



Division Directives

Fiscal Year 2021

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DSAMH FY2021 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, 2020 through June 30, 2021.

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 FY2021, the required Area Plan from all Local Authorities will consist of forms the Division has developed for Mental Health (Form A), 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 Area Plan Training to be held Tuesday, March 31, 2020. 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, B, C, D and the required fee policy and fee schedule, pursuant to Administrative Rule Section R523-2-5. The Area Plan packet must be completed by May 15th 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 31st. 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. The Local Authority shall provide an organization chart/listing of staff and subcontractors. Organizational chart shall include prevention and recovery support staff.
- v. Monitoring reports for FY2021 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 monitoring, as outlined in UCA 17-43-201, UCA 17-43-301, and the DHS Contract, utilizing a formalized monitoring tool that describes each area of the review and its outcome. Both the monitoring done by the county and the monitoring by the local authority will be reviewed annually by DSAMH during annual monitoring.
 - a. The Local Authority will include copies of current insurance certificates, as outlined in the contract.
 - b. The Local Authority will ensure that providers have current licenses, certifications, BCI checks and conflict of interest forms by one of the following methods:
 1. keeping physical/electronic copies,
 2. through the Medicaid credentialing process,
 3. annual monitoring;
 4. another monitoring report in the past year that has verified these items.
 - c. The Local Authority will provide documented assurance of monitoring in accordance with UCA 17-43-201, UCA 17-43-301, and the DHS Contract, upon request from DSAMH.
- ix. For each site visit, 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 electronic remote access to the selected charts and all other documents requested by DSAMH 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 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 electronic signature platform for obtaining signatures in the contracting process. The Local Authorities shall participate in this process by using electronic signature platform 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. Local Substance Abuse Authorities and Local Mental Health Authorities are expected to facilitate the health insurance application and enrollment process for eligible uninsured clients.
- ii. Each client shall have a strength-based assessment. (Please note that when the client is a minor, the word client also refers to the parent/guardian/family.) At a minimum assessments, planning and treatment shall comply with the Medicaid Provider Manual and current Administrative Rule as described in R523. The current version of the approved Utah Preferred Practice Guidelines is an additional resource that may be used to guide assessments, treatment planning and services.
- iii. 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.
- iv. Participation with key community partners (e.g.: Multi-Agency Coordinating Committees, Regional Advisory Councils, Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committees, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts, Regional Healthcare Coalitions, and other partnership groups relevant in individual communities) shall occur consistently. Participation will be evidenced through stakeholder feedback, applicable records (minutes, communication), use of shared Utah Family and Children Engagement Tool (UFACET) assessment, and/or program manager discussions.
- v. Local Authorities shall continue to establish and/or expand Adult, Youth, and Family Peer Support Services. Certified Peer Specialists and Family Resource Facilitators (Family Peer Support) 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

Local Authorities to have policy and procedures to provide guidelines and supports for Certified Peer Support Specialists and Family Resource Facilitators.

- vi. 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.
- vii. Local Authorities shall partner with the DHS System of Care and participate on High Fidelity Wraparound teams to provide mental health expertise and 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.
- viii. Suicide prevention, intervention and postvention: During FY2021, Local Authorities will continue to participate in and report on suicide prevention, intervention, and postvention activities.
 - a. Prevention: Local Authorities will submit a localized suicide prevention plan for the agency or broader local community. This plan should include a comprehensive approach to suicide prevention (primary prevention,

intervention, postvention). The state plan should be used as a guide.

https://drive.google.com/file/d/1V4cgYvf_JGs1CNvBYY2XmoFfwSPQIPM3/view

- b. Intervention: Records must contain a safety/crisis plan that includes indication of lethal means counseling when clinically indicated which can be quickly and easily accessed and updated as needed.
 - c. Intervention: Local Authorities shall create a training implementation plan for Counseling on Access to Lethal Means (CALM) and report on the number and percentage of staff who completed the training.
(<https://www.train.org/utah/course/1081014/>)
 - d. Postvention: Local Authorities shall develop a plan for coordination with Local Health Departments to identify roles and support implementation of a community postvention plan in alignment with the state Community Postvention Toolkit.
 - e. Local Authorities participating in the Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant Program will implement skill based programming, gatekeeper training, community or school based screening activities, and crisis follow up services after inpatient or emergency department visits.
- ix. 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 nicotine use in the assessment.
 - b. Provide services in a nicotine free environment.
 - c. Provide appropriate nicotine 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.
- x. Drug Testing Program Requirements: All drug testing conducted by DSAMH, Local Substance Abuse Authorities, Local Mental Health Authorities or contractors, vendors and programs, shall comply with the requirements outlined in Administrative Rule R523-15.

- xi. Adult Justice Reform (JRI) : LMHA and LSAA shall:
 - a. Provide ongoing training to staff on criminogenic risk, need, and responsivity.
 - b. Prioritize recommendations from the 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.
 - c. 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.
 - d. All 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.
 - e. Funds may be expended on the following: training on risk, need and responsivity, forensic screening & assessments to determine if treatment should be ordered, criminogenic risk screening and assessment, treatment services including medications for individuals without other payer resource, recovery support services as outlined in RSS manual, and care coordination with criminal justice stakeholders.
- xii. Juvenile Justice Reform: DSAMH encourages LA participation in State and Local juvenile justice reform efforts. This includes collaboration with the Division of Juvenile Justice Services' Youth Service Centers and their Youth Services Model.
- xiii. Local Authorities shall have access to a telehealth platform. Local Authorities may utilize telehealth to provide services to supplement the continuum of care offered in traditional settings. These are services delivered in real-time using internet-based videoconferencing technologies through personal computers and mobile devices. In providing telehealth services, it is also encouraged to develop policies and procedures that are specific to the provision of services using this technology. Sample guidelines may be found at <http://hub.americantelemed.org/resources/telemedicine-practice-guidelines>.
- xiv. All Recovery Support Services (RSS) 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.
 - a. 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/pdf/ATR/FY21%20RSS%20Manual.pdf>

- b. Services that are provided outside of the approved list of services will not be reimbursable.
- xv. 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.
- xvi. Local Authorities who engage in the Utah Promoting Integration of Primary and Behavioral Health Care (U-PIPBHC) grant will recognize funding is dedicated to all of the specifications of the SAMHSA request for Proposal, U-PIPBHC Bid application documents and any revisions approved with SAMHSA. Local Authorities will coordinate with DSAMH and SAMHSA in all required planning, implementation, data, billing and reporting requirements in the grant and will hold any subcontractors to the same specifications.
- xvii. Local Authorities shall develop a disaster preparedness and recovery plan for programs that provide prevention, treatment and recovery support for mental illness and substance use programs. The Local Authorities (LA) shall identify the critical functions of its business operations and develop an emergency management and business continuity plan that will allow the LA to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business. The plan must address at least the following areas: evacuation procedures; temporary or alternate living plans; plans for isolation or quarantine; maintenance, inspection, and replenishment of vital supplies (including food, water, clothing, first aid supplies, medical necessities, client medications, infection control supplies, and hazardous material protections); communications with LA staff, governmental agencies, and clients' families; transportation; recovery and maintenance of client records; and policies and procedures that: 1) ensure maintenance of required staffing ratios; 2) address both leave for and the recall of LA employees unable to work for extended periods due to illness during periods of declared pandemic; and 3) ensure the

timely discharge of the LA financial obligations, including payroll. The LA shall provide at least annual training for its staff on its plan. The LA shall provide DSAMH with a copy of its plan and evidence of staff training. The LA shall evaluate its plan at least annually.

- xviii. Each Local Authority will work to identify at least one provider that is a specialist in maternal mental health, or will identify a provider to be trained as a specialist in maternal mental health. Specialists will have received 12 hours of maternal mental health training and will be available for in-person and telehealth services. Local Authorities will provide the name and stage of training for each identified maternal mental health specialist by December 31 each year.
- xix. DSAMH encourages Local Authorities to identify a staff member or team to be trained in infant and early childhood mental health to provide evidenced based modalities for children birth to five. Local Authorities, when appropriate, should also refer and collaborate with other early childhood community partners to ensure coordinated treatment and increase support for young children and their families.
- xx: Each local mental health/substance use authority will identify a staff member/position responsible to collaborate with DSAMH to conduct needs assessment/gap analysis for health disparities and for youth in transition services 2020-2021. The responsible position will work with DSAMH staff to design, plan, and implement local assessments, which may include focus groups.
- xxi: All local authorities and all sub-recipients shall comply with the following: Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended. . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

- xxii Substance Abuse Block Grant and Mental Health Block Grant funds may be used to provide cost-sharing assistance for behavioral health insurance deductibles, coinsurance, and copayments to assist eligible clients receiving service at an eligible provider. Block grant may also be used to help individuals meet their cost-sharing responsibilities under a health insurance or benefits program, including high risk pools.
- a. Eligible clients include individuals and families below 400 percent of the federal poverty level in need of medically necessary substance use disorder or mental health treatment.
 - b. Local Authorities may develop policy to determine the amount of assistance an individual may receive based on income and family size.
 - c. Block grant funds may only be used to pay for deductibles, coinsurance, and copayments directly related to the provision of medically necessary substance use or mental health treatment.
 - d. All payments shall be made directly to the provider of service.
 - e. Payments shall only be made to public or nonprofit entities.
 - f. In all circumstances, cash payments to the intended recipient of health services is strictly prohibited
- xxiii. Local Authorities receiving funding appropriated by the Utah State Legislature for the operation of a Behavioral Health Home for individuals with substance use and mental health disorders. The Local Authority shall use the funds to operate a Behavioral Health Home for individuals with substance use and mental health disorders. The Behavioral Health Home shall:
- a. Screen individuals with substance use and mental health disorders for general health and for conditions for which they are at high risk.
 - b. Ensure clients receive treatment for heart disease diabetes, obesity and other physical health conditions prevalent in populations with substance use and mental health disorders.
 - c. Provide smoking cessation services that include medication and other evidence-based approaches.
 - d. Offer prevention and intervention for modifiable risk factors

associated with poor health outcomes and care gaps.

- e. Provide comprehensive care management services that include identification and targeting of high-risk individuals, monitoring of health status and adherence to treatment plans, development of treatment guidelines and individualized planning with clients.
- f. Provide mobile crisis outreach services to individuals experiencing, or at risk of a physical health or mental health crisis, and who require intervention.
- g. Provide follow-up services including information and referrals, linkage with appropriate services for ongoing treatment.
- h. Track and improve performance through creation and operation of a patient disease registry that includes historic information on clients, the results of metabolic screening and other assessments.

The Local Authority shall:

- a. Include the Behavioral Health Home as a Cost Center in the Medicaid Cost Report if it is to be included as an expense against the budget for allocation.
 - b. Submit the following to the DHS/DSAMH Adult Mental Health program administrator a quarterly report due by the 15th of the quarter to provide:
 - 1. Narrative that outlines the major accomplishments, activities and challenges of operating the Behavioral Health Home during the reporting period.
 - 2. A statistical report that identifies how many unique clients have been served by the behavioral home health, the type of services received and the number of hours of direct care provided.
 - 3. An outcome report that identifies how many clients from admission to discharge show improved health and functioning related obesity, cholesterol, triglycerides, blood pressure, blood sugar, smoking and mental illness symptomology.
- xxiv. Local Authorities receiving funding from the Substance Abuse Block Grant and Mental Health Block Grant funds for nicotine cessation train-the-trainer or nicotine cessation training (DIMENSIONS) will be required to train at least two groups to provide nicotine cessation annually.

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 Outcome Questionnaire (OQ) or Youth Outcome Questionnaire (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, work collaboratively 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 and/or participate in High Fidelity Wraparound (as defined by Nationally accepted evidence based practices and standards for High Fidelity Wraparound) 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, at annual monitoring and observed compliance of High Fidelity Wraparound as defined.
- v. Local Authorities shall participate in Utah State Hospital (USH) Adult and Children Continuity of Care meetings in accordance with R523-2-12 .
 - 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). Patients referred for discharge shall be discharged

from USH within 30 calendar days, with consistent documentation in the USH electronic system.

- 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. If funds are received through Local Education Agency (LEA) contracting, report the new funding in Form A2 and Form A. This legislative funding requires the tracking of spending and outcomes related to each service provision, per legislative intent language and requires quarterly completion of the MHEI Quarterly Data and Annual Outcomes Report via the qualtrics survey: https://utahgov.co1.qualtrics.com/jfe/form/SV_43nStXZzUBHtekt. Funds will be allocated on formula and are subject to the County 20% match requirement.

Local Authorities are encouraged to work with LEAs to offer telehealth based services for children and youth within a school setting. Local Authorities are encouraged to have policies and procedures regarding the provision of telehealth based services in a school setting. Data collection for school based telehealth services shall align with the reporting measures for the MHEI Quarterly Data and Annual Outcomes Report above.

- vii. Operation Rio Grande: Salt Lake County 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 and according to the Assertive Community Outreach Treatment (ACOT) model to include Housing First, Trauma-informed care, and motivational interviewing. Ensure the assessments of eligible individuals include, but not be limited to, the Service Prioritization and Decision Assistance Tool (SPDAT). Data shall be entered and reportable to DSAMH at least annually or upon request, using the Homeless Management Information System (HMIS) on the following performance measures including the following elements as available, in addition to demographic data: Abstinence from use, Housing status, Employment status, Criminal justice system involvement, Access to services, Retention in services; and Social connectedness; Number of unduplicated individuals served Number of

unduplicated individuals housed; Number of individuals receiving mental health treatment; Number of individuals receiving substance use treatment; Number of individuals experiencing housing stability six months or longer; Number of individuals with increased enrollment in mainstream benefits; Number of individuals with increased income overall; Number of individuals with increased earned income. Salt Lake County Behavioral Health shall also coordinate with DSAMH to report to the Legislature according to the intent language “(1) what specific savings were generated, (2) who received the savings, and (3) what the funding sources were for these savings. For FY 2020 items, the recipient shall provide the report by August 31, 2020.”

- viii. Local Authorities (LA) who engage in community oriented crisis services shall utilize [SAMHSA’s National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#) as guidance for development, implementation, and quality improvement efforts.
 - a. Local Authorities who provide Mental Health Crisis Outreach Teams (MCOT) will provide services as outlined in Utah R523-18, related Utah Annotated Code. Any requests to be exempted for any requirement outlined in rule shall be submitted to the Division Director and if approved be attached as an addendum to the area plan. Area plans should describe all services to be included under “ crisis stabilization”. Providers shall submit data via MCOT/SMR data spec quarterly on the following dates:
 - July 1- September 30, due October 20;
 - October 1- December 31, due January 20;
 - January 1- March 31, due April 20; and
 - April 1- June 30, due July 20;
 - b. Local Authorities who operate Receiving Centers will provide services as outlined in Utah Code 62A-15-118 and Utah Rule governing receiving centers once adopted. Providers shall submit data as outlined in the agreed upon grant agreement.
 - c. Local Authorities receiving funding from the Utah Emergency COVID-19 Program for Mental Health/Substance Use Disorders for Receiving Centers will provide:
 - 1. The Substance Abuse and Mental Health Services Administration Government Performance and Results Act (GPRA”) at intake and at 6 months or discharge, whichever is sooner, for individuals receiving medication or Bridge follow-up if either is paid for with grant funds.

2. Provide written reports on January 31, 2021 and October 1, 2021 that include:
 - (a) Increase in number of admissions to the receiving center.
 - (b) Increase in number of persons provided Medication Assisted Treatment as initiated by the Receiving Center.
 - (c) Number of clients served that are SMI/SUD or co-occurring.
 - (d) Number of healthcare professionals or paraprofessionals served.
 - (e) Number with mental illness that do not meet SMI criteria

3. Meet virtually to review progress with the Department of Human Services, Division of Substance Abuse and Mental Health (DHS) grant staff every other month as follows: October 2020, December 2020, February 2021, April 2021, June 2021, August 2021.

- ix. In accordance with 62A-15-631 the Local Mental Health Authorities shall develop tracking and protocols, and shall provide a current list of the individuals and their providers upon request, for all adults who have been civilly committed and those placed on an assisted outpatient treatment court order to their agency.

- x. Local Authorities that receive funding from DSAMH for development and operation of, Assisted Outpatient Treatment (AOT) services shall meet the following goals:
 - a. Establish AOT at their sites, including petitioning the court for AOT court orders when appropriate.
 - b. Provide evidence-based services aimed at improving treatment outcomes for adults with Serious Mental Illness (SMI) who are either civilly committed or have an AOT court order, and who have a history of poor treatment compliance.
 - c. Train staff in the AOT model of treatment, which includes a combination of Evidence Based treatment and support services.
 - d. Develop enhanced relationships, communication, coordination between courts, police, hospitals, jails, and other community partners.

- xi. Local Authorities providing Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment (ACOT): Local Authorities shall provide and/or contract for evidence based practices to improve behavioral health and access to mainstream public health benefits to the target population who have

serious mental illness. Local Authorities are expected to adhere to Utah Rule governing ACT once adopted and follow the SAMHSA ACT Program to fidelity see as follows: <https://store.samhsa.gov/>. The Contractor shall provide individualized treatment, case management and Recovery Support Services based on need through ACT or ACOT to include trauma-informed care, motivational interviewing, and other evidence based supports. The populations to be served are individuals who:

- a. Are 18 years and over;
 - b. Are adults with serious mental illness, with severe functional impairments, who have not engaged in or responded well to traditional outpatient mental health care and psychiatric rehabilitation
- xii. Southwest Behavioral Health Center (SBHC), the principal Local Authority involved with “SafetyNet” and “Domestic Violence: Self-Protection and Dating Violence Prevention for FLDS Refugee Women” services and “Personal Safety and Healthy Relationship Classes”, shall provide short-term mental health services to individuals and families in plural marriage communities who are in a coverage gap and women from restrictive fundamentalists sects who are refugees from FLDS groups recovering victimizations from these groups. Clinical services related to this funding are not intended to supplant established Medicaid coverage but rather to enhance the service delivery capacity available. The primary goal of short-term mental health services funded under these initiatives is to reduce identified mental health symptoms so current and former members of plural marriage communities can increase the likelihood of wellness, recovery and employment.
- a. Program Services: Ensure State General Funds dollars earmarked for the SafetyNet Initiative are utilized to provide short-term mental health services and personal safety and healthy relationship classes to current and former members of polygamous communities ineligible for Medicaid. SBHC may utilize subcontractors to provide short-term mental health services.
 - b. SBHC shall ensure that eligibility requirements and/or determination processes are followed as outlined below. Every individual identified as being a current or former member of polygamous communities requesting mental health services and classes who does not have Medicaid will be screened for eligibility for Medicaid. The eligibility screening will 'rule-out' those who clearly do not qualify for Medicaid. For Individuals 'ruled-out': Subcontractors will explore other options for funding including but not limited to insurance, VOCA, other grants, or private-pay. Where no other resources are found, the individuals will be screened to see if they qualify for these funds. Those who qualify will meet all of the following: Have a diagnosable mental illness or substance use disorder or are participating in

treatment with a family member with a diagnosis; Have a history or current participation within a plural marriage community; Have no other resource for funding; Are residents of Utah, and are willing to consent to behavioral health treatment or classes. The eligibility screening will 'rule-in' those who have ANY likelihood of qualifying for Medicaid. It will not guarantee eligibility, but will suggest the possibility. SBHC will ensure individuals 'ruled-in' complete a Medicaid application. If the client is enrolled in Medicaid, DHS will then complete the process they use for registering clients with the local Medicaid provider. If the client is denied Medicaid and there is no option for a successful appeal, follow the 'ruled out' process above.

- c. Outcomes/Deliverables. With respect to the purpose of clinical services, a minimum of 30 individuals being served under this contract will receive appropriate clinical treatment and interventions for SafetyNet funding. In addition a minimum of 30 individuals in the first year and 60 individuals in subsequent years will receive personal safety courses and 80 women and youth will receive health relationships courses. The treatment and intervention will increase their ability to actively move toward self-sufficiency as mental, emotional, and social barriers are addressed. For individuals who successfully complete services, DHS shall conduct pre & post evaluations using an established tool that measures a level of functioning and benefit from services or classes. Compared results should show a reduction in identified mental health symptoms and improvement in overall functioning.
 - d. SBHC shall submit at least quarterly reports and an annual report containing the following: Total number of individuals served; Average length of short-term therapy and successful therapy and class completion rate. Of those who successfully complete therapy: Number who do not return for additional services 90 days after completing therapy; Number who do not return for additional services 120 days after completing therapy; Number of individuals identified/served who were transitioned to another funding source
 - e. Reports shall be submitted in an approved file type in accordance with State Fiscal Year quarterly and annual reporting dates.
- xiii. Local Authorities (LA) who receive funding through Projects for Assistance in Transition from Homelessness (PATH), will provide or contract for services to assist eligible individuals not funded through other programs. PATH funds are to be used for those who are literally homeless or at imminent risk of becoming homeless, are 18 years and over, and have a serious mental illness or co-occurring substance use disorders. PATH funds are intended for street outreach, case management, and services which are not financially supported by mainstream services and/or behavioral health programs.

- a. LAs providing PATH services will use the Homeless Management Information System (HMIS) for tracking PATH data and provide to the DHS/DSAMH PATH Program Director or as otherwise directed the following:
 1. PATH budget
 2. PATH Intended Use Plan
 3. Annual Provider Report
 4. Quarterly reports that include at a minimum:
 - (a) At least 50% of the individual clients served should be enrolled in PATH
 - (b) Of the total eligible PATH individuals served, at least 50% shall be literally homeless in the urban areas and at least 30% in rural areas.
 - (c) Ensure the assessments of PATH eligible clients include, but not be limited to, the Service Prioritization and Decision Assistance Tool (SPDAT).
 - b. The PATH provider shall not expend PATH program funds for Medicaid funded services or other federal match purposes, to purchase or to pay for construction of any building or structure, or any of the PATH eligible client's lease expenses beyond the project period. The portion of the space leased with PATH funds shall not be used for purposes not supported by the PATH grant or as specified in the US Code 42 USC 290cc-22.
 - c. A cash match of \$1 for every \$3 of federal PATH funds is required. No more than 4% of the federal PATH funds received shall be used for administrative expenses. No more than 20% of the federal PATH funds allocated to the state may be expended for eligible housing services, as specified in Section 522(b)(10) and 522(f) of the Public Health Services Act, as amended (42 U.S.C. § 290cc-22(b)(f)(h) and (h)(1)).
 - d. Required services for the PATH program are defined in the following US Code:
[https://uscode.house.gov/view.xhtml?req=\(title:42%20section:290cc-22%20edition:prelim\)](https://uscode.house.gov/view.xhtml?req=(title:42%20section:290cc-22%20edition:prelim))
- xiv. Local Authorities who receive funding for the Autism Spectrum Disorders (ASD) Mental Health Preschool program will focus on providing services for preschool-aged children with ASD, typically aged two through five, and their families, but exceptions are allowed with approval from DSAMH. Services for children include assessment of ASD and related mental health concerns,

therapeutic interventions to address ASD needs, and referral to other resources. Parents/guardians and siblings of these children should receive psychoeducation, guidance, and counseling with respect to the child with ASD. Current available funding is for non-Medicaid services. Each program will maintain a minimum constant enrollment of at least 24 children and maintain a waiting list of other eligible children who are not yet enrolled in Kindergarten. Use of evidence-based curriculum in the provision of therapeutic and education services for individuals with autism is expected. Local Authorities will provide the following;

- a. Data collection, tracking, and monitoring to guide treatment planning and implementation.
 - b. Auxiliary services that include but are not limited to psychiatric services including diagnosis and treatment, medication management, case management, and linking families to other treatment and community resources as needed.
 - c. Conduct strength-based assessment of each child that includes an evaluation of the child's developmental, cognitive, adaptive, and behavioral functioning.
 - d. Develop an individualized treatment plan for each child enrolled.
 - e. Coordinate transition planning with the child, parent/guardian and the school district prior to the end of services.
 - f. Parents are to participate in the classroom on a weekly basis as their schedule allows.
 - g. Provide employee training opportunities to keep current on quality program services. Each employee must receive at least six (6) hours of training yearly.
- xv. The Local Authorities shall submit six month progress reports each year by January 31st and an annual report by July 31st. Each progress report must include but are not limited to the following data:
- a. General overview of the autism services provided
 - b. Eligibility requirements for the program
 - c. Achievements/progress/outcomes during the previous six-months

- d. Barriers/Possible solutions or goals
- e. Family satisfaction/input/in-services
- f. The number of:
 1. Preschool children (unduplicated) currently enrolled who received services funded by DHS/DSAMH
 2. Parents/guardians (unduplicated) who received services funded by DHS/DSAMH during the past fiscal year
 3. Siblings (unduplicated) who received services funded by DHS/DSAMH during the past fiscal year
- g. The number of children currently on a waiting list
- h. The number of children in the last six (6) months who:
 1. Have been accepted off of the currently waiting list
 2. Have aged off of the waiting list
 3. Have been denied services and the reasons for denial
 4. Have terminated services and the reason for termination
- i. Other program demographics as defined by DHS/DSAMH

D. SUBSTANCE USE DISORDER TREATMENT SERVICES

- i. The Local Substance Abuse Authority (LSAA) shall provide ongoing training and monitoring to ensure that clinical services including assessment, withdrawal management, treatment planning, treatment management, care coordination and continuing care management are consistent with the ASAM Criteria.
<https://www.asam.org/docs/default-source/practice-support/quality-improvement/standards-of-care-final-design-document.pdf?sfvrsn=0>
- ii. All LSAA treatment programs shall:
 - a. educate staff to identify overdose and to administer Naloxone;
 - b. maintain Naloxone in facilities;
 - c. provide Naloxone kits, education and training to individuals with opioid use disorders and when possible to their families, friends, and significant others.
- iii. LSAA's shall provide directly or through contract access to Methadone, Buprenorphine and Naltrexone for individuals with opioid use disorder and

medications approved by the FDA for alcohol use disorder.

- iv. 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.
- v. Drug Courts (ADC)
 - a. Drug Courts shall:
 - 1. 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. ensure drug testing occurs on weekends and holidays as required by Utah Council Rule 4-409,
 - 3. serve participants identified as High Risk/High Need by using a validated criminogenic risk tool,
 - 4. identify and document criminogenic risk and need for Substance use disorder treatment in each participant's clinical record,
 - 5. submit Drug Court Service Reports or any alternative data collection system adopted by DHS/DSAMH annually, and as requested to the DHS/DSAMH Justice Program Manager,
 - 6. disclose all participant fees related to Drug Court participation (treatment,

case management, drug testing, court fees etc.) 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,

7. 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. 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,
9. submit any evaluation or research to the DHS/DSAMH Justice Program Manager within 90 days of completion of the evaluation and research.
10. Use funds for treatment, case management, recovery support and drug testing expenses,
11. not use funds to pay for law enforcement, tracking or supervision conducted by law enforcement officers,
12. 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 throughout their episode of care with Medicaid enrollment.

- b. Drug Court Funding shall be determined in accordance with statute by the Director of the Department of Human Services, the Director of the Department of Corrections and the State Courts Administrator.
 1. Drug Courts that are non-compliant with Drug Court certification standards may have drug court funding withheld by DSAMH.
 2. LSSA's shall notify DSAMH of any court changes including court closures, changes in judges or court coordinators.

vi. Women's Treatment (WTA)

- a. Funds shall be used to serve pregnant women, and women with dependent children and women involved with the Division of Child and Family Services in need of substance use disorder treatment.
- b. Funds may 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.
7. Medications approved by the FDA for the treatment of substance use disorders.

vii. Women and Children's Residential Treatment (WTX):

- a. Salt Lake County, Utah County, Weber and Southwest shall submit a proposal with the area plan that demonstrates:
 1. the need for continued funding in light of Medicaid expansion and Targeted Adult Medicaid.,
 2. the proposed use of the funds,
 3. the strategy to ensure that services provided meet a statewide need, including access from other substance abuse authorities,
 4. includes a comprehensive budget.

viii. Utah Quality Youth Treatment Project (SYT)

- a. LSAA's shall participate in the Utah Quality Youth Treatment Project. Site visits will be conducted by the University of Utah, Social Research Institute (SRI) for all local authorities each year. This will include each agency's consideration of recruitment of youth to their programs, and referral out if services cannot be provided. Site visits will evaluate the quality of youth substance use disorder treatment programs with 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

ix. Opioid Treatment and Recovery Support Funds: (SOR)

- a. Federal Opioid grant funds are for the provision of evidence-based treatment and recovery support for individuals with opioid use disorders (OUD).
- b. Allowable uses for this funding shall 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 monoprodut formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine) in combination with psychosocial interventions.
 - 6. Provide treatment transition and coverage for patients who are incarcerated or who are reentering communities from criminal justice settings or other rehabilitative settings.
 - 7. Enhance or support the provision of Peer Support and other 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 LSAA's using the formula established in Administrative Rule.
- x. DUI: The LSAA shall comply with Utah Administrative Rule R523-2-9
- xi. Operation Rio Grande-Recovery Residence (SLF)
 - a. State General Funds are provided to Salt Lake County for the Operation Rio Grande (ORG) project to provide and or contract to provide vouchers for State Licensed Recovery Residence Facilities for the target population referred to in Section C, Subsection vii, as well as Case Management of the program. Services shall be reimbursed based on the approved service rates listed in the most current Recovery Support Services (RSS) Manual, which can be found at: <https://dsamh.utah.gov/pdf/ATR/FY21%20RSS%20Manual.pdf>
 - b. Client's Eligibility:
 - 1. Individuals in a residential level of care who are ready to step down to an Intensive Outpatient (IOP), day treatment, or general outpatient level

- of care;
 - 2. Individuals who are currently in Intensive Outpatient (IOP), day treatment or general outpatient treatment;
 - 3. Participants of any Salt Lake County drug court who can maintain an outpatient level of care;
 - 4. Individuals who have substantially completed the Correctional Addiction Treatment Services (CATS) program while housed in the Salt Lake County jail;
 - 5. Participant in Utah Highway Patrol (UHP) Frequent Utilizer Program;
 - 6. Participant in VOA, UT Journey Program;
 - 7. On an as-needed basis, placement following a team meeting discussion and approval from the local authority director.
- c. Salt Lake County shall collect and report quarterly on October 20, January 20, April 20, and July 20:
- 1. Number of individuals placed in Recovery Residence facilities
 - 2. Percent of clients with positive and negative random urinalysis tests while participating in voucher program
 - 3. Percent of clients with positive and negative exits from the program during the quarter
- xii. Recovery Residence Housing (SLF):
- a. Recovery Residences provide drug and alcohol free housing to clients who are at immediate risk for relapse as a result of their current housing situation. Sober supportive housing means a 24-hour group living environment providing room and board to eligible clients.
 - b. Recovery Residence housing providers shall meet one of the following:
 - 1. Be licensed through the Utah Department of Human Services, Office of Licensing as a Residential Support agency
 - 2. Be licensed by DHS, OL license as a residential treatment agency that is associated with the sober/transitional housing unit
 - 3. Be licensed by DHS, OL as a Recovery Residence
 - c. Services shall be reimbursed based on the approved service rates listed in the most current Recovery Support Services (RSS) Manual, which can be found at: <https://dsamh.utah.gov/pdf/ATR/FY21%20RSS%20Manual.pdf>

- d. Data shall be submitted in accordance with the RSS data spec file.
- xiii. Children with Parent in Residential Treatment Funds (CFT) (Salt Lake County) Funds for children reunifying in family treatment programs and children living with parents receiving residential substance use disorder treatment services:
- a. Purpose of Funds:
 - 1. Funds appropriated shall be used to provide services to children at risk of permanent removal from their parents.
 - 2. Funding is contingent on maintaining concurrent residential therapeutic services for children with the goal of reunification with their birth mother or father.
 - b. 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 immunization history; interaction with mother and other adults; language and general affect.
 - c. The following measures shall be gathered when services are provided:
 - 1. Family Reunification
 - (a) The number of children remaining with parents and kept out of foster care or
 - (b) The number of treatment days or average length of stay, the average age of the children served, including the number of babies born into treatment.
 - 2. Parental Abstinence
 - (a) The percentage of parents served will show abstinence from substances at discharge. Target: 90%
 - 3. Parental Employment
 - (a) The numbers of parents gainfully employed at the time of discharge. Target: 90%
 - 4. Stable Housing

- (a) The numbers of families connected to stable housing at discharge.
Target: 90%

- d. Salt Lake County shall collect and report data gathered from contracted agencies participating in the program to DSAMH on a quarterly basis, by the 15th of each consecutive month, October 15th, January 15th, April 15th, and July 15.

E. **SUBSTANCE USE DISORDER PREVENTION SERVICES**

- i. General Prevention Requirements: The Local Substance Abuse Authority (LSAA) shall work with communities using an evidence based community system, such as Communities that Care (CTC), PROSPER, or CADCA, to implement the Strategic Prevention Framework (SPF)
<https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf>
 - a. Implement Community Centered Evidence Based Prevention (CCEBP). DSAMH encourages the LSAA to utilize the CTC model to meet this directive.
 - b. CCEBP is defined as prevention work driven by community coalitions utilizing CSAP's Strategic Prevention Framework (SPF).
 - c. Coalitions should be defined by the following:
 - 1. prioritize substance use related risk and protective factors (as found on www.dsamh.utah.gov); and
 - 2. Serving one of the 99 small areas within Utah; Or
 - 3. Serving the communities that feed into a common high school;
 - 4. Any other definition with DSAMH approval.
 - d. The LSAA shall assess community readiness using the Community Readiness Tool.
 - e. The LSAA shall support communities identified in increasing capacity. Use Communities that Care Tools for Community Leaders Milestones and Benchmarks, PROSPER, or CADCA Coalition Academy.
 - f. The LSAA shall provide a brief description of the LSAA strategy for increasing effectiveness of CCEBP for each community identified in the Area Plan for identified/prioritized communities. Provide Logic Models for

programs funded through LSAA (regardless of funding) Identify funding source on the logic model.

- g. 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.
- h. Submit an annual Prevention Review 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.
- i. 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.
- j. 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.
- k. 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 the Evidence Based Workgroup (EBW) within one year.
- l. The evidence- based policies, programs and strategies shall be broken down as follows:
 - 1. A minimum of 90% of the policies, programs and strategies shall be tier 3 or 4 per tool provided by EBW, or be programs listed on a national evidenced based registry approved by DSAMH.
 - 2. A maximum of 10% of the policies, programs and strategies may be tier 1 or 2 per the tool provided by EBW. The tool is available on the DSAMH website.
- m. The LSAA shall submit an annual report (Budget Form C Actuals) that documents the number and costs of evidence based policy, programs and strategies each year to ensure prevention funding is spent on approved services.

- n. **Billing Requirements for Prevention:** The LSAA shall submit monthly invoices with sufficient detail to ensure that DSAMH can attribute billings to specific prevention activities. The invoices shall include categories found on the Form C Budget sheet.
- ii. **CTC:** The LSAA may request \$10,000 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 to the following guidelines:
 - a. Hire a CTC Coordinator and implement the CTC process.
 - b. The CTC coordinator must serve on the county’s prevention coalition as the CTC coordinator and work closely with the LA prevention coordinator to ensure CTC is implemented with fidelity.
 - c. The CTC/FPL funding must be matched by both dollars and in-kind contributions by county, city or community partners.
 - d. 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.
 - e. The LSAA shall:
 - 1. 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.
 - 2. Monitoring the CTC Coordinator’s performance to ensure fidelity to the CTC program guidelines. Annual checklists shall be kept on file.
 - 3. 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.
 - 4. 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.
 - 5. Ensure that prevention is delivered with high-fidelity as defined in the Communities of Care model, Community Plan Implementation Training Module 3:
 (http://www.sdr.org/ctcresource/Community%20Plan%20Implementation%20Training/Trainer%20Guide/CPIT_TG_mod3.pdf).
- iii. **Carbon County Prevention Initiative:**

- a. Funding shall be used by Southeast Health Department and Four Corners Behavioral Health to accomplish the following goals:
 1. Decrease opioid misuse and opioid overdose deaths in Carbon County;
 2. Decrease suicide attempts and suicide deaths in Carbon County;
 3. Increase evidence-based prevention activities in Carbon County.

- b. Southeast Health Department shall hire a full time Opioid Prevention/Intervention Specialist: to provide services which may include:
 1. Increase community readiness to deploy evidence based prevention programs, strategies and policies.
 2. Participate in community coalitions to address the risk and protective factors associated with opioid misuse and overdose.
 3. Provide Hepatitis C and HIV education and care coordination;
 4. Coordinate care for individuals/families after an overdose;
 5. Collaborate with community and other partners on using a statewide campaign as a foundation to develop a local public health campaign to increase awareness of and decrease opioid misuse and opiate overdose.
 - (a) Extend the reach of existing Statewide “Use Only as Directed and/or Stop the Opidemic” campaigns to increase awareness and decrease opioid- related problems.
 6. Collaborate with community and other partners to educate community members of the usefulness of Naloxone, and distribute naloxone.
 7. Provide training to teachers, hospitals, coalition members, schools and the public.

- c. Southeast Health Department shall hire a full time Suicide Prevention/Intervention Specialist: to provide services which may include:
 1. Increase community readiness to deploy evidence based suicide prevention programs, strategies, policies.
 2. Participate in community coalitions to address the risk and protective factors associated with suicide ideation, suicide attempts and suicide deaths.
 3. Coordinate care including crisis response and bereavement supports for individuals/families after suicides and attempts.
 4. Promote the state public health campaign designed to reduce the number of suicides in Carbon County.
 5. Aim to decrease the stigma of mental illness.
 6. Provide or coordinate Mental Health First Aid and QPR Trainings.

7. Work to identify and incorporate shared risk and protective factors into a Suicide Prevention plan for Southeast Health District/Carbon that includes universal, selective and indicated prevention.
 8. Provide evidence based training to teachers, hospitals, coalition members, schools and the public
- d. Four Corners Counseling Center shall employ a full time therapist (Masters level credential and licensed in the State of Utah) to provide services that may include:
1. Assess individuals incarcerated in jail and identify clinical and social needs and public safety risks;
 2. Plan for the treatment and services required to address the individual's needs, both in custody and upon reentry;
 3. Identify required community and correctional programs responsible for post-release services;
 4. Coordinate transition to avoid gaps in care with community-based services;
 5. Provide treatment services in the county jail;
 6. Expand crisis center staffing & managing 24-7 crisis services.
- e. Reporting requirements: Southeast Health Department and Four Corners Counseling Center will work individually with DSAMH to provide necessary data on their performance including:
1. identification of performance metrics for each component of this project. that include baseline data, and targets.
 2. Completion of a brief annual report that outlines project outcomes, challenges and accomplishments to be submitted by September 1 of each year.

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 shall 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, 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 Substance Use Disorder Event Data is the SUD.
 - d. The Information System Data Set for Recovery Support Services is the RS.
 - e. The Information System Data Set for Indicated Prevention is IP.
 - f. The Information System Data Set for MCOT/SMR is SR
 - g. The Information System Data Set for Universal and Selected Prevention is DUGS (Data User Gateway System).
 - h. Data Specifications are available for download from the DSAMH website at <https://dsamh.utah.gov/reports/data-specs>.
 - i. Electronic submissions must be made through the SAMHIS file utility app, or other method as instructed by DSAMH staff.
 - j. 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.
 - k. 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.
- l. Local Substance Abuse Authorities shall meet a 10% MHSIP survey sampling of Adult clients reported in the fiscal year and should meet a positive outcome of at least 75% of the national averages in consumer reported domains.
 - m. OQ Measure instruments are to be completed in the OQ Analyst Hosted System (OQA-HS).
 - n. 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.
 - o. Data findings may result if performance measures and/or scorecard results, used for contract monitoring, are determined to be inaccurately reported by the provider.
 - p. 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.
 - q. 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) and Youth Satisfaction Survey (YSS/YSS-F) Method
 1. Introduction: The MHSIP is a self-report consumer satisfaction survey for adults in mental health and/or substance use disorder treatment. 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 surveys are available in English and Spanish. The surveys are given as a point-in-time convenience survey

during the approved survey period (from January 1st through May 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 MHSIP is given to adult substance use disorder and mental health consumers regardless of the modality of treatment or length of stay in treatment. 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 (all ages).

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 based on the appropriate age population for each survey. 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. 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.

iv. OQ/YOQ Requirements and Reporting Guidelines:

- a. DSAMH requires a 50% utilization rate for the LMHA for clients served in publicly funded programs who experience serious mental illness or serious emotional disturbance. The instruments will require repeated administrations.
- b. DSAMH will require that the OQ/YOQ be given to patients and consumers who experience serious mental illness or serious emotional disturbance. 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 to individuals who experience serious mental illness or serious emotional disturbance 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 for clients with serious mental illness and serious emotional disturbance 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 45 calendar days of the delivery of service.

G. PERFORMANCE MEASURES

- i. For all performance measures, the Division shall continue to work with ROSC, clinical directors 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 FY2021 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 FY2021 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 FY2021: 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 FY2020 treatment retention in FY2021 and will work towards achieving a goal of 70%. Local Substance Abuse Authorities whose FY2020 retention rate was over 70% are required to meet or exceed a 70% retention rate in FY2021. Retention is defined as the percentage of clients who remain in treatment over 90 days.
 - b. Successful Treatment Episode Completion: Local Substance Abuse Authorities will meet or exceed their FY2020 Successful Treatment Episode Completion rates in FY2021 and will work towards achieving a goal of 60%. Local Substance Abuse Authorities whose FY2020 completion rate was over 60% are required to meet or exceed a 60% completion rate in FY2021. 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 a student from admit to discharge at a rate greater than 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 than 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 voluntary social support recovery activities increased from admission to discharge by at least 10%. Participation is measured as those participating in voluntary 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%.
- i. Recovery Support Services: Local Substance Abuse Authorities' shall increase the number of Recovery Support Services provided to clients as reported in the RSS data spec file (Target for FY2021 is an increase from the previous year).
- j. MHSIP: Local Substance Abuse Authorities' shall show percentage meets or exceeds National Average in FY2021 for Quality and Appropriateness of Services. .
- k. Government Performance and Results Act, GPRA: Local Substance Abuse Authorities' shall complete the required GPRA surveys for all applicable funding streams. For clients using federal funds, for treatment or recovery services, GPRA surveys should be completed at intake, three months post intake, six months post intake and at discharge. The follow up rate after

intake should be 80% .

- iv. Substance Use Disorder Prevention Performance Measures:
- a. Percent of retail establishments within the LA area that refused to sell tobacco to minors during Synar tobacco compliance checks. (Target for FY2021 is 90%.)
 - b. Number of “Eliminate Alcohol Sales to Youth” (EASY) alcohol compliance checks within the Local Authority area. (Target for FY2021 is an increase from the previous year.)
 - c. Percentage of communities identified in (area plan) using an evidence based operating system.
 - d. Number of communities that have increased readiness according to the Community Readiness Tool. Target for FY2021 is to establish a baseline measure.
 - e. Number of non-prevention professional coalition members that attend a prevention conference. (CADCA, NPN, Coalition Summit, Fall Conference, etc.) Target is to reach a minimum of two members from each coalition to a conference annually.
 - f. Percent of youth alcohol use within the past 30 days.. Use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019. Multiple Targets for FY2021: decrease use from previous SHARP administration.
 - g. Percent of youth and adult prescription drug misuse within the past 30 days. Use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019. Multiple Targets for FY2021: decrease use from previous SHARP administration. For adult measure, as available through BRFSS.
 - h. Percent of youth marijuana use within the past 30 days. Use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019. Multiple Targets for FY2021: decrease use from previous SHARP administration.
 - i. Reduce the number of opioid overdose deaths. Use Utah Department of Health overdose death data.
 - j. Increase the number of engaged community prevention coalitions.
 - k. Percent of youth nicotine use, including e-cigs within the Past 30 day use, e-cigs. Use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019). Multiple Targets for FY2021: decrease use from previous SHARP administration.

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Changes made to FY2021 Division Directives

Division of Substance Abuse and Mental Health

A. GOVERNANCE AND OVERSIGHT

- ii. The Area Plan packet must include the completed Forms A, B, C, D and the required fee policy and fee schedule, pursuant to Administrative Rule Section R523-2-5. The Area Plan packet must be completed by May 15th through the shared DSAMH/Local Authority Google Drive folder.
- ix. For each site visit, 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 [electronic remote](#) access to the selected charts [and all other documents requested by DSAMH](#) 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 chart reviews for the two years prior to the current monitoring year.
- xiv. DSAMH utilizes ~~DocuSign~~ [electronic signature platform](#) for obtaining signatures in the contracting process. The Local Authorities shall participate in this process by using ~~DocuSign~~ [electronic signature platform](#) 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.

- i. [Local Substance Abuse Authorities and Local Mental Health Authorities are expected to facilitate the health insurance application and enrollment process for eligible uninsured clients.](#)
- iv. Participation with key community partners (e.g.: Multi-Agency Coordinating Committees, ~~System of Care Committees~~ [Regional Advisory Councils](#), Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committees, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, ~~Juvenile Courts~~ [Courts](#), [Regional Healthcare Coalitions](#), 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/or program manager discussions.

- v. Local Authorities shall continue to establish and/or expand Adult, Youth, and Family Peer Support Services. Certified Peer Specialists and Family Resource Facilitators (Family Peer Support) 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 Local Authorities to have policy and procedures to provide guidelines and supports for Certified Peer Support Specialists and Family Resource Facilitators.
- vii. Local Authorities shall ~~work~~ partner with the DHS System of Care ~~to provide and participate on High Fidelity Wraparound teams to provide mental health expertise~~ and 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.
- viii. Suicide prevention, intervention and postvention: During FY2021, Local Authorities will continue to ~~implement, monitor~~ participate in and report on ~~their plans~~ suicide prevention, intervention, and postvention activities.
 - a. Prevention: Local Authorities will submit a localized suicide prevention plan for the agency or broader local community. This plan should include a comprehensive approach to suicide prevention (primary prevention, intervention, postvention). The state plan should be used as a guide. https://drive.google.com/file/d/1V4cgYvf_JGs1CNvBYY2XmoFfwSPOIPM3/view
 - b. Intervention: Records must contain a safety/crisis plan that includes indication of lethal means counseling when clinically indicated which can be quickly and easily accessed and updated as needed.
 - c. Intervention: Local Authorities shall create a training implementation plan for Counseling on Access to Lethal Means (CALM) and report on the number and percentage of staff who completed the training. (<https://www.train.org/utah/course/1081014/>)
 - d. Postvention: Local Authorities shall develop a plan for coordination with Local Health Departments to identify roles and support implementation of a community postvention plan in alignment with the state Community Postvention Toolkit.

- e. Local Authorities participating in the Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant Program will implement skill based programming, gatekeeper training, community or school based screening activities, and crisis follow up services after inpatient or emergency department visits.
- ix. 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:
 - f. Identify ~~to~~ ~~ba~~ ~~ce~~ ~~e~~ ~~n~~ ~~i~~ ~~c~~ ~~o~~ ~~t~~ ~~i~~ ~~n~~ ~~e~~ use in the assessment.
 - g. Provide services in a nicotine free environment.
 - h. Provide appropriate ~~smoking~~ ~~n~~ ~~i~~ ~~c~~ ~~o~~ ~~t~~ ~~i~~ ~~n~~ ~~e~~ cessation services and resources (including medication).
 - i. Implement a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB.
 - j. Train staff in recognizing health issues often seen in the behavioral health population, and provide information and referrals as appropriate.
- 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:~~
- xi. **Adult Justice Reform (JRI) : LMHA and LSAA shall:**
 - a. Provide ongoing training to staff on criminogenic risk, need, and responsivity.
 - b. Prioritize recommendations from **the** 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.
 - c. **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.**
 - d. **All 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.

- e. Funds may be expended on the following: training on risk, need and responsivity, forensic screening & assessments to determine if treatment should be ordered, criminogenic risk screening and assessment, treatment services including medications for individuals without other payer resource, recovery support services as outlined in RSS manual, and care coordination with criminal justice stakeholders.

- xii. Juvenile Justice Reform: DSAMH encourages ~~LMHA and LSAA~~ LA participation in State and Local juvenile justice reform efforts. ~~This includes collaboration with the Division of Juvenile Justice Services' Youth Service Centers and their Youth Services Model.~~

- xiii. ~~Local Authorities shall have access to a telehealth platform.~~ Local Authorities may utilize telehealth to provide services to supplement the continuum of care offered in traditional settings. These are services delivered in real-time using internet-based videoconferencing technologies through personal computers and mobile devices. In providing telehealth services, it is also encouraged to develop policies and procedures that are specific to the provision of services using this technology. Sample guidelines may be found at <http://hub.americantelemed.org/resources/telemedicine-practice-guidelines>.

- ~~xvi. Local Authorities who engage in the Utah Behavioral Health Outcome Improvement Initiative Pilot (OHP) and Technical Assistance (TA) Collaborative Sponsored by the Utah Quality of Care Committee of DSAMH as either a TA provider or recipient will recognize funding is dedicated to the following specifications:~~
 - ~~a. Provide or receive TA for in utilizing implementation frameworks and strategies to increase the effective use of treatments that improve client outcomes. Senior management will alter the organizational infrastructure of the agency to support the uptake and sustainability of treatments that work, be able to select sustainable research-based treatments and implement them as designed in the research settings and be able to accomplish the work in each phase of implementation such that clients benefit from the research-based treatment.~~

 - ~~b. provide or receive TA support for any managers or supervisor involvement including the CEO, CFO, and Clinical Director or designee authorized with decision making authority and will participate in all training, consultation calls, and in-person meetings associated with the initiative. Identify and use internal agency resources to select and implement one new research-based treatment during the initiative time period. Commit time and other necessary resources to ensure the stages of implementation are followed. Commit resources and time through organizational infrastructure changes necessary to~~

~~provide internal, ongoing supervision and monitoring of the research-based treatment(s).~~

~~e. Provide or participate in: May to July 2019—2 day in-depth training; June to Aug through Oct to Dec 2019—1.5 hour consultation calls monthly; November 2019 to Jan 2020—½ day mutual learning collaborative; December 2019 to Feb 2020 through May to July 2020 1.5 hour consultation calls and; June to Aug 2020—1 day reporting of capstone projects~~

~~d. Provide support or Implement planning from 2 day in-depth training to influence quality culture and implement at least one evidence based practice to fidelity as outlined in training implementation science model with sustainability planning.~~

~~e. Support compilation and provide Pre-Post Measures: Number of implementation drivers present in the organization prior to involvement with the initiative compared to post-initiative and Number of evidence based practices available within the organization pre-initiative compared to post-initiative.~~

~~f. Each fiscal year support submission or submit the following reports to the DSAMH Assistant Director at the Annual in-person or phone monitoring at the conclusion of services: Dates of each in person training including the number of participants/agencies in each training. Dates and names of each person on consultation call. Pre-Post Measures for each participating organization, including names of evidence based practices implemented.~~

xvii. Local Authorities shall develop a disaster preparedness and recovery plan for programs that provide prevention, treatment and recovery support for mental illness and substance use programs. The Local Authorities (LA) shall identify the critical functions of its business operations and develop an emergency management and business continuity plan that will allow the LA to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business. The plan must address at least the following areas: evacuation procedures; temporary or alternate living plans; plans for isolation or quarantine; maintenance, inspection, and replenishment of vital supplies (including food, water, clothing, first aid supplies, medical necessities, client medications, infection control supplies, and hazardous material protections); communications with LA staff, governmental agencies, and clients' families; transportation; recovery and maintenance of client records; and policies and procedures that: 1) ensure maintenance of required staffing ratios; 2) address both leave for and the recall of LA employees unable to work for extended periods due to illness during periods of declared pandemic; and 3) ensure the

timely discharge of the LA financial obligations, including payroll. The LA shall provide at least annual training for its staff on its plan. The LA shall provide DSAMH with a copy of its plan and evidence of staff training. The LA shall evaluate its plan at least annually.

changed on 10/7/20

- xviii. Each Local Authority will work to identify at least one provider that is a specialist in maternal mental health, or will identify a provider to be trained as a specialist in maternal mental health. **Specialists will have received 12 hours of maternal mental health training and will be available for in-person and telehealth services.** Local Authorities will provide the name and stage of training for each identified maternal mental health specialist by December 31 each year.
- xix. DSAMH encourages Local Authorities to identify a staff member or team to be trained in infant and early childhood mental health to provide evidenced based modalities for children birth to five. Local Authorities, when appropriate, should also refer and collaborate with other early childhood community partners to ensure coordinated treatment and increase support for young children and their families.
- xx: Each local mental health/substance use authority will identify a staff member/position responsible to collaborate with DSAMH to conduct needs assessment/gap analysis for health disparities and for youth in transition services 2020-2021. The responsible position will work with DSAMH staff to design, plan, and implement local assessments, which may include focus groups.
- xxi: All local authorities and all sub-recipients shall comply with the following: Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended. . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

- xxii Substance Abuse Block Grant and Mental Health Block Grant funds may be used to provide cost-sharing assistance for behavioral health insurance deductibles, coinsurance, and copayments to assist eligible clients receiving service at an eligible provider. Block grant may also be used to help individuals meet their cost-sharing responsibilities under a health insurance or benefits program, including high risk pools.
- a. Eligible clients include individuals and families below 400 percent of the federal poverty level in need of medically necessary substance use disorder or mental health treatment.
 - b. Local Authorities may develop policy to determine the amount of assistance an individual may receive based on income and family size.
 - c. Block grant funds may only be used to pay for deductibles, coinsurance, and copayments directly related to the provision of medically necessary substance use or mental health treatment.
 - d. All payments shall be made directly to the provider of service.
 - e. Payments shall only be made to public or nonprofit entities.
 - f. In all circumstances, cash payments to the intended recipient of health services is strictly prohibited
- xxiii. Local Authorities receiving funding appropriated by the Utah State Legislature for the operation of a Behavioral Health Home for individuals with substance use and mental health disorders. The Local Authority shall use the funds to operate a Behavioral Health Home for individuals with substance use and mental health disorders. The Behavioral Health Home shall:
- c. Screen individuals with substance use and mental health disorders for general health and for conditions for which they are at high risk.
 - d. Ensure clients receive treatment for heart disease diabetes, obesity and other physical health conditions prevalent in populations with substance use and mental health disorders.
 - c. Provide smoking cessation services that include medication and other evidence-based approaches.

- d. Offer prevention and intervention for modifiable risk factors associated with poor health outcomes and care gaps.
- e. Provide comprehensive care management services that include identification and targeting of high-risk individuals, monitoring of health status and adherence to treatment plans, development of treatment guidelines and individualized planning with clients.
- f. Provide mobile crisis outreach services to individuals experiencing, or at risk of a physical health or mental health crisis, and who require intervention.
- g. Provide follow-up services including information and referrals, linkage with appropriate services for ongoing treatment.
- h. Track and improve performance through creation and operation of a patient disease registry that includes historic information on clients, the results of metabolic screening and other assessments.

The Local Authority shall:

- a. Include the Behavioral Health Home as a Cost Center in the Medicaid Cost Report if it is to be included as an expense against the budget for allocation.
- b. Submit the following to the DHS/DSAMH Adult Mental Health program administrator a quarterly report due by the 15th of the quarter to provide:
 - 4. Narrative that outlines the major accomplishments, activities and challenges of operating the Behavioral Health Home during the reporting period.
 - 5. A statistical report that identifies how many unique clients have been served by the behavioral home health, the type of services received and the number of hours of direct care provided.
 - 6. An outcome report that identifies how many clients from admission to discharge show improved health and functioning related obesity, cholesterol, triglycerides, blood pressure, blood sugar, smoking and mental illness symptomology.

C. MENTAL HEALTH SERVICES

- iv. Local Authorities shall utilize ~~Wraparound Facilitation (as defined by the Utah Family Coalition and/or Nationally accepted evidence-based Wraparound~~

~~Facilitation Definition~~ and/or participate in High Fidelity Wraparound (as defined by Nationally accepted evidence based practices and standards for High Fidelity Wraparound) 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, at annual monitoring and observed compliance of ~~Wraparound Facilitation~~ High Fidelity Wraparound as defined.

- v. ~~Participation in USH~~ Local Authorities shall participate in Utah State Hospital (USH) Adult and Children Continuity of Care meetings in accordance with R523-2-12 .
 - 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). Patients referred for discharge shall be discharged from USH within 30 calendar days, with consistent documentation ~~unless otherwise documented in the REDI System (Readiness and Evaluation Discharge Implementation)~~ in the USH electronic system.
- 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. If funds are received through Local Education Agency (LEA) contracting, report the new funding in Form A2 and Form A. This legislative funding requires the tracking of spending and outcomes related to each service provision, per legislative intent language and requires quarterly completion of the MHEI Quarterly Data and Annual Outcomes Report via the qualtrics survey: https://utahgov.co1.qualtrics.com/jfe/form/SV_43nStXZzUBHtekt. Funds will be allocated on formula and are subject to the County 20% match requirement.

Local Authorities are encouraged to work with LEAs to offer telehealth based services for children and youth within a school setting. Local Authorities are encouraged to have policies and procedures regarding the provision of telehealth based services in a school setting. Data collection for school based telehealth services shall align with the reporting measures for the MHEI Quarterly Data and Annual Outcomes Report above.
- vii. ~~Salt Lake County Behavioral Health, the principal Local Authority involved with~~

Operation Rio Grande: Salt Lake County 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 and according to the Assertive Community Outreach Treatment (ACOT) model to include Housing First, Trauma-informed care, and motivational interviewing. Ensure the assessments of eligible individuals include, but not be limited to, the Service Prioritization and Decision Assistance Tool (SPDAT). Data shall be entered and reportable to DSAMH at least annually or upon request, using the Homeless Management Information System (HMIS) on the following performance measures including the following elements as available, in addition to demographic data: Abstinence from use, Housing status, Employment status, Criminal justice system involvement, Access to services, Retention in services; and Social connectedness; Number of unduplicated individuals served Number of unduplicated individuals housed; Number of individuals receiving mental health treatment; Number of individuals receiving substance use treatment; Number of individuals experiencing housing stability six months or longer; Number of individuals with increased enrollment in mainstream benefits; Number of individuals with increased income overall; Number of individuals with increased earned income. Salt Lake County Behavioral Health shall also coordinate with DSAMH to report to the Legislature according to the intent language “(1) what specific savings were generated, (2) who received the savings, and (3) what the funding sources were for these savings. For FY 2020 items, the recipient shall provide the report by August 31, 2020.”

- ~~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 according to standard quarterly state fiscal year reporting. 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.~~
 - ~~b. 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) ~~At home;~~
 - (b) ~~Hospital/ER;~~
 - (c) ~~Residential;~~
 - (d) ~~Detention/Jail;~~
 - (e) ~~Emergency shelter/Homeless shelter;~~
 - (f) ~~Other family;~~
 - (g) ~~Foster/Proctor placement;~~
 - (h) ~~Went missing;~~
 - (i) ~~Access center/23 hour crisis bed/receiving center;~~
 - (j) ~~Detox (outside of ER)~~
 - (k) ~~Other - please describe.~~
 4. ~~Number of Contacts by Referral Source for both Adults and Youth, including:~~
 - (a) ~~Parent;~~
 - (b) ~~Child;~~
 - (c) ~~Other family member or friend;~~
 - (d) ~~Physician or medical facility;~~
 - (e) ~~Social or community agency;~~
 - (f) ~~Educational system;~~
 - (g) ~~Courts, law enforcement, correctional agency;~~
 - (h) ~~Private psychiatric/mental health program;~~
 - (i) ~~Public psychiatric/mental health program;~~
 - (j) ~~Clergy;~~
 - (k) ~~Private practice mental health professional;~~
 - (l) ~~Stabilization worker;~~
 - (m) ~~Utah Crisis Line;~~
 - (n) ~~Other - please describe;~~
 - (o) ~~Unknown;~~
 - (p) ~~Not Applicable.~~
 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) CHIP;~~
- ~~(e) None;~~
- ~~(f) Unknown;~~
- ~~(g) Other - please describe.~~

~~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;~~

viii. Local Authorities (LA) who engage in community oriented crisis services shall utilize [SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#) as guidance for development, implementation, and quality improvement efforts.

a. Local Authorities who provide Mental Health Crisis Outreach Teams (MCOT) will provide services as outlined in Utah R523-18, related Utah Annotated Code. Any requests to be exempted for any requirement outlined in rule shall be submitted to the Division Director and if approved be attached as an addendum to the area plan. Area plans should describe all services to be included under "crisis stabilization". Providers shall submit data via MCOT/SMR data spec quarterly on the following dates:

July 1- September 30, due October 20;
 October 1- December 31, due January 20;
 January 1- March 31, due April 20; and
 April 1- June 30, due July 20;

b. Local Authorities who operate Receiving Centers will provide services as outlined in Utah Code 62A-15-118 and Utah Rule governing receiving centers once adopted. Providers shall submit data as outlined in the agreed upon grant agreement.

ix. In accordance with 62A-15-631 ~~and the Assisted Outpatient Treatment bill passed in the 2019 Legislative session;~~ the Local Mental Health Authorities shall develop tracking and protocols, and shall provide a current list of the individuals and their providers upon request, for all adults who have been civilly committed and those

placed on an assisted outpatient treatment court order to their agency.

changes made 10/7/20

- x. Local Authorities that receive funding from DSAMH for development and maintenance-operation of ~~specifically Davis Behavioral Health (DBH) and Weber Human Services (WHS), who are participating in the Utah~~ Assisted Outpatient Treatment (AOT) services ~~grant through September 2020 shall recognize funding is dedicated to all of the specifications of this Substance Abuse Mental Health Services Administration (SAMHSA) grant (SM63545). Local Authorities will shall coordinate with DSAMH and SAMHSA in all required planning, implementation, data, billing and reporting requirements in the grant and will shall hold any subcontractors to the same specifications. DBH and WHS recognize that the goals below are ongoing and require evaluation and process improvement throughout the life of the grant. DBH and WHS will shall~~ meet the following goals:
 - b. Provide evidence-based services aimed at improving treatment outcomes for adults with Serious Mental Illness (SMI) who are either civilly committed or have an AOT court order ~~court-ordered into the AOT Program~~ and who have a history of poor treatment compliance.
 - ~~e. Provide services aimed at decreasing inpatient healthcare and incarceration service/system utilization.~~
 - c. Train staff in the AOT model of treatment, which includes a combination of Evidence Based treatment and support services.
 - d. Develop enhanced relationships, communication, coordination between courts, police, hospitals, jails, and other community partners.
 - ~~f. Participate in the AOT Steering Committee Meeting in an effort to improve and sustain AOT services at their sites and to make recommendations for expanding and sustaining the AOT Program state-wide.~~
 - ~~g. Collect data on their patient populations as required by SAMHSA and submit data through the SAMHSA Performance Accountability and Reporting System (SPARS). Sites will then use the outcome data to improve the AOT Program for their clients.~~
- xi. Local Authorities providing Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment (ACOT): Local Authorities shall provide and/or contract for evidence based practices to improve behavioral health

and access to mainstream public health benefits to the target population who have serious mental illness. Local Authorities are expected to adhere to Utah Rule governing ACT once adopted and follow SAMHSA ACT Program to fidelity see as follows: <https://store.samhsa.gov/>. The Contractor shall provide individualized treatment, case management and Recovery Support Services based on need through ACT or ACOT to include trauma-informed care, motivational interviewing, and other evidence based supports. The populations to be served are individuals who:

- a. Are 18 years and over;
 - b. Are adults with serious mental illness, with severe functional impairments, who have not engaged in or responded well to traditional outpatient mental health care and psychiatric rehabilitation
- xiv. Local Authorities who receive funding for the Autism Spectrum Disorders (ASD) Mental Health Preschool program will focus on providing services for preschool-aged children with ASD, typically aged two through five, and their families, but exceptions are allowed with approval from DSAMH. Services for children include assessment of ASD and related mental health concerns, therapeutic interventions to address ASD needs, and referral to other resources. Parents/guardians and siblings of these children should receive psychoeducation, guidance, and counseling with respect to the child with ASD. Current available funding is for non-Medicaid services. Each program will maintain a minimum constant enrollment of at least 24 children and maintain a waiting list of other eligible children who are not yet enrolled in Kindergarten. Use of evidence-based curriculum in the provision of therapeutic and education services for individuals with autism is expected. Local Authorities will provide the following;
- a. Data collection, tracking, and monitoring to guide treatment planning and implementation.
 - b. Auxiliary services that include but are not limited to psychiatric services including diagnosis and treatment, medication management, case management, and linking families to other treatment and community resources as needed.
 - c. Conduct strength-based assessment of each child that includes an evaluation of the child's developmental, cognitive, adaptive, and behavioral functioning.
 - d. Develop an individualized treatment plan for each child enrolled.

- e. Coordinate transition planning with the child, parent/guardian and the school district prior to the end of services.
 - f. Parents are to participate in the classroom on a weekly basis as their schedule allows.
 - g. Provide employee training opportunities to keep current on quality program services. Each employee must receive at least six (6) hours of training yearly.
- xv. The Local Authorities shall submit six month progress reports each year by January 31st and an annual report by July 31st. Each progress report must include but are not limited to the following data:
- a. General overview of the autism services provided
 - b. Eligibility requirements for the program
 - c. Achievements/progress/outcomes during the previous six-months
 - d. Barriers/Possible solutions or goals
 - e. Family satisfaction/input/in-services
 - f. The number of:
 - 1. Preschool children (unduplicated) currently enrolled who received services funded by DHS/DSAMH
 - 2. Parents/guardians (unduplicated) who received services funded by DHS/DSAMH during the past fiscal year
 - 3. Siblings (unduplicated) who received services funded by DHS/DSAMH during the past fiscal year
 - g. The number of children currently on a waiting list
 - h. The number of children in the last six (6) months who:
 - 1. Have been accepted off of the currently waiting list
 - 2. Have aged off of the waiting list
 - 3. Have been denied services and the reasons for denial
 - 4. Have terminated services and the reason for termination

- i. Other program demographics as defined by DHS/DSAMH

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.~~
- i. The Local Substance Abuse Authority (LSAA) shall provide ongoing training and monitoring to ensure that clinical services including assessment, withdrawal management, treatment planning, treatment management, care coordination and continuing care management are consistent with the ASAM Criteria.
<https://www.asam.org/docs/default-source/practice-support/quality-improvement/standards-of-care-final-design-document.pdf?sfvrsn=0>
- ii. All LSAA treatment programs shall:
 - a. educate staff to identify overdose and to administer Naloxone;
 - b. maintain Naloxone in facilities;
 - c. provide Naloxone kits, education and training to individuals with opioid use disorders and when possible to their families, friends, and significant others.
- iii. LSAA's shall provide directly or through contract access to Methadone, Buprenorphine and Naltrexone for individuals with opioid use disorder and medications approved by the FDA for alcohol use disorder.
- v. Drug Courts (ADC)
 - a. Drug Courts shall ~~comply with the following requirements:~~
 - 1. 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. ensure drug testing occurs on weekends and holidays as required by Utah Council Rule 4-409,
 - 3. serve participants identified as High Risk/High Need by using a validated criminogenic risk tool,
 - 4. ~~identify and document criminogenic risk and need for Substance use disorder treatment~~ Documentation of High Risk/High Need shall be ~~placed/maintained~~ in each participant's clinical record,
 - 5. ~~submit~~ 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,
 - 6. ~~disclose~~ all participant fees related to Drug Court participation (treatment,

case management, drug testing, court fees etc.) 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,

7. ~~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. 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,

~~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. [submit any evaluation or research to the DHS/DSAMH Justice Program Manager within 90 days of completion of the evaluation and research.](#)

10. Use funds for treatment, case management, recovery support and drug testing expenses,

11. not use funds to pay for law enforcement, tracking or supervision conducted by law enforcement officers,

12. 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 throughout their episode of care with Medicaid enrollment.

b. Drug Court Funding shall be determined in accordance with statute by the Director of the Department of Human Services, the Director of the Department of Corrections and the State Courts Administrator.

1. Drug Courts that are non-compliant with Drug Court certification standards may have drug court funding withheld by DSAMH.

2. LSSA's shall notify DSAMH of any court changes including court closures, changes in judges or court coordinators.

~~iv. The Local Authority shall provide ongoing training and monitoring to ensure that clinical services are consistent with the ASAM Criteria.~~

~~v. Drug-Related Offenses Reform Act (DORA)~~

~~a. 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.~~

vi. ~~Women's SAPTBG set aside~~ **Women's Treatment (WTA)**

- b. Funds shall be used to serve pregnant women, and women with dependent children ~~in need of substance use disorder treatment~~ and women involved with the Division of Child and Family Services ~~with the permanency goal of reunification are also eligible for SAPTBG funds, which should be documented in the clinical chart~~ **in need of substance use disorder treatment.**

~~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);~~

- b. Funds may 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.
 7. **Medications approved by the FDA for the treatment of substance use disorders.**

vii. ~~For local authorities receiving State General Funds for children living with parents receiving residential substance use disorder treatment services:~~

- a. ~~Purpose of Funds:~~

1. Funds appropriated shall be used to provide services to children at risk of permanent removal from their parents.
 2. Funding is contingent on maintaining concurrent residential therapeutic services for children with the goal of reunification with their birth mother or father.
- b. 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 immunization history; interaction with mother and other adults; language and general affect.
- viii. ~~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.~~
- vii. ~~Women and Children's Residential Treatment (WTR):~~
- a. Salt Lake County, Utah County, Weber and Southwest shall submit a proposal with the area plan that demonstrates:
 1. the need for continued funding in light of Medicaid expansion and Targeted Adult Medicaid.,
 2. the proposed use of the funds,
 3. the strategy to ensure that services provided meet a statewide need, including access from other substance abuse authorities,
 4. includes a comprehensive budget.
- xix. Opioid Treatment and Recovery Support Funds: (SOR)
6. Provide treatment transition and coverage for patients who are incarcerated or who are reentering communities from criminal justice settings or other rehabilitative settings.
- x. ~~DUI Fee-On-Fine Funds:~~ The LSAA shall comply with Utah Administrative Rule R523-2-9
- xi. ~~Operation Rio Grande-Sober Living~~ Recovery Residence (SLF)

- a. State General Funds are provided to Salt Lake County for the Operation Rio Grande (ORG) project to provide and or contract to provide vouchers for State Licensed ~~Sober Living~~ Recovery Residence Facilities for the target population referred to in Section C, Subsection vii, as well as Case Management of the program. Services shall be reimbursed based on the approved service rates listed in the most current Recovery Support Services (RSS) Manual, which can be found at:
<https://dsamh.utah.gov/pdf/ATR/FY21%20RSS%20Manual.pdf>

- b. Client's Eligibility ~~shall include one of the following requirements:~~
 1. Individuals in a residential level of care who are ready to step down to an Intensive Outpatient (IOP), day treatment, or ~~general~~ outpatient level of care;
~~ORG drug court participants who can maintain an outpatient level of care;~~
~~Graduates of the Correctional Addiction Treatment Services (CATS) program while housed in the Salt Lake County jail;~~
 2. Individuals who are currently in Intensive Outpatient (IOP), day treatment or general outpatient treatment;
 3. Participants of any Salt Lake County drug court who can maintain an outpatient level of care;
 4. Individuals who have substantially completed the Correctional Addiction Treatment Services (CATS) program while housed in the Salt Lake County jail;
 5. Participant in Utah Highway Patrol (UHP) Frequent Utilizer Program;
 6. Participant in VOA, UT Journey Program;
 7. On an as-needed basis, placement following a team meeting discussion and approval from the local authority director.

- ~~e. Invoices shall be submitted to DSAMH monthly via electronic billing system established by the Division~~

- c. ~~Local Authorities participating in the program~~ Salt Lake County shall collect and report quarterly on October 20, January 20, April 20, and July 20:
 1. Number of individuals placed in ~~Sober Living~~ Recovery Residence facilities
 2. Percent of clients with positive and negative random urinalysis tests while participating in voucher program

3. Percent of clients with positive and negative exits from the program during the quarter
- ~~3. Ensure there is a priority placed on clients established as ORG eligible~~
- ~~4. Available beds are backfilled with ORG clients~~

~~xiii. Medication Assisted Treatment (MAT)~~

- ~~a. State General Funds are provided to Salt Lake County Behavioral Health and Davis County Behavioral Health for the purpose of providing MAT in combination with counseling and behavioral therapies to provide a “whole-patient” approach.~~
- ~~b. Local Authorities participating in the program shall collect and report to DSAMH the following Metrics quarterly on October 20, January 20, April 20, and July 20:

 - ~~1. Cost per client,~~
 - ~~2. Changes in employment, housing, and income among clients~~
 - ~~3. The number of new charge bookings among clients,~~
 - ~~4. Measures of cost-effectiveness,~~
 - ~~5. Options for reducing the cost of treatment, and~~
 - ~~6. Options for continued funding beyond the current one-time funding~~~~
- ~~e. Invoices shall be submitted to DSAMH monthly via electronic billing system established by the Division.~~

~~xiv. Salt Lake County Behavioral Health is the principal Local Authority involved with agencies receiving State General Funds for children reunifying in family treatment programs and children living with parents receiving residential substance use disorder treatment services:~~

- ~~a. Purpose of Funds:

 - ~~1. Funds appropriated shall be used to provide services to children at risk of permanent removal from their parents.~~
 - ~~2. Funding is contingent on maintaining concurrent residential therapeutic services for children with the goal of reunification with their birth mother or father.~~~~
- ~~b. 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 immunization history; interaction with mother and other adults; language and general affect.~~

~~e. The following measures shall be gathered when services are provided:~~

~~1. Family Reunification~~

~~(a) The number of children remaining with parents and kept out of foster care or~~

~~(b) The number of treatment days or average length of stay, the average age of the children served, including the number of babies born into treatment.~~

~~2. Parental Abstinence~~

~~(a) The percentage of parents served will show abstinence from substances at discharge. Target: 90%~~

~~3. Parental Employment~~

~~(a) The numbers of parents gainfully employed at the time of discharge. Target: 90%~~

~~4. Stable Housing~~

~~(a) The numbers of families connected to stable housing at discharge. Target: 90%~~

~~d. Salt Lake County shall collect and report data gathered from contracted agencies participating in the program to DSAMH on a quarterly basis, by the 15th of each consecutive month, October 15th, January 15th, April 15th, and July 15th.~~

xii. Recovery Residence Housing (SLF):

- a. Recovery Residences provide drug and alcohol free housing to clients who are at immediate risk for relapse as a result of their current housing situation. Sober supportive housing means a 24-hour group living environment providing room and board to eligible clients.
- b. Recovery Residence housing providers shall meet one of the following:
 1. Be licensed through the Utah Department of Human Services, Office of

- Licensing as a Residential Support agency
 - 2. Be licensed by DHS, OL license as a residential treatment agency that is associated with the sober/transitional housing unit
 - 3. Be licensed by DHS, OL as a Recovery Residence
 - c. Services shall be reimbursed based on the approved service rates listed in the most current Recovery Support Services (RSS) Manual, which can be found at: <https://dsamh.utah.gov/pdf/ATR/FY21%20RSS%20Manual.pdf>
 - d. Data shall be submitted in accordance with the RSS data spec file.
- xiii. Children with Parent in Residential Treatment Funds (CFT) (Salt Lake County) Funds for children reunifying in family treatment programs and children living with parents receiving residential substance use disorder treatment services:
 - a. Purpose of Funds:
 - 1. Funds appropriated shall be used to provide services to children at risk of permanent removal from their parents.
 - 2. Funding is contingent on maintaining concurrent residential therapeutic services for children with the goal of reunification with their birth mother or father.
 - b. 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 immunization history; interaction with mother and other adults; language and general affect.
 - c. The following measures shall be gathered when services are provided:
 - 1. Family Reunification
 - (a) The number of children remaining with parents and kept out of foster care or
 - (b) The number of treatment days or average length of stay, the average

age of the children served, including the number of babies born into treatment.

2. Parental Abstinence

(a) The percentage of parents served will show abstinence from substances at discharge. Target: 90%

3. Parental Employment

(a) The numbers of parents gainfully employed at the time of discharge. Target: 90%

4. Stable Housing

(a) The numbers of families connected to stable housing at discharge. Target: 90%

d. Salt Lake County shall collect and report data gathered from contracted agencies participating in the program to DSAMH on a quarterly basis, by the 15th of each consecutive month, October 15th, January 15th, April 15th, and July 15.

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://trichniccenter.colostate.edu/docs/CR_Handbook_8-3-15](http://trichniccenter.colostate.edu/docs/CR_Handbook_8-3-15)~~

[.pdf](#)

(d) ~~Communities that Care, Community Assessment Training (CAT)~~
~~<http://www.communitiesthatare.net/getting-started/etc-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) and recertified at least every 3 years. It is an option between FY2019 and FY2020 to certify all local authority prevention coordinators in Universal Prevention Curriculum (UPC):~~
 6. ~~Identify all training needed and planned to complete in the 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.~~
- e. ~~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, LSAA's shall identify prioritized communities. Each prioritized community shall have a strategic plan.~~
 2. ~~LSAA's Strategic plan shall include how the LSAA will work with and support coalitions in their strategic plan:~~
- d. ~~Implement or support 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
- e. — The LSAA may request \$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 to 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.communitiesthatare.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.communitiesthatare.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.
- f. — 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.sdr.org/eteresource/Community%20Plan%20Implementation%20Training/Trainer%20Guide/CPIT_TG_mod3.pdf).
1. — LSAAs will identify tools or techniques to ensure high fidelity of implementation of prevention programs, policies and practices.
- g. — 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.

- h. ~~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.~~
- i. ~~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.~~
- j. ~~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
- k. ~~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.~~
- l. ~~The LSAA shall submit an annual report that documents the number and costs of evidence based policy, programs and strategies each year to ensure prevention funding is spent on approved services.~~

- m. ~~Billing Requirements for Prevention: The LSAA shall submit monthly invoices with sufficient detail to ensure that DSAMH can attribute billings to specific prevention activities. The invoices shall include categories found on the Form C Budget sheet.~~

- i. General Prevention Requirements: The Local Substance Abuse Authority (LSAA) shall work with communities using an evidence based community system, such as Communities that Care (CTC), PROSPER, or CADCA, to implement the Strategic Prevention Framework (SPF)
<https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf>
 - a. Implement Community Centered Evidence Based Prevention (CCEBP). DSAMH encourages the LSAA to utilize the CTC model to meet this directive.
 - b. CCEBP is defined as prevention work driven by community coalitions utilizing CSAP's Strategic Prevention Framework (SPF).
 - c. Coalitions should be defined by the following:
 - 1. prioritize substance use related risk and protective factors (as found on www.dsamh.utah.gov); and
 - 2. Serving one of the 99small areas within Utah; Or
 - 3. Serving the communities that feed into a common high school;
 - 4. Any other definition with DSAMH approval.
 - d. The LSAA shall assess community readiness using the Community Readiness Tool.
 - e. The LSAA shall support communities identified in increasing capacity. Use Communities that Care Tools for Community Leaders Milestones and Benchmarks, PROSPER, or CADCA Coalition Academy.
 - f. TheLSAA shall provide a brief description of the LSSA strategy for increasing effectiveness of CCEBP for each community identified in the Area Plan for identified/prioritized communities. Provide Logic Models for programs funded through LSAA (regardless of funding) Identify funding source on the logic model.
 - g. 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.

- h. Submit an annual Prevention Review 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.
 - i. 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.
 - j. 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.
 - k. 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 the Evidence Based Workgroup (EBW) within one year.
 - l. The evidence- based policies, programs and strategies shall be broken down as follows:
 - 3. A minimum of 90% of the policies, programs and strategies shall be tier 3 or 4 per tool provided by EBW, or be programs listed on a national evidenced based registry approved by DSAMH.
 - 4. A maximum of 10% of the policies, programs and strategies may be tier 1 or 2 per the tool provided by EBW. The tool is available on the DSAMH website.
 - m. The LSAA shall submit an annual report (Budget Form C Actuals) that documents the number and costs of evidence based policy, programs and strategies each year to ensure prevention funding is spent on approved services.
 - n. Billing Requirements for Prevention: The LSAA shall submit monthly invoices with sufficient detail to ensure that DSAMH can attribute billings to specific prevention activities. The invoices shall include categories found on the Form C Budget sheet.
- ii. CTC: The LSAA may request \$10,000 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 to the following guidelines:

- a. Hire a CTC Coordinator and implement the CTC process.
- b. The CTC coordinator must serve on the county's prevention coalition as the CTC coordinator and work closely with the LA prevention coordinator to ensure CTC is implemented with fidelity.
- c. The CTC/FPL funding must be matched by both dollars and in-kind contributions by county, city or community partners.
- d. 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.
- e. The LSAA shall:
 1. 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.
 2. Monitoring the CTC Coordinator's performance to ensure fidelity to the CTC program guidelines. Annual checklists shall be kept on file.
 3. 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.
 4. 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.
 5. Ensure that prevention is delivered with high-fidelity as defined in the Communities of Care model, Community Plan Implementation Training Module 3:
(http://www.sdr.org/ctcresource/Community%20Plan%20Implementation%20Training/Trainer%20Guide/CPIT_TG_mod3.pdf).

iii. Carbon County Prevention Initiative:

- c. Southeast Health Department shall hire a full time Suicide Prevention/Intervention Specialist: to provide services which may include:
 1. Increase community readiness to deploy evidence based suicide prevention programs, strategies, policies.

2. Participate in community coalitions to address the risk and protective factors associated with suicide ideation, [suicide attempts](#) and suicide ~~attempts~~ [deaths](#).
3. Coordinate care [including crisis response and bereavement supports](#) for individuals/families after suicides and attempts.
4. ~~Develop a local~~ [Promote the state](#) public health campaign designed to reduce the number of suicides in Carbon County.
5. Aim to decrease the stigma of mental illness.
6. Provide or coordinate Mental Health First Aid and QPR Trainings.
7. Work to identify and incorporate shared risk and protective factors into a Suicide Prevention plan for Southeast Health District/Carbon that includes universal, selective and indicated prevention.
8. Provide [evidence based](#) training to teachers, hospitals, coalition hmembers, schools and the public

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~~ [shall](#) 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 Substance Use Disorder Event Data is the SUD.](#)
 - d. The Information System Data Set for Recovery Support Services is the RS.
 - e. The Information System Data Set for Indicated Prevention is IP.
 - f. [The Information System Data Set for MCOT/SMR is SR](#)
 - g. [The Information System Data Set for Universal and Selected Prevention is](#)

DUGS (Data User Gateway System).

1. Local Substance Abuse Authorities shall meet a 10% MHSIP survey sampling of Adult clients reported in the fiscal year and should meet a positive outcome of at least 75% of the national averages in consumer reported domains.
- iv. OQ/YOQ Requirements and Reporting Guidelines:
- a. DSAMH requires a 50% utilization rate for the LMHA for clients served in publicly funded programs **who experience serious mental illness or serious emotional disturbance**. The instruments will require repeated administrations.
 - b. DSAMH will require that the OQ/YOQ be given to patients and consumers **who experience serious mental illness or serious emotional disturbance**. 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 **to individuals who experience serious mental illness or serious emotional disturbance** 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 for clients with serious mental illness and serious emotional disturbance 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.

G. PERFORMANCE MEASURES

- i. For all performance measures, the Division shall continue to work with ROSC, clinical directors 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.

- iv. Substance Use Disorder Prevention Performance Measures:

~~100% of Universal and Selective prevention services provided by the LSAA or contracted provide shall be entered in Data User Gateway System (DUGS) within 45 days of services. <https://easy.dhs.utah.gov/eventAction.do> 100% of Indicated Prevention services entered in SAMHHS by the end of the month following the month of delivery.~~

- a. Percent of retail establishments within the LA area that refused to sell tobacco to minors during Synar tobacco compliance checks. (Target for FY2021 is 90%.)

~~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). (Multiple Targets for FY2020: decrease use from previous administration.)~~

- ~~—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). (Multiple Targets for FY2020: decrease use from previous administration and be below state average.)~~

- b. Number of “Eliminate Alcohol Sales to Youth” (EASY) alcohol compliance checks within the Local Authority area. (Target for FY2021 is an increase from the previous year.)

- c. Percentage of communities identified in (area plan) using an evidence based operating system.
- d. Number of communities that have increased readiness according to the Community Readiness Tool. Target for FY2021 is to establish a baseline measure.
- e. Number of non-prevention professional coalition members that attend a prevention conference. (CADCA, NPN, Coalition Summit, Fall Conference, etc.) Target is to reach a minimum of two members from each coalition to a conference annually.
- f. Percent of youth alcohol use within the past 30 days.. Use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019. Multiple Targets for FY2021: decrease use from previous SHARP administration.
- g. Percent of youth and adult prescription drug misuse within the past 30 days. Use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019. Multiple Targets for FY2021: decrease use from previous SHARP administration. For adult measure, as available through BRFSS.
- h. Percent of youth marijuana use within the past 30 days. Use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019. Multiple Targets for FY2021: decrease use from previous SHARP administration.
- i. Reduce the number of opioid overdose deaths. Use Utah Department of Health overdose death data.
- j. Increase the number of engaged community prevention coalitions.
- k. Percent of youth nicotine use, including e-cigs within the Past 30 day use, e-cigs. Use trend data from 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019). Multiple Targets for FY2021: decrease use from previous SHARP administration.