GOVERNANCE & OVERSIGHT NARRATIVE

Local Authority: Salt Lake County Division of Behavioral Health Services (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, and documentation can be provided to indicate the homeless status, 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 waitlist 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 waitlist, 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 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 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:

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 - FY22 Amount Budgeted:	**$6,409,632**	**Form A1 - FY22 Projected clients Served:**	**303**
Form A1 - Amount budgeted in FY21 Area Plan	**$7,193,368**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**350**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$6,775,917**	**Form A1 - Actual FY20 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.

For Medicaid clientele, DBHS's/Optum's Network consists of contracts with the Huntsman Mental Health Institute (HMHI), University of Utah Inpatient Medical Psychiatry (IMP), Jordan Valley West, and St. Mark's Hospital in Salt Lake County for Adult Inpatient Care. Salt Lake County/Optum will contract with out-of-Network facilities on a client-by-client basis if a client is admitted to a hospital outside of the network.

For those who are unfunded, DBHS has contracted with HMHI for Adult Inpatient Care. Other than who is contracted, the process differs for the unfunded as those who are admitted into a hospital do not require a preauthorization. This is due to the fact that the money for unfunded hospitalization is limited and HMHI has repeatedly shown that they provide far more bed days to the unfunded population that regularly exceeds the contracted amount. Valley Behavioral Health (VBH) does work with these clients while in the hospital to either continue or set-up services upon discharge.

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 expected change

Describe any significant programmatic changes from the previous year.

The University Neuropsychiatric Institute (UNI) changed their name to the Huntsman Mental Health Institute (HMHI) and the University of Utah 5 West floor was changed to University of Utah Inpatient Medical Psychiatry (IMP).

2) Children/Youth Inpatient

Form A1 - FY22 Amount Budgeted:	**$4,489,820**	**Form A1 - FY22 Projected clients Served:**	**264**
Form A1 - Amount budgeted in FY21 Area Plan	**$4,442,941**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**264**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$4,706,943**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**258**

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 HMHI in Salt Lake County for youth inpatient care. Initial assessment for hospitalization is done either in the primary care unit or by the crisis staff in emergency departments at any hospital. Should HMHI be at capacity, DBHS/Optum has the ability to implement a single case agreement (SCA) with any willing provider.

Describe your efforts to support the transition from this level of care back to the community.

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

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 expected change

Describe any significant programmatic changes from the previous year.

The addition of the dedicated care coordinator for youth was described above. Additionally, DBHS/Optum is in the process of credentialing Salt Lake Behavioral Hospital for inpatient care for youth ages 12 – 17.

3) Adult Residential Care

Form A1 - FY22 Amount Budgeted:	**$9,622,917**	**Form A1 - FY22 Projected clients Served:**	**1,622**
Form A1 - Amount budgeted in FY21 Area Plan	**$8,354,042**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**1,421**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$6,689,757**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**1,484**

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. Summit Subacute – Highland Ridge Hospital operates a short-term residential and inpatient diversion program for male and female adults with acute mental health (MH) needs. Although a 10 bed facility, Summit Subacute has the flexibility to increase the number of beds when the need is identified. Optum has an identified Care Advocate on their team who works closely with internal staff, community partners and the Summit Subacute unit to facilitate the increase. Odyssey House added a 16-bed residential facility for mentally ill adult female clients who also have substance use disorder (SUD) treatment needs and are involved in criminal justice services. Treatment focuses on behavioral health issues and criminogenic risk factors.
How is access to this level of care determined? How is the effectiveness and accessibility of residential care evaluated?
DBHS/Optum uses the LOCUS-Level of Care Utilization System for Adults to determine if a residential level of care is indicated for mental health treatment.
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).
Since FY 20 there have been two new programs opened. A third program is set to open the first of August 21. Also Medicaid set a new RTC rate to pay for reimbursement. These four explanations explain the increase in costs and number of clients that will be served.
Describe any significant programmatic changes from the previous year.
3 additional programs will be operational in FY 2022 from FY 2020.. As explained in the increase in costs above.

4) Children/Youth Residential Care

Form A1 - FY22 Amount Budgeted:	**$309,460**	**Form A1 - FY22 Projected clients Served:**	**50**
Form A1 - Amount budgeted in FY21 Area Plan	**$290,480**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**75**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$277,243**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**45**

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. They are in the process of moving to a new location in Draper. The youth have access to school services along with therapeutic services, including medication management.

Synergy Youth Treatment
DBHS/Optum is in the process of credentialing/contracting with Synergy Youth Treatment as an additional resource for males aged 12 to 18 with more acute behavioral and mental health issues.

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.

We are finding a limited number of providers offering residential treatment for youth with more severe eating disorder symptoms and additional acute mental health issues.

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

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

Referrals for the FAST program are made through hospital emergency rooms, other service providers, and through Salt Lake County Division of Youth Services Juvenile Receiving Center. Transition from FAST to home is determined clinically in collaboration with the family to assess barriers to stabilization and successful reunification. Follow-up calls are made to assure needs have been met and to provide additional referrals and resources as necessary.

Through concurrent reviews for ongoing care, Optum Care Advocates evaluate agency discharge planning to ensure the youth's natural supports are included and access to follow-up care is coordinated. The goal is to help kids transition back home and into their community. Access to needed

clinical services (i.e. day treatment, intensive outpatient, medication management services, respite care, FPSS referral, school-based supports) is also coordinated. Each discharge plan is expected to be individualized. The Optum Clinical Team is available to staff cases with providers and offer assistance throughout the discharging planning process, while the plan is based on needs identified by the treatment providers. The Recovery & Resiliency Team can offer support to parents dealing with challenges of caring for a child with behavioral health needs and can link parents to community supports like the Utah Parent Association and NAMI.

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 expected change

Describe any significant programmatic changes from the previous year.

No significant changes

5) Adult Outpatient Care

Form A1 - FY22 Amount Budgeted:	**$12,009,345**	**Form A1 - FY22 Projected clients Served:**	**7,600**
Form A1 - Amount budgeted in FY21 Area Plan	**$11,184,042**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**8,172**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$13,112,927**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**7,630**

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 (RIC-AAU). RIC-AAU provides focused and culturally appropriate treatment to serve the refugee population located in the valley. VBH's outpatient clinics also serve the refugee population.

Medication management services are offered by multiple providers throughout the county to include outpatient clinics, nursing homes, and via telehealth. Prescribers on the ACT (Assertive Community Treatment) 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.

Volunteers of America (VOA) has expanded their ACT capacity from 100 to 150 over the past year to meet increased need in Salt Lake County. To do this, they have started a second ACT team.

Valley Behavioral Health has started an ACT team that will serve approximately 100 members as well.

Guardian and Conservator Services has developed a small outpatient clinic over the past year to provide services for members with Representative Payee services. This was developed for these members who have not connected with or are struggling to connect with a community mental health provider.

First Step House has developed an outpatient program (Charter) in conjunction with the new 75 bed housing facility they have opened. Charter will serve residents at this facility, as well as accept community referrals in the near future.

DBHS/OPTUM has increased Telehealth services over the past year, mostly as the result of the pandemic going from 4 providers to over 90 currently. Most of these providers report planning to attest through credentialing and keep telehealth capabilities as an option for treatment after the pandemic.

Describe community based services for high acuity patients including Assertive Community Treatment (ACT), Assertive Community Outreach Treatment (ACOT), and/or Intensive Case Management (ICM) 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.

Valley Behavioral Health ACT (started March 2021)
ACT is a national, evidenced-based service delivery model with a primary goal of recovery through community treatment and habilitation. For consumers with the most challenging and persistent problems, ACT assumes primary responsibility for all services — from psychiatry and social work to rehabilitation and substance use disorder treatment. Rather than referring members to multiple programs and services, the ACT program takes a team approach to provide the treatment and services that members need. The ACT team follows the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures is completed by VBH 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.

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 expected change
Describe any significant programmatic changes from the previous year.
VBH ACT began in the current fiscal year expanding the total number of available spots. As mentioned above, VOA also expanded their ACT enrollment from 100 to 150 members.
Describe the programmatic approach for serving individuals in the least restrictive level of care who are civilly committed or court-ordered to Assisted Outpatient Treatment. Include the process to track the individuals, including progress in treatment.
DBHS/Optum has a large network of providers who are available to provide a vast array of outpatient services. Clients have the freedom to choose any provider from the network that provides services to meet their needs. All levels of care are available and DBHS/Optum works with all clients to assist them in determining the level of care needed and align them with a provider at their request. DBHS/Optum uses the ECSII: Early Childhood Service Intensity Instrument for Youth to determine if a residential level of care is indicated. See Section #29 for information regarding fidelity monitoring and outcome measures.

6) Children/Youth Outpatient Care

Form A1 - FY22 Amount Budgeted:	**$14,314,834**	**Form A1 - FY22 Projected clients Served:**	**4,700**
Form A1 - Amount budgeted in FY21 Area Plan	**$11,228,192**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**5,755**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$15,136,760**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**4,668**

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 highlight approaches to engage family systems.
DBHS/Optum has a large network of providers who are available to provide a vast array of outpatient services. Clients have the freedom to choose any provider from the network that provides services to meet their needs. Additionally, in some cases clients may opt to receive services from a provider not in the network. These services can be provided as long as preauthorization requirements are met. DBHS's/Optum's network offers a comprehensive outpatient program that serves children 0-18 with mental illness and their families in Salt Lake County. Services include individual, family and group therapy, psychiatric evaluation, medication management, psychological testing, respite, Family 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. The Children's Center employs 5 certified Child Parent Psychotherapy (CPP) providers and is certified in training future in-house clinicians in this modality working with youth and families with domestic violence and trauma issues. They are also completing certification in providing Attachment and Biobehavioral Catch-up (ABC).

Valley Behavioral Health
VBH offers outpatient and medication management services for youth. 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. In addition, Valley is working toward an extension of their DBT Day Treatment with a track focusing on treating mild to moderate eating disorders.

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

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

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

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

The following programs are offered through Salt Lake County Division of Youth Services (DYS):
Counseling services include immediate crisis counseling for youth and families, 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.

We have reached out and sent a list of 6 – 7 providers interested in Perinatal Mood Disorder training. We do have some providers with this certification (Reach and Children's Services Society), and we are working to increase the number of providers in the network with this training.
Describe community based services/approaches for high acuity youth and families. Describe the programmatic approach to serving individuals in the least restrictive level of care. Identify your proposed fidelity monitoring and outcome measures.
DBHS/Optum supports both community-based in-home and school-based services whenever viable for the youth and family. We have several providers that offer in-home services to youth/families who have transportation challenges and/or whose needs are better addressed in the client's home. (Some of these providers are listed above.) In addition, DBHS/Optum works with several providers that have designated school-based clinicians assigned to schools within each district at the school districts' discretion. These providers are Valley Behavioral Health, Hopeful Beginnings, Project Connection and Odyssey House. Optum collaborates with Intermountain Healthcare's Stabilization and Mobile Response (SMR) to facilitate transition for youth and families into the Optum SLCo Medicaid Network. See Section #29 for information regarding fidelity monitoring and outcome measures.
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 expected change
Describe any significant programmatic changes from the previous year.
No significant change

7) Adult 24-Hour Crisis Care

Form A1 - FY22 Amount Budgeted:	**$9,713,715**	**Form A1 - FY22 Projected clients Served:**	**2.077**
Form A1 - Amount budgeted in FY21 Area Plan	**$6,067,368**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**470**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$4,707,142**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**2,058**

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 and what gaps need to still be addressed to offer a full continuum of care. Identify plans for meeting any statutory or administrative rule governing crisis services. For each service, identify whether you will provide services directly or through a contracted provider. Describe how you coordinate with state and local partners for services to include the Utah Crisis Line, JJS and other DHS systems of care, for the provision of services to at risk youth, children, and their families.

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

Mobile Crisis Outreach Teams – HMHI

The HMHI MCOT is an interdisciplinary team of mental health therapists and Certified Peer Specialists, who provide a combination of crisis services including crisis intervention, psychiatric emergency care, urgent care, referrals and connection to community resources, and crisis follow-up for residents of Salt Lake County 24/7, 365 days per year. The team is committed to responding within 30 minutes to law enforcement requests and within 60 minutes to community requests. At the time of this writing the average law enforcement response time was 21.5 minutes and the average community response time was 26 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 FY20, 82% of those receiving an outreach visit were diverted from inpatient and emergency room visits. This was a decrease from the previous year. The HMHI MCOT averages almost 281 contacts per month, a decrease of 97 contacts per month. This decrease was due to efforts that were made to better align MCOT scope of services with state code and the county contract, resulting in less work for the court system that used to count toward monthly outreaches totals. Of the 281 contacts, an average of 261/month 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 FY20, there were 252 admissions with an average length of stay of 11.32 days, for a total of 2,852 bed days. The increase in the number of bed days was most notable during April and June, 2020. The spike being attributed to the COVID-19 pandemic which impacted the mental health of members as well as disposition options when returning to a lower level of care.

Receiving Center – HMHI

The Receiving Center (operating 24/7 365 days a year) diverts people from inpatient services and the jail. It is able to receive referrals from law enforcement, MCOT, stakeholders and the community. Consumer-centered crisis services are offered through this "living room" style center and individuals can stay at the center for up to 23 hours to receive what they need to resolve the current crisis — including assessments, medications and other support. During FY21, through March, the center receives an average of 97 consumer visits per month, which is a decrease average of 41 per month during the same time in FY20. This was directly proportional to the reduction in beds the Receiving Center was required to make due to COVID-19 precautions, which was in order to maintain safe patient distancing the Receiving Center capacity was reduced from 6 to 4 patients at any given time. This was a drop to 67% of our typical bed capacity; however, considering the additional measures taken for COVID-19, the Receiving Center was still seeing 70% of the typical annual average. Of these, only 11.5% continued on to inpatient stays, no one was diverted to the County jail (through March, FY21), with 61.6% returning to their home or family (the latter representing a 4.6% increase).

Crisis Line – HMHI
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 FY21, through March, the crisis line, including Life Line, has received an average of 6071 calls per month, which represents an average monthly increase of 1,127 during the same time in FY20.

Warm Line – HMHI
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 FY21, through March, the warm line has received an average of 2072 calls per month. An increase of 24 from the average during the same time in FY20.

Descriptions of the additional adult crisis services funded through JRI (HMHI/UPD Pilot and DPS/VOA Program) can be found under 35) Justice Treatment Services.

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

Each month, both HMHI and Highland Ridge-Summit Subacute submit data. The data is reviewed to assess for increases/decreases in referral sources, as well as disposition planning, month over month. On a quarterly basis, this same information is evaluated against the same quarter from the previous FY. When significant changes are noted, discussions occur internally and with stakeholders to analyze the contributing factors to those significant changes.

Internally, HMHI uses the following to evaluate crisis intervention services to measure access and outcomes:

- Documentation of services to monitor anticipated outcomes and costs
- Continuous Quality improvement utilizing data to improve outcomes and efficiencies
- Demonstrating effectiveness of services/programs such as inpatient and jail diversion, reduced law enforcement resources etc.
- Ensure financial sustainability into perpetuity through program validation and programs value
- Maximizing utilization of resources being wise stewards of public dollars

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 increase in costs comes from four million dollars of State of Utah funding and seven hundred thousand of Salt Lake County funds. These funds are for the construction of the new receiving center being built by HMHI. Actual operation costs are expected to be similar to FY 20 actual spend the number of clients served is expected to be similar.

Describe any significant programmatic changes from the previous year.

No programmatic changes have occurred during this past year. However, due to the COVID-19 pandemic, the number of adults that could be served in these programs was adjusted as per CDC

protocols.

8) Children/Youth 24-Hour Crisis Care

Form A1 - FY22 Amount Budgeted:	**$1,264,856**	**Form A1 - FY22 Projected clients Served:**	**475**
Form A1 - Amount budgeted in FY21 Area Plan	**$1,494,323**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**92**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$1,166,625**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**468**

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, where services are provided, and what gaps need to still be addressed to offer a full continuum of care. 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, to include JJS and other DHS systems of care, for the provision of services to at risk youth, children, and their families.

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 HMHI MCOT is an interdisciplinary team of mental health therapists and Certified Peer Specialists, who provide a combination of crisis services including crisis intervention, psychiatric emergency care, urgent care, referrals and connection to community resources, and crisis follow-up for residents of Salt Lake County 24/7, 365 days per year. The team is committed to responding within 30 minutes to law enforcement requests and within 60 minutes to community requests. At the time of this writing the average law enforcement response time was 21.5 minutes and the average community response time was 26 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 FY 21, through March, 89.0% of those receiving an outreach visit were diverted from inpatient hospitalizations, which represents a 3% improvement during the same time in FY20. The HMHI MCOT averages 92 youth contacts per month, which is a decrease of 9 per month compared to the same time during FY20, of which an average of 82 resulted 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 need a crisis timeout, are runaway, homeless, ungovernable youth or youth who have committed minor offenses. Youth may come to the facility on their own, with parents or police may bring in youth who have committed a status offense or delinquent act that does not meet Detention Admission Guidelines. This may include but not limited to running away from home, truancy, substance abuse, curfew violation or acting beyond the control of the youth's parents. No appointment is needed to access the Juvenile Receiving Center services including individual or family crisis counseling. Serving two locations: Salt Lake and West Jordan.

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

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

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

Family Support Center - The Family Support Center also offers a free Crisis Nursery 24/7 for families with children ages 0-11 in three locations in the Salt Lake Valley.

Description of the additional youth crisis services funded through JRI (HMHI/UPD Pilot and DPS/VOA Program) can be found under 35) Justice Treatment Services.

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

Each month, both HMHI and Highland Ridge-Summit Subacute submit data. The data is reviewed to assess for increases/decreases in referral sources, as well as disposition planning, month over month. On a quarterly basis, this same information is evaluated against the same quarter from the previous FY. When significant changes are noted, discussions occur internally and with stakeholders to analyze the contributing factors to those significant changes.

Internally, HMHI uses the following to evaluate crisis intervention services to measure access and outcomes:

- Documentation of services to monitor anticipated outcomes and costs
- Continuous Quality improvement utilizing data to improve outcomes and efficiencies
- Demonstrating effectiveness of services/programs such as inpatient and jail diversion, reduced law enforcement resources etc.
- Ensure financial sustainability into perpetuity through program validation and programs value
- Maximizing utilization of resources being wise stewards of public dollars

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 expected change

Describe any significant programmatic changes from the previous year.

No programmatic changes have occurred during this past year. However, due to the COVID-19 pandemic, the number of youth that could be served in these programs was adjusted as per CDC protocols.

9) Adult Psychotropic Medication Management

Form A1 - FY22 Amount Budgeted:	**$2,158,787**	**Form A1 - FY22 Projected clients Served:**	**4,782**
Form A1 - Amount budgeted in FY21 Area Plan	**$2,387,197**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**4,778**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$2,226,334**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**4,726**

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 or between providers/settings.

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 FY22.

Currently, DBHS/Optum has 97 prescribers (M.D.s, D.O.s, and APRNs) across 26 agencies within the Optum Salt Lake County Medicaid Network. Some prescribers are counted more than once, as some

offer their services at more than one contracted agency/provider.

DBHS/Optum have worked with providers such as Anderson Wellness to credential 2 additional APRNs. This provider offers medication management services for receiving primary behavioral services with another provider without psychiatric services. In addition, DBHS/Optum has added Dr. Sachin Rajhans as an independent solo practitioner offering outpatient 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 expected change

Describe any significant programmatic changes from the previous year.

No significant changes

10) Children/Youth Psychotropic Medication Management

Form A1 - FY22 Amount Budgeted:	**$512,256**	**Form A1 - FY22 Projected clients Served:**	**936**
Form A1 - Amount budgeted in FY21 Area Plan	**$502,947**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**1,057**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$555,499**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**941**

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 or between providers/settings.

Medication management services are offered by multiple providers throughout the county to include outpatient clinics and telehealth services. Hopeful Beginnings, New Beginnings, The Children's Center, Valley Behavioral Health, Lotus Center, Primary Children's Safe and Healthy Families, Primary Children's Pediatric Behavioral Health, and others have delivered medication management to children and adolescents in FY21 and will continue into FY22. 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.

Currently, DBHS/Optum has 97 prescribers (M.D.s, D.O.s, and APRNs) across 26 agencies within the Optum Salt Lake County Medicaid Network. Some prescribers are counted more than once, as some offer their services at more than one contracted agency/provider.

We have added 2 APRN's with Anderson Wellness and working on additional options; DBHS/Optum will continue to seek out prescribers in the community for FY22.

When youth are discharged from inpatient services, a follow-up medication management appointment is to be scheduled as part of the discharge plan. The discharge plan with the medication orders are

sent to the receiving provider. When a youth shifts from an outpatient prescriber to another, the guardian is asked to sign a release of information so the current/historical medication information may be shared with the receiving prescriber. If a member needs assistance identifying prescribers in the network, Optum Care Advocates, Care Coordinators and Recovery & Resiliency Peers can assist with this process.

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 expected change

Describe any significant programmatic changes from the previous year.

No significant changes

11) Adult Psychoeducation Services & Psychosocial Rehabilitation

Form A1 - FY22 Amount Budgeted:	**$1,499,276**	**Form A1 - FY22 Projected clients Served:**	**950**
Form A1 - Amount budgeted in FY21 Area Plan	**$1,480,787**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**1,180**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$1,471,520**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**937**

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 Accredited Clubhouse model program, in Salt Lake City to provide skills development programs for adults. The mission of the Alliance House is to help those with a 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 28) Client Employment.

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

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

Describe how clients are identified for Psychoeducation and/or Psychosocial Rehabilitation services. How is the effectiveness of the services measured?
Clients are identified for these services through a biopsychosocial assessment and services are prescribed by an independently licensed clinician. Effectiveness of services is measured by a regular review of the objectives developed for each client receiving the service and their progress on these objectives. Members must meet the criteria for 1915(b)(3) services, which includes SMI classification, to qualify for Psychoeducational services.
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 expected change
Describe any significant programmatic changes from the previous year.
No significant changes

12) Children/Youth Psychoeducation Services & Psychosocial Rehabilitation

Form A1 - FY22 Amount Budgeted:	**$5,322,230**	**Form A1 - FY22 Projected clients Served:**	**730**
Form A1 - Amount budgeted in FY21 Area Plan	**$6,589,849**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**862**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$5,622,525**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**738**

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 the Salt Lake School District at Beacon Heights 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.

DBT Day Treatment offers an intensive day program option for up to 12 adolescents addressing behavioral and emotional challenges focusing specifically on DBT skill development. The goal is to help the youth and family develop and utilize these skills across settings. Valley BH is in the process of adding a track for youth suffering with mild to moderate eating disorders.

AIM Day Treatment is a day program option for youth struggling with behavioral health issues across multiple settings (i.e. home and school). Services include individual, group and family therapy as well as skills training.

There are several providers who provide Psychosocial Rehabilitation including: Hopeful Beginnings, Utah Youth Village, Youth Empowerment Services, Summit Community Counseling, Utah Behavior Services, The Children's Center, and Utah House.

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

Clients are identified for these services through a biopsychosocial assessment and services are prescribed by an independently licensed clinician. Effectiveness of services is measured by a regular review of the objectives developed for each client receiving the service and their progress on these objectives.

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 expected change

Describe any significant programmatic changes from the previous year.

Granite School District has chosen to discontinue the program at Robert Frost Elementary due to District budgetary issues.

13) Adult Case Management

Form A1 - FY22 Amount Budgeted:	**$4,428,743**	**Form A1 - FY22 Projected clients Served:**	**3,900**
Form A1 - Amount budgeted in FY21 Area Plan	**$4,694,082**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**2,908**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$4,488,028**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**3,874**

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 SMI (Seriously Mentally Ill) throughout the service continuum from outpatient services to in-home skills training programs. The goals of TCM are to:

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

Optum employs a Housing Support Specialist to coordinate case management services for clients who need housing and/or supports to stay housed.

Optum has four providers who offer intensive, targeted case management for our clients: Valley Behavioral Health, Project Connection, VOA, and Psychiatric Behavioral Services. These same agencies have committed to delivering services to those who are Medicaid eligible and either homeless or recently housed.

VBH offers a new intensive Care Navigation program for adult clients who are in need of extra support while transitioning from an inpatient/subacute facility or who are experiencing instability in their care. The team is designed to be flexible so they can respond quickly to both members and others who are in need of their assistance.

Historically, VBH has also offered an Assertive Commuity Outreach Team (ACOT) for adult clients with SPMI/SMI. The ACOTsubscribed 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 ACOTprimarily provided case management services to Medicaid and non-Medicaid clientele. However, effective March 1, 2021, VBH took the necessary steps to convert the ACOT to a SAMHSA full fidelity ACT team. Though VBH will serve any person who meets criteria, they will specialize in those with criminal justice involvement. Most of those who were already clients of ACOT transitioned into the new ACT team. Additionally, some JDOT clients (described below) also transitioned to this new ACT team.

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.

Project Connection has implemented an evidenced-based program known as Critical Time Intervention (CTI). This program offers intensive case management services designed to start with the client focusing on their interests and treatment needs, what services are available to help them achieve their interests and maintain stability with their mental health issues while moving forward on the recovery path.

RIC-AAU offers case management services for the refugee populations, coordinating treatment, employment training, housing, insurance access, and other services to support refugees as they integrate into the community.

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

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

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

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

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 expected change

Describe any significant programmatic changes from the previous year.

With the exception of the addition of the VBH Care Navigation program and conversion of the AOT to a full fidelity ACT team, there are no significant programmatic changes from the previous year

14) Children/Youth Case Management

Form A1 - FY22 Amount Budgeted:	**$339,326**	**Form A1 - FY22 Projected clients Served:**	**1,011**
Form A1 - Amount budgeted in FY21 Area Plan	**$300,029**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**1,009**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$363,540**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**1,006**

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 with a serious emotional disturbance (SED) and who are receiving primarily mental health treatment. The goals of TCM are to:

- Help clients access appropriate services and supports
- Assure that services are relevant and meet consumer needs

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

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

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

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

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

DYS Milestone Transitional Living Program: 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.

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

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

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

In addition to the above, for the DYS programs, any youth between the ages of 18 to 21 that is experiencing homelessness is eligible and can submit an application. The Milestone Program measures effectiveness by collecting information about education, employment and housing upon

entrance and exit of the program. A successful transition is determined when a client is employed and/or attending school and housed upon exit.
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 expected change
Describe any significant programmatic changes from the previous year.
No significant changes

15) Adult Community Supports (housing services)

Form A1 - FY22 Amount Budgeted:	**$2,028,167**	**Form A1 - FY22 Projected clients Served:**	**350**
Form A1 - Amount budgeted in FY21 Area Plan	**$1,222,263**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**361**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$1,105,173**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**277**

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.

During FY22, DBHS anticipates to fund and contract for approximately 225 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 57 units for the State Hospital Diversion program, 57 units for the Project RIO Housing (master leased units for SMI clients), 58 units for HARP Housing (short and long term rental assistance), 22 units at the VOA Denver Apartments, 25 units at the Central City Apartments (see more below on these tax credit projects), and 6 master lease units at First Step House's Fisher House (congregate site for SMI clients referred to housing through their Mental Health Court participation). All partners referring 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 Diversion 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, or as a measure to prevent decompensating mental health and inpatient hospitalization. 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. 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 mentally ill (SMI) population. This tax credit project targets 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 opened in 2020.

Additional Housing and Resources:

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

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, eligible participants from Volunteers of America (VOA) detox programming, 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 provided program flexibility and relaxed protocols (allowing clients to return multiple times based on job loss, or allowing clients to stay longer than 6 months) due to the negative economic impacts of the pandemic. In FY22, DBHS anticipates providing approximately 900 clients with sober living vouchers. Due to funding and other resource constraints, the monthly program capacity is approximately 275 vouchers.

Indicate what assessment tools are used to determine criteria, level of care and outcomes for placement in treatment-based and/or supportive housing?

A complete biopsychosocial assessment is completed by a LMHT and used to determine if a member demonstrates a clinical need for receiving supportive housing. All individuals in these housing units have been identified as SMI and their level of ability to independently function is taken into account. Ongoing assessment is required to warrant ongoing supportive living placement. For USH patients, an Occupational Therapy evaluation is requested to assess activities of daily living skills.

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).

Due to the ongoing and growing need for housing subsidy for individuals struggling with severe mental illness (clients housed in project-based programs like First Step House's Central City Apartments and VOA's Denver Street Apartments), additional funds have been added to the FY22 budget. Closely related, in FY22 DBHS will begin contracting for and administering housing support for Mental Health Court's master lease units and the six placements at First Step House's Fisher House (previously administered through Salt Lake County Criminal Justice Services). All of these items account for the increase in costs and the additional clients that will be served.

Describe any significant programmatic changes from the previous year.

In FY22, Central City will have the first complete year of full housing capacity (75 units), Fisher House and other additional master lease Mental Health Court units will now be funded through DBHS, and additional housing will be developed, contracted for, and supported as the need arises across the various housing programs and populations described above (including new residential MH programs and expanding/new ACT teams).

16) Children/Youth Community Supports (respite services)

Form A1 - FY22 Amount Budgeted:	**$1,115,552**	**Form A1 - FY22 Projected clients Served:**	**266**
Form A1 - Amount budgeted in FY21 Area Plan	**$1,388,081**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**402**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$984,234**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**258**

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.
Please describe how you determine eligibility for respite services. How is the effectiveness of the service measured?
The youth must meet the criteria for this 1915(b)(3) service with SED status and eligibility for Traditional Medicaid. In addition, a licensed mental health therapist must prescribe respite services and include it in the treatment plan. Respite providers collaborate with the referring clinician regarding the member's presentation during respite outings. Since respite is not considered a therapeutic intervention, rather a supportive service, the goal which includes this service would be assessed during the treatment plan review.
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 expected change
Describe any significant programmatic changes from the previous year.
No significant changes

17) Adult Peer Support Services

Form A1 - FY22 Amount Budgeted:	**$816,481**	**Form A1 - FY22 Projected clients Served:**	**1,100**
Form A1 - Amount budgeted in FY21 Area Plan	**$789,932**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**1,274**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$908,731**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**1,173**
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. Describe your policies and procedures for peer support.			

Providing and receiving peer support stands as an integral component of rehabilitation and recovery. DBHS/Optum is dedicated to the Peer Support Specialist Program and continues to work to expand the peer workforce in Salt Lake County. Peer Support Specialists are critical to the Salt Lake County Behavioral Health System and DBHS/Optum utilizes providers within DBHS/Optum's network of providers to provide this service.

Optum continues to offer services through the Peer Navigator Program. Peer mentoring, support, advocacy, and skill building will be provided for these individuals through regular, individual contact over a period of time. The goal is to ease the transition of individuals being discharged from hospital settings back into community life, to significantly decrease the need for readmission to the hospital, and to significantly decrease the need for hospitalization by engaging people prior to entry into the inpatient facilities. Peer Support Specialists provide consumers with support and linkage to mental and physical health, and social services. Referrals are received from multiple sources including Utah State Hospital for patients transitioning back into the community, provider agencies (i.e. VBH, HMHI, individual providers), and other systems.

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.

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

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

Referrals are made to the Optum Peer Support Specialists via providers, community stakeholders and internal Optum meetings. The effectiveness of services is measured through reports presented by the CPSS on the outcomes of the meetings with members.

Describe your policies and procedures for peer support. Do Certified Peer Support Specialists participate in clinical staffings?

Optum Peer Support Specialists participate in Optum clinical rounds 2x a week as well as internal Utah State Hospital Committee meetings. Their participation in these meetings is considered critical.

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.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served and number of services provided(15% or greater change).
No significant expected change
Describe any significant programmatic changes from the previous year.
No significant changes

18) Children/Youth Peer Support Services

Form A1 - FY22 Amount Budgeted:	**$792,067**	**Form A1 - FY22 Projected clients Served:**	**115**
Form A1 - Amount budgeted in FY21 Area Plan	**$738,433**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**155**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$812,991**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**105**

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. *Describe how Family Peer Support Specialists will partner with other Department of Human Services child serving agencies, including DCFS, DJJS, DSPD, and HFW.*

Children/Youth Peer Support Services are provided primarily by Family Peer Support Specialists (FPSSs). DBHS is providing peer support offered to the parents and/or caregivers of children and youth receiving services. Salt Lake County Division of Youth Services (DYS) is the administrator of anchoring sites for FPSSs. Training, mentoring, data collection and reporting is the responsibility of Allies with Families.

The FPSS program services are designed to provide family peer support services to parents and/or caregivers of children/youth with complex needs. Generally, FPSSs 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).. 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 7 FPSSs placed with 7 agencies throughout Salt Lake County. Presently FPSSs are anchored at the following agencies or organizations:
• 1 FTEs Salt Lake County Division of Youth Services
• 1 FTE Utah Division of Juvenile Justice Services
• 1 FTE Granite School District
• 2 FTE State of Utah Division of Child and Family Services (DCFS)
• 1 FTE 3rd District Juvenile Court
• 1 FTE Family Support Center

Allies with Families is being added to the Optum Salt Lake County Network to ensure the sustainability of FPSS services within this county.

Describe your policies and procedures for peer support. Do Certified Peer Support Specialists participate in clinical staffings?
DYS does not currently have specific policies and procedures for peer support. Instead, to help guide the process and utilization of the FPSS, DYS utilizes the FPSS Code of Ethics and DHS Code of Conduct which the FPSS must sign annually. Yes. Based on the level of experience the FPSS has with the family/youth, it is possible they might be asked to participate in a clinical staffing to share relevant information with those involved in the youth's treatment. Optum Peer Support Specialists participate in Optum clinical rounds 2x a week as well as internal Utah State Hospital Committee meetings. Their participation in these meetings is considered critical as their input and support help to keep the member at the forefront of the discussion.
Please identify how youth and family eligibility for this service is determined.
The continuum of care within the Salt Lake City region is structured in a way to support an appropriate referral. Any youth under the age of 26 still living at home with a behavioral health need, WITHOUT 2 arms of DHS systems involved, would be an appropriate referral. Peer support services are rendered to the parents of a youth under the age of 16 per Medicaid. No income verification or insurance coverage is required of the family to receive services.
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served and number of services provided (15% or greater change).
No significant expected change
How is Family Peer Support supervision provided? Who provides the supervision? What training do supervisors receive? What training does clinical staff receive on engaging Certified Family Peer Support services in the continuum of care?
Supervision of the FPSSs is two-fold. The FPSS Supervisor at DYS oversees all programmatic and personnel issues for all 7 FPSSs and serves as the liaison between the employing agency and the FPSS, provides guidance and support to the FPSS to promote competent and ethical delivery of services and assures effective implementation of the agency's policies and procedures, and advocates for peer support roles within the agency. In addition, the FPSSs placed at various site locations also report to a site supervisor. This person is available for any immediate questions or concerns an FPSS may have in the course of working with families referred through site staffings. Site supervision of the FPSS takes place as needed and involves the DYS FPSS Supervisor, the site supervisor, the mentor, and the FPSS. The on-site supervisor can contact the DYS FPSS Supervisor at any time to discuss any problems or issues involving the FPSS. The mentor can also provide input.
Describe any significant programmatic changes from the previous year.
No significant changes from the previous year. Allies with Families will be contracted with Optum Salt Lake County in FY22

19) Adult Consultation & Education Services

Form A1 - FY22 Amount Budgeted:	**$837,808**		
Form A1 - Amount budgeted in FY21 Area Plan	**$1,137,067**		
Form A1 - Actual FY20 Expenditures Reported by Locals	**$836,122**		

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 FY21:
• 30 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.
• 87 people were trained and certified to become a Certified Peer Support Specialist

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

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

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

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

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 expected change

Describe any significant programmatic changes from the previous year.

No significant changes

20) Children/Youth Consultation & Education Services

Form A1 - FY22 Amount Budgeted:	**$216,499**		
Form A1 - Amount budgeted in FY21 Area Plan	**$269,389**		
Form A1 - Actual FY20 Expenditures Reported by Locals	**$198,195**		

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 FY22, 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.

In FY22, Optum will add Certified Peer Support Specialist Refresher Trainings.

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 expected change

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

21) Services to Incarcerated Persons

Form A1 - FY22 Amount Budgeted:	**$153,350**	**Form A1 - FY22 Projected clients Served:**	**1,070**
Form A1 - Amount budgeted in FY21 Area Plan	**$153,424**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**1,002**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$140,399**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**1,072**

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, and how you will coordinate with the jail to ensure service delivery is adequate.

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 SMI 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.

Alternatives to Incarceration (ATI) Transport
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 Salt Lake Legal Defender Association's (LDA) 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 LDA's office, offering invaluable assistance in connecting large numbers of clients to treatment from the jail.

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

- Ensure jail mental health is aware of an individual's diagnosis and medications prescribed in the community prior to arrest, and vice-versa, ensure community mental health programs are aware of an individual's diagnosis and medications prescribed in jail prior to release.
- Develop a pre-release relationship with the inmate prior to release whenever possible.
- Work to assertively engage the client in treatment upon release, address continuity of

care/medications and transport if appropriate.

- Refer into appropriate programs (Mental Health Court, ACT Teams, dual-diagnosis residential programs, Jail Diversion Outreach Team, other outpatient services, housing, 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.
- Support the client to resolve open court cases.
- Coordinate with medical providers when appropriate.
- Coordinate with other community providers (VA, private providers, etc.).
- Assist with housing, entitlements, and other needed supports.
- Address individuals as pre-contemplative rather than non-compliant when unable to engage them into services. That is, try, try again.

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, VBH Forensics, Recovery International Forensics ACT team, Valley Behavioral Health ACT team, VOA ACT Team, Odyssey House Mental Health Residential Program, Central City Housing program, Denver Apartments program, and others.

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

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

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

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

The jail employs MH discharge planners that coordinate with the programs mentioned in the box above, such as CRT, ATI Transport and LDA Social Services positions, and also attend the monthly Top Ten group that staffs frequently booked SPMI individuals to connect them to care upon release.

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

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

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 expected change

Describe any significant programmatic changes from the previous year.

In the previous year, due to COVID-19, the jail implemented stringent booking restrictions that significantly reduced the jail's overall population. Instead of having approximately 2,200 inmates, they had approximately 1,200. This affected the numbers dramatically, with fewer clients served (only because there were fewer patients booked into the jail). Additionally, class sizes were modified to more one-on-one interactions to avoid having multiple people in close proximity.

Due to the uncertainty of COVID-19 (and associated impacts to the jail population), it is difficult to project changes in FY22 programming, but at this time we are hopeful programming and numbers served will normalize to previous years.

22) Adult Outplacement

Form A1 - FY22 Amount Budgeted:	**$1,182,269**	**Form A1 - FY22 Projected clients Served:**	**125**
Form A1 - Amount budgeted in FY21 Area Plan	**$1,305,771**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**101**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$1,140,481**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**122**

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

DBHS/Optum will continue to assist with independent living placements that offer wraparound supports

such as an ACT Team. Housing options include but are not limited to: VBH housing; master lease units; Denver Apartments; programs which offer meals and supervision such as Nephi Todd's, Evergreen and Oasis; Fisher House and the new Central City Apartments, both 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 expected change

Describe any significant programmatic changes from the previous year.

No significant changes

23) Children/Youth Outplacement

Form A1 - FY22 Amount Budgeted:	**$**	**Form A1 - FY22 Projected clients Served:**	
Form A1 - Amount budgeted in FY21 Area Plan	**$**	**Form A1 - Projected Clients Served in FY21 Area Plan**	
Form A1 - Actual FY20 Expenditures Reported by Locals	**$**	**Form A1 - Actual FY20 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 - FY22 Amount Budgeted:	**$11,753,971**	**Form A1 - FY22 Projected clients Served:**	**3,800**
Form A1 - Amount budgeted in FY21 Area Plan	**$5,799,817**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**4,243**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$5,836,375**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**3,733**

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. However, please note that In the spring of 2020 when the City Library closed, the Library Engagement Team continued to work with library management and pivoted to primarily providing outreach to homeless individuals who were sleeping around the Salt Lake City library as well as other libraries throughout the County. The team participated with the Salt Lake County Health Department and County central command to educate homeless people who were sleeping outside about the COVID-19 pandemic. They went with County nurses to offer COVID-19 tests to people camping and coordinated moves to the County quarantine and isolation unit when needed. In September, after temporarily working out of the Geraldine Women's Resource Center, the Library Engagement team moved to an office on library square where homeless individuals come for information and services. Outreach around the libraries has continued from that location as well. The team continues to have regular communication with library staff and responds to issues and questions that arise.

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. Additionally, with the conversion of the AOT to a full fidelity ACT team described in 13), VBH will also be able to enroll a limited number of unfunded individuals in ACT.

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

Describe efforts to help unfunded adults become funded and address barriers to maintaining funding coverage. Please report the number of individuals who came in unfunded who you helped secure coverage (public or private).

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

Long before the expansions of Medicaid, DBHS began funding Department of Workforce Services (DWS) Medicaid eligibility specialists, drawing down federal dollars as match to assist DBHS' network of providers with enrollment into Medicaid. This effort includes one FTE roaming between the jail, the provider network, and multiple Third District Courts. Additional DWS assistance is housed in one of the network's largest providers, Valley Behavioral Health (VBH).

Education, trainings and connections to Take Care Utah were made to the provider network beginning in 2014, as Marketplace Plans became an option to households earning more than 100% FPL. DBHS leadership also approached judges in the Third District Court to gain their permission to provide enrollment space and internet access to Take Care Utah staff to assist with enrollment into Medicaid, Marketplace Plans and Medicare. The court was not amenable to this option at that time, but in 2017, with the advent of Targeted Adult Medicaid (TAM), embraced the idea. DBHS also approached the jail in considering a partnership with Take Care Utah during these early years, it was embraced in later years as you will see below. Multiple meetings were held with Take Care Utah sharing with them the touchpoints both within the DBHS network and the criminal justice system, to expand enrollment efforts. Throughout the years, more than 250 presentations were made explaining the importance of expanding Medicaid, options through the Marketplace, and highlighted Take Care Utah and DWS Medicaid eligibility specialists (utilizing federal matching dollars), including presentations to UBHC, UAC, NACO and NACBHDD to promote enrollment throughout Utah and other states.

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

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

In addition to specialty enrollment efforts put in place during the TAM expansion, two large eligibility and enrollment trainings were held 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. Providers such as VOA eventually partnered directly with Take Care Utah (efforts expanded greatly once social detox became a Medicaid benefit).

While some of these efforts originate in adult populations, they often extend to household members

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

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

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

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

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

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

Although some components of these enrollment efforts were curtailed due to COVID-19, such as in-court enrollment assistance, stakeholders will be working to resume them as soon as restrictions allow. Providers were also immediately notified when the new administration opened up a new special enrollment period, and expanded eligibility to new populations, such as those who have received unemployment or those above 400% FPL.

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

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

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

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

Due to the Public Health Emergency (PHE), individuals may not be removed from Medicaid unless they

move out of state, request to be removed, or pass away. Due to this temporary status, although individuals may be sorted into different Medicaid plans as appropriate, they are not removed. Once the PHE ends, providers will need to be proactive in assisting any clients that may have neglected responding to Medicaid reviews, etc., to ensure the client remains on Medicaid, or is assisted in signing up for a Marketplace plan if their income exceeds Medicaid limits.

Number of individuals that came in unfunded that were assisted with enrollment - This metric has not been requested previously, and DBHS does not currently have a process in place to track this from contracted network providers. Additionally, a substantial portion of enrollment assistance occurs through collaborations with programs outside of our network, like Take Care Utah in jail and courtroom settings and the Legal Defenders Association, entities DBHS is unable to pull data from. Upon the expansion of Medicaid DBHS took an all hands on deck approach, encouraging anyone and everyone a client touches to assist with Medicaid enrollment, making this a very successful effort, but a difficult metric to track.

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 increase in funding is coming from 4,000,080 from the State of Utah and 700,000 from Salt Lake County. This increase in funding for the receiving center is for their construction of the new receiving center. The other main increase in funding is coming from increased housing support for the growing number of housing programs that have come online in the last few years (including but not limited to Denver Street, Central City, and Fisher House).

Describe any significant programmatic changes from the previous year.

Other than the new housing supports mentioned, no significant changes

25) Unfunded Children/Youth Clients

Form A1 - FY22 Amount Budgeted:	**$1,923,735**	**Form A1 - FY22 Projected clients Served:**	**1,200**
Form A1 - Amount budgeted in FY21 Area Plan	**$1,837,972**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**900**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$1,726,955**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**1,128**

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 6 different schools, within three school districts.

Describe efforts to help unfunded youth and families become funded and address barriers to maintaining funding coverage. Please report the number of individuals who came in unfunded who you helped secure coverage (public or private).

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

Long before the expansions of Medicaid, DBHS began funding Department of Workforce Services (DWS) Medicaid eligibility specialists, drawing down federal dollars as match to assist DBHS' network of providers with enrollment into Medicaid. This effort includes one FTE roaming between the jail, the provider network, and multiple Third District Courts. Additional DWS assistance is housed in one of the network's largest providers, Valley Behavioral Health (VBH).

Education, trainings and connections to Take Care Utah were made to the provider network beginning in 2014, as Marketplace Plans became an option to households earning more than 100% FPL. DBHS leadership also approached judges in the Third District Court to gain their permission to provide enrollment space and internet access to Take Care Utah staff to assist with enrollment into Medicaid, Marketplace Plans and Medicare. The court was not amenable to this option at that time, but in 2017, with the advent of Targeted Adult Medicaid (TAM), embraced the idea. DBHS also approached the jail in considering a partnership with Take Care Utah during these early years, it was embraced in later years as you will see below. Multiple meetings were held with Take Care Utah sharing with them the touchpoints both within the DBHS network and the criminal justice system, to expand enrollment efforts. Throughout the years, more than 250 presentations were made explaining the importance of expanding Medicaid, options through the Marketplace, and highlighted Take Care Utah and DWS Medicaid eligibility specialists (utilizing federal matching dollars), including presentations to UBHC, UAC, NACO and NACBHDD to promote enrollment throughout Utah and other states.

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

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

In addition to specialty enrollment efforts put in place during the TAM expansion, two large eligibility and enrollment trainings were held 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. Providers such as VOA eventually partnered directly with Take Care Utah (efforts expanded greatly once social detox became a Medicaid benefit).

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

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

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

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

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

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

Although some components of these enrollment efforts were curtailed due to COVID-19, such as in-court enrollment assistance, stakeholders will be working to resume them as soon as restrictions allow. Providers were also immediately notified when the new administration opened up a new special enrollment period, and expanded eligibility to new populations, such as those who have received unemployment or those above 400% FPL.

In addition, in 2019, DBHS began working with the State Medicaid Office, the four Accountable Care Organizations (ACOs), and the Local Authorities from Weber, Davis, Utah and Washington Counties to support an integrated benefit for the Adult Medicaid Expansion Population. Numerous meetings were held with these stakeholders, and later with the Salt Lake County Provider Network. Through these meetings, the ACOs agreed to contract with the Salt Lake County essential provider network. As the integration effort neared implementation on January 1, 2020, we engaged our provider network with the ACOs to facilitate agreement on many of the needed next steps: guidelines for utilization management; billing requirements; and coordination of county funded services not covered by Medicaid. Since

implementation, DBHS has worked diligently to support resolution of concerns identified by the provider network as they arise, and look forward to a successful integrated benefit. DBHS recognizes that an integrated physical and behavioral health benefit is in the best interest of the residents we serve.

In Salt Lake County, behavioral health services are delivered through a network model. Below are examples from seven providers of children's services, detailing the process that occurs within their programs to enroll children in Medicaid.

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

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

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

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

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

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

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

In addition, in 2019, DBHS began working with the State Medicaid Office, the four Accountable Care

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

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

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

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

Due to the Public Health Emergency (PHE), individuals may not be removed from Medicaid unless they move out of state, request to be removed, or pass away. Due to this temporary status, although individuals may be sorted into different Medicaid plans as appropriate, they are not removed. Once the PHE ends, providers will need to be proactive in assisting any clients that may have neglected responding to Medicaid reviews, etc., to ensure the client remains on Medicaid, or is assisted in signing up for a Marketplace plan if their income exceeds Medicaid limits.

Number of individuals that came in unfunded that were assisted with enrollment - This metric has not been requested previously, and DBHS does not currently have a process in place to track this from contracted network providers. Additionally, a substantial portion of enrollment assistance occurs through collaborations with programs outside of our network, like Take Care Utah in jail and courtroom settings and the legal defenders association, entities DBHS is unable to pull data from. Upon the expansion of Medicaid DBHS took an all hands on deck approach, encouraging anyone and everyone a client touches to assist with Medicaid enrollment, making this a very successful effort, but a difficult metric to track.

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 expected change

Describe any significant programmatic changes from the previous year.

No significant changes

26) Other non-mandated Services

Form A1 - FY22 Amount Budgeted:	**$1,243,406**	**Form A1 - FY22 Projected clients Served:**	**645**

Form A1 - Amount budgeted in FY21 Area Plan	**$1,107,819**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**684**
Form A1 - Actual FY20 Expenditures Reported by Locals	**$1,351,635**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**650**

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

On average 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. DYS also offers these three programs online and at various schools and community locations throughout Salt Lake County. 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.

Recovery Support Services: For Local Authorities intending to use Mental Health Block Grant funding for Mental Health Recovery Support Services - 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. For a list of RSS services, please refer to the following link: https://dsamh.utah.gov/pdf/ATR/FY21 RSS Manual.pdf
N/A
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 expected change
Describe any significant programmatic changes from the previous year.
No significant changes

27) First Episode Psychosis Services

Form A1 - FY22 Amount Budgeted:	**N/A**	**Form A1 - FY22 Projected clients Served:**	**N/A**
Form A1 - Amount budgeted in FY21 Area Plan	**N/A**	**Form A1 - Projected Clients Served in FY21 Area Plan**	**N/A**
Form A1 - Actual FY20 Expenditures Reported by Locals	**N/A**	**Form A1 - Actual FY20 Clients Serviced as Reported by Locals**	**N/A**

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.
N/A - DBHS does not have a current mechanism to deliver these specific services. We continue to search for a partner to do so.
Describe how clients are identified for FEP services. How is the effectiveness of the services measured?
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).
Describe any significant programmatic changes from the previous year.

28) Client Employment

Increasing evidence exists to support the claim that competitive, integrated and meaningful employment is an essential part of the recovery process and is a key factor in supporting mental wellness.
In the following spaces, please describe your efforts to increase client employment in accordance with Employment First 62A-15-105.2

Competitive, integrated and meaningful employment in the community (include both adults and transition aged youth).

Each ACT team has a Vocational Rehabilitation Specialist as part of the multidisciplinary team that works with clients to focus on education and employment goals. The Voc Rehab Specialist and the Team 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 413 participants with 30% of the individuals maintaining continuous employment for 90 days or more. Additionally, 32% of the job starts (38 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. Due to COVID-19, many of the Transitional Employment sites have temporarily closed. Alliance House has 8 Transitional Employment sites, there are only two actively running. Two members are employed part-time in Transitional Employment. Alliance House continues our partnership with the other sites and hopes to have more open in during FY22. For FY20, 66 members were employed. In FY21, Alliance House has assisted 49 members in obtaining supported employment.

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

First Step House also developed an Employment Services Program using the IPS Model. Launched in 2018, this program has connected with hundreds of businesses, partners, and potential employers in Salt Lake County. In FY20, FSH served 83 participants and 57% were employed within six months of receiving services. Unique to this program, the First Step House Employment Services Program actually targets primarily SUD clients in need of supported employment services, many of which are co-occurring mental health clients as well.

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

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

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

Collaborative employment efforts involving other community partners.
DBHS/Optum supports and collaborates with Utah State Division of Substance Abuse and Mental Health in the Peer Support Certification area and provided the CPSS training to USARA employees in FY20.
Employment of people with lived experience as staff through the Local Authority or subcontractors.
DBHS/Optum contracts directly with Alliance House, an International Accredited Clubhouse model program, in Salt Lake City to provide skills development programs for adults. The Alliance House's objective is to help severely mentally ill individuals gain or recapture the ability to function in the community through meaningful work. The clubhouse incorporates several different work units, which are important in the maintenance of the clubhouse. Participation in these units gives members an opportunity to develop skills that foster their recovery and ultimately their reintegration into the community at large. The major focus of the program is transitional employment placements. The education unit has helped members obtain GEDs or high school diplomas, college education skills and support, and increased life skills. Though not all Alliance House members will go on to be employed as staff for a behavioral health provider, the Alliance House does prepare them to be able to work within the behavioral health system should they have this interest. It is anticipated that DBHS/Optum will continue to work with Alliance House through FY22. 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 FY22, 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 worldwide 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. 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 413 participants with 30% of the individuals maintaining continuous employment for 90 days or more. Additionally, 32% of the job starts (38 total to date) have moved out of the Employment Services Program and no longer receive services due to successful employment. First Step House also developed an Employment Services Program using the IPS Model. Launched in 2018, this program has connected with hundreds of businesses, partners, and potential employers in Salt Lake County. In FY20, FSH served 83 participants and 57% were employed within six months of receiving services. Unique to this program, the First Step House Employment Services Program actually targets primarily SUD clients in need of supported employment services, many of which are co-occurring mental health clients as well.

29) Quality & Access Improvements

Identify process improvement activities including implementation and training of:

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 intervention for FY22 is under development at the time of this submission.

• 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.

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. Monitoring for EBPs was added to the Optum Site Audit Tool for FY21. Providers will be asked to explain their methods for monitoring EBPs to fidelity. 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)

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 that vary from program to program. Please reference sections in the justice services narrative for some examples. Data DBHS collects include hospital diversion rates, treatment engagement, graduation rates, reductions in Risk Scores, positive drug testing rates, number of bed nights funded for individuals in permanent supportive housing, changes in census in co-occurring residential programs, changes in ACT Team census numbers and NOMS data such as employment, housing and "frequency of use" changes. New outcome measures for ACT teams are in development. DBHS also tracks reductions in jail recidivism for certain cohorts. 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.

Significant anomalies may occur in data and outcome metrics for FY21 and FY22 due to COVID responses both within the treatment system and within our county jail.

Increased service capacity

The VOA ACT Team had an initial capacity of 100 clients and offers the program to fidelity. VOA began a second ACT team with a capacity 50 clients during FY21. DBHS and Optum will continue to monitor adherence to these standards with the addition of the Medicaid code.

Valley Behavioral Health began enrolling clients into their new ACT Team at the beginning March 2021. When at capacity, this team will serve approximately 100 members needing these community-based services. VBH will follow the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures will be completed by VBH and reported to Optum. Dependent upon the measure, evaluation will be completed weekly or monthly. Outcome measures include increase in community tenure including housing stability and employment/volunteering involvement while simultaneously reviewing reduction of inpatient admissions.

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

DBHS/Optum partnered with First Step House to increase the number of housing opportunities by

expanding housing options for an additional 75 members (Central City Apartments). In addition to these apartments for members with severe mental illness, First Step House has developed an outpatient mental health program to support those members not connected to other agencies (CHARTER).

Optum has completed a geo-map annually 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.

In order to address the need for some of the most in-demand services, DBHS is planning to add the following services in FY22.

1) The passage of HB 32 during the 2020 general session, allowed for counties to apply for funding to develop and implement Receiving Centers. DBHS was awarded funding for a new non-refusal receiving Center. SLCo transferred the property, and thanks to the Huntsman Mental Health Institute (HMHI) and additional partners and funding, a groundbreaking is scheduled for May 2021. This program will serve Salt Lake County community members who are in psychiatric or substance use-related crisis; however, the new Receiving Center will accept any and all individuals including walk-ins, secure drop-offs, and referrals for assessment. As a non-refusal RC for police, firefighters, and EMS, many of these individuals will be low-level offenders cycling through the county jail, whose crimes are secondary to untreated or undertreated mental illness or substance use disorders. Others may be frequent patients in emergency departments throughout the Salt Lake Valley. These individuals will benefit from medical and psychiatric triage, clinical assessment, peer support, discharge planning, connection to community resources and partners, and referral to treatment programs such as inpatient care, medical care, and detox.

2) 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.

3) Key to further expansions will be workforce capacity. Thanks to an appropriation made during the 2020 general session, great efforts are ongoing to expand the number of students enrolled in this field, along with tuition reimbursement opportunities for those willing to work in publicly funded programs.

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.

Through the expansion of Targeted Adult Medicaid (TAM) and the Adult Medicaid Expansion (AME),

DBHS has seen a dramatic increase in access to services. For example, in 2016 there were approximately 170 SUD residential beds. By the end of FY 21, this number is anticipated to be ~600 beds. The primary funding source is TAM and AME, and is not included in the budget due to it going directly to our provider network. Key to further expansions will be workforce capacity. Thanks to an appropriation made during the 2020 general session, great efforts are ongoing to expand the number of students enrolled in this field, along with tuition reimbursement opportunities for those willing to work in publicly funded programs.

In FY22, Optum providers will continue to offer telehealth services to Medicaid recipients, which has positively impacted the rates of follow-up after hospitalization. With the Odyssey House mental health residential treatment program, those participating in Mental Health Court are able to obtain much needed access to higher levels of care. In FY22, the changes to the IMD rule for residential mental health treatment will allow members to remain engaged in treatment for longer periods of time without losing their eligibility. Bundled rates for residential treatment, payable by Medicaid, will create opportunities for contracting with providers who are only able to document and submit claims for services using a bundled code.

Efforts to respond to community input/need. Describe your participation with key community partners (e.g.: Multi-Agency Coordinating Committees, Regional Advisory Councils, High Fidelity Wraparound teams, Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committees, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts, Regional Healthcare Coalitions, and other partnership groups relevant in individual communities) shall occur consistently.

Optum continually assesses the needs of the community. The Optum Recovery and Resiliency (R&R) team participates on the Crisis Response Services Community Collaboration meeting, the Salt Lake Valley Coalition to End Homelessness, the Salt Lake County Suicide Prevention Coalition, and most recently, the Department of Corrections Stakeholder Group/Committee.

Optum continues to share with their network information on Take Care Utah through the Utah Health Policy Project which is designed 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 Support Specialist 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 Support Specialist lends her knowledge of behavioral health services to these groups as well.

The Optum USH Liaisons works with USH consumers, USH treatment team members, the Optum Utah State Hospital Committee, the Utah Division of Substance Abuse and Mental Health, the Salt Lake County Legal Defender's Office, and Salt Lake County service providers to arrange housing, behavioral and physical health care to transition to community based living and care.

DBHS is a member of the Criminal Justice Advisory Council, where ongoing systemic needs are

addressed monthly, coordinated and planned for. The committee includes representatives from the courts, law enforcement, mayors, county council, state legislators, Legal Defenders Association, District Attorney's office, Department of Corrections, Criminal Justice Services, Human Services, Diversity Affairs, and an individual with lived experience in the criminal justice system. One example is the new Receiving Center. This item is on the monthly agenda to provide updates and receive feedback from stakeholders.

Describe Coalition Development efforts

DBHS/Optum works closely with the three inpatient facilities in the network, the subacute facility, community providers and DBHS, meeting multiple times 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 your agency plan to maintain telehealth services in your area as agencies return to in-person service provision. Include programming involved. How will you measure the quality of services provided by telehealth?

DBHS/Optum currently has over 90 providers utilizing telehealth platforms during the pandemic. The services on the authorization for telehealth mirror the in person (in clinic) services as pertinent. In regular communication with providers (by phone, in training, etc.), we have found that many of our providers have gone through or are completing the process to continue telehealth services beyond the pandemic. We have notified providers and will continue to reinforce that once the "Emergency Period" ends, telephone only (Telephonic services) will be discontinued.

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

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

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

Reach Counseling offers specialized services for women during and after pregnancy. In addition, Children's Service Society has been added to our provider network to offer specialized programming to address maternal mental health. Optum has notified providers of the opportunity for training and certification in this area. We are currently following-up with providers who have recently responded.

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

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

Describe (or attach) your policies for improving cultural responsiveness across agency staff and in services.

The Cultural Responsiveness Committee meets quarterly and has a cultural competence plan (reviewed and approved annually) 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 has been focused on identifying training needs within the network to better recognize the diverse needs of our members. The committee offers training, sometimes with CEUs, to establish a foundation for cultural responsiveness. All Optum SLCo staff also participate in the annual CRC trainings. DBHS/ Optum is committed to offering annual trainings to enhance our ability to meet the diverse needs of the Medicaid mental health population. In this last year, providers were encouraged to complete self and/or agency evaluations to assess for cultural responsiveness. A panel of CRC members will share their experiences with the evaluations and implementing changes. Panelists will also be able to field questions from providers and offer practical strategies to increase responsiveness in clinical practice.

Identify a staff member responsible to collaborate with DSAMH to develop an "Eliminating Health Disparity Strategic Plan" with long term five-year goals and short term action plans. The short term action plans will be based on the needs assessment recommendations.

Optum Behavioral Health Clinical Program Manager, Mark Schull has been selected for this role.

Other Quality and Access Improvements (not included above)

During the COVID Emergency Period, the volume of telehealth visits increased, as well as the rates for follow-up after hospitalization appointments within the first seven days post-discharge for youth and adults.

30) Integrated Care

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

Providers within the SLCo network have taken great steps towards integrating physical health and behavioral health services. Please find examples below of integrated efforts within their programs:

Odyssey House (OH)
Odyssey House operates the Martindale Clinic, an integrated primary care/behavioral health clinic focused on serving individuals with behavioral health issues and their families. Within the clinic, they

provide typical family practice medical services and procedures, such as chronic care management, labs, wound care, diabetes management, blood pressure management, etc.; MAT prescribing and administration; mental health medication prescribing; women's health and family planning services and procedures; and HEP C treatment.

More recently, the Martindale Clinic has become a syringe exchange site and facilitates providing clean syringes to current injecting users.

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

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

Finally, they have an addiction medicine fellow that is developing a program within the residential sites that combines nutrition, exercise, and life skills that is sustainable for this population as they transition back to independence.

First Step House (FSH)
Services include a history and physical screen on admission, a medical needs assessment and plan, MAT prescriptions (Suboxone and Vivitrol), office visits/exams, assessments, patient medication education and monitoring, seasonal vaccination program management, COVID-19 testing, and referral for care management of medical issues that arise during the course of the episode of care.

The FSH medical department is housed at 434 South 500 East, SLC, Ut, but provides services co-located mostly to their three residential treatment programs and Valor House (providing house calls). They plan to have a clinic in their outpatient treatment center in the next 12 months.

This care is provided internally by a FSH APRN, two RNs and three medication techs. Primary community-based partners include 4th Street Clinic, UofU School of Dentistry, Salt Lake VA Medical Center, Martindale Clinic & various community-based healthcare providers. Vacant positions include a second APRN, LPN & Certified Medical Assistant (CMA).

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

Valley Behavioral Health (VBH)
Valley Behavioral Health has been providing PH services to their clients in residential treatment since 2019 when they launched a pilot on their EPIC Campus. They have since become credentialed to provide both physical and behavioral health services through most major payors. They have provided

these services as primarily telehealth services in 2020 and onsite when needed. They will soon be providing onsite physical health at their ValleyWest Integrated Care Clinic serving youth, families and children.

In early 2022 they expect to launch an onsite clinic at their North Valley building serving adult clients. They will provide this through their ValleyFIT model with a team of physical health providers that work collaboratively with their prescribers and other teams to coordinate care. They also have recently launched a chronic care management model that they are implementing to support individuals with 3 or more chronic conditions.

Please refer to the VBH integrated care PowerPoint attached for additional information and timeline on these services.

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

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

Volunteers of America (VOA)
Volunteers of America, Utah is dedicated to providing integrated primary and behavioral health care. They partner with Fourth Street Clinic to provide onsite triage and medical care at their Detoxification facilities and Homeless Resource Centers (this service has been less active/suspended during the pandemic). Their outpatient clinics partner with Midtown Community Health Center. They have hired a medical assistant to triage client needs, coordinate care, and make the referral to Midtown seamless. For several years they have been a recipient of the Utah State Primary Care Grant which provides funding to pay for the primary care needs of clients who are unfunded.

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.

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

In addition to the efforts mentioned above, Optum continues to collaborate with the four Accountable

Care Organizations (ACOs), with frequent PRN contact, and 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. Optum frequently works with the ACOs on finding/researching providers and supplying information to help all providers to work with members more effectively.

Finally, in 2019, DBHS began working with the State Medicaid Office, the four 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.

Describe your efforts to integrate care and ensure that children, youth and adults 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. In FY21, Odyssey House opened a residential program for women who have co-occurring disorders and are justice involved.

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 an Integration and Care Coordination Specialist who collaborates 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 for children, youth and adults.

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

What education does your staff receive regarding health and wellness for client care including youth-in-transition and adults? Describe how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).

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.

Describe your plan to reduce tobacco and nicotine use in SFY 2022, and how you will maintain a *nicotine free environment* as a direct service or subcontracting agency. For ongoing engagement, it is recommended to use an evidence-based nicotine dependence tool such as the Fagerstrom scale. SUD Target= reduce tobacco and nicotine use by 4.8%.

DBHS/Optum continues to educate providers on the mandate to diagnose and provide treatment for nicotine addiction as a healthcare issue. Screening for use and abuse with referrals to smoking cessation supports continues to be addressed at provider meetings and trainings for MH and SUD treatment providers. Clinicians are reminded of the health implications of smoking for our clients, the need to ask clients if they are interested in cessation services, and the need for proper documentation of these efforts. Except for the very small providers, all providers have some level of cessation services, from the basic referring to a quitline (and helping the client access that) to formal classes. In addition, for those who do want to quit tobacco, CBT is used, and MI for those who have not committed yet to quitting. Due to the popularity of previously non-traditional ways to use nicotine, the providers are also being educated to ensure that any type of nicotine delivery system is addressed with the client. Salt Lake County/Optum has also incorporated a review of nicotine-free environment initiatives during audits providing a forum for another conversation about the importance of offering cessation services to clients. The Optum Recovery & Resiliency Team has incorporated education about tobacco cessation in their CPSS trainings. In this last year, an Optum CPSS and DBHS Quality Assurance Coordinator completed the Train the Trainer sessions for Smoking Cessation module of the Dimensions system. Subsequently, during FY21 and COVID-19, 11 people from six separate agencies were trained in the module and will offer the nicotine cessation classes to members before the end of June 2021. This training will be offered again in FY22, as providers have already expressed interest in training more staff.

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.

31) Children/Youth Mental Health Early Intervention

Describe the Family Peer Support activities you propose to undertake and identify where services are provided. *Describe how you partner with LEAs and other Department of Human Services child serving agencies, including DCFS, DJJS, DSPD, and HFW.* For each service, identify whether you will provide services directly or through a contracted provider. For those not using MHEI funding for this service, please indicate "N/A" in the box below.

Family Peer Support Specialists (FPSSs): These facilitators, who are specially trained family members, work to develop a formalized, family-driven and child-centered public mental health system in the state of Utah. At no charge to families, FPSSs provide referrals to local resources; advocacy for culturally appropriate services; links to information and support groups; 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 FPSS program services are designed to provide family peer support services to parents and/or caregivers of children/youth with complex needs. Generally, FPSSs 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). 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 7 FPSSs placed with 7 agencies throughout Salt Lake County. Presently FPSSs are anchored at the following agencies or organizations:
• 1 FTEs Salt Lake County Division of Youth Services
• 1 FTE Utah Division of Juvenile Justice Services
• 1 FTE Granite School District
• 2 FTE State of Utah Division of Child and Family Services (DCFS)
• 1 FTE 3rd District Juvenile Court
• 1 FTE Family Support Center

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

No significant expected change

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

32) 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. For those not using MHEI funding for this service, please indicate "N/A" in the box below.

The HMHI MCOT is an interdisciplinary team of mental health professionals, including 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 21.5 minutes and the average community response time was 26 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%.

No significant expected change

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.

33) 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. For those not using MHEI funding for this service, please indicate "N/A" in the box below.

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 provide individual and family therapy, as well as targeted case management services to Optum Salt Lake County Medicaid eligible youth. They focus on partnering with school leadership and personnel to help youth access much needed resources and accomplish therapeutic objectives.

(See school locations for each agency below)

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

No significant expected change

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
Hunter High School*
Kearns' Jr. High*
* This position has recently become vacant and recruitment is in process.

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
Altaview Elementary
Mt. Jordan Middle School
Eastmont Middle School
Hillcrest High School
Alta High School
Jordan High School
Bridges (SPED)

Murray School District
McMillan Elementary
Horizon Elementary
Longview Elementary
Viewmont Elementary
Grant Elementary
Liberty Elementary
Parkside Elementary
Riverview Elementary
Hillcrest Middle School
Murray High School

Charter School Site
East Hollywood High School

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

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

Charter School Site
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
Mary W. Jackson Elementary
Beacon Heights Elementary
Whittier Elementary
Emerson Elementary
Uintah Elementary
Mountainview Elementary
Indian Hills Elementary

Clayton Middle School
Bryant Middle School
Glendale Middle School
Northwest Middle School
Horizonte High School
East High School
West High School
Highland High School
Innovations High School

Charter School:
Salt Lake School for the Performing Arts (SPA)

Canyons School District
Diamond Ridge High
Entrada

Jordan School District
Bastian Elementary
JSD MHAP Program

Granite School District
Granite Connections High
sStep (Granite SD)
Granite Peaks

Murray School District
Parkside Elementary
Viewmont Elementary

Please describe how you plan to collect data including MHEI required data points and YOQ outcomes in your school programs. Please identify who the MHEI Quarterly Reporting should be sent to including their email.

DBHS will continue to use the Mental Health Early Intervention Data & Outcomes Report form which has been provided by DSAMH. Specifically for the school-based programs, data for total clients served, number of schools and school districts served, YOQ, and other indicators such as Office Disciplinary Referral, and grade point average will be reported.

34) Suicide Prevention, Intervention & Postvention

Describe all current activities in place in suicide prevention, including evaluation of the activities and their effectiveness on a program and community level. Please include a link or attach your localized suicide prevention plan for the agency or broader local community.

Through the Recovery and Resiliency team, Optum provides both Mental Health First Aid (MHFA) and Question Persuade and Refer (QPR) trainings free of charge to any organization or community group interested in receiving the training. Both trainings follow a structured curriculum and include a feedback component available to all participants. The feedback information is used to improve future trainings.

Through the audit process, providers are monitored to ensure they comply with the DBHS requirements to assess for suicide risk and provide subsequent needed safety plans and clinical care. Contracted providers out of compliance are placed on a corrective action plan. In FY21, providers were also required to complete CALM training as outlined in the previous Area Plan. When quality of care issues are identified which may have contributed to a completed suicide or a serious suicide attempt requiring

overnight hospitalization for medical treatment, providers implement a corrective action plan to improve specific areas of treatment, risk assessment, treatment coordination and/or policies and procedures to help prevent future occurrences.

Describe all currently suicide intervention/treatment services and activities including the use of evidence based tools and strategies. Describe your policies and procedures for suicide screening, risk assessment, and safety planning as well as suicide specific treatment and follow up/care transition services. Describe how clients are identified for suicide specific services. How is the effectiveness of the services measured?

Providers within the DBHS/Optum network are mandated to provide a systematic approach in their efforts with suicide follow-up by administering the C-SSRS upon intake and admission. If a client initially screens negative for suicide but later suicidal risk is suspected by the clinician or other staff member during the course of treatment, a C-SSRS will be re-administered. Safety plans are created and updated when clients demonstrate an affirmative response to question #2 or to subsequent questions.

Safety plans are also used as a tool to assist members with other safety issues or to improve their ability to manage the symptoms of their mental illness. DBHS/Optum adheres to a Sentinel Events policy and procedure to investigate serious suicide attempts requiring hospitalization while members are receiving treatment and when members complete suicide during or shortly after completing suicide. Each of these reported incidents are reviewed to determine if any quality of care issues exist and to partner with the provider to improve treatment for all members. More than 77% of our providers have submitted verification of completed Counseling on Access to Lethal Means (CALM).

Describe all current strategies in place in suicide postvention including any grief supports. Please describe your current postvention response plan, or include a link, or attach your localized suicide postvention plan for the agency and/or broader local community.

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

Optum has developed the following postvention plan:

- Identify and partner with providers within the Optum Network who are immediately able to offer support and engage with suicide loss survivors.
- Educate and build relationships among those systems who will interact with bereaved people to enable a coordinated community response.
- Work with those affected by the suicide death to aid mourning in ways that avoid increasing the risk of contagion.
- Suicide Loss survivors may seek support and referrals from the Optum Recovery & Resiliency Team who can help to identify local grief support and suicide survivor groups. These include, but are not limited to, The Sharing Place, Bradley House, Caring Connections and NAMI

Describe your plan for coordination with Local Health Departments and local school districts 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, SAFEUT text line, MCOT, case management, psychotropic medications and, when necessary, access to acute inpatient hospitalization.

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

For those not participating in this grant program, please indicate "N/A" in the box below.

N/A

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

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

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

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

N/A

For Local Authorities receiving mini grant funding for the Live On Utah statewide suicide prevention campaign, summarize your implementation and sustainability plans for the implementation of culturally appropriate suicide prevention messaging in your area.

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

N/A

35) Justice Treatment Services (Justice Involved)

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

DBHS Alternatives to Incarceration Program Initiatives

Project RIO (Right Person In/Right Person Out) began in 2006 when the Salt Lake County Criminal Justice and Mental Health Systems concurred with Munetz and Griffin, that in the ideal case, persons with mental illness would have the same rate of contact with the criminal justice system as does any other person. Systemic improvements were implemented that involved all five of the "sequential intercepts" in which persons with behavioral health conditions contact the criminal justice system, with the goal of diverting persons who have mental illness or substance use disorders and who are non-dangerous offenders from inappropriate incarceration. These programs supported an already active CIT program and Mental Health Court, and were the product of a rich collaboration of numerous agencies. Below please find an array of federal, state, and county funded programs that exist today. Programs supported in varying degrees by JRI funds have a **red*** next to them and more detailed program descriptions. The budget listed applies to JRI programming only. 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.

Sequential Intercept #1 - Law Enforcement & Emergency Services

- **Crisis Line & Warm Line** - The UNI Crisis Line is in operation 24/7, 365 days of the year, acts as the front door to the UNI Crisis System, and is staffed by experienced Licensed Mental Health Therapists. The Warm Line is a peer-run phone line staffed by individuals in recovery. Peer operators are trained to attentively and empathically listen to anonymous callers, offer compassion and validation, and assist callers in connecting with their own internal resources, strengths, and direction.

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

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

  Although progressive for its time in 2012, the Receiving Center is currently underutilized by law enforcement and emergency services. Though it is set up to receive referrals from law

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

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

- **Volunteers of America Detox Centers** *

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

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

  Volunteers of America Men's Adult Detoxification Center: This social model residential detoxification and withdrawal management program provides 83 beds for men 18 and older in need of detoxification & withdrawal management services. This program provides a safe and trauma-informed environment wherein clients can receive help managing intoxication and withdrawal symptoms and decide the next steps in their recovery journey. Clients may stay at this facility for up to 14 days (this has been extended to 30 days due to the pandemic). While in residence clients receive 3 meals per day and snacks, case management services, and access to medication-assisted treatment (MAT). Qualifying clients who are interested in treatment for substance use disorders will receive a full ASAM-driven biopsychosocial assessment and referral to an appropriate treatment program.

  Throughout the stay, clients will have access to case management services. These services include linking clients to essential behavioral health treatment, enrollment in Medicaid, referral to primary care, assistance with legal issues, and connection to peer support and community recovery meetings. This facility is located at 252 W. Brooklyn Ave. Salt Lake City, UT, 84101.

  Volunteers of America Center for Women and Children: This social model residential detoxification and withdrawal management program provides 32 beds for homeless and low-income women, 18 years and older, in need of detoxification and withdrawal management services. This program provides a safe and trauma-informed environment wherein clients can receive help managing intoxication and withdrawal symptoms and decide the next steps in their recovery journey. Clients may stay at this facility for up to 14 days (this has been extended to 30 days due to the pandemic). In addition, women may bring their children age 10 and under into the program. This mitigates a barrier many women face when they do not have safe

alternative childcare. While in residence, clients receive 3 meals per day and snacks, case management services, and access to medication-assisted treatment (MAT). Qualifying clients who are interested in treatment for substance use disorders will receive a full ASAM-driven biopsychosocial assessment and referral to an appropriate treatment program.

Throughout the stay, clients will have access to case management services. These services include linking clients to essential behavioral health treatment, enrollment in Medicaid, referral to primary care, assistance with legal issues, and connection to peer support and community recovery meetings. In addition, clients have access to an outdoor area and onsite garden. It is located at 697 W 4170 S, Murray, UT, 84123.

- **Unified Police Department (UPD) Mental Health Unit** *

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

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

  Through additional county dollars, the Mental Health Unit is made up of one sergeant, one detective, and seven secondary officers from various precincts.

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

  The program enjoys a 98.4% diversion rate from medical or psychiatric hospitalization through the first half of FY21, while making 510 outreaches (479 adults and 31 youth).

- **Utah Department of Public Safety Mental Health and Substance Use Disorder Evaluation Triage Team (METT)** *

  DBHS began funding a mental health therapist during Operation Rio Grande, for the Utah Highway Patrol as they worked with the homeless and behavioral health population in the Rio Grande area. These officers no longer serve in this area, but seeing the value of pairing law enforcement with mental health resources, wished to continue this model, and expand it statewide.

  With no funding to do so, DBHS offered to fund this position as a bridge to the statewide expansion, through FY22. JRI dollars are utilized for this position.

Through this model, a Volunteers of America (VOA) therapist assists vulnerable individuals suffering from a mental health or addiction crisis by providing assessments and connecting individuals to mental health services. This position plays a valuable role in reducing the potential for violence during police interactions, aids Department of Public Safety (DPS) officers in identifying and addressing the mental health and substance use disorder concerns and assists officers in handling calls for service.

The METT is comprised of a licensed clinician, 4 DPS sworn outreach officers and a supervisory sergeant. The clinician is housed within DPS Headquarters located at 4501 S 2700 W and under the direction of the METT supervisory sergeant, with the following duties:

- Provide intervention, referral, or placement for a person with mental illness and addiction, to facilitate the speedy return of field officers to other duties.
- Endeavor 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.
- Provide a variety of clinical services for persons suffering from severe mental and emotional disorders and addiction; assist patients; their families; law enforcement and other social agencies in understanding and finding solutions to problems that lead to and result from mental illness and severe emotional disorders.
- Provide follow-up to support access to care and associated reductions in recidivism.
- Coordinate with service providers throughout the state to address needs of individuals.

The last 7 months, this program has served 33 juveniles and 39 adults for a total of 72 individuals. Case management can vary depending on each individual, which could be as short as a few weeks to in excess of over a year. The area of operation is the State of Utah and housed out of the Utah Highway Patrol Calvin Rampton Building - State Bureau of Investigation.

Sequential Intercept #2 – Jail

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

  Mental Health services are funded through a direct appropriation from the County Council to the SLCo Sheriff's Office. In addition to providing mental health services and medication management, the Sheriff's Office provides discharge planners that collaborate with community mental health treatment providers and social workers at the Legal Defenders Association to coordinate continuity of medications and treatment for severely mentally ill (SMI) individuals. The Salt Lake County Jail has two dedicated units that can address more severe mental health needs – a 17-bed unit for individuals who have been identified as high risk for suicide and a 48-bed unit for individuals with a mental health diagnosis that would benefit from not being with the general population. In addition to these, the jail team provides group therapy and crisis services for individuals in the general population.

  DBHS funds the SUD services in the jail, including:
  The CATS Program (contracted through Odyssey House) - an addictions treatment therapeutic community, based on a day treatment level of care (20 hours per week of treatment services with additional services included). The program is operated within both the ADC and Oxbow Jails. The capacity for males is 152 beds (Oxbow) and 32 beds for females (ADC) based on an average length of stay of 3 months.

  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.

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

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

Sequential Intercept #3 – Courts

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

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

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

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

legal defenders office, offering invaluable assistance in connecting large numbers of clients to treatment.

Sequential Intercept #4 – Reentry

- **Top Ten** - Once a month, DBHS facilitates a group that meets to staff frequently booked individuals with severe mental illness. Partners include the Legal Defender's Association (LDA), Valley Behavioral Health, HMHI Crisis Programs, Jail Mental Health, DBHS, Optum, The Road Home, Volunteers of America, the SLC PD Community Connections Center, and 4th Street Clinic. Team goals are to:
    - Ensure jail mental health is aware of an individual's diagnosis and medications prescribed in the community prior to arrest, and vice-versa, ensure community mental health programs are aware of an individual's diagnosis and medications prescribed in jail prior to release.
    - Develop a pre-release relationship with the inmate prior to release whenever possible.
    - Work to assertively engage the client in treatment upon release, address continuity of care/medications and transport if appropriate.
    - Refer into appropriate programs (Mental Health Court, ACT Teams, dual-diagnosis residential programs, Jail Diversion Outreach Team, other outpatient services, housing, etc.).
    - Communicate with the individual's attorney.
    - Communicate with county supervising case managers, state AP&P officers or other private supervising agencies.
    - Coordinate jail releases when appropriate.
    - Support the client to resolve open court cases.
    - Coordinate with medical providers when appropriate.
    - Coordinate with other community providers (VA, private providers, etc.).
    - Assist with housing, entitlements, and other needed supports.
    - Address individuals as pre-contemplative rather than non-compliant when unable to engage them into services. That is, try, try again.

- **Jail Diversion Outreach Team (JDOT)** - This VBH assertive community treatment "like" team is a multidisciplinary team that assists severely mentally ill individuals that are frequent recidivists in the county jail.

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

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

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

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

these units.

- **Odyssey House Women's MH Residential Program -** This 16-bed facility is a dual-diagnosis residential facility for women, mirroring components of the CORE programs. Due to high demand from Mental Health Court and other stakeholders, this new program was brought online in 2020.

  An additional 16-bed facility for men is expected to be brought online in 2021.

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

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

- **The 4th Street Clinic** - Collaborates with the jail and with the LDA Mental Health Liaison to assist homeless individuals with both physical and behavioral health services upon release from jail.

- **DWS Medicaid Eligibility Specialists** - DBHS funds Medicaid Eligibility Specialists to assist with enrollment into Medicaid. One is mobile, visiting various locations such as court settings and Criminal Justice Services, the others are embedded within the largest behavioral health provider.

- **Navigator and Certified Application Counselor Assistance** - DBHS providers, the jail, Criminal Justice Services and the Legal Defenders Association collaborate with navigators and certified application counselors to enroll individuals in Marketplace Plans, Medicaid and other health plan options. These services are provided at many different locations, including court settings, the jail, provider locations, pretrial and probation settings. DBHS worked aggressively throughout the years to develop a coordinated response to enrollment efforts with the criminal justice and behavioral health populations.

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

Sequential Intercept #5 - Community

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

- **Housing Programs** – DBHS funds multiple housing first initiatives for individuals involved in the justice system. Some serve individuals with severe mental illness, while others are tailored towards supporting individuals with SUDs. These programs are a combination of scattered units throughout the valley, boarding homes, rental assistance vouchers, sober living homes, and partnerships on tax credit housing projects where DBHS funds Medicaid supportive living rates, rental subsidies, and even some capital expenses.

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

- **Intensive Supervision Probation (ISP) 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 dedicated assessment staff 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 32% of all clients have identified opiates as a primary substance of abuse (26.9% of all males and 35.7% of all females).

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

  An additional $1.4M was awarded to ISP in July 2017 from the Justice Reinvestment Committee (JRC funds cut in FY20). Leveraging these funds, ISP was able to fund a third licensed mental health therapist (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 a recent evaluation, 406 clients admitted into the ISP program during a 12 month period (January 2020 – December 2020). Since the program's inception 320individuals have graduated, and multiple successful outcomes documented: 75.4% of all clients referred into ISP have been assessed for treatment. Looking at a snapshot of the program in March of FY20, 73.1% of all open clients remain actively engaged in treatment. Graduates of the program enjoy a 34% reduction in risk scores. Successful clients saw an 86% reduction in new-charge bookings (comparing one year prior to one year post-program intake); revoked clients showed a 59.2% reduction; with the total population showing a 71.6% reduction.

  FY20 was a time of transition for this program due to the elimination of JRC funding. While the number of uninsured and underinsured individuals post-Medicaid Expansion is unknown, it was our intention to maintain current levels of programming throughout this time by transitioning from JRC funding to Medicaid funding. Every effort was made to enroll participants into Medicaid. In addition to specialty enrollment efforts put in place during the Targeted Adult

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

- **Mental Health Court Housing** – beginning in FY22, mental health court housing units will transfer from Salt Lake County Criminal Justice Services to DBHS.

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

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

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

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

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

- **Community Mental Health and SUD programs** - there are many other mental health or substance use disorder treatment programs, in all levels of care, that serve the criminal justice population. Medicaid expansion has enabled an unprecedented expansion of these services. As an example, ~170 SUD residential beds existed in 2016, and is estimated to be ~600 in 2021, more than tripling capacity within the Salt Lake County network. Additional services have expanded outside this network as well. For further information, please reference the attachment entitled “The Evolving Landscape of Behavioral Health Services in Salt Lake

County".

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.

Strategies used with low and high risk offenders

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

Describe how clients are identified as justice involved clients

There are many ways that a client can be identified as a justice-involved person.

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

How do you measure effectiveness and outcomes for justice involved clients?

DBHS has developed multiple outcome measures that vary from program to program. Please reference sections in the justice services narrative for some examples. Data DBHS collects include hospital diversion rates, treatment engagement, graduation rates, reductions in Risk Scores, positive drug testing rates, number of bed nights funded for individuals in permanent supportive housing, changes in census in co-occurring residential programs, changes in ACT Team census numbers and NOMS data such as employment, housing and "frequency of use" changes. New outcome measures for ACT teams are in development. DBHS also tracks reductions in jail recidivism for certain cohorts. 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.

Identify training and/or technical assistance needs.

None presently

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

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

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

Additionally, DBHS/Optum is participating in the creation and tracking of MHC outcome measures. This is a joint task with participation from various MHC stakeholders.

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

implementation committee plan.

DBHS recognizes Justice Reinvestment Initiative (JRI) Programming as a countywide initiative affecting multiple stakeholders including law enforcement, the county jail, courts, criminal justice services, legal defender's office and district attorney's office. As a result when implementing a JRI strategy DBHS was committed to broad support of county stakeholders, including approval from the following Criminal Justice Advisory Council stakeholders prior to implementing programming with JRI community based treatment funding:

Chair, Mayor Jenny Wilson	Salt Lake County Mayor
Vice Chair, Sim Gill	District Attorney, Salt Lake County
Jojo Liu	CJAC Director
Honorable Mark Kouris	Presiding Judge, Third District Court
Honorable Brendan McCullaugh	Judge, West Valley City Justice Court
Honorable John Baxter	Judge, Salt Lake City Justice Court
Representative Jim Dunnigan	Utah House of Representatives
Senator Karen Mayne	Utah State Senate
Rosie Rivera	Salt Lake County Sheriff
Jim Bradley	Salt Lake County Council
Dave Alvord	Salt Lake County Council
Mike Brown	Chief, Salt Lake City Police Department
Ken Wallentine	Chief, West Jordan Police Dept, LEADS Chair
Jack Carruth	Chief, South Salt Lake City Police Dept
Vacant	Director, Utah State Department of Corrections
Karen Crompton	Director, Salt Lake County Human Services
Kele Griffone	Director, Criminal Justice Services
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
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
Luna Banuri	Chair, SLCo Diversity Affairs

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

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

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

Examples of services to these populations include:

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

Odyssey House - Their adolescent continuum serves JJS and DCFS youth and works closely with JJS and DCFS workers to coordinate care. Their school-based behavioral health services work with JJS and DCFS youth K-12 schools in every district in the county. Finally, their Parents with Children Program works with DCFS custody youth to re-unify them with their parent while concurrently providing mental health and developmental services.

In addition, they were recently awarded a contract with JJS to open an afterschool IOP for JJS youth. It will be housed at their Taylorsville outpatient location. They anticipate it being operational at the beginning of the fiscal year.

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

36) 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 quarterly 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.

37) Speciality Services

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

The ORG funding has been used for VBH's ACOT team. Historically, VBH has offered an Assertive Community Outreach Team (ACOT) for adult clients with SPMI/SMI. The ACOT subscribed to an Assertive Community Treatment Team approach with services to promote a client's growth and recovery and to enhance the quality of their personal, family, and community life. The ACOT primarily provided case management services to Medicaid and non-Medicaid clientele. However, effective March 1, 2021, VBH took the necessary steps to convert the ACOT to a SAMHSA full fidelity ACT team. Though VBH will serve any person who meets criteria, they will specialize in those with criminal justice involvement. Most of those who were already clients of ACOT transitioned into the new ACT team. Additionally, some JDOT clients (described below) also transitioned to this new ACT team.

Valley Behavioral Health began enrolling clients into their new ACT Team at the beginning March 2021. When at capacity, this team will serve approximately 100 members needing these community-based services. VBH will follow the SAMHSA fidelity measures. Evaluation of adherence to the fidelity measures will be completed by VBH and reported to Optum. Dependent upon the measure, evaluation will be completed weekly or monthly. Outcome measures include increase in community tenure including housing stability and employment/volunteering involvement while simultaneously reviewing reduction of inpatient admissions.

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

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

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

Client Requirements:

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

Treatment Process:

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

1. Screening and Diagnostic Treatment Services
2. Habilitation and Rehabilitation Services
3. Community Mental Health Center Services
    1. Provide or refer the PATH eligible clients to the following services as necessary:
        1. Mental health diagnosis;

2. Evaluation of treatment needs;
3. Mental health treatment;
4. Medication management; and
5. Psychosocial rehabilitation services

2. Ensure that providers of referred services meet the same qualifications required of the Contractor for the applicable services and all other contract requirements.

4. Substance use treatment: The Contractor shall provide or refer for preventive, diagnostic, and other services and supports for people who have a psychological and/or physical dependence on one or more substances.
5. Case Management: The Contractor shall provide case management services that includes advocacy, communication, and resource management that are used to design and implement a wellness plan specific to a PATH-enrolled individual's recovery needs as follows:
   1. Developing and implementing a service plan for the provision of community mental health services, and reviewing such plan not less than once every 90 days;
   2. Assisting the PATH eligible client in obtaining and coordinating social and maintenance services including services related to daily living activities, transportation, prevocational-vocational training and housing;
   3. Arrange with medical and dental providers to provide services to the PATH eligible clients.
   4. Assisting the PATH eligible clients in applying for and obtaining income support services, such as, food stamps, housing assistance, and supplemental security income benefits, other public entitlements and medical insurance; and
   5. Referring PATH eligible clients to other appropriate agencies and representative payee services in accordance with Section 1631 (a) (2) of the Social Security Act.
6. Residential supportive services: Contractor shall provide services that help PATH-enrolled individuals practice the skills necessary to maintain residence in the least restrictive community-based setting possible. The Contractor shall provide these services, refer and arrange for these services for PATH eligible clients in residential settings. The Contractor shall *not* provide or refer clients for services that are funded under: 1) the transition housing demonstration program of the Housing and Urban Development (HUD) pursuant to section the supportive housing demonstration program established in subtitle C, Title V of the Stewart B. McKinney Homeless Assistance Act.
7. Referral Services: The Contractor shall refer PATH eligible clients and facilitate or arrange access to, and referral for, primary health services, job training, and educational services as follows:
   1. Community mental health referral
   2. Substance use treatment referral
   3. Primary health/dental care referral
   4. Job training referral
   5. Employment assistance referral
   6. Educational services referral
   7. Income assistance referral
   8. Medical insurance referral
   9. Housing services referral
   10. Temporary housing referral
   11. Permanent housing referral
8. Housing Services
9. Transition to Mainstream: Assist PATH eligible clients to make a formal change from PATH to housing and services funded through other programs such as Section 8, Medicaid, Public Health, Mental Health / Substance Abuse Block Grant.

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) Early Intervention

Form B - FY22 Amount Budgeted:	**$200,000**	**Form B - FY22 Projected clients Served:**	**612**
Form B - Amount Budgeted in FY21 Area Plan	**N/A**	**Form B - Projected Clients Served in FY21 Area Plan**	**N/A**
Form B - Actual FY20 Expenditures Reported by Locals	**$205,778**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**629**

Describe local authority efforts to provide for individuals convicted of driving under the influence, a screening; an assessment; an educational series; and substance abuse treatment as required in Utah Code § 17-43-201(5)(m).

The Salt Lake County Division of Behavioral Health Services (DBHS), acting as the local substance abuse authority in Salt Lake County, has contracted with Assessment & Referral Services (ARS) at the University of Utah, since 2003, to provide comprehensive screening and assessment for individuals who have been convicted of Driving Under the Influence of Alcohol/Drugs or Impaired Driving.

This contractual relationship came into being as a means to meet the legal requirements under the minimum mandatory sentencing guidelines for DUI offenders in the State of Utah as well as meet the needs of the courts and offenders alike. Subsidized dollars are provided to ARS in order to ensure that every DUI offender in Salt Lake County has financial access to screening and assessment after conviction via a sliding fee scale based on an individual's total income. If individuals are without income, homeless or virtually homeless they are provided with this service at no cost to them. ARS provides assessment-only; they do not provide any education or treatment services, thus they are able to provide objective assessments eliminating any conflict of interest to the individual related to referrals for education or treatment. ARS screens for an offender's ability to pay for education and treatment services and refers to resources (such as applying for Medicaid) to ensure that finances are not a barrier to completing referrals. If an offender has health insurance or the ability to self-pay for services, they are referred to an agency that accepts their insurance or can provide appropriate treatment services that are affordable. ARS has also been given authority to grant Salt Lake County subsidies to individuals who do not have the means to pay for treatment services, do not qualify for Medicaid, have little to no income and no health insurance. Thus, finances, or the lack thereof, do not present a barrier for compliance with the court-ordered assessment or ARS recommendations related to their DUI conviction.

DUI offenders are provided a screening via the SASSI-4, BCI information and a brief clinical interview. If individuals do not meet the criteria for a substance use disorder they are referred to Prime for Life, the minimum mandatory requirement for DUI offenders. ARS refers out only to providers certified to administer Prime for Life and those listed on the Department of Human Services website.

If the screening indicates a likely substance use disorder, a full assessment is conducted which employs screening and assessment tools approved by the Salt Lake County Division of Behavioral Health Services and that are evidence-based tools. They include, but are not limited to a full biopsychosocial interview, The SASSI-4, The Risk & Needs Triage, information from the Bureau of Criminal Investigation, The Colombia-Suicide Severity Rating Scale, GAD-7, PHQ-9, LS/CMI information (obtained from collateral source if individuals have been placed on supervised probation), collateral information from a multitude of sources when required, The Diagnostic & Statistical Manual of Mental Health Disorders, Fifth Edition and the American Society of Addiction Medicine Placement Criteria.

If an offender meets criteria for a substance use disorder requiring treatment, they are referred out to an agency that is licensed by the State to provide substance use disorder treatment. The same financial basis indicated above related to screening is also used for referrals to treatment. All financial means (individual health insurance, self-pay, Medicaid etc.) options are exhausted first. If an individual is not eligible for any of those resources, Salt Lake County funding is authorized and individuals are referred to an agency contracted with the Salt Lake County Division of Behavioral Health Services which provides treatment service levels that include general outpatient treatment (1-8 hours of service weekly), intensive outpatient treatment (typically 9 hours of treatment services weekly), day treatment (typically 20 hours of services weekly), low/medium and high intensity residential treatment services (hours vary) and access to social detoxification programs.

ARS estimates that approximately 30% of DUI offenders do not meet the criteria for a substance use disorder, thus are referred to Prime for Life while approximately 70% of individuals meet diagnostic criteria for one or more substance use disorders and are referred to treatment. Tobacco use disorders are highly correlated with individuals requiring substance use treatment.

Identify evidenced-based strategies designed to intervene with youth and adults who are misusing alcohol and other drugs.

Please see the EBP references in Section 10: Quality & Access Improvements

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

School based providers collaborate with the administration at local schools to support efforts to screen youth and their families for needed services. They also serve on school committees to share their expertise and offer support with community initiatives to meet the needs of students and the areas in which they live. Clinicians are onsite at school and in homes and can provide brief motivational interventions when needed.

Peers from USARA enter emergency departments to assist individuals who have overdosed and been medically cleared. The Peer Recovery Coach engages the individual where they are in their Stage of Change and uses motivational interviewing techniques to engage the person, offering information and

resources to assist with immediate needs (i.e. Naloxone kits, resources related to SDOH, treatment resources, etc.).

Describe work to identify individuals with substance disorder in your community, implement brief motivational interventions and/or supportive monitoring in healthcare, schools and other settings

Optum Salt Lake County mental health providers have been trained on how to screen individuals for nicotine, substance use and other addictive behaviors as part of the initial and on-going assessment processes. A list of covered providers to further assess for SUD has been distributed. Medicaid and Unfunded individuals are able to be screened.

Our indicated clients are often referred by counselors/therapists or from other programs inside the providing agency itself. Providing agencies partner with school therapists/school counseling centers and with juvenile justice service providers to refer youth in need. For efforts outside the school setting providers use social media advertising and community partners to disseminate information about the program- relying heavily on strong partnerships with other community based agencies to share program information to families. Agencies also advertise through outreach efforts at in-person outreach events such as parent teacher conferences and health and safety fairs in local municipalities.

Describe effort to assist individuals with enrollment in public or private health insurance directly or through collaboration with community partners (healthcare navigators or the Department of Workforce Services) to increase the number of people who have public or private health insurance.

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

Long before the expansions of Medicaid, DBHS began funding Department of Workforce Services (DWS) Medicaid eligibility specialists, drawing down federal dollars as match to assist DBHS' network of providers with enrollment into Medicaid. This effort includes one FTE roaming between the jail, the provider network, and multiple Third District Courts. Additional DWS assistance is housed in one of the network's largest providers, Valley Behavioral Health (VBH).

Education, trainings and connections to Take Care Utah were made to the provider network beginning in 2014, as Marketplace Plans became an option to households earning more than 100% FPL. DBHS leadership also approached judges in the Third District Court to gain their permission to provide enrollment space and internet access to Take Care Utah staff to assist with enrollment into Medicaid, Marketplace Plans and Medicare. The court was not amenable to this option at that time, but in 2017, with the advent of Targeted Adult Medicaid (TAM), embraced the idea. DBHS also approached the jail in considering a partnership with Take Care Utah during these early years. It was embraced in later years as you will see below. Multiple meetings were held with Take Care Utah sharing with them the touchpoints both within the DBHS network and the criminal justice system, to expand enrollment efforts. Throughout the years, more than 250 presentations were made explaining the importance of expanding Medicaid, options through the Marketplace, and highlighted Take Care Utah and DWS Medicaid eligibility specialists (utilizing federal matching dollars), including presentations to UBHC, UAC, NACO and NACBHDD to promote enrollment throughout Utah and other states.

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

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

In addition to specialty enrollment efforts put in place during the TAM expansion, two large eligibility and enrollment trainings were held 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. Providers such as VOA eventually partnered directly with Take Care Utah (efforts expanded greatly once social detox became a Medicaid benefit).

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

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

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

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

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

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

Although some components of these enrollment efforts were curtailed due to COVID-19, such as in-court enrollment assistance, stakeholders will be working to resume them as soon as restrictions allow. Providers were also immediately notified when the new administration opened up a new special enrollment period, and expanded eligibility to new populations, such as those who have received unemployment or those above 400% FPL.

Describe activities to reduce overdose.

1. **educate staff to identify overdose and to administer Naloxone;**
2. **maintain Naloxone in facilities,**
3. **Provide Naloxone kits, education and training about overdose risk factors to individuals with opioid use disorders and when possible to their families, friends, and significant others.**

Opioid overdose prevention continues to be a key facet of all treatment programming supported by DBHS. The division has worked closely within the contracted provider network over the last few years to fund and distribute thousands of Narcan (Naloxone) nasal kits to agencies and programs that serve at-risk clients, their friends, family members and their significant others when financially viable.

Beginning with the global pandemic, finances became a concern based on the economic uncertainty experienced. The support of Naloxone within programs continued in FY21, but rather than directly funding and distributing kits to agencies and programs, DBHS worked with DSAMH and the Utah Department of Health to provide access to Naloxone and associated educational resources. DBHS will continue to educate providers on access to kits and training through these channels. All contracted providers are required to adhere to DSAMH Division Directives on identifying overdose and risk factors, administering Naloxone, maintaining and distributing kits to individuals, friends, family and significant others, and providing training to clients and staff. Adherence to these directives is part of the agency site monitoring performed by DBHS.

Historically, kits have been provided to all contracted SUD providers within the County network (including the University of Utah's Assessment and Referral Services), to various programs within the Salt Lake County Sheriff's Office, to the Utah Support Advocates for Recovery Awareness (USARA), and various Salt Lake County agencies (Behavioral Health, Health Department and Criminal Justice Services). Finally, within DBHS, all staff are trained annually on the signs of overdose, use of Naloxone, and the office policy on storage, ordering and administering of Naloxone.

Describe any significant programmatic changes from the previous year.

No significant changes

2) Ambulatory Care and Withdrawal Management (Detox) ASAM IV-D, III.7-D, III.2-D, I-D or II-D)

Form B - FY22 Amount Budgeted:	**$1,816,785**	**Form B - FY22 Projected clients Served:**	**2,484**
Form B - Amount Budgeted in FY21 Area Plan	**$1,455,767**	**Form B - Projected Clients Served in FY21 Area Plan**	**2,500**
Form B - Actual FY20 Expenditures Reported by Locals	**$1,952,237**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**2,484**

Describe the activities you propose to assist individuals prevent/alleviate medical complications related to no longer using, or decreasing the use of, a substance. 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:

- Volunteers of America Men's Adult Detoxification Center: This social model residential detoxification and withdrawal management program provides 83 beds for men 18 and older in need of detoxification & withdrawal management services. This program provides a safe and trauma-informed environment wherein clients can receive help managing intoxication and withdrawal

symptoms and decide the next steps in their recovery journey. Clients may stay at this facility for up to 14 days (this has been extended to 30 days due to the pandemic). While in residence clients receive 3 meals per day and snacks, case management services, and access to medication-assisted treatment (MAT). Qualifying clients who are interested in treatment for substance use disorders will receive a full ASAM-driven biopsychosocial assessment and referral to an appropriate treatment program.

Throughout the stay, clients will have access to case management services. These services include linking clients to essential behavioral health treatment, enrollment in Medicaid, referral to primary care, assistance with legal issues, and connection to peer support and community recovery meetings. This facility is located at 252 W. Brooklyn Ave. Salt Lake City, UT, 84101.

- Volunteers of America Center for Women and Children: This social model residential detoxification and withdrawal management program provides 32 beds for homeless and low-income women, 18 years and older, in need of detoxification and withdrawal management services. This program provides a safe and trauma-informed environment wherein clients can receive help managing intoxication and withdrawal symptoms and decide the next steps in their recovery journey. Clients may stay at this facility for up to 14 days (this has been extended to 30 days due to the pandemic). In addition, women may bring their children age 10 and under into the program. This mitigates a barrier many women face when they do not have safe alternative childcare. While in residence, clients receive 3 meals per day and snacks, case management services, and access to medication-assisted treatment (MAT). Qualifying clients who are interested in treatment for substance use disorders will receive a full ASAM-driven biopsychosocial assessment and referral to an appropriate treatment program.

  Throughout the stay, clients will have access to case management services. These services include linking clients to essential behavioral health treatment, enrollment in Medicaid, referral to primary care, assistance with legal issues, and connection to peer support and community recovery meetings. In addition, clients have access to a lovely outdoor area and onsite garden. It is located at 697 W 4170 S, Murray, UT, 84123.

  - 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 both VOA facilities.

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 FY20 actuals.

Describe any significant programmatic changes from the previous year.

No significant change as compared to FY20 actuals.

DBHS/Optum is in the process of credentialing White Tree Medical to the Optum Medicaid network. White Tree Medical is an outpatient detox program that follows a Harm Reduction Model. They do encourage ongoing and follow up treatment, but it is not required to go through the detox program.

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) **Shanel Long**

Form B - FY22 Amount Budgeted:	**$8,037,914**	**Form B - FY22 Projected clients Served:**	**1,230**
Form B - Amount Budgeted in FY21 Area Plan	**$6,771,968**	**Form B - Projected Clients Served in FY21 Area Plan**	**964**
Form B - Actual FY20 Expenditures Reported by Locals	**$7,769,464**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**1,189**

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 3.5 and 3.1, 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).

No significant change as compared to FY20 actuals.

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 FY21, this number is anticipated to be ~600 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) **VaRonica Little**

Form B - FY22 Amount Budgeted:	**$1,275,963**	**Form B - FY22 Projected clients Served:**	**763**
Form B - Amount Budgeted in FY21 Area Plan	**$2,303,946**	**Form B - Projected Clients Served in FY21 Area Plan**	**1,324**
Form B - Actual FY20 Expenditures Reported by Locals	**$1,692,657**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**1,012**

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 section 11, which includes information on 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).

The comparison to FY20 actuals shows a significant decrease, which is primarily due to this Area Plan only reflecting the first quarter of the FY22 expense. We have only been asked to show how we will utilize the last quarter Jul-Sep of the Federal FY21 of the SSOR funding.

Describe any significant programmatic changes from the previous year.

No significant changes

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

Form B - FY22 Amount Budgeted:	**$858,817**	**Form B - FY22 Projected clients Served:**	**372**
Form B - Amount Budgeted in FY21 Area Plan	**$1,846,222**	**Form B - Projected Clients Served in FY21 Area Plan**	**1,100**
Form B - Actual FY20 Expenditures Reported by Locals	**$1,606,495**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**695**

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.

DBHS continues to provide access to Vivitrol for clients actively engaged in SUD treatment, as well as to those working towards treatment engagement.. 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, as well as those working with case management teams with a goal of accessing ongoing treatment, are eligible to receive monthly Vivitrol treatment at no additional charge to the client.

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.

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 SSOR funding. DBHS has made consistent efforts to coordinate with the SSOR OTPs to transfer over any clients who are eligible to utilize SSOR 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).

The comparison to FY20 actuals shows a significant decrease, which is primarily due to this Area Plan only reflecting the first quarter of the FY22 expense. We have only been asked to show how we will utilize the last quarter Jul-Sep of the Federal FY21 of the SSOR funding.

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) **Shanel Long**

Form B - FY22 Amount Budgeted:	**$3,458,254**	**Form B - FY22 Projected clients Served:**	**2,831**

Form B - Amount Budgeted in FY21 Area Plan	**$3,732,879**	**Form B - Projected Clients Served in FY21 Area Plan**	**3,123**
Form B - Actual FY20 Expenditures Reported by Locals	**$3,440,535**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**2,816**

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 FY20 actuals.

Describe any significant programmatic changes from the previous year.

No significant change

7) Intensive Outpatient (ASAM II.5 or II.1) **Shanel Long**

Form B - FY22 Amount Budgeted:	**$2,905,431**	**Form B - FY22 Projected clients Served:**	**1,593**
Form B - Amount Budgeted in FY21 Area Plan	**$4,304,267**	**Form B - Projected Clients Served in FY21 Area Plan**	**1,799**
Form B - Actual FY20 Expenditures Reported by	**$2,790,118**	**Form B - Actual FY20 Clients Serviced as**	**1,530**

Locals		Reported by Locals	

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.

Contracted Providers:
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
Valley Behavioral Health – Adult 2.1, 2.5; Children with Parents 2.1
Volunteers of America / Cornerstone Counseling – Adult; Youth 1.0; 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 FY20 actuals.

Describe any significant programmatic changes from the previous year.

No significant change

8) Recovery Support Services **Christine Simonette**

Form B - FY22 Amount Budgeted:	**$6,128,226**	**Form B - FY22 Projected clients Served:**	**3,294**
Form B - Amount Budgeted in FY21 Area Plan	**$4,304,267**	**Form B - Projected Clients Served in FY21 Area Plan**	**1,799**
Form B - Actual FY20 Expenditures Reported by Locals	**$5,478,812**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**2,945**

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. 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, eligible participants from Volunteers of America (VOA) detox programming, 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 provided program flexibility and relaxed protocols (allowing clients to return multiple times based on job loss, or allowing clients to stay longer than 6 months) due to the negative economic impacts of the pandemic. In FY22, DBHS anticipates providing approximately 900 clients with sober living vouchers. Due to funding and other resource constraints, the monthly program capacity is approximately 275 vouchers.

During FY22, DBHS anticipates to fund and contract for approximately 225 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 57 units for the State Hospital Diversion program, 57 units for the Project RIO Housing (master leased units for SMI clients), 58 units for HARP Housing (short and long term rental assistance), 22 units at the VOA Denver Apartments, 25 units at the Central City Apartments (see more below on these tax credit projects), and 6 master lease units at First Step House's Fisher House (congregate site for SMI clients referred to housing through their Mental Health Court participation). All partners referring 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 those who qualify as having a severe mental illnessl (SMI) population. This tax credit project targets 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 opened in 2020.

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. This effort continues today, with one FTE roaming between

the jail, the provider network, and multiple Third District Courts. Additional DWS assistance is housed in one of the network's largest providers, VBH. Education, trainings and connections to Take Care Utah were made to the provider network beginning in 2014, as Marketplace Plans became an option to households earning more than 100% FPL. Division leadership also approached judges in the Third District Court to gain their permission to provide enrollment space and internet access to Take Care Utah staff to assist with enrollment into Medicaid, Marketplace Plans and Medicare. The court was not amenable to this option at that time, but in 2017, with the advent of TAM, embraced the idea. DBHS also approached the jail in considering a partnership with Take Care Utah during these early years, it was embraced in later years as you will see below. Multiple meetings were held with Take Care Utah sharing with them the touchpoints both within the DBHS network and the criminal justice system, in hopes of expanding enrollment efforts. Throughout the years, more than 250 presentations were made explaining the importance of expanding Medicaid, options through the Marketplace, and highlighted Take Care Utah and DWS Medicaid eligibility specialists (utilizing federal matching dollars), including presentations to UBHC, UAC, NACO and NACBHDD to promote enrollment throughout Utah and other states.

Numerous specialty enrollment efforts were initiated as TAM opened in November of 2017. This 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 Association's (LDA) Office; and Criminal Justice Services. Trainings were also held with AP&P to assist them in their enrollment efforts (both upon release from prison and also in halfway houses), along with introductions to Take Care Utah, which later led to partnerships there. In addition to specialty enrollment efforts put in place during the TAM expansion, two large eligibility and enrollment trainings were held 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. Providers such as VOA eventually partnered directly with Take Care Utah (efforts expanded greatly once social detox became a Medicaid benefit). While some of these efforts originate in adult populations, they often extend to household members (including children) as individuals begin the enrollment assistance process and request assistance for additional household members (for example, while attending an intake at Criminal Justice Services). Research has shown that Medicaid Expansion states have increased Medicaid enrollment for children. It is believed that as adults become aware of their eligibility, they pursue Medicaid enrollment assistance for children in the household as well. Enrollment assistance planning was provided to other local authorities when they requested it.

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 (later sharing these statewide with LA directors). DBHS has been planning for these enrollment touchpoints and educating providers since 2014 (the year Medicaid Expansion became an option for states), and saw the provider system respond quickly and nimbly with each new expansion. Additionally, in 2020 outreach was made to Take Care Utah to advise them of legislative changes that would enable them to submit applications prior to release from jail (due to Utah becoming a suspension, rather than a termination state).

Although some components of these enrollment efforts were curtailed due to COVID-19, such as in-court enrollment assistance, stakeholders will be working to resume them as soon as restrictions allow.

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 FY20 actuals.
Describe any significant programmatic changes from the previous year.
As the majority of clients served within the County behavioral health system suffer from co-occurring mental health and substance use disorders, DBHS housing 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. In FY22, DBHS will offer housing support (clinical services delivered onsite [including supportive living and case management], and the housing subsidy) for the full capacity of clients in First Step House's 75 unit Central City Apartment development (which opened in August 2020). As new residential mental health programs and ACT teams are funded and brought online, DBHS will work to offer housing subsidy and associated treatment support for these programs. DBHS will also contract for additional master lease and congregate site support as the need arises. The division anticipates administering the housing contract at First Step House's Fisher House unit, which offers six units of congregate site living for SMI clients participating in Mental Health Court, as well as support for 2 additional master lease units for Mental Health Court clients beginning in FY22.

9) Peer Support Services-Substance Use Disorder **Christine Simonette**

Form B - FY22 Amount Budgeted:	**$15,000**	**Form B - FY22 Projected clients Served:**	**121**
Form B - Amount Budgeted in FY21 Area Plan	**$15,000**	**Form B - Projected Clients Served in FY21 Area Plan**	**170**
Form B - Actual FY20 Expenditures Reported by Locals	**$10,282**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**83**

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. Describe your policies and procedures for peer support.
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, Psychiatric and Behavioral Solutions, and Central City Housing. 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.

Describe how clients are identified for Peer Support Specialist services. How is the effectiveness of the services measured?
Referrals are made to the Optum Peer Support Specialists via providers, community stakeholders and internal Optum staff and committees. Optum educates our providers and expects them to identify when PSS services could be beneficial. If providers do not offer this service in-house, they refer the case to Optum. Additionally, when these needs are identified via various clinical staffings and/or committees, Optum ensures that PSS services are offered, either through our provider network, or directly through Optum CPSS staff. The effectiveness of services is measured through reporting by the CPSS offering services to members.
Describe your policies and procedures for peer support. Do Certified Peer Support Specialists participate in clinical staffings?
Optum Peer Support Specialists participate in Optum clinical rounds 2x a week, as well as internal Utah State Hospital Committee meetings. Their participation in these meetings is considered critical.
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. Optum employed Certified Peer Support Specialists are supervised by the Optum Deputy Director (LCSW), and weekly meetings occur at minimum.
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served and number of services provided(15% or greater change).
As compared to SFY20 actuals, the SFY22 budget is materially higher due to COVID. SFY20 actual spend and client count was significantly down due to COVID but we anticipate it bouncing back in SFY22.
Describe any significant programmatic changes from the previous year.
No significant change.

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 21, this number is anticipated to be ~600 beds. The primary funding source is TAM and AME, and is not included in the budget due to it going directly to our provider network. Key to further expansions will be workforce capacity. Thanks to an appropriation made during the 2020 general session, great efforts are ongoing to expand the number of students enrolled in this field, along with tuition reimbursement opportunities for those willing to work in publicly funded programs.

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 during the 2020 general session, allowed for counties to apply for funding to develop and implement Receiving Centers. DBHS was awarded funding for a new non-refusal receiving Center. SLCo transferred the property, and thanks to the Huntsman Mental Health Institute (HMHI) and additional partners and funding, a groundbreaking is scheduled for May 2021. This program will serve Salt Lake County community members who are in psychiatric or substance use-related crisis; however, the new Receiving Center will accept any and all individuals including walk-ins, secure drop-offs, and referrals for assessment. As a non-refusal RC for police, firefighters, and EMS, many of these individuals will be low-level offenders cycling through the county jail, whose crimes are secondary to untreated or undertreated mental illness or substance use disorders. Others may be frequent patients in emergency departments throughout the Salt Lake Valley. These individuals will benefit from medical and psychiatric triage, clinical assessment, peer support, discharge planning, connection to community resources and partners, and referral to treatment programs such as inpatient care, medical care, and detox.

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 efforts to respond to community input/need. Describe your participation with key community partners (e.g.: Multi-Agency Coordinating Committees, Regional Advisory Councils, High Fidelity Wraparound teams, Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committees, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts, Regional Healthcare Coalitions, and other partnership groups relevant in individual communities) shall occur consistently.

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.

DBHS is a member of the Criminal Justice Advisory Council, where ongoing systemic needs are addressed monthly, coordinated and planned for. The committee includes representatives from the courts, law enforcement, mayors, county council, state legislators, Legal Defenders Association, District

Attorney's office, Department of Corrections, Criminal Justice Services, Human Services, Diversity Affairs, and an individual with lived experience in the criminal justice system. One example is the new Receiving Center. This item is on the monthly agenda to provide updates and receive feedback from stakeholders.

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 evidence-based practices 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 and priorities to improve the quality of care.

DBHS' priority has always been to provide constant and consistent utilization management and quality assurance (i.e., monitoring visits) in order to ensure that any given client is afforded the best quality of care in the most appropriate treatment level. To this end, 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 constantly. 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 that vary from program to program. Please reference sections in the justice services narrative for some examples. Data DBHS collects include hospital diversion rates, treatment engagement, graduation rates, reductions in Risk Scores, positive drug testing rates, number of bed nights funded for individuals in permanent supportive housing, changes in census in co-occurring residential programs, changes in ACT Team census numbers and NOMS data such as employment, housing and “frequency of use” changes. New outcome measures for ACT teams are in development. DBHS also tracks reductions in jail recidivism for certain cohorts. 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.

Significant anomalies may occur in data and outcome metrics for FY21 and FY22 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

Describe your agency plan to maintain telehealth services in your area as agencies return to in-person service provision. Include programming involved. How will you measure the quality of services provided by telehealth?

DBHS/Optum currently has over 90 (MH and SUD combined) providers utilizing telehealth platforms

during the pandemic. The services on the authorization for telehealth mirror the in person (in clinic) services, as pertinent. In regular communication with providers (by phone, in training, etc.), we have found that many of our providers have gone through or are completing the process to continue telehealth services beyond the pandemic.

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

All providers currently providing telehealth services have completed training on the following which will still apply if they attest and continue to provide telehealth services:

- Proper claim submission protocols
- Appropriate malpractice insurance for providing telehealth services

Telehealth services are included in treatment record reviews during monitoring visits of our providers. Auditors will ensure all required components of the service provided are included, even as the service was not rendered in person. Justification or ongoing treatment and demonstrated improvement through treatment plan reviews of SMART treatment objectives is expected. When individuals are not improving, the treatment plan is to be adjusted accordingly.

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

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 152 beds (Oxbow) and 32 beds for females (ADC) based on an average length of stay of 3 months. The CATS program is also a direct referring partner for the Vivitrol Program.

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 the Justice Services section for additional information on these programs.

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

In addition, federal grant dollars allowed for an expansion of MAT services in the jail in 2019. 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 (Vivitrol). The MAT program provides a whole-patient approach to the treatment of substance use disorders and is clinically-driven with a focus on individualized patient care. Services are provided through the jail's health services staff and through a contract with Project Reality.

Qualifying participants have an 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.

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).

Not significant.

Describe any significant programmatic changes from the previous year.

In the previous year, due to COVID-19, the jail implemented stringent booking restrictions that significantly reduced the jail's overall population. Instead of having approximately 2,200 inmates, they had approximately 1,200. This affected the jail MAT numbers and CATS numbers dramatically, with fewer clients served (only because there were fewer patients booked into the jail). Additionally, class sizes were modified to more one-on-one interactions to avoid having multiple people in close proximity. As an example, the CATS program dropped to approximately 26% of its normal capacity (dropping from 184 participants, down to 46 participants).

Due to the uncertainty of COVID-19 (and associated impacts to the jail population), it is difficult to project changes in FY22 programming, but at this time we are hopeful programming and numbers served will normalize to previous years.

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, clients working towards treatment engagement, or those 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. Any Salt Lake County resident engaged in SUD treatment or continuing care services, as well as those working with case management teams with a goal of accessing ongoing treatment, are eligible to participate in the Vivitrol program. Our criminal justice partners, including CATS in the jail, the Department of Corrections Treatment Resource Centers (TRCs) and halfway houses, and Intensive Supervision Probation, constitute the bulk of our referrals. Those who attend regular case management appointments and remain engaged in treatment are eligible to receive monthly Vivitrol treatment at no additional charge to the client.

In addition, federal grant dollars allowed for 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 (Vivitrol). The MAT program provides a whole-patient approach to the treatment of substance use disorders and is clinically-driven with a focus on individualized patient care. Services are provided through the jail's health services staff and through a contract with Project Reality.

Qualifying participants have an 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.

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, SSOR Grant (previously STR and SOR) dollars, and other State funds for these programs.

12) Integrated Care **Shanel Long**

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

Providers within the SLCo network have taken steps towards integrating physical health and behavioral health services. Additional coordination between behavioral health providers and physical health providers occur. Please find examples below of integrated efforts within their programs:

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

More recently, the Martindale Clinic has become a syringe exchange site and facilitates providing clean syringes to current injecting users.
Additionally, Martindale providers in conjunction with Soap to Hope, provide weekly street-based medical care to sex workers and homeless individuals, typically treating wounds, STDs, MAT, among others. These individuals are typically resistant to coming into a traditional medical setting because of fear of going to jail or getting in trouble with their pimp, so they are going to them and having real success.

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

University of Utah followed a couple of years later and now SL Regional, St. Marks, and other hospital systems across the state have been referring in, seeing patients from across the state.

Finally, they have an addiction medicine fellow that is developing a program within the residential sites that combines nutrition, exercise, and life skills that is sustainable for this population as they transition back to independence.

First Step House (FSH)
Services include a history and physical screen on admission, a medical needs assessment and plan, MAT prescriptions (Suboxone and Vivitrol), office visits/exams, assessments, patient medication education and monitoring, seasonal vaccination program management, COVID-19 testing, and referral for care management of medical issues that arise during the course of the episode of care.

The FSH medical department is housed at 434 South 500 East, SLC, Ut, but provides services co-located mostly to their three residential treatment programs and Valor House (providing house calls). They plan to have a clinic in their outpatient treatment center in the next 12 months.

This care is provided internally by a FSH APRN, two RNs and three medication techs. Primary community-based partners include 4th Street Clinic, UofU School of Dentistry, Salt Lake VA Medical Center, Martindale Clinic & various community-based healthcare providers. Vacant positions include a second APRN, LPN & Certified Medical Assistant (CMA).

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

Valley Behavioral Health (VBH)
Valley Behavioral Health has been providing PH services to their clients in residential treatment since 2019 when they launched a pilot on their EPIC Campus. They have since become credentialed to provide both physical and behavioral health services through most major payors. They have provided these services as primarily telehealth services in 2020 and onsite when needed. They will soon be providing onsite physical health at their ValleyWest Integrated Care Clinic serving youth, families and children.

In early 2022 they expect to launch an onsite clinic at their North Valley building serving adult clients. They will provide this through their ValleyFIT model with a team of physical health providers that work collaboratively with their prescribers and other teams to coordinate care. They also have recently launched a chronic care management model that they are implementing to support individuals with 3 or more chronic conditions.

Please refer to the VBH integrated care PowerPoint attached for additional information and timeline on these services.

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

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

Volunteers of America (VOA)
Volunteers of America, Utah is dedicated to providing integrated primary and behavioral health care. They partner with Fourth Street Clinic to provide onsite triage and medical care at their Detoxification

facilities and Homeless Resource Centers (this service has been less active/suspended during the pandemic). Their outpatient clinics partner with Midtown Community Health Center. They have hired a medical assistant to triage client needs, coordinate care, and make the referral to Midtown seamless. For several years they have been a recipient of the Utah State Primary Care Grant which provides funding to pay for the primary care needs of clients who are unfunded.

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.

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

In addition to the efforts mentioned above, Optum and each of the four Accountable Care Organizations (ACOs) 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.

Finally, in 2019, DBHS began working with the State Medicaid Office, the four 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.

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.

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, RIC-AAU expanded their services to become a dual diagnosis enhanced program. In FY21, Odyssey House opened a residential program for women who have co-occurring disorders and are justice involved.

The Optum Care Coordination 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 an Integration and Care Coordination Specialist who collaborates 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,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. In this last year, an Optum CPSS and DBHS Quality Assurance Coordinator completed the Train the Trainer sessions for Smoking Cessation module of the Dimensions system. Subsequently, during FY21 and COVID-19, 11 individuals from six separate agencies were trained in the module and will offer the nicotine cessation classes to members before the end of June 2021. This training will be offered again in FY22, as providers have already expressed interest in training more staff.

13) Women's Treatment (WTA and WTX) **Rebecca King**

Form B - FY22 Amount Budgeted:	**$11,654,990**	**Form B - FY22 Projected clients Served:**	**2,416**
Form B - Amount Budgeted in FY21 Area Plan	**$10,891,563**	**Form B - Projected Clients Served in FY21 Area Plan**	**N/A**
Form B - Actual FY20 Expenditures Reported by Locals	**$11,691,593**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**2,416**

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 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 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 provides 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 access to 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. As part of our new expanded integrated care services, women have access to smoking cessation groups, hepatitis screening and treatment referrals, and complete medical evaluations by a trained family medicine physician and physician assistants.

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 changes

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

Rebecca King

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 FY22 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 **4/26/2021**

14) Adolescent (Youth) Treatment **Shanin Rapp**

Form B - FY22 Amount Budgeted:	**$985,310**	**Form B - FY22 Projected clients Served:**	**195**
Form B - Amount Budgeted in FY21 Area Plan	**$1,770,894**	**Form B - Projected Clients Served in FY21 Area Plan**	**N/A**
Form B - Actual FY20 Expenditures Reported by Locals	**$1,072,685**	**Form B - Actual FY20 Clients Serviced as Reported by Locals**	**212**

Describe services provided for adolescents and families. Please identify the ASAM levels of care available for youth.

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, 1 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 SUD treatment services 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.

Describe efforts to engage, educate, screen, recruit, and engage youth. Identify gaps in the youth treatment referral system within your community and how you plan to address the gaps.

Optum 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 mental health services and 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.

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).
As compared to FY20 actuals, the decrease is not significant. Projected clients was not requested in 2021 and so no figure was estimated or reported.

15) Drug Court **Shanel Long**

Form B - FY22 Amount Budgeted: Felony	**$105,000**	**Form B - FY21 Amount Budgeted: Felony**	**$210,577**
Form B - FY22 Amount Budgeted: Family Dep.	**$428,985**	**Form B - FY21 Amount Budgeted: Family Dep.**	**$879,202**
Form B - FY22 Amount Budgeted: Juvenile	**$114,642**	**Form B - FY21 Amount Budgeted: Juvenile**	**$241,474**
Form B - FY22 Recovery Support Budgeted	**$2,170,812**	**Form B - FY21 Recovery Support Budgeted**	**$2,927,514**

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. Upon completion of the assessment, CJS sends the LS/CMI results to the DA who uses the results and other legal information to assign to a Judge and Court. CJS also arranges for an assessment to be conducted by ARS/IGS. Upon completion of the assessment, CJS sends the treatment recommendation and appropriateness back to the DA to make final determination. 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. There are currently 249 total participants. In 2020 courts were closed due to the COVID-19 pandemic which has affected the number of referrals and new clients to the program. We anticipate an increase of referrals in the upcoming months as the courts and other services begin to open.

Family Recovery Court (FRC): Clients participating in the FRC program must meet the eligibility criteria of being high risk and high need, have reunification services ordered, and voluntarily sign-up for FRC. DBHS works closely with the Third District Juvenile Court and DCFS to identify clients that may be eligible for the FRC program. FRC is using the ASAM assessment and/or the RANT to assess the needs of clients and determine risk. Indicators of high risk would include DCFS involvement, order for reunification services, and treatment needs indicating an ASAM 2.1 or higher LOC. There are four Family Recovery Courts in Salt Lake County. The amount of participants served in each FRC is an average of 30, which is approximately 120 participants collectively per year.

Juvenile Drug Treatment Court (JDTC): Participants in the JDTC program must meet the eligibility criteria of being moderate or high risk and high need. DBHS works closely with the Third District Juvenile Court to identify participants that may be eligible for the program. The JDTC program uses the Pre-Screen Risk Assessment, Protective and Risk Assessment, and SASSI to identify moderate and high risk/high need youth. Additionally, all JDTC participants receive an ASAM assessment to determine the appropriate level of care for treatment. There is one Juvenile Drug Treatment Court in Salt Lake County. The amount for participants served is an average of 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 DBHS contracted providers (ASAM 1.0, 2.1, 2.5, 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: Participants have access to DBHS' full network of contracted providers for treatment and case management services that include outpatient, day treatment, and residential treatment services. Additionally, DBHS employs an assessment worker to conduct initial assessments and serve as a liaison between treatment providers and the Court. Participants are assisted with Medicaid enrollment in multiple touchpoints.

Juvenile Drug Treatment Court: Participants have access to DBHS' full network of contracted youth providers for treatment and case management services that include outpatient, day treatment, and residential treatment services. Third District Juvenile Court staff collaborate with the DBHS liaison to assist with Medicaid enrollment services.

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 DBHS' 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.

FRC participants may engage in MAT support through community clinics that offer methadone, Suboxone and Vivitrol based on client preference and clinical recommendations. FRC does not provide direct MAT services but is supportive of participants seeking MAT through a licensed private provider.

The JDTC does not provide MAT services for youth participants.

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 Treatment Court participants are tested randomly at a minimum of twice a week, including weekends and holidays, by the treatment provider they are being served through or through a contracted agency (i.e., Averhealth). 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. In some cases, if the provider does not have the resources for specific drug testing or is not able to provide the minimum drug testing requirements,, the participant will be required to drug test through their treatment provider and Averhealth.

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.

Participants in Family Recovery Court and Juvenile Drug Treatment Court are not assessed fees for their participation in these speciality treatment courts. When accessing 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. Drug testing fees are covered through the contract with Averhealth or the treatment provider they are receiving treatment services from.

Describe any significant programmatic changes from the previous year (Adult, Family, Juvenile Speciality 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. No significant program changes were made during FY20.

While there was not a significant programmatic change in and of itself, the pandemic significantly impacted Family Recovery Court (FRC) and Juvenile Drug Treatment Court. These treatment courts were required to transition to remote court hearings and case management services. During the transition to remote work, referrals, court hearings, and drug testing services were suspended for approximately three to six months. In effort to meet the needs of our participants, weekly team staffings and monthly provider meetings were implemented and daily check-in calls with participants were required.

Efforts have continued to be made to implement best practices from previous collaboration with the Office of Juvenile Justice and Delinquency Prevention and Children and Family Futures to improve outcomes for children and families. A second case manager position was created in February, 202I. This allows a case manager to be assigned to two Family Recovery Courts to provide a better continuum of care from when a participant enrolled in FRC to their graduation.

16) Justice Services **Thomas Dunford**

Form B - FY22 Amount Budgeted:	**2,196,939**	**Form B - FY21 Amount Budgeted:**	**$542,824**

Describe screening to identify criminal risk factors.

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.

Identify the continuum of services for individuals involved in the justice system. Identify strategies used with low risk offenders. Identify strategies used with high risk offenders.

DBHS Alternatives to Incarceration Program Initiatives

Project RIO (Right Person In/Right Person Out) began in 2006 when the Salt Lake County Criminal Justice and Mental Health Systems concurred with Munetz and Griffin, that in the ideal case, persons with mental illness would have the same rate of contact with the criminal justice system as does any other person. Systemic improvements were implemented that involved all five of the "sequential intercepts" in which persons with behavioral health conditions contact the criminal justice system, with the goal of diverting persons who have mental illness or substance use disorders and who are non-dangerous offenders from inappropriate incarceration. These programs supported an already active CIT program and Mental Health Court, and were the product of a rich collaboration of numerous agencies. Below please find an array of federal, state, and county funded programs that exist today. Programs supported in varying degrees by JRI funds have a **red*** next to them and more detailed program descriptions. The budget listed applies to JRI programming only. 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.

Sequential Intercept #1 - Law Enforcement & Emergency Services

- **Crisis Line & Warm Line** - The UNI Crisis Line is in operation 24/7, 365 days of the year, acts as the front door to the UNI Crisis System, and is staffed by experienced Licensed Mental Health Therapists. The Warm Line is a peer-run phone line staffed by individuals in recovery. Peer operators are trained to attentively and empathically listen to anonymous callers, offer compassion and validation, and assist callers in connecting with their own internal resources, strengths, and direction.

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

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

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

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

- **Volunteers of America Detox Centers** *

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

stable and willing to go to the detox center.

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

Volunteers of America Men's Adult Detoxification Center: This social model residential detoxification and withdrawal management program provides 83 beds for men 18 and older in need of detoxification & withdrawal management services. This program provides a safe and trauma-informed environment wherein clients can receive help managing intoxication and withdrawal symptoms and decide the next steps in their recovery journey. Clients may stay at this facility for up to 14 days (this has been extended to 30 days due to the pandemic). While in residence clients receive 3 meals per day and snacks, case management services, and access to medication-assisted treatment (MAT). Qualifying clients who are interested in treatment for substance use disorders will receive a full ASAM-driven biopsychosocial assessment and referral to an appropriate treatment program.

Throughout the stay, clients will have access to case management services. These services include linking clients to essential behavioral health treatment, enrollment in Medicaid, referral to primary care, assistance with legal issues, and connection to peer support and community recovery meetings. This facility is located at 252 W. Brooklyn Ave. Salt Lake City, UT, 84101.

Volunteers of America Center for Women and Children: This social model residential detoxification and withdrawal management program provides 32 beds for homeless and low-income women, 18 years and older, in need of detoxification and withdrawal management services. This program provides a safe and trauma-informed environment wherein clients can receive help managing intoxication and withdrawal symptoms and decide the next steps in their recovery journey. Clients may stay at this facility for up to 14 days (this has been extended to 30 days due to the pandemic). In addition, women may bring their children age 10 and under into the program. This mitigates a barrier many women face when they do not have safe alternative childcare. While in residence, clients receive 3 meals per day and snacks, case management services, and access to medication-assisted treatment (MAT). Qualifying clients who are interested in treatment for substance use disorders will receive a full ASAM-driven biopsychosocial assessment and referral to an appropriate treatment program.

Throughout the stay, clients will have access to case management services. These services include linking clients to essential behavioral health treatment, enrollment in Medicaid, referral to primary care, assistance with legal issues, and connection to peer support and community recovery meetings. In addition, clients have access to an outdoor area and onsite garden. It is located at 697 W 4170 S, Murray, UT, 84123.

- **Unified Police Department (UPD) Mental Health Unit** *

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

The objectives of the Mental Health Unit are to:

- Assist with the de-escalation of volatile situations, reducing the potential for violence during police contacts

- Provide mental health consumers and their families with linkages to services and supports
- Serve consumers in the least restrictive setting, diverting from jail and hospitalization as appropriate
- Reduce repeated law enforcement responses to the same location, and
- Free up patrol officers to respond to other calls.

Through additional county dollars, the Mental Health Unit is made up of one sergeant, one detective, and seven secondary officers from various precincts.

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

The program enjoys a 98.4% diversion rate from medical or psychiatric hospitalization through the first half of FY21, while making 510 outreaches (479 adults and 31 youth).

- **Utah Department of Public Safety Mental Health and Substance Use Disorder Evaluation Triage Team (METT)** *

DBHS began funding a mental health therapist during Operation Rio Grande, for the Utah Highway Patrol, as they worked with the homeless and behavioral health population in the Rio Grande area. These officers no longer serve in this area, but seeing the value of pairing law enforcement with mental health resources, wished to continue this model, and expand it statewide.

With no funding to do so, DBHS offered to fund this position as a bridge to the statewide expansion, through FY22. JRI dollars are utilized for this position.

Through this model, a Volunteers of America (VOA) therapist assists vulnerable individuals suffering from a mental health or addiction crisis by providing assessments and connecting individuals to mental health services. This position plays a valuable role in reducing the potential for violence during police interactions, aids Department of Public Safety (DPS) officers in identifying and addressing the mental health and substance use disorder concerns and assists officers in handling calls for service.

The METT is comprised of a licensed clinician, 4 DPS sworn outreach officers and a supervisory sergeant. The clinician is housed within DPS Headquarters located at 4501 S 2700 W and under the direction of the METT supervisory sergeant, with the following duties:

- Provide intervention, referral, or placement for a person with mental illness and addiction, to facilitate the speedy return of field officers to other duties.
- Endeavor 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.
- Provide a variety of clinical services for persons suffering from severe mental and emotional disorders and addiction; assist patients; their families; law enforcement and other social agencies in understanding and finding solutions to problems that lead to and result from mental illness and severe emotional disorders.
- Provide follow-up to support access to care and associated reductions in recidivism.
- Coordinate with service providers throughout the state to address needs of individuals.

The last 7 months, this program has served 33 juveniles and 39 adults for a total of 72 individuals. Case management can vary depending on each individual, which could be as short as a few weeks to in excess of over a year. The area of operation is the State of Utah and

housed out of the Utah Highway Patrol Calvin Rampton Building - State Bureau of Investigation.

Sequential Intercept #2 – Jail

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

  Mental Health services are funded through a direct appropriation from the County Council to the SLCo Sheriff's Office. In addition to providing mental health services and medication management, the Sheriff's Office provides discharge planners that collaborate with community mental health treatment providers and social workers at the Legal Defenders Association to coordinate continuity of medications and treatment for severely mentally ill (SMI) individuals. The Salt Lake County Jail has two dedicated units that can address more severe mental health needs – a 17-bed unit for individuals who have been identified as high risk for suicide and a 48-bed unit for individuals with a mental health diagnosis that would benefit from not being with the general population. In addition to these, the jail team provides group therapy and crisis services for individuals in the general population.

  DBHS funds the SUD services in the jail, including:
  The CATS Program (contracted through Odyssey House) - an addictions treatment therapeutic community, based on a day treatment level of care (20 hours per week of treatment services with additional services included). The program is operated within both the ADC and Oxbow Jails. The capacity for males is 152 beds (Oxbow) and 32 beds for females (ADC) based on an average length of stay of 3 months.

  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.

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

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

Sequential Intercept #3 – Courts

- **Mental Health Courts** - Mental Health Court is a collaboration between criminal justice and mental health agencies in Salt Lake County. The Mental Health Court provides case management, treatment services, and community supervision for the purpose of improving the mental health and well-being of participants, protecting public safety, reducing recidivism, and improving access to mental health resources. Every participant who is accepted into MHC has completed a criminogenic risk assessment which providers have access to and can use as a

means of targeting client specific areas of risk. Providers provide interventions at the individual, group and case management level to target areas of risk as well. DBHS funds coordination of care, treatment services and housing programs for this population.

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

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

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

Sequential Intercept #4 – Reentry

- **Top Ten** - Once a month, DBHS facilitates a group that meets to staff frequently booked individuals with severe mental illness. Partners include the Legal Defender's Association (LDA), Valley Behavioral Health, HMHI Crisis Programs, Jail Mental Health, DBHS, Optum, The Road Home, Volunteers of America, the SLC PD Community Connections Center, and 4th Street Clinic. Team goals are to:
    - Ensure jail mental health is aware of an individual's diagnosis and medications prescribed in the community prior to arrest, and vice-versa, ensure community mental health programs are aware of an individual's diagnosis and medications prescribed in jail prior to release.
    - Develop a pre-release relationship with the inmate prior to release whenever possible.
    - Work to assertively engage the client in treatment upon release, address continuity of care/medications and transport if appropriate.
    - Refer into appropriate programs (Mental Health Court, ACT Teams, dual-diagnosis residential programs, Jail Diversion Outreach Team, other outpatient services, housing, etc.).
    - Communicate with the individual's attorney.
    - Communicate with county supervising case managers, state AP&P officers or other private supervising agencies.
    - Coordinate jail releases when appropriate.
    - Support the client to resolve open court cases.
    - Coordinate with medical providers when appropriate.
    - Coordinate with other community providers (VA, private providers, etc.).

- Assist with housing, entitlements, and other needed supports.
- Address individuals as pre-contemplative rather than non-compliant when unable to engage them into services. That is, try, try again.

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

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

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

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

- **Odyssey House Women's MH Residential Program -** This 16-bed facility is a dual-diagnosis residential facility for women, mirroring components of the CORE programs. Due to high demand from Mental Health Court and other stakeholders, this new program was brought online in 2020.

  An additional 16-bed facility for men is expected to be brought online in 2021.

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

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

- **The 4th Street Clinic** - Collaborates with the jail and with the LDA Mental Health Liaison to assist homeless individuals with both physical and behavioral health services upon release from jail.

- **DWS Medicaid Eligibility Specialists** - DBHS funds Medicaid Eligibility Specialists to assist with enrollment into Medicaid. One is mobile, visiting various locations such as court settings and Criminal Justice Services, the others are embedded within the largest behavioral health provider.

- **Navigator and Certified Application Counselor Assistance** - DBHS providers, the jail, Criminal Justice Services and the Legal Defenders Association collaborate with navigators and

certified application counselors to enroll individuals in Marketplace Plans, Medicaid and other health plan options. These services are provided at many different locations, including court settings, the jail, provider locations, pretrial and probation settings. DBHS worked aggressively throughout the years to develop a coordinated response to enrollment efforts with the criminal justice and behavioral health populations.

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

Sequential Intercept #5 - Community

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

- **Housing Programs** – DBHS funds multiple housing first initiatives for individuals involved in the justice system. Some serve individuals with severe mental illness, while others are tailored towards supporting individuals with SUDs. These programs are a combination of scattered units throughout the valley, boarding homes, rental assistance vouchers, sober living homes, and partnerships on tax credit housing projects where DBHS funds Medicaid supportive living rates, rental subsidies, and even some capital expenses.

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

- **Intensive Supervision Probation (ISP) 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 dedicated assessment staff 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 32% of all clients have identified opiates as a primary substance of abuse (26.9% of all males and 35.7% of all females).

  In March 2016 this program was presented to the County Council and received unanimous support for an increase in ongoing county funds ($2.3 million overall, $790,000 for community treatment) to grow the program. County funds for this program are not included in this budget narrative. After successful implementation, ISP received several accolades for the innovative strategies employed to stop the revolving door of recidivism in Salt Lake County, including: the

2016 National Association of Counties (NACo) Achievement Award; was selected to present at the national 2016 American Probation and Parole Association Conference in Cleveland; the 2017 Salt Lake County Sheriff's Office Distinguished Unit award; and, was recognized by the Honorary Colonels of Salt Lake in 2018.

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

In a recent evaluation 406 clients were admitted into the ISP program during a 12 month period (January 2020 – December 2020). Since the program's inception 320 individuals have graduated, and multiple successful outcomes documented: 75.4% of all clients referred into ISP have been assessed for treatment. Looking at a snapshot of the program in March of FY20, 73.1% of all open clients remain actively engaged in treatment. Graduates of the program enjoy a 34% reduction in risk scores. Successful clients saw an 86% reduction in new-charge bookings (comparing one year prior to one year post-program intake); revoked clients showed a 59.2% reduction; with the total population showing a 71.6% reduction.

FY20 was a time of transition for this program due to the elimination of JRC funding. While the number of uninsured and underinsured individuals post-Medicaid Expansion is unknown, it was our intention to maintain current levels of programming throughout this time by transitioning from JRC funding to Medicaid funding. Every effort was made to enroll participants into Medicaid. In addition to specialty enrollment efforts put in place during the Targeted Adult Medicaid (TAM) expansion, two large eligibility and enrollment 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 were no longer needed for this program. The participating treatment providers assisted with a seamless transition in funding source to Medicaid without service interruption to the clients. With the Medicaid expansions being open to other providers outside of the DBHS network, additional providers have begun to serve ISP clients as well. JRI funds continue however to play a large role in funding the correctional staff and other ancillary, non-Medicaid funded services such as UA testing, RSS services and recovery coaching through USARA.

- **Mental Health Court Housing** – beginning in FY22, mental health court housing units will transfer from Salt Lake County Criminal Justice Services to DBHS.

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

- **Supported Employment Programs** – multiple Salt Lake County network providers operate

successful employment assistance programs for justice-involved populations.

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

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

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

- **Community Mental Health and SUD programs** - there are many other mental health or substance use disorder treatment programs, in all levels of care, that serve the criminal justice population. Medicaid expansion has enabled an unprecedented expansion of these services. As an example, ~170 SUD residential beds existed in 2016, and is estimated to be ~600 in 2021, more than tripling capacity within the Salt Lake County network. Additional services have expanded outside this network as well. For further information, please reference the attachment entitled “The Evolving Landscape of Behavioral Health Services in Salt Lake County”.

Strategies used with low and high risk offenders

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

Identify a quality improvement goal to better serve individuals involved in the criminal justice system. Your goal may be based on the recommendations provided by the University of Utah Criminal Justice Center in SFY 2020.

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

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

Identify coalitions, planning groups or councils (or other efforts) at the county level working to improve coordination and outcomes for adults involved in the justice system.

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, Mayor Jenny Wilson	Salt Lake County Mayor
Vice Chair, Sim Gill	District Attorney, Salt Lake County
Jojo Liu	CJAC Director
Honorable Mark Kouris	Presiding Judge, Third District Court
Honorable Brendan McCullaugh	Judge, West Valley City Justice Court
Honorable John Baxter	Judge, Salt Lake City Justice Court
Representative Jim Dunnigan	Utah House of Representatives
Senator Karen Mayne	Utah State Senate
Rosie Rivera	Salt Lake County Sheriff
Jim Bradley	Salt Lake County Council
Dave Alvord	Salt Lake County Council
Mike Brown	Chief, Salt Lake City Police Department
Ken Wallentine	Chief, West Jordan Police Dept, LEADS Chair
Jack Carruth	Chief, South Salt Lake City Police Dept
Vacant	Director, Utah State Department of Corrections
Karen Crompton	Director, Salt Lake County Human Services
Kele Griffone	Director, Criminal Justice Services
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

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
Luna Banuri	Chair, SLCo Diversity Affairs

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

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

Identify efforts as a community stakeholder for children and youth involved with the juvenile justice system, local DCFS, DJJS, Juvenile Courts, and other agencies.

Examples of services to these populations include:

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

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

In addition, they were recently awarded a contract with JJS to open an afterschool IOP for JJS youth. It will be housed at their Taylorsville outpatient location. They anticipate it being operational at the beginning of the fiscal year.

Salt Lake County Division of Youth Services-Juvenile Receiving Center (JRC) - This program offers screening, evaluation and referral services to youth, families and law enforcement 24/7. Services are for youth ages 8 to 17 who need a crisis timeout, are runaway, homeless, ungovernable youth or youth who have committed minor offenses. Youth may come to the facility on their own, with parents or police may bring in youth who have committed a status offense or delinquent act that does not meet Detention Admission Guidelines. This may include, but not limited to, running away from home, truancy, substance misuse, curfew violation or acting beyond the control of the youth's parents. No appointment

is needed to access the Juvenile Receiving Center services including individual or family crisis counseling. Serving two locations: Salt Lake and West Jordan.
Provide data and outcomes used to evaluate Justice Services.
DBHS has developed multiple outcome measures that vary from program to program. Please reference sections in the narrative above for examples. In addition to hospital diversion rates, treatment engagement, graduation rates, reductions in Risk Scores, positive drug testing rates, and NOMS data such as employment, housing and "frequency of use" changes, DBHS tracks reductions in jail recidivism for certain cohorts. 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.

17)Suicide Prevention, Intervention & Postvention (ONLY COMPLETE IF NOT COMPLETED ON FORM A)

Describe all current activitiesin place in suicide prevention, including evaluation of the activites and their effectiveness on a program and community level. Please include a link or attach your localized suicide prevention plan for the agency.
See Form A
Describe all currently suicide intervention/treatment services and activities including the use of evidence based tools and strategies. Describe your policies and procedures for suicide screening, risk assessment, and safety planning as well as suicide specific treatment and follow up/care transition services. Describe how Describe how clients are identified for suicide specific services. How is the effectiveness of the services measured?
Describe all current strategies in place in suicide postvention including any grief supports. Please describe your current postvention response plan, or include a link or attach your localized suicide postvention plan for the agency and/or broader local community.
Describe your plan for coordination with Local Health Departments and local school districts to identify roles and support implementation of a community postvention plan in alignment with the state Community Postvention Toolkit.

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

For those not participating in this grant program, please indicate "N/A" in the box below.

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

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

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

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

For Local Authorities receiving mini grant funding for the Live On Utah statewide suicide prevention campaign, summarize your implentation and sustainability plans for the implementation of culturally appropriate suicide prevention messaging in your area.

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

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. For instructions on how to complete this table, please see the Community Coalition Status Tool here.

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

CCEBP Community	**CCEBP Community Coalition Status (see tool here)**	**Priority** High Medium Low	**Notes/ Justification of Priority**	**List of Programs Provided (if applicable)**	**Evidence Based Operating System (e.g. CTC, CADCA Coalition Academy, PROSPER)**	**Links to community strategic plan**
Central 9th Salt Lake City	E5b	High	Coordinator is working with CTC coach and is familiar with CTC, KLO done, currently starting phase 3 of CTC.	CTC	CTC	n/a
Evidence2Success Kearns Community Coalition	G	High	Coordinator has completed CTC TOF and coalition has completed the CADCA academy. In year 4 of DFC. Been functioning as a CTC for 5.5	CTC, BLUES, ME Time, Strengthening Families	CTC	https://www.kearnse2s.org/

			years.			
Magna	E7	High	Coordinator has completed CTC TOF, KLO completed and priorities have been set. Currently in phase 4 of CTC.	CTC	CTC	n/a
Murray	C1	High	Was learning about CTC and trying to decide which direction to go.Was on track to use CTC but then a new coordinator was hired by the school district. New coordinator did not do any new coalition work during the last year due to the pandemic. Meetings are starting back up again.	None	None	n/a
Midvale	B	Medium	Community coalition focusing on student health in local schools.Went stagnant during pandemic.	None	None	n/a
South Salt Lake	C2 A234	Low	Focuses on neighborhood development as a whole.	None specific to SUD Prevention	Neighborhood Centers Model	http://www.southsaltlakecity.com/department-listings/promise-ssl
West Valley City	D1	Medium	Talks of getting a coalition	None	None	n/a

			started are happening.			
Draper	A23	Low	Old CTC	None	Used to use CTC. Has since disbanded	n/a
West Jordan	C3 A234	Medium	Community coalition mostly focusing on physical health.	None	None	n/a
South Jordan	C3 A234	Medium	Community coalition mostly focusing on mental health resources.	None	None	n/a
Riverton/Bluffdale	C3 A234	Medium	Community Coalition mostly focusing on sucicide prevention.	None	None	n/a
Sandy	C3 A234	Medium	Has money for mini-grants for health initiatives in the community.	None	None	n/a
Holladay	C3 A234	Medium	Community health coalition focusing on physical health.	None	None	n/a
Herriman	C3 A234	Medium	Community coalition focusing on suicide prevention and mental health.	None	None	n/a
Glendale	D2	High	Currently in the planning phase. Working with UNP to outline a systems map of the strengths and challenges facing the community.	None	None- has elements of SPF in the process. Community driven.	n/a

			Now working on gathering key leaders in the community.			
Millcreek	C2 A234	Low	Community Coalition working to address barriers to education, health and safety, and economic well being.	Promise Millcreek	None	https://millcreek.us/221/Promise-Program
Daybreak	A234	Low	There has been some discussion about breaking off from South Jordan to form own coalition.	None	None	n/a
Avenues	A234	Low	No expressed community interest and not a high need area at this time.	None	None	n/a
Foothill/East Bench	A234	Low	No expressed community interest and not a high need area at this time.	None	None	n/a
Southeast Liberty	A234	Low	Some of Southeast Liberty will be encompassed in the central 9th coalition.	None	None	n/a
Sugarhouse	A234	Low	No expressed community interest and not a high need area at this time.	None	None	n/a

Rose Park	A234	Low	No expressed community interest and gets served by coalitions sounding this small area.	None	None	n/a
Cottonwood	A234	Low	No expressed community interest and not a high need area at this time.	None	None	n/a
Taylorsville	A234	Low	No expressed community interest.	None	None	n/a

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. A minimum response is at least two sentences per community identified.

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. Because of a delay due to the pandemic and staffing this assessment is targeted to be completed by 6/30/2022.

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. The coordinator is being coached by the RD. The KLO has been completed and the coalition is starting phase 3 of CTC.

Community: Evidence2Success Kearns Community Coalition

Kearns E2S is a CTC in Kearns that has been up and running for 5.5 years. This coalition is currently in year 4 of DFC funding. This coalition has graduated from the CADCA Academy. SLCoHD houses the coordinator for the coalition and serves as the fiscal agent for the coalition managing budgets and grant reporting. Our previous coordinator left in February of 2021 and we are in the process of hiring a new coordinator who should start in May 2021.

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. This coalition coordinator has completed the CTC TOF. The coalition has completed the CTC KLO and priorities have been set. This coalition is currently in phase 4 of the CTC process.

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. A new coordinator for this coalition was hired by Murray School District but due to the pandemic the coordinator was unable to continue coalition meetings. The coordinator has scheduled a meeting for May 2021 to start the coalition again.

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. This coalition became stagnant during the pandemic. SLCo staff plan to reach out to see if there is interest in resuming coalition activities this year.

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. SLCo staff were unable to assist this coalition during the pandemic due to staff being redeployed for our COVID emergency response. Staff will reach out to this coalition this year to see how we can support this coalition's efforts.

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. This coalition recently discussed starting a CTC. SLCo staff will encourage these conversations and provide TA to 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. A key leader meeting is to be held in May 2021.

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 is 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: $62,075 State General Funds: Discretionary Funds: $2.925 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 Difficulties Questionnaires	Strength and Difficulties Questionnaire (SDQ)	Intake forms and quarterly administration of the SDQ	Quarterly SDQ Questionnaire administrations; Quarterly School	SDQ testing; Quarterly Report Cards/School Attendance	2023 SHARP Testing

			Report Cards		

Program Name	Cost of Program	Evidence Based: Yes or No
STEP Parenting Program	Block Grant Funds: $46,795 State General Funds: Discretionary Funds:$2,205	Yes
	Total: $49,000	

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: $32,470 State General Funds: Discretionary Funds:$1,530 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: $23,288 State General Funds: Discretionary Funds:$1,097 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: $47,669 State General Funds: Discretionary Funds:$2,246	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: $55,271 State General Funds: Discretionary Funds:$2,604 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 involvement in their children's lives.	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 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: $36,433 State General Funds: Discretionary Funds:$1,717 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: $34,129 eneral Funds: onary Funds:$1,608	
	35,737	

Coalition	el:
South Salt Lake	iewed

			Population: U/S/I	es	Outcomes	
			Selective			

	articipant Families aged in d's nd civic ce uth trate y, motional ence APP youth onstrate/ that they owledge g risk arm from e. uth are progress academic cy	tal Attitudes le to Anti-social , y Attachment, rds for Pro-social ment ed risk of drug use mmitment to school	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 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 1x/week x 9 x 40 weeks, tion in regular fitness, dance, ecreation high quality c tutoring, STEM n, experiential n, summer ming, literacy s	parents ting ing increase in ment decrease of -3 (at left) by 2% uth reporting favorable to al behavior will e from 28.6% in 2021 ave accurate ion regarding ences of drug in attendance. te of SSL schools 80% of youth progress toward cy in Lang arts & reater than 1 year er year)	tal Attitudes e to anti-social will decrease 6% (2017) by 2021 APP youth nts will trate resiliency, ate social s as shown by e in SSL youth te ubstance Abuse will decrease over th will experience ase in school ment as trated by e in failing and dropouts, in % students on graduation
es &	oles and nce for ment/inter d Surveys	Family Research endorsement- parent ment, PSSL Parent	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

	g s re: pro- ehavior iaison	aily program activity ETO), anecdotal office referrals IARP report data for cates 40.2% of SSL e at risk of eption regarding om drug use	nce records /CTC Risk and ve Factors Survey	tivity Reports, nce Records, Action Pre and ts	IARP (Baseline), ark: 5% reported 2021 & CTC R&P	IARP as ed to 2021 & 2023 disaggregated r SSL, SSL Youth te
	2019 rvey, Survey		nce records /CTC Risk and ve Factors Parent	nce Records ation, pre and post	2017 (Baseline) ark: % reported in IARP Survey	IARP as ed to 2021, 2023 for SSL Youth
	outh re: th hips, Pre test to harms, ata for L School	IARP NREPP for program	nce records /CTC Risk and ve Factors Parent	nce Records, pre t tests, DIBELS shrink in ESL gap & ic risk	e in risk of ment to school 17 Sharp e) compared to	IARP 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: $34,129 State General Funds: Discretionary Funds:$1.608 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: $47,750 State General Funds: Discretionary Funds:$2,250 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: $84,040 State General Funds: Discretionary Funds:$3,960 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: $66,377 State General Funds: Discretionary Funds:$3,128 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: $46,986 State General Funds: Discretionary Funds:$2,214 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: $27,325 State General Funds: Discretionary Funds:$1,288 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: $42,975 State General Funds: Discretionary Funds:$2,025 Total: $45,000	Yes

Agency/Coalition	Tier Level:
Salt Lake County Division of Youth Services Evidence2Success Coalition partners with 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: $11,518 State General Funds: Discretionary Funds:$543 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: $53,957 State General Funds: Discretionary Funds:$2,543 Total: $56,500	Yes

Agency/Coalition			Tier Level:			
Salt Lake County Division of Youth Services & Evidence2Success Coalition			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: $31,992 State General Funds: Discretionary Funds:$1508	Yes
	Total: $33,500	

Agency/Coalition	Tier Level:
Salt Lake County Division of Youth Services & Magna Coalition	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: $31,992 State General Funds: Discretionary Funds:$1,508 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: $37,722 State General Funds: Discretionary Funds:$1778 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: $95,500 State General Funds: Discretionary Funds:$4,500 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: $85,950 State General Funds: Discretionary Funds:$4,050 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: $28,464 State General Funds: Discretionary Funds:$1,341 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: $136,669 State General Funds: Discretionary Funds:$6,440 Total: $143,109	Yes

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: $16,449.50 State General Funds: Discretionary Funds:$775 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: $16,449.50 State General Funds: Discretionary Funds:$775 Total: $17,224.50	Yes

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: $12,296 State General Funds: Discretionary Funds:$579 Total: $12,875	Yes

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: $39,155 State General Funds: Discretionary Funds:$1,845 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: $98,999 State General Funds: Discretionary Funds:$4,665	Yes
	Total: $104,664	

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: $25,159 State General Funds: Discretionary Funds:$1,185 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: $17,190 State General Funds: Discretionary Funds:$810 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: $73,616 State General Funds: Discretionary Funds:$3,467 Total: $77,083	Yes

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	

FY22 Mental Health Area Plan & Budget

Local Authority: Salt Lake Co.

Form A

	State General Fund			County Funds									
FY2022 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 FY2022 Revenue
JRI/JRC	$1,000,000												$1,000,000
Local Treatment Services	$1,673,029	$12,295,336	$349,968	$5,452,661	$6,203,909	$47,750,505	$822,580		$4,379,468	$854,346			$79,781,802
FY2022 Mental Health Revenue by Source	$2,673,029	$12,295,336	$349,968	$5,452,661	$6,203,909	$47,750,505	$822,580	$0	$4,379,468	$854,346	$0	$0	$80,781,802

	State General Fund			County Funds											
FY2022 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 FY2022 Expenditures Budget	Total Clients Served	TOTAL FY2022 Cost/Client Served
Inpatient Care (170)		$1,983,539			$1,000,842	$7,703,327				$211,744			$10,899,452	567	$19,223.02
Residential Care (171 & 173)		$1,823,842			$920,263	$7,083,117	$105,155						$9,932,377	1,672	$5,940.42
Outpatient Care (22-24 and 30-50)	$379,202	$4,428,293	$349,968	$455,039	$2,234,400	$17,197,860	$590,203		$119,217	$569,997			$26,324,179	12,300	$2,140.18
24-Hour Crisis Care (outpatient based service with emergency_ind = yes)	$500,000	$841,041		$1,902,761	$424,368	$3,266,291	$22,902		$4,021,208				$10,978,571	2,552	$4,301.95
Psychotropic Medication Management (61 & 62)		$430,138		$164,137	$217,036	$1,670,497	$83,456		$33,174	$72,605			$2,671,043	5,718	$467.13
Psychoeducation Services (Vocational 80) Psychosocial Rehabilitation (Skills Dev. 100)	$42,290	$1,243,096		$78,553	$627,234	$4,827,725	$2,608						$6,821,506	1,680	$4,060.42
Case Management (120 & 130)	$17,133	$816,803		$165,710	$412,138	$3,172,160	$18,256		$165,869				$4,768,069	4,911	$970.90
Community Supports, including - Housing (174) (Adult) - Respite services (150) (Child/Youth)	$710,973	$207,036		$1,317,194	$104,465	$804,051							$3,143,719	616	$5,103.44
Peer Support Services (140): - Adult Peer Specialist - Family Support Services (FRF Database)	$719,860	$165,118			$83,314	$641,256							$1,609,548	1,215	$1,324.73
Consultation and education services, including case consultation, collaboration with other county service agencies, public education and public information		$195,669			$98,730	$759,908							$1,054,307		
Services to persons incarcerated in a county jail or other county correctional facility	$153,350												$153,350	1,070	$143.32
Adult Outplacement (USH Liaison)		$98,614		$650,957	$49,756	$382,948							$1,182,275	125	$9,458.20
Other Non-mandated MH Services	$150,221	$62,147		$718,310	$31,362	$241,366			$40,000				$1,243,406	645	$1,927.76
FY2022 Mental Health Expenditures Budget	$2,673,029	$12,295,336	$349,968	$5,452,661	$6,203,908	$47,750,506	$822,580	$0	$4,379,468	$854,346	$0	$0	$80,781,802		

	State General Fund			County Funds											
FY2022 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 FY2022 Expenditures Budget	Total FY2022 Clients Served	TOTAL FY2022 Cost/Client Served
ADULT	$1,598,000	$7,342,758	$349,968	$4,857,461	$3,704,964	$28,516,518	$609,074		$4,339,468	$621,674			$51,939,885	10,395	$4,996.62
YOUTH/CHILDREN	$1,075,029	$4,952,578		$595,200	$2,498,944	$19,233,988	$213,506		$40,000	$232,672			$28,841,917	5,759	$5,008.15
Total FY2022 Mental Health Expenditures	$2,673,029	$12,295,336	$349,968	$5,452,661	$6,203,908	$47,750,506	$822,580	$0	$4,379,468	$854,346	$0	$0	$80,781,802		#DIV/0!

FY22 Proposed Cost & Clients Served by Population

Local Authority: Salt Lake Co.

Form A (1)

Budget and Clients Served Data to Accompany Area Plan Narrative

MH Budgets		Clients Served	FY2022 Expected Cost/Client Served
Inpatient Care Budget			
$6,409,632	ADULT	303	21154
$4,489,820	CHILD/YOUTH	264	17007
Residential Care Budget			
$9,622,917	ADULT	1,622	$5,933
$309,460	CHILD/YOUTH	50	$6,189
Outpatient Care Budget			
$12,009,345	ADULT	7,600	1580
$14,314,834	CHILD/YOUTH	4,700	3046
24-Hour Crisis Care Budget			
$9,713,715	ADULT	2,077	4677
$1,264,856	CHILD/YOUTH	475	2663
Psychotropic Medication Management Budget			
$2,158,787	ADULT	4,782	451
$512,256	CHILD/YOUTH	936	547
Psychoeducation and Psychosocial Rehabilitation Budget			
$1,499,276	ADULT	950	1578
$5,322,230	CHILD/YOUTH	730	7291
Case Management Budget			
$4,428,743	ADULT	3,900	1136
$339,326	CHILD/YOUTH	1,011	336
Community Supports Budget (including Respite)			
$2,028,167	ADULT (Housing)	350	5795
$1,115,552	CHILD/YOUTH (Respite)	266	4194
Peer Support Services Budget			
$816,481	ADULT	1,100	742
$793,067	CHILD/YOUTH (includes FRF)	115	6896
Consultation & Education Services Budget			
$837,808	ADULT		
$216,499	CHILD/YOUTH		
Services to Incarcerated Persons Budget			
$153,350	ADULT Jail Services	1,070	143
Outplacement Budget			
$1,182,275	ADULT	125	9458
Other Non-mandated Services Budget			
$1,079,389	ADULT	600	$1,799
$164,017	CHILD/YOUTH	45	$3,645

Summary

Totals

$51,939,885	Total Adult
$28,841,917	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)			
$349,968	ADULT	280	1250
	CHILD/YOUTH		#DIV/0!
Unfunded (all other)			
$11,404,003	ADULT	3,600	3168
$1,923,735	CHILD/YOUTH	1,200	1603

FY22 Mental Health Early Intervention Plan & Budget **Local Authority:** Salt Lake Co. **Form A2**

	State General Fund		County Funds						
FY2022 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 FY2022 Revenue
FY2022 Mental Health Revenue by Source	$1,075,029	$291,889	$340,468	$811,360	$1,647,308			$10,481	$4,176,535

	State General Fund		County Funds								
FY2022 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 FY2022 Expenditures Budget	Total Clients Served	TOTAL FY2022 Cost/Client Served
MCOT 24-Hour Crisis Care-CLINICAL			$326,369	$105,539	$214,277				$646,185	971	$665.48
MCOT 24-Hour Crisis Care-ADMIN			$14,099	$4,559	$9,257				$27,915		
FRF-CLINICAL	$690,050							$10,028	$700,078	341	$2,053.01
FRF-ADMIN	$29,810							$453	$30,263		
School Based Behavioral Health-CLINICAL	$339,826	$279,279		$672,222	$1,364,814				$2,656,141	604	$4,397.58
School Based Behavioral Health-ADMIN	$15,343	$12,610		$29,040	$58,960				$115,953		
FY2022 Mental Health Expenditures Budget	$1,075,029	$291,889	$340,468	$811,360	$1,647,308	$0	$0	$10,481	$4,176,535	1,916	$7,116.08

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

FY22 Substance Use Disorder Treatment Area Plan Budget **Local Authority:** Salt Lake County **Form B**

FY2022 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 FY2022 Revenue
Drug Court	$697,052	$105,000	$1,580,674	$0	$213,182	$210,260	$0	$0	$400	$0	$0	$2,806,568
JRI	$508,567	$0	$1,686,872	$0	$0	$0	$0	$0	$0	$1,500	$0	$2,196,939
Local Treatment Services	$4,597,032	$2,295,000	$1,510,000	$100,000	$4,105,000	$4,470,459	$840,109	$887,909	$12,000	$110,000	$1,650,000	$20,577,509
Total FY2022 Substance Use Disorder Treatment Revenue	$5,802,651	$2,400,000	$4,777,546	$100,000	$4,318,182	$4,680,719	$840,109	$887,909	$12,400	$111,500	$1,650,000	$25,581,016

FY2022 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 FY2022 Expenditures	Total FY2022 Client Served	Total FY2022 Cost/ Client Served
Screening and Assessment Only	$242,909	$46,054	$265,121	$0	$82,861	$169,721	$82,289	$4,919	$0	$42,965	$162,787	$1,099,626	2,645	$416
Detoxification: ASAM IV-D or III.7-D) (ASAM III.2-D) ASAM I-D or II-D)	$277,429	$0	$152,493	$100,000	$0	$560,284	$130,405	$44,362	$0	$3,675	$548,137	$1,816,785	2,484	$731
Residential Services (ASAM III.7, III.5, III.1 III.3 1II.1 or III.3)	$1,675,535	$1,642,436	$464,249	$0	$2,955,140	$920,409	$214,224	$12,806	$0	$5,511	$147,604	$8,037,914	1,230	$6,535
Outpatient: Contracts with Opioid Treatment Providers (Methadone: ASAM I)	$254,085	$49,003	$460,360	$0	$88,170	$0	$119,432	$173,184	$0	$34,438	$97,291	$1,275,963	763	$1,672
Office based Opiod Treatment (Buprenorphine, Vivitrol, Naloxone and prescriber cost)) Non-Methadone	$512,629	$0	$150,000	$0	$0	$0	$0	$196,188	$0	$0	$0	$858,817	372	$2,309
Outpatient: Non-Methadone (ASAM I)	$528,398	$364,654	$513,264	$0	$656,100	$774,902	$170,308	$54,070	$9,326	$22,475	$364,757	$3,458,254	2,831	$1,222
Intensive Outpatient (ASAM II.5 or II.1)	$372,281	$297,853	$294,513	$0	$535,911	$1,184,204	$123,451	$7,380	$3,074	$1,704	$85,060	$2,905,431	1,593	$1,824
Recovery Support (includes housing, peer support, case management and other non-clinical)	$1,939,385	$0	$2,477,546	$0	$0	$1,071,199	$0	$395,000	$0	$732	$244,364	$6,128,226	3,294	$1,860
FY2022 Substance Use Disorder Treatment Expenditures Budget	$5,802,651	$2,400,000	$4,777,546	$100,000	$4,318,182	$4,680,719	$840,109	$887,909	$12,400	$111,500	$1,650,000	$25,581,016	15,212	$1,682

FY2022 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 FY2022 Expenditures
Pregnant Women and Women with Dependent Children, (Please include pregnant women under age of 18)	$2,165,487	$1,328,427	$1,132,862	$20,034	$2,393,325	$470,600	$840,109	$210,466	$6,526	$22,446	$358,588	$8,948,870
All Other Women (18+)	$511,031	$297,339	$488,810	$8,345	$531,183	$583,630	$0	$108,308	$2,051	$13,145	$162,278	$2,706,120
Men (18+)	$3,052,430	$514,307	$3,134,944	$71,621	$922,327	$3,531,688	$0	$520,723	$3,823	$75,909	$1,112,944	$12,940,716
Youth (12- 17) (Not Including pregnant women or women with dependent children)	$73,703	$259,927	$20,930	$0	$471,347	$94,801	$0	$48,412	$0	$0	$16,190	$985,310
Total FY2022 Substance Use Disorder Expenditures Budget by Population Served	$5,802,651	$2,400,000	$4,777,546	$100,000	$4,318,182	$4,680,719	$840,109	$887,909	$12,400	$111,500	$1,650,000	$25,581,016

FY22 Drug Offender Reform Act & Drug Court Expenditures

Local Authority: Salt Lake County

Form B1

FY2022 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 FY2022 Expenditures
Screening and Assessment Only	$0	$2,092	$4,930	$1,709	$0	$8,731
Detoxification: ASAM IV-D or III.7-D) (ASAM III.2-D) ASAM I-D or II-D)	$0	$0	$0	$0	$0	$0
Residential Services (ASAM III.7, III.5, III.1 III.3 1II.1 or III.3)	$0	$48,901	$274,364	$60,932	$0	$384,197
Outpatient: Contracts with Opioid Treatment Providers (Methadone: ASAM I)	$0	$4,445	$5,246	$1,818	$0	$11,509
Office based Opiod Treatment (Buprenorphine, Vivitrol, Naloxone and prescriber cost)) Non-Methadone	$0	$0	$0	$0	$0	$0
Outpatient: Non-Methadone (ASAM I)	$0	$23,767	$55,537	$36,413	$0	$115,717
Intensive Outpatient (ASAM II.5 or II.1)	$0	$25,795	$64,023	$25,784	$0	$115,602
Recovery Support (includes housing, peer support, case management and other non-clinical)	$0	$2,170,812	$0	$0	$0	$2,170,812
FY2022 DORA and Drug Court Expenditures Budget	$0	$105,000	$404,100	$126,656	$0	$635,756

SFY 22 Opioid Budget **Local Authority:** Salt Lake County **Form B**

State Fiscal Year	Projected SOR SFY 2020 Revenue Not Used	State Opioid Response SFY2022 Revenue	Total SFY 2021 SOR Revenue
		SOR 2	
2022	0	452259	**$452,259.00**

*These funds expire 09.29.2020 as the SOR grant ends

SFY2022 State Opioid Response Budget Expenditure	Estimated Cost	
Direct Services	**$29,655.00**	
Salary Expenses	**$0.00**	
Title 1		
Title 2		
Title 3		
Administrative Expenses	**$29,655.00**	
Supplies		
Communication		
Travel		
Conference/Workshops		*Insert a note providing details
Equipment/Furniture		
Miscellaneous (6.557% Admin Rate)	29655	*Insert a note describing it
Screening & Assessment	**$0.00**	
Drug Testing	**$0.00**	
Office Based Opioid Treatment (Buprenorphine, Vivitrol, Nalaxon	**$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	**$0.00**	
Contracted Services	**$422,604.00**	
Clinical Consultants	$90,607.00	
Project Reality - OTP	$192,857.00	
Sheriff - Jail MAT	$139,140.00	
Total Expenditure FY2022	**$452,259.00**	

FY22 Substance Abuse Prevention Area Plan & Budget **Local Authority:** Salt Lake Co **Form C** DRAFT

	State Funds		County Funds									
FY2022 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 FY2022 Revenue
FY2022 Substance Abuse Prevention Revenue	$169,234	$0	$240,000	$0	$0	$1,793,920	$90,000	$95,000	$0	$0	$0	$2,388,154

	State Funds		County Funds											
FY2022 Substance Abuse Prevention Expenditures Budget	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 FY2022 Expenditures	TOTAL FY2022 Evidence-based Program Expenditures
Universal Direct			$55,152			$395,000		$45,000				1,000	$496,152	$400,000
Universal Indirect	$169,234		$31,014			$277,413	$90,000	$0				0	$567,661	
Selective Services			$121,925			$903,507		$25,000				36,000	$1,086,432	$928,507
Indicated Services			$31,909			$218,000		$25,000				1,600	$276,509	$243,000
FY2022 Substance Abuse Prevention Expenditures Budget	$169,234	$0	$240,000	$0	$0	$1,793,920	$90,000	$95,000	$0	$0	$0	38,600	$2,388,154	$1,571,507

SAPT Prevention Set Aside	Information Dissemination	Education	Alternatives	Problem Identification & Referral	Community Based Process	Environmental	Total
Primary Prevention Expenditures	$45,413	$1,306,507	4000	125000	$310,000	$3,000	$1,793,920

Cost Breakdown	Salary	Fringe Benefits	Travel	Equipment	Contracted	Other	Indirect	Total FY2022 Expenditures
Total by Expense Category	435000	204450	40000	0	1661507	47197	0	$2,388,154

Salt Lake County Fee Schedule Methodology and Use

Overview

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 2021 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 Services for Youth

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.

DUI Fees

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 FY22 approximately $280).

Drug Testing

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.

Waiving Fees

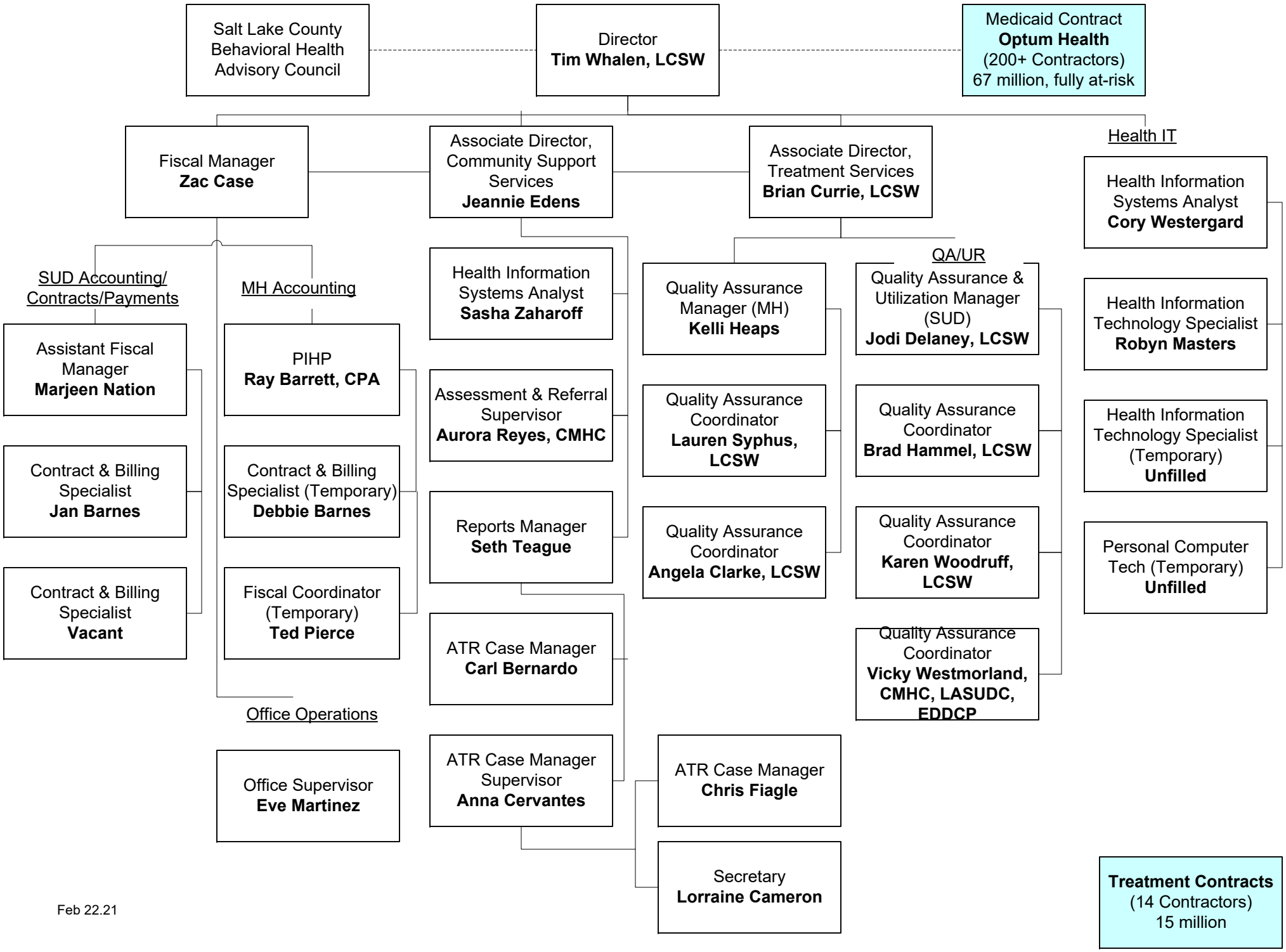
Providers and clinicians are given discretion to waive fees as judged necessary to reduce barriers to treatment in consideration of individual circumstances. When fees are waived documentation must be kept on file explaining these circumstances for waiving or reducing the rate. For incarcerated individuals,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

Alternative Fee Schedules

Providers may utilize an alternative fee 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 2021 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 - $268	$269 - $537	$538 - $1,610	$1,611 - $2,147	$2,148 - $2,683	$2,684 - $3,220	$3,221 - $3,757	$3,758 - $4,293	$4,294
2	$0 - $363	$364 - $726	$727 - $2,178	$2,179 - $2,903	$2,904 - $3,629	$3,630 - $4,355	$4,356 - $5,081	$5,082 - $5,807	$5,808
3	$0 - $458	$459 - $915	$916 - $2,745	$2,746 - $3,660	$3,661 - $4,575	$4,576 - $5,490	$5,491 - $6,405	$6,406 - $7,320	$7,321
4	$0 - $552	$553 - $1,104	$1,105 - $3,313	$3,314 - $4,417	$4,418 - $5,521	$5,522 - $6,625	$6,626 - $7,729	$7,730 - $8,833	$8,834
5	$0 - $647	$648 - $1,293	$1,294 - $3,880	$3,881 - $5,173	$5,174 - $6,467	$6,468 - $7,760	$7,761 - $9,053	$9,054 - $10,347	$10,348
6	$0 - $741	$742 - $1,483	$1,484 - $4,448	$4,449 - $5,930	$5,931 - $7,413	$7,414 - $8,895	$8,896 - $10,378	$10,379 - $11,860	$11,861
7	$0 - $836	$837 - $1,672	$1,673 - $5,015	$5,016 - $6,687	$6,688 - $8,358	$8,359 - $10,030	$10,031 - $11,702	$11,703 - $13,373	$13,374
8	$0 - $930	$931 - $1,861	$1,862 - $5,583	$5,584 - $7,443	$7,444 - $9,304	$9,305 - $11,165	$11,166 - $13,026	$13,027 - $14,887	$14,888
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)			

DIVISION OF BEHAVIORAL HEALTH SERVICES



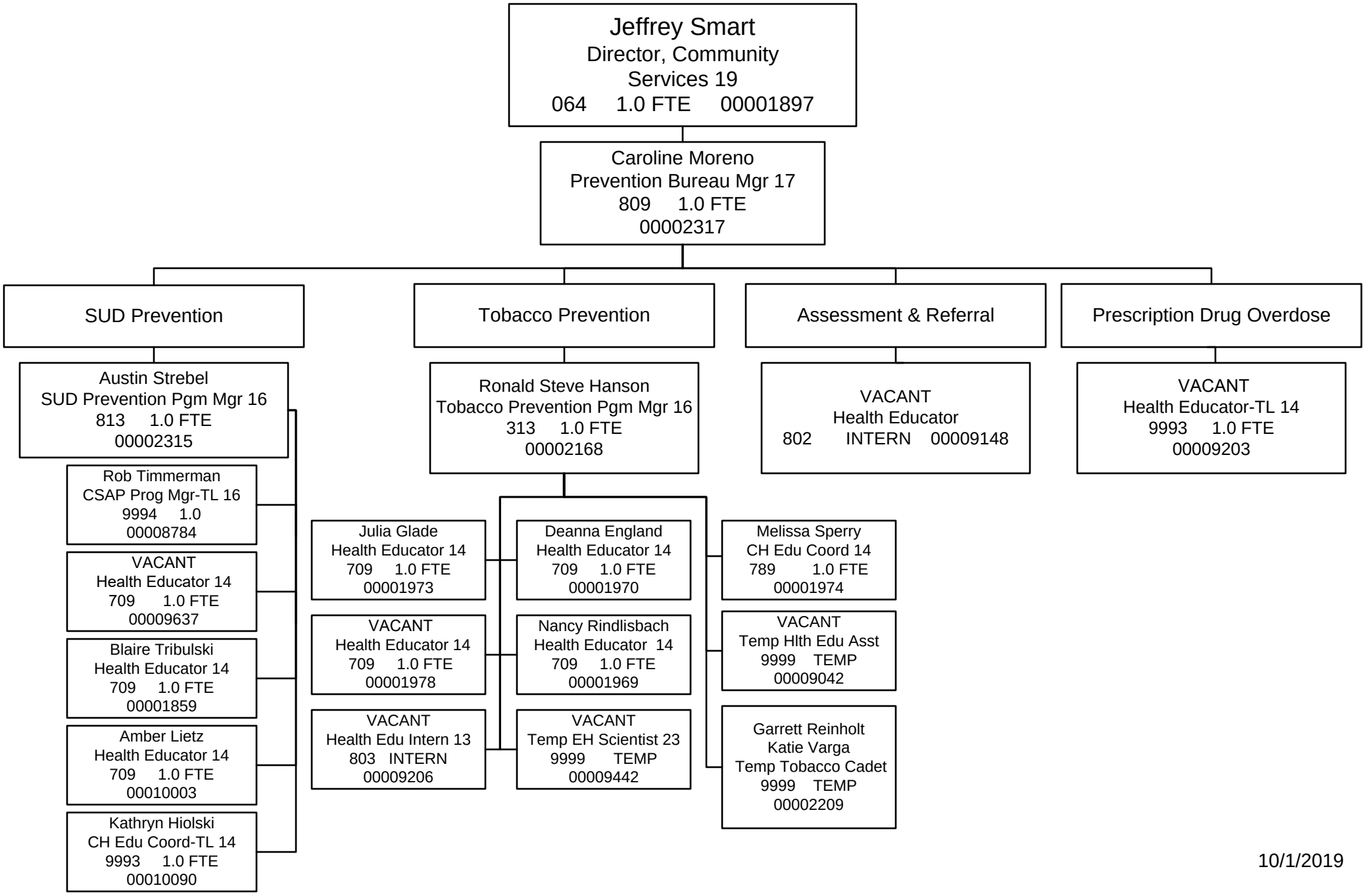
Feb 22.21

SALT LAKE COUNTY HEALTH DEPARTMENT

Location Code: 1134

Salt Lake County Health Department
Community Health Division
Prevention Bureau

Department Code:
Outreach - 2150002023



10/1/2019

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:

_____

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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: 385-468-4723 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: 385-468-4723 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.

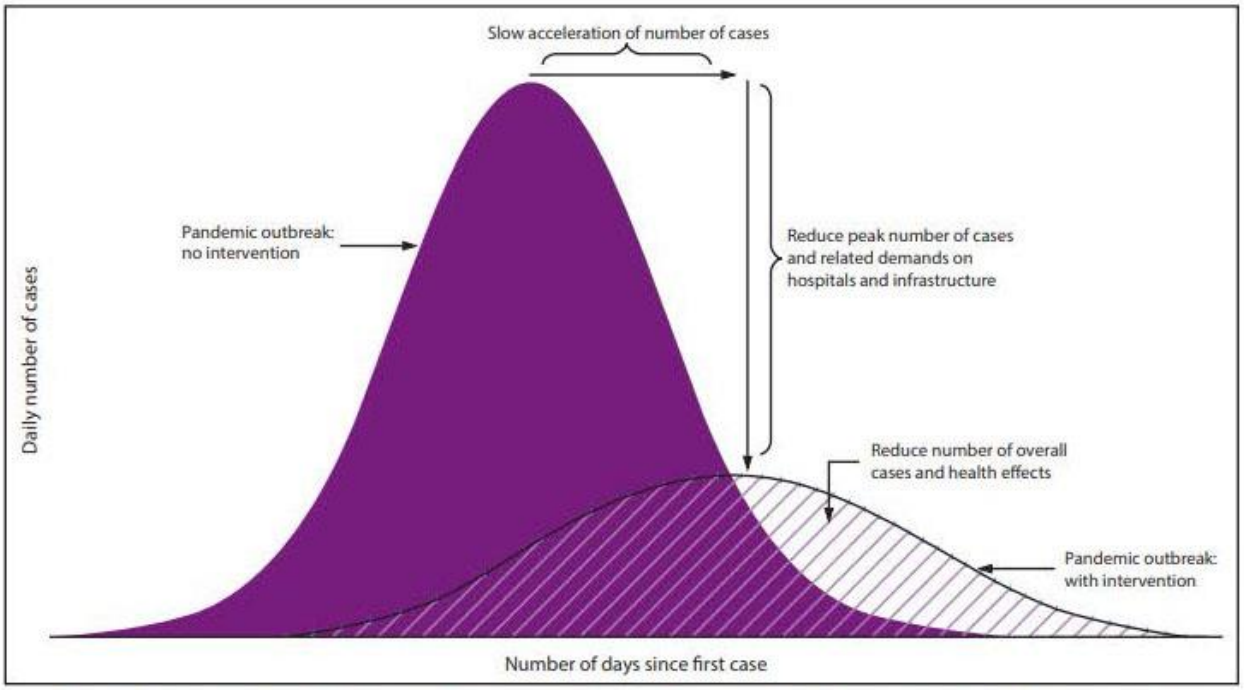
Our nation's pandemic goals, which are first, to minimize serious illness and overall deaths, and second to minimize societal disruption, will guide our response to COVID-19. This guidance is based on currently available scientific evidence, expert opinion and public health assumptions. Given the evolving 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

Integrated Care

Introduction to Integrated Care

Definition

- The coordination of primary healthcare and mental healthcare in the same setting

Goal for the U.S. Healthcare System

- Reduced healthcare costs and improved quality of care

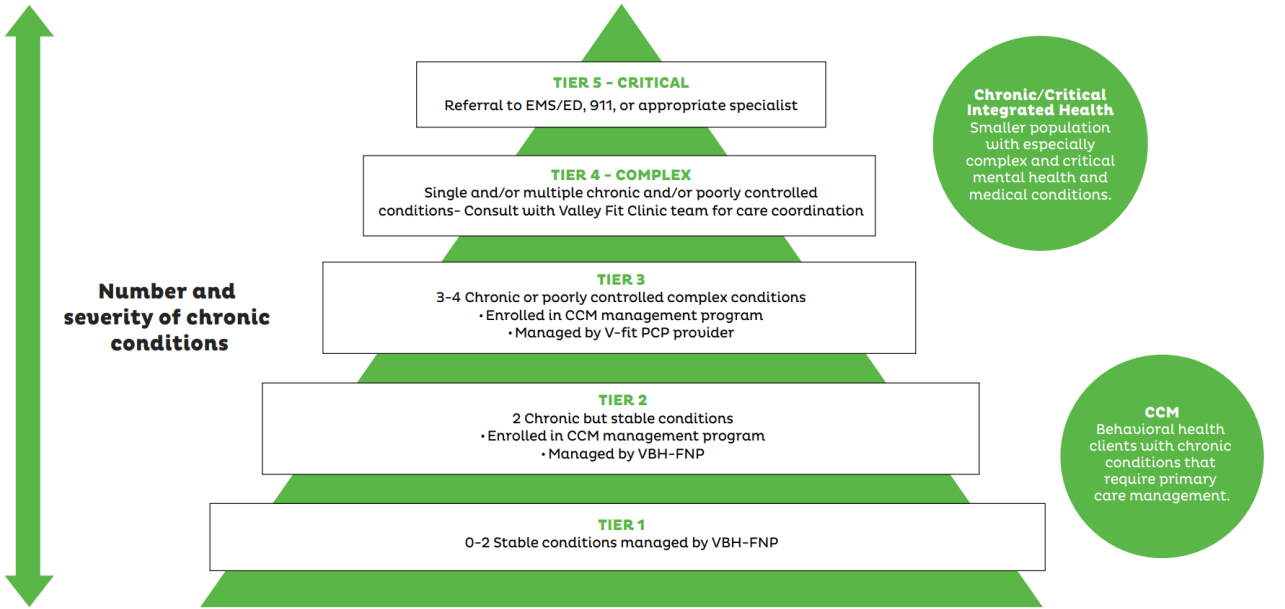
How Integrated Care Achieves this Goal

- Addressing the whole person and their physical and behavioral health is essential for positive health outcomes and cost-effective care
- Care coordination allows for patients to get timely treatment and get all needs met in one place (especially important for high utilizers with multiple, complex chronic illnesses)
- Care coordination improves overall health of the population, reducing healthcare costs and needs over time

Criteria, Plan, and Level Assignments

Let's deal with it together.

VALLEYFIT INTEGRATED CARE MODEL

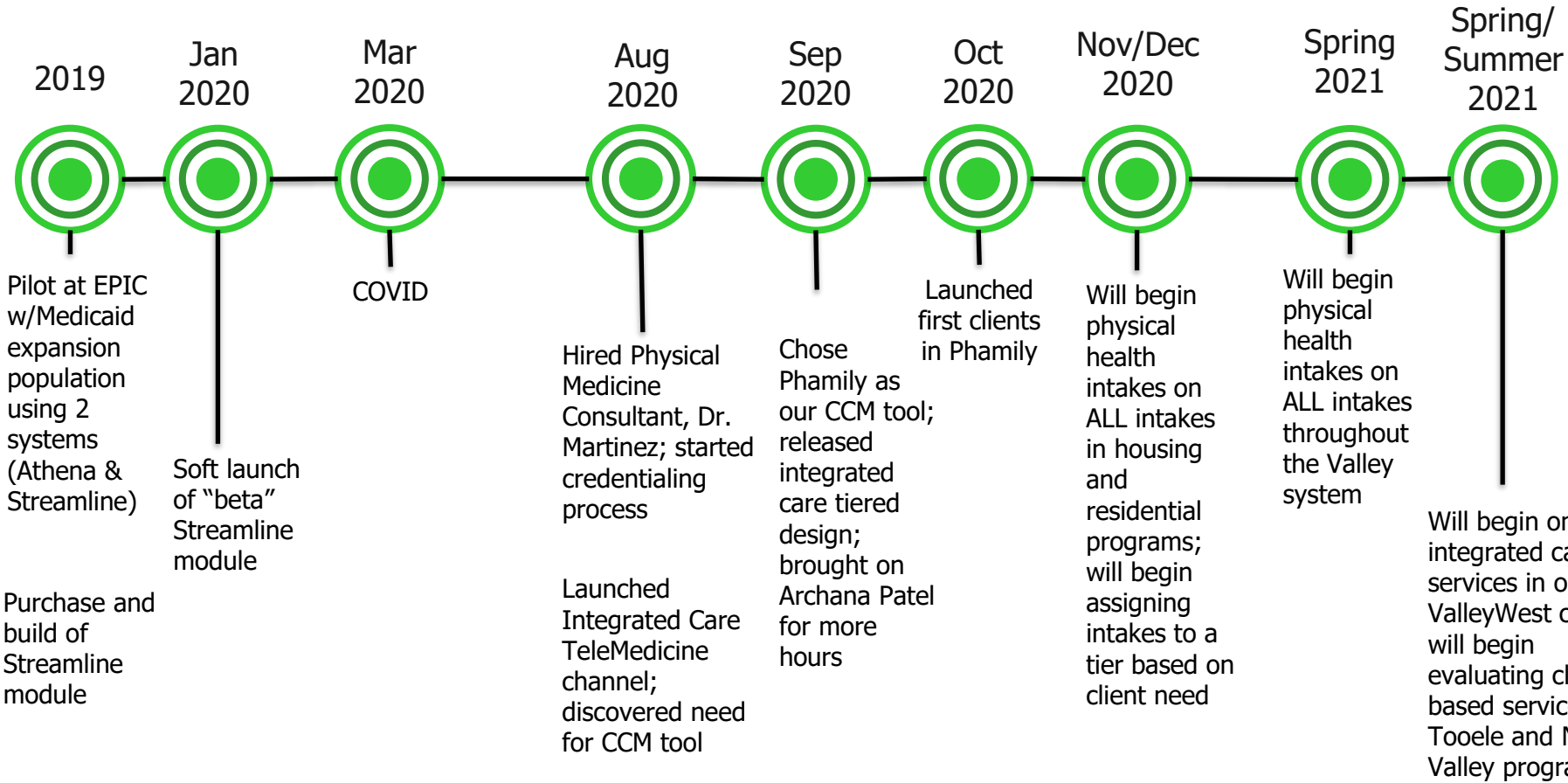


All VBH clients will identify a PCP upon admission or will be assigned a Valley PCP + Tier level on Intake to all Residential, Housing and Outpatient units to ensure primary care needs are being met. Weekly, Monthly or Quarterly visits will be provided by Valley primary care as deemed necessary by team.

ValleyFit CLINIC

Timeline

Let's deal with it together.



SALT LAKE COUNTY

The Evolving Landscape of Behavioral Health Services in Salt Lake County

SALT LAKE COUNTY DIVISION OF BEHAVIORAL HEALTH SERVICES

March 9, 2021

The Evolving Landscape of Behavioral Health Services in Salt Lake County

Executive Summary

Access to mental health and substance use disorder services are an integral part in addressing homelessness, suicide, and drug overdose fatalities in Utah, topics that are top-of-mind to many policy makers in Utah. Yet, the landscape of behavioral health services can be complicated and sometimes overwhelming to understand. This paper seeks to provide the reader a high-level digestible view of the significant gaps that have existed in services in the past, the reasons for these gaps, what was done to address the needs during this period and the seismic shifts that began occurring in 2017 that have resulted in an unprecedented expansion of services in Salt Lake County. This effort more than tripled the capacity of some services, and has led to "openings as needed", rather than long wait lists, in certain areas such as residential treatment in substance use disorder (SUD) settings.

Unprecedented expansions of Medicaid and services are accompanied by first of its kind challenges in accessing and reporting data. With no oversight or view into the data for the expansion populations, no longer can county data (reported to the state) solely be relied upon to give a full or accurate picture. Understandably, state auditors, analysts and legislators are finding themselves grappling with understanding the new streams of funding and searching for an accurate accounting of outcomes to inform policy.

Additionally, while analyzing data, it is important to consider outside influences such as the mass arrests that began in August 2017 as Operation Rio Grande rolled out, the Opioid Epidemic that swept our state and nation, the housing affordability crisis, a behavioral health workforce shortage, and now the impacts of COVID-19. This paper provides a high-level timeline and summary of these events.

Having a firm grasp on COVID-19 impacts to behavioral health settings will be imperative for policy makers moving forward. Changes in the criminal justice system led to reduced treatment referrals, policies to address quarantine and isolation protocols in congregate behavioral health settings resulted in decreased capacity, all as providers experienced unusual strains on the workforce. As examples, the capacity of the County's men's detox program dropped initially to 27% of normal and operates today at 73% capacity, while the largest provider of SUD residential services dropped initially to 50% and today remains at approximately 70% of pre-pandemic levels. The reverberations from COVID-19 responses will be felt for many years to come and should be expected to result in deviations in data for: numbers served, connections to employment, housing, and other significant variables. Last, while the 2020 state budget cuts (related to COVID-19) left harmless the funding to implement a new non-refusal receiving center in Salt Lake County, funding for 2020 House Bill 35 was cut, which resulted in a loss of 30 new Utah State Hospital beds. Fortunately, this funding was restored in the 2021 general session.

In summary, incredible advancements have been made in recent years, and although 2020 presented unforeseen challenges, it also brought hope and opportunities through expanded Medicaid and services. As the workforce shortage eases, and if funding continues for services outside of Medicaid (such as housing, milieu, drug testing, etc.), and as vaccines become widely distributed, the future looks bright.

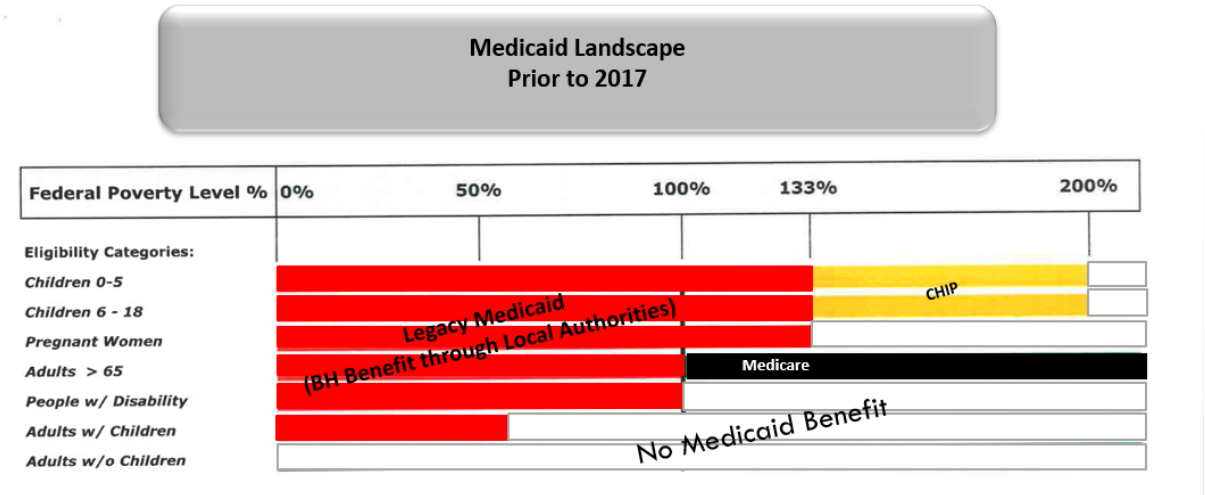
Background

Seismic shifts in funding and access to behavioral health services in Salt Lake County have occurred in recent years. Traditionally, especially prior to 2017, the largest source of funding available for these services focused on individuals with serious mental illness, through Medicaid. This occurred because an acute substance use disorder did not qualify an individual for disability Medicaid. For every Medicaid dollar spent, approximately 70% was federally funded, with the remaining 30% provided by a combination of state general fund and county general fund. This Medicaid plan is now referred to as "Legacy Medicaid". Counties manage the behavioral health (BH) benefit for this plan through a prepaid at-risk contract with the State Medicaid Office.

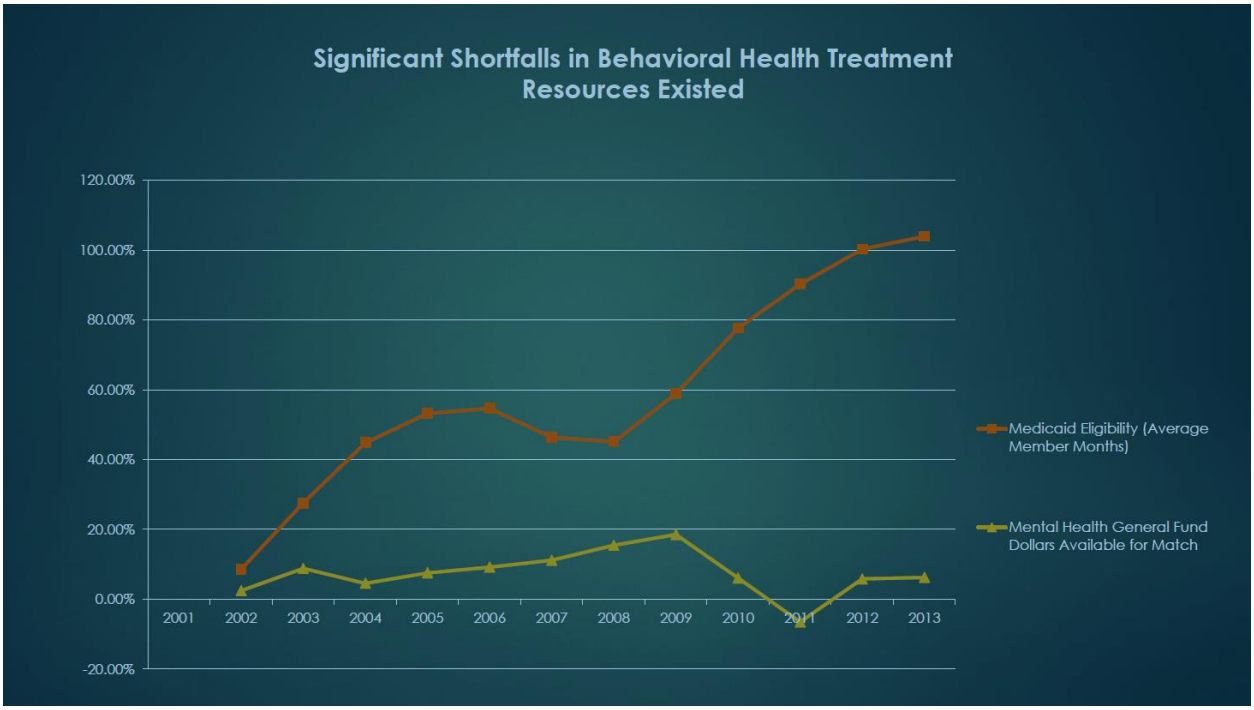
Even though Salt Lake County overmatched the state general fund dollars they received, the remaining funding for the uninsured or underinsured population (i.e., non-Medicaid) was a small fraction to meet the needs of this population, largely low-income individuals with substance use disorders.

Counties are required by statute to match the state general fund dollars they receive for behavioral health services (mental health and substance use disorder services), at a rate of 20%. Salt Lake County has consistently overmatched this requirement due to strong support from the county council and mayor who believe strongly in connecting residents to care, rather than the likely alternative of incarceration or hospitalization. Yet, individuals in need of residential substance use disorder (SUD) services found themselves waiting 6-9 months for an opening.

In the graph below, please reference the bottom line "Adults w/o Children" (without dependent children) as an example of the uninsured/underinsured population with a significant rate of BH conditions and criminal justice involvement. Low-income, non-parenting adults, often homeless and suffering with substance use disorders.



Budget cuts during the recession widened "the gap" just as the Opioid Crisis began to emerge in 2009, leading to a health and homeless crisis in following years. As the numbers of Medicaid eligibles increased, the funding did not. State general fund dollars increased in later years, but the gap remained large.



Understanding the gap in prior years and even more so after the recession, and wanting to serve as many individuals as possible, the Division of Behavioral Health Services (DBHS) worked to implement programs with an eye towards diversion from jails and hospitals, such as the University of Utah Crisis Line, Warm Line, Mobile Crisis Outreach Teams and Receiving Center, to connect individuals to care early, prevent loss of housing and employment, and avoid more costly levels of care to expand the reach of these dollars. Social detox programming offered individuals who had been picked up for public intoxication an alternative to jail and a safe environment focused on connection to treatment and recovery. A jail diversion outreach team was implemented, and a men's dual-diagnosis residential facility soon after, both connecting severely mentally ill individuals to treatment. The first Assertive Community Treatment (ACT) Team to SAMHSA fidelity was implemented, designed for severely mentally ill (SMI) individuals, commonly known as a hospital without walls, bringing a multidisciplinary team to where the client is. DBHS also funded housing projects to further support the success of these populations. Later studies would show significant reductions in jail recidivism for those housed within these programs.

During this period, even with this gap in funding, behavioral health programming presented through Salt Lake County's Sequential Intercept Model [1](SAMHSA's GAINS Center gold standard), was requested nationally and from the White House, and drew representatives from other states to tour local programs. These programs were designed to divert individuals with BH conditions from the criminal

[1] https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

justice system at numerous intercepts (i.e., emergency services, jail, courts, reentry and in the community). When visiting counties learned of Salt Lake County's overmatch, they were often left wondering how their counties could replicate this model. *Please reference the current Sequential Intercept Model in Attachment I, program descriptions are available upon request.*

It was a great model, but not to scale for the SUD population, something that Medicaid Expansion could remedy.

In 2014, as states were given the option to expand Medicaid, DBHS began in earnest to educate and advocate for a Utah model. Research showed that individuals in jails were expected to shift from ~90% uninsured to ~90% *insured*, should the state expand. Approximately 30% of the total expansion population was anticipated to have a behavioral health condition, equating to 18,000 individuals in Salt Lake County, essentially closing the gap. Estimates were made of behavioral health savings that could be enjoyed should the state expand and shared widely with policy makers.

Changing Policies and Funding (2015 – present)

2015

An all-hands-on-deck approach, with braided funding (federal, state and county), allowed several new initiatives to be launched.

- **The First Salt Lake County jail-based Medication-Assisted Treatment (MAT) program** – this program began in 2015, as an evidence-based treatment for individuals with Opioid Use Disorders (OUDs). Only one of the three FDA approved medications was offered, but it was innovative in its time, and a great start. State and County funding made this possible. This program showed a 71% reduction in jail recidivism when comparing one-year prior and one-year post.
- **The Justice Reinvestment Initiative** - the Justice Reinvestment Initiative passed, with a focus on connecting offenders to treatment, but the intended funding mechanism for treatment, Healthy Utah (the governor's Medicaid Expansion plan), did not pass the House. Counties instead received limited dollars, *meeting only a fraction of the need*. With these dollars used as seed dollars, a combination of state, federal and county funding supported two new highly successful programs called the Intensive Supervision Probation (ISP) Program, and CORE 2 a 16-bed women's residential program for severely mentally ill offenders (and other smaller initiatives), that yielded impressive reductions in recidivism (85.8% and 92.5% respectively). ISP later went on to win awards, including the National Association of Counties Achievement Award.

  These programs were highly successful and needed, but due to funding limitations, served only a small fraction of the criminal justice involved population.

2016

- **Legislative support for a Targeted Adult Medicaid Waiver** - although legislative support was not there for a full Medicaid Expansion, in the spring of 2016 a bill passed for a smaller Targeted

Adult Medicaid (TAM) expansion that focused on very low-income individuals with behavioral health conditions, earning less than $50/month. If approved by CMS (at the federal level), this waiver would also provide the opportunity to serve individuals with SUDs in programs with more than 16 beds through Medicaid funding. Although increasing the number of individuals eligible for Medicaid was important, allowing providers to implement programs in this fashion, with this type of economy of scale, would be the key to an impressive expansion of services. The TAM waiver was submitted, and the state began waiting for CMS approval. Approval and implementation would take more than a year, with implementation occurring in November 2017.

- **Health & Safety Crisis** - at the same time, a health and safety crisis brewed as the number of homeless individuals in Salt Lake City grew in tandem with an affordable housing crisis and the Opioid Epidemic as Utah ranked 7th in the nation for overdose deaths.
- **Operation Diversion** - Salt Lake County, in partnership with Salt Lake City, made an unprecedented attempt to address the problem, referred to as *Operation Diversion*. Utilizing one-time dollars, Salt Lake County DBHS funded approximately 60 additional SUD residential beds (including detoxification beds), MAT services, and additional outpatient services.

  Through this project a temporary pop-up receiving center was set up where a person was booked, received legal advice from a legal defender on what to expect, then after receiving a risk/need assessment, and an assessment for placement into behavioral health services, they ended by meeting with both the district attorney and legal defender's office, and entered into a voluntary diversion agreement. Under this agreement, no charges would be filed as long as the person was willing to enter into treatment that day. These individuals were then provided transportation directly to a treatment provider, most making a first stop at a MAT treatment facility to limit the impacts of withdrawal and enhance treatment engagement. This effort occurred three times in 2016.

  After the three operations ended, the Salt Lake City Police Department Social Work Program was given authority to make voluntary referrals from the Rio Grande area, which quickly consumed the remaining capacity. The project was scheduled to end on March 31st, 2017, but fortunately Salt Lake County, Salt Lake City, and CCJJ came forward with enough additional one-time funding to extend the program for an additional period. Though many benefited from this effort, and the one-time dollars were substantial (millions), the homeless crisis continued, barely addressing the need for services.
- **New Medication-Assisted Treatment Programs** - community MAT programing was expanded in Salt Lake City to support individuals with Opioid Use Disorders, and two new clinics opened in Murray and West Jordan through federal State Targeted Response dollars, to address hot spots for Opioid overdose deaths and emergency department encounters.
- **Justice Reinvestment Initiative** - additional JRI funding was allocated enabling the expansion of the ISP program, drug court treatment, and the hiring of a licensed mental health therapist housed within the UPD offices, co-responding with law enforcement to mental health crises within the community, and providing individualized follow-up. The UPD program serves the

cities of Taylorsville, Kearns, Magna, Copperton, Holladay, Millcreek, Midvale, Canyons, Brighton, and White City (and other jurisdictions upon request). JRI dollars, while appreciated, continued to serve only a small fraction of the criminal justice population.

2017

- **Operation Rio Grande** - finally, in August of 2017, unable to curb the crisis in the Rio Grande area of Salt Lake City with one-time dollars, the state, in collaboration with the city and county, launched Operation Rio Grande (ORG). A portion of inmates in the Salt Lake County jail were moved to another jail to make space for the surge in arrests, initially with no funding for additional treatment. The Lt. Governor, Senate President, House Speaker, city and county mayors, SL Co District Attorney, SL Co Behavioral Health Director and others can be seen below, in one of many meetings that occurred over time.

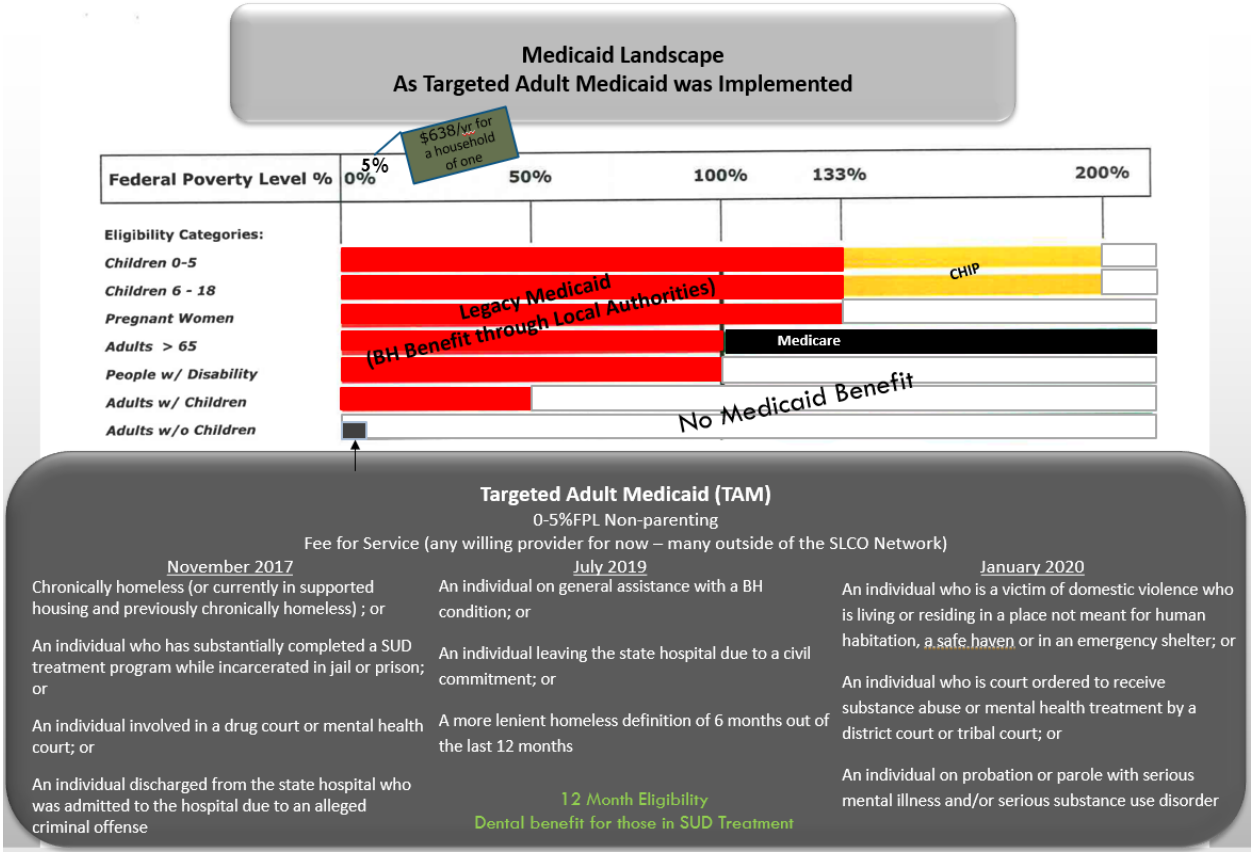
- **Targeted Adult Medicaid Waiver** - fortunately, in November of 2017, the TAM waiver was approved. This waiver dovetailed nicely with the low-income homeless population in the Rio Grande area, many suffering with mental health and substance use disorders. Prior to this waiver's implementation, DBHS' network of providers had ~170 SUD residential beds. **Today more than 550 exist**. As reliable ongoing funding became available, community treatment providers responded in a great way, **more than tripling residential capacity**, while also expanding other levels of care. Additional services were added outside of the Salt Lake County network of providers, exact numbers are unknown.

  This waiver had immense and long-reaching impacts on the behavioral health system, as it allowed an individual to remain eligible for a 1-year period and allowed for Medicaid reimbursement for SUD services provided in programs with more than 16 beds, the latter

supporting expansion in a very great way. The impact of this change, referred to as an IMD (Institution for Mental Diseases) waiver, was a revolutionary change in service delivery and/or reimbursement, allowing providers to quickly triple capacity, and still exists today as an integral piece of service delivery. Rep Dunnigan, the sponsor of this bill, would later receive an award for his outstanding efforts in the behavioral health field.

This Medicaid plan is NOT managed by counties. It is fee-for-service (any willing provider) and managed directly by the State Medicaid Office (lending DBHS no view into the data for this population). DBHS continues to fund this population for non-Medicaid reimbursable services such as milieu (room and board while in residential treatment), drug testing, sober living housing, bus passes, work clothes, etc., when receiving services through a county contracted provider.

Please reference the gray boxes in the graph below, for further information on the populations that qualify for TAM, and the ways in which the criteria expanded through the years.



- **Sober Living Program** - finally, in December 2017, with funding through the State Division of Substance Abuse and Mental Health (DSAMH) and the Department of Workforce Services (DWS), the County implemented a highly successful Sober Living Program. This program is administered through DBHS, and to date has served more than 1,500 individuals. Individuals in

this program demonstrate an 82.1% reduction in recidivism and an ~90% rate of negative drug tests.

This program supplemented an already active housing effort that houses hundreds of individuals annually with mental health or substance use disorders. These programs include permanent supportive housing units and are a combination of voucher-based or master leased units serving individuals with mental illness or substance use disorders. Some are specifically tailored to meet the needs of severely mentally ill individuals discharging from the state hospital. In-home BH case management is required by treatment providers for admittance into these programs. Funding for these programs runs in the millions.

2018

- **Expansion of BH Services** - providers in Salt Lake County began to respond to the expansion of TAM almost immediately, bringing the Speaker of the House, Rep Dunnigan, and Mayor McAdams to openings of new facilities expanding access to SUD residential facilities.

January 11, 2018 Ribbon Cutting Ceremony at a new Odyssey House SUD Residential Program (3944 S 400 E)

August 2018

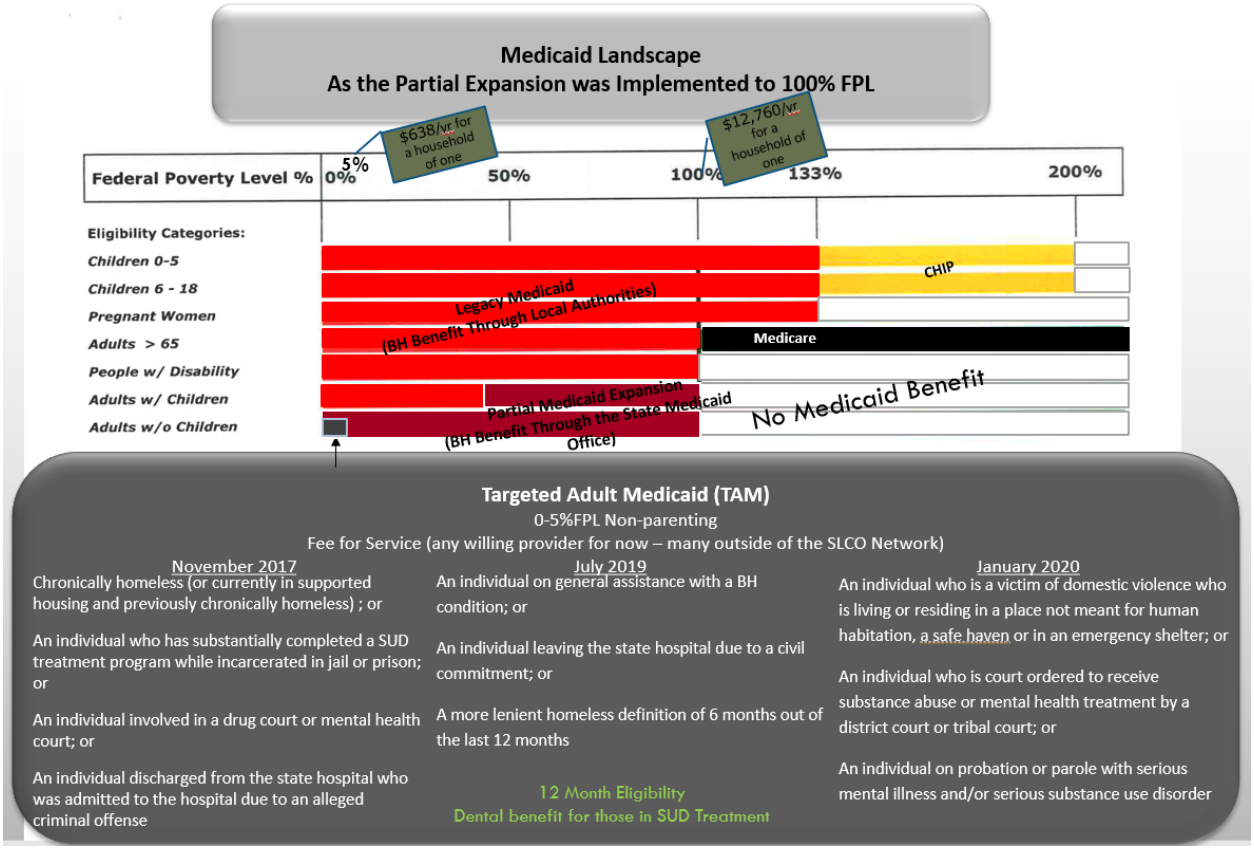
- **Naloxone Overdose Reversal Kits** - integral in responding to the Opioid epidemic, is Naloxone, a medication that reverses the effects of an overdose from opioids such as heroin, fentanyl, and morphine. Thanks to a federal grant, DBHS distributed 1,400 overdose reversal kits in 2018 totaling more than $100,000, to local treatment programs, including the jail's MAT program. This number would more than double in 2019. *Please refer to attachment II for additional details on numbers and recipients.*
- **Proposition 3** - in November of 2018, Proposition 3 supporting the full expansion of Medicaid to 138% FPL passed (but would be replaced in the following general session, in the spring of 2019).

2019

- **Naloxone Overdose Reversal Kits** - demand for Naloxone overdose reversal kits increased as the Opioid Epidemic continued. DBHS dispersed twice as many as the previous year, 3,244 kits, totaling approximately $242,000, to treatment providers in Salt Lake County, including the jail's MAT program. *Please refer to attachment II for additional details on numbers and recipients.*
- **New Housing Projects** - DBHS and Optum worked with community partners on three new low-income tax credit housing projects, assisting with the application process, rental subsidies,

supportive living funds through Medicaid, and by funding treatment for residents. The first project, the Denver Apartments for the SMI population, was a partnership between DBHS, Optum, Volunteers of America (VOA), Housing Connect, and Salt Lake City. VOA was awarded tax credits to fund housing for 22 VOA ACT Team participants. The project was also greatly supported by the Salt Lake County Council through a $400,000 capital investment through DBHS and opened in 2019.

- **Partial Medicaid Expansion** - another seismic shift occurred in February 2019, as the governor signed SB 96 into law, the replacement for Proposition 3. This allowed for a partial expansion of Medicaid on April 1st, referred to as the "Bridge Plan", up to 100% FPL, with many strings attached, such as a work requirement. Please refer to the maroon lines in the graph below. This expansion was anticipated to serve ~90,000 individuals across the state, and a large expansion of BH services followed again.



- **Budget Cuts** - due to anticipated savings through expansion, DBHS received state budgets cuts of $1M in SFY 2019, and $3.3 M in SFY 2020. Fortunately, with the additional Medicaid coverage these state cuts did not have a negative effect on treatment access.
- **Added Medicaid Benefit** - DBHS worked with the State Medicaid Office to pilot the first social detox benefit for Medicaid members, and designated VOA as the provider for these services. This provided for the first time the ability to draw down the Medicaid share from the federal government for these services, with the county or state providing the required match depending

on the Medicaid plan. Due to the partial expansion of Medicaid, this benefit covered a large number of clients.

- **Expansion of the Salt Lake County Jail MAT Program** - utilizing a federal grant as seed dollars, DBHS worked with the Salt Lake County jail, Project Reality, and DSAMH to expand the jail MAT program to all three FDA approved medications and to increase the number of individuals able to access these services. Now, through this effort, an individual on MAT in the community prior to being booked in jail, can continue his/her medication while incarcerated, receive behavioral therapies, coordinated referrals into the community upon release, and have the option of all three medications: Methadone, Buprenorphine or Naltrexone, as deemed clinically appropriate by the physician and in consultation with the patient. This expansion began in June of 2019 and served ~350 individuals in the first 12 months. This population also receives information and education regarding the use of Naloxone overdose reversal kits, and an actual kit while supplies last. Once supplies are depleted information will be provided on access within the community.
- **BH Workforce Shortage** - a new first was encountered in 2019, a shortage of BH workforce to accommodate the expansion of services. Some providers had the space and eligible Medicaid funding to pay for services, but not enough staff to provide the services. This workforce shortage continues to be a primary issue for providing care. It has replaced the lack of funding as the most significant barrier to treatment on demand. Efforts to address this workforce shortage would be addressed in the upcoming general session in 2020.

2020

- **Full Medicaid Expansion** - although 2020 brought with it some incredible challenges, it also arrived with more opportunities for expanding services.

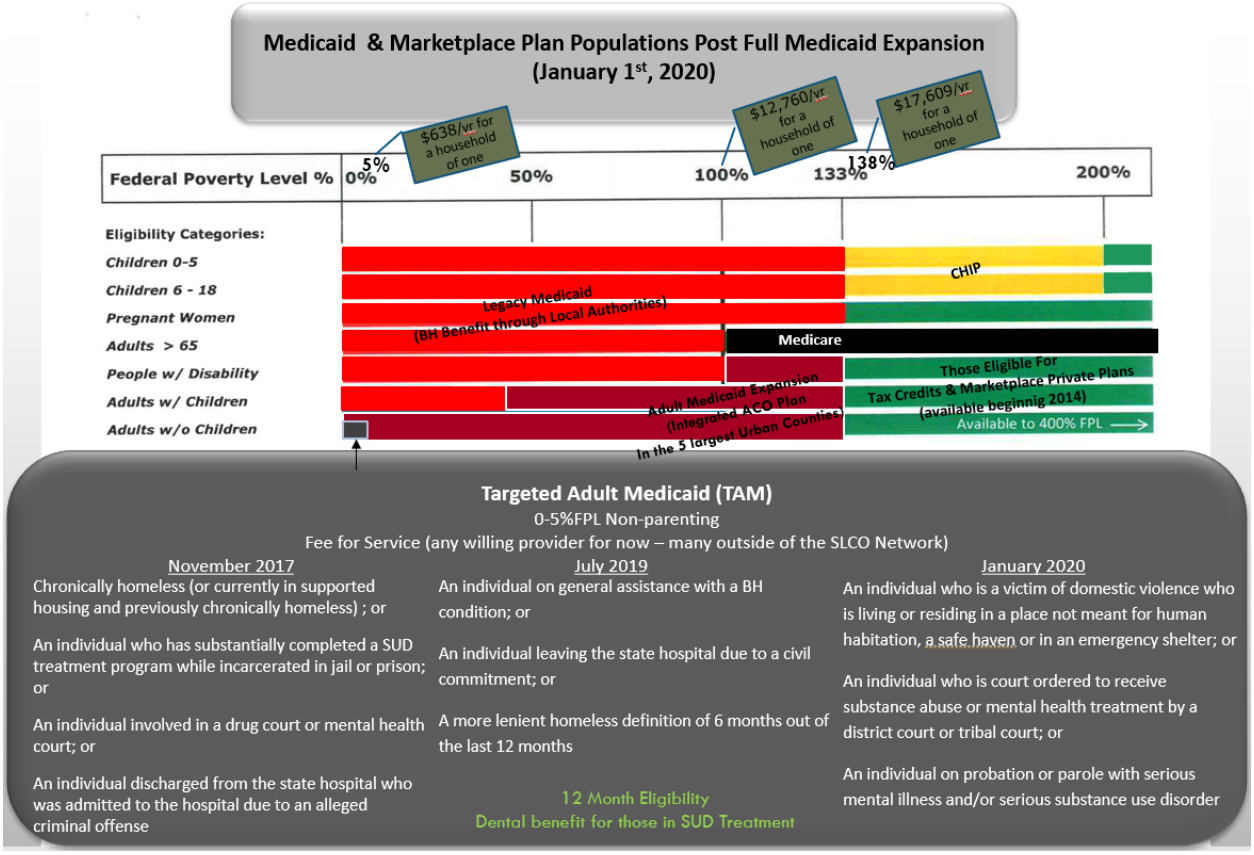
  January 1st began the implementation of Utah's "Fallback Plan", a full Medicaid Expansion, up to 133% FPL (138% when factoring in the 5% income disregard). As you will notice in the maroon bars of the graph below, this essentially filled "the gap", with the exception of undocumented individuals, the underinsured (individuals with skinny benefit plans or unable to afford their copays or deductibles), and those services not covered by Medicaid (such as milieu, drug testing, housing support, bus passes and other assistance for work clothes, etc.).

  Also depicted below, in the green bars, are individuals eligible for tax credits and subsidies to purchase private plans on the Marketplace. This coverage became available in Utahns in 2014 and is offered to individuals with incomes ranging from 133% FPL to 400% FPL.

  In the five largest counties, including Salt Lake County, the Adult Medicaid Expansion (AME) population became an integrated benefit (physical and behavioral health) managed by the four Accountable Care Organizations (ACOs). These are Select Health, Healthy U, Molina and Steward Health Choice.

  So, while the expansion itself, to total ~150,000 individuals from 0-138% FPL was a historical moment, it also offered the opportunity in some counties to provide BH services as an integrated benefit. This effort is recognized as an evidence-based practice by improving the

health of individuals and lowering costs, especially on the physical health side, as individuals are guided to address both. DBHS worked diligently to aid the four ACOs in contracting with DBHS's essential providers, educating on the recommended levels-of-care and duration of care for this population, and convening providers and ACOs to address initial barriers as they broke new ground. DBHS continues to work with the ACOs and provider network, and to fund this population for non-Medicaid reimbursable services such as milieu (room and board while in residential treatment), drug testing, sober living housing, bus passes, work clothes, etc., when receiving services through a county contracted provider.



Data

While the benefits of Utah's Medicaid expansions are many, it is imperative at this juncture to understand the implications of data sharing, and the newfound barriers in accessing program outcomes such as connections to treatment, changes in employment, changes in income, changes in housing, or time in treatment.

Bear in mind during treatment an individual may move within plans multiple times by losing/gaining a job, losing/gaining custody of a child, having a baby, changes in income, etc. When this occurs, the provider has the complicated task of switching payors (County for Legacy Medicaid, State Medicaid Office for TAM, and the four ACOs for AME), with each payor having no view into the data of others (due to federal privacy law, including HIPAA and 42CFR Part 2). Additionally, data at the end of "a treatment

episode" for one payor may not be the true "completion of treatment" for a client in flux between plans and yield faulty data.

No longer can data analysts rely solely upon County data submitted to DSAMH for reports or matching efforts regarding the provision of BH services.

The only entity with a view to all Medicaid data currently is the State Medicaid Office. Private health plans are the only entities with this data for Marketplace plans. A good example of this dynamic was recently shown in a legislative audit of the JRI initiative. The report referenced Legacy Medicaid data submitted through DSAMH, but did not include TAM or AME data, even though the TAM expansion is the largest payer now for the SUD criminal justice population.

Additionally, as the efficacy of BH treatment is examined, the analyst may no longer look solely to county programming, as large portions are now managed outside of counties. TAM through the State Medicaid Office, AME in the 5 largest counties by the ACOs. This is a huge shift in data gathering that state auditors, legislative analysts, etc., are only beginning to grapple with. *For additional information, please reference State Medicaid data in attachment III highlighting the numbers served and treatment dollars expended for the TAM and AME populations.*

Additional changes in 2020:

- **COVID-19** - The first challenges came with COVID-19 as DBHS worked to address their first priority, supporting their network of behavioral health providers during this unprecedented time, and by doing so, citizens in need of mental health and substance use disorder services. This included a quick transition to the ability to bill for telehealth services, keeping providers "whole" fiscally when unable to perform services in the same quantity and manner, assisting with access to Personal Protective Equipment (PPE)/Rapid Test kits, modifying utilization management and audit requirements to allow providers to focus on the tasks at hand, modifying drug testing requirements to keep everyone safe, and modifying sober living requirements for those experiencing barriers to employment and housing, allowing them to stay longer periods of time if needed.

  Providers have been impacted in a great way by the reduction in court operations, a primary referral source for treatment; a decline in jail SUD programming as the census decreased to accommodate quarantine and isolation protocols; and a diminished capacity in behavioral health congregate settings such as SUD residential programs and social detoxification programs as they struggled to address COVID infection safety protocols. Immense efforts were undertaken in congregate settings to separate residents, acquiring additional space when able, referring to the county's quarantine and isolation facility as needed, deploying rapid testing kits provided by the county, all as they faced the additional struggle of maintaining workforce as staff became ill, too high risk to remain in certain positions or redeployed to work on ordering and disseminating personal protective equipment and rapid test kits.

As an example, the VOA men's detox facility, normally with a capacity of 75, on occasions plummeted to 20 in the early stages of the pandemic. DBHS quickly worked with the state to utilize CARES Act funds to assist with retrofitting the detox facilities with physical barriers including visqueen and plexiglass for client and staff safety. Some prospective clients expressed fear in admitting into services due to fears of the Coronavirus, others left en masse when they learned that a client in the facility had tested positive. When clients tested positive at the residential detox facility, they were relocated outside of the facility and intakes were stopped until test results came back for other clients who may have been exposed by the positive individual. Once VOA received a CLIA waiver for the rapid COVID-19 tests, they were able to handle situations more rapidly and keep open for intakes on a regular basis, but their capacity today remains significantly impacted, at 55, rather than the 75 prior to the pandemic.

As another example, the impact on Odyssey House (OH) residential programming has been immense. Early in the pandemic, OH converted 3 of their smaller sites into new admission quarantine units. This required them to halt admissions for 6 weeks to allow for attrition to open the 80 beds they needed to accomplish this. This also required staffing these units 24/7 with entire treatment teams as these sites had only been used as sleeping quarters pre-pandemic. This was exceptionally expensive as you might imagine. Flow into treatment became more difficult as well for two reasons. First, when a positive patient admitted, they had to quarantine the entire unit. Testing times early on ranged from 36 hours to 7 days. So, assuming there were no additional positives they would have an admission unit locked down and unable to admit new people for 3 weeks or more. It has been tremendously hard for them to get back up to capacity when needing to lock down for extended periods of time. And second, the criminal justice system ground to a halt resulting in a significant decline in referrals. Previously court referrals comprised approximately 75-80% of the treatment beds available. Currently they equate to about 30%. In total, OH residential settings initially dipped to 50% of normal capacity, now they sit at approximately 70%. Prior to the pandemic, the program was full.

- **Receiving Center Funding** – DBHS applied for and was awarded the funds to implement a state-of-the-art non-refusal receiving center that will allow individuals in crisis to receive mental health and/or substance use disorder services and allow law enforcement and other emergency responders to bring individuals directly to these services, rather than jails or hospitals.

The expansions of Medicaid brought with them an incredibly fast and dramatic increase in services to the previously uninsured or underinsured SUD population, going from 6-9 month wait lists, to nearly treatment on demand. Lost over the years, however, were needed expansions in treatment for individuals with severe mental illness as this population increased. Mental Health Court stakeholders assisted in a new wave of program expansions in 2020 and planned for 2021, as they met with DBHS to educate on the demand and advocate for more programming. The reader will find many new programs coming online during this time as a full-out effort was and is underway to address the need. Examples include an additional ACT team, two new residential facilities, and housing programs listed below.

- **New Women's Mental Health Dual Diagnosis Residential Program** - The opening of a new women's Mental Health Residential Program through Odyssey House, for seriously mentally ill individuals, often homeless and cycling through the criminal justice system. This program opened in November 2020.
- **New Assertive Community Treatment Team** - The implementation of a second assertive community treatment (ACT) team to SAMHSA fidelity, this one to work specifically with the forensic population. An ACT Team is often referred to as a hospital without walls, a very high level of care to assist individuals with serious mental illness, meeting them "where they are at", often homeless, with the goal of enhancing their quality of life and reducing or eliminating their interaction with the criminal justice system. This program is now up and running through Recovery Innovations (RI) International.
- **New Permanent Supportive Housing Program** - The opening of a new permanent supportive housing tax credit project through First Step House (FSH), housing 75 individuals with serious mental illness. This program was a collaboration between FSH, DBHS, Optum, Housing Connect and the SLC Housing Authority. It opened late summer 2020 with assistance through DBHS for rental subsidies, a supportive living Medicaid benefit, and BH treatment to the residents residing there. This program is at full capacity today.
- **Additional housing** was made available to support the new women's residential program and ACT Team, with assistance through Housing Connect as managers of these funds.
- **Medicaid Enrollment** - DBHS assisted providers in navigating the new enrollment requirements as the state fully expanded Medicaid. Many trainings were held.
- **Data analysis -** efforts continued to support data driven decisions with alternatives to incarceration efforts, including monthly matching with jail data to inform on program efficacy as it relates to jail recidivism. This effort was made possible in years previous through a data sharing agreement between DBHS and the Salt Lake County Jail.
- **BH Workforce Capacity** - efforts were made to expand the BH workforce, the biggest barrier to date in access to services. Through the efforts of many, in the 2020 general session, millions of dollars were appropriated to schools to expand the output of behavioral health professionals, and in the form of education/tuition reimbursement to those in the behavioral health field in exchange for serving in a publicly funded program in the state of Utah.
- **Lost Funding for an Expansion of Utah State Hospital Beds** – due to the impacts of COVID-19, the state legislature cut funding to a great deal of appropriations in the 2020 budget. One of those cuts included a proposed expansion of 30 beds in the Utah State Hospital.

2021

- **New Women's Mental Health Dual Diagnosis Residential Program** - DBHS and Optum are working to implement a new MH residential program for men through RI, for the severely mentally ill population, with an anticipated opening in the spring of 2021. Expanding this type of programming became a high priority due to its success in the past and the demand from criminal justice stakeholders as waitlists grew to months.

- **A Third ACT Team** – Valley Behavioral Health implemented the county's third ACT team to SAMHSA fidelity.
- **60-Bed SUD Residential Program** – First Step House plans to open a new 60-bed SUD residential program in 2021.
- **40-Unit Permanent Supportive Housing Program** – First Step House opened a 40-unit housing program for individuals with acute substance use disorders.
- **Education on Data Analysis Barriers** - Efforts are ongoing to educate and advocate for the ability to report data across all Medicaid plans, to allow accurate reporting and data driven decisions.
- **Utah State Hospital Beds** - Additional efforts were made in the 2021 general session to advocate for the funding to expand the number of beds in the Utah State Hospital (USH). A 30-bed expansion was funded in the 2020 general session, but subsequently cut during a special session due to the COVID-19 pandemic response. Over the years, due to a lawsuit to address long wait times for admittance to the USH from jails, the numbers of forensics patients have encroached on the number of beds available to civil patients in need of this level-of-care. There is a great need for this resource, especially as counties continue to fund some of these patients in other hospital settings as they await a bed in the USH (~$1,000/day). The funding for this effort was passed at the end of the 2021 general session.
- **New Receiving Center** - Last, but not least, significant efforts are underway to support the implementation of a new non-refusal Receiving Center in Salt Lake County.

Conclusion

In earlier years, many great programs were implemented, some receiving national attention and recognition. But due to the gap in funding for the uninsured population, long waitlists existed for certain services. Nothing interrupted this gap in behavioral health services as much as the various expansions of Medicaid beginning in November 2017. The Salt Lake County provider network expanded from ~170 SUD residential beds to more than ~550, more than tripling capacity (and this does not account for expansions in providers outside of this network). What were once 6-9 month waiting lists for this level of care, are now "openings as needed" in many programs. As the number of Medicaid eligibles grew, DBHS worked to add new Medicaid eligible services to enhance the effort further.

This blend of newfound funding, with a continued eye to services that support this population early on in a person's illness, such as Mobile Crisis Outreach Teams or a Receiving Center; and those diverting individuals with mental illness or substance use disorders from the criminal justice system such as ACT Teams, MAT programs, and housing, has enabled systems to make seismic shifts never seen before in Utah.

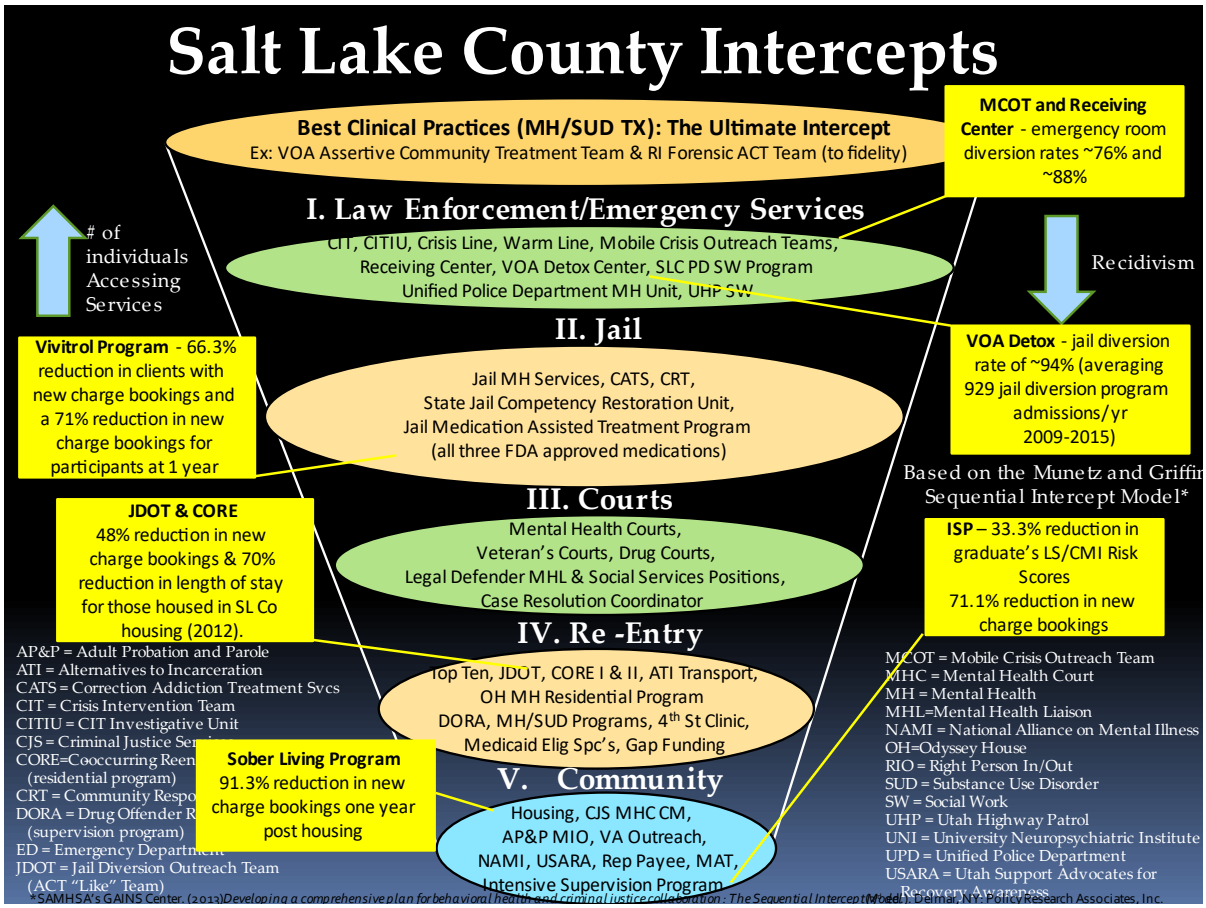
While these shifts occur, analysts need to incorporate data from *all three Medicaid systems*, Legacy Medicaid, Targeted Adult Medicaid (TAM), and Adult Medicaid Expansion (AME). Recent reporting on JRI treatment engagement did not include data from the largest SUD payors for the criminal justice population, TAM and AME (nor engagement for those in employer or private health plans). With no view into TAM or AME data, no longer can county data (reported to the state) solely be relied upon to give a full or accurate picture. Also integral in such reporting will be highlighting outside influencers in data

such as the mass arrests that began in August 2017 as Operation Rio Grande rolled out, the Opioid Epidemic that swept our state and nation, the housing affordability crisis, a BH workforce shortage, and now the impacts of COVID-19.

COVID-19 has impacted services in a great way. Court calendars were dramatically altered resulting in decreases in court-ordered referrals. The jail decreased their census to allow for social distancing. BH providers saw an immediate drop in capacity in detox and residential settings as they incorporated quarantine and isolation protocols, and quickly pivoted their outpatient services to telehealth. As examples, capacity of the County's men's detox program dropped initially to 27% of normal and operates today at 73% capacity, while the largest provider of SUD residential services dropped initially to 50% and today remains at approximately 70% of pre-pandemic levels. Many staff became ill or were too high-risk to work and others saw their duties transfer to COVID related efforts such as ordering and distributing PPE and Rapid Test Kits. Lastly, COVID-19 related state budget reductions cut funding for an expansion of 30 Utah State Hospital beds, a loss felt statewide to providers and residents, but fortunately was restored in the 2021 general session.

In conclusion, the landscape of behavioral health services in Salt Lake County and Utah has changed in a dramatic way in recent years, bringing both unprecedented challenges and opportunities. As the workforce shortage eases, and if funding continues for services outside of Medicaid (such as housing, milieu, drug testing, etc.), and as vaccines become widely distributed, the future looks bright.

Attachment I



Attachment II

March 8, 2018
1,400 kits distributed
Spend: $105,000
Funding Source: State Targeted Response (STR) Grant

Agency	Kits	Date Received
Odyssey House	500	3/16/2018
Volunteers of America	50	3/16/2018
House of Hope	100	3/14/2018
Project Reality	100	3/15/2018
UofU Assessment and Referral Services	10	3/14/2018
Clinical Consultants	60	3/14/2018
First Step House	50	3/13/2018
Valley Behavioral Health	200	3/21/2018
Sheriff's Office (ISP Program)	30	3/14/2018
Behavioral Health Services	4	3/12/2018
Health Department	296	3/8/2018
Overall	1,400	3/8/2018

April 8, 2019
3,024 kits distributed
Spend: $226,800
Funding Source: State Opioid Response (SOR) Grant

Agency	Kits	Date Received
Odyssey House	1,000	4/15/2019
Volunteers of America	420	5/20/2019
House of Hope	300	4/12/2019
Project Reality	400	4/15/2019
UofU Assessment and Referral Services	20	5/8/2019
First Step House	200	4/15/2019
Valley Behavioral Health	600	4/18/2019
Sheriff's Office (ISP Program)	24	5/8/2019
Behavioral Health Services	10	5/29/2019
Salt Lake County Criminal Justice Services	50	5/8/2019
Overall	3,024	4/8/2019

July 18, 2019
204 kits distributed
Spend: $15,300
Funding Source: State Opioid Response (SOR) Grant

Agency	Kits	Date Received
Jail MAT Program	100	7/26/2019
Clinical Consultants	48	10/11/2019
Jail MAT Program	56	11/8/2019
Overall	204	7/18/2019

Attachment III

Medicaid Adult Expansion Report

December 11, 2020

Expansion Enrollment by Subgroup

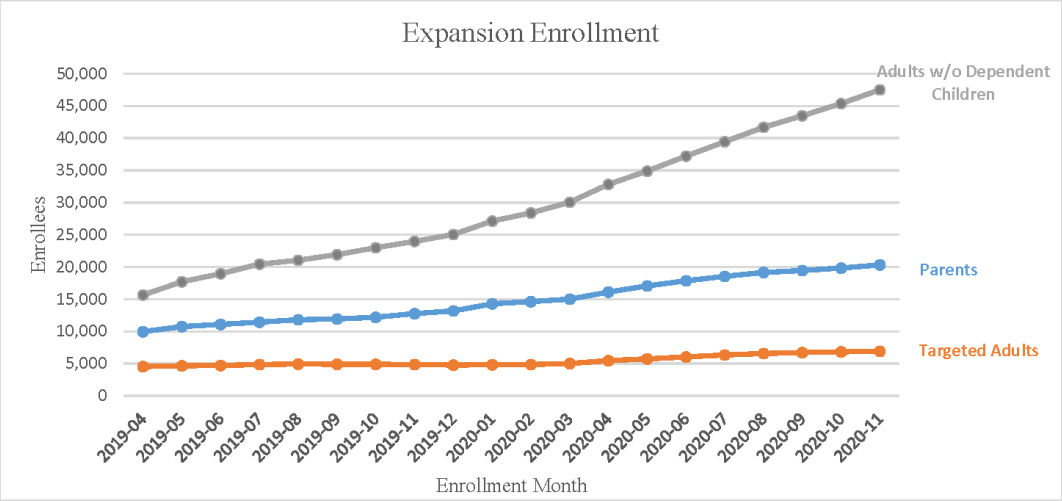


Figure 1

Expansion Enrollment

Bridge

Category	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
Adults w/o Dep. Children	15,674	17,721	18,977	20,451	21,066	21,910	22,995	23,999	25,031
Parents	9,975	10,766	11,092	11,453	11,812	11,941	12,198	12,773	13,178
Targeted Adults	4,553	4,682	4,703	4,871	4,931	4,901	4,901	4,878	4,795
Total	**30,202**	**33,169**	**34,772**	**36,775**	**37,809**	**38,752**	**40,094**	**41,650**	**43,004**

Table 1a

Fallback

Category	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11
Adults w/o Dep. Children	27,152	28,390	30,058	32,818	34,876	37,188	39,465	41,674	43,475	45,378	47,501
Parents	14,286	14,636	15,015	16,126	17,062	17,844	18,529	19,152	19,474	19,846	20,321
Targeted Adults	4,839	4,853	5,018	5,458	5,740	6,061	6,340	6,559	6,740	6,833	6,919
Total	**46,277**	**47,879**	**50,091**	**54,402**	**57,678**	**61,093**	**64,334**	**67,385**	**69,689**	**72,057**	**74,741**

Table 1b

Notes:
Enrollment as of December 11, 2020. Enrollment includes retroactive applications processed up to the run date.
Enrollment numbers reported here are subject to change with future applications that may include retroactive coverage.

Expansion Demographics

Last update: October 2020

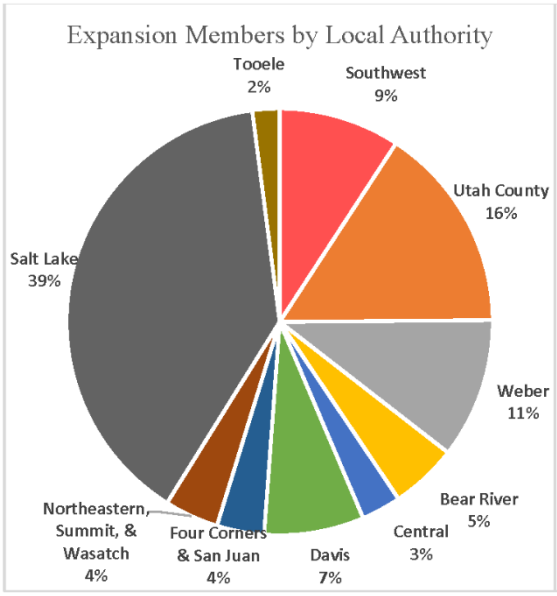


Figure 2

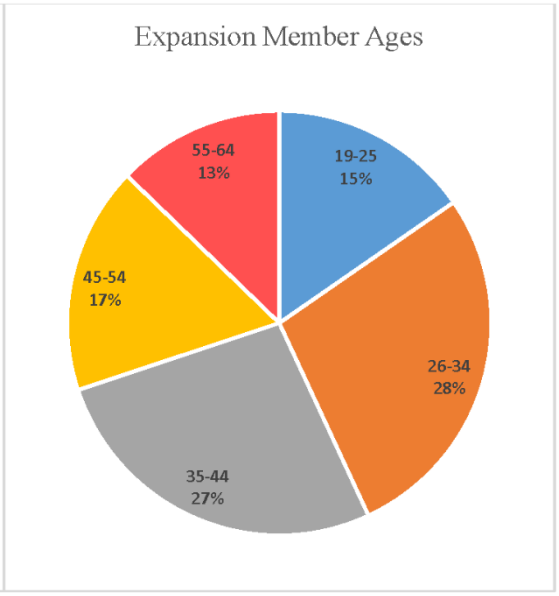


Figure 3

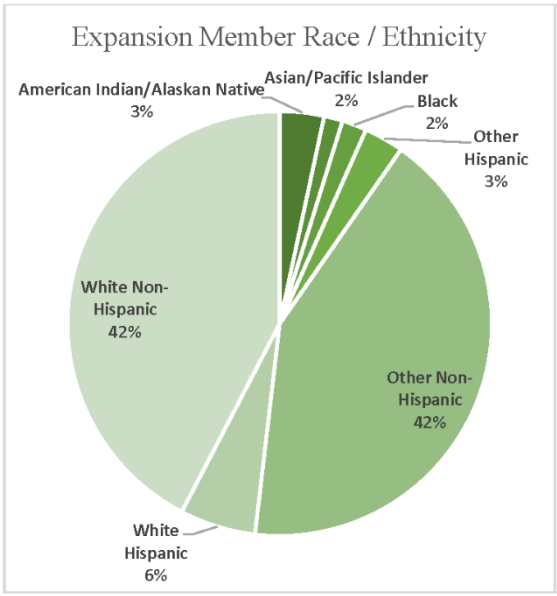


Figure 4

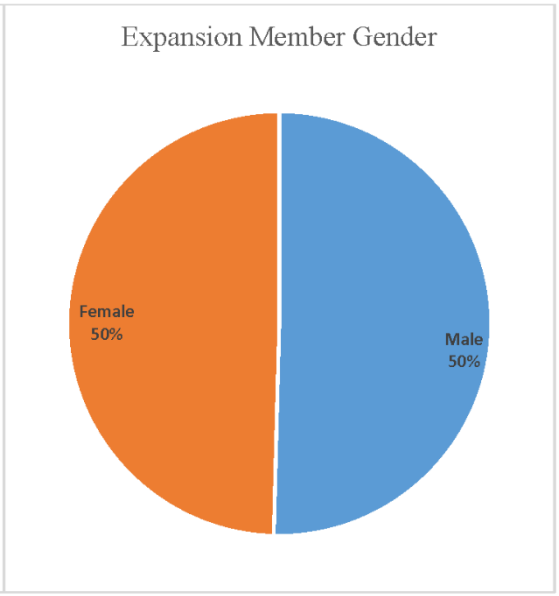


Figure 5

Targeted Adult Medicaid (TAM) Enrollment by Subgroup

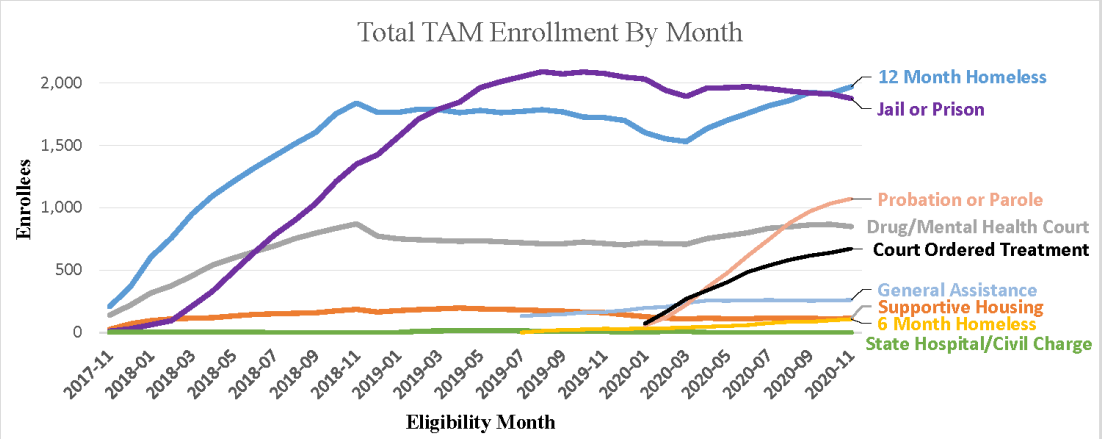


Figure 6

TAM Enrollment by Month

FY19 Totals	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06
Total	**3,042**	**3,321**	**3,591**	**3,975**	**4,243**	**4,126**	**4,256**	**4,438**	**4,517**	**4,553**	**4,682**	**4,703**

Table 2a

FY20 Category	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06
12 Month Homeless	1,771	1,786	1,768	1,727	1,723	1,698	1,600	1,552	1,530	1,633	1,701	1,758
6 Month Homeless	*	14	21	24	30	29	35	34	40	47	52	60
Supportive Housing	182	176	172	165	160	143	127	115	108	114	112	112
General Assistance	133	141	147	161	165	178	197	205	236	256	255	259
Court Ordered Treatmnt							72	164	270	337	403	487
Drug/Mental Health Crt	720	712	712	726	714	701	719	711	708	752	777	800
Jail or Prison	2,051	2,090	2,071	2,088	2,075	2,046	2,031	1,941	1,891	1,957	1,961	1,969
Probation or Parole							58	119	223	361	478	617
State Hospital/Civil Chrg	14	12	10	10	11	*	*	12	12	*	*	*
Total	**4,871**	**4,931**	**4,901**	**4,901**	**4,878**	**4,795**	**4,839**	**4,853**	**5,018**	**5,458**	**5,740**	**6,061**

Table 2b

FY21 Category	2020-07	2020-08	2020-09	2020-10	2020-11
12 Month Homeless	1,816	1,858	1,922	1,916	1,968
6 Month Homeless	76	85	85	97	107
Supportive Housing	115	115	114	112	113
General Assistance	260	259	254	257	261
Court Ordered Treatmnt	538	582	615	639	672
Drug/Mental Health Crt	835	848	862	867	849
Jail or Prison	1,954	1,935	1,918	1,911	1,876
Probation or Parole	746	877	970	1,034	1,072
Total	**6,340**	**6,559**	**6,740**	**6,833**	**6,919**

Table 2c

*Domestic Violence and selected months from State Hospital/Civil Charge are suppressed due to low enrollment

Notes: Enrollment as of December 11, 2020. Enrollment includes retroactive applications processed up to the run date. Enrollment numbers reported here are subject to change with future applications that may include retroactive coverage.

Targeted Adult Medicaid Reimbursements

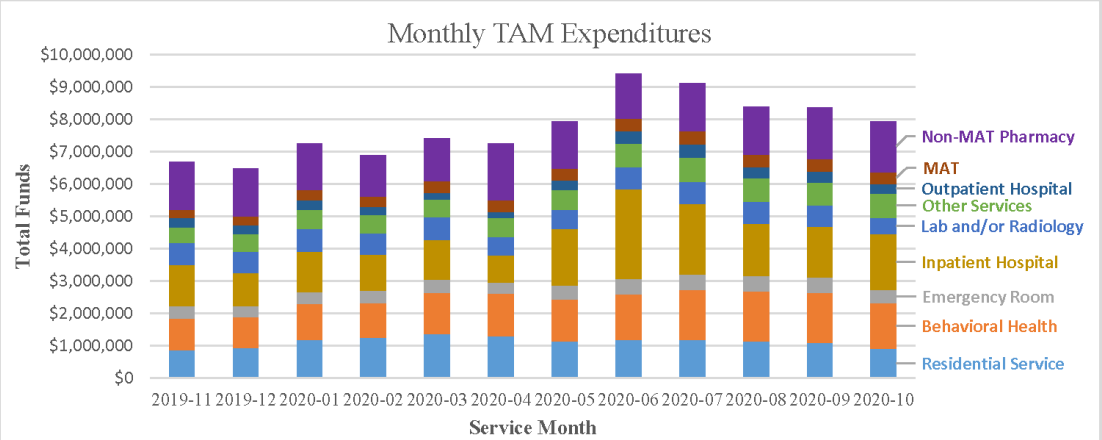


Figure 7

Monthly Expenditures (in 1,000's)						FY20				FY21			
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**	**Total**
Residential Serv.	$879	$932	$1,198	$1,259	$1,366	$1,298	$1,142	$1,185	$1,189	$1,144	$1,101	$917	**$13,611**
Behavioral Health	$982	$952	$1,096	$1,060	$1,282	$1,325	$1,290	$1,422	$1,540	$1,534	$1,537	$1,417	**$15,436**
Emergency Room	$369	$347	$375	$393	$411	$329	$443	$480	$486	$492	$473	$408	**$5,007**
Inpatient Hospital	$1,277	$1,025	$1,250	$1,104	$1,217	$844	$1,738	$2,763	$2,175	$1,614	$1,579	$1,725	**$18,311**
Lab & Radiology	$679	$668	$703	$664	$706	$577	$608	$691	$675	$667	$649	$507	**$7,794**
Other Services	$494	$544	$601	$569	$541	$580	$619	$714	$768	$735	$705	$752	**$7,622**
Outpatient Hosp.	$276	$263	$293	$254	$208	$201	$281	$384	$409	$341	$355	$292	**$3,556**
MAT	$266	$278	$305	$308	$366	$351	$365	$387	$411	$385	$379	$359	**$4,161**
Non-MAT Pharm.	$1,480	$1,486	$1,440	$1,276	$1,323	$1,747	$1,458	$1,401	$1,466	$1,478	$1,598	$1,578	**$17,731**
Grand Total	**$6,702**	**$6,495**	**$7,262**	**$6,890**	**$7,421**	**$7,254**	**$7,942**	**$9,426**	**$9,118**	**$8,390**	**$8,376**	**$7,954**	**$93,229**

Table 3

Distinct Members Served						FY20				FY21			
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**	
Residential Serv.	315	335	419	462	524	484	449	429	414	396	392	351	
Behavioral Health	1,364	1,275	1,423	1,442	1,579	1,608	1,678	1,710	1,645	1,667	1,539	1,442	
Emergency Room	498	509	504	502	556	438	544	577	608	625	619	632	
Inpatient Hospital	96	99	109	102	115	110	168	174	163	152	151	162	
Lab & Radiology	993	1,030	1,140	1,198	1,277	1,134	1,165	1,283	1,230	1,200	1,214	1,109	
Other Services	4,722	4,626	4,486	4,527	4,732	5,225	5,495	5,826	6,084	6,369	6,598	6,722	
Outpatient Hosp.	370	364	422	433	370	361	395	520	579	612	564	573	
MAT	480	506	546	550	605	655	686	735	749	751	771	696	
Non-MAT Pharm.	1,739	1,769	1,809	1,816	1,941	2,005	2,137	2,213	2,242	2,275	2,299	2,359	
Grand Total	**4,784**	**4,674**	**4,609**	**4,620**	**4,818**	**5,270**	**5,547**	**5,878**	**6,147**	**6,428**	**6,643**	**6,760**	

Table 4

- Monthly expenditures represent total fund payments to providers. Expenditures may not precisely sum up to total due to rounding.
- These total fund amounts consist of federal funds, state restricted funds, and hospital share.
- Pharmacy expenses shown here are subject to future reductions due to rebates.
- The months shown here represent the month of service, which is not necessarily the month of payment. They are subject to change with future billings and adjustments. Providers may bill up to one year after the date of service.

Expansion Parents Enrollment

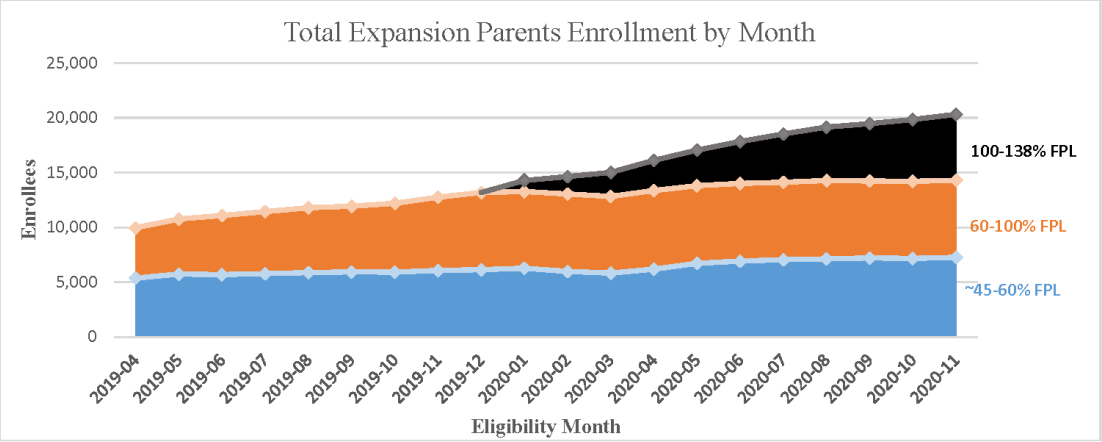


Figure 8

Expansion Parents Enrollment by Month

Bridge

Category	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
60-100% FPL	4,594	5,033	5,393	5,654	5,934	5,994	6,271	6,683	7,022
~45-60% FPL	5,381	5,733	5,699	5,799	5,878	5,947	5,927	6,090	6,156
Total	**9,975**	**10,766**	**11,092**	**11,453**	**11,812**	**11,941**	**12,198**	**12,773**	**13,178**

Table 5a

Fallback

Category	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11
100-138% FPL	1,000	1,592	2,192	2,766	3,258	3,840	4,402	4,875	5,226	5,630	6,022
60-100% FPL	7,014	7,061	6,994	7,161	7,083	7,079	7,073	7,158	7,037	7,040	7,026
~45-60% FPL	6,272	5,983	5,829	6,199	6,721	6,925	7,054	7,119	7,211	7,176	7,273
Total	**14,286**	**14,636**	**15,015**	**16,126**	**17,062**	**17,844**	**18,529**	**19,152**	**19,474**	**19,846**	**20,321**

Table 5b

Notes:
Enrollment as of December 11, 2020. Enrollment includes retroactive applications processed up to the run date.
Enrollment numbers reported here are subject to change with future applications that may include retroactive coverage

Expansion Parents Reimbursements

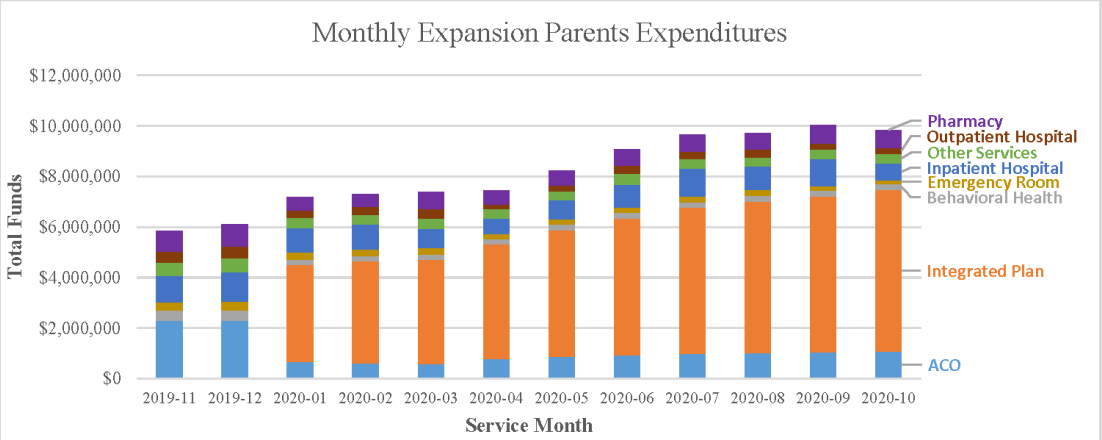


Figure 9

Monthly Expenditures (in 1,000's)						FY20			FY21				
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**	**Total**
ACO	$2,301	$2,297	$673	$620	$600	$788	$864	$935	$989	$1,015	$1,048	$1,087	**$13,217**
Integrated Plan	$0	$0	$3,835	$4,043	$4,104	$4,530	$5,006	$5,418	$5,782	$5,992	$6,163	$6,379	**$51,254**
Behavioral Health	$407	$427	$206	$201	$209	$217	$229	$229	$229	$245	$250	$242	**$3,090**
Emergency Room	$330	$325	$284	$269	$277	$183	$227	$190	$216	$223	$157	$149	**$2,831**
Inpatient Hospital	$1,026	$1,185	$965	$974	$762	$614	$731	$906	$1,105	$926	$1,071	$666	**$10,931**
Other Services	$551	$551	$417	$396	$404	$392	$351	$451	$390	$367	$398	$386	**$5,052**
Outpatient Hospital	$431	$445	$277	$317	$377	$165	$238	$312	$279	$316	$229	$237	**$3,622**
Pharmacy	$810	$895	$541	$479	$652	$568	$593	$637	$679	$634	$706	$693	**$7,889**
Grand Total	**$5,855**	**$6,124**	**$7,198**	**$7,300**	**$7,386**	**$7,458**	**$8,238**	**$9,078**	**$9,668**	**$9,720**	**$10,021**	**$9,840**	**$97,885**

Table 6

Distinct Members Served						FY20			FY21			
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**
ACO	4,537	4,539	1,553	1,438	1,417	1,861	2,043	2,202	2,325	2,381	2,436	2,532
Integrated Plan			7,844	8,283	8,401	9,299	10,263	11,085	11,822	12,257	12,596	13,006
Behavioral Health	6,314	6,401	3,717	3,858	3,939	4,160	4,369	4,517	4,677	4,847	4,924	5,001
Emergency Room	388	394	340	299	297	190	217	204	235	219	174	174
Inpatient Hospital	74	68	78	84	74	50	53	79	77	60	60	46
Other Services	1,949	1,935	1,331	1,349	1,404	1,199	1,187	1,355	1,259	1,252	1,311	1,278
Outpatient Hospital	659	638	409	399	367	240	311	398	391	340	341	335
Pharmacy	3,151	3,284	2,785	2,722	3,004	2,944	3,047	3,286	3,392	3,518	3,594	3,718
Grand Total	**8,783**	**8,899**	**12,374**	**12,870**	**13,095**	**14,163**	**15,252**	**16,275**	**17,183**	**17,674**	**17,991**	**18,489**

Table 7

- Monthly expenditures represent total fund payments to providers. Expenditures may not precisely sum up to total due to rounding.
- These total fund amounts consist of federal funds, state restricted funds, and hospital share.
- Pharmacy expenses shown here are subject to future reductions due to rebates.
- The months shown here represent the month of service, which is not necessarily the month of payment. They are subject to change with future billings and adjustments. Providers may bill up to one year after the date of service.

Expansion Adults without Dependent Children Enrollment

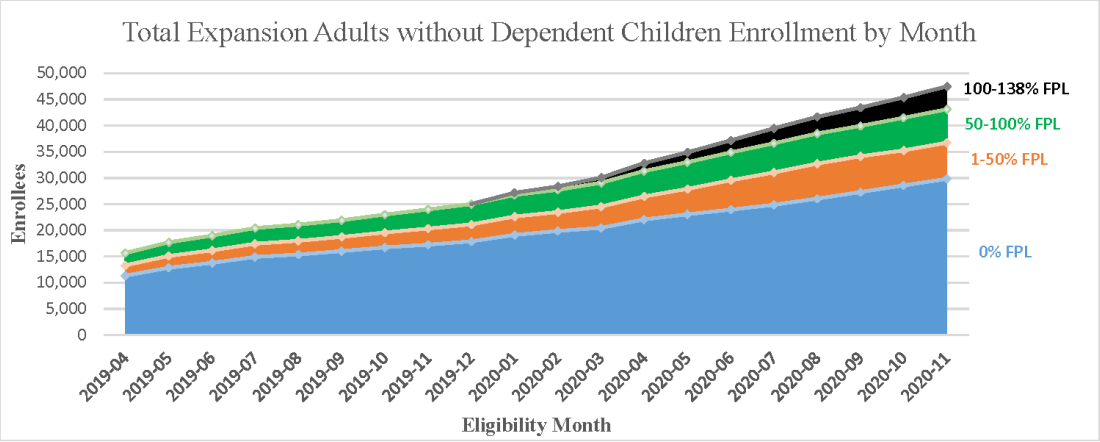


Figure 10

Expansion Adults without Dependent Children Enrollment by Month

Bridge

Category	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
50-100% FPL	2,343	2,615	2,824	3,007	3,080	3,164	3,389	3,666	3,889
1-50% FPL	1,996	2,258	2,388	2,547	2,609	2,715	2,870	3,068	3,224
0% FPL	11,335	12,848	13,765	14,897	15,377	16,031	16,736	17,265	17,918
Total	**15,674**	**17,721**	**18,977**	**20,451**	**21,066**	**21,910**	**22,995**	**23,999**	**25,031**

Table 8a

Fallback

Category	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11
100-138% FPL	390	642	960	1,482	1,849	2,308	2,826	3,163	3,503	3,897	4,383
50-100% FPL	4,142	4,262	4,542	4,843	5,095	5,323	5,574	5,786	5,802	6,211	6,380
1-50% FPL	3,494	3,621	4,058	4,431	4,886	5,625	6,187	6,692	6,863	6,684	6,917
0% FPL	19,126	19,865	20,498	22,062	23,046	23,932	24,878	26,033	27,307	28,586	29,821
Total	**27,152**	**28,390**	**30,058**	**32,818**	**34,876**	**37,188**	**39,465**	**41,674**	**43,475**	**45,378**	**47,501**

Table 8b

Notes:
Enrollment as of December 11, 2020. Enrollment includes retroactive applications processed up to the run date.
Enrollment numbers reported here are subject to change with future applications that may include retroactive coverage

Expansion Adults without Dependent Children Reimbursements

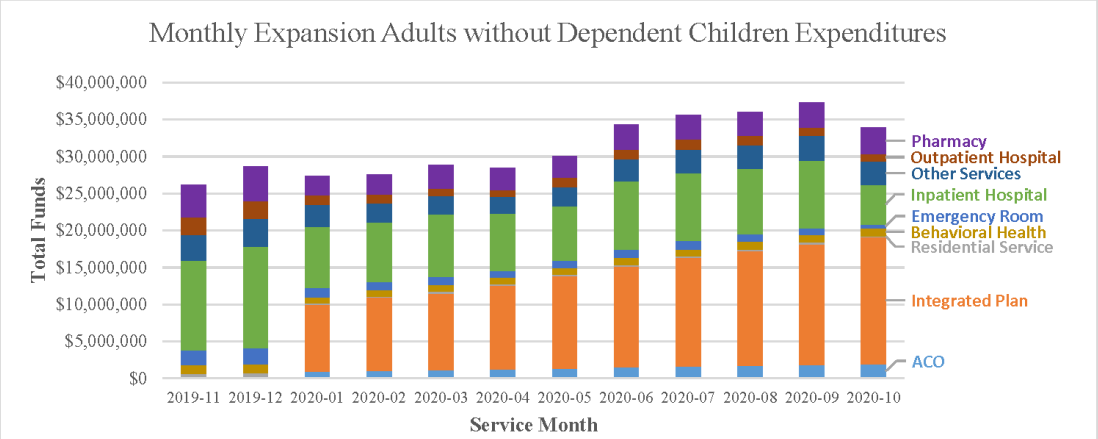


Figure 11

Monthly Expenditures (in 1,000's)						FY20			FY21				
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**	**Total**
ACO	$0	$0	$967	$1,050	$1,097	$1,234	$1,373	$1,514	$1,634	$1,751	$1,842	$1,972	**$14,432**
Integrated Plan	$0	$0	$9,056	$9,864	$10,406	$11,328	$12,508	$13,640	$14,667	$15,440	$16,315	$17,179	**$130,403**
Behavioral Health	$1,182	$1,241	$817	$832	$875	$862	$874	$933	$984	$1,050	$996	$1,020	**$11,665**
Emergency Room	$1,990	$2,130	$1,250	$1,153	$1,146	$885	$966	$1,115	$1,116	$1,060	$868	$572	**$14,251**
Inpatient Hospital	$12,136	$13,709	$8,299	$7,983	$8,393	$7,796	$7,378	$9,238	$9,157	$8,769	$9,206	$5,318	**$107,382**
Other Services	$3,506	$3,787	$2,919	$2,599	$2,558	$2,272	$2,595	$3,044	$3,155	$3,271	$3,377	$3,219	**$36,303**
Outpatient Hosp.	$2,390	$2,387	$1,320	$1,167	$995	$832	$1,290	$1,204	$1,426	$1,269	$1,045	$988	**$16,314**
Pharmacy	$4,347	$4,745	$2,611	$2,758	$3,181	$3,046	$2,831	$3,377	$3,308	$3,202	$3,364	$3,516	**$40,286**
Residential Serv.	$623	$704	$160	$191	$227	$209	$203	$195	$180	$233	$235	$111	**$3,271**
Grand Total	**$26,174**	**$28,704**	**$27,401**	**$27,597**	**$28,876**	**$28,463**	**$30,018**	**$34,260**	**$35,626**	**$36,044**	**$37,248**	**$33,895**	**$374,307**

Table 9

Distinct Members Served FY20									FY21			
Service Type	**2019-11**	**2019-12**	**2020-01**	**2020-02**	**2020-03**	**2020-04**	**2020-05**	**2020-06**	**2020-07**	**2020-08**	**2020-09**	**2020-10**
ACO			2,065	2,249	2,364	2,650	2,973	3,282	3,540	3,808	4,028	4,340
Integrated Plan			15,587	17,060	18,050	19,708	21,872	23,964	25,856	27,301	28,929	30,566
Behavioral Health	2,601	2,596	6,469	6,700	7,059	7,472	7,907	8,418	8,783	9,296	9,569	9,914
Emergency Room	2,392	2,535	1,364	1,328	1,328	1,014	1,056	1,137	1,181	1,096	1,011	829
Inpatient Hospital	800	830	575	531	528	453	476	545	533	536	494	413
Other Services	22,432	23,365	25,419	26,653	27,774	30,676	32,749	35,029	37,068	39,156	41,145	43,327
Outpatient Hosp.	2,753	2,899	1,187	1,084	942	755	900	1,115	1,038	1,026	1,028	942
Pharmacy	9,013	9,445	7,560	7,935	8,443	8,481	8,911	9,632	10,005	10,311	10,716	11,264
Residential Serv.	239	284	70	66	53	40	50	58	45	46	50	36
Grand Total	**23,027**	**24,012**	**26,530**	**27,750**	**28,970**	**31,769**	**33,811**	**36,142**	**38,236**	**40,296**	**42,201**	**44,233**

Table 10

- Monthly expenditures represent total fund payments to providers. Expenditures may not precisely sum up to total due to rounding.
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