pay, fees)	Other Expenditures	TOTAL FY2021 Expenditures Budget	Total Clients Served	TOTAL FY2021 Cost/Client Served
Inpatient Care (170)		$2,144,247			$1,190,549	$8,072,281				$229,232			$11,636,309	614	$18,951.64
Residential Care (171 & 173)	$105,205	$1,605,181			$891,243	$6,042,893							$8,644,522	1,496	$5,778.42
Outpatient Care (22-24 and 30-50)	$391,448	$3,803,022	$355,547	$273,578	$2,111,544	$14,316,926	$669,847			$494,215			$22,416,127	13,927	$1,609.54
24-Hour Crisis Care (outpatient based service with emergency_ind = yes)	$490,000	$1,131,069		$1,054,570	$628,003	$4,258,049							$7,561,691	562	$13,454.97
Psychotropic Medication Management (61 & 62)	$107,404	$481,649		$12,945	$267,426	$1,813,225	$127,362			$80,133			$2,890,144	5,835	$495.31
Psychoeducation Services (Vocational 80) Psychosocial Rehabilitation (Skills Dev. 100)	$58,593	$1,495,543		$53,371	$830,369	$5,630,151	$2,609						$8,070,636	2,042	$3,952.32
Case Management (120 & 130)	$53,615	$901,397		$126,932	$500,482	$3,393,420	$18,265						$4,994,111	3,917	$1,274.98
Community Supports, including - Housing (174) (Adult) - Respite services (150) (Child/Youth)	$489,495	$260,925		$732,768	$144,873	$982,283							$2,610,344	763	$3,421.16
Peer Support Services (140): - Adult Peer Specialist - Family Support Services (FRF Database)	$709,724	$151,914			$84,347	$571,899	$10,481						$1,528,365	1,429	$1,069.53
Consultation and education services, including case consultation, collaboration with other county service agencies, public education and public information		$264,378			$146,791	$995,287							$1,406,456		
Services to persons incarcerated in a county jail or other county correctional facility	$153,424												$153,424	1,002	$153.12
Adult Outplacement (USH Liaison)		$124,273		$644,659	$69,000	$467,839							$1,305,771	101	$12,928.43
Other Non-mandated MH Services	$112,042	$42,766		$756,905	$23,749	$161,007			$130,000				$1,226,469	684	$1,793.08
FY2021 Mental Health Expenditures Budget	$2,670,950	$12,406,364	$355,547	$3,655,728	$6,888,376	$46,705,260	$828,564	$0	$130,000	$803,580	$0	$0	$74,444,369		

	State General Fund			County Funds											
FY2021 Mental Health Expenditures Budget	State General Fund	State General Fund used for Medicaid Match	$2.7 million Unfunded	NOTused for Medicaid Match	Used for Medicaid Match	Net Medicaid	Mental Health Block Grant (Formula)	10% Set Aside Federal - Early Intervention	Other State/Federal	Third Party Collections	Cleint Collections (eg, co-pays, private pay, fees)	Other Expenditures	TOTAL FY2021 Expenditures Budget	Total FY2021 Clients Served	TOTAL FY2021 Cost/Client Served
ADULT	$1,588,000	$7,643,193	$352,547	$3,114,804	$4,243,725	$28,773,734	$654,466		$90,000	$617,586			$47,078,055	10,395	$4,528.91
YOUTH/CHILDREN	$1,082,950	$4,763,171		$540,924	$2,644,651	$17,931,526	$174,098		$40,000	$185,994			$27,363,314	5,759	$4,751.40
Total FY2021 Mental Health Expenditures	$2,670,950	$12,406,364	$352,547	$3,655,728	$6,888,376	$46,705,260	$828,564	$0	$130,000	$803,580	$0	$0	$74,441,369	16,154	$4,608.23

FY21 Proposed Cost & Clients Served by Population **Local Authority:** Salt Lake County **Form A (1)**

Budget and Clients Served Data to Accompany Area Plan Narrative

MH Budgets		Clients Served	Expected
Inpatient Care Budget			
$7,193,368	ADULT	350	$20,552
$4,442,941	CHILD/YOUTH	264	$16,829
Residential Care Budget			
$8,354,042	ADULT	1,421	$5,879
$290,480	CHILD/YOUTH	75	$3,873
Outpatient Care Budget			
$11,184,935	ADULT	8,172	$1,369
$11,228,192	CHILD/YOUTH	5,755	$1,951
24-Hour Crisis Care Budget			
$6,067,368	ADULT	470	$12,909
$1,494,323	CHILD/YOUTH	92	$16,243
Psychotropic Medication Management Budget			
$2,387,197	ADULT	4,778	$500
$502,947	CHILD/YOUTH	1,057	$476
Psychoeducation and Psychosocial Rehabilitation Budget			
$1,480,787	ADULT	1,180	$1,255
$6,589,849	CHILD/YOUTH	862	$7,645
Case Management Budget			
$4,694,082	ADULT	2,908	$1,614
$300,029	CHILD/YOUTH	1,009	$297
Community Supports Budget (including Respite)			
$1,222,263	ADULT (Housing)	361	$3,386
$1,388,081	CHILD/YOUTH (Respite)	402	$3,453
Peer Support Services Budget			
$789,932	ADULT	1,274	$620
$738,433	CHILD/YOUTH (includes FRF)	155	$4,764
Consultation & Education Services Budget			
$1,137,067	ADULT		
$269,389	CHILD/YOUTH		
Services to Incarcerated Persons Budget			
$153,424	ADULT Jail Services	1,002	$153
Outplacement Budget			
$1,305,771	ADULT	101	$12,928
Other Non-mandated Services Budget			
$1,107,819	ADULT	655	$1,691
$118,650	CHILD/YOUTH	29	$4,091

Summary

Totals

$47,078,055	Total Adult
$27,363,314	Total Children/Youth

From the budgets and clients served data reported above, please breakout the following information regarding unfunded (duplicated from above)

Unfunded ($2.7 million)			
$352,547	ADULT	113	$3,120
	CHILD/YOUTH		
Unfunded (all other)			
$5,447,270	ADULT	4,130	$1,319
$1,837,972	CHILD/YOUTH	900	$2,042

FY21 Mental Health Early Intervention Plan & Budget **Local Authority:** Salt Lake County **Form A2**

	State General Fund		County Funds						
FY2021 Mental Health Revenue	State General Fund	State General Fund used for Medicaid Match	NOTused for Medicaid Match	Used for Medicaid Match	Net Medicaid	Third Party Collections	Client Collections (eg, co-pays, private pay, fees)	Other Revenue	TOTAL FY2021 Revenue
FY2021 Mental Health Revenue by Source	$1,082,950		$540,924	$907,775	$1,843,059				$4,374,708

	State General Fund		County Funds								
FY2021 Mental Health Expenditures Budget	State General Fund	State General Fund used for Medicaid Match	NOTused for Medicaid Match	Used for Medicaid Match	Net Medicaid	Third Party Collections	Client Collections (eg, co-pays, private pay, fees)	Other Expenditures	TOTAL FY2021 Expenditures Budget	Total Clients Served	TOTAL FY2021 Cost/Client Served
MCOT 24-Hour Crisis Care-CLINICAL			$312,107	$164,027	$333,025				$809,159	1,022	$791.74
MCOT 24-Hour Crisis Care-ADMIN			$14,262	$7,496	$15,218				$36,976		
FRF-CLINICAL	$678,709								$678,709	354	$1,917.26
FRF-ADMIN	$31,015								$31,015		
School Based Behavioral Health-CLINICAL	$356,916		$205,179	$704,078	$1,429,493				$2,695,666	635	$4,245.14
School Based Behavioral Health-ADMIN	$16,310		$9,376	$32,174	$65,323				$123,183		
FY2021 Mental Health Expenditures Budget	$1,082,950	$0	$540,924	$907,775	$1,843,059	$0	$0	$0	$4,374,708	2,011	$6,954.14

* Data reported on this worksheet is a breakdown of data reported on Form A.

FY21 Substance Use Disorder Treatment Area Plan Budget **Local Authority:** Salt Lake Co **Form B**

FY2021 Substance Use Disorder Treatment Revenue	State Funds NOT used for Medicaid Match	State Funds used for Medicaid Match	County Funds NOT used for Medicaid Match	County Funds Used for Medicaid Match	Federal Medicaid	SAPT Treatment Revenue	SAPT Women's Treatment Set aside	Other State/Federal	3rd Party Collections (eg, insurance)	Client Collections (eg, co-pays, private pay, fees)	Other Revenue (gifts, donations, reserves etc)	TOTAL FY2021 Revenue
Drug Court	$701,487	$90,000	$2,262,000	$350,000	$650,046	$204,734	$0	$0	$500	$4,000	$0	$4,262,767
JRI	$526,324	$0	$105,265	$0	$0	$0	$0	$0	$1,500	$15,000	$0	$648,089
Local Treatment Services	$5,217,100	$914,203	$1,768,059	$276,676	$3,919,075	$4,308,685	$840,109	$969,859	$40,000	$225,000	$3,151,974	$21,630,740
Total FY2021 Substance Use Disorder Treatment Revenue	$6,444,911	$1,004,203	$4,135,324	$626,676	$4,569,121	$4,513,419	$840,109	$969,859	$42,000	$244,000	$3,151,974	$26,541,596

FY2021 Substance Use Disorder Treatment Expenditures Budget by Level of Care	State Funds NOT used for Medicaid Match	State Funds used for Medicaid Match	County Funds NOT used for Medicaid Match	County Funds Used for Medicaid Match	Federal Medicaid	SAPT Treatment Revenue	SAPT Women's Treatment Set aside	Other State/Federal	3rd Party Collections (eg, insurance)	Client Collections (eg, co-pays, private pay, fees)	Other Revenue	TOTAL FY2021 Expenditures	Total FY2021 Client Served	Total FY2021 Cost/ Client Served
Screening and Assessment Only	$143,481	$20,011	$139,479	$7,885	$91,051	$268,239	$62,551	$0	$0	$75,034	$144,160	$951,891	2,244	$424
Detoxification: ASAM IV-D or III.7-D) (ASAM III.2-D) ASAM I-D or II-D)	$79,713	$0	$156,252	$231,000	$0	$753,656	$43,429	$0	$0	$887	$283,052	$1,547,989	2,500	$619
Residential Services (ASAM III.7, III.5, III.1 III.3 1II.1 or III.3)	$2,290,780	$467,681	$511,305	$184,276	$2,127,948	$983,314	$229,299	$0	$2,426	$102,118	$140,806	$7,039,953	1,002	$7,026
Outpatient: Contracts with Opioid Treatment Providers (Methadone: ASAM I)	$57,565	$42,513	$244,055	$16,751	$193,433	$426,446	$109,449	$184,282	$0	$43,538	$1,000,582	$2,318,614	1,332	$1,741
Office based Opiod Treatment (Buprenorphine, Vivitrol, Naloxone and prescriber cost)) Non-Methadone	$235,021	$0	$0	$0	$0	$0	$0	$267,977	$0	$0	$1,371,334	$1,874,332	1,100	$1,704
Outpatient: Non-Methadone (ASAM I)	$1,362,195	$227,304	$242,588	$89,562	$1,034,233	$466,527	$183,789	$162,600	$32,571	$15,326	$57,196	$3,873,891	3,240	$1,196
Intensive Outpatient (ASAM II.5 or II.1)	$1,464,132	$246,694	$579,645	$97,202	$1,122,456	$585,748	$211,592	$0	$7,003	$3,553	$154,844	$4,472,869	1,869	$2,393
Recovery Support (includes housing, peer support, case management and other non-clinical)	$812,024	$0	$2,262,000	$0	$0	$1,029,489	$0	$355,000	$0	$3,544	$0	$4,462,057	1,516	$2,943
FY2021 Substance Use Disorder Treatment Expenditures Budget	$6,444,911	$1,004,203	$4,135,324	$626,676	$4,569,121	$4,513,419	$840,109	$969,859	$42,000	$244,000	$3,151,974	$26,541,596	14,803	$1,793

FY2021 Substance Use Disorder Treatment Expenditures Budget By Population	State Funds NOT used for Medicaid Match	State Funds used for Medicaid Match	County Funds NOT used for Medicaid Match	County Funds Used for Medicaid Match	Federal Medicaid	SAPT Treatment Revenue	SAPT Women's Treatment Set aside	Other State/Federal	3rd Party Collections (eg, insurance)	Client Collections (eg, co-pays, private pay, fees)	Other Revenue	TOTAL FY2021 Expenditures
Pregnant Women and Women with Dependent Children, (Please include pregnant women under age of 18)	$1,570,992	$511,898	$1,189,401	$367,781	$2,682,438	$130,880	$840,109	$251,633	$5,374	$40,639	$542,407	$8,133,552
All Other Women (18+)	$730,014	$88,686	$215,190	$29,975	$280,412	$743,942	$0	$118,831	$9,386	$40,201	$459,977	$2,716,614
Men (18+)	$4,035,981	$118,462	$2,705,746	$117,660	$636,420	$3,538,553	$0	$470,669	$27,240	$163,160	$2,107,892	$13,921,783
Youth (12- 17) (Not Including pregnant women or women with dependent children)	$107,924	$285,157	$24,987	$111,260	$969,851	$100,044	$0	$128,726	$0	$0	$41,698	$1,769,647
Total FY2021 Substance Use Disorder Expenditures Budget by Population Served	$6,444,911	$1,004,203	$4,135,324	$626,676	$4,569,121	$4,513,419	$840,109	$969,859	$42,000	$244,000	$3,151,974	$26,541,596

FY21 Drug Offender Reform Act & Drug Court Expenditures **Local Authority:** Salt Lake County **Form B1**

FY2021 DORA and Drug Court Expenditures Budget by Level of Care	Drug Offender Reform Act (DORA)	Felony Drug Court	Family Drug Court	Juvenile Drug Court	DUI Fee on Fines	TOTAL FY2021 Expenditures
Screening and Assessment Only	$0	$27,545	$13,974	$3,819	$277,622	$322,960
Detoxification: ASAM IV-D or III.7-D) (ASAM III.2-D)	$0	$0	$0	$0	$0	$0
Residential Services	$0	$216,845	$466,352	$110,918	$72,328	$866,443
Outpatient: Contracts with Opioid Treatment	$0	$13,023	$30,945	$0	$4,344	$48,312
Office based Opiod Treatment (Buprenorphine,	$0	$0	$0	$0	$0	$0
Outpatient: Non-Methadone (ASAM I)	$0	$172,797	$162,137	$59,296	$57,636	$451,866
Intensive Outpatient	$0	$120,133	$205,794	$67,441	$40,070	$433,438
Recovery Support (includes housing, peer support,	$0	$2,829,748	$0	$0	$0	$2,829,748
FY2021 DORA and Drug Court	$0	$3,380,091	$879,202	$241,474	$452,000	$4,952,767

SFY 21 Opioid Budget **Local Authority:** SLC **Form B2**

State Fiscal Year	Projected SOR SFY 2020 Revenue Not Used	State Opioid Response SFY2021 Revenue	Total SFY 2021 SOR Revenue
		SOR 2	
2021	0	$ 452,259.00	**$452,259.00**

SFY2021 State Opioid Response Budget Expenditure	Estimated Cost
Indirect Expense - 6.485%	**$29,329.00**
Direct Services	**$0.00**
Salary Expenses	**$0.00**
Title 1	
Title 2	
Title 3	
Administrative Expenses	**$0.00**
Supplies	
Communication	
Travel	
Conference/Workshops	
Equipment/Furniture	
Miscellaneous	
Screening & Assessment	**$0.00**
Drug Testing	**$0.00**
Office Based Opioid Treatment (Buprenorphine, Vivitrol, Nalaxone)	**$0.00**
Opioid Treatment Providers (Methadone)	**$0.00**
Intensive Outpatient	**$0.00**
Residential Services	**$0.00**
Outreach/Advertising Activities	**$0.00**
Recovery Support (housing, contracted peer support, contracted ca	**$0.00**
Contracted Services	**$422,930.00**
Project Reality - OTP	$214,820.00
Clinical Consultants - Office Based OT Program	$134,262.50
Sheriff MAT Program	$73,847.50
Total Expenditure FY2021	**$452,259.00**

FY21 Substance Abuse Prevention Area Plan & Budget **Local Authority:** Salt Lake County Behavioral Health **Form C**

	State Funds		County Funds									
FY2021 Substance Abuse Prevention Revenue	State Funds NOT used for Medicaid Match	State Funds used for Medicaid Match	County Funds NOT used for Medicaid Match	County Funds Used for Medicaid Match	Federal Medicaid	SAPT Prevention Revenue	Partnerships for Success PFS Grant	Other Federal (TANF, Discretionary Grants, etc)	3rd Party Collections (eg, insurance)	Client Collections (eg, co-pays, private pay, fees)	Other Revenue (gifts, donations, reserves etc)	TOTAL FY2021 Revenue
FY2021 Substance Abuse Prevention Revenue	$153,464		$240,000			$1,852,443	$32,500					$2,278,407

	State Funds		County Funds											
FY2021 Substance Abuse Prevention Expenditures Bu	State Funds NOT used for Medicaid Match	State Funds used for Medicaid Match	County Funds NOT used for Medicaid Match	County Funds Used for Medicaid Match	Federal Medicaid	SAPT Prevention Revenue	Partnerships for Success PFS Grant	Other Federal (TANF, Discretionary Grants, etc)	3rd Party Collections (eg, insurance)	Client Collections (eg, co-pays, private pay, fees)	Other Revenue (gifts, donations, reserves etc)	Projected number of clients served	TOTAL FY2021 Expenditures	TOTAL FY2021 Evidence-based Program Expenditures
Universal Direct			$54,415			$420,000						500	$474,915	$400,000
Universal Indirect	$153,464		$33,807			$260,936	$32,500					0	$480,707	
Selective Services			$120,296			$928,507						16,700	$1,065,503	$928,507
Indicated Services			$31,483			$243,000						800	$275,283	$243,000
FY2021 Substance Abuse Prevention Expenditures Bu	$153,464	$0	$240,000	$0	$0	$1,852,443	$32,500	$0	$0	$0	$0	18,000	$2,278,407	$1,571,507

SAPT Prevention Set Aside	Information Dissemination	Education	Alternatives	Problem Identification & Referral	Community Based Process	Environmental	Total
Primary Prevention Expenditures	$48,936	$1,381,507	$4,000	$125,000	$290,000	$3,000	$1,852,443

Cost Breakdown	Salary	Fringe Benefits	Travel	Equipment	Contracted	Other	Indirect	Total FY2021 Expenditures
Category	$ 373,500	$ 175,000	$ 55,000	$ -	$ 1,641,507	$ 33,400		$2,278,407

Salt Lake County Fee Schedule Methodology and Use

In applying treatment copays, much is left to the discretion of the service provider and attending clinician. Generally, the adult outpatient copay schedule is to be applied for low intensity outpatient services or non-DUI assessments. The maximum Adult Outpatient copay rate of $50 was determined based approximately on the lowest cost service an individual might receive during a single visit and with the intent to not far exceed a typical copay rate under an insurance plan. The Adult IOP rate generally will be used for clients that are receiving more intensive outpatient services or day treatment and maxes out at twice the outpatient copay. The monthly Adult Residential copay rate is lower than the lowest residential provider rate in the Division of Behavioral Health Services' (DBHS) network. The copay schedule increases the fees up to the maximum amount based on the 2018 Federal Poverty Level (FPL), which accounts for gross household income and family size. All copays are based upon one FPL framework and assume greater ability to pay as income increases. For all adult services, at or above 400% of FPL, consumers are provided no county subsidy.

Fees for youth services have been strategically reduced to ensure no barriers to service exist. Copays are not to be assessed until monthly gross income exceeds 350% of the FPL. The Youth Residential schedule maxes out at $50 per month, while the Youth Outpatient schedule maxes out at $5 per week.

In State Code there is an expectation that individuals convicted of DUI are responsible for the cost of their treatment services. Often these individuals require no additional treatment services beyond the initial assessment. For this reason, the sliding fee schedule more quickly reaches the full cost of the assessment service provided (for FY20 approximately $280).

Copay amounts can only be charged for clinical services provided. Drug testing is not deemed to be a clinical service. If a drug test is the only service provided, then the County can be billed for this service at the contracted rate. Copay amounts cannot exceed the rate that you would bill the County for the service provided.

Providers and clinicians are given discretion to waive fees as judged necessary to reduce barriers to treatment in consideration of individual circumstances. When fees are waived documentation must be kept on file explaining these circumstances for waiving or reducing the rate. For incarcerated individuals, all copays for service are waived.

Providers may utilize an alternative copay schedule if it is believed that it would be in their clients' and the County's best interest. All alternative fee policies/schedules must be approved by the County prior to being implemented and must not create an excessive barrier to treatment.

Family Size	Monthly Gross Income (based on the 2018 Federal Poverty Guidelines)								
	0-25% FPL	25-50% FPL	50-150% FPL	150-200% FPL	200-250% FPL	250-300% FPL	300-350% FPL	350-400% FPL	>400% FPL
1	$0 - $253	$254 - $506	$507 - $1,518	$1,519 - $2,023	$2,024 - $2,529	$2,530 - $3,035	$3,036 - $3,541	$3,542 - $4,047	$4,048
2	$0 - $343	$344 - $686	$687 - $2,058	$2,059 - $2,743	$2,744 - $3,429	$3,430 - $4,115	$4,116 - $4,801	$4,802 - $5,487	$5,488
3	$0 - $433	$434 - $866	$867 - $2,598	$2,599 - $3,463	$3,464 - $4,329	$4,330 - $5,195	$5,196 - $6,061	$6,062 - $6,927	$6,928
4	$0 - $523	$524 - $1,046	$1,047 - $3,138	$3,139 - $4,183	$4,184 - $5,229	$5,230 - $6,275	$6,276 - $7,321	$7,322 - $8,367	$8,368
5	$0 - $613	$614 - $1,226	$1,227 - $3,678	$3,679 - $4,903	$4,904 - $6,129	$6,130 - $7,355	$7,356 - $8,581	$8,582 - $9,807	$9,808
6	$0 - $703	$704 - $1,406	$1,407 - $4,218	$4,219 - $5,623	$5,624 - $7,029	$7,030 - $8,435	$8,436 - $9,841	$9,842 - $11,247	$11,248
7	$0 - $793	$794 - $1,586	$1,587 - $4,758	$4,759 - $6,343	$6,344 - $7,929	$7,930 - $9,515	$9,516 - $11,101	$11,102 - $12,687	$12,688
8	$0 - $883	$884 - $1,766	$1,767 - $5,298	$5,299 - $7,063	$7,064 - $8,829	$8,830 - $10,595	$10,596 - $12,361	$12,362 - $14,127	$14,128
Copays									
Adult Residential (once/month)	No Copay			$ 200	$ 400	$ 600	$ 800	$ 1,000	No Subsidy (consumer pays full cost)
Adult Outpatient (weekly max)				$ 10	$ 20	$ 30	$ 40	$ 50	
Adult IOP (weekly max)				$ 20	$ 40	$ 60	$ 80	$ 100	
Youth Residential (once monthly)				No Copay				$ 50	
Youth Outpatient (weekly max)								$ 5	
DUI Assessment	No Copay	$15	$50	$125	$200	No Subsidy (consumer pays full cost)			

Salt Lake County

Continuity of Operations Plan

Department of Human Services
Behavioral Health Services Division

Updated March 20th, 2020

SALT LAKE COUNTY

In accordance with Utah Code § 63G-2-305(48), this document is held by a Division of Emergency Management and the information contained within this document is a protected record intended only for the use of those individuals and agencies to which this document is issued. It is being shared pursuant to the requirements and obligations of Utah Code § 63G-2-206.

This document may also be exempt from disclosure pursuant to Utah Code § 63G-2-106.

SALT LAKE COUNTY

Signatory Page of this Document

Approval on

03/20/2020

By:

Organization Head Responsible for Business Continuity:

Table of Contents

Transmission Statement

Transmitted herewith is the Continuity of Operations (COOP) Plan for the Department of Human Services, Behavioral Health Services Division. It provides a framework in which Department of Human Services, Behavioral Health Services Division can plan for and perform their respective essential functions during a disruption, disaster or emergency event. This COOP Plan was prepared in accordance with the highest level of continuity principles and standards. This plan supersedes any previous COOP Plan and has been concurred. It will be reviewed and recertified annually and transmitted to the Salt Lake County Division of Emergency Management (SLCoEM) for reference. Recipients are requested to advise the Department of Human Services, Behavioral Health Services Divisionof any changes which might result in its improvement or increase in its usefulness.

Approved: _____ **Date:**_____

Record of Changes

When changes are made to the plan outside the official cycle of plan review, coordination, and update, planners should track and record the changes using a record of changes table below and also record them in the Review, Training, Exercise, and Updates portion of this plan. The record of changes will contain, at a minimum, a change number, the date of the change, the name of the person who made the change, and a description of the change.

Change Number	Section	Date	Person Making Change	Change Description

I. Introduction

The mission statement as provided by the Department of Human Services, Behavioral Health Services Division is as follows:

Here at the Division, we believe that behavioral health is an essential part of overall health and that together we can make a difference for those among us that suffer from the symptoms of mental health and substance use disorders. We know that prevention is effective, treatment works, and that individuals with a behavioral health condition can and do recover. Salt Lake County Behavioral Health Services works to ensure access to evidence-based treatment practices throughout the community and appropriate community-based services that provide support along the road to recovery and healing. The results of our efforts are improved outcomes for individuals and families, and a stronger and healthier community.

A. Purpose

This COOP has been created for the Department of Human Services, Behavioral Health Services Division. The COOP Plan establishes policy and guidance to ensure the execution of the essential functions for the Department of Human Services, Behavioral Health Services Division in the event that an emergency threatens or incapacitates operations; and the relocation of selected personnel and functions of any essential facilities of the Department of Human Services, Behavioral Health Services Division are required. Specifically, this COOP is designed to:

- Communication
- Mental Health Appeals
- Managed Care
- Contract Payments
- Auditing
- RSS/client services

B. Applicability and Scope

The provisions of this document apply to the Department of Human Services, Behavioral Health Services Division and its offices. Support from other organizations as described herein will be coordinated with the as applicable. This document applies to situations that require relocation of mission-essential functions of the Department of Human Services, Behavioral Health Services Division as determined by the . The scope does not apply to temporary disruptions of service during short-term building evacuations or other situations where services are anticipated to be restored in the primary facility within a short period. The determine situations that require implementation of the COOP in concert with the Mayor or designated Deputy Mayor.

C. Supersession

This plan supersedes the previous COOP plan dated prior to March 8, 2020.

D. Authorities

- Federal Continuity Directive 1 (FCD1) - September 23rd, 2013 - Federal Executive Branch National Continuity Program and Requirements - Federal Continuity Directive 1 (FCD1) provides direction to all Federal organizations for developing continuity plans and programs. Continuity planning facilitates the performance of essential functions during all-hazards

emergencies or other situations that may disrupt normal operations. The ultimate goal of continuity is the continuation of National Essential Functions (NEFs).

- Federal Continuity Directive 2 (FCD2) - September 18th, 2013 - FCD 2 provides direction that aids Federal Executive Branch organizations in identifying their Mission Essential Functions (MEFs) and candidate Primary Mission Essential Functions (PMEFs) and implement the requirements of FCD 1. It provides guidance to Federal executive branch departments and agencies for identification of their Mission Essential Functions (MEFs) and potential Primary Mission Essential Functions (PMEFs). It includes guidance and checklists to assist departments and agencies in assessing their essential functions through a risk management process and in identifying potential 6 PMEFs that support the National Essential Functions (NEFs) - the most critical functions necessary to lead and sustain the nation during a catastrophic emergency. FCD2 provides direction on the formalized process for submission of a department's or agency's potential PMEFs that are supportive of the NEFs. It also includes guidance on the processes for conducting a Business Process Analysis (BPA) and Business Impact Analysis (BIA) for each of the potential PMEFs that assist in identifying essential function relationships and interdependencies, time sensitivities, threat and vulnerability analyses, and mitigation strategies that impact and support the PMEFs.
- Continuity Guidance Circular 1 (CGC1) - December 9th, 2013 - Continuity Guidance for Non-Federal Entities - Continuity Guidance Circular 1 (CGC1) in cooperation with the Department of Homeland Security and non-federal partners, CGC1 provides guidance to non-federal entities for the development of continuity plans and programs. Continuity planning facilitates the performance of essential functions during all-hazards emergencies or other situations that may disrupt normal operations. By continuing the performance of essential functions through a catastrophic emergency, the State, local, territorial, and tribal governments (non-Federal Governments entities or NFGs) support the ability of the Federal Government to perform National Essential Functions (NEFs), continue Enduring Constitutional Government, and ensure that essential services are provided to the Nation's citizens. A comprehensive and integrated continuity capability will enhance the credibility of our national security posture and enable a more rapid and effective response to, and recovery from, a national emergency.
- Continuity Guidance Circular 2 (CGC2) - October 31st, 2013 - Continuity Guidance for Non-Federal Entities: Mission Essential Functions Identification Process (States, Territories, Tribes, and Local Government Jurisdictions), provides additional planning guidance to assist non-Federal entities and organizations in identifying their essential functions. GCG2 also works to identify the relationships between these functions, as well as governmental and non-governmental agencies alike. Additionally, through the use of a systematic Business Process Analysis, Business Impact Analysis, and the development of risk mitigation strategies, CGC 2 provides guidance to non-Federal entities to ensure the continued performance of these essential functions during and following a significant disruption to normal operations.
- Executive Order 13347 - July 22nd, 2004 - The Executive Order, Individuals with Disabilities in Emergency Preparedness, calls for the Federal Government to appropriately support safety and security for individuals with disabilities in all types of emergency situations through a coordinated effort among federal agencies.
- ADA Title II and III, including, but not limited to, US Code Title 42, Chapter 126:
    - Title II: State and Local Government Activities All activities of state and local governments, regardless of the entity's size or receipt of federal funding, are covered. Additionally, state and local governments are required to allow people with disabilities an equal opportunity to benefit from all programs, services, and activities (e.g. public

education, employment, transportation, recreation, health care, social services, courts, voting, and town meetings). This includes relocating programs or otherwise providing access in inaccessible older buildings, and communicating effectively with people who have hearing, vision, or speech disabilities.

- Title III: Public Accommodations This title covers businesses and nonprofit service providers that are public accommodations, privately operated entities offering certain types of courses and examinations, privately operated transportation, and commercial facilities. Public accommodations are defined as 7 private entities that own, lease, lease to, or operate facilities. This includes restaurants, retail stores, hotels, private schools, convention centers, doctors' offices, homeless shelters, transportation depots, day care centers, and recreation facilities (e.g., sports stadiums and fitness clubs). Transportation provided by private entities is also covered.

- National Security Presidential Directive-51/Homeland Security Presidential Directive-20; National Continuity Policy, May 2007. NSPD 51/20 emphasizes the importance of a comprehensive national program involving all government levels and the private sector for integrated and scalable continuity planning.
- Comprehensive Preparedness Guidance (CPG) 101, Developing and Maintaining Emergency Operations Plans, Version 2, November 2010, updated May 2014.
- Presidential Policy Directive 8, National Preparedness, dated March 30, 2011. PPD-8 and its component policies intend to guide how the nation, from the federal level to private citizens, can "prevent, protect against, mitigate the effects of, respond to, and recover from those threats that pose the greatest risk to the security of the Nation." These threats include terrorist acts, natural disasters, and other man-made incidents. PPD-8 evolves from, and supersedes, Homeland Security Presidential Directive 8, PPD8 is intended to meet many requirements of Subtitle C of the Post-Katrina Emergency Reform Act of 2006 (P.L. 109-295, 6 U.S.C. §741-764).

E. References

- National Response Framework (NRF), Fourth Edition, October 2019
- National Incident Management System (NIMS) - NRF Update October 2017

F. Policy

The Department of Human Services, Behavioral Health Services Division recognizes and acknowledges that the protection of its assets and business operations is a major responsibility to its employees and respective jurisdiction. Therefore, it is a policy of the Department of Human Services, Behavioral Health Services Division that a viable COOP be established and maintained to ensure high levels of service quality and availability. It is also a policy of the Department of Human Services, Behavioral Health Services Division to protect life, information, and property, in that order. To this end, procedures have been developed to support the resumption of time-sensitive business operations and functions in the event of their disruption at the facilities identified in this plan. The Department of Human Services, Behavioral Health Services Division is committed to supporting service resumption and recovery efforts at alternate facilities, if required. Likewise, the Department of Human Services, Behavioral Health Services Division and its management are responsible for developing and maintaining a viable COOP that conforms to acceptable insurance, regulatory, and ethical practices and is consistent with the provisions and direction of other Department of Human Services, Behavioral Health Services Division policy, plans, and procedures.

Activation – Once a continuity of operations (COOP) plan has been implemented, whether in whole or in part, it is considered "activated."

After Action Review (AAR) - is a structured review or de-brief process for analyzing what happened, why it happened, and how it can be done better by the participants and those responsible for the project or event.

All-Hazards – The spectrum of all types of hazards including accidents, technological events, natural disasters, terrorist attacks, warfare, and chemical, biological including pandemic influenza, radiological, nuclear, or explosive events.

Business Impact Analysis (BIA) – A method of identifying the effects of failing to perform a function or requirement.

Communications – Voice, video, and data capabilities that enable the leadership and staff to conduct the mission essential functions of the organization. Robust communications help ensure that the leadership receives coordinated, integrated policy and operational advice and recommendations and will provide the ability for governments and the private sector to communicate internally and with other entities (including with other Federal agencies, State, territorial, tribal, and local governments, and the private sector) as necessary to perform their mission essential functions.

Continuity – An uninterrupted ability to provide services and support, while maintaining organizational viability, before, during, and after an event.

Continuity Communications – Communications that provide the capability to perform Essential Functions in conjunction with other organizations/entities under continuity conditions.

Continuity Facilities – Locations, other than the primary facility, used to carry out mission essential functions, particularly in a continuity situation. "Continuity facilities" refers to not only other locations, but also nontraditional options such as working at home (teleworking), telecommuting, and mobile-office concepts.

Continuity of Operations (COOP) – An effort within individual agencies to ensure they can continue to perform their mission essential functions during a wide range of emergencies, including localized acts of nature, accidents, and technological or attack-related emergencies.

Continuity Event – Any event that causes an agency to relocate or devolve its operations to a continuity facility to assure the continuance of its mission essential functions.

Continuity Personnel – Those personnel, both senior and core, who provide the leadership advice, recommendations, and functional support necessary to continue mission essential functions.

Corrective Action Program (CAP) – An organized method to document and track improvement actions for a program. Users may enter data from a finalized After-Action Report/Improvement Plan, track the progress of corrective action implementation, and analyze and report on trends in improvement plans.

Delegation of Authority – Identification, by position, of the authorities for making policy determinations and decisions at headquarters, field levels, and all other organizational locations. Generally, pre-determined delegations of authority will take effect when normal

channels of direction have been disrupted and will lapse when these channels have been reestablished.

Devolution – The capability to transfer statutory authority and responsibility for mission essential functions from an agency's primary operating staff and facilities to other agency employees and facilities, and to sustain that operational capability for an extended period.

EMA - Emergency Management Agency - refers to county and municipal agencies that coordinate phases of preparedness in an emergency/disaster in their jurisdiction.

Essential Functions - those normal, daily functions that must be continued in order for an organization to be considered operational

Essential Records – Electronic and hardcopy documents, references, and records that are needed to support mission essential functions during a continuity situation. The two basic categories of Essential Records are (1) emergency operating records and (2) rights and interests records.

Emergency Relocation Group (ERG) – Pre-designated staff who move to alternate continuity facility to continue mission essential functions in the event that their normal work locations are threatened or rendered unusable.

Facilities – Locations where an organization's leadership and staff operate. Leadership and staff may be co-located in one facility or dispersed across many locations and connected by communications systems. Facilities must be able to provide staff with survivable protection and must enable continued and endurable operations.

Leadership – The senior decision makers who have been elected or designated to head a branch of government or other organization.

Memorandum of Agreement/Memorandum of Understanding – Written agreement between departments/agencies that require specific goods or services to be furnished or tasks to be accomplished by one organization in support of the other.

Mission Essential Functions – The critical activities performed by organizations, especially after a disruption of normal activities. Specifically, the limited set of agency-level government functions that must be continued throughout, or resumed rapidly after, a disruption of normal activities.

NIMS - National Incident Management System Orders of Succession – Provisions for the assumption by individuals of organization senior leadership positions during an emergency in the event that any of those officials are unavailable to execute their legal duties.

Public Information Officer (PIO) - An individual responsible for disseminating information directly from the Organization to the media via a reliable and preidentified mechanism.

Primary Operating Facility – The site of an organization's normal, day-to-day operations; the location where the employee usually goes to work.

Reconstitution – The process by which surviving and/or replacement organization personnel resume normal operations from the original or replacement primary operating facility.

Review, Training, and Exercise, and Update – Measures to ensure that an agency's continuity plan is capable of supporting the continued execution of the agency's mission essential functions throughout the duration of a continuity situation. Risk Analysis – The process by which risks are identified and evaluated.

Risk Assessment – The identification and assessment of hazards.

Risk Management – The process of identifying, controlling, and minimizing the impact of events whose consequences are or may be unknown, or events that are fraught with uncertainty.

Telework – The ability to work at a location other than the official duty station to perform work or emergency duties. This may include, but is not limited to, using portable computers, personal computers, high-speed telecommunications links, and mobile communications devices.

II. Concept of Operations

A. Objectives

The objective of this COOP is to ensure that a viable capability exists for Department of Human Services, Behavioral Health Services Division to continue essential functions across a wide range of potential emergencies, specifically when the primary facility is either threatened or inaccessible. The objectives of this COOP include:

- To ensure the continuous performance of essential functions/operations during an emergency.
- To protect essential facilities, equipment, records, and other assets.
- To reduce or mitigate disruptions to operations.
- To reduce loss of life, minimize damage and losses.
- To identify and designate principals and support staff to be relocated.
- To facilitate decision-making for execution of the COOP and the subsequent conduct of operations.
- To achieve a timely and orderly recovery from the emergency and resumption of full service to all customers.

B. Planning Considerations and Assumptions

In accordance with continuity guidelines and emergency management principles/best practices, a viable COOP capability:

- Must be maintained at a high-level of readiness.
- Must be capable of implementation, both with and without warning.
- Must be operational no later than 12 hours after activation.
- Must maintain sustained operations for up to 30 days.
- Should take maximum advantage of existing local, State, or federal government infrastructures.

C. COOP Execution

This section outlines situations that can potentially lead to activation of the COOP due to emergencies or potential emergencies that may affect the ability of the Department of Human Services, Behavioral Health Services Division to perform its mission-essential functions from its primary and other essential facilities. This section also provides a general description of actions that will be taken by the Department of Human Services, Behavioral Health Services Division to transition from normal operations to COOP activation.

COOP Activation Scenarios

The following scenarios would likely require the activation of the Department of Human Services, Behavioral Health Services Division COOP:

- The primary facility or any other essential facility of the Department of Human Services, Behavioral Health Services Division is closed for normal business activities as a result of an event or credible threat of an event that would preclude access or use of the facility and the surrounding area.
- The area in which the primary facility or any other essential Department of Human Services, Behavioral Health Services Division facility is located is closed for normal business activities

as a result of a widespread utility failure, natural disaster, significant hazardous material incident, civil disturbance, or active threat event.

- Under this scenario, there could be uncertainty regarding whether additional events such as secondary explosions or cascading utility failures could occur.
- In a situation where a pandemic outbreak may occur, the Pandemic Continuity of Operations may be used as a support document to this COOP plan.

The following scenario would NOT require the activation of the Department of Human Services, Behavioral Health Services Division COOP:

- The primary facility or any other essential facility is temporarily unavailable due to a sudden emergency such as a fire, bomb threat, or hazardous materials emergency that requires the evacuation of the facility, but only for a short duration that does not impact normal operations.

COOP Activation

The following measures may be taken in an event that interrupts normal operations, or if such an incident appears imminent and it would be prudent to evacuate the primary facility or any other essential facility as a precaution:

- The may activate the COOP to include activation of the alternate facility.
- The will direct some or all of the COOP Teams to initiate the process of relocation to the alternate facility (see Sections II-D and II-F). The COOP Teams will be notified using the notification procedures outlined in Section IV of this document.
- The COOP Teams will initiate relocation to the alternate facility site and will ensure that the mission-essential functions of the closed primary or other impacted facility are maintained and capable of being performed using the alternate facility and available resources, until full operations are re-established at the primary/impacted facility.
- Department of Human Services, Behavioral Health Services Division staff members who do not have specific COOP assignments may be called upon to supplement the COOP Team operations.
- Representatives from other government or private organizations may also be called upon to support COOP operations.
- The COOP Teams and their members will be responsible for ensuring the continuation of the mission-essential functions of the Department of Human Services, Behavioral Health Services Division within 12 hours and for a period up to 30 days pending regaining access to the affected facility or the occupation of the alternate facility.

*** *Section IV of this document provides additional detail on the procedures that will be used for COOP activation and implementation.*

Incidents could occur with or without warning and during duty or non-duty hours. Whatever the incident or threat, the Department of Human Services, Behavioral Health Services Division COOP will be executed in response to a full range of disasters and emergencies, to include natural disasters, terrorist threats and incidents, and technological disruptions and failures. In most cases, it is likely there will be a warning of at least a few hours prior to an incident. Under these circumstances, the process of activation would normally enable the partial, limited, or full activation of the COOP with a complete and orderly alert, notification of all personnel, and activation of the COOP Teams.

Without warning, the process becomes less routine and potentially more serious and difficult. The ability to execute the COOP following an incident that occurs with little or no warning will depend on the severity of the incident's impact on the physical facilities, and whether personnel are present in the affected facility or in the surrounding area. Positive personnel accountability throughout all phases of emergencies, including COOP activation, is of utmost concern, especially if the emergency occurs without warning, during duty hours.

**** Section II-I of this document provides additional information on warning conditions and related procedures.*

D. Time-Phased Implementation

In order to maximize the preservation of life and property in the event of any natural or human-caused disaster or threat, time-phased implementation may be applied. Time-phased implementation is used to prepare and respond to current threat levels, to anticipate escalation of those threat levels and, accordingly, plan for increased response efforts and ultimately full COOP activation and facility relocation.

The extent to which time-phased implementation will be applied will depend upon the emergency, the amount of warning received, whether personnel are on duty or off-duty at home or elsewhere, and, possibly, the extent of damage to essential facilities and their occupants. The Disaster Magnitude Classification definitions may be used to determine the execution level of the COOP. These levels of disaster are defined as:

- **Minor Disaster** - Any disaster that is likely to be within the response capabilities of local government and results in only minimal need for state or federal assistance.
- **Major Disaster** - Any disaster that will likely exceed local capabilities and require a broad range of outside resource support including state or federal assistance. The State of Utah Division of Emergency Management and the Federal Emergency Management Agency (FEMA) will be notified and potential state and federal assistance will likely be predominantly recovery oriented.
- Catastrophic Disaster - Any disaster that will require massive state and federal assistance. State and federal assistance will involve response and recovery needs.

As described in Section II-C of this document, COOP activation applies to events or incidents impacting a facility where mission-essential functions are performed to the point that the facility is unable to continue to perform those functions for a duration that will affect normal operations. Using the Disaster Magnitude Classification above, it is possible that a minor disaster would not render a facility unusable. However, minor disasters can escalate into major disasters, and even into catastrophic disasters. Conversely, events that are of short duration and do not impact normal operations (e.g., require a building evacuation only) must also be handled as though they could escalate into a more serious situation. Time-phased implementation of the COOP is a way to be prepared for all levels of emergency/potential emergency scenarios that may or may not require relocation of the primary or other essential facility. This implementation method allows the individual(s) responsible for making decisions to be prepared to fully activate the COOP on very short notice, if necessary, but not prematurely activate the COOP for situations such as the building evacuation-only scenario described above. Listed below is a general summary of the sequence of events that can be followed using time-phased implementation of the COOP:

Phase I – Activation (0 to 12 hours)

During this phase, alert and notification of all employees, COOP Teams, and other organizations identified as "critical customers" (e.g., vendors or public/private entities that may provide resource support) will take place. It is during this phase that the transition to alternate operations at the alternate facility begins. However, if events turn out to be less severe than initially anticipated, the time-phased COOP activation may terminate during this phase and a return to normal operations will take place.

Phase II – Continuity Operation at Alternate Facility (12 hours to Termination)

During this phase, the transition to the alternate facility is complete and the performance of mission-essential functions should be underway. Also, during this phase, plans should begin for transitioning back to normal operations at the primary facility or other designated facility.

Phase III – Reconstitution and Termination

During this phase, all personnel, including those that are not involved in the COOP activation, will be informed that the threat or actual emergency no longer exists, and instructions will be provided for resumption of normal operations.

*** *Section IV of this document covers more detailed, specific time-phased implementation procedures that will be followed during COOP activation and execution.*

E. Critical Service COOP Staff

The Department of Human Services, Behavioral Health Services Division management and staff that relocate to the alternate facility must be able to continue operations and perform mission-essential functions for up to 30 days with resource support. Specific Department of Human Services, Behavioral Health Services Division management and staff will be appointed to serve on COOP Teams to support COOP activations and relocation. It is important that COOP Teams and corresponding responsibilities are established prior to COOP activations so team members can be trained on their team roles and responsibilities. Depending upon the nature and severity of the event requiring COOP activation, the roster and size of the COOP Teams may be adjusted by the as necessary.

*** *Annex A provides a description of each COOP Team developed for the Department of Human Services, Behavioral Health Services Division COOP including each team member's role and contact information.*

Because alternate facility space and support capabilities may be limited, staff may need to be restricted to those specific personnel who possess the skills and experience needed for the execution of mission-essential functions. Staff may be directed to move to other facilities or duty stations or may be advised to remain at or return home, pending further instructions. Individuals may be used to replace unavailable staff or to augment the overall COOP response. COOP activation will not, in most circumstances, affect the pay and benefits of the Department of Human Services, Behavioral Health Services Division management and staff.

*** *Section IV of this document covers more detailed, specific time-phased implementation procedures that will be followed during COOP activation and execution.*

F. Alternate Facility

The determination of 1) the appropriate alternate facility for relocation, and 2) whether to relocate the Department of Human Services, Behavioral Health Services Division to the alternate facility will be

made at the time of activation by the ; the decision will be based on the incident, threat, risk assessments, and execution timeframe. Arrangements should be made with the management of all pre-identified alternate facilities to appoint an Alternate Facility Manager who will be responsible for developing site support procedures that establish the requirements for receiving and supporting the staff of the Department of Human Services, Behavioral Health Services Division.

To ensure the adequacy of assigned space and other resources, all locations currently identified as alternate facilities and those being considered for alternate facility locations should be reviewed by the Department of Human Services, Behavioral Health Services Division management on an annual basis. The and associated COOP Team Chiefs will be advised of the findings of this review and made aware of any updates made to the alternate facility details. In conducting a review of an existing alternate facility to determine its adequacy for supporting the operation of mission-essential functions, the following should be considered:

- Ensure that the facility has sufficient space to maintain and support the Department of Human Services, Behavioral Health Services Division].
- Ensure that the facility, along with acquired resources, are capable of sustaining operations for performing mission-essential functions for up to 30 days.
- Ensure that the facility has reliable logistical support, services, and infrastructure systems (e.g., electrical power, heating/ventilation/air conditioning (HVAC), water/plumbing).
- Ensure that personal convenience and comfort considerations (including toilet facilities) are given to provide for the overall emotional well-being of staff.
- Ensure that adequate physical security and access controls are in place.
- Ensure that the alternate facility is not in the same immediate geographical area as the primary facility, thereby reducing the likelihood that the alternate facility could be impacted by the same incident that impacts the primary facility.
- Consider cooperative agreements such as Memoranda of Understanding (MOUs)/Mutual Aid Agreements with other agencies or contract agreements with vendors who provide services such as virtual office technologies.

*** *Annex B provides the location of the Department of Human Services, Behavioral Health Services Division alternate facility sites and additional information on alternate facility requirements.*

G. Mission Essential Functions

In planning for COOP activation, it is important to establish operational priorities prior to an emergency to ensure that the Department of Human Services, Behavioral Health Services Division can complete the mission-essential functions that are critical to its overall operation. The and associated COOP Teams shall ensure that mission-essential functions can continue or resume as rapidly and efficiently as possible during an emergency relocation. Any task not deemed mission-essential must be deferred until additional personnel, time, or resources become available. Department of Human Services, Behavioral Health Services Division has identified a comprehensive list of mission-essential functions.

*** *Annex C provides a complete list of prioritized mission-essential functions identified for Department of Human Services, Behavioral Health Services Division.*

H. Delineation of Mission Essential Functions

To ensure that mission-essential functions referenced in Section II-G are effectively transferred to the alternate facility and continued with minimal interruption, it is imperative that each function have qualified staff and resources assigned to it. The Department of Human Services, Behavioral Health

Services Division COOP should be formed with mission-essential functions in mind. As the COOP is developed, specific staff should be matched up to each of the mission-essential function(s) within the plan. These staff will be assigned to perform these specific mission-essential functions at the alternate facility during COOP activations. The staff working at the alternate facility must be able to ensure that mission-essential functions are carried out. In some cases, the number of staff assigned to the alternate facility may be limited due to lack of facility resources and/or reduced capacity.

*** *Annex C provides a complete prioritized list of mission-essential functions for Department of Human Services, Behavioral Health Services Division. Each mission-essential function includes a breakdown of estimated personnel requirements and estimated equipment requirements needed to ensure the continuation of that specific mission essential function during COOP activations.*

I. Warning Conditions

When planning and preparing for emergencies that may require activation of the COOP, a wide range of scenarios must be considered. Impending events such as wildfires or winter storms may provide ample warning for notification of staff and identification and pre-positioning of resources in preparing for possible COOP activation; other types of events such as earthquakes or active threat events, may provide no warning:

- **With Warning** - It is expected that, in most cases, the Department of Human Services, Behavioral Health Services Division will receive a warning of at least a few hours prior to an event. This will normally enable the full execution of the COOP with a complete and orderly alert, notification, and/or deployment of the COOP Teams to an assembly site or the alternate facility.
- **Without Warning** - The ability to execute the COOP following an event that occurs with little or no warning will depend on the severity of the emergency and the number of personnel impacted. If the deployment of the COOP Teams is not feasible because of the unavailability or loss of personnel, including the ; temporary leadership of the Department of Human Services, Behavioral Health Services Division will be passed to the Assistant Fiscal Manager;, as identified in Section II-J of this document.
- **Duty Hours** - If an event or incident occurs during work hours, which requires relocation of the primary facility, the COOP will be activated, and available members of the COOP Teams will be deployed as directed to support operations for the duration of the emergency. Those individuals who do not have assigned roles in the COOP, will either be sent home or possibly used to provide support to the COOP Teams, if additional assistance is required.
- **Non-Duty Hours** - The ability to contact members of the COOP Teams at all times during duty hours or non-duty hours is critical for ensuring that the COOP can be activated quickly if needed. Procedures must be in place that account for notifying and mobilizing (if necessary) the COOP Teams on extremely short notice.

*** *Section II-L of this document provides additional information and procedures to be followed based on warning conditions. Section IV-C of this document provides staff activation procedures for duty hours and non-duty hours. Annex F provides detailed instructions regarding Alert Notification Procedures for* the *Department of Human Services, Behavioral Health Services Division.*

Annex A: COOP Teams and Responsibilities

I. Planning Team

In preparation of potential continuity events, Planning Team members are responsible for scheduling and conducting continuity meetings (minimum of one meeting per year), establishing a framework for the organization's continuity plan design and strategy, reviewing the accuracy of the personnel information contained within the plan, developing an ongoing process for reviewing and updating the plan, and scheduling and participating in continuity trainings and exercises.

Planning Team – Department of Human Services, Behavioral Health Services Division

Team Member	Role Responsibilities
Marjeen Nation – Assistant Fiscal Manager **Department of Human Services, Behavioral Health Services Division** Work Phone: 801-680-0739 Work Phone: Work E-Mail: mnation@slco.org	Attending meetings, reviewing and updating, participating in training, etc.
Zac Case – Fiscal Manager **Department of Human Services, Behavioral Health Services Division** Work Phone: 801-633-0122 Work Phone: Work E-Mail: zcase@slco.org	Assisting with updating plan and training staff
Cory Westergard – Health Info Manager **Department of Human Services, Behavioral Health Services Division** Work Phone: 801-573-2584 Work Phone: Work E-Mail: cwestergard@slco.org	Assists with updating plan
Seth Teague – Program Manager **Department of Human Services, Behavioral Health Services Division** Work Phone: 951-515-6423 Work Phone: 801-680-0739 Work E-Mail: steague@slco.org	Assists with updating plan

II. Continuity Team

In preparation of potential continuity events, Continuity Team members are responsible for attending continuity meetings as scheduled, reviewing and updating organization's essential functions, developing notification cascades for key staff and personnel, participating in continuity training and exercises, and developing a plan and methodology for off-site storage of data to include vital records and databases. During a continuity event, members of the Continuity Team are responsible for executing the necessary procedures and responsibilities for re-establishing and recovering the operations of the organization's essential functions as identified in Annex C.

Continuity Team – Department of Human Services, Behavioral Health Services Division

Team Member	Role Responsibilities
Marjeen Nation– Assistant Fiscal Manager Department of Human Services, Behavioral Health Services Division Work Phone: 801-680-0739 Work Cell Phone: Work E-Mail: mnation@slco.org	Scheduling and conducting training/meetings, Reviewing and updating plan
Zac Case– Fiscal Manager Department of Human Services, Behavioral Health Services Division Work Phone: 801-633-0122 Work Cell Phone: 385-468-4729 Work E-Mail: zcase@slco.org	Attending meetings, reviewing and updating, participating in training, etc.
Cory Westergard– Health Info Manager Department of Human Services, Behavioral Health Services Division Work Phone: 801-573-2584 Work Cell Phone: 385-468-4714 Work E-Mail: cwestergard@slco.org	Attending meetings, reviewing and updating, participating in training, etc.

Annex B: Facilities

The following are primary facilities identified for Department of Human Services, Behavioral Health Services Division:

Primary Facility 1	
Behavioral Health Services **2001 S State Street, S2-300** Number of Staff: 29	**Pre-Positioned Resources** Workspaces: 29 Desktops: MANUAL Printers: 9 Land Lines: 29

Alternative Facility 1	
Telecommuting **Employee homes** Facility Manager: Work Phone: Cell Phone: Email:	**Pre-Positioned Resources** Workspaces: 1 Desktops: MANUAL Printers: 1 Land Lines: MANUAL

*Identify resources needed to continue the operation of mission-essential functions that have been pre-positioned at the alternate facility and those that will need to be transported to the facility. Examples of resources include office equipment/supplies, computers, chairs, tables, telephones, printers, and copiers

Alternate Facility Operations

The alternate facility should have pre-positioned resources to sustain operations for three days without resource support. The alternate facility will require installation of:

- Telephones
- Computers/LAN
- Fax machines
- Copiers
- Furniture

Setup of the alternate facility may require vendor and resource support to provide the labor and equipment to outfit the facility.

Memorandum of Understanding (MOU) Considerations

The will establish MOU(s) or pre-arranged contracts with Facility Managers and other organizations to provide basic support to the Department of Human Services, Behavioral Health Services Division during COOP events, including exercises, if needed.

Joint Facility Support Requirements

The or designee will be responsible for developing a coordinated support plan with the Facility Manager of the primary alternate facility. At a minimum, the plan will address the following items:

- Receiving, supporting, and relocating personnel at the alternate facility;
- Repositioning supplies and equipment at the alternate facility;
- Adequate logistical support;
- Adequate infrastructure;
- Adequate services;
- Capability of the facility to accept the COOP Teams and operations; and
- Capability of the facility to sustain COOP operations for a minimum of 30 days.

The details of the coordinated support plan will be incorporated as part of this annex.

Review and Update

The will conduct an annual review of space allocations at the alternate facility to ensure the adequacy of assigned space and other resources.

Annex C: Mission Essential Functions

MISSION ESSENTIAL FUNCTIONS

Mission-Essential functions for the Department of Human Services, Behavioral Health Services Division have been identified and prioritized below. In addition to identifying each mission-essential function, the DHS has associated the personnel resources and vital record resources required to carry out each specific function. The performance of the highest priority mission-essential functions will need to be resumed as quickly as possible.

Essential Functions for Department of Human Services, Behavioral Health Services Division

1. "MEF" - Functions to be performed with a One Day Recovery Time Objective (RTO). Functions must remain operational at all times.:
    - Communication
    - Mental Health Appeals
2. "Immediate" Post-Incident Functions to be performed with a One Day - One Week Recovery Time Objective (RTO). Functions that must be brought back online as soon as possible.:
    - Continuation of functions listed under previous Tier(s) identified above
    - Managed Care
    - Contract Payments
3. Normal" Functions to be performed with a One Week - One Month Recovery Time Objective (RTO). Functions can be restored once incident has passed.:
    - Continuation of functions listed under previous Tier(s) identified above
    - Auditing
    - RSS/Client Services

Communication

TIER: I

PRIORITY: 1

MAJOR ORGANIZATION: Department of Human Services, Behavioral Health Services Division

PRIMARY FACILITY FOR NORMAL OPERATIONS: #1 County Government Center

ALTNERATIVE FACILITIES IDENTIFIED TO SUPPORT CONTINUITY OPERATIONS:

KEY PERSONNEL REQUIRED: Tim Whalen - Director, Brian Currie - Associate Director, Zac Case-Fiscal Manager, Cory Westergard - Health Info Manager, Marjeen Nation - Assistant Fiscal Manager

ADDITIONAL PERSONNEL REQUIRED: Seth Teague - Program Manager, Jeannie Edens - Associate Director, Carl Bernardo - Case Manager, Ray Barrett - Medicaid Finance, Jodi Delaney - Quality Assurance Manager, Lindsay Bowton - Quality Assurance Manager, Anna Cervantes - RSS Manager

RESOURCE(S) REQUIRED: 12 laptop computers, 12 phone lines, communicating with ~20 contracted providers

VITAL RECORDS: E-mail

Mental Health Appeals

TIER: I

PRIORITY: 2

MAJOR ORGANIZATION:

PRIMARY FACILITY FOR NORMAL OPERATIONS: #1 County Government Center

ALTNERATIVE FACILITIES IDENTIFIED TO SUPPORT CONTINUITY OPERATIONS: #2 telecommuting

KEY PERSONNEL REQUIRED: Brian Currie - Associate Director, Lindsay Bowton - Quality Assurance Manager, Lauren Syphus - Quality Assurance Coordinator, Kelli Heaps - Quality Assurance Admin Assistant

ADDITIONAL PERSONNEL REQUIRED:

RESOURCE(S) REQUIRED: 4 laptop computers, 4 phone lines, 1 copy machine, 1 printer

VITAL RECORDS: encrypted e-mail, Microsoft Word

Managed Care

TIER: II

PRIORITY: 3

MAJOR ORGANIZATION:

PRIMARY FACILITY FOR NORMAL OPERATIONS: County Government Center

ALTNERATIVE FACILITIES IDENTIFIED TO SUPPORT CONTINUITY OPERATIONS: telecommuting

KEY PERSONNEL REQUIRED: Brian Currie - Associate Director, Lindsay Bowton - Quality Assurance Manager, Lauren Syphus - Quality Assurance Coordinator, Brad Hammel - Quality Assurance Coordinator, Jodi Delaney - Quality Assurance Manager, Vicky Westmoreland - Quality Assurance Coordinator, Karen Woodruff - Quality Assurance Coordinator, Kelli Heaps - Quality Assurance Admin Assistant

ADDITIONAL PERSONNEL REQUIRED:

RESOURCE(S) REQUIRED: 8 laptop computers, 8 phone lines, 1 copy machine, 1 printer, VPN for 8 employees

VITAL RECORDS: UWITS, Microsoft Word, Microsoft Excel

Contract Payments

TIER: II

PRIORITY: 4

MAJOR ORGANIZATION:

PRIMARY FACILITY FOR NORMAL OPERATIONS: County Government Center

ALTNERATIVE FACILITIES IDENTIFIED TO SUPPORT CONTINUITY OPERATIONS: telecommuting

KEY PERSONNEL REQUIRED: Zac Case - Fiscal Manager, Marjeen Nation - Assistant Fiscal Manager, Ray Barrett - Medicaid Finance

ADDITIONAL PERSONNEL REQUIRED: Jan Barnes - Contract and Billing Specialist, Debbie Barnes - Contract and Billing Specailist, Vonnie Fisher - Office Manager, Eve Martinez - Office Manager

RESOURCE(S) REQUIRED: 7 laptop computers, 7 phone lines, 1 copy machine, 1 printer, VPN for 7 users

VITAL RECORDS: UWITS, PeopleSoft, Microsoft Access, Microsfot Excel, UHIN

Auditing

TIER: III

PRIORITY: 5

MAJOR ORGANIZATION:

PRIMARY FACILITY FOR NORMAL OPERATIONS: County Government Center

ALTNERATIVE FACILITIES IDENTIFIED TO SUPPORT CONTINUITY OPERATIONS: telecommuting

KEY PERSONNEL REQUIRED: Jodi Delaney - Quality Assurance Manger, Vicky Westmoreland - Quality Assurance Coordinator, Karen Woodruff - Quality Assurance Coordinator, Brad Hammel - quality assurance coordinator, Marjeen Nation - Assistant Fiscal Manager, Jan Barnes - Contract and Billing Specialist, Debbie Barnes - Contract and Billing Specialist, Lindsay Bowton - Quality Assurance Manager, Lauren Syphus - quality assurance coordinator, Zac Case - Fiscal Manager, Ray Barrett - Medicaid Finance, Ted Pierce - Fiscal coordiantor

ADDITIONAL PERSONNEL REQUIRED: Brian Currie - Associate Director

RESOURCE(S) REQUIRED: 13 laptop computers, 13 phone lines, VPN for 13 employees, 1 printer, 1 copy machine

VITAL RECORDS: UWITS, Microsoft Word, Microsoft Excel, Microsoft Access

RSS/client services

TIER: III

PRIORITY: 6

MAJOR ORGANIZATION:

PRIMARY FACILITY FOR NORMAL OPERATIONS: County Government Center

ALTNERATIVE FACILITIES IDENTIFIED TO SUPPORT CONTINUITY OPERATIONS: ARS/IGS

KEY PERSONNEL REQUIRED: Anna Cervantes - RSS Manager, Chris Fiagle - Case Manager, Carl Bernardo - Case Manager

ADDITIONAL PERSONNEL REQUIRED: Seth Teague - Program Manager, Lindsay Bowton - quality assurance manager, Brian Currie - associate director

RESOURCE(S) REQUIRED: 6 laptop computers, 6 phone lines, 1 printer, 1 copy machine, 1 fax machine

VITAL RECORDS: UWITS, Microsoft Word, Microsoft Excel

Annex D: Orders of Succession

ORDERS OF SUCCESSION

The Department of Human Services, Behavioral Health Services Division has developed an Orders of Succession for all key positions held within the organization. Provided below is the title and name of each primary person currently holding each key position, followed by a list of designated successors. The successors are listed by title in order of precedence.

– Head of Organization

Primary: Tim Whalen

First:

Second:

Third:

Marjeem Nation– Additional Role

Primary: Jeannie Edens

First: Zac Case

Second: Brian Currie

Third:

Annex E: Delegation of Authority

MEMORANDUM

TO:

FROM:

DATE:

SUBJECT: Delegation of Authority

ALL AUTHORITY HEREBY DELEGATED SHALL BE EXERCISED IN ACCORDANCE WITH APPLICABLE LAWS, RULES, BUDGET ALLOCATIONS AND ADMINISTRATIVE DIRECTIVES. THIS AUTHORITY CANNOT BE RE-DELEGATED.

To ensure continuity of operations for the Department of Human Services, Behavioral Health Services Division during continuity events, the following personnel are hereby delegated the authority to conduct the following assignments provided below.

Tim Whalen
Triggering Conditions:

1. Head of Organization Authorization unavailable

Limitations:

1. Under guidance of pre-established transfer of power in the event the Tim Whalen is unavailable for any reason.

Acting Agents:

Zac Case/ Fiscal Manager

Delegated Agents:

Brian Currie/ Associate Director

Travel Authorization
Triggering Conditions:

Absence of the travel authorizing agent if the travel requirement approval must be completed prior to the known or anticipated return of the primary agent.

Limitations:

Limited to established travel restrictions/ costs as set for by the DOA and the Director's decisions and guidance.

Acting Agents:

Karen Crompton/ Director

Delegated Agents:

Leave Authorization
Triggering Conditions:

Absence of the Leave Agent when the leave decision must be made prior to the expected and anticipated return of the primary agent.

Limitations:

Limited to standard contractual limitations or union restrictions as appropriate for the requesting employee(s).

Acting Agents:

Zac Case/ Fiscal Manager

Delegated Agents:

Purchase Requisitions/Spending Authority
Triggering Conditions:

Absence of the Purchasing Authority when the purchase is critical and must be approved before the anticipated return of the Authority.

Limitations:

Limitation are concurrent with established purchasing organization rules: ie, MPA list used; amount limitation; bids, etc.

Acting Agents:

Zac Case/ Fiscal Manager

Delegated Agents:

Execution of Contractual Agreements
Triggering Conditions:

When the Contracting agent is absent, and the current request is needed before the expected / anticipated return of the primary agent.

Limitations:

Limited by standard operationally used contracting procedures.

Acting Agents:

Brian Currie/ Associate Director

Delegated Agents:

Jeannie Edens/ Associate Director, Zac Case / Fiscal Manager, /

Communications
Triggering Conditions:

When the main communications agent is absent, and the current request is needed before the expected / anticipated return of the primary agent.

Limitations:

Limited by authority to speak on behalf of the organization.

Acting Agents:

Brian Currie/ Associate Director

Delegated Agents:

_____

Authorized Signature
Department of Human Services, Behavioral Health Services Division

ALERT NOTIFICATION PROCEDURES

The will notify the Continuity Team Chief to activate the continuity plan. Upon notification to activate the continuity plan, the Continuity Team Chief will perform the following duties:

- Contact the key staff members identified within this annex, informing them of the current situation and that the continuity plan is being activated.
- For facility related activations, notify the Alternate Facility Manager of the appropriate alternate facility regarding the activation of the continuity plan.
- As needed, notify the Salt Lake County Emergency Coordination Center that an emergency activation or anticipated activation of the continuity plan is expected or in progress.
- Report the progress of the notification process to the

Once the continuity plan is activated, the key staff members will contact their staffs using the following procedures:

- Attempt to call each person in his or her chain-of-command to relay the information and guidance provided by the Continuity Team Chief.
- Make a second attempt to contact those individuals who were not initially available. If this attempt is unsuccessful, the key staff members will leave a message, send a text, or use any other method of communications available to make contact.
- Report status of cascade, including names of personnel not contacted, to the Continuity Team Chief.

KEY STAFF NOTIFICATION LIST

NAME/ORGANIZATION	PHONE NUMBERS	E-MAIL ADDRESS
See directory		

Annex G: Vital Records

Vital Records

The following checklist can be used when determining which vital records are critical to ensure continuation of mission-essential functions:

- Storage of duplicate records off-site.
- Back-up off-site of electronic records and databases.
- Pre-position vital records and databases at the alternate facility prior to deployment.
- The COOP should describe a maintenance program to assure the records are accurate, current, and frequently updated.
- Identifying vital records, systems, and data (hard copy and electronic) critical to performing functions.
- Assuring availability of emergency operating records.
- Ensuring back-up for legal and financial records.

Additional Recommendations

Ensure backup copies of vital records and databases, both paper and electronic, are maintained, updated, and stored in a secure off-site location. The COOP identifies vital records, systems, and data (hard copy and electronic) critical to performing mission-essential functions. The COOP provides for ensuring availability of emergency operating records and ensuring back-up for legal and financial records. The Department of Human Services, Behavioral Health Services Division will maintain current copies of vital records essential to the continued functioning or reconstitution in a secure off-site location.

Included within the COOP are records having such value that their loss would significantly impair the Department of Human Services, Behavioral Health Services Division of conducting mission-essential functions, to the detriment of the legal or financial rights or entitlements of the organization or of the affected individuals. Examples of this category of vital records are:

- Accounts receivable/Accounts payable
- Contracting and acquisition files
- Official personnel files
- Social security documentation
- Payroll
- Retirement
- Insurance records
- Property management and inventory records

The following identifies Vital Records required by Department of Human Services, Behavioral Health Services Division to complete mission-essential functions:

Vital Record: UWITS

Type: UWITS

Description: Electronic health care record

Plans for Protection, Duplication, Movement of Records: Solution is webbased, housed in Maryland and backup in Virginia, HIPAA and 42 CFR protected

Location and Accessibility of Vital Records:

Primary Location: Online

Format: Electronic

Secondary Location:

Format:

Remote Accessibility: Yes

Accuracy of Records:

Date of Last Update: 3/11/2020

Vital Record: PeopleSoft/MyFin

Type: PeopleSoft/MyFin

Description: County timekeeping and finance systems

Plans for Protection, Duplication, Movement of Records: Mayor's finance

Location and Accessibility of Vital Records:

Primary Location: Government Center

Format: Electronic

Secondary Location:

Format:

Remote Accessibility: Yes

Accuracy of Records:

Date of Last Update: 3/11/2020

Vital Record: Encrypted Email

Type: Encrypted Email

Description: secured sending and receiving of HIPAA and 42 CFR information

Plans for Protection, Duplication, Movement of Records:

Location and Accessibility of Vital Records:

Primary Location:

Format: Electronic

Secondary Location:

Format:

Remote Accessibility: Yes

Accuracy of Records:

Date of Last Update:

Vital Record: Microsoft Word, Excel and Access

Type: Microsoft Word, Excel and Access

Description: multiple word, excel and access files most are HIPAA and 42 CFR protected

Plans for Protection, Duplication, Movement of Records:

Location and Accessibility of Vital Records:

Primary Location:

Format: Electronic

Secondary Location:

Format:

Remote Accessibility: Yes

Accuracy of Records:

Date of Last Update:

Legend

Vital records, systems, and data - Information, records, databases, procedures, and other information necessary to support mission-essential functions and sustain operations.

Protection, duplication, and movement - Identify policies in place to restrict how the information is guarded, procedures for duplication, how the information is backed-up and stored, and how the material is distributed.

Location - Where are the vital records/systems/data currently located? Where are the back-up records/systems/data located? Are records in electronic or hard copy format? Can records be accessed from an alternate site if the primary site is inaccessible?

Accuracy and currency of records - Are records up to date? On what date was the records/systems/data last reviewed/updated?

Annex H: Communications

COMMUNICATIONS

The ability to communicate with internal and external resources during COOP events will be vital to the operations of the Department of Human Services, Behavioral Health Services Division. Internal and external resources could include Department of Human Services, Behavioral Health Services Division. staff, partner organizations, emergency responders, vendors, the media, and/or the public. The Department of Human Services, Behavioral Health Services Division has identified below the various modes of communication that currently exist and/or communications that must be arranged at an Alternate Facility. The communications are listed in order of priority and include a written description for each. Also, each communication item identifies whether the communication is for internal/external use, mobile, or if it requires any level of security measures.

COMMUNICATIONS		
Communication: Internet		
Priority: High	**Type:** Data	**Quantity:** 29
Description: Internal Use, External Use, Mobile, Secure Century Link is provider.		
Communication: Cell Phone		
Priority: High	**Type:** Voice	**Quantity: 8**
Description: Internal Use, External Use, Mobile, Secure. Verizon Wireless is provider.		
Communication: E-mail		
Priority: High	**Type:** Data	**Quantity: 29**
Description: Internal Use, External Use, Mobile, Secure. Century Link is provider.		
Communication: Landline		
Priority: High	**Type:** Voice	**Quantity: 29**
Description: Internal Use, External Use. Century Link is provider.		

Annex I: Devolution

DEVOLUTION Department of Human Services, Behavioral Health Services Division

Devolution is the capability to transfer statutory authority and responsibility for mission-essential functions from an organization's primary operating staff and facilities to another organization's employees and facilities. Devolution planning supports overall COOP planning and addresses catastrophic or other disasters that render an organization's leadership and staff unavailable or incapable of performing its mission-essential functions from either its primary or alternate facilities.

If devolution is necessary, prioritized mission-essential functions are transferred to a preidentified devolution organization. Direction and control of mission-essential functions is transferred to the devolution organization site and/or identified personnel.

Devolution planning involves several special issues:

- Personnel at the devolution site must be trained to perform the essential functions to the same level of proficiency as the Department of Human Services, Behavioral Health Services Division personnel.
- Vital records, documents, and databases must be up to date and available at the devolution site.
- Communications and information management systems must be able to be transferred to the devolution site.
- Delegations of authority planning must include senior personnel at the devolution site.

Department of Human Services, Behavioral Health Services Division prioritized mission-essential functions which must be carried out in its devolution of authority are identified in Annex C of the Department of Human Services, Behavioral Health Services Division COOP.

The pre-identified devolution organization(s) for the Department of Human Services, Behavioral Health Services Division are Department of Human Services, Behavioral Health Services Division. Devolution Triggers, Process, Resources and their Availability, and Restoration guidelines are noted below. The preidentified Devolution Memorandum is also included within this Annex.

Devolution Triggers

Pre-devolution preparation begins when staffing levels in one or more critical areas are reduced by 40%. Critical areas are defined as: 1) leadership, 2) communication capabilities, 3) administrative support, and 4) prioritized MEFs. Pre-devolution preparation includes assessment of:

- Available devolution organizations
- Location and availability of resources and information needed to transfer critical operations to the devolution organization
- Approach to notify and train (as needed) devolution organization staff
- Prioritization of mission-essential functions necessary to provide continuity of government during the devolution process

Once this assessment is complete, the intended devolution organization should be notified that devolution is likely and transfer of knowledge/resources necessary for devolution should begin.

The key staff members of the devolution organization should also be informed on how to access the Department of Human Services, Behavioral Health Services Division COOP information contained within COOP SharePoint and the SLCo. Emergency Coordination Center.

Devolution is initiated through the issuance of the Devolution Memorandum. Organizational devolution is triggered when staffing levels are reduced by 60% in one or more critical areas.

Devolution Process

The Department of Human Services, Behavioral Health Services Division is responsible for identifying devolution triggers and is responsible for deciding when devolution is necessary. The Department of Human Services, Behavioral Health Services Division is responsible for issuing the Devolution Memorandum and begin actually transferring responsibilities to the devolution organization.

Every attempt will be made to retain expertise and authority through all COOP Teams. All available COOP Teams will continue to work with and for the new devolution organization in carrying out COOP, devolution, and restoration/reconstitution duties.

Resources and Availability

All resources necessary for devolution will be retained at Department of Human Services, Behavioral Health Services Division primary facility, on the COOP SharePoint, and at SLCo. Emergency Coordination Center. The executives and support staff working on devolution will be given access to these resources and will be trained in the use of available communication tools in advance of COOP activations.

Restoration (Pre-Event)

Because the nature of a catastrophic event that would create the need for devolution is so difficult to predict and may have a wide array of circumstances to respond to, we cannot specify exact measures needed to recover and restore pre-event operations in advance. However, the devolution organization will work with the existing Department of Human Services, Behavioral Health Services Division staff to identify all actions needed to provide restoration to pre-event conditions. Reconstitution and termination plan as identified in the COOP are available and should be used by the devolution organization.

MEMORANDUM

TO: Highest Ranking Official(s)/

FROM: , Department of Human Services, Behavioral Health Services Division

DATE:

SUBJECT: Devolution of Department of Human Services, Behavioral Health Services Division

As of Date/Time, an emergency occurred that required the activation of the Department of Human Services, Behavioral Health Services Division Continuity of Operations Plan (COOP). As of Date/Time, the emergency has affected staffing to levels such that we can no longer carry out our prioritized mission-essential functions and maintain our mandated operations. In order to provide continuity of government operations within Department of Human Services, Behavioral Health Services Division, as of Time today I am hereby transferring mission-essential function responsibilities as identified in the Department of Human Services, Behavioral Health Services Division COOP to the Department of Human Services, Behavioral Health Services Division. In addition, I am extending all delegations of authority of key actions and responsibilities to the Department of Human Services, Behavioral Health Services Division. This delegation is effective as of Date/Time.

Thank you in advance for your assistance as we continue to provide critical services during this challenging time and work to restore full Department of Human Services, Behavioral Health Services Division operations. Access to all critical Department of Human Services, Behavioral Health Services Division COOP information, including mission-essential functions, delegation responsibilities, and personnel contact lists can be found at: Salt Lake County COOP SharePoint and physically at the Salt Lake County Emergency Coordination Center.

_____

Tim Whalen,

Annex J: Review, Training, Exercise, and Update

REVIEW, TRAINING, EXERCISES, AND UPDATE

- This plan will be reviewed annually or as required by statute by all CONTINUITY OF OPERATIONS PLAN Team members and approved by the .
- The ensure training of all Department of Human Services, Behavioral Health Services Division employees on the key aspects of this plan. This training will be conducted at new employee orientation and quarterly staff meetings.
- This CONTINUITY OF OPERATIONS PLAN will be assessed annually through a discussion-based and operations-exercise, with notification and reporting submitted to Salt Lake County Division of Emergency Management.
- Support plans and communications equipment will be tested annually as part of the Review, Training, Exercises, and Update.
- Equipment pre-positioned at Alternate Facilities will be tested annually as part of the Review, Training, Exercises, and Update program.
- The exercise will include a test of the alert and notification procedures within this CONTINUITY OF OPERATIONS PLAN, with and without warning, during duty and nonduty hours.
- The or designee will identify and incorporate lessons learned and remedial actions from exercises or actual events into annual revisions of this CONTINUITY OF OPERATIONS PLAN
- Copies of AAR (After Action Review) reports will be placed in the File Archive of this system. The Department of Human Services, Behavioral Health Services Division documents the past, present, and future events that support their Test, Training, and Exercise program for their CONTINUITY OF OPERATIONS PLAN.

Salt Lake County

Pandemic-Specific Continuity of Operations Annex

Department of Human Services, Behavioral Health Services Division

Updated March 20th, 2020

SALT LAKE COUNTY

In accordance with Utah Code § 63G-2-305(48), this document is held by a Division of Emergency Management and the information contained within this document is a protected record intended only for the use of those individuals and agencies to which this document is issued. It is being shared pursuant to the requirements and obligations of Utah Code § 63G-2-206.

This document may also be exempt from disclosure pursuant to Utah Code § 63G-2-106.

I. INTRODUCTION

Department of Human Services, Behavioral Health Services Division, on behalf of Salt Lake County Government (hereafter referred to as "SLCo"), performs essential functions and services that may be adversely affected in the event of a natural or human-caused disaster. In such events, Department of Human Services, Behavioral Health Services Division needs to have continuity plans to assist in the continuance of their essential functions. Continuing to perform essential functions and provide essential services is vital to their ability to remain a viable entity during times of increased threats from all hazards; whether natural and human-caused. Since the threat to Department of Human Services, Behavioral Health Services Division continuity of operations is heightened during any type of pandemic outbreak, it is important for organizations; particularly emergency management and public safety organizations and agencies, to have a Pandemic-Specific Continuity of Operations (COOP) Annex in place to ensure they can carry out their essential functions and services. While Department of Human Services, Behavioral Health Services Division may be forced to suspend some operations due to the severity of pandemic outbreaks; as observed with the COVID-19 outbreak, an effective Pandemic-Specific COOP Annex can assist Department of Human Services, Behavioral Health Services Division to remain operational as well as strengthen their ability to resume operations upon endemic resolution.

A. Purpose

This annex provides guidance to SLCo government and serves as the plan for maintaining essential functions and services of Department of Human Services, Behavioral Health Services Division during a pandemic outbreak; such as COVID-19, in Salt Lake County.

The guidance in this annex stresses that essential functions can be maintained during the pandemic outbreak through mitigation strategies, such as increased hygiene, vaccinations of staff and families, social distancing, and similar approaches. Continuity operations in a pandemic outbreak may not require the traditional level of service and/or continuance of certain essential functions (as would otherwise be the case in a partial or full relocation of the organization's essential functions due to inaccessibility of primary facilities). Although this response may be concurrently necessary due to other extenuating circumstances, a pandemic outbreak may result in the need to either partially or fully devolve control and direction where it wouldn't be necessary in a typical all-hazards COOP plan.

B. Relationship to COOP Planning Initiatives

The guidance provided in Department of Human Services, Behavioral Health Services Division's Pandemic-Specific COOP Annex neither replaces nor supersedes the current, approved SLCo Government continuity plan for Department of Human Services, Behavioral Health Services Division but rather supplements it; bridging the gap between traditional, all-hazards continuity planning and the specialized continuity planning required for pandemic outbreaks. This is accomplished by addressing additional considerations, challenges, caveats and elements specific to the dynamic nature of a pandemic outbreak.

Department of Human Services, Behavioral Health Services Division's Pandemic-Specific COOP Annex should be read in conjunction with Department of Human Services, Behavioral Health Services Division's Base COOP Plan. It supplements the Base COOP plan by addressing considerations and planning assumptions specific to pandemic outbreaks.

II. ASSUMPTIONS

The following assumptions are inferred in the development of this annex for the COVID-19 Pandemic:

A. Pandemic Planning Assumptions

- Susceptibility to a pandemic virus will be universal.
- Efficient and sustained person-to-person transmission is ongoing.
- The clinical disease attack rate will likely be 30 percent or higher in the overall population during the COVID-19 pandemic.
- Illness rates may be higher among vulnerable populations, specifically older populations with existing co-morbidities such as COPD, cardiac conditions, acute hypertension, renal failure, smokers, and populations with compromised immune systems
- Rates of absenteeism will depend on the severity and cascading impact of the pandemic. In a severe pandemic, absenteeism may be attributed to several factors; including illness, the need to care for ill family members, self-imposed isolation, and/or the fear of infection.
- Absenteeism rates may reach 40 percent during peak weeks of a community outbreak, with lower rates of absenteeism prior to and following peak weeks.
- Certain public health measures are likely to increase rates of absenteeism.
- Some persons may become infected but not develop clinically significant symptoms. For COVID-19 to date, children and adults below the age of 65 are showing the fewest indications of clinical disease. Most who have been exposed to COVID-19 in these demographics are recovering without additional sequala.
- Asymptomatic or minimally symptomatic individuals can transmit infection and develop immunity to subsequent infection. This may prove to make previous epidemic and pandemic concepts including containment and quarantine only marginally effective enough measures to cease transmission.
- While the number of patients seeking medical care cannot be predicted with certainty, in previous pandemics (i.e., influenza), about half of those who become ill sought care. Without the availability of effective antiviral drugs for treatment, this proportion may be lower in the COVID-19 pandemic outbreak.
- Rates of serious illness, hospitalization, and deaths will depend on the virulence of the virus and differ in order of magnitude between more and less severe scenarios. Risk groups for severe and fatal infection cannot be predicted with certainty.
- Incubation periods (intervals between infection and onset of symptoms) have ranged widely with the COVID-19 virus, from two days to fourteen days and beyond.
- Persons who become ill may shed virus and can transmit infection before the onset of symptoms.
- The period of outbreak may last weeks to months.

B. Organizational Assumptions

- Department of Human Services, Behavioral Health Services Division will be provided with guidance and/or direction by federal, state, and SLCo government public health agencies regarding current pandemic status in the area.
- Department of Human Services, Behavioral Health Services Division will have actionable plans and procedures to assist in their ability to remain operational during the pandemic. Plans and procedures may include (but not limited to) hygiene recommendations, telework, staggering of work hours, re-assignment in an emergency response role, social distancing, use of personal protection equipment (PPE), and temporary suspension of some non-essential activities.

- Direction on mitigation of transmission will be provided under a unified communications strategy between the SLCo Mayor, Director of SLCo Public Health Department, and Chief of SLCo EM.
- Department of Human Services, Behavioral Health Services Division has viable organization-wide continuity capabilities, and an executable Base COOP Plan.
- Department of Human Services, Behavioral Health Services Division has and will review its viable organization-wide continuity capabilities to ensure that they are fully capable of supporting the response requirements of a pandemic outbreak, and consider supporting telework, virtual working options, and social distancing operations to facilitate disease transmission reduction.
- Department of Human Services, Behavioral Health Services Division's facilities may be accessible, but right of entry may be limited during the pandemic period to facilitate disease transmission reduction to mission essential personnel and minimize overall community spread.
- Department of Human Services, Behavioral Health Services Division may choose to deploy to alternate facilities (including telework options) to enhance virus exposure protection for mission essential personnel.
- During a COOP event, SLCo Government may make its alternate facilities which remain available to staff, implement pandemic COOP protocols.
- Department of Human Services, Behavioral Health Services Division's essential functions, operations, and support requirements may be people-dependent; however, human interactions may be limited, remote, or virtual, resulting in the employment of appropriate teleworking, remote meeting, and other approved social distancing protocols.
- Travel restrictions, such as limited travel, may affect the ability of some staff to report to work.
- Type of employment and start date may affect the ability of employees to be compensated.

C. County-Level Assumptions

- As with previous planning for incidents of national significance, responsibility for a domestic pandemic response will rest primarily with local, state, and tribal authorities, mandating an optimum level of readiness at the county-level where responsibility will be accepted and leadership demonstrated.
- A pandemic will increase the likelihood of sudden and potentially significant gaps in public service and safety for SLCo.
- A severe pandemic may overwhelm existing healthcare capabilities and capacity within the county and result in an increased number of deaths.
- The Office of the Mayor can increase the response posture of the SLCo EM Emergency Coordination Center (ECC) at any time.
- Under certain scenarios, some of the usual functions of the SLCo Government and the SLCo EM will be significantly reduced or suspended in order to "surge support" and accomplish essential pandemic functions and critical public health and safety responsibilities associated with the response.
- Increased public anxiety within the SLCo community will cause increased psychogenic and stress-related illness among the citizens, compounding the strain on health care facilities and staff.
- Special needs populations within SLCo (including, but not limited to, geriatric populations that are homebound or in nursing homes; those with existing chronic medical conditions; mental health patients; alcohol and drug dependent persons; correctional facility inmates; individuals with language barriers; and the vulnerable populations) will not only require additional planning considerations to ensure they are being accommodated, but in the specific case of COVID-19, they represent the most at-risk populations in our county community, and will likely suffer far higher degrees of morbidity and mortality if left unaccommodated.
- A significant number of non-U.S. citizens as well as uninsured citizens within the county will require medical and public health intervention.

III. CONCEPTS OF OPERATIONS

The Concept of Operations (ConOps) is supported by four components, consisting of: (1) Programs, Plans, and Procedures, (2) Risk Management, (3) Budgeting and Acquisitions, and (4) Pandemic Continuity Planning Operational Phases and Implementation.

A. Programs, Plans, and Procedures

Department of Human Services, Behavioral Health Services Division will develop and maintain continuity plans and procedures that, when implemented, support the continued performance of essential functions under all circumstances.

SLCo government, and its principal emergency response agency, the SLCo EM, will immediately provide the incident management response to pandemic outbreaks. It will engage in all available strategies in an attempt to delay and deter the introduction of a virus into the community. SLCo will provide assistance to public safety organizations and agencies across the spectrum of the first responder and first receiver communities to help them maximize their preparedness capacity and understand their roles in a pandemic incident management mission.

B. Risk Management

Risk Management is the process of identifying, assessing, and prioritizing the potential negative effects of uncertain events (risks) and applying resources to monitor, control, or minimize those negative effects. A risk management program supports the viable continuity capabilities by identifying risks to the continued performance of essential functions and suggesting strategies to mitigate those risks.

Risk management strategies during a pandemic outbreak introduce modifications to the Base COOP plan for Department of Human Services, Behavioral Health Services Division to determine necessary adjustments of essential functions in order to maximize employee and public safety. These strategies might include implementation of limited, modified or relinquished staff and/or public access to facilities as well as the introduction of other techniques to minimize staff overlap at facilities; including staggered hours, social distancing and re-designed workspaces allowing at least 6 feet apart.

Recognizing that the healthcare and public health infrastructure of SLCo will bear the preponderant load in managing any pandemic outbreak, SLCo EM will prioritize that portion of SLCo health-related critical infrastructure and key resource (CI/KR) to ensure stability and sustained continuity of operations. Finally, SLCo government and SLCo EM will assist other state and local authorities in the development of comprehensive and collaborative strategies for the collective management of a pandemic outbreak.

C. Budgeting and Acquisitions

To support the continuity program, it is necessary to align and allocate budget resources. Through the budgeting and planning process, Department of Human Services, Behavioral Health Services Division's leaders can ensure that critical resources are available to support essential functions before, during, and after a continuity event. During a pandemic outbreak and, especially when extended periods of heightened absenteeism are observed or expected, fiscally conservative measures might need to be taken by Department of Human Services, Behavioral Health Services Division as guided by SLCo government leadership.

These measures might include decreasing the level of services for certain essential functions as well as placing other essential functions on hold temporarily. Additionally, considerations for staffing levels will need to be made to mirror the decrease in level of services and overall functions being provided by Department of Human Services, Behavioral Health Services Division.

D. Pandemic Continuity Planning Operational Phases and Implementation

Department of Human Services, Behavioral Health Services Division's leadership, through activation of the COOP Continuity Team, should be prepared to review their COOP plans in an emergency or disaster as it unfolds, make decisions about how to react to it at each stage, and then implement those decisions that are deemed the best course of action and integrate implementation procedures and criteria into continuity plans. Department of Human Services, Behavioral Health Services Division's Base COOP plan addresses four phases: (I) readiness and preparedness, (II) activation and relocation, (III) continuity of operations, and (IV) reconstitution.

While Department of Human Services, Behavioral Health Services Division will refer to its COOP Plan for implementation procedures across these four phases, SLCo will consider the following implementation procedures in the context of a pandemic outbreak:

Readiness and Preparedness in a Pandemic

Department of Human Services, Behavioral Health Services Division's COOP Planning team reviews this Pandemic-Specific COOP Annex on at least an annual basis. In preparation for pandemic outbreaks, a number of caveats and modifications to each of the essential functions from the Base COOP plan have been identified and documented later in this annex.

Department of Human Services, Behavioral Health Services Division's COOP Planning team shall explore needed interagency agreements, MOUs, and other pre-agreed upon contractual scopes of work necessary for a partial and/or total devolution of direction and control during a pandemic outbreak that, due to potential heightened absenteeism, would not depend as much on an alternate facility as on an alternate workforce.

Activation of Continuity Plans in a Pandemic

Upon the declaration of a pandemic by the World Health Organization (WHO) and/or a declaration by a public health emergency by the SLCo Director of Public Health, Department of Human Services, Behavioral Health Services Division shall immediately activate this Pandemic-Specific COOP Plan as well as all members of the COOP Continuity Team.

Continuity of Operations during a Pandemic

Department of Human Services, Behavioral Health Services Division shall maintain the essential functions outlined in their Base COOP plan during a pandemic outbreak with any pre-determined modifications to that plan identified within this annex. Decisions related to essential functions will need to be made by members of the COOP Continuity Team as well as reinforced by the Office of the Mayor. For this reason, it is essential to ensure the membership of the COOP Continuity Team includes those responsible for such decisions as well as liaising authority with the Office of the Mayor.

Reconstitution after a Pandemic Outbreak

The reconstitution process begins when Department of Human Services, Behavioral Health Services Division has regained the capability and physical resources necessary to return to normal (pre-pandemic) operations. The

objective during reconstitution is to effectively manage, control, and, with safety in mind, expedite the return to normal operations. Department of Human Services, Behavioral Health Services Division has developed reconstitution plans and procedures for each of the essential functions and in conjunction with local public health authorities, to ensure facilities/buildings are safe to return for both staff and public access.

Department of Human Services, Behavioral Health Services Division's reconstitution plan considers the possibility that not all employees may be able to return to work at the time of reconstitution. It may be necessary to either maintain or implement reconstitution strategies such as staggered hours, social distancing or limited or no access for a period of time for both staff and public and, in some cases hire temporary or permanent workers in order to complete the reconstitution process if absenteeism rates continue.

IV. ELEMENTS OF VIABLE CONTINUITY CAPABILITIES IN A PANDEMIC

The ten elements of Viable Continuity Capabilities in continuity planning in this Pandemic-Specific COOP Plan outline special actions or deviations when responding to a pandemic outbreak as compared to responding to other hazards; including earthquakes, fires, and floods. These continuity capabilities can be broken down as either organization-wide or essential mission-specific.

A. Organization-Wide Continuity Capabilities

Orders of Succession

Pandemic outbreaks may affect Salt Lake County differently than other regions in the United States in terms of timing, severity, and duration. Due to increased potential for extended absences of key personnel and to help assure continuity of operations over an extended period, the Department of Human Services, Behavioral Health Services Division has identified the following caveats to orders of succession during a pandemic outbreak:

No changes expected upon activation of Pandemic-Specific COOP Plan

Delegation of Authority

At the height of a pandemic outbreak, absenteeism may be significant. Due to increased potential for extended absences of delegated authorities for each of key areas of operations: *Head of Organization Authorization*, *Travel Authorization*, *Leave Authorization*, *Purchase Requisitions / Spending Authorization*, and *Execution of Contracts*. The Department of Human Services, Behavioral Health Services Division has established the following caveats during a pandemic outbreak to established delegations of authority in each of the following key operational areas over an extended period:

Head of Organization Authorization

The COOP planning team expects no changes to this essential function upon activation of Pandemic-Specific COOP Plan

Guidance will be provided by agency heads to authorize digital signatures and approvals when wet signatures are normally required

Travel Authorization

The COOP planning team expects no changes to this essential function upon activation of Pandemic-Specific COOP Plan

Guidance will be provided by agency heads to authorize digital signatures and approvals when wet signatures are normally required

Leave Authorization

The COOP planning team expects no changes to this essential function upon activation of Pandemic-Specific COOP Plan

Guidance will be provided by agency heads to authorize digital signatures and approvals when wet signatures are normally required

Purchase Requisitions / Spending Authorization

The COOP planning team expects no changes to this essential function upon activation of Pandemic-Specific COOP Plan

Guidance will be provided by agency heads to authorize digital signatures and approvals when wet signatures are normally required

Execution of Contracts Authorization

The COOP planning team expects no changes to this essential function upon activation of Pandemic-Specific COOP Plan

Guidance will be provided by agency heads to authorize digital signatures and approvals when wet signatures are normally required

Human Resources

Although a pandemic outbreak may not directly affect physical infrastructure of an organization, a pandemic will ultimately threaten all operations by its impact on an organization's human resources. The public health threat to personnel is the primary threat to maintaining essential functions and services during a pandemic outbreak

Review, Training, Exercise, and Updates

Review, training, exercise and updating this annex is essential to assessing, demonstrating, and improving an organization's ability to maintain its essential function and services. The Department of Human Services, Behavioral Health Services Division will conduct a COOP review, training, exercise series (a discussion-based exercise for organization management, and an operations-based drill), and update their plan and annex based off exercise findings on an annual basis. Additionally, the caveat for review, training, exercise and updates for continuity of operations in a pandemic applies:

The COOP Planning Group for Department of Human Services, Behavioral Health Services Division shall review the Pandemic-Specific Continuity of Operations Annex on an annual basis for accurate information and need to revise/update as needed.

The COOP Planning Group for Department of Human Services, Behavioral Health Services Division shall provide training to essential staff of the Pandemic-Specific Continuity of Operations Annex on an annual basis.

The Pandemic-Specific Continuity of Operations Annex shall be used as a primary document to validate in a discussion-based exercise and an operations-based drill every other year for Department of Human Services, Behavioral Health Services Division, in tandem with a more traditional, physical hazard continuity exercise series.

Department of Human Services, Behavioral Health Services Division shall provide a reviewed and updated Pandemic- Specific Continuity of Operations Annex to Salt Lake County Division of Emergency Management by March 31 of every year for final review of changes and storage of annex in paper and electronic form.

B. Essential Function-Centric Continuity Capabilities Overview

The following Viable Continuity Capabilities are considered essential function-specific and might vary for each essential function identified and prioritized in the base COOP Plan. General pandemic- specific considerations for each capability are detailed as follows:

Essential Functions

Given the expected duration and cascading impact(s) from pandemic outbreaks, organizations need to consider processes in carrying out essential functions and services in order to develop plans that mitigate the effects of the pandemic while simultaneously allowing for the continuation of operations which support essential functions.

Facility Guidelines (Primary and Alternate Continuity Facilities)

The traditional use of primary and alternate continuity facilitates to maintain essential functions and services may not be a viable option during a pandemic. Rather, safe work practices, which may include telework, staggered work hours, or social distancing, reduce the likelihood on contacts with other people that could lead to viral transmission. Department of Human Services, Behavioral Health Services Division have identified procedures, including those stated above along with hygiene etiquette and postponement/cancellation of non-essential activities to reduce the spread of a pandemic (identified in Appendix B).

Continuity Communications

Workplace risk of contraction and transmission may be minimized through implementation of systems and technologies that facilitate communication without person-to-person contact.

Vital Records Management

Department of Human Services, Behavioral Health Services Division shall identify, protect, and ensure the availability of electronic and hardcopy documents, references, records, and information systems needed to support essential functions during a pandemic.

Devolution of Control and Direction

Devolution is the process of transferring operational control of one or more essential functions to a pre-determined alternate agency or third-party. Pandemic outbreaks will occur at different times, have variable durations, and may differ in severity. Therefore, full or partial devolution of essential functions may be necessary to continue essential functions and services.

Reconstitution

Reconstitution is the process whereby an organization has regained the capabilities and resources necessary to return to normal (pre-disaster) operations. The objective during reconstitution is to effectively manage, control, and, with safety and precaution in mind, expedite the return to normal operations.

V. ESSENTIAL FUNCTION PANDEMIC-SPECIFIC MODIFICATIONS

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following modifications for each essential function when responding to a pandemic outbreak for all essential functions identified in the base COOP Plan. All modifications would be reinforced by guidelines from the agency head and the COOP continuity team:

Communication

A. Priority Ranking

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **maintain the priority ranking** of this essential function during a pandemic outbreak.

B. Level of Services

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **maintain the level of services** of this essential function during a pandemic outbreak.

Telework Capability:

The Department of Human Services, Behavioral Health Services Division's COOP planning team expects to have **no limitations to telework capability (100% remote capability)** for this essential function during a pandemic outbreak.

NOTE: Telework guidance will be made by the agency head and COOP continuity team based on Salt Lake County human resource policies once the Pandemic-Specific COOP Plan has been activated.

C. Facility Guideline Caveats

Staff Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for staff access to facilities for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected to facility access and usage for this essential function

Public Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for public access to facilities for this essential function during a pandemic outbreak.

The COOP planning team has identified that no changes are expected to public facility access and usage for this essential function

Continuity Communications Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified

the following caveats for continuity communications for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes for phone, email or remote-meeting communication methods are expected for this essential function based on current utilization of remote-capable communication methods.

Vital Records Management Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for vital records management for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function based on either no vital records needed or remote input and maintenance of necessary records.

The input of the vital records can be placed on hold: **Yes / Less than 1 week**

The maintenance of the vital records can be placed on hold: **No**

Devolution of Control and Direction Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for devolution of control and direction for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function

Partial transfer: **Yes / Less than 25% / A contracted third-party / Network providers and Optum**

Reconstitution Caveats

Staff Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of staff access to support this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that no changes are expected to occur based on either no modifications to facility usage / access and/or pre-existing remote staff arrangements.

Social Distancing: **Yes / 1 week or less**

Essential Staff Access Only**: Yes / 1 week or less**

No Staff Access: **Yes / 1 week or less**

Limited or Isolated Staff Access: **Yes / 1 week or less**

Public Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of public access for this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that NO changes are expected to occur for PUBLIC ACCESS to facilities based on either no modifications to facility usage / access and/or no pre-existing public access to the facility(ies)

A. Priority Ranking

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **maintain the priority ranking** of this essential function during a pandemic outbreak.

B. Level of Services

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **maintain the level of services** of this essential function during a pandemic outbreak.

Telework Capability:

The Department of Human Services, Behavioral Health Services Division's COOP planning team expects to have **no limitations to telework capability (100% remote capability)** for this essential function during a pandemic outbreak.

NOTE: Telework guidance will be made by the agency head and COOP continuity team based on Salt Lake County human resource policies once the Pandemic-Specific COOP Plan has been activated.

C. Facility Guideline Caveats

Staff Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for staff access to facilities for this essential function during a pandemic outbreak:

The COOP planning team has identified that social distancing policies; to include workspace re-designs that allow for at least 6 feet between persons, will be utilized to support this essential function

Public Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for public access to facilities for this essential function during a pandemic outbreak.

The COOP planning team has identified that no changes are expected to public facility access and usage for this essential function

Continuity Communications Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for continuity communications for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes for phone, email or remote-meeting communication methods are expected for this essential function based on current utilization of remote-capable communication methods.

Vital Records Management Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for vital records management for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function based on either no vital records needed or remote input and maintenance of necessary records.

The input of the vital records can be placed on hold: **No**

The maintenance of the vital records can be placed on hold: **No**

Devolution of Control and Direction Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for devolution of control and direction for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function

Reconstitution Caveats

Staff Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of staff access to support this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that no changes are expected to occur based on either no modifications to facility usage / access and/or pre-existing remote staff arrangements.

Social Distancing: **Yes / 1 week or less**

Essential Staff Access Only: **No**

No Staff Access: **No**

Limited or Isolated Staff Access: **No**

Public Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of public access for this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that NO changes are expected to occur for PUBLIC ACCESS to facilities based on either no modifications to facility usage / access and/or no pre-existing public access to the facility(ies)

A. Priority Ranking

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **maintain the priority ranking** of this essential function during a pandemic outbreak.

B. Level of Services

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **maintain the level of services** of this essential function during a pandemic outbreak.

Telework Capability:

The Department of Human Services, Behavioral Health Services Division's COOP planning team expects to have **no limitations to telework capability (100% remote capability)** for this essential function during a pandemic outbreak.

NOTE: Telework guidance will be made by the agency head and COOP continuity team based on Salt Lake County human resource policies once the Pandemic-Specific COOP Plan has been activated.

C. Facility Guideline Caveats

Staff Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for staff access to facilities for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected to facility access and usage for this essential function

Public Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for public access to facilities for this essential function during a pandemic outbreak.

The COOP planning team has identified that no changes are expected to public facility access and usage for this essential function

Continuity Communications Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for continuity communications for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes for phone, email or remote-meeting communication methods are expected for this essential function based on current utilization of remote-capable communication methods.

Vital Records Management Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for vital records management for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function based on either no vital records needed or remote input and maintenance of necessary records.

The input of the vital records can be placed on hold: **Yes / 2 weeks-1 month**

The maintenance of the vital records can be placed on hold: **Yes / 2 weeks-1 month**

Devolution of Control and Direction Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for devolution of control and direction for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function

Reconstitution Caveats

Staff Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of staff access to support this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that no changes are expected to occur based on either no modifications to facility usage / access and/or pre-existing remote staff arrangements.

Social Distancing: **Yes / 1 week or less**

Essential Staff Access Only: No

No Staff Access: **No**

Limited or Isolated Staff Access: **No**

Public Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of public access for this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that NO changes are expected to occur for PUBLIC ACCESS to facilities based on either no modifications to facility usage / access and/or no pre-existing public access to the facility(ies)

A. Priority Ranking

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **maintain the priority ranking** of this essential function during a pandemic outbreak.

B. Level of Services

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **maintain the level of services** of this essential function during a pandemic outbreak.

Telework Capability:

The Department of Human Services, Behavioral Health Services Division's COOP planning team expects to have **no limitations to telework capability (100% remote capability)** for this essential function during a pandemic outbreak.

NOTE: Telework guidance will be made by the agency head and COOP continuity team based on Salt Lake County human resource policies once the Pandemic-Specific COOP Plan has been activated.

C. Facility Guideline Caveats

Staff Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for staff access to facilities for this essential function during a pandemic outbreak:

The COOP planning team has identified that social distancing policies; to include workspace re-designs that allow for at least 6 feet between persons, will be utilized to support this essential function

Public Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for public access to facilities for this essential function during a pandemic outbreak.

The COOP planning team has identified that no changes are expected to public facility access and usage for this essential function

Continuity Communications Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for continuity communications for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes for phone, email or remote-meeting communication methods are expected for this essential function based on current utilization of remote-capable communication methods.

Vital Records Management Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for vital records management for this essential function during a pandemic outbreak:

The COOP planning team has identified that digital signatures and approvals would be authorized when wet signatures are normally required for this essential function.

The input of the vital records can be placed on hold: **Yes / Greater than 1 month**

The maintenance of the vital records can be placed on hold: **Yes / Greater than 1 month**

Devolution of Control and Direction Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for devolution of control and direction for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function

Reconstitution Caveats

Staff Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of staff access to support this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that no changes are expected to occur based on either no modifications to facility usage / access and/or pre-existing remote staff arrangements.

Social Distancing: **Yes / 1 week or less**

Essential Staff Access Only: **No**

No Staff Access: **No**

Limited or Isolated Staff Access: **No**

Public Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of public access for this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that NO changes are expected to occur for PUBLIC ACCESS to facilities based on either no modifications to facility usage / access and/or no pre-existing public access to the facility(ies)

Auditing

A. Priority Ranking

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **decrease the priority ranking** of this essential function during a pandemic outbreak.

The updated priority ranking for this essential function is based on the following reason:

We feel that client services are more important than auditing providers in the case of a pandemic

B. Level of Services

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **decrease the level of services** of this essential function during a pandemic outbreak.

The decision to decrease the level of services for this essential function is based on the following:

We feel that client services are more important than auditing in the case of a pandemic

Telework Capability:

The Department of Human Services, Behavioral Health Services Division's COOP planning team expects to have **minor limitations to telework capability (50-75% remote capability)** for this essential function during a pandemic outbreak.

NOTE: Telework guidance will be made by the agency head and COOP continuity team based on Salt Lake County human resource policies once the Pandemic-Specific COOP Plan has been activated.

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified that the following telework capability limitations exist for this essential function:

Auditing involves going onsite to providers which can't be done remotely

C. Facility Guideline Caveats

Staff Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for staff access to facilities for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected to facility access and usage for this essential function

Public Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for public access to facilities for this essential function during a pandemic outbreak.

The COOP planning team has identified that no changes are expected to public facility access and usage for this essential function

Continuity Communications Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for continuity communications for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes for phone, email or remote-meeting communication methods are expected for this essential function based on current utilization of remote-capable communication methods.

Vital Records Management Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for vital records management for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function based on either no vital records needed or remote input and maintenance of necessary records.

The input of the vital records can be placed on hold: **No**

The maintenance of the vital records can be placed on hold: **No**

Devolution of Control and Direction Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for devolution of control and direction for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function

Reconstitution Caveats

Staff Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of staff access to support this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that no changes are expected to occur based on either no modifications to facility usage / access and/or pre-existing remote staff arrangements.

Social Distancing: **Yes / 1 week or less**

Essential Staff Access Only: **No**

No Staff Access: **No**

Limited or Isolated Staff Access: **No**

Public Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of public access for this essential function as the pandemic outbreak begins to resolve:

The COOP planning team has identified that NO changes are expected to occur for PUBLIC ACCESS to facilities based on either no modifications to facility usage / access and/or no pre-existing public access to the facility(ies)

RSS/client services

A. Priority Ranking

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **increase the priority ranking** of this essential function during a pandemic outbreak.

The updated priority ranking for this essential function is based on the following reason:

Client services are more important than auditing in the case of a pandemic

B. Level of Services

The Department of Human Services, Behavioral Health Services Division's COOP continuity team would **decrease the level of services** of this essential function during a pandemic outbreak.

The decision to decrease the level of services for this essential function is based on the following:

Staff may need to work from home and would not be able to provide all necessary resources to clients. We will work to develop workarounds through phone contact but many of the services require a wet signature from the client.

Telework Capability:

The Department of Human Services, Behavioral Health Services Division's COOP planning team expects to have **only a few limitations to telework capability (more than 75% remote capability)** for this essential function during a pandemic outbreak.

NOTE: Telework guidance will be made by the agency head and COOP continuity team based on Salt Lake County human resource policies once the Pandemic-Specific COOP Plan has been activated.

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified that the following telework capability limitations exist for this essential function:

Some services require a wet client signature.

C. Facility Guideline Caveats

Staff Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for staff access to facilities for this essential function during a pandemic outbreak:

The COOP planning team has identified that social distancing policies; to include workspace re-designs that allow for at least 6 feet between persons, will be utilized to support this essential function

Public Facility Access

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for public access to facilities for this essential function during a pandemic outbreak.

The COOP planning team has identified that limited and/or isolated public access to facilities would be implemented for this essential function

Continuity Communications Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for continuity communications for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes for phone, email or remote-meeting communication methods are expected for this essential function based on current utilization of remote-capable communication methods.

Vital Records Management Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for vital records management for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function based on either no vital records needed or remote input and maintenance of necessary records.

The input of the vital records can be placed on hold: **No**

The maintenance of the vital records can be placed on hold: **No**

Devolution of Control and Direction Caveats

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for devolution of control and direction for this essential function during a pandemic outbreak:

The COOP planning team has identified that no changes are expected for this essential function

Reconstitution Caveats

Staff Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of staff access to support this essential function as the pandemic outbreak begins to resolve:

The COOP planning team would expect some reconstitution processes to be implemented

Staggered Hours: **Yes / 2 weeks-1 month**

Social Distancing: **Yes / 2 weeks-1 month**

Essential Staff Access Only: **Yes / 2 weeks-1 month**

No Staff Access: **No**

Limited or Isolated Staff Access: Yes / 2 weeks-1 month

Public Access Reconstitution

The Department of Human Services, Behavioral Health Services Division's COOP planning team has identified the following caveats for reconstitution of public access for this essential function as the pandemic outbreak begins to resolve:

The COOP planning team would expect some reconstitution processes for PUBLIC ACCESS to be implemented

No Public Access: **Yes / 2 weeks-1 month**

Limited or Isolated Public Access: **Yes / 2 weeks-1 month**

VI. CONCLUSION

Maintaining Department of Human Services, Behavioral Health Services Division's essential functions and services in the face of a pandemic outbreak, especially novel viruses like COVID-19, requires additional considerations beyond traditional continuity planning.

Unlike other hazards that necessitate the relocation of staff performing essential functions to an alternate operating facility, pandemics may not directly affect physical infrastructure of any organization. Rather, a pandemic threatens an organization's human resources and delivery of services by removing personnel (some essential) from the workplace for extended amounts of time.

Protecting the health and safety of personnel in order to enable Department of Human Services, Behavioral Health Services Division to continue to operations effectively and perform essential functions and services during a pandemic is the unified goal across all of Salt Lake County.

APPENDIX A: PANDEMIC BACKGROUND

A. The Overarching Pandemic Threat

- Viruses have threatened the health of animal and human populations for centuries. The genetic and antigenic diversities and their ability to change rapidly due to genetic reassortment and mutation has made it very difficult to develop either vaccines or highly effective antiviral drugs.
- A pandemic occurs when a novel strain of virus emerges with the ability to infect and efficiently spread among humans. Because humans lack immunity to a new virus, a world-wide epidemic, or pandemic can result.
- There have been four declared pandemics in the 20th Century: 1) 1918-29 H1N1 Influenza A (erroneously dubbed the so-called "Spanish Flu"1); 2) 1952 H2N2 Influenza A (dubbed the "Asian Flu"); 1968 H3N2 Influenza A (dubbed the "Hong Kong Flu"; 4) 1981 HIV/AIDS (still ongoing); and one in the 21st Century, the 2009-10 H1N1 Influenza A (dubbed the "Swine Flu"). These pandemics resulted in infection of on average 30% of the world's population and the death of from 0.2 to 2 percent of those infected.
- Avian viruses were involved in all three of the 20th Century pandemics. The 1918-19 pandemic is generally regarded as the deadliest disease event in recorded history. Updated assessments of the morbidity and mortality of the pandemic indicate an attack rate of 50% of the entire human population at the time (1.8B) that is believed to have resulted in more than 100M deaths.
- On or about 21 December 2019, Chinese government officials were apprised of an index cluster of ~44 patients who had been admitted to hospitals in Wuhan City in the Hubei Province Eastern Central China for severe pneumonia of an unknown etiology. On 31 December, the Chinese government reported the outbreak to WHO China Country Authorities.
- The virus was quickly identified as a novel version of the coronavirus, which had caused severe outbreaks in 2002 (i.e., Sudden Acute Respiratory Syndrome or "SARS", which a resulted 8,098 cases with 774 deaths [9.6% CFR] in 17 countries world-wide); and 2012 (i.e., Middle East Respiratory Syndrome Coronavirus or "MERS-CoV [officially known as EMC/212], which resulted in 2,298 cases with 811 deaths [35% CFR] in 21 countries world-wide) (although most were centered in Middle Eastern countries). All three of these versions of coronavirus are believed to be zoonotic (i.e., originating in animals), and can be traced to bats.
- In February 2020, WHO officials officially named the latest strain of coronavirus "COVID-19," and declared it "a global public health emergency of grave concern". As of this writing (16 March 2020), COVID-19 has spread to over 120 countries world-wide with more than 180,000 confirmed cases causing more than 7,000 deaths (3.8% CFR).2 In the U.S., there are currently 16,638 cases with 212 deaths currently reported (1.2% CFR). Both the global and U.S. specific numbers continue to make significant progressions daily, making the overall morbidity and mortality (M&M) associated with the COVID-19 Pandemic a highly fluid event.
    - On 11 March 2020, COVID-19 was officially declared a global pandemic by the WHO.

[1] The 1918-19 Influenza Pandemic was thought to have had its original index cluster and primary infectivity bloom in Spain as U.S. and Allied Forces staged for their movement to the Western Front of WWI, hence it's moniker "Spanish Flu". In reality, the index cluster occurred in a U.S. Army barracks located at Camp Funston in Kansas.

[2] While the CFR appears to remain relatively low, the true outcome of relational mortality globally won't be known until the outbreak reaches the peak of the epidemic (or now, more accurately, pandemic) curve. It should be pointed out that even what appears to be a low CFR may, in the end, demonstrate an exceptionally high level of mortality associated with COVID-19.

B. Potential Global Impact of a Pandemic

- All nations face considerable challenges in mounting a potentially unprecedented, coordinated global response to a pandemic. Global spread of COVID-19 has already occurred. Countries might, through measures such as border closures and travel restrictions, delay further transmission of the virus, but they cannot stop it. Containment—the first of a global three-part strategy (i.e., containment, stockpiling and use of effective antivirals, and rapid characterization of an emerging virus for vaccine development)—was proven to be useless in the 2009-10 Pandemic and quickly dropped. There is no reason to consider it will be effective now given symptomatic latency, previously porous international borders, and the ability of global air travel to hyper-speed disease around the globe.
- Pandemics of the previous century encircled the global in anywhere from 6 to 9 months, even when much of international travel was limited to rail and ship intra-continentally and inter-continentally, respectively. Given the speed and volume of international air travel today, the airline industry has become of unwitting vector accelerant of this declared (and any future) pandemic(s). Virus now spreads more rapidly than ever before, reaching all continents in weeks or months. An additional complication is that COVID-19—like many other viruses—can infect people and cause them to "shed" virus and infect others before they ever become symptomatic in the first place, making any strategy related to containment a virtual impossibility.
- Five discreet factors are showing an increased level of risk and the potential for significantly more profound impact in terms of the scope and scale of a pandemic (or for that matter, any other natural or man-made disasters that have the potential for the production of a catastrophic casualty event: 1) Since the first quarter of the 20th Century, the human population has more than tripled from 1.8B to 7.6B people. In terms of exposure to a disaster, we simply have a greater global "population-at-risk" (or "PAR"); 2) Climate change has significantly increased the number of (primarily) meteorological and hydrological disaster events. How climate change is affecting the incidence of disease, especially as it relates to newly emerging infectious diseases, has yet to be determined. However, it should be pointed out the glacier recession as a result of global warming has caused virologists to discover pathogens that have been seen before in the natural world. 3) The emergence of numerous "mega-cities" around the globe (populations with >20M residents occupying limited geographic space) has led to the phenomenon of "clustering" where these population end up placing an enormous burden on the critical infrastructure and key resource (CI/KR) necessary to support them. When disasters do occur, the limited CI/KR is likely to be propelled to a tipping point of collapse as demand increases. This is particularly true in the healthcare CI/KR, where demand from a rapid, vertical expansion of the epidemic curve may collapse healthcare resources in the most concentrated U.S. population centers. 4) By this year, 75% of the world's population is expected to reside within 75 miles of the world's littorals (i.e., coasts), making ports of embarkation and debarkation (APOE/D)—traditional jumping off points of disease outbreaks—more closely confluent with the global population. And, finally, 5) With the advent of global air travel now functioning as the principal transportation modality of the common era, the air industry is going to function as a vector accelerant of any pandemic-capable infectious disease outbreak involving a novel virus.
- Widespread illness is now occurring, although at the time of this writing the State of Utah has had a relatively small number of cases in comparison to other, harder hit states. Infection and illness are expected to significantly exceed seasonal epidemics of normal, non-pandemic strains of seasonal influenza (which have had considerably high levels of morbidity and mortality for the 2019-20 season, already considered have been the worst seasonal flu in more than 40 years). It is estimated that if the COVID-19 outbreak continues its present level of transmission, or if that level accelerates, a substantial portion of the world's population will require some form of medical care.
- Antiviral medications—which treat only the symptoms of a virus and not its cause—and an effective vaccine to help prevent acquiring the disease will be in great demand. However, at this time, antiviral medications such as Oseltamivir ("Tamiflu") which have been used to treat severe influenza

symptoms are demonstrating no efficacy against COVID-19, and an accurate characterization that can lead to the rapid development of an effective vaccine are thought to be at least a year to 18 months away at best.

- Inadequate supplies of vaccine—when they do become available—are of particular concern, as vaccines are generally considered the best countermeasure for protecting populations. Many resource poor countries may have no access to vaccines throughout the duration of the pandemic (assuming a vaccine becomes available during the actual declared pandemic period) and have very limited supplies of other infection control and supportive care material, which will further propel dangerous cascading failures amongst their populations. Even countries with large investments in healthcare and public health infrastructure will face significant challenges of scare resources and limited surge capacity in an atmosphere of extreme demand.
- The number of deaths during influenza pandemics has varied greatly. Death rates are largely determined by four factors: the number of people who become infected; the virulence of the virus; the underlying characteristics and vulnerability of affected populations; and the effectiveness of clinical interventions and preventive measures. Within some countries those who do not receive effective medical care during pandemic periods (e.g., low rates of influenza vaccine coverage) are likely to bear a disproportionate burden of excess deaths from a pandemic. Accurate predictions of mortality cannot be made before the pandemic reaches maximum transmissibility. Mass fatality management (MFM) will arguably be one of our greatest challenges, as noted from our experience with the 1918-19 Influenza Pandemic.3
- Economic and social disruption may be high. High rates of illness, hospitalization, and worker absenteeism are expected, and these will contribute markedly to social and economic disruptions. Social disruption may be greatest when rates of absenteeism impair essential services such as healthcare, public safety, power, food supply, transportation, and communications.

C. Potential U.S. Domestic Impact of a Pandemic

- Despite annual vaccination programs and advanced medical technologies, an estimated 36,000 seasonal influenza deaths and 226,000 hospitalizations occur on average each year in the United States. Based on current models of pandemic disease transmission involving a novel virus, a new pandemic could affect as much as 30-40% of the U.S. population and result in the deaths of 200,000 to two million U.S. residents. By comparison, there were 675,000 U.S. fatalities as a result of the 1918-19 pandemic.
- A pandemic's impact will extend far beyond human health. It will undermine many of the day-to-day functions within our society and thus could significantly weaken our economy and national security.
- Worker absentee rates (due to illness, care giving responsibilities, exposure avoidance, fear, etc.) are projected to reach 40% at the height of a pandemic. Businesses and government agencies must address how they will perform their essential tasks with a high rate of employee absenteeism.
- The longer it takes for an influenza pandemic to begin, the more likely it is that its effects can be mitigated by informed citizens, prepared healthcare teams and public health systems, and proactive leaders. Ultimately, the center of gravity of the pandemic response will be in communities where coordinated efforts will be essential.
- Because of poverty, household crowding, and higher prevalence of chronic conditions that suppress immunity, the incidence, complications, and mortality from the pandemic may be higher among some sectors of society than among others. During a pandemic, historically lower rates of vaccine coverage in these populations may become exacerbated by shortages. Efforts to distribute vaccines and antiviral drugs (should they become available in such populations) may be hampered by deterioration in usual sources of medical care. Real or perceived injustice may impede the

[3] Barry, J.M. (2004). *The great influenza: The story of the deadliest plague in history.* Penguin Books: New York, NY.

acceptance and effectiveness of isolation and quarantine measures.

- There is little doubt that the Achilles' Heel of our U.S. critical infrastructure and key resource (CI/KR) sectors will be the healthcare sector. If the epidemic curve (i.e., the apogee of the casualty load) associated with the COVID-19 Pandemic exceeds the static and ultimately finite capacity of the Nation's healthcare system, there is real risk of propelling the system to collapse. Markedly exacerbating this situation is the fact that the managed care system that dominates the U.S. healthcare industry has turned hospital beds into profit centers. If beds remain unfilled, healthcare organizations and systems remain unprofitable and many ultimately close. The net result is that we lack virtually any extent surge capacity in our healthcare system to accommodate sudden spikes in casualty loads. Surge capacity planning—including the development and staging of alternate care facilities to accommodate the surge load—must be given careful and prioritized planning at these earliest stages of the COVID-19 Pandemic.

APPENDIX B: COVID-19 HYGIENE

The following limitations may affect the ability to successfully execute COVID-19 specific continuity operations and incident management efforts under this annex.

- Defining the magnitude of the COVID-19 pandemic is impossible due to both the lack of scientific data associated with the COVID-19 virus, as a newly emerging infectious disease, and the current unpredictability of the virus and any future possible mutations.
- If there is a moderate to severe pandemic, there is insufficient surge capacity throughout the healthcare infrastructure of the U.S. Even with innovative attempts at accommodating substantially increased patient care requirements (e.g., fielding deployable medical contingency stations, leveraging "locations of opportunity," etc.), it is highly unlikely that sufficient treatment facilities would be available to support affected populations across the U.S. even if the pandemic presents itself as "the moderate scenario (i.e., 1958/68-like Pandemic)" (HHS Pandemic Influenza Plan/Part 1 Strategic Plan, p. 18).
- Simultaneous or near-simultaneous outbreaks of COVID-19 in communities across the U.S. will limit the ability of any jurisdiction to provide support and assistance to another area (e.g., Emergency Management Assistance Compacts [EMACs] in place from state-to-state.)
- There is no COVID-19 vaccine or effective antivirals.
- There are critical shortages of equipment and supplies (e.g., ventilators) to adequately support projected requirements for hospitalized patients.
- There are burgeoning shortages of masks and personal protective equipment [PPE] to support the occupational health requirements of healthcare workers during the pandemic outbreak.
- Reliance on non-U.S., overseas manufacturers for high-demand items will exacerbate existent shortfalls and further complicate our ability to effectively respond to the COVID-19 Pandemic outbreak.
- By its nature, vaccine production must await the appearance of the strain of a newly emerging virus which meets the criteria of easy transmissibility among humans and high virulence (which has occurred). Even if aggressive methods are used to shorten the manufacturing cycle, it is reasonable to believe that vaccine stocks may not be available for at least 12 to 18 months after the start of the COVID-19 outbreak.
- In accordance with the planning assumptions of the National Response Framework, it is possible that the Universal Adversary may find it opportunistic to launch an attack against the United States. In addition, it is possible that currently circulating strains of Influenza A that have been assessed as having pandemic potential (i.e., H5N21, H7N9, and H1N1) may emerge either during or after the COVID-19 Pandemic. In either case, mounting successful incident management efforts will prove extraordinarily difficult.

APPENDIX C: CONSIDERATIONS OF HYGIENE ETIQUETTE AND COMMUNITY-BASED MEASURES TO MITIGATE TRANSMISSION OF COVID-19

The U.S. Centers for Disease and Prevention (CDC), in collaboration with U.S. public health experts has developed this guidance for federal/state/tribal/local public health authorities (PHA) on the use of public health measures (PHM) to reduce and delay transmission of COVID-19 in the community.

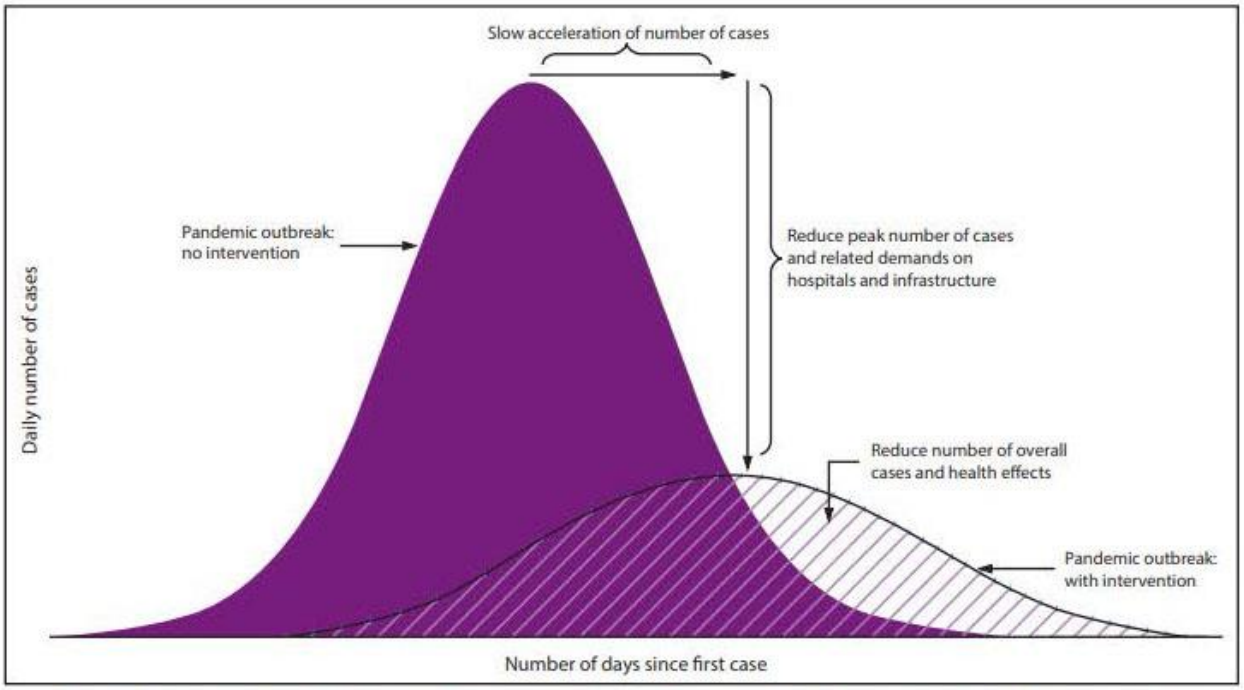
Our nation's pandemic goals, which are first, to minimize serious illness and overall deaths, and second to minimize societal disruption, will guide our response to COVID-19. This guidance is based on currently available scientific evidence, expert opinion and public health assumptions. Given the evolving nature of COVID-19 epidemiology, the intent of this guidance is to prepare in the event of community-based spread seen in the U.S. and elsewhere in the world. This guidance is subject to change as information emerges on transmissibility and epidemiology, and if treatment options or new information on clinical management becomes available. It is expected that the timing and intensity of virus activity will vary across the U.S. and within state and local environments, i.e., some may be experiencing sustained community transmission while others are only having isolated cases with limited person-to-person transmission. The focus of this guidance is to delay and mitigate the community transmission of COVID-19; however, the containment approaches outlined in Public Health Management of cases and contacts associated with novel coronavirus disease (COVID-19) are applicable and are still in the containment strategy given the relatively limited number of cases in the U.S.. This guidance should be read in conjunction with relevant state and local legislation, regulations, and policies. For information regarding COVID-19, visit the CDC and WHO web sites.

D. Introduction

Public health measures (PHM) include non-pharmaceutical interventions that can be used to reduce and delay community transmission of the novel coronavirus that causes COVID-19. Implemented early, PHM seek to reduce the speed with which cases are occurring to delay and to reduce the peak of virus activity in the community (see figure 1) and reduce the demand for health care services. Some measures are used commonly in the U.S. for seasonal influenza and other communicable disease outbreaks, while others will likely only be considered during a more severe pandemic. Given that there is currently no effective vaccine or specific treatment (e.g. antiviral medication) for COVID-19, public health measures will be the only tools available to mitigate the impact of the virus. A crucial aspect of PHM is effective communications by PHA to promote and support public trust. Refer to the section below on public education and communication for additional considerations.

Public health measures are usually implemented as combinations of two or more measures, which is sometimes referred to as "layered use". The theoretical rationale for layering public health measures is based on the expectation that combinations are likely to be more effective than the partial effectiveness of a single measure.

Figure 1: Goal of Public Health Measures



Source: Adapted from: CDC. Interim pre-pandemic planning guidance: community strategy for pandemic influenza mitigation in the United States—early, targeted, layered use of nonpharmaceutical interventions. Atlanta, GA: US Department of Health and Human Services, CDC; 2007. https://stacks.cdc.gov/view/cdc/11425.

Public health measures outlined in this guidance include actions taken by individuals (healthy, those potentially exposed, and those with COVID-19) designed to protect themselves and others as well as community-based approaches whereby planners, employers, community organizers can implement strategies to protect groups and the community at large. Compliance with recommendations and sustainability of them over time may be influenced by a variety of factors, including, but not limited to cultural, financial, social, and spiritual circumstances. Some communities may require tailored approaches based on geography, culture and living circumstances.

Guidance for individuals who are self-isolating or caring for someone in the home or co-living setting (including university dormitories, shelters, communal living facilities) has been developed: Public Health Management of cases and contacts associated with novel coronavirus disease (COVID-19).

Public health measures such as hand hygiene, respiratory etiquette, and environmental cleaning in the home are the cornerstone public measures to protect individuals, their families and others against seasonal influenza and other respiratory viruses. The same measures are also effective when COVID-19 is circulating in the community. The application of these principles will help prevent and control transmission of any respiratory infectious disease, including COVID-19.

E. Hand Hygiene

Refers to hand washing with soap and water or hand sanitizing with alcoholic solutions, gels or tissues to maintain clean hands and fingernails. It should be performed frequently with soap and water for at least 30 seconds:

- Before and after preparing food
- Before and after eating
- After using the toilet

- After coughing/sneezing into a tissue (or if non-compliant with respiratory etiquette)
- Before and after using a surgical/procedure mask and after removing gloves
- After handling body fluid-contaminated waste or laundry
- Whenever hands look dirty

If soap and water are not available, hands can be cleaned with an alcohol-based hand sanitizer (ABHS) that contains at least 60% alcohol, ensuring that all surfaces of the hands are covered (e.g. front and back of hands as well as between fingers) and rubbed together until they feel dry. For visibly soiled hands, soiling should be removed with an alcohol-based hand wipe first, followed by use of ABHS.

Touching one's eyes, nose, and mouth with unwashed hands should be avoided.

F. Respiratory Etiquette

Describes a combination of measures intended to minimize the dispersion of large particle respiratory droplets when an ill person is coughing, sneezing and talking to reduce virus transmission.

Cover coughs and sneezes with a surgical/procedure mask or tissue. Dispose of tissues in a lined waste container and perform hand hygiene immediately after a cough or sneeze.

OR

Cough/sneeze into the bend of your arm, not your hand.

G. Environmental Cleaning and Ventilation

Refers to routine cleaning of frequently used surfaces and objects to help to prevent the transmission of COVID-19 to help to mitigate the risk of people becoming infected through self-inoculation after touching contaminated surfaces. The virus that causes COVID-19 has the potential to survive in the environment for up to 3-5 days. Cleaning, particularly of frequently touched surfaces, can kill the virus, making it no longer possible to infect people.

Cleaning the home and co-living setting

Frequently touched areas such as toilets, bedside tables, light switches and door handles should be first cleaned (to physically remove dirt) and disinfected daily with water and regular household cleaning products or a diluted bleach solution (0.5% sodium hypochlorite). If they can withstand the use of liquids for disinfection, frequently touched electronics such as phones, computers and other devices may be disinfected with 70% alcohol (e.g. alcohol prep wipes). All used disposable contaminated items should be placed in a lined container before disposing of them with other household waste.

Cleaning public spaces

Cleaning of high traffic public spaces (e.g. malls, airports, public transportation) should follow regular cleaning and disinfecting regimes, both in terms of products used and surfaces targeted, as it is not likely practical/sustainable to increase the frequency of cleaning. Community settings are encouraged to develop protocols for cleaning public spaces if they currently do not have an established cleaning routine.

Workplaces and other similar community settings are encouraged to clean highly touched surfaces (e.g. phones, elevator buttons, washrooms, tables) frequently and to recommend and facilitate increased hand hygiene. It is

also recommended that items that cannot be easily cleaned (e.g., newspapers, magazines, stuffed toys) be removed.

Ventilation

Increasing ventilation (e.g. opening windows when weather permits) may help reduce transmission, though evidence is limited as to its effectiveness. Simulation studies show that increased ventilation was shown to reduce influenza transmission and is usually simple and feasible in many locations.

H. Social Distancing

Social distancing measures are approaches taken to minimize close contact with others in the community and include: quarantine and self-isolation at the individual level as well as other community based approaches (e.g. avoiding crowding, school measures and closures, workplace measures and closures, public/mass gathering cancellations) which are further described in the section titled **community-based measures** below.

Social distancing measures are likely to have secondary consequences for individuals, families and communities, such as loss of income, an elevated need for support services, and potentially reduced availability of certain services. Some measures require extensive preparation and engagement across sectors. During a pandemic of lesser severity, the infection control benefits of implementing some community measures (e.g., proactive school closures) may not be offset by the cost and societal disruption caused by these measures.

Whenever public health authorities impose restrictions on individual freedoms, the intervention should be proportional to the magnitude of the threat. This principle of 'least restrictive means' should always be a consideration when enacting social distancing measures. Reference 8 outlines the ethical considerations with respect to the selection and use of PHMs in a pandemic.

It is crucial that individuals follow self-isolation recommendations properly to prevent transmission of COVID-19 to others in the home setting or in the community. It is recommended that all individuals in the community plan ahead by maintaining a supply of essential medications, home supplies and extra non-perishable food in the event they require voluntary self-isolation.

Isolation

Isolation is recommended for a symptomatic individual that is suspected of having, or known to have, COVID-19. They are directed by PHA to isolate themselves in the home-setting and avoid contact with others until PHA has advised that they are no longer considered contagious. Isolation includes:

- Not going out of the home setting. This includes school, work, or other public areas
- Not using public transportation (e.g. buses, subways, taxis)
- Identifying a "buddy" to check on and do errands for each another, especially for those who live alone or at high risk for developing complications.
- Having supplies delivered home instead of running errands (supplies should be left on the front door or at least a 2-meter distance maintained between people)
- If leaving the home setting cannot be avoided (e.g. to go to a medical appointment), wear a mask (if not available, cover mouth and nose with tissues) and maintain a 2-meter distance from others. The health care facility should be informed in advance that the person may be infectious.

Voluntary home sequestration ("self-isolation")

Self-isolation is recommended for an asymptomatic person, when they have a high risk of exposure to the virus that causes COVID-19, (i.e., through close contact with a symptomatic person or their body fluids). They are asked to self- isolate in the home-setting to avoid contact with others in order to prevent transmission of the virus at the earliest stage of illness (i.e., should they develop COVID-19).

Protective self-separation

Protective self-separation is recommended for a person who is at high-risk for severe illness from COVID-19 (e.g., older adults, those with chronic underlying medical conditions or immunocompromised) when the virus is circulating in their community.

Voluntary avoidance of crowded places

This is recommended for a person who is asymptomatic and who is considered to have had a medium risk of exposure to the virus that causes COVID-19. This involves avoiding crowded public spaces and places where rapid self-isolation upon onset of symptoms may not be feasible. Examples of these settings include mass gatherings, such as concerts and sporting events; not including hospitals (for HCWs) and schools.

Mandatory sequestration

This is the imposed separation or restriction of movement of individuals, groups or communities, for a defined period of time and in a location determined by the PHA. As local circumstances will vary across the U.S. and within states, quarantine may be used to contain, delay or mitigate COVID-19, although its effectiveness once there is widespread community transmission is unknown. An individual in mandatory quarantine is asymptomatic but may have been exposed to the virus causing COVID-19. A decision to implement mandatory quarantine requires careful consideration of the safety of the individual/group/community, the anticipated effectiveness, feasibility and implications.

I. Self-Monitoring

Self-monitoring is implemented when individuals are potentially exposed to the virus and includes monitoring for the occurrence of symptoms compatible with COVID-19. If symptoms develop, the individual should follow the recommended public health actions regarding convalescing at home versus seeking medical care, depending on severity of symptoms and the presence of underlying medical conditions.

J. Use of Masks

Masks should be used by a symptomatic individual, if available, to provide a physical barrier that may help to prevent the transmission of the virus by blocking the dispersion of large particle respiratory droplets propelled by coughing, sneezing and talking. A face mask should always be combined with other measures such as respiratory etiquette and hand hygiene. They can be worn by people suspected or confirmed of having COVID-19 when in close contact with other people in the home-setting or if they must leave the home-setting for medical attention.

The use of a mask by a healthy person who is providing direct care for a person with COVID-19 should always be combined with eye protection and gloves and other droplet/contact prevention measures including hand hygiene and environmental cleaning. Refer to the CDC's Case and Contact Management Guidance for additional advice.

There is no evidence on the usefulness of face masks worn by healthy/asymptomatic persons as a mitigation measure, therefore it is not recommended. Globally masks are in short supply and the current demand for masks cannot be met; therefore, appropriate use of face masks should be encouraged.

K. Community-based Measures

Community-based measures are actions taken by planners, administrators, and employers to protect groups, employees and the population. The measures outlined below are relevant to all non-health care settings and aim to reduce transmission within the community settings such as workplaces, schools, public transportation, communal living settings, spiritual and cultural settings, community centers and other places where people gather such as shopping centers, camps and entertainment facilities. These measures will always be layered with personal protective measures described above.

Guidance developed for acute health settings is available and can be applied to any setting where healthcare is being provided.

Many of these community-based actions require extensive preparation and engagement across sectors, and secondary consequences (e.g. financial implications, interruptions in social supports, reduction in services, societal disruptions) may be anticipated and should be considered in planning. The implementation of some public health measures may be more disruptive (e.g., school closures) and their use should be based on a risk assessment [in] collaboration with local authorities, which may result in jurisdictional variations across the states. These measures are usually associated with pandemics of moderate to high impact given their societal and economic costs. As much as possible, a harmonized approach should be taken. It is recognized that some individuals, groups, or communities may adopt or decline to adopt measures that are inconsistent with public health advice or are based on cultural norms (e.g., healthy individuals wearing masks). PHAs should reinforce the rationale for the recommendations, avoid stigmatization of these groups or communities, and plan communications and stakeholder outreach accordingly.

L. Avoid Crowding

Measures taken to reduce the amount of time individuals spend in large crowds or in crowded spaces can be effective to reduce the transmission of COVID-19 in a community. It is recognized that while this intervention may reduce the viral transmission, some measures (e.g. closing public transit) could also have significant impact on societal function and compliance may be challenging. Restrictions on non-essential gatherings could pose a barrier to accessing group support and personal freedoms (e.g., cancelling church services, closing community centers). It may also have cultural or religious implications (e.g. funerals, religious services, weddings). The feasibility of avoiding crowds is uncertain as crowding occurs in large cities daily (e.g. public transportation, subways, airports, shopping centers, movie theatres). Discretionary gatherings, like churches and theatres, might be left to individual groups, rather than PHAs. Refer to mass gatherings, which provides advice related to mass gathering events in the context of COVID-19.

Factors to consider when making decisions:

- The likelihood that people will comply with crowd avoidance;
- People who are suspected or confirmed of having COVID-19 who are self-isolating, should isolate in the home setting and not go out in public;
- People who are self-monitoring for symptoms (see section above) should always avoid crowded settings (e.g. sporting events, concerts, airplanes, subway) and places where rapid self-isolation may not be feasible should symptoms develop;

- When in crowded settings, people should practice personal protective measures (e.g., frequent hand hygiene, avoid touching eyes/nose/mouth);
- Employers/businesses could consider implementing staggered work hours to reduce crowding on public transit during peak commuting hours and in large workplaces during normal workday hours;
- Voluntary quarantine of a community can be considered based on the local epidemiologic and social assessment of the situation;
- If public transportation is shut down, transportation alternatives may need to be considered for emergency medical services or medical treatments (dialysis, chemotherapy), as well as for critical infrastructure workers.

M. School and Daycare Measures

Public health measures implemented in schools and daycare settings are intended to provide a safer school environment by encouraging personal protective measures, communication to teachers and parents, and environmental cleaning. Public Health Guidance for Schools (K-12) and Childcare Programs (COVID-19) is available. Given the current epidemiology of the virus, it is unknown what role children play in community transmission of COVID-19, therefore the impact of school mitigation measures on community transmission of COVID-19 is uncertain, though strategies such as more frequent hand washing, respiratory etiquette and separation of ill students from healthy students is always prudent.

School/daycare measures can vary in scope from very simple measures (e.g. increasing distancing between desks) through to more extensive measures, such as closures. Widespread school closures as a control measure have the potential of coming at a high economic and social cost since school closures would impact the many families that have one or both parents working outside of the home. School closures can reduce virus transmission, but the timing and duration of the closure is critical (before the peak of the epidemic), and later closures could be ineffective and be socially disruptive. Consideration also needs to be given to the likeliness that students will congregate elsewhere in less controlled environments, thus reducing the intended benefits of school closures and potentially shifting the transmission of the virus to other community settings.

Definitions of terms relevant to school measures

Term	Definition
School mitigation measures	School remains open and alternative measures are implemented to promote social distancing and decrease density among students and staff.
Class dismissal	School remains open with core staff, but most children stay home (similar to a "snow day").
School closure	School is closed to all children and staff.
Reactive closure or dismissal	School is closed after a substantial incidence of illness is reported among children or staff (or both) in that school.
Proactive closure or dismissal	School is closed before a substantial transmission among children and staff. Is only helpful before the peak of an outbreak in the community.

School Mitigation Measures

School mitigation measures are implemented to reduce the unintended consequences of school closures or dismissal. The following strategies can be considered:

- Strict exclusion policies for students exhibiting symptoms of COVID-19

- Increasing desk distance between students
- Cancelling or postponing after-school events
- Restricting access to common areas
- Staggering the school schedule to limit the numbers of students/children in attendance at one time (e.g. staggered lunch breaks, recesses)
- Reducing mixing students during transport to and from school (separation of children on school buses by 2 meters where possible)
- dividing classes into smaller groups
- cancelling classes that bring students together from multiple classrooms

Class Dismissal

Class dismissal is intended to serve the purpose of mitigating some of the unintended consequences resulting in school closures e.g. parents/caregivers who miss work to take care of children can have negative financial implications and students/children who access free school meals could be negatively impacted if those meals are not otherwise available. Additionally, keeping facilities open will allow teachers to consider delivering lessons and material remotely, maintaining continuity with teaching and learning.

School Closures

School closure decisions should be made in consultation with local public health authorities and based on a risk assessment. Closure considerations should include:

- The priority goal of minimizing social disruption and child safety
- Epidemiology and transmissibility of the disease
- Contact patterns in the school/childcare program
- Amount of contact between individuals within the environment
- Size of classrooms
- Interaction of students between classes
- The impact of certain programs (e.g., school meal programs) on families who access them.
- Innate protective factors built into schools and childcare settings including:
    - A forum to educate, inform and communicate with students/ children and their families in an efficient and timely manner.
    - A defined structure to support the economic and social elements of the community by allowing parents to continue to work and volunteer.

Reactive School Closures

Reactive school closures are in response to virus activity (i.e. a consequence of disease activity) impacting the safe functioning of the school due to increased staff absenteeism and co-infection potential among students. Considerations should include:

- The number of ill students/children and staff.
- The impact of school absenteeism and/or staff shortages on schools/childcare operations.

Proactive School Closures

Proactive school closures may be considered to interrupt the transmission amongst children and indirectly protect other age groups who may be vulnerable to COVID-19. The decision about the school closure at local/regional/national level will largely depend on the timing and epidemiological situation. Considerations should include:

- The timing of school/daycare closures in relation to the epidemic peak is an important consideration.
- School closures of less than 2 weeks have been shown to have minimal impact on disruption of virus transmission in communities.
- Holiday schedules should also be considered as opportunistic (i.e. early closures).

N. Workplaces

Public health measures implemented in workplaces can be taken to prevent the spread of the virus causing COVID-19 in workplaces and other similar community settings. Further information on preparing workplaces for COVID-19 is available from the CDC or WHO.

Strategies that workplaces can put into effect include:

- Increased awareness about and communication to staff about COVID-19.
- Encouraging the use of individual measures described above such as frequent hand hygiene, respiratory etiquette and self-isolation when ill.
- Evaluate the workplace for areas where people have frequent contact with each other and share spaces and objects.
- Workplaces/community settings should identify possible COVID-19 exposure risks and mitigation approaches. Although not conclusive, there may be benefit to increasing the spatial separation between desks and workstations as well as individuals (e.g., employees, customers) from each other, ideally a 2 meter separation should be maintained, unless there is a physical barrier (e.g., cubicle, Plexiglas window).
- Workplaces and other similar community settings are encouraged to increase frequency of cleaning of frequently touched surfaces (e.g., phones, elevator buttons, computers, desks, lunch tables, kitchens, washrooms, cash registers, seating areas, surface counters, customer service counters, bars, restaurant tables/menus).
- Provide access to handwashing facilities and place hand sanitizing dispensers in prominent locations throughout the workplace, if possible.
- Consider providing additional tissues should someone develop respiratory symptoms. If symptoms develop the person should immediately be separated from others, instructed on respiratory etiquette and sent home (not using public transit, if possible).
- Where feasible, adjustments to policies and procedures may be put in place to reduce social contact, such as teleworking arrangements, flexible hours, staggering start times, use of email and teleconferencing.
- For business travel, employers should be aware of the latest information on COVID-19 affected areas and any travel health advisories. The risks and benefits related to upcoming business travel should be assessed and consideration given to alternative approaches such as virtually attending meetings. Returning international business travelers returning from affected areas should self-monitor for symptoms and follow advice provide by PHAs regarding the recommended actions.
- Consider relaxing sick leave policies that support employees in self-isolating when ill. This includes suspending the need for medical notes to return to work (reduces the burden on an already stressed health care system).
- Employers should prepare for increases in absenteeism due to illness among employees and their families or possibly school closures. Employers should access their business continuity plans, which should include a plan for how to maintain key business functions if faced with high absenteeism. Consideration should also be given to the need for cross-training personnel to function in key positions. This is an important element of Business Continuity Planning.
- Workplace and community setting closures may be considered, based on local conditions and a risk assessment in an exceptional circumstance, such as if COVID-19 evolves into one with high severity and

if many employees must be off to prevent transmission. The selection of measures will depend on the company and the type of work; some measures (e.g. cancellation or closures) may have significant economic consequences and decisions should be made based on a risk-benefit analysis.

O. Mass Gatherings

Mass gatherings are highly visible events with the potential for serious public health consequences if they are not planned and managed carefully. They can amplify the spread of infectious diseases and have the potential to cause additional strain on the health care system when held during outbreaks. The transmission of respiratory infections such as influenza has been frequently associated with mass gatherings. There have been examples of COVID-19 transmission during mass gatherings. Such infections can be transmitted during a mass gathering, during transit to and from the event, and in participants' home communities upon their return. Examples of mass gatherings include large meetings, conferences, sporting events, religious events, national and international events. It is recognized that while cancelling a mass gathering may reduce the viral transmission, it may also pose a barrier to personal freedoms. Mass gatherings may have cultural or religious implications (e.g. pilgrimages, large religious events) and cancelling such events may have significant cost considerations for jurisdictions, organizations and individuals. Decisions about whether to proceed with, restrict, cancel or postpone a mass-gathering event should be based on thorough risk assessment undertaken by event organizers in consultation with all relevant PHAs (e.g., local, state, federal).

Considerations used in the risk assessment generally include transmission dynamics, severity of illness, periods of communicability, incubation period, treatment options, potential for prevention (e.g., available vaccine, pharmaceuticals). Organizers should also consider the type of event (crowd density, nature of contact between participants, whether the event will be attended by registered on non-registered participants) and the host communities' capacity to respond to and mitigate the impacts of virus activity (e.g. health system capacity). A tool has been developed to assist planners with the risk assessment.

Measures to reduce the risks posed by mass gathering events include:

- Providing clear communication to participants before attending about the risks and advice on how to protect themselves and others to reduce virus transmission to allow for individual decision making about attending the event
- Encouraging personal protective, individual and environmental measures by all attendees
- Increasing interpersonal distancing (ideally separation of at least 2 meters, not shaking hands, avoiding communal sleeping areas)
- Eliminating self-serve buffet style eating at social/religious gatherings
- Support frequent hand hygiene by providing hand sanitizers dispensers in prominent locations
- Discourage attendees from sharing food or drinks
- Requiring that ill or those with high-risk medical conditions be excluded from attending gatherings and ensuring event organizers have arrangements in place to safely isolate and transport people who become ill on-site.
- Implementing organizational measures for the event such as cancellation, postponement, or rearrangement of the event (e.g., offering virtual participation, live streaming to allow participation from a distance, moving venue from indoors to outdoors)

P. Public Education and Communication

Public education aims to promote and support the implementation and adoption of public health measures at the individual and community levels. Communication of information and advice is often the first and most important

public health intervention during an emergency, especially where behavior change is essential for an effective response. Providing clear and consistent information about COVID-19 through authoritative sources and the use of public health measures is an essential component of their successful implementation. Messages should include ways to reduce risk as well as rationales for decision-making to encourage trust and adherence to advice. Tailoring approaches to specific audiences (e.g. high-risk groups, Indigenous communities, homeless, socially isolated, new immigrants, non-English speaking) will be needed, especially for those who may not be able to use or access standard resources.

Conveying the basis for, and value of, public health measures and recommendations (e.g. reducing transmission, reducing burden on health care systems), uncertainties (e.g. timing, extent of their use) and limitations (e.g. effectiveness of preventing transmission) should be incorporated into the public health communications strategy.

When faced with uncertainty and unpredictability, communicating early during a crisis can be critical to building essential trust. Misinformation that is spread through social media is a significant concern. Building trust in institutions and spokespersons in advance of a pandemic can mitigate the potential risks of misinformation, along with creating a clear focal point for accessing information about the pandemic. It is important to ensure that F/P/T governments are using common messaging to ensure that there is not conflicting public health measures advice being messaged across the country.

Q. Considerations for a Communications Response

- Proactively communicate when information (or even limited information) is available that the public can use to protect themselves.
- Anticipate that higher transmissibility will heighten public concern and increase demand for information from the public and media.
- Anticipate that public risk perception plays an important role in taking public health advice. Early, pro-active communications by public health authorities is important to influence early decisions and establish public health authorities as a trusted source of expert guidance and advice.
- Engage community leaders and non-public health groups to transmit accurate messages where there is a trust-based relationship with the community (e.g. Elders, spiritual leaders, educators, and community leaders/organizations)
- Leverage opportunities to use stakeholder networks and information vehicles to share information (and obtain feedback on) the relevance and value of these materials. Consider using existing networks (e.g. those already in place for seasonal influenza messaging)
- Rumors and misinformation can circulate rapidly and widely via social media. Communicate with audiences early, with a commitment to provide additional information when it becomes available and as the situation evolves. Monitor social media and identify rumors, adapt messages and strategies as needed.
- Address stigma at every opportunity through general education about the disease, considering tailored messages to schools and workplaces. Stigma can undermine social cohesion and prompt possible social isolation of groups, which might contribute to a situation where the virus is more, not less, likely to spread. Guidance on how to address social stigma, including communication tips and messages, is available.
- Develop communications tools/products to empower people and reinforce public health measures (e.g. hand hygiene, social distancing measures) and caring for the ill. Tailor information products and tools to the specific needs and capacities of target audiences and ensure materials are culturally relevant.
- Anticipate that more disruptive social distancing measures (e.g. cancellation of large/popular public events) may be met with resistance.

APPENDIX D: PANDEMIC COOP EXERCISE TOOL

R. Exercise Guidance

Background

Planning and preparedness will be the most effective instruments to reduce losses and mitigate the impacts of a pandemic. An integral part of planning and preparedness is the establishment of a comprehensive exercise and training program. This annex represents the efforts to fulfill this responsibility.

The following sections contained within the exercise guidance annex detail the requisite information and resources needed to design, develop, execute and assess exercises.

Types of Exercises

Discussion-Based Exercises

Discussion-based exercises are typically the starting point for an exercise planning cycle. Discussion-based exercises include seminars, workshops, tabletop exercises (TTXs), and games. These exercises are ideal for orienting agencies and personnel with plans, policies, mutual aid agreements, procedures and existing capabilities. Overall, discussion-based exercises are broadly focused on strategic and policy-oriented issues and the corresponding discussion topics.

Seminars

Seminars are generally employed to provide an overview of, authorities, strategies, plans, policies, procedures, protocols, response resources, or concepts and ideas. Seminars will provide a good starting point to develop or make major changes to plans and procedures. They are characterized by the following attributes:

- Low-stress environment employing a number of instruction techniques such as lectures, multimedia presentations, panel discussions, case study discussions, expert testimony, and decision support tools
- Informal discussions led by a seminar leader
- Lack of time constraints caused by real-time portrayal of events
- Effective with both large and small groups

Workshops

Although similar to seminars, workshops differ in two important aspects; participant interaction is increased, and the focus is on achieving or building a product (such as a plan or a policy). Workshops provide an ideal forum for:

- Collecting or sharing information
- Obtaining new or different perspectives
- Testing new ideas, processes, or procedures
- Training groups in coordinated activities
- Resolving complex issues
- Reaching consensus
- Team building

In conjunction with exercise development, workshops are most useful in achieving specific aspects of exercise design such as:

- Determining program or exercise objectives
- Developing exercise scenario and key events listings
- Determining evaluation elements and standards of performance

A workshop may be used to produce new standard/emergency operating procedures (SOPs/EOPs), mutual aid agreements, and various other documentation. To be effective, workshops must be highly focused on a specific issue and the desired outcome or goal must be clearly defined. Potentially relevant topics and goals are diverse, but all workshops share the following common attributes:

- Low-stress environment
- No-fault forum
- Information conveyed employing various instructional techniques
- Facilitated, working breakout sessions
- Plenum discussions led by a workshop leader
- Goals oriented toward an identifiable product
- Lack of time constraint caused by real-time portrayal of events
- Effective with both small and large groups

Tabletop Exercises

TTXs provide a forum for senior staff, elected or appointed officials, or other key personnel to discuss simulated situations in an informal setting. This type of exercise is intended to stimulate discussion of various issues regarding a hypothetical situation. It can be used to assess plans, policies, and procedures or to assess types of systems needed to guide the prevention of, response to, and recovery from a defined event. TTXs typically are aimed at facilitating understanding of concepts, identifying strengths and shortfalls, and/or achieving a change in attitude. Participants are encouraged to discuss issues in depth and come to decisions through methodical problem-solving rather than the rapid, spontaneous decision-making that occurs during actual or simulated emergency conditions. TTXs are more modest in scale and cost than operations-based exercises and games. When used in conjunction with more complex exercises TTXs are a particularly cost-effective tool. The effectiveness of a TTX is derived from the energetic involvement of participants and their assessment of recommended revisions to current policies, procedures, and plans.

TTX methods are divided into two categories: basic and advanced. In a basic TTX, the scene set by the scenario materials remains constant. It describes an event or emergency incident and brings discussion participants up to the simulated present time. Players apply their knowledge and skills to a list of problems presented by the leader/moderator, problems are discussed as a group, and solutions are generally agreed upon and summarized by the leader. In an advanced TTX, play revolves around delivery of pre-scripted messages to players that alter the original scenario. The exercise controller (moderator) typically introduces problems one at a time in the form of a written message, simulated telephone call, videotape, or other means. Participants discuss the issues raised by the problem citing appropriate plans and procedures. TTX attributes may include:

- Practicing group problem-solving
- Familiarizing senior officials with a situation
- Conducting a specific case study
- Examining personnel contingencies
- Testing group message interpretation
- Participating in information sharing
- Assessing interagency coordination

Games

A game is a simulation of operations that often involves two or more teams, usually in a competitive environment, using rules, data, and procedures designed to depict an actual or assumed real-life situation. It does not involve the use of actual resources, and the sequence of events affects, and is in turn affected by, the decisions made by the players.

Players are commonly presented with scenarios and asked to perform a task associated with the scenario episode. Each episode is moved to the next level of detail and complexity, taking into account the players' earlier decisions. The decisions made by the participants determine the flow of the game. The goal is to explore decision–making processes and the consequences of decisions. In a game, the same situation can be examined from a series of perspectives by changing variables and parameters that guide player actions. Large-scale games are multi-jurisdictional and can include active participation from local to national levels of government. Games stress the importance of the planners' and players' understanding of interrelated processes.

With the evolving complexity and sophistication of current simulations, there are increased opportunities to provide enhanced realism for game participants. The use of computer-generated scenarios and simulations can provide a more realistic and time-sensitive method of introducing situations and analysis. Planner decisions can input and run models to show the effect of decisions made during a game. Distributed games (available through the internet) offer many additional benefits, such as saving participants time and travel expenses, providing more frequent training opportunities, and taking away less time from primary functions. They also provide a collaborative environment that reflects realistic conditions. Games are excellent vehicles to do the following:

- Gain policy or process consensus
- Conduct "what-if" analyses of existing plans
- Develop new plans

Operations-Based Exercise

Operations-based exercises represent the next level of escalating difficulty; typically, these exercises are used to validate the plans, policies, agreements, and procedures previously solidified in discussion-based exercises.

Operations-based exercises include drills, functional exercises (FEs), and Full-Scale Exercises (FSEs). They can clarify roles and responsibilities, identify gaps in resources needed to implement plans and procedures, and improve individual and team performance. Operations-based exercises are characterized by actual response, mobilization of apparatus and resources, and commitment of personnel, usually over an extended period of time.

Drills

A drill is a coordinated, supervised activity usually employed to test a single specific operation or function in a single agency. Drills are commonly used to provide training on new equipment, develop or test new policies or procedures, or practice and maintain current skills. Typical attributes include:

- A narrow focus, measured against established standards
- Instant feedback
- A Realistic environment
- Performance in isolation

Functional Exercises

The FE, also known as a command post exercise (CPX), is designed to test and evaluate individual capabilities, multiple functions or activities within a function, or interdependent groups of functions. FEs are generally focused

on exercising the plans, policies, procedures, and staffs of the direction of the Incident Command (IC) and Unified Command (UC). Generally, events are projected through an exercise scenario with event updates that drive activity at the management level. Movement of personnel and equipment is simulated.

The objective of the FE is to execute specific plans and procedures and apply established policies, plans, and procedures under crisis conditions, within or by teams with a particular function. An FE simulates the reality of operations in a functional area by presenting complex and realistic problems that require rapid and effective responses by trained personnel in a highly stressful environment. FEs can be used to:

- Evaluate functions
- Evaluate Emergency Operations Centers (EOCs), headquarters, and staff
- Reinforce established policies and procedures
- Measure resource adequacy
- Examine inter-jurisdictional relationships

Full-Scale Exercises

The FSE is the most complex exercise. FSEs are multi-agency, multi-jurisdictional exercises that test many facets of emergency response and recovery. They include many first responders operating under the Incident Command System (ICS) or Unified Command System (UCS) to effectively and efficiently respond to, and recover from, an incident. An FSE focuses on implementing and analyzing the plans, policies, and procedures developed in discussion-based exercises and honed in previous, smaller, operations-based exercises. The events are projected through a scripted exercise scenario with built-in flexibility to allow for updates to drive activity. It is conducted in a real-time, stressful environment that closely mirrors a real event. First responders and resources are mobilized and deployed to the scene where they conduct their actions as if a real incident had occurred (with minor exceptions). The FSE simulates the reality of operations in multiple functional areas by presenting complex and realistic problems requiring critical thinking, rapid problem-solving, and effective responses by trained personnel in a highly stressful environment. Other entities who are not involved in the exercise, but who would be involved in an actual event, should be instructed not to respond.

The level of support needed to conduct an FSE is greater than that needed to conduct other types of exercises. The exercise site is usually extensive with complex site logistics. Food and water must be supplied to participants and volunteers. Safety issues, including those surrounding the use of props and special effects, must be monitored.

FSE controllers ensure that participants' behavior remains within predefined boundaries. Simulation Cell (SIMCELL) controllers continuously inject scenario elements to simulate real events. Evaluators observe behaviors and compare them against established plans, policies, procedures, and standard practices (if applicable). Safety controllers ensure all activity is executed within a safe environment.

An FSE provides an opportunity to execute plans, procedures, and cooperative (mutual aid) agreements in response to a simulated live event in a highly stressful environment. FSEs can be used to:

- Assess organizational and individual performance
- Demonstrate interagency cooperation
- Allocate resources and personnel
- Assess equipment capabilities
- Activate personnel and equipment
- Assess inter-jurisdictional cooperation
- Exercise public information systems

- Test communications systems and procedures
- Analyze memorandums of understanding (MOUs), SOPs, plans, policies, and procedures

Exercise Definitions Source: To maintain consistency with federal agencies' exercise programs, the Department of Homeland Security Exercise Definitions are utilized.

Exercise Planning Team

Prior to the establishment of a comprehensive exercise program, a dedicated exercise planning team must be established. The exercise planning team is comprised of individuals who bear the responsibility for designing, developing, conducting and evaluating each exercise. In addition to the responsibilities directly related to exercise planning and execution, the planning team members must also establish a method by which to manage the overall exercise effort. The management of an exercise includes establishing the project timeline, setting milestones, scheduling requisite meetings, and adding additional planning team members as needed.

During the planning process, team members may take on multiple responsibilities including: defining the scenario, developing objectives, tailoring the exercise effort to meet the desired outcomes, drafting all exercise documentation and multimedia presentations, conducting all related training sessions and orientations, and designing the assessment methodology to be employed for the exercise. Based upon the substantial efforts that the planning process requires, it is strongly recommended the exercise planning team members not be engaged in other work obligations but serve as full time planning personnel.

The exercise planning team is led by a Lead Exercise Planner. This individual may also be commonly referred to as the Exercise Director, Exercise Planning Team Leader, or Point of Contact (POC). Based upon the lead exercise planner's understanding of the needs for the upcoming exercise, this individual will select other appropriate planning team members. These members also serve in distinct execution roles. Ideally, the team should be small enough to collectively maintain efficiency, while large enough to include representation from each of the principal elements participating in the exercise. Ultimately, the composition of the exercise planning team is largely dependent upon the size and scope of the exercise. However, a team is typically comprised of the following core individuals:

- Planning Team Member/Execution Observer: Observers document key strategic actions and decisions, as well as the corresponding analytical processes made by participants. Observers are not analysts and do not necessarily interpret their observations. For most observer requirements, a pre-determined format is employed for documenting observations.
- Planning Team Member/Execution Controller: Controllers are primarily responsible for ensuring the continuity of exercise play by providing approved injects to keep the exercise on track with the scenario and the exercise timeline.
- Planning Team Member/Execution Analyst/Evaluator: Analysts/evaluators have specialized knowledge and/or skill sets. They utilize their expertise to record key observations and interpret them, targeting specific product development. Analysts/evaluators document and analyze participants' key discussion points and issues for immediate feedback and product generation. They do not actively participate in workgroup discussions; rather, they observe the activities and record their observations for later compilation and further analyses.

Planning Team Member/Execution Facilitator: The role of the facilitator is to manage, facilitate, guide, and focus discussion, encouraging the group to find its own solutions to problems or tasks. A facilitator may also be a Subject Matter Expert (SME). Facilitators need to empower their assigned note taker to ensure continuity of effort and to guarantee that all mission requirements are accounted for.

- Planning Team Member/Execution Note Taker: A recorder may capture specific content or provide transcription-quality notes in breakout sessions, and/or in plenary. When utilized, note takers are usually assigned to a specific facilitator. The facilitator and note taker must coordinate their roles and responsibilities to best serve the goals of the exercise. Note takers may also help with registration tasks and act as runners for inter-group communications.
- Planning Team Member/Execution Trainer: A trainer prepares the groups to execute tasks in support of event play and facilitator training sessions.

Establishment of an Exercise Program

When properly designed and executed, an exercise program provides a forum in which plans, policies, procedures, and response capabilities can be tested and validated. Overall, a successful exercise program employs a pre-selected combination of exercise types to meet the agency's goals and objectives. Exercises can be executed as standalone events; however, a greater degree of success is achieved when an extended exercise schedule is developed in which exercises are utilized in a stage-wise method and continually build upon each other. The most tangible benefit to this approach is that lessons learned are continually improved upon and participants are gradually oriented to the increasing complexity of agency plans, policy, procedures and response capabilities.

The ideal exercise program for a specific agency plan begins with an executive-level seminar in which roles and responsibilities and plan intricacies are explored. This would then be followed by a TTX in which an expanded participant base engages in a strategic overview of the aforementioned plan. Based upon the outcomes of the TTX (captured within the after-action report (AAR) the examined plan is adjusted and refined accordingly. Following the alteration of the plan, subsets of the participant base or the agency as a whole would conduct several drills or a comprehensive FE to examine the operational and communication elements of the document. A final FSE would then be conducted to engage all participants in a real-world response scenario that can be established within exercise parameters.

Exercise Timelines

The following timelines identify the critical planning actions for a TTX, FE and FSE. These timelines detail the overall pace of the exercise planning process and identify those goals that must be met in order to successfully advance the planning process. However, in addition to each of the identified critical actions, several supplementary planning actions and events must occur. The pace of the supplemental events is more fluid and is typically at the discretion of the lead exercise planner.

A timeline is not provided for seminars, workshops, games or drills because any of these exercises can be easily executed based on the corresponding discussion-based or operations-based planning timelines. For a seminar or workshop an abridged TTX timeline can be employed, and for a drill, an abridged FE timeline.

In addition to the individual exercise timelines, an overall exercise program timeline must be established. Following example exercise program timeline should be employed to test and validate a specific agency plan:

Exercise Planning Meeting and Documentation

Prior to the Initial Planning Meeting (IPM), the lead exercise planner is responsible for completing the following actions:

- Establish the exercise execution date
- Schedule all planning meetings based on appropriate timeline
- Establish exercise milestones

- Select appropriate planning team members
- Determine if representatives from external agencies/organizations will participate in the planning process
- Establish method for exercise planning management
- Select the appropriate exercise concept
- Draft all necessary IPM material (this material may consist of proposed exercise concepts, overall goals, etc.)

Initial Planning Meeting (IPM)

The Initial Planning Meeting (IPM) is the first formal meeting of the exercise planning process. Each member of the exercise planning team is required to attend and the meeting is chaired by the lead exercise planner.

Exercise Plan

The Exercise Plan is a document utilized by the participants during execution of the exercise. This document contains the critical exercise components that participants will need to actively contribute to the exercise. As with the EPD, the contents of this document are left up to the discretion of the lead exercise planner and vary with the type of exercise; however, at a minimum the Exercise Plan should include the following:

- Exercise introduction and overview
- Exercise scenario
- Exercise assumptions and artificialities
- Player instructions
- Exercise safety considerations
- Participant logistics
- References

Mid Planning Meeting (MPM)

The Mid Planning Meeting (MPM) is conducted at the mid-point of the exercise planning timeline. Prior to this meeting the EPD and EPM are continually reviewed and refined by the planning team members. During this meeting, these documents are again reviewed and the logistical elements of the exercise are examined. Moreover, the MPM serves as a time to review and discuss any independent planning actions that have been conducted by planning team members or other involved agencies (if applicable). The MPM is the time during the planning process that corrections and adjustments to the methodology can still be incorporated in order to achieve the desired concept and objectives. The only additional document that is produced following the MPM is a Master Scenario Events List (MSEL). However, this document is only produced if the exercise is a FE or FSE.

Master Scenario Events List (MSEL)

The Master Scenario Events List (MSEL) is a document utilized by the exercise execution staff during execution. This document is a comprehensive chronological listing of the scripted events that are injected into the exercise by the exercise execution staff in order to generate activity. Each scripted inject designates an action or requirement that prompts or drives exercise play. In its entirety, the MSEL contains sequential injects that support the overall exercise scenario and assist participants in attaining the exercise objectives. The contents of this document are left up to the discretion of the lead exercise planner; however, at a minimum the MSEL should include the following:

- Time inject is to be inserted into exercise play
- How inject is to be inserted into exercise play (phone call, faxed message, etc.)

- Which participant should receive the inject (may not be a specific individual, but rather an agency or functional area)?
- The inject
- Any special notes needed by the exercise execution staff member delivering the inject

Final Planning Meeting (FPM)

The Final Planning Meeting (FPM) is the last formal meeting of the exercise planning process. It is the final opportunity for the planning team to collectively review and finalize, prior to printing, all exercise documentation including the MSEL (if applicable) and logistics. One document is produced as a result of the FPM: the exercise direction and control manual (DCM)

Controller/Evaluator (C/E) Handbook

The C/E Handbook is a document utilized by the exercise execution staff during execution. This document contains the critical exercise execution components that the staff will control and evaluate during the exercise. As with all exercise documentation, the contents of this document are left up to the discretion of the lead exercise planner and vary with the type of exercise; however, at a minimum the C/E Handbook should include the following:

- Exercise overview
- Exercise staffing and control structure
- Exercise staff roles and responsibilities
- Staff communication plan and/or phone roster
- Key execution events
- MSEL
- Exercise safety plan
- Evaluation methodology and observation techniques
- Evaluation guides and tools

Exercise Briefings and Trainings

In addition to the planning meeting, the exercise planning team may opt to conduct additional briefings and trainings prior to execution. Although these briefings and trainings are optional for discussion-based exercises, they are an essential component of operations-based exercise preparations.

Senior Leader Briefing

At some point during the exercise planning process, it may be necessary to conduct a senior leader briefing. This briefing is used to familiarize the agency or organizational leadership with the overall exercise goals, objectives and desired outcomes. Additional information may also be included in the briefing depending on the size and scope of the exercise. Moreover, if the senior leaders are participating in the execution of the exercise (either as a participant or exercise execution staff), this briefing must also clearly define their role and the expectations for execution.

Exercise Participant Briefing

Prior to engaging in an exercise, participants need to be provided with information regarding their roles and execution requirements. Typically, in discussion-based exercises participant information is limited and can easily be incorporated into the first part of the execution. However, in more extensive operations-based exercises it is necessary to provide a comprehensive orientation to the exercise prior to the execution date. To accomplish this, the exercise planning team may opt to conduct a separate participant briefing the week preceding execution. All participants should be present at the scheduled briefing and attendance should be taken. In

addition to the comprehensive briefing, a brief recap of the safety concerns and issues should be conducted on execution day in an FSE.

Exercise Execution Staff Training

Prior to execution, the lead exercise planner conducts a training session tailored for the exercise execution staff. This training provides the execution staff with their designated roles and responsibilities as well as all relevant exercise details. In operations-based exercises, a discussion of the communications network and the safety plan to be utilized during execution should be included in the briefing.

EXERCISE ASSESSMENT TOOL METHODOLOGY

An exercise assessment tool is established during the exercise planning process and utilized during execution to assess how successful the exercise was in meeting the objectives. As each exercise requires a unique design and planning process each assessment tool must be tailored to the specific needs of the exercise. Thus, no single uniform assessment tool is recommended for use in all exercise types. However, there is a particular methodology that the exercise planning team should employ to design the appropriate assessment tool.

When designing an exercise assessment tool, the exercise planning team should consider three major factors:

- Type of exercise, including the size and scope
- Exercise objectives
- Desired end products of the exercise (what are the intended uses of the results of this exercise and are they linked to future exercises)

The type of exercise is the first component to consider when designing the assessment tool. This factor assists in determining the complexity of the tool and the overall format. In discussion-based exercises, such as a seminar, the assessment tool may be a simplistic note-taking template in which strategic issues are captured and overarching policy issues are noted. However, in more complicated operations-based exercises, it may be necessary to adjust the complexity of the tool to capture data specific to particular operations and functional areas.

The exercise objectives are also an important consideration when designing the assessment tool. Based on the complexity of the objectives and how global each objective is (is the entire participant base expected to achieve this objective or is the objective tailored for a given functional area) the assessment tool must be designed to capture the relevant data. In very complex operations-based exercises, such as a FE or FSE, it may be necessary to use a tool specific to an operational or functional area so the execution staff can focus on capturing data related to exactly what they are observing, rather than large overarching issues which may not be obvious to an individual during a large exercise.

The desired end product of the exercise is the final consideration when designing the assessment tool. This factor dictates the exact type of data that should be collected based upon the ends this data will eventually serve.

Exercise Products

Hot Wash

Immediately following the conclusion of the exercise, a hotwash is conducted. The attendees of the hotwash include all execution and planning team members and may include senior leaders as well as selected participants.

Typically, during the hotwash, the lead exercise planner conducts a moderated discussion of the key events and observations that occurred during the exercise. Accurate and comprehensive capture of participant and

controller/evaluator data is critical immediately following the end of any exercise, as it provides the initial level of analysis needed for the after-action reporting process.

After Action Report and Improvement Plan

An after-action report (AAR) provides a historical account of the exercise and contains valuable insight into strategy development and program planning. An improvement plan (IP) provides next steps for the organization to act on based on lessons learned in the exercise.

At a minimum the AAR should include:

- Date, time and place of exercise
- Type of exercise: tabletop, functional, or full-scale.
- Size and scope of the exercise
- Focus of the exercise: Was it oriented toward prevention, response, or recovery from an event? What initiating event is being highlighted?
- Participants: Who were the participants, how many were present, what agencies were involved, and what types of responders or officials were involved in exercise play.
- Exercise objectives
- Discussion or observations with corresponding recommendations: Discussions are summarized by execution staff for discussion-based exercises. Observations are captured by execution staff for operations-based exercises. These discussions or observations should be broken down by function (i.e., incident command, etc.) in the AAR. For each issue discussed or observed, there should be corresponding recommendations included that help determine lessons learned from the exercise.
- Lessons learned: "Lessons learned" refers to knowledge gained from an innovation or experience that provides valuable information – positive or negative – that helps to guide an approach to a similar problem in the future. Lessons learned are not simply summaries of what went right or wrong – rather, they should provide insight into the situation by describing a change that was made to address a particular issue. More broadly, these lessons should be suitable to share with other agencies in an effort to enhance preparedness.
- Principal findings or significant observations: Principal findings are the most important issues culled from a discussion-based exercise. Significant observations are the most important observations recognized by one or more evaluators during a operations-based exercise. These generally apply to all functional disciplines or highlight areas within a function that are found to be critical for elevating preparedness within an agency. They are often directly connected to the objectives of the exercise.
- The IP lists the corrective actions that will be taken, the responsible party or agency, and the expected completion date. The IP is included at the end of the After-Action Report.

APPENDIX E: GLOSSARY OF ACRONYMS

Acronym	Term
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ACP	American College of Physicians
AERS	Adverse Event Reporting System
AI	Avian Influenza
AIC	Antivirals Issues Coordinator
AI/NA	American Indian/Native American
ANA	American Nurses Association
AOA	Administration on Aging
APEC	Asia-Pacific Economic Cooperation
APHA	American Public Health Association
APIC	Association for Practitioners in Infection Control and Epidemiology
ARC	American Red Cross
ASPA	Assistant Secretary for Public Affairs
ASTHO	Association of State and Territorial Health Officers
BRFSS	Behavioral Risk Factor Surveillance System
BT	Bioterrorism
CAN	Cost Accounting Number
CBP	Customs and Border Patrol
CC	Coordinating Centers
CCID	Coordinating Center for Infectious Diseases
CDC	Centers for Disease Control and Prevention

CERT	Center for Education and Research in Therapeutics
CIO	Centers, Institutes and Offices
CMS	Centers for Medicare & Medicaid Services
cGMP	Common Good Manufacturing Practices
CISA	Clinical Immunization Safety
CMRS	Cities Mortality Reporting System
COCA	Communication Outreach Conference Calls
CoCHIS	Coordinating Center for Health Information and Service
COG	Continuity of Government
COOP	Continuity of Operations
COTPER	Coordinating Office of Terrorism Preparedness and Emergency Response
CoV	Coronavirus
COVID-19	“2019-nCoV” or 2019 Novel Coronavirus
CSTE	Council of State and Territorial Epidemiologists
DEO	Director of Emergency Operations
DEOC	Director’s Emergency Operations Center
DHQP	Division of Healthcare Quality Promotion
DGM	Division of Global
DGMQ	Division of Global Migration and Quarantine
DMR	Division Media Relations
DOD	Department of Defense
DOI	Department of the Interior
DOS	Department of State

DOT	Department of Transportation
DSNS	Division of the Strategic National Stockpile
DTAC	Disaster Technical Assistance Center
DTC	Direct to Consumer
EAG	Enterprise Architecture Group
EARS	Early Aberration Reporting System
ECS	Emergency Communications System
EDRP	Electronic Death Registration Project
EIP	Emerging Infections Program
EMAC	Emergency Management Assistance Compact
ESF	Emergency Support Function
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
FETP	Field Epidemiology Training Programs
FIS	Federal Inspection Service
FMO	Financial Management Office
FQHC	Federally-qualified Health Centers
FTE	Full-time Employees
GISN	Global Influenza Surveillance Network
GOARN	Global Outbreak Alert and Response Network
HAN	Health Advisory Network
HHS	Health and Human Services
HPAI	Highly Pathogenic Avian Influenza

HRSA	Health Resources and Services Administration
HUD	Housing and Urban Development
ICLN	Integrated Consortium of Laboratory Networks
IEIP	International Emerging Infections Program
IIS	Immunization Information Systems
ILI	Influenza-like Illness
IND	Investigational New Drug
IPOE	International Point-of-Entry
ISO	Immunization Safety Office
KABP	Knowledge, Attitudes, Beliefs and Perceptions
LIS	Laboratory Information System
LRN	Laboratory Response Network
MCO	Managed Care Organizations
MERS-CoV	Middle Eastern Respiratory Syndrome-Coronavirus
MIDAS	Models of Infectious Disease Agent Study
MMSA	Metropolitan and Micropolitan Statistical Areas
MoH	Ministry of Health
NACCHO	National Association of County Health Officers
NAHDO	National Association of Health Data Organizations
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCHM	National Center for Health Marketing
NCHS	National Center for Health Statistics
NCPHI	National Center for Public Health Informatics

NDMS	National Disaster Medical System
NEDSS	National Electronic Disease Surveillance System
NEISS-CADE	National Electronic Injury Surveillance System Cooperative Adverse
NIH	National Institutes of Health
NIMS	National Incident Management System
NIOSH	National Institute of Occupational Safety and Health
NIP	National Immunization Program
NIS	National Immunization Survey
NIVS	National Influenza Vaccine Summit
NRP	National Response Plan
NVPO	National Vaccine Policy Office
NVSN	New Vaccine Surveillance Network
OD	Office of the Director
OEC	Office of Enterprise Communication
OGC	Office of General Council
OPHEP	Office of Public Health Emergency Preparedness
OSG	Office of the Surgeon General
OSHA	Occupational Safety and Health Administration
OWCD	Office of Workforce and Career Development
PAM	Program Area Module
PCB	Process Coordination Branch
PCR	Polymerase Chain Reaction
PDD	Presidential Disaster Declaration

PHEP CA	Public Health Emergency Preparedness Cooperative Agreement
PHLIS	Public Health Laboratory Information Systems
PI	Pandemic Influenza
PICA	Pandemic Influenza Communications Activity
QA/QC	Quality Assurance/Quality Control
REDI	Regional Emerging Disease Intervention
RFI	Requests for Information
RT-PCR	Reverse Transcriptase Polymerase Chain Reaction
SAMHSA	Substance Abuse and Mental Health Services Administration
SARS	Sudden Acute Respirator Syndrome
SHEA	Society for Healthcare Epidemiology of America
SLC	Salt Lake County
SLCo EM	Salt Lake County Division of Emergency Management
SME	Subject Matter Experts
SNS	Strategic National Stockpile
SOC	Secretary's Operations Center
SPN	Sentinel Provider Network
THAN	Traveler's Health Advisory Notice
TSA	Transportation Safety Administration
USDA	U.S. Department of Agriculture
USG	U.S. Government
VAERS	Vaccine Adverse Event Reporting System
VODS	Vaccine Ordering and Distribution System

VIC	Vaccine Issues Coordinator
WHO	World Health Organization

APPENDIX F: REFERENCES

1. World Health Organization COVID-19 Pandemic Declaration, 11 March 2020

2. Global Influenza Preparedness Plan, World Health Organization, 2005

3. Federal Implementation Plan for the National Strategy for Pandemic Influenza, National Security Council, May 2009

4. The Department of Homeland Security National Response Framework, February 2020

5. Emergency Support Functions #8 (Public Health and Medical Support Annex) to the National Response Framework, February 2020

6. Pandemic Influenza Plan, Department of Health and Human Services
   Part 1 – Strategic Plan, April 2009

   Part 2 – Public Health Guidance for State and Local Partner, April 2009

   Part 3 – HHS Implementation Plan, April 2009

7. Pandemic Influenza Operational Plan, Department of Health and Human Services, April 2009

8. Ethical Guidelines in Pandemic Influenza, Center for Disease Control and Prevention, February 2007

9. State of Utah Pandemic Response Plan, XXXXX XX

10. Salt Lake County Division of Emergency Management Incident Action Plan, 10 March 2020

11. The Robert T. Stafford Disaster Relief and Emergency Assistance Act
    (Referred to herein as "The Stafford Act"), 42 USC § 5121-5206

    a. Public Health Service Act, 42 USC § 201

    b. Social Security Act, 42 USC § 301

    c. The Economy Act of 1932, 31 USC § 1535-1536