



Division Directives

Fiscal Year 2019

March 2018

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DSAMH FY2019 DIRECTIVES

- I. The Local Authority (LA) shall refer to the contract, state and federal statute and Administrative Rule to comply with all of the requirements attached to the funding in these contracts. The directives are intended to be additional requirements that are not already identified in the contract, state and federal statute and Administrative Rule. These directives shall remain in effect from July 1, 2018 through June 30, 2019. The Local Authority shall comply with the directives, as identified below.

A. GOVERNANCE AND OVERSIGHT

- i. As required by statute, all Local Authorities must prepare and submit to the Division a plan approved by the county legislative body for funding and service delivery. For FY2019, the required Area Plan from all Local Authorities will consist of forms the Division has developed for Mental Health (Forms A, A1 & A2), Substance Use Disorder (SUD) Treatment (Form B), and SUD Prevention (Form C). Each budget and narrative form has been prepared in an electronic format. Do not change any of the formats or formulas. All forms must be completed in the shared DSAMH/Local Authority Google Drive folder. The forms require specific information that is applicable to each program. DSAMH will review the forms with the Local Authority staff and provide instructions on completing them electronically during the annual UBHC conference to be held Thursday, March 29, 2018. The financial information of each form will be assessed by the Division and compared to each Local Authority's audited financial statements.
- ii. The Area Plan packet must include the completed Forms A, A1, A2, B, C, D and the required fee policy and fee schedule, pursuant to Administrative Rule Section R523-1-5. The Area Plan packet must be completed by May 15, 2018 through the shared DSAMH/Local Authority Google Drive folder.
- iii. All Local Authorities shall complete specific year-end reports that must be submitted to the Division no later than August 31, 2018. The forms will be provided to the Local Authorities no later than 45 days prior to the due date. The reports must be completed with the most recent actual fiscal data available.
- iv. In regards to 62A-15-103. Division -- Creation -- Responsibilities, the division shall "(a) (viii) evaluate the effectiveness of programs described in this Subsection (2);" and provide feedback and suggestions when appropriate.
- v. The Local Authority shall provide an organization chart/listing of staff and subcontractors. Organizational chart shall include prevention and recovery support staff. A separate attachment shall include the discipline/position of each individual and percentage of time devoted to administrative and clinical work (FTE).

- vi. Monitoring reports for FY2019 may contain findings and/or further discussion narrative resulting from any red and yellow scores on the SUD Treatment Scorecard, the Mental Health Youth and Adult Scorecards, Consumer Satisfaction Scorecard, and the Client Cost Report. A green score will be regarded as a positive outcome.
- vii. DSAMH will use the following definitions in the monitoring process:
 - a. **Compliance**: DSAMH has reviewed and verified that the Local Authority or its designees' performance is sufficient and that it meets the requirements of service delivery and provisions within the contract.
 - b. **Corrective Action**: The use of this contractual compliance term requires 1) a written formal **Action Plan** to be developed, signed, and dated by the Local Authority or its designee; 2) acceptance by DSAMH evidenced by the dated signature of the Division director or designee; 3) follow-up and verification actions by DSAMH; and 4) a formal written notification of a return to compliance by the Local Authority or its designee. This notification shall be provided to the Bureau of Contract Management (BCM), the Office of Inspector General (OIG) with a copy placed in the files maintained by DSAMH Administration.
 - c. **Action Plan**: A written plan sufficient to resolve a non-compliance issue identified by Division reviewers. The development of the plan is the primary responsibility of the Local Authority or its designee. Each corrective action plan must be approved by Division staff and should include a date by which the Local Authority will return to compliance. This completion date and the steps by which the corrective action plan will return the Local Authority to contract compliance must be specific and measurable. Each action plan must also include the person(s) responsible to ensure its completion. If requested, the Division will provide technical assistance and guidance in its formulation.
 - d. **Recommendation**: The Local Authority or its designee is in compliance. DSAMH will use this term to make a best practice or technical suggestion. The Local Authority is encouraged to implement the suggestion, however implementation is not required.
 - e. Each performance inadequacy will be classified according to one of the following classification levels:
 - 1. **Major Non-Compliance**: Major non-compliance is an issue that affects the imminent health, safety, or well-being of individuals and requires immediate resolution. Non-compliance at this level will require **Corrective Action** sufficient to return the issue to compliance within 24 hours or less. The Division of Substance Abuse and Mental Health's response to a major non-compliance issue may include the removal of

clients from the current setting into other placements and/or contract termination.

2. **Significant Non-Compliance**: Significant non-compliance is: 1) non-compliance with contract requirements that do not pose an imminent danger to clients but result in inadequate treatment and/or care that jeopardizes the long-term well-being of individual clients; or, 2) non-compliance in training or required paperwork/documentation that is so severe or pervasive as to jeopardize continued funding to the Department and to the Local Authority or its designee. Non-compliance at this level will require that **Corrective Action** be initiated within 10 days and compliance achieved within 30 days.
 3. **Minor Non-Compliance**: Minor non-compliance is a non-compliance issue in contract requirements that is relatively insignificant in nature and does not impact client well-being or jeopardize Department or Local Authority funding. This level of non-compliance requires **Corrective Action** be initiated within 15 days and compliance achieved within 60 days.
 4. **Deficiency**: The Local Authority or its designee is not in full contract compliance. The deficiency discovered is not severe enough nor is it pervasive enough in scope as to require a formal action plan. DSAMH will identify the deficiency to the Local Authority or its designee and require the appropriate actions necessary to resolve the problem by a negotiated date. This informal plan and negotiated resolution date shall be included as a narrative in the monitoring report response. DSAMH will follow-up to determine if the problem has been resolved and will notify the Local Authority or its designee that the resolution has been achieved by the negotiated date. If the Local Authority or its designee fails to resolve the identified deficiency by the negotiated date, formal **Corrective Action** will be required.
- viii. The Local Authority shall perform annual subcontractor monitoring, as outlined in the DHS Contract, utilizing a formalized monitoring tool that describes each area of the review and its outcome.
- a. The Local Authority will include copies of current insurance certificates, as outlined in contract, with each subcontractor file.
 - b. The Local Authority will ensure that subcontracted providers have current licenses, certifications, BCI checks and conflict of interest forms by one of the following methods:
 1. keeping physical copies
 2. through the Medicaid credentialing process
 3. annual subcontractor monitoring
 4. another monitoring report in the past year that has verified these items.
 - c. The Local Authority will provide documented assurance that this step has

been completed upon request from DSAMH. If the Local Authority subcontracts with a Managed Care Organization (MCO) to secure provider services, either the Local Authority or its subcontracted MCO must comply with this section.

- ix. For each site visit, 10-20 random client numbers shall be provided by the Division for chart review. Additional charts may be requested by the monitoring teams to be pulled by the Local Authority for specific populations or areas of concern. The Local Authority shall provide the monitoring team access to the selected charts at least two weeks before the site visit, including passwords and instructions needed to access the files in their electronic health record. Local Authorities shall provide internal Peer chart reviews for the two years prior to the current monitoring year.
- x. Each Local Authority shall provide an electronic copy of their annual PMHP Financial Report (Medicaid Cost Report) to the Division as it is submitted to the Department of Health.
 - a. Local Authorities shall provide DSAMH with the initial submission and also the finalized version of the report after it has been accepted and finalized by Medicaid.
 - b. All sections and schedules of the report must be completed (e.g. Sch 1A WC).
- xi. Wherever possible, and for service codes identified by the division, justification for payment of funds shall be determined by the Current Procedural Terminology Codes (CPT) used in the Local Authorities' Electronic Health Record (EHR) and the rate determined in their most recently approved Medicaid Cost Report. The rate is determined using information from Schedule 4: Dividing amounts listed under column titled *All Allowable Costs From Sched 5* by service units listed under *All MH/SA Service Units*. For services where CPT codes are not used, DSAMH will develop separate standards for justifying payment that may include direct labor and/or current expense costs. In these cases, the Local Authority is responsible to demonstrate that any overhead costs allocated to these non-CPT code expenses are consistent with the overall cost allocation plan (CAP) used by the Local Authority. Where a Medicaid Cost Report has been done, this report becomes the CAP of record for the Local Authority. The Local Authority shall complete Schedule 4 Part II: *Non-covered and Disallowed Services and Costs*, providing the following: a description of each item listed, a service unit definition, all non-covered and disallowed costs and the number of service units provided.
- xii. The Local Authorities shall receive payment via Electronic Funds Transfer (EFT) from the Division. It is the responsibility of each Local Authority to apply for EFT payment services from the Utah Department of State Finance and to notify DSAMH if a payment is received via check from DSAMH.

- xiii. Invoices shall be submitted to DSAMH monthly via electronic billing system established by the Division. Invoices for services shall be submitted by the Local Authorities monthly, dividing billing into discrete calendar month blocks where applicable. Local Authorities shall use electronic billing submission systems provided by the State where applicable and available. DSAMH shall continue to work towards efficiencies to provide payments back within agreed time frames.
- xiv. DSAMH utilizes DocuSign for obtaining signatures in the contracting process. The Local Authorities shall participate in this process by using DocuSign and updating the Local Authority Contract Approval Path file on the shared Google Drive. Local Authorities that are not currently utilizing this process must demonstrate that they are proactively working towards accommodating its use with a detailed written plan.

B. COMBINED MENTAL HEALTH AND SUD DIRECTIVES.

- i. Each client shall have a strength-based assessment. (Please note that when the client is a child or youth, the word client also refers to the parent/guardian.) The current version of the approved Utah Preferred Practice Guidelines shall be the preferred standard for assessments, planning and treatment. At a minimum assessments, planning and treatment shall comply with the Medicaid Provider Manual and current Administrative Rule as described in R523.
- ii. Local Authority Clinical Records will be reviewed using the approved checklist which will be provided to each Local Authority prior to their site visit. The approved checklist shall be cross checked with the Office of Licensing chart monitoring tools and other regular monitoring tools and results from related monitoring reports from the previous year may be referenced to avoid duplication of effort.
- iii. Participation with key community partners (e.g.: Multi-Agency Coordinating Committees, System of Care Committees, Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committee, Peer Advocacy Groups and other partnership groups relevant in individual communities) shall occur consistently. Participation will be evidenced through stakeholder feedback, applicable records (minutes, communication), use of shared Utah Family and Children Engagement Tool (UFACET) assessment, and program manager discussions.
- iv. Local Authorities shall continue to establish and/or expand Adult, Youth, and Family Peer Support Services. Certified Peer Specialists and Family Resource Facilitators who are employed by the local authorities are to be integrated meaningfully into all levels of agency process and service, effectively utilizing peer and family voice. Local Authorities shall seek ways to maximize effective on-going training for peers and peer supervisors specific to the unique make up,

resources and structure of each local area. DSAMH requires LA to have policy and procedures to provide guidelines and supports for Certified Peer Support Specialists and Family Resource Facilitators.

- v. Local Authorities who engage with the Department of Human Services (DHS) in the provision of Stabilization and Mobile Response Services shall coordinate with DHS regarding service delivery, reporting requirements, quality improvement efforts and reimbursement. The lead Local Authority"ies" shall oversee "Administer" and coordinate the delivery of Stabilization and Mobile Response (SMR) services in all counties in their region including subcontracting with other local authorities or other providers as necessary to ensure SMR services are performed in accordance with the SMR model
 - a. Ensure SMR services include triage, mobile response, and stabilization services
 - b. Make SMR services available to children, youth and families regardless of custody, status and funding
 - c. Deliver SMR services consistent with the SMR Model
 - d. Ensure SMR services are based on System of Care values and principles
 - e. Ensure Triage services are available 24 hours per day, 7 days a week, year round
 - f. Allow the parent/family/caregiver to define the crisis
 - g. Collect and report agreed upon data and outcome measures to DHS
 - h. Provide verification of services and authorizations prior to submission of invoices to DHS for payment.
- vi. Local Authorities may choose to engage with the DHS System of Care to provide individualized services to children and youth with complex needs and their families. Services are based on the client's care plan developed by the child and family team. Local Authorities will be paid for services through a mutually agreed upon cost reimbursement model.
- vii. Suicide prevention, intervention and postvention: During FY2019, Local Authorities will continue to implement, monitor and report on their plans.
 - a. Records must contain a safety/crisis plan when clinically indicated which can be quickly and easily accessed and updated as needed.
 - b. Local Authorities shall develop a plan for coordination of follow up care based

on best practices with inpatient and emergency department services for clients being treated for a suicide related event.

- c. Local Authorities will monitor implementation of their comprehensive suicide prevention/quality improvement plan annually using a fidelity measure (to be provided by DSAMH) in order to measure progress and as an assessment of fidelity to the Zero Suicide approach. LAs will submit an updated plan based on outcomes from the assessment. Fidelity measures can be done on paper or electronically.
- viii. Local Authorities will promote integrated programs that address an individual's substance use disorder, mental health, intellectual/developmental disabilities, physical health, and criminal risk factors as described in UCA 62A-15-103(2)(vi). Local Authorities will use a Holistic Approach to Wellness and will:
 - a. Identify tobacco use in the assessment.
 - b. Provide services in a nicotine free environment.
 - c. Provide appropriate smoking cessation services and resources (including medication).
 - d. Implement a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB.
 - e. Train staff in recognizing health issues often seen in the behavioral health population, and provide information and referrals as appropriate.
- ix. Drug Testing Program Requirements: All drug testing conducted by DSAMH, Local Substance Abuse Authorities, Local Mental Health Authorities or contractors, vendors, programs, shall comply with the requirements outlined in Administrative Rule R523-15
- x. Justice Reinvestment Initiative: LMHA and LSAA shall participate in State and Local justice reform efforts.
 - a. Adherence to Evidence-Based Practice in Community Treatment . Local Authorities shall:
 - 1. Provide ongoing training to staff on criminogenic risk, need, and responsivity.
 - 2. Prioritize recommendations from local Correctional Program Checklist (CPC) Report provided by the University of Utah Criminal Justice Center in SFY 2018 and implement practices or policies that improve adherence to evidence-based practice.
- xi. Juvenile Justice Reform: [HB 239 Juvenile Justice Amendments](#) outlines changes

to the Juvenile Justice System. DSAMH encourages LMHA and LSAA participation in State and Local juvenile justice reform efforts.

- xii. Recovery Support Services (RSS): RSS include culturally and linguistically appropriate services that assist individuals and families working toward recovery from mental and/or substance use problems. They incorporate a full range of social, legal, and other services that facilitate recovery, wellness, and linkage to and coordination among service providers, and other supports shown to improve quality of life for people in and seeking recovery and their families.
 - a. RSS also include access to [evidence-based practices](#) such as supported employment, education, and housing; assertive community treatment; illness management; and peer-operated services. RSS may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment but seek support services. These services, provided by professionals and peers, are delivered through a variety of community and faith-based groups, treatment providers, schools, and other specialized services.
 - b. All RSS services provided by the Local Authorities shall be documented and reported in the Substance Abuse Mental Health Information System (SAMHIS) recovery support data specifications file as indicated in the data specs and as approved and directed by the Division.
 - c. Billing Requirements: Services shall be reimbursed based on the approved service rates listed in the most current RSS manual located on the Division website at <https://dsamh.utah.gov/provider-information/patr-org-program-manual/>. Services that are provided outside of the approved list of services will not be reimbursable. Services that are submitted under “billing contracts” through SAMHIS will be billed automatically through the DSAMH KiSSFLOW system (Currently all PATR Services and Drug Court Services if the Local Authority Chooses). All other invoices submitted for billing must be submitted monthly through the DSAMH KiSSFLOW system. Each RSS funding program must be submitted separately and in accordance to the appropriate funding program code.
- xiii. Utah Behavioral Health Planning & Advisory Council (UBHPAC). Each local authority shall ensure regular attendance at the monthly UBHPAC meetings, preferably by a peer representative but it may be a citizen representative from their respective area.
- xiv. Local Authorities who engage with the First Episode Psychosis (FEP) Mental Health Block Grant (MHBG) set aside programming will recognize funding is dedicated to treatment for those "with early serious mental illness" and those at high risk of serious mental illness, but is not for primary prevention. Coordinated specialty care (CSC) is a recovery-oriented treatment program for people with

first episode psychosis (FEP). CSC promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The client and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin. Participating Local Authorities will recognize that the grant funds cannot be used to supplant current funding of existing activities and will maintain client records, maintain training records, and submit semi-annual reports that follow a template provided by DHS/DSAMH in addition to the following:

- a. Follow the established "Coordinated Specialty Care" (CSC) model adapted from the model found at:
<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosis-manual-i-outreach-and-recruitment.shtml>
- b. Conduct outreach and community education activities to promote community awareness on early psychosis.
- c. Develop an administrative and clinical process/structure to implement the selected CSC, including: A staffing plan, process for training and ongoing supervision of staff, provision of training to staff, monitoring procedure for implementation of the CSC - collaborate with DSAMH to assess and determine how closely the program meets the CSC model, and provide continuous quality improvement processes.
- d. Develop a service delivery process to ensure eligible individuals receive appropriate services regardless of their insurance or funding source: Develop eligibility criteria for the early psychosis program (based on requirements of CSC), Develop screening and assessment process for appropriate individuals (based on requirements of CSC).
- e. Follow DHS System of Care approach to ensure services are strengths-based, family driven and youth-guided, community-based and culturally competent. Treatment plans must prescribe an integrated program of therapies, activities, and experiences to meet the client's treatment objectives and include reasonable measures to evaluate and ensure objectives are met.

- f. Document cultural background and linguistic preferences, incorporate cultural practice into treatment plan and service delivery, provide services in preferred language (bilingual therapist or interpreter).
- g. Set aside a minimum of \$4,000.00 for flexible funds to provide short-term assistance (e.g., one month rent, car repair) to stabilize the life of the individuals who receive early psychosis services.
- h. Conduct evaluations to assess the effectiveness and outcomes of the early psychosis program, create an evaluation plan, collect data as outlined in the evaluation plan, and include the evaluation data in the semi-annual reports.
- i. Provide technical assistance and disseminate information as follows: provide information on lessons learned on the planning and implementation, provide case consultation with other behavioral health providers on an as-needed basis.
- j. Develop a plan for sustaining the Program's financial viability.

C. **MENTAL HEALTH SERVICES**

- i. Local Authorities shall use the "unfunded" State General Funds dedicated to children, youth and adults with mental illness with no funding available in the following manner.
 - a. Each Local Authority is required to spend their portion of the "unfunded" allocation serving unfunded clients. These funds are subject to the County 20% match requirement.
 - b. This money may not be used for Medicaid match, for services not paid for by Medicaid for a Medicaid client, emergency services or inpatient services.
- ii. Data from the OQ or YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart (excluding children age five and under).
- iii. In accordance with 62A-15-105.2. Employment First emphasis on the provision of Supported Employment services. The local authority shall, in accordance with the requirements of federal and state law and memorandums of understanding between the division and other state entities that provide services to a recipient, collaboratively work with other agencies to provide Supported Employment services that assist an eligible recipient in obtaining and retaining competitive,

integrated, meaningful permanent employment.

- iv. Local Authorities shall utilize Wraparound Facilitation (as defined by the Utah Family Coalition and/or Nationally accepted evidence based Wraparound Facilitation Definition) and Multi-Agency Collaboration in the provision of services for Children, Youth and Families. Evidence of compliance shall be determined by discussion with agency staff and observed compliance of Wraparound Facilitation as defined.
- v. Participation in USH Adult and Children Continuity of Care meetings.
 - a. Adult Outplacement funds shall be expended as needed up to a level equal to the funding identified in the allocation letter. Services may include: creative interventions, non-covered Medicaid services, wrap-around supports, housing and recovery enhancement of the patient and must be documented within the plan of care. Outplacement expenditures specific to individual patients must be tracked internally. Eligibility includes patients who are currently receiving inpatient care at USH when current available resources to discharge from USH are inadequate to meet the individual's needs, or patients who are targeted for diversion (diversion is defined as preventing or diverting from USH inpatient admission).
 - b. Written requests for Children's Outplacement Funds are submitted to DSAMH by the LMHA representative for each individual client. Requests are then reviewed at the Children's Continuity of Care meeting. Funding is awarded by committee vote with DSAMH approval. The ultimate decision regarding the use of Outplacement Funds rests with the Children's Behavioral Health Assistant Director.
- vi. Mental Health Early Intervention (MHEI) Funding is reserved for children and youth who may or may not have a Serious Emotional Disturbance (SED) designation, but are at risk to become so without early intervention services. Service provision is limited to Family Resource Facilitation, Mobile Crisis Teams, and School-Based Behavioral Health. This legislative funding requires the tracking of spending and outcomes related to each service provision, per legislative intent language and requires quarterly completion of the attached MHEI Quarterly Data and Annual Outcomes Report. Funds will be allocated on formula and are subject to County 20% match requirement. TANF funds focused on School-Based Behavioral Health for counties with the highest rates of intergenerational poverty shall be allocated according to the previous schedule and tracked by the local authority and submitted to the Division.
- vii. Salt Lake County Behavioral Health, the principal Local Authority involved with Operation Rio Grande, shall provide and/or contract for evidence based practices to improve behavioral health and housing coordination and access to mainstream public health benefits to the target population of homeless and chronically

homeless veterans and other homeless individuals who have behavioral health disorders. The Contractor shall provide treatment, case management and Recovery Support Services based on need through Assertive Community Outreach Treatment (ACOT) to include Housing First, Trauma-informed care, and motivational interviewing. Ensure the assessments of eligible individuals include, but not be limited to, the Service Prioritization and Decision Assistance Tool (SPDAT).

- a. SERVICE POPULATION: The populations to be served are individuals who:
 1. Are 18 years and over;
 2. Have a mental illness and/or co-occurring substance use and mental illness or a substance use disorder only;
 3. Are homeless and chronically homeless veterans and other homeless individuals who have behavioral health disorders;
 4. Are not already receiving public health insurance benefits.

- b. The contractor shall use the Homeless Management Information System (HMIS) for tracking data. In addition to demographics (gender, age, race, and ethnicity) data on all clients served, contractors shall be required to report monthly and/or as required by DSAMH, on the following performance measures:
 1. Abstinence from use,
 2. Housing status,
 3. Employment status,
 4. Criminal justice system involvement,
 5. Access to services,
 6. Retention in services; and
 7. Social connectedness
 8. Number of unduplicated individuals served
 9. Number of unduplicated individuals housed
 10. Number of individuals receiving mental health treatment
 11. Number of individuals receiving substance use treatment
 12. Number of individuals experiencing housing stability six months or longer
 13. Number of individuals with increased enrollment in mainstream benefits
 14. Number of individuals with increased income overall
 15. Number of individuals with increased earned income

- viii. Local Authorities (LA) who engage in Mental Health Crisis Outreach Teams (MCOT) as described in Utah R523-18 will provide services as outlined in Utah R523-18, related Utah Annotated Code as well as the following requirements.

- a. Each fiscal year, the participating LA will submit the following reports to the DHS/DSAMH MCOT/Crisis Services Program Administrator quarterly as follows:
 1. July 1- September 30, due October 20;
 2. October 1- December 31, due January 20;
 3. January 1- March 31, due April 20; and
 4. April 1- June 30, due July 20;

- b. Year-end reports are due July 20 of each year. Year-end reports will include a summary of quarterly data, barriers, objectives met, and program plans for the following year.

- c. Reports will include the following data:
 1. The number of MCOT outreaches performed monthly for both Adult and Youth;
 2. The average response time from initial request to engagement for community outreaches and for law enforcement outreaches. Include an explanation if average response times fall outside of recommendations (Urban: 30 minutes law enforcement response and 60 minutes for community response/Rural: 2 hour response)
 3. The number of MCOT outreaches by Discharge Disposition for both Adult and Youth to include those who:
 - (a) Remained in place;
 - (b) Were hospitalized;
 - (c) Were sent to the emergency department for detox;
 - (d) Were sent to the emergency department for medical reasons or any other reasons excluding detox;
 - (e) Went to the receiving center/crisis walk in center;
 - (f) Were sent to residential;
 - (g) Were sent to JRC/Youth Services;
 - (h) Were incarcerated.
 - (i) Were sent to Social Detox.
 4. Number of Contacts by Referral Source for both Adults and Youth, including:
 - (a) Statewide Crisis Line;
 - (b) Outpatient Provider (Behavioral Health);
 - (c) Outpatient Provider (Physical Health);
 - (d) Self/Family;
 - (e) Law Enforcement;

- (f) School;
 - (g) Any Division within the Department of Human Services (i.e. DCFS, DSPD, JSS, etc).
 - (h) Other – please describe.
5. Local Authorities/MCOT teams will provide details of the outcome and plan of each MCOT outreach as described in section 3 to the statewide crisis line within 24 hours of the outreach. Each Local Authority will arrange for business case agreements to allow the sharing of this information in accordance with applicable State and Federal Law.
 6. Number of Contacts by Insurance Type
 - (a) Medicaid;
 - (b) Medicare;
 - (c) Private Insurance;
 - (d) None;
 - (e) Unknown;
 - (f) Not Collected;
 7. Number of mobile referrals not dispatched including if or why:
 - (a) There was inadequate staffing;
 - (b) The client denied services or withdrew the request;
 - (c) The client presentation changed/De-escalated;
 - (d) The client needed higher level of care including law enforcement;
 - (e) Other- please describe,

D. SUBSTANCE USE DISORDER TREATMENT SERVICES

- i. Local Substance Abuse Authority treatment programs shall provide Naloxone education, training and assistance to individuals with opioid use disorders and when possible to their families, friends, and significant others.
- ii. Funds allocated by DSAMH shall not be expended by any agency which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine).
 - a. Clients shall be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate

medication treatment for the individual's opioid use disorder.

- b. Medications available by prescription or office-based implantation shall be permitted if it is appropriately authorized through prescription by a licensed prescriber or provider.
- c. In all cases, medications shall be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial.
- d. Entities in receipt of funds shall assure that clients will not be compelled to taper or abstain from medications as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

iii. Drug Courts:

- a. Drug Courts shall comply with the following requirements:
 - 1. All Drug Courts shall be certified by the Administrative Office of the Courts in accordance with Utah Judicial Council Rule 4-409, and retain certification throughout the contracted period. This rule is available online at: <http://www.utcourts.gov/resources/rules/ucja/ch04/4-409.htm>
 - 2. All Drug Courts shall serve participants identified as High Risk/High Need by using a validated criminogenic risk tool.
 - 3. Documentation of High Risk/ High Need shall be placed/ maintained in each participant's clinical record.
 - 4. Drug Court Service Reports or any alternative data collection system adopted by DHS/DSAMH are to be submitted annually, and as requested to the DHS/DSAMH Justice Program Manager.
 - 5. All participant fees related to Drug Court participation (treatment, case management, drug testing, court fees etc.) shall be disclosed to individuals prior to their admission.
 - (a) All fees shall be based on the fee policy and fee schedule approved by the local authority.
 - (b) Copies of the fee schedule and the fee reduction policy shall be submitted to DHS/DSAMH and the Administrative Office of the Courts (AOC) as part of the LSAA Area Plan each year.
 - 6. Consistent with ii above, have no prohibitions against Medication Assisted Treatment (MAT) or a requirement to be abstinent from medications used in addiction treatment in order to enter drug court, progress or complete drug court. Drug Courts or LA that are non compliant may have funding withheld.
 - 7. Ensure each Drug Court program team member, who interacts or has decision-making authority regarding the participants of the Drug Court process; attend a minimum of eight hours of continuing education per year. The continuing education shall have a focus on substance use

- disorders.
8. If a Drug Court participant is in an evaluation or research as part of a federal grant, the Drug Court shall submit a copy of the evaluations and research to the DHS/DSAMH Justice Program Manager within 90 days of completion of the evaluation and research.
 9. Drug Court funds shall be used for treatment, case management, recovery support and drug testing expenses.
 10. DHS-DSAMH Drug Court funds shall not be used to pay for law enforcement, tracking or supervision conducted by law enforcement officers.
 11. Drug Courts shall ensure that participants meet with the Department of Workforce Services (DWS) and/or health care navigators to determine eligibility for Medicaid, other public insurance or commercial insurance.
 - (a) LA shall ensure that drug court participants receive assistance throughout their episode of care with Medicaid enrollment.
 12. LA shall ensure that public funds are the payor of last resort.
 13. Drug Court Funding shall be determined in accordance with statute by the Director of the Department Human Services the Director of the Department of Corrections and the State Courts Administrator.
 14. Drug Courts that are non-compliant with Drug Court certification standards as cited above in section iii may have drug court funding withheld by DSAMH.
 15. LA's will notify DSAMH of any court changes including court closures, changes in Judges or court coordinators.
- iv. Drug-Related Offenses Reform Act (DORA)
- a. Funds Available and Allowable Uses
 1. Funds appropriated by the Legislature for DORA are not subject to any matching requirement.
 2. DORA funds may not be used to replace or supplant funds from other sources that have been appropriated for the same purpose.
 - b. Evidence-based Treatment Requirement
 1. Services shall adhere to the standards prescribed in R523-4. Screening, Assessment, Prevention, Treatment and Recovery Support Standards for Adults Required to Participate in Services by the Criminal Justice System.
 2. Services shall be provided by programs certified by the Division of Substance Abuse and Mental Health to provide treatment for persons involved in the criminal justice system.
 3. Eligibility for DORA is based on the most current criteria approved by the USAAV+ Council.
- v. Women's SAPTBG set aside.

- a. Funds shall be used to serve pregnant women, and women with dependent children in need of substance use disorder treatment.
 - b. Funds may be used to provide: Treatment services at the I.0, II.1, II.5, III.1, III.3, and III.5 American Society of Addiction Medicine (ASAM) Levels of Care, as defined in the American Society of Addiction Medicine's (ASAM) Criteria 3rd Edition (ASAM);
 - c. Funds may also be used to provide any of the following services:
 - 1. Gender-specific substance use disorder treatment and other therapeutic interventions for women that address issues of trauma, relationships, sexual and physical abuse, vocational skills, networking, and parenting;
 - 2. Child-care while the women are receiving services;
 - 3. Therapeutic interventions for the children which may address their developmental needs, their potential for substance use disorders, and their issues of sexual and physical abuse and neglect;
 - 4. Sufficient case management and transportation services to ensure the women and their children have access to the services listed above; and
 - 5. Regular Urinalysis (UA) testing;
 - 6. Ongoing assessment of the children who are in the mothers and children's programs that will include, but not be limited to: developmental adjustment; motor skills; cognitive skills; health, including immunization history; interaction with mother and other adults; language and general affect.
- vi. FY19 State General Funds for children living with parents receiving residential substance use disorder treatment services:
- a. Funds shall be used to pay for the following services:
 - 1. Room and board.
 - 2. Therapeutic day care to address developmental needs, their potential for substance use disorders, and their issues of sexual and physical abuse and neglect.
 - 3. Case Management and transportation for behavioral and physical health care services
 - 4. Ongoing assessment that will include, but not be limited to: developmental adjustment; motor skills; cognitive skills, health, including immunizations history; interaction with mother and other adults; language and general affect.
- vii. Women's Funds.
- a. Funds shall be used to provide evidence-based treatment and/or recovery support services for women. Priority shall be given to women referred or involved with the Utah Division of Child and Family Services.

viii. Utah Quality Youth Treatment Project

- a. Local Authorities shall participate in the Utah Quality Youth Treatment Project to evaluate the quality of their youth substance use disorder treatment programs and implement the following 10 key principles:
 1. Screening/Assessment
 2. Attention to Mental Health
 3. Comprehensive Treatment
 4. Developmentally Informed Programming
 5. Family Involvement
 6. Engage and Retain Clients
 7. Staff Qualification / Training
 8. Continuing Care / Recovery Support
 9. Person-First Treatment
 10. Program Evaluation

viv.. Opioid Treatment and Recovery Support Funds:

- a. DSAMH shall allocate a portion of the federal Opioid STR grant funds to the LSAs on formula and may allocate additional funds based on demonstrated need for provision of evidence-based treatment and recovery supports services for individuals with opioid use disorders (OUD).
- b. LSAs shall demonstrate that services are consistent with all grant requirements, and funds expand current capacity.
- c. DSAMH shall require each LSA to submit with the FY2019 Area Plan a local needs assessment, detailed description of planned services and a budget.
- d. Allowable uses for this funding will be limited to:
 1. Services provided by federally certified Opioid Treatment Programs (OTP) to individuals with OUD.
 2. Services provided by Office Based Treatment providers to treat OUD using MAT.
 3. Provision of evidence based-behavioral therapies for individuals with OUD.
 4. Support innovative telehealth in rural and underserved areas to increase the capacity of communities to support OUD prevention and treatment.
 5. Implement or expand access to clinically appropriate evidence-based practices (EBPs) for OUD treatment, particularly, the use of MAT, i.e., the use of FDA-approved medications (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine) in combination with psychosocial interventions.
 6. Provide treatment transition and coverage for patients reentering

- communities from criminal justice settings or other rehabilitative settings.
7. Enhance or support the provision of Peer Support and other RSS designed to improve treatment access and retention and support long-term recovery to include relapse and suicide prevention efforts.
 8. Funds shall be allocated to LSAAs using the formula established in Administrative Rule.

E. **SUBSTANCE USE DISORDER PREVENTION SERVICES**

- i. Local Authority shall follow the Strategic Prevention Framework (SPF) developed by the Substance Abuse Mental Health Services Administration (SAMHSA) to implement comprehensive community level prevention systems within their area. DSAMH encourages LSAA to utilize the Communities that Care model to meet this directive.
- ii. Local Authority shall produce a comprehensive Strategic plan that includes narrative describing actions to complete the following:
 - a. Assess local prevention needs based on epidemiological data. This assessment shall include the most current Student Health and Risk Prevention Survey (SHARP) data and additional local data.
 1. Assessments shall be done at minimum every two years. Assessments shall be reviewed at least annually and amendments made as necessary.
 2. Identify process used to prioritize consumption behaviors, risk and protective factors and outcomes.
 3. Describe community readiness, available resources, strengths and gaps.
 4. Resources that shall be used to perform the assessment include, but are not limited to:
 - (a) <http://bach-harrison.com/utsocialindicators.html>
 - (b) <http://ibis.health.utah.gov>
 - (c) [Community Readiness surveys, such as http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf](http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf)
 - (d) Communities that Care, Community Assessment Training (CAT) <http://www.communitiesthatcare.net/getting-started/ctc-training/>.
 - b. Build prevention capacity within their area. The key components of capacity building include:
 1. Increasing the availability of fiscal, human, organizational, and other resources.
 2. Raising awareness of substance use disorder and other related problems and readiness of stakeholders to use evidence based prevention to

- address these problems.
3. Readiness of stakeholders to use evidence-based prevention to address these problems.
 4. Strengthen existing partnerships and/or identify new opportunities for collaboration. Some activities include but are not limited to:
 - (a) Building and supporting coalitions
 - (b) Training, including travel/conferences
 - (c) Engaging community stakeholders
 - (d) Educating service providers
 5. Developing and preparing the prevention workforce by ensuring that all prevention personnel (excluding support staff), including contracted staff, are certified in the Utah Substance Abuse Prevention Specialist Training (SAPST). It is an option between FY2019 and FY2020 to certify all local authority prevention coordinators in Universal Prevention Curriculum (UPC).
 6. Identify all trainings needed and planned to complete in current fiscal year.
 7. Prevention workers have completed all necessary certification and training requirements for the programs they implement and deliver.
 - (a) List all staff/contractors and certifications for programs, including dates of training and certification.
- c. Develop a strategic plan that is comprehensive, logical and data driven to address the problems identified during assessment with the current and future capacity developed. Post this plan publicly.
1. There shall be a minimum of one (1) strategic plan per LSAA. Within the plan, LSAAs shall identify prioritized communities. Each prioritized community shall have a strategic plan.
 2. LSAAs Strategic plan shall include how the LSAA will work with and support coalitions in their strategic plan.
- d. The LSAA may use federal funding provided under the FPL code to implement the Communities That Care coalition model as part of their area plan. The LSAA may request an additional \$10,000 FPL per year for five years to hire a CTC coordinator. The funding amount must be matched by the participating county, city or community partner. The LSAA must adhere the following guidelines:
1. Hire a CTC Coordinator and implement the CTC process.
 - (a) CTC coordinator must serve on the county's prevention coalition as the CTC coordinator and work closely with the LSAA prevention coordinator to ensure CTC is implemented with fidelity.
 - (b) The CTC/FPL funding must be matched by both dollars and in-kind contributions by county, city or community partners.
 - (c) Funds are primarily to be used for the CTC Coordinator position but the LSAA may use a portion of these funds, with permission from DHS/DSAMH program manager, to fund additional

- prevention activities as described in the CTC model as found at www.communitiesthatcare.net.
2. The LSAA shall:
 - (a) Ensure CTC training and technical assistance to the CTC coordinator within 60 days of coordinator hire date and proceeding as outlined in the CTC planning model found at www.communitiesthatcare.net.
 - (b) Monitoring the CTC Coordinator's performance to ensure fidelity to the CTC program guidelines. Annual checklists shall be kept on file.
 - (c) Using DSAMH approved CTC report template, provide annual progress reports, due December 31 of each year to the DHS/DSAMH program manager that shall include progress reports on the phases of CTC implementation.
 3. The CTC Coordinator shall be certified in the Substance Abuse Prevention Specialist Training and CTC coordinator training within one year of coordinator's start date. The LSAA must email or fax a copy of the completion certificates to the DHS/DSAMH program manager within one month of the completion date. Develop a strategic plan that is comprehensive, logical and data driven to address the problems identified during assessment with the current and future capacity developed. Post this plan publicly.
- e. Ensure that effective, evidence based community prevention programs, policies and practices are being implemented with high- fidelity as defined in the Communities of Care model, Community Plan Implementation Training Module 3 (http://www.sdrg.org/ctcresource/Community%20Plan%20Implementation%20Training/Trainer%20Guide/CPIT_TG_mod3.pdf).
 1. LSAA's will identify tools or techniques to ensure high fidelity of implementation of prevention programs, policies and practices.
 - f. Use DSAMH approved logic models as the basis for the evaluation plan and to demonstrate expected short and long term outcomes for each policy, practice and/or program implemented. Logic models shall also collect target populations and brief descriptions of programs, policies, and practices. Review and update as needed.
 - g. Submit an annual report by November 15th of each year that summarizes performance of prevention programs policies and strategies based on the short and long term outcomes identified in the approved logic models.
 - h. All LSAA's will receive SAPT Block Grant and all prevention discretionary grant funding via allocation letters at the beginning of each fiscal year. Each LSAA shall spend a minimum of 30% of SAPT Block Grant funds on prevention policies, programs, strategies, and administration. A budget for all

prevention discretionary funding must be submitted. All expenditures must adhere to OMB Circular A-87 spending and grant reporting requirements for use of federal funds to determine all costs and reimbursements with DSAMH. A copy of the OMB document will accompany these directives.

- i. Use principles as outlined in the NIDA Research Guide for Preventing Drug Use Among Children and Adolescents (Redbook) as a guide for implementing the Strategic Prevention Framework.
http://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf
- j. Increase the number of evidence-based policies, programs and strategies to a standard of 90%. The remaining 10% of prevention policies, programs and strategies are to be research informed with a plan to be submitted to Evidence Based Workgroup (EBW) within one year.
 1. The evidence- based policies, programs and strategies shall be broken down as follows:
 - (a) A minimum of 90% of the policies, programs and strategies shall be tier 3 or 4 per PART, or be programs listed on a national evidenced based registry approved by DSAMH.
 - (b) A maximum of 10% of the policies, programs and strategies may be tier 1 or 2 per the program assessment rating tool Program Assessment Rating tool (PART). PART is available on the DSAMH website.

F. **MENTAL HEALTH AND SUBSTANCE USE DISORDER DATA**

- i. Substance Use Disorder and Mental Health Data Reporting Deadlines
 - a. All information and outcomes system data are to be submitted electronically.
 - b. Providers will submit the substance use disorder “Treatment Episode Data Set” (TEDS) and/or the mental health “Mental Health Event Data Set” (MHE), Recovery Support Services (RS) and Indicated Prevention (IP) data monthly for the prior month (on or before the last day of every month).
- ii. Substance Use Disorder, Mental Health, and Indicated Prevention Data and Outcome Reporting Requirements
 - a. The Information System Data Set for Mental Health is the MHE.
 - b. The Information System Data Set for Substance Use Disorders is the TEDS.
 - c. The Information System Data Set for Recovery Support Services is the RS.
 - d. The Information System Data Set for Indicated Prevention is IP.

- e. Data Specifications are available for download from the DSAMH website at <http://dsamh.utah.gov/data/data-specifications/>.
- f. Electronic submissions must be made through the SAMHIS file utility app, or other method as instructed by DSAMH staff.
- g. Outcomes system for Mental Health data includes:
 - 1. Adults:
 - (a) OQ[®] 45.2 - Adult Outcome measure (ages 18+);
 - (b) OQ[®] 30.0 – Adult Outcome measure (ages 18+);
 - (c) SOQ[®] 2.0 - SPMI Outcome instruments (self or clinician); and
 - (d) Mental Health Statistical Improvement Program (MHSIP) Consumer Survey.
 - 2. Children/Youth:
 - (a) YOQ[®] 30.1;
 - (b) YOQ[®] 2.01 - Youth Outcome measure (ages 4-17);
 - (c) YOQ[®] 2.01SR - Youth Outcome measure (ages 12-18);
 - (d) YOQ[®] 30.1 - Omni form Youth Outcome measure (ages 4-17); and
 - (e) YOQ[®] 30.1SR Omni form Youth Outcome measure (ages 12-18).
 - (f) Youth Satisfaction Survey (YSS) Consumer Survey.
 - 3. Parents/Youth:
 - (a) Parents Satisfaction Survey: (YSS-F) Consumer Survey; and
 - (b) Youth Satisfaction Survey: (YSS) Consumer Survey.
- h. Outcomes system for Substance Use Disorder data includes:
 - 1. Adults:
 - (a) Mental Health Statistical Improvement Program (MHSIP) Consumer Survey.
 - 2. Children/Youth:
 - (a) Youth Satisfaction Survey (YSS) Consumer Survey.
 - 3. Parents/Youth:
 - (a) Parents Satisfaction Survey: (YSS-F) Consumer Survey; and
 - (b) Youth Satisfaction Survey: (YSS) Consumer Survey.
- i. OQ Measure instruments are to be completed in the OQ Analyst Hosted System (OQA-HS).
- j. Data findings may result for substance use disorder providers when old open non-methadone outpatient or intensive outpatient admissions, opened more than 2 years prior (and clients are no longer in service), account for more than 4% of clients served for a given fiscal year, or for any residential and/or detox admissions open for more than 2 years prior.
- k. Data findings may result if performance measures and/or scorecard results, used for contract monitoring, are determined to be inaccurately reported by the provider.

1. Providers who contract out for services are required to report client service data to the Division for these clients regardless of where that service is being provided.
 - m. With emphasis on Employment First, mental health providers will update employment status in event files in accordance with the published data specification.
- iii. Adult and Youth Consumer Satisfaction Surveys
- a. The Mental Health Statistical Improvement Program (MHSIP) Method
 1. Introduction: The MHSIP is a self-report consumer satisfaction survey for adults in mental health and/or substance use disorder treatment. The survey results are used for reporting information to the Federal Government, for the Mental Health Block Grant, for annual reporting, to assess client perception of treatment and to improve services to consumers.
 2. Data Collection Procedures: The MHSIP is a survey, available in English and Spanish. The MHSIP is given as a point-in-time convenience survey during the approved survey period (from December 1st through April 1st of every year). Instruments are to be completed electronically through the OQ Analyst System, through a website, or other method as instructed by DSAMH staff. Surveys administered after the approved time period will not be used in scoring and analysis. The surveys are given to adult substance use disorder and mental health consumers regardless of the modality of treatment or length of stay in treatment.
 3. Scoring and Data Analysis:
 - (a) Completed survey data is analyzed by DSAMH. Aggregate numbers for the State and specific data for the center/county are then returned to the center.
 - (b) A minimum sample rate of 10% of the number of annual unduplicated clients served for the prior year is required by all providers. Providers returning less than 10% will be considered deficient and will receive a finding in the audit report.
 - (c) Providers who receive less than 75% of the established target for the outcome domains may receive a finding in the audit report.
 - (d) Trend arrows on the scorecard will only indicate a trend upward or downward when there is a change in the score color.
 - b. YSS/YSS-F METHOD
 1. Introduction: There are two parallel versions of the survey for youth in substance use disorder and/or mental health treatment, one for youth (YSS) and one for children and youth's parent or caregiver (YSS-F).

The survey results are used for reporting information to the Federal Government, for the Mental Health Block Grant, for annual reporting, to assess client perception of treatment and to improve services to consumers.

2. Data Collection Procedures: The YSS and YSS-F are surveys, available in English and Spanish. The YSS and YSS-F are given as point-in-time convenience surveys during the approved survey period (from December 1st through April 1st of every year). Instruments are to be completed electronically through the OQ Analyst System, through a website provided by DSAMH, or other method as instructed by DSAMH staff. Surveys administered after the approved time period will not be used in scoring and analysis. The YSS survey is given to open youth (ages 12-17) substance use disorder and/or mental health clients, regardless of the modality of treatment or length of stay in treatment. The YSS-F survey is given to the parent or caretaker of the children/youth consumer.
3. Scoring and Data Analysis:
 - (a) Completed survey data is analyzed by DSAMH. Aggregate numbers for the State and specific data for the center/county are then returned to the center.
 - (b) Providers who receive less than 75% of the established target for the outcome domains may receive a finding in the audit report.
 - (c) A minimum sample rate of 10% of the number of annual unduplicated clients served for the prior year is required by all providers. Providers returning less than 10% will be considered deficient and will receive a finding in the audit report.
 - (d) Trend arrows on the scorecard will only indicate a trend upward or downward when there is a change in the score color.
 - (e) Only youth 12-17 will be counted in clients served for the YSS, but all children/youth under the age of 18 will be counted in the client counts for the YSS-F.

iv. OQ/YOQ Requirements and Reporting Guidelines:

- a. DSAMH requires a 50% utilization rate for the LMHA for clients served in publicly funded programs. The instruments will require repeated administrations.
- b. DSAMH will require that the OQ/YOQ be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt).
- c. DSAMH recommends that for ease of internal monitoring of these minimum frequency requirements, and to increase clinical effectiveness, providers are encouraged to administer the instruments at every encounter for relevant

services. The instruments are to be completed by the patient/consumer or by the parent/guardian for consumers under the age of 12.

- d. The OQ/YOQ should be included in and adopted as part of the standard intake and ongoing clinical protocol. DSAMH requires policy to be in place that prescribes the appropriate clinical response, follow-through, and patient, family, or guardian involvement for the empirical results of the OQ/YOQ.
- e. Scoring and Data Analysis:
 1. DSAMH will be a user of this system, similarly to LMHAs, and will obtain results directly from the OQ Analyst system. DSAMH will use results to evaluate program and patient treatment effectiveness. Aggregated results of data analysis and reporting will be shared with LMHAs and used to inform others regarding system effectiveness and clinical best practice.
 2. Clients who receive an assessment only service, or are served while in jail during the course of the reporting period, will be excluded from the client served denominator.
 3. Children 5 and under will be excluded from the client served denominator.
 4. LMHAs will be required to satisfy frequency requirements for a majority of the annual unduplicated number of clients served (denominator used for clients participating scorecard measure).
 5. LMHAs who do not satisfy the minimum frequency requirements for a majority of their annual unduplicated number of clients served may be reported in the scorecard as red and may receive a finding in the audit report.
 6. Client match rates must exceed 90% for the provider to be included in the outcome results. This will result in the provider not having results shown on the scorecard with insufficient data and may result in a finding. It is highly recommended that providers incorporate the client demographic Web Services Interface (WSI) into their Electronic Health Record (EHR) so identifying data items are kept accurate in the OQA system.
- v. Substance Use Disorder Universal and Selective Prevention Data: The Local Authority shall enter prevention data into the DSAMH approved system within 60 calendar days of the delivery of service.

G. **PERFORMANCE MEASURES**

- i. For all performance measures, the Division shall continue to work with ROSC and PDC in order to determine performance measures that will best represent a recovery-oriented system of care. Those measures shall be made available as soon as approved and communicated through UBHC Directors.
- ii. Mental Health Performance Measures:

- a. The mental health scorecard shall be used to measure performance. Monitoring reports for FY2019 shall contain automatic findings resulting from any red scores, a yellow score shall indicate need for further review and a green (or black) score shall be reported as a positive outcome in the monitoring report.
 - b. Performance indicators on the scorecard will be reviewed with the centers by the Division during monitoring visits.
 - c. For successful performance, the Local Mental Health Authorities shall meet or exceed their previous year numbers, average, or percent (as applicable) for the following measures: Supported Employment; Percent Employed (full time, part time, or supported employment) divided by the number of clients in the workforce (full time, part time or supported employment and/or unemployed but seeking work); Enrolled/Attendance in School; Supported Housing; Clients Served; Unfunded Clients Served; Percent in Need Served; Percent in Need SPMI/SED Served and Clients Served in Jail/Justice Services. Providers are encouraged during FY2019 to focus on percent increase or decrease, during an annual reporting period, for the Mental Health National Outcome Measures (NOMs); (Clients Served, Employment, School Enrollment/Attendance, and Criminal Justice Involvement).
- iii. Substance Use Disorder Treatment Performance Measures FY2019: Achievement of these measures will be reviewed in the annual site visit.
- a. Retention in Treatment: Local Substance Abuse Authorities will meet or exceed their FY2018 treatment retention in FY2019 and will work towards achieving a goal of 70%. Local Substance Abuse Authorities whose FY2018 retention rate was over 70% are required to meet or exceed a 70% retention rate in FY2019. Retention is defined as the percentage of clients who remain in treatment over 60 days.
 - b. Successful Treatment Episode Completion: Local Substance Abuse Authorities will meet or exceed their FY2018 Successful Treatment Episode Completion rates in FY2019 and will work towards achieving a goal of 60%. Local Substance Abuse Authorities whose FY2018 completion rate was over 60% are required to meet or exceed a 60% completion rate in FY2019. Successful Treatment Episode Completion is defined as a successful completion of an episode of treatment without a readmission within 30 days. An episode of treatment is defined in the Treatment Episode Data Set.
 - c. Abstinence from Alcohol: Local Substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of clients who are abstinent from alcohol from admission to discharge at a rate that is greater than or equal to 75% of the national average. Abstinence from alcohol is

defined as no alcohol use for 30 days.

- d. **Abstinence from Drugs:** The Local Substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of clients who are abstinent from drugs from admission to discharge at a rate that is greater than or equal to 75% of the National Average. Abstinence from drugs is defined as no drug use for 30 days.
 - e. **Increase in Employment:** Local substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of their clients who were employed full/part time or enrolled as student from admit to discharge at a rate greater to or equal to 75% of the national Average.
 - f. **Decrease in Criminal Activity:** Local Substance Abuse Authorities' Outcome Scorecard will show that they decreased the percentage of their clients who were involved in criminal activity from admission to discharge at a rate greater to or equal to 75% of the national average. Criminal activity is defined as being arrested within the past 30 days.
 - g. **Recovery Support:** Local Substance Abuse Authorities' Scorecard will show that the percent of clients participating in social support recovery activities increased from admission to discharge by at least 10%. Participation is measured as those participating in social support recovery activities during the 30 days prior to discharge minus percent of clients participating in social support of recovery activities in 30 days prior to admission
 - h. **Tobacco Cessation:** Local Substance Abuse Authorities' scorecard will show that the percent of clients who use tobacco will decrease from admission to discharge by 5%.
- iv. **Substance Use Disorder Prevention Performance Measures:**
- a. All Universal and Selective prevention services entered in DSAMH approved data system accurately and within 45 days of services.
<https://easy.dhs.utah.gov/dhseasy/planAction.do> All Indicated Prevention services entered in SAMHIS by the end of the month following the month of delivery.
 - b. Percent of retail establishments within Local Authority area that refused to sell tobacco to minors during Synar tobacco compliance checks. (Target for FY2019 is 90%.)
 - c. Percentage of students in each grade (6, 8, 10, 12) using alcohol during the past 30 days (will use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017).

- d. Percent of students in each grade (6, 8, 10, 12) using illegal drugs during the past 30 days (will use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017).
 - e. Number of “Eliminate Alcohol Sales to Youth” (EASY) alcohol compliance checks within Local Authority area. (Target for FY2019 is an increase from the previous year.)
 - f. Number of coalitions that prioritize substance use related risk and protective factors (as found on www.dsamh.utah.gov) in local substance abuse authority area. The coalitions should be defined by one of the following:
 - 1) serving one of the 64 small areas within Utah
 - 2) serving the communities that feed into a common high school
 - 3) serving a community population of no more than 50,000 residents
 - g. Annually report to DSAMH actual number and costs of evidence based policy, programs and strategies. FY2019, monthly invoices shall include costs of evidence based policy, programs, and strategies.
- v. Recovery Support Performance Measures
- a. Local Substance Abuse and Mental Health Authorities will work with DSAMH to identify performance metrics designed to evaluate cost, quality, access and person centered outcomes.



DORA 4: Guidelines for the Implementation of DORA-Funded Services

APPROVED BY THE UTAH SUBSTANCE USE AND MENTAL HEALTH ADVISORY COUNCIL ON APRIL 25, 2017

DORA Eligibility Criteria

- Individual must be convicted of a class A misdemeanor or felony offense.
- Individual's total score on the Level of Service/Risk, Need, Responsivity screen (LS/RNR) must fall within the range of 15-43.
- Individual's score on the Alcohol/Drug Problems (ADP) scale of the LS/RNR must be 4 or higher.
- Individual's score on the Texas Christian University Drug Screen (TCUDS) must be 4 or higher.

The DORA Process

- Individual is pre-screened to eliminate those not eligible for DORA-funded services.
- Individual is screened by AP&P utilizing the LS/RNR.
- Individuals who are screened and meet the DORA criteria are assessed by the Local Substance Abuse Authority agency utilizing a comprehensive substance use disorder assessment instrument in compliance with current Division of Substance Abuse and Mental Health (DSAMH) standards (R523-4), to determine level of treatment needed.
- Review by the local DORA team of the combined LS/RNR results and initial recommended level of treatment that may result in a modification of the supervision level and treatment modality for the individual.
- Release of information form is obtained from the individual to participate in DORA-funded services and in program evaluation.
- Pre-Sentence Report (PSR) prepared by AP&P will indicate if the individual is eligible for DORA-funded services and recommend a level of treatment and a treatment program based on the assessment by the Local Substance Abuse Authority agency, and a level of supervision as indicated by the LS/RNR. If the assessment is not completed prior to sentencing, the PSR will reflect eligibility for DORA-funded services pending the assessment to determine level of treatment needed.
- Substance use disorder treatment order is to be included in the Judgment and Commitment issued by a Utah court or a special condition imposed by the Board of Pardons and Parole.
- DORA participant to be case managed by AP&P DORA agent in consultation with treatment provider.
- Outcomes measurement will be administered by the treatment agency and overall outcomes will be tracked by CCJJ within appropriation.

DORA Screening and Assessment

- Pre-screen to eliminate the following, who are **not** eligible for DORA-funded services:
 - Out-of-state detainers
 - Immigration holds
 - U.S. Marshal holds
 - Mandatory commitments to prison
 - Individuals who are seriously and persistently mentally ill (SPMI)
- DORA Screening and Assessment:
 - Ordered by a Utah court or the Board of Pardons and Parole for a class A misdemeanor or felony offense
 - Conducted by AP&P utilizing the established criteria
 - Assessment conducted with a comprehensive substance use disorder assessment instrument, in compliance with current DSAMH standards (R523-4) and within appropriation.

DORA Treatment Standards (R523-4)

Program Standards for Community-Based Treatment Programs

- All programs shall maintain the appropriate license from the Department of Human Services Office of Licensing for the type(s) of services provided.
- Treatment programs shall:
 - Ensure that public funds are the payor of last resort and:
 - Coordinate or refer individuals to the Department of Workforce Services or healthcare navigators for assistance with eligibility for public or private insurance plans.
 - May negotiate and assess usual and customary fees to adults.
 - All substance use providers complete and submit the National Survey on Substance Abuse Treatment Services (N-SSATS), and all mental health providers complete the National Mental Health Services Survey (N-MHSS).

- All public substance use providers, including the Local Substance Abuse Authorities and their contracted providers, shall submit Treatment Episode Data (TEDs) admission and discharge data as outlined in the Division's most current Division Directives.
- Programs seeking a quality certification that provides services to justice involved individuals shall:
 - Evaluate all participants for criminogenic risk and need, and deliver services that target the specific risk and needs identified;
 - Ensure individuals with high risk and individuals with low risk to re-offend are treated separately;
 - Provide multi-dimensional treatment that targets the validated criminogenic risk factors; and
 - Coordinate and communicate with Adult Probation and Parole, county sheriff's offices, or other necessary criminal justice agencies on a regular and consistent basis as agreed.

Treatment Standards for Community-Based Treatment Programs

- Treatment intensity, duration and modality for:
 - Substance use disorders shall be based on the current ASAM criteria; and
 - Mental health disorders shall be determined by the clinical assessment process and medical necessity.
- Treatment programs shall:
 - Have qualified staff licensed and capable of assessing individuals for both mental health and substance use disorders;
 - Develop strategies to screen for, prevent, and refer to treatment adults with serious chronic conditions such as, but not limited to, HIV/AIDS, Hepatitis B and C, and tuberculosis;
 - Ensure that assessment is an ongoing component of treatment;
 - Diagnose, treat or ensure treatment for co-occurring conditions;
 - Ensure treatment participation and length shall be of sufficient dosage/duration to affect stable behavioral change and long term recovery supports;
 - Develop an individualized treatment plan that identifies a comprehensive set of tools and strategies that address the client's identifiable strengths as well as their problems and deficits; and
 - Provide comprehensive treatment services that includes but is not limited to:
 - Developmentally appropriate and informed treatments;
 - Recognition of gender, cultural, linguistic, and other individual differences in the treatment approach;
 - Ensuring all individuals with alcohol and/or opioid disorders are educated and screened for the potential use of medication-assisted treatment;
 - Monitoring drug use through drug testing and other means;
 - Individuals testing positive for drugs or alcohol shall not be denied entry to or removed from a treatment program solely for positive drug tests;
 - All public substance use providers, including the Local Substance Abuse Authorities and their contracted providers shall comply with all Division Directives for drug testing as published in the annual DSAMH Division Directives and/or preferred practice guidelines;
 - As appropriate and with consent, involve families and support persons in the treatment and recovery process; and
 - Provide naloxone education, training and assistance to individuals with opiate use disorders and when possible to their families, friends, and significant others.
- Treatment programs shall work with individuals to identify needed and desired recovery supports and ensure that:
 - Participation in recovery support shall be voluntary; and
 - Whenever possible, individuals are encouraged and given a choice of potential recovery support services and a choice of programs.
- Services such as case management, housing, employment training, transportation, childcare, healthcare, peer support and other social supports shall be strongly considered and implemented if appropriate before, during and after the completion of acute treatment services.

Collaboration Standards

- Treatment providers shall report to AP&P:
 - Non-compliance with treatment within 24 hours;
 - Treatment completion within 24 hours;
 - UA results weekly or within 24 hours for positive tests; and
 - Weekly updates on progress in treatment (either via weekly staff meeting [urban] or through written or oral reports delivered to the AP&P agent [rural]).
- Discharge planning shall be a collaborative effort involving Adult Probation and Parole (AP&P), treatment providers, the DORA participant, family members and other community supports, and shall include a formal plan for recovery support and transition services, as well as a plan for continued AP&P supervision. Discharge summaries shall include this coordinated plan.

DORA Supervision Standards for Davis, Salt Lake, Utah and Weber Counties

- AP&P will follow the Standards of Supervision for DORA CASELOADS developed by the Utah Department of Corrections, with additional requirements outlined below:
- Start of Treatment
 - Hand-off meeting with DORA participant, assessor, agent and provider
 - Release of information
 - Review treatment plan
 - Discuss consequences of program failure/success
- During Treatment
 - Frequent communication on DORA participant's progress/violations
 - Case management team approach
 - Random, frequent, and observed urinalysis tests
 - Immediate response to problems
 - Positive reinforcement
- Conclusion of Treatment
 - Collaborative discharge planning involving Adult Probation and Parole (AP&P), treatment providers, families, and other community supports
 - Pre-release planning for recovery support services
 - Consequence of unsuccessful completion and alternatives
 - A face-to-face meeting will be held with AP&P and the treatment provider to develop the treatment discharge plan, including continued supervision

DORA Supervision Standards for Cache, Carbon, Emery, Iron, Tooele and Washington Counties

- AP&P will follow the Standards of Supervision outlined by the Utah Department of Corrections, with possible modifications made in collaboration with the Local Substance Abuse Authority agency (treatment provider)
- Random, frequent, and observed urinalysis tests conducted by the Local Substance Abuse Authority agency during treatment phases

DORA Funding Mechanism

- Following annual approval of the DSAMH Local Substance Abuse Authority funding plan by the Utah Substance Use and Mental Health Advisory Council, the DSAMH will award funds to participating Local Substance Abuse Authorities.
- Where appropriate, Local Substance Abuse Authorities will contract with treatment providers.
- DORA funds may not be used to pay for mental health services for seriously and persistently mentally ill (SPMI) individuals.

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Changes made to FY2019 Division Directives

Division of Substance Abuse and Mental Health

A. Governance and Oversight

ii. The Area Plan packet must include the completed Forms A, A1, A2, B, C, D and the required fee policy and fee schedule, pursuant to Administrative Rule Section R523-1-5. The Area Plan packet must be completed by May 15, 2018 through the electronic medium designated by the Division [shared DSAMH/Local Authority Google Drive folder](#).

iv. ~~The Local Authority shall meet an overall client cost within fifty (50) percent of the statewide Local Authority overall average cost per client and within twenty-five (25) percent of their previous year actual cost per client. If the Local Authority does not fall within the overall average cost, the Division will contact the Local Authority to discuss whether or not accurate data has been submitted. If the data is not accurate, the Local Authority will resubmit the correct financial or cost data. Client data cannot be changed for the prior year after August 15th. If the data is correct, the Local Authority shall identify and explore reasons for the outliers and provide rationale for the outliers through area plan or another written response.~~

[In regards to 62A-15-103. Division -- Creation -- Responsibilities, the division shall "\(a\) \(viii\) evaluate the effectiveness of programs described in this Subsection \(2\);" and provide feedback and suggestions when appropriate.](#)

~~x. The walk through and review results from FY2016 and FY2017 will be used in FY2018 to help initiate an access related change project as outlined by the NIATx change process at <http://www.niatx.net/Home/Home.aspx>, or similar structured change model.~~

x. Each Local Authority ~~will~~ [shall](#) provide an electronic copy of their annual PMHP Financial Report (Medicaid Cost Report) to the Division as it is submitted to the Department of Health.

a. Local Authorities ~~will~~ [shall](#) provide DSAMH with the initial submission and also the finalized version of the report after it has been accepted and finalized by Medicaid.

b. All sections and schedules of the report must be completed (e.g. Sch 1A WC).

- xi. Wherever possible, **and for service codes identified by the division**, justification for payment of funds shall be determined by the Current Procedural Terminology Codes (CPT) used in the Local Authorities' Electronic Health Record (EHR) and the rate determined in their most recently approved Medicaid Cost Report. **The rate is determined using information from Schedule 4: Dividing amounts listed under column titled All Allowable Costs From Sched 5 by service units listed under All MH/SA Service Units.** For services where CPT codes are not used, DSAMH will develop separate standards for justifying payment that may include direct labor and/or current expense costs. In these cases, the Local Authority is responsible to demonstrate that any overhead costs allocated to these non-CPT code expenses are consistent with the overall cost allocation plan (CAP) used by the Local Authority. Where a Medicaid Cost Report has been done, this report becomes the CAP of record for the Local Authority. **The Local Authority shall complete Schedule 4 Part II: Non-covered and Disallowed Services and Costs, providing the following: a description of each item listed, a service unit definition, all non-covered and disallowed costs and the number of service units provided.**
- xiv. DSAMH utilizes DocuSign for obtaining signatures in the contracting process. The Local Authorities shall participate in this process by using DocuSign and updating the Local Authority Contract Approval Path file on the shared Google Drive. Local Authorities that are not currently utilizing this process must demonstrate that they are proactively working towards accommodating its use with a detailed written plan.

B. COMBINED MENTAL HEALTH AND SUBSTANCE USE DISORDER DIRECTIVES.

- iii. Participation with key community partners (e.g.: Multi-Agency Coordinating Committees, System of Care Committees, Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committee, Peer Advocacy Groups ~~or~~ **and** other partnership groups relevant in individual communities) **shall occur consistently.** Participation will be evidenced through stakeholder feedback, applicable records (minutes, communication), **use of shared UFACET assessment,** and program manager discussions.
- iv. Local Authorities shall continue to establish and/or expand Adult ~~and Children,~~ Youth, and Family Peer Support Services. Certified Peer Specialists and Family Resource Facilitators who are employed ~~with~~ **by** the local authorities are to be integrated meaningfully into all levels of agency process and service, effectively utilizing peer and family voice. Local Authorities shall seek ways to maximize effective on-going training for peers and peer supervisors specific to the unique make up, resources and structure of each local area. **DSAMH requires LA to have policy and procedures to provide guidelines and supports for Certified Peer Support Specialists and Family Resource Facilitators.**
- v. **Local Authorities who engage with the Department of Human Services (DHS) in**

the provision of Stabilization and Mobile Response Services shall coordinate with DHS regarding service delivery, reporting requirements, quality improvement efforts and reimbursement. The lead Local Authority"ies" shall oversee "Administer" and coordinate the delivery of Stabilization and Mobile Response (SMR) services in all counties in their region including subcontracting with other local authorities or other providers as necessary to ensure SMR services are performed in accordance with the SMR model

- a. Ensure SMR services include triage, mobile response, and stabilization services
 - b. Make SMR services available to children, youth and families regardless of custody, status and funding
 - c. Deliver SMR services consistent with the SMR Model
 - d. Ensure SMR services are based on System of Care values and principles
 - e. Ensure Triage services are available 24 hours per day, 7 days a week, year round
 - f. Allow the parent/family/caregiver to define the crisis
 - g. Collect and report agreed upon data and outcome measures to DHS
 - h. Provide verification of services and authorizations prior to submission of invoices to DHS for payment.
- vi. Local Authorities may choose to engage with the DHS System of Care to provide individualized services to children and youth with complex needs and their families. Services are based on the client's care plan developed by the child and family team. Local Authorities will be paid for services through a mutually agreed upon cost reimbursement model.
- vii. Suicide prevention, intervention and postvention: During FY2019, Local Authorities will continue to implement, monitor and report on their plans.
- c. Local Authorities will monitor implementation of their comprehensive suicide prevention/quality improvement plan annually using a fidelity measure (to be provided by DSAMH) in order to measure progress and as an assessment of fidelity to the Zero Suicide approach. LAs will submit an updated plan based on outcomes from the assessment. Fidelity measures can be done on paper or electronically.
- viii. Local Authorities will promote integrated programs that address an individual's substance use disorder, mental health, intellectual/developmental disabilities,

physical health, and criminal risk factors as described in UCA 62A-15-103(2)(vi). Local Authorities will use a Holistic Approach to Wellness and will:

- a. Identify tobacco use in the assessment.
 - b. Provide services in a ~~tobacco~~ nicotine free environment.
 - c. Provide appropriate ~~tobacco~~ smoking cessation services and resources (including medication).
 - d. Implement a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB.
 - e. ~~Provide training for Train staff in recognizing health issues often seen in the behavioral health population, and provide information to clients on physical health concerns and ways to improve their physical health and referrals as appropriate.~~
 - ~~g. Incorporate wellness into individual person-centered Recovery Plans.~~
- ix. Drug Testing Program Requirements: All drug testing conducted by DSAMH, Local Substance Abuse Authorities, Local Mental Health Authorities or contractors, vendors, programs, shall comply with the requirements outlined in ~~Section C: SUBSTANCE USE DISORDER TREATMENT SERVICES of the Division Directives, until new Administrative Rule for drug testing is adopted at which time the Administrative rule shall supersede this section of the Directives~~ [Administrative Rule R523-15](#)
- x. Justice Reinvestment Initiative: ~~Identify and engage key stakeholders in a local planning and implementation process centered around~~ [LMHA and LSAA shall participate in State and Local justice reform efforts.](#)
- ~~a. Language in Utah Code to establish and promote an evidence-based continuum of screening, assessment, prevention, treatment, and recovery support services in the community for individuals with substance use disorder and mental illness that addresses criminal risk factors and reduces recidivism to Jail and Prison.~~
 - ~~b. Local Authorities shall collaborate with local key stakeholders to enhance a statewide comprehensive continuum of community-based services designed to reduce criminal risk factors for individuals who are determined to have substance use disorder or mental illness conditions or both, and who are involved in the criminal justice system. Stakeholders should include but not be limited to Courts (including any appropriate Specialty Courts), Corrections, Adult Probation & Parole, County Jail(s), County Attorney(s), County Commissioner(s), Legal Defender(s), Treatment Providers, Prevention~~

~~Coordinators and other advocates or interested parties while including collaboration with DSAMH.~~

- ~~e. At a minimum, Local Authorities will comply with Utah Administrative Code R 523-4 Screening, Assessment, Prevention, Treatment and Recovery Support Standards for Adults Required to Participate in Services by the Criminal Justice System. Local Authorities shall strive to apply Utah Preferred Practice Guidelines to enhance care in local system to optimum levels within resources. DSAMH shall provide support and Technical Assistance towards the Preferred Practice Guidelines whenever possible.~~
- a. Adherence to Evidence-Based Practice in Community Treatment . Local Authorities shall:
1. Provide ongoing training to staff on criminogenic risk, need, and responsivity.
 2. Prioritize recommendations from local Correctional Program Checklist (CPC) Report provided by the University of Utah Criminal Justice Center in SFY 2018 and implement practices or policies that improve adherence to evidence-based practice.
- xii. Recovery Support Services (RSS): RSS include culturally and linguistically appropriate services that assist individuals and families working toward recovery from mental and/or substance use problems. They incorporate a full range of social, legal, and other services that facilitate recovery, wellness, and linkage to and coordination among service providers, and other supports shown to improve quality of life for people in and seeking recovery and their families.
- c. Billing Requirements: Services shall be reimbursed based on the approved service rates listed in the most current RSS manual located on the Division website at <https://dsamh.utah.gov/provider-information/patr-org-program-manual/> Services that are provided outside of the approved list of services will not be reimbursable. ~~Invoices~~ ~~Services that are submitted under “billing contracts” through SAMHIS will be billed automatically through the DSAMH KiSSFLOW system (Currently all PATR Services and Drug Court Services if the Local Authority Chooses). All other invoices~~ submitted for billing must be submitted monthly through the DSAMH KiSSFLOW system. Each RSS funding program must be submitted separately and in accordance to the appropriate funding program code.
- ~~xii. Each Local Authority shall build capacity within their area related to workforce, stigma reduction, prevention, harm reduction, and the readiness of community stakeholders to use evidence based practices to address mental health and substance misuse in their community. For additional information on capacity building see Section E(ii)(b) of Division Directives.~~

- ~~xiii. Local Authorities who engage with the Department of Human Services (DHS) in the provision of Stabilization and Mobile Response Services shall coordinate with DHS regarding service delivery, reporting requirements, quality improvement efforts and reimbursement. The lead Local Authority "ies" shall oversee "Administer" and coordinate the delivery of Stabilization and Mobile Response (SMR) services in all counties in their region including subcontracting with other local authorities or other providers as necessary to ensure SMR services are performed in accordance with the SMR model~~
- ~~a. Ensure SMR services include triage, mobile response, and stabilization services~~
 - ~~b. Make SMR services available to children, youth and families regardless of custody status and funding~~
 - ~~c. Deliver SMR services consistent with the SMR Model~~
 - ~~d. Ensure SMR services are based on System of Care values and principles~~
 - ~~e. Ensure Triage services are available 24 hours per day, 7 days a week, year round~~
 - ~~f. Allow the parent/family/caregiver to define the crisis~~
 - ~~g. Collect and report agreed upon data and outcome measures to DHS~~
 - ~~h. Provide verification of services and authorizations prior to submission of invoices to DHS for payment~~

** change made 8/2/18

- xiv. Local Authorities who engage with the First Episode Psychosis (FEP) Mental Health Block Grant (MHBG) set aside programming will recognize funding is dedicated to treatment for those "with early serious mental illness" and those at high risk of serious mental illness, is not for primary prevention. Coordinated specialty care (CSC) is a recovery-oriented treatment program for people with first episode psychosis (FEP). CSC promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The client and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin. Participating Local Authorities will recognize that the grant funds cannot be used to supplant current funding of existing activities and will maintain client records, maintain training records, and submit semi-annual reports that follow a template provided by DHS/DSAMH in addition to the following:
- a. Follow the established "Coordinated Specialty Care" (CSC) model adapted from the model found at:

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosis-manual-i-outreach-and-recruitment.shtml>

- b. Conduct outreach and community education activities to promote community awareness on early psychosis.
- c. Develop an administrative and clinical process/structure to implement the selected CSC, including: A staffing plan, process for training and ongoing supervision of staff, provision of training to staff, monitoring procedure for implementation of the CSC - collaborate with DSAMH to assess and determine how closely the program meets the CSC model, and provide continuous quality improvement processes.
- d. Develop a service delivery process to ensure eligible individuals receive appropriate services regardless of their insurance or funding source: Develop eligibility criteria for the early psychosis program (based on requirements of CSC), Develop screening and assessment process for appropriate individuals (based on requirements of CSC).
- e. Follow DHS System of Care approach to ensure services are strengths-based, family driven and youth-guided, community-based and culturally competent. Treatment plans must prescribe an integrated program of therapies, activities, and experiences to meet the client's treatment objectives and include reasonable measures to evaluate and ensure objectives are met.
- f. Document cultural background and linguistic preferences, incorporate cultural practice into treatment plan and service delivery, provide services in preferred language (bilingual therapist or interpreter).
- g. Set aside a minimum of \$4,000.00 for flexible funds to provide short-term assistance (e.g., one month rent, car repair) to stabilize the life of the individuals who receive early psychosis services.
- h. Conduct evaluations to assess the effectiveness and outcomes of the early psychosis program, create an evaluation plan, collect data as outlined in the evaluation plan, and include the evaluation data in the semi-annual reports.
- i. Provide technical assistance and disseminate information as follows: provide information on lessons learned on the planning and implementation, provide

case consultation with other behavioral health providers on an as-needed basis.

j. Develop a plan for sustaining the Program's financial viability.

C. Mental Health Services

iii. In accordance with 62A-15-105.2. Employment First emphasis on the provision of services. ~~Supported Employment includes recipient choice, integration with mental health treatment, and individualized follow along services. When providing services to a recipient, the~~ Supported Employment services. The local authority shall, in accordance with the requirements of federal and state law and memorandums of understanding between the division and other state entities that provide services to a recipient, collaboratively work with other agencies to ~~promote providing~~ provide Supported Employment services that assist an eligible recipient in obtaining and retaining competitive, integrated, meaningful ~~and gainful~~ permanent employment that enables the recipient to earn sufficient income to:

~~a. purchase goods and services;~~

~~b. establish self-sufficiency; and~~

~~c. exercise economic control of the recipient's life.~~

iv. Local Authorities ~~will~~ shall utilize Wraparound Facilitation (as defined by the Utah Family Coalition and/or Nationally accepted evidence based Wraparound Facilitation Definition) and Multi-Agency Collaboration in the provision of services for Children, Youth and Families. Evidence of compliance shall be determined by discussion with agency staff and observed compliance of Wraparound Facilitation as defined.

v. Participation in USH Adult and Children Continuity of Care meetings.

** change made 8/2/18

a. Adult Outplacement funds shall be expended as needed up to a level equal to the funding identified in the allocation letter. Services may include: creative interventions, non-covered Medicaid services, wrap-around supports, housing and recovery enhancement of the patient, and must be documented within the plan of care. Outplacement expenditures specific to individual patients must be tracked internally. Eligibility includes patients who are currently receiving inpatient care at USH when current available resources to discharge from USH are inadequate to meet the individual's needs, or patients who are targeted for diversion (diversion is defined as

preventing or diverting from USH inpatient admission).

- b. Written ~~children's outplacement~~ requests for **Children's Outplacement Funds** are submitted to DSAMH by the LMHA representative for each individual client. Requests are then ~~presented~~ **reviewed** at the **Children's** Continuity of Care meeting. Funding is awarded by committee vote with DSAMH approval. The ultimate decision regarding the use of Outplacement Funds rests with the Children's Behavioral Health Assistant Director.

- vi. Mental Health Early Intervention (MHEI) Funding is **reserved** for children and youth who may or may not have a Serious Emotional Disturbance (SED) designation, but are at risk to become so without early intervention services. Service provision is limited to Family Resource Facilitation, Mobile Crisis Teams, and School-Based Behavioral Health. This legislative funding requires the tracking of spending and outcomes related to each service provision, per legislative intent language and requires quarterly completion of the attached MHEI Quarterly Data and Annual Outcomes Report. Funds will be allocated on formula and are subject to County 20% match requirement. TANF funds focused on School-Based Behavioral Health for counties with the highest rates of intergenerational poverty shall be allocated according to the previous schedule and tracked by the local authority and submitted to the Division.

****change made 8/21/18**

- vii. Salt Lake County Behavioral Health, the principal Local Authority involved with Operation Rio Grande, shall provide and/or contract for evidence based practices to improve behavioral health and housing coordination and access to mainstream public health benefits to the target population of homeless and chronically homeless veterans and other homeless individuals who have behavioral health disorders. The contractor shall provide treatment, case management and Recovery Support Services based on need through Assertive Community Outreach Treatment (ACOT) to include Housing First, Trauma-informed care, and motivational interviewing. Ensure the assessments of eligible individuals include, but not be limited to, the Service Prioritization and Decision Assistance Tool (SPDAT).

- b. **SERVICE POPULATION:** The populations to be served are individuals who:
 - 1. Are 18 years and over;
 - 2. Have a mental illness and/or co-occurring substance use and mental illness or a substance use disorder only;
 - 3. Are homeless and chronically homeless veterans and other homeless individuals who have behavioral health disorders;
 - 4. Are not already receiving public health insurance benefits.

- b. The contractor shall use the Homeless Management Information System (HMIS) for tracking data. In addition to demographics (gender, age, race, and ethnicity) data on all clients served, contractors shall be required to report monthly and/or as required by DSAMH, on the following performance measures:
 - 1. Abstinence from use,
 - 2. Housing status,
 - 3. Employment status,
 - 4. Criminal justice system involvement,
 - 5. Access to services,
 - 6. Retention in services; and
 - 7. Social connectedness
 - 8. Number of unduplicated individuals served
 - 9. Number of unduplicated individuals housed
 - 10. Number of individuals receiving mental health treatment
 - 11. Number of individuals receiving substance use treatment
 - 12. Number of individuals experiencing housing stability six months or longer
 - 13. Number of individuals with increased enrollment in mainstream benefits
 - 14. Number of individuals with increased income overall
 - 15. Number of individuals with increase earned income.

**change made 12/3/18 **change made 12/20/18

- viii. Local Authorities (LA) who engage in Mental Health Crisis Outreach Teams (MCOT) as described in Utah R523-18 will provide services as outlined in Utah R523-18, related Utah Annotated Code as well as the following requirements.
 - a. Each fiscal year, the participating LA will submit the following reports to the DHS/DSAMH MCOT/Crisis Services Program Administrator quarterly as follows:
 - 1. July 1- September 30, due October 20;
 - 2. October 1- December 31, due January 20;
 - 3. January 1- March 31, due April 20; and
 - 4. April 1- June 30, due July 20;
 - b. Year-end reports are due July 20 of each year. Year-end reports will include a summary of quarterly data, barriers, objectives met, and program plans for the following year.

- c. Reports will include the following data:
1. The number of MCOT outreaches performed monthly for both Adult and Youth;
 2. The average response time from initial request to engagement for community outreaches and for law enforcement outreaches. Include an explanation if average response times fall outside of recommendations (Urban: 30 minutes law enforcement response and 60 minutes for community response/Rural: 2 hour response)
 - ~~3. A breakdown of outreaches initiated by LA deployment and Statewide Crisis Line Deployment~~
 3. The number of MCOT outreaches by Discharge Disposition for both Adult and Youth to include those who:
 - (a) Remained in place;
 - (b) Were hospitalized;
 - (c) Were sent to the emergency department for detox;
 - (d) Were sent to the emergency department for medical reasons or any other reasons excluding detox;
 - (e) Went to the receiving center/crisis walk in center;
 - (f) Were sent to ~~short term crisis~~ residential;
 - (g) Were sent to JRC/Youth Services;
 - (h) Were incarcerated.
 - (i) Social Detox
 4. Number of Contacts by Referral Source for both Adults and Youth, including:
 - (a) Statewide Crisis Line;
 - (b) Outpatient Provider (Behavioral Health);
 - (c) Outpatient Provider (Physical Health);
 - (d) Self/Family;
 - (e) Law Enforcement;
 - (f) School;
 - (g) Any Division within the Department of Human Services (i.e. DCFS, DSPD, JSS, etc).
 - ~~(g) Fire Department.~~
 - (h) Other – please describe.
 5. Local Authorities/MCOT teams will provide details of the outcome and plan of each MCOT outreach as described in section 3 to the statewide crisis line within 24 hours of the outreach. Each Local Authority will arrange for business case agreements to allow the sharing of this information in accordance with applicable State and Federal Law.
 6. Number of Contacts by Insurance Type

- (a) Medicaid;
 - (b) Medicare;
 - (c) Private Insurance;
 - (d) None;
 - (e) Unknown;
 - (f) Not Collected;
7. Number of mobile referrals not dispatched including if or why:
- (a) There was inadequate staffing;
 - (b) The client denied services or withdrew the request;
 - (c) The client presentation changed/De-escalated;
 - (d) The client needed higher level of care including law enforcement;
 - (e) Other- please describe,

D. Substance Use Disorder Treatment Services

- ii. Funds allocated by DSAMH shall not be expended by any agency which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine).
 - c. In all cases, MAT medications shall be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial.
 - d. Entities in receipt of funds shall assure that clients will not be compelled to ~~no longer use MAT~~ taper or abstain from medications as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.
- iii. Drug Courts:
 - a. Drug Courts shall comply with the following requirements:
 - 6. Consistent with ii above, have no prohibitions against Medication Assisted Treatment (MAT) or a requirement to be abstinent from medications used in addiction treatment in order to enter drug court, progress or complete drug court. Drug Courts or LA that are non compliant may have funding withheld.
 - 8. If a Drug Court ~~participates~~ participant is in an evaluation or research as part of a federal grant, the Drug Court shall submit a copy of the evaluations and research to the DHS/DSAMH Justice Program Manager within 90 days of completion of the evaluation and research.

11. Drug Courts shall ensure that participants meet with the Department of Workforce Services (DWS) and/or health care navigators to determine eligibility for Medicaid, other public insurance or commercial insurance.
 - (a) LA shall ensure that drug court participants receive assistance throughout their episode of care with Medicaid enrollment.
 12. LA shall ensure that public funds are the payor of last resort.
 13. Drug Court Funding will shall be determined in accordance with statute by the Director of the Department Human Services the Director of the Department of Corrections and the State Courts Administrator.
 14. Drug Courts that are non-compliant with Drug Court certification standards as cited above in section iii may have drug court funding withheld by DSAMH.
 15. LA's will notify DSAMH of any court changes including court closures, changes in Judges or court coordinators.
- vi. FY19 State General Funds for children living with parents receiving residential substance use disorder treatment services:
- a. Funds shall be used to pay for the following services:
 1. Room and board.
 2. Therapeutic day care to address developmental needs, their potential for substance use disorders, and their issues of sexual and physical abuse and neglect.
 3. Case Management and transportation for behavioral and physical health care services
 4. Ongoing assessment that will include, but not be limited to: developmental adjustment; motor skills; cognitive skills, health, including immunizations history; interaction with mother and other adults; language and general affect.
- viii. Utah Quality Youth Treatment Project
- a. Local Authorities shall participate in the Utah Quality Youth Treatment Project to evaluate the quality of their youth substance use disorder treatment programs and implement the following 10 key principles:
 1. Screening/Assessment
 2. Attention to Mental Health
 3. Comprehensive Treatment
 4. Developmentally Informed Programming
 5. Family Involvement
 6. Engage and Retain Clients
 7. Staff Qualification / Training
 8. Continuing Care / Recovery Support
 9. Person-First Treatment
 10. Program Evaluation

- viv. Opioid Treatment and Recovery Support Funds:
 - d. Allowable uses for this funding will be limited to:
 - 7. Enhance or support the provision of ~~peer~~ Peer Support and other RSS designed to improve treatment access and retention and support long-term recovery to include relapse and suicide prevention efforts.

E. Substance Use Disorder Prevention Services

- ii. Local Authority shall produce a comprehensive Strategic plan that includes narrative describing actions to complete the following:
 - b. Build prevention capacity within their area. The key components of capacity building include:
 - 5. Developing and preparing the prevention workforce by ensuring that all prevention personnel (excluding support staff), including contracted staff, are certified in the Utah Substance Abuse Prevention Specialist Training (SAPST) ~~or credentialed and in current standing with International Certification & Reciprocity Consortium (IC&RC).~~ It is an option between FY2019 and FY2020 to certify all local authority prevention coordinators in Universal Prevention Curriculum (UPC).
 - d. The LSAA may use federal funding provided under the FPL code to implement the Communities That Care coalition model as part of their area plan. The LSAA may request an additional \$10,000 FPL per year for five years to hire a CTC coordinator. The funding amount must be matched by the participating county, city or community partner. . The LSAA must adhere the following guidelines:
 - 1. Hire a CTC Coordinator and implement the CTC process.
 - (a) CTC coordinator must serve on the county’s prevention coalition as the CTC coordinator and work closely with the LSAA prevention coordinator to ensure CTC is implemented with fidelity.
 - (b) The CTC/FPL funding must be matched by both dollars and in-kind contributions by county, city or community partners.
 - (c) Funds are primarily to be used for the CTC Coordinator position but the LSAA may use a portion of these funds, with permission from DHS/DSAMH program manager, to fund additional prevention activities as described in the CTC model as found at www.communitiesthatcare.net.
 - 2. The LSAA shall:
 - (a) Ensure CTC training and technical assistance to the CTC coordinator within 60 days of coordinator hire date and proceeding as outlined in the CTC planning model found at www.communitiesthatcare.net.
 - (b) Monitoring the CTC Coordinator’s performance to ensure fidelity to the CTC program guidelines. Annual checklists shall be kept on file.

- (c) Using DSAMH approved CTC report template, provide annual progress reports, due December 31 of each year to the DHS/DSAMH program manager that shall include progress reports on the phases of CTC implementation.
- 3. The CTC Coordinator shall be certified in the Substance Abuse Prevention Specialist Training and CTC coordinator training within one year of coordinator's start date. The LSAA must email or fax a copy of the completion certificates to the DHS/DSAMH program manager within one month of the completion date. Develop a strategic plan that is comprehensive, logical and data driven to address the problems identified during assessment with the current and future capacity developed. Post this plan publicly.

F. Mental Health and Substance Use Disorder Data

- ii. Substance Use Disorder Mental Health, and Indicated Prevention Data and Outcome Reporting Requirements
 - e. ~~MHE, TEDS and RS~~ Data Specifications are available for download from the DSAMH Substance Abuse Mental Health Information System (SAMHIS) and from the DSAMH website at <http://dsamh.utah.gov/data/data-specifications/>. ~~IP data specifications will be vetted through PDC and available prior to the start of the fiscal year.~~
 - h. Outcomes system for Substance Use Disorder data includes:
 - 1. Adults:
 - (a) Mental Health Statistical Improvement Program (MHSIP) Consumer Survey.
 - 2. Children/Youth:
 - (a) Youth Satisfaction Survey (YSS) Consumer Survey.
 - 3. Parents/Youth:
 - (a) Parents Satisfaction Survey: (YSS-F) Consumer Survey; and
 - (b) Youth Satisfaction Survey: (YSS) Consumer Survey.

G. Performance Measures

- i. For all performance measures, the Division shall continue to work with ROSC and PDC in order to determine performance measures that will best represent a recovery-oriented system of care. Those measures shall be made available as soon as approved and communicated through ~~ROSC, UBHC Directors, UBHC PDC and the UBHC Clinical Committee.~~
- iv. Substance Use Disorder Prevention Performance Measures:
 - a. All **Universal and Selective** prevention services entered in DSAMH approved

data system accurately and within 45 days of services.

<https://easy.dhs.utah.gov/dhseasy/planAction.do> All Indicated Prevention services entered in SAMHIS by the end of the month following the month of delivery.

- f. Number of coalitions that prioritize substance use related risk and protective factors (as found on www.dsamh.utah.gov) in local substance abuse authority area. The coalitions should be defined by one of the following:
 - 1) serving one of the 64 small areas within Utah
 - 2) serving the communities that feed into a common high school
 - 3) serving a community population of no more than 50,000 residents
 - g. Annually report to DSAMH actual number and costs of evidence based policy, programs and strategies. ~~Note:~~ FY2019, monthly invoices will ~~will~~ shall include costs of evidence based policy, programs, and strategies.
- v. Recovery Support Performance Measures
- a. Local Substance Abuse and Mental Health Authorities will work with DSAMH to identify performance metrics designed to evaluate cost, quality, access and person centered outcomes.
 - ~~a. Recovery Capital Culture and Score: As this is an emerging field, Local Substance Abuse and Mental Health Centers may choose their own recovery support performance measure tool to report this score for recovery support services. Scores should be converted to a 100 point percentage score to be reported in the RS file as per the file specification.~~
 - ~~1. For FY2018, this will be required on Recovery Support clients only. Current tools under consideration include (not exhaustive): DLA-20, OQ Recovery Questions, RCI, WHODAS 2.0.~~
 - ~~2. FY2019 the selected tool may be expanded to the entire SUD population and/or mental health population in the context of expanding a culture of recovery capital.~~
 - ~~3. FY2020 selected tools and data will be reviewed and discussed in collaboration with the UBHC ROSC Committee to help make decisions about identifying evidence based or evidence informed tools to help expand this performance measure.~~