

Utah Behavioral Health Assessment & Master Plan

*A guide for state, private, and public sectors, systems, and stakeholders striving to create more accessible, equitable, aligned, and effective mental health and substance use disorder systems in Utah.*

**DRAFT Version 1.0 | November 2023**

Shared Vision

**The vision of the Utah Behavioral Health Coalition is to improve equitable access to high-quality behavioral health services and supports for all Utahns.**

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# The Utah Behavioral Health Coalition

**Behavioral health is an essential component of every Utahns’ health and well-being.**

When people have better behavioral health,\* they are healthier, happier, and more productive—positively impacting communities, safety, and the economy. Utah is invested in creating a comprehensive and coordinated approach to improve people’s behavioral health by enhancing equitable access to behavioral health services, eliminating gaps, and implementing system changes to drive outcomes.

To accomplish these objectives, the Utah Behavioral Health Coalition came together to better understand and assess the state’s current system of behavioral health services and supports and develop a Master Plan for improvement. This process includes:

1

Conducting an environmental scan to understand current behavioral health initiatives; gaps in services; challenges, barriers, inequities, and needs related to providing and accessing behavioral health services in Utah; and the changing and future needs of relevant stakeholders connected to Utah’s behavioral health system.

Assessing the information, data, and feedback collected during the environ­ mental scan to identify system-level gaps and key areas of need—utilizing both a top-down and bottom-up approach to system-level reform.

2

3

Developing a Master Plan that can serve as a guide for state, private, and public sectors, systems, and stakeholders striving to create more equitable, aligned, and effective behavioral health systems for all Utahns that provide timely access to high­ quality care across the lifespan with a comprehensive continuum of behavioral health services and supports.

This Master Plan is a living document updated over time. This version outlines strategic priorities for behavioral health system reform, key questions to consider, and recommended focus areas for future programmatic changes. Future versions will identify specific objectives, actionable steps, and measurable outcomes for select priority areas. As the work begins and systems evolve, key questions and recommended focus areas may change, and new priorities, questions, and focus areas will be identified.

While some of the recommended programmatic changes may result in state-directed reform, the Master Plan is designed to call attention to high-priority areas and help facilitate the development of solutions by other sectors and private systems. It does not intend to dictate or oversee all activities within or connected to Utah’s behavioral health system.

*\*In this report, the term “behavioral health” describes both mental health conditions and substance use disorders (SUD), unless otherwise specified. When mental health conditions or SUDs are separate, the report uses the term “mental health” or “SUD.” More definitions are in Appendix: Acronyms & Definitions.*

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Introduction

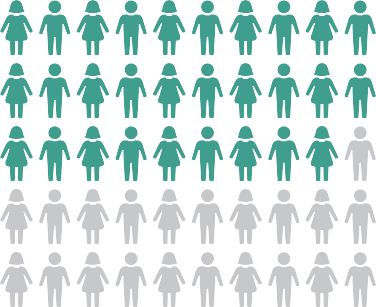
U

tah is working to address a growing behavioral health crisis. While the state is

leading the nation on many behavioral health innovations, interventions, and

reforms, high suicide rates, untreated anxiety and depression, serious mental illness,

and drug-related deaths are all signs of the need for more accessible, equitable, aligned, and effective behavioral health services.

**Access**

Unfortunately, many Utahns do not have access to the care they need. While data show utilization may have improved for some populations, nearly half of Utah’s adults and youth with mental health needs do not receive services or treatment.1 For example, 58% children ages 3-17 in Utah with a clinically diagnosed mental or behavioral health condition did not receive treatment or counseling (2020-2021).2 Among children who need treatment, 40% of parents report that services are difficult or, sometimes, impossible to obtain.3

**58%**

of children in Utah with clinically diagnosed mental or behavioral health conditions did not receive treatment or counseling.

The share of adults ages 18 or older with any mental illness (AMI) that received mental health services is 49.8% (2017–2019). This represents a 7.9 percentage point increase from 2008–2010, indicating an improvement in utilization. However, close to 50% of adults with AMI are still not receiving treatment.4 A 2023 survey issued by the Office of Professional Licensure Review found the average wait time for outpatient behavioral health services in Utah is close to two months, while the recommended guideline is 10 calendar days. A limited number of rural, language accessible, and culturally literate behavioral health providers makes access even more difficult for Utah’s rural and culturally diverse communities.

Nearly **50%**



of adults in Utah with a mental illness are not receiving treatment.

**More than half** of Americans say **mental health** is the **biggest health problem** facing our country.6

**Workforce Shortages and Gaps in Care**

Behavioral health needs in Utah currently outweigh the supply of services and supports. Utah has mental health provider shortages in every county and fewer mental health providers per 100,000 people than the national average.7

The COVID-19 pandemic amplified pressures on Utah’s limited workforce, with mental health providers reporting a 20% median increase in caseloads since April 2020.8 This is reflected in national numbers with nearly half of adults ages 18 or older with serious mental illness (SMI) feeling the COVID-19 pandemic negatively impacted their mental health.9

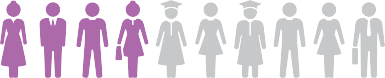
Numerous gaps in care exist across Utah’s continuum of behavioral health services and supports,10 in rural and culturally diverse communities, as well as across the population lifespan (from infant and early childhood to older adults). Improving Utah’s behavioral health system requires expanding Utah’s behavioral health workforce and services and supports to address these gaps, particularly for individuals with crisis and complex behavioral health needs.

Utah’s mental health providers reported a

increase in caseloads since the start of the COVID-19 pandemic in April 2020.

**20%**

**Need for System-Level Coordination and Innovation**

An assessment of Utah’s behavioral health system indicates system fragmentation limits the ability to access the right care at the right place and at the right time. For example, behavioral health services are often bifurcated across different delivery systems making

***“We cannot continue to do the same things in terms of treatment, workforce, and access if we want to move the needle.”***

it more difficult to consistently and efficiently deliver integrated care. Many primary care providers lack the training and resources to engage in behavioral health screenings, early intervention, and treatment of mild-to-moderate behavioral health conditions. Limited reimbursement for both public and private behavioral health services is a major barrier to providing and accessing services.

An increasing number of siloed systems, such as self-pay (or cash-only) providers, further divides the system. This siloing creates additional challenges with equitable access, accountability, transparency, and monitoring the quality and efficacy of services provided. Some national studies estimate that only a portion of persons receiving behavioral health care benefit from treatment received.11, 12

Utah’s behavioral health system needs more focus on prevention, early intervention, and coordinating points of access by better integrating physical and behavioral health care. A focus on improving care quality—utilizing evidence-based treatment and measurement-based care—would also help address Utah’s growing behavioral health crisis.

**Benefit of Addressing Behavioral Health**

Utah’s experience is part of a national problem, where depression is estimated to cause 200 million lost workdays each year, and SMI results in $193.2 billion in lost earnings.13 Depression is a leading cause of disability nationwide14 and national cost estimates of mental, emotional, and behavioral disorders among youth amount to $247 billion per year in mental health and health services, lost productivity, and crime.15 This increases costs to other sectors such as public and private health systems, corrections, criminal justice, housing, and child welfare.16, 17

Investing in and improving access to high-quality behavioral health services can help reduce or neutralize costs across public and private health systems and sectors such as education, corrections, criminal justice, housing, and child welfare.18 More importantly, investing in and improving access to high-quality behavioral health services saves lives.

Mental, emotional, and behavioral disorders among youth amount to

**$247 billion**

per year in mental health and health services, lost productivity, and crime.

Key Findings from the Assessment

**Assessment process**

Under the direction of the Utah Hospital Association (UHA) and the Utah Department of Health and Human Services (DHHS), the Kem C. Gardner Policy Institute and Leavitt Partners, a Health Management Associates company (LP/HMA), assisted the Utah Behavioral Health Coalition assess needs, gaps, and challenges in Utah’s behavioral health system. This assessment informed the development of the Master Plan, which can serve as a guide for state, private, and public sectors, systems, and stakeholders striving to create more accessible, equitable, aligned, and effective behavioral health systems for all Utahns.

As part of the assessment process, the Gardner Institute and LP/HMA conducted an environmental scan which included 30 formal discussion groups and in-depth interviews held from June 2022 to January 2023. [See “Discussion Group Details” text box for more information.] The Gardner Institute also engaged in many informal interviews with additional groups and individuals interested in more targeted discussions about current initiatives and concerns. These discussions occurred through July 2023.

The Gardner Institute released a draft of the Master Plan report for public review and feedback at the end of July 2023. Public feedback was formally collected through the end of August and additional feedback from presentations, discussions, and outreach was gathered through October 2023. Version 1.0 of the Master Plan incorporates this feedback.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Discussion Group Details: Over 30 groups and 300 participants | | | | |
| * 30 discussion groups and in-depth interviews held from June 2022 to January 2023, as well as many additional informal interviews. * Over 300 participants engaged across discussion groups, interviews, and other feedback mechanisms. * Participants comprise a diverse range of stakeholders involved in or connected to Utah’s behavioral health system, including representation from:   + Persons with lived experience (individuals who serve on Utah Behavioral Health Planning and Advisory Council (UBHPAC), USAAV+ subcommittees, and others)   + Community-based providers (local authorities, community health centers, federally qualified health centers, and other nonprofit community-based providers and others) | – | Private behavioral health providers (behavioral health treatment providers, psychiatrists, residential and institutional providers, and others)  Providers serving racially diverse and minority populations and other marginalized and underserved communities  Homeless service providers  Medical providers (pediatricians, family care practice physicians, clinical practitioners, and others)  Payers (representatives from Utah’s Medicaid Accountable Care Organizations (ACOs), the state’s health insurance plan (PEHP), private health insurance companies, and high-deductible health plans (HDHPs))  Providers of health promotion and prevention services (local and state coalitions, local authorities, and others) | – | Crisis services  Recovery and treatment support (e.g., recovery community and other nonprofit organizations)  Health systems  State agencies, including representatives from the Department of Health and Human Services, Department of Workforce Services, Department of Insurance, the Utah State Board of Education (USBE), Department of Corrections, Utah State Courts, Utah’s Attorney General’s Office, and others  Legislators  Education (both K-12 and higher education institutions)  Court, criminal, and juvenile justice systems  Employer representatives |

**System-level issues**

An assessment of the information and feedback collected during this process indicates that five system-level issues are creating and exacerbating gaps and challenges in Utah’s behavioral health system and limiting access to care (Figure 2). These system-level issues interconnect and impact providers and services across Utah’s continuum of behavioral health services and supports (Figure 1) for all persons across the population lifespan (from infants and young children to older adults).

The following section provides an overview of the system-level issues. Detailed findings from the environmental scan provide more information on the underlying gaps, challenges, and needs that contribute to these issues (see “Environmental Scan: Detailed Findings” section for more information).

**Figure 1: Utah’s Continuum of Behavioral Health Services and Supports**

**n and Pre**

Community Primary Care Education & Based Behavioral

Services Health

Integrated Physical & Behavioral

Health Care

Outpatient Specialty Services

Crisis/ Diversion Services

Subacute Care

Acute/ Inpatient Care

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Note: This continuum was developed as a part of the 2020 Roadmap for Improving Utah’s Behavioral Health System. Source: Utah Hospital Association

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**It is not possible to mentioned all the positives in this report, but it is clear that:**

Silver Linings

While the findings from the environmental scan and the system- level issues primarily focus on improvements to Utah’s behavioral health system, it is important to recognize there are a lot of positives.

* Utah’s leaders, including the Governor and Legislature, understand the importance of addressing Utah’s behavioral health needs.
* Utah’s behavioral health community is passionate about addressing these

needs. There is also a growing number of sectors and stakeholders invested

in improving Utah’s behavioral health, including employers.

* There is a desire to meet people where they are and provide services that are easily accessible.
* Utah is leading the nation on many behavioral health innovations and reforms (e.g., SafeUT, 988, development of Utah's comprehensive crisis system, supported employment, etc.).
* There are examples of successful

coordination at the local level.

**A lack of system-level coordination and a unified approach to behavioral health**

**1**

Findings from the environmental scan indicate a strong need to improve system-level coordination between all sectors, systems, and stakeholders involved in Utah’s behavioral health system to develop a comprehensive system of care. These include, but are not limited to public and private mental health and substance use disorder (SUD) systems and providers, public and private physical health systems and providers, Medicaid and private health insurance plans (both commercial and self-funded), housing and homeless services, child welfare, services for persons with disabilities, K-12 schools, higher education, the court systems and criminal justice (including corrections and law enforcement), etc.

The lack of system-level coordination extends beyond payer- and provider-level integration. It stems from an increasing number of state agencies, health systems, public and private providers, payers, schools, nonprofit organizations, and advocates addressing behavioral health issues in positive ways with initiatives that are needed, well-intentioned, and often well-designed—but often doing so in an uncoordinated way.

Diagram of a system

Description automatically generated

In general, discussion groups noted a need for better linkages or connecting points between the:

* Different sectors, systems, and stakeholders connected to Utah’s behavioral health system
* Different sections on the continuum of behavioral health services and supports
* Different initiatives and groups working within each section

A lack of system-level coordination increases fragmentation and complexity of the behavioral health care delivery system, creating challenges and potentially reducing quality for Utahns seeking behavioral health care. As noted above, system-level fragmentation leads to the development of an increasing number of “siloed” initiatives and systems and administrative burdens for providers. This creates challenges with transition support and patient navigation and contributes to the state’s access issues. The lack of a coordinated system also means public funds are not being maximized for efficiency or effectiveness.

<<New text to include with Figure 2>>

A lack of system-level coordination across Utah’s public and private sectors, systems, and stakeholders contributes to:

* Increased administrative burden from tracking and managing different contracts and grants (all with different reporting requirements) from multiple public and private entities.
* Siloed approaches to addressing behavioral health needs due to a lack of awareness of existing efforts. Siloed approaches are also emerging as alternatives to administratively complex public and private systems, which leads to less coordination overall.

These issues exacerbate workforce shortages. Siloed systems create new workforce demands that result in shortages in other parts of the system. Administrative burdens result in some behavioral health workers moving to less complex, but siloed systems (e.g., cash-only payment), while others leave the system altogether.

Historically low funding levels, inadequate reimbursement, and having to navigate a complex patchwork of multiple funding streams intensifies all these problems.

**Outcome:** These system-level issues result in delays or even an inability to access behavioral health services and supports and produce complex, often confusing systems for individuals seeking services.

**2**

**Administrative burdens**

A common theme heard across multiple provider and services-based discussion groups was the need to

reduce the administrative burden placed on behavioral health treatment, service, and support providers. While a large part of this burden comes from federal rules, regulations, and reporting requirements, part of it stems from a lack of administrative standardization or simplification (where possible) that could be improved through better system-level coordination.

For example, one discussion group noted that providers can have up to twenty different behavioral health contracts with the state alone, all of which have different contract, reporting, and documentation requirements. Other discussion groups noted the difficulty of having to navigate through multiple contracts and manuals to determine what services may be covered for a patient depending on the patient’s eligibility (if in the public system) or health insurance plan (if in the private system). Discussion groups also noted the administrative complexities associated with licensing and certification as a challenge.

Discussion group participants suggested that these administrative burdens are resulting in workers leaving the state’s public behavioral health system and that an increasing number of providers are also not paneling with private health insurance companies because of the complexity of credentialing and seeking reimbursement.

*“This country’s behavioral health system is based on an ad hoc approach to system development. It has been decades of organized chaos.”*

**Siloed systems**

Having multiple, uncoordinated behavioral health administrative and service delivery systems contributes to well-intentioned but often siloed

**3**

approaches to addressing Utah’s behavioral health needs. Some of these initiatives stem from the desire to attend to specific behavioral health needs of certain populations, others develop because of a lack of awareness of similar efforts already taking place, and others are emerging as alternatives to administratively complex public and private systems. However, when these efforts are developed or implemented without coordination or consideration of their impact on the larger behavioral health system, they can result in inefficiencies, lost opportunities for broader positive impact, and possible unintended consequences. As noted by one discussion group participant:

Some of the main concerns with these siloes are that they:

* Create challenges with accountability, transparency, and

monitoring the quality and efficacy of services.

* Are not always connected back into the broader behavioral health system (limiting referrals to other services and supports patients may need, limiting the ability to support transitions within the system, and complicating patient navigation).
* Duplicate services in a system that is already under-resourced.
* Exacerbate workforce shortages by creating systems of unconnected mental health and SUD service providers.

Some of these siloes may be contributing to less access overall as well. For example, the growing number of providers that are moving to self-pay (or cash-only payments) to avoid the complexities of working with public and private payers leads to system fragmentation, makes it difficult for the state and private health insurance plans to contract with a sufficient number of providers to meet the state’s growing behavioral health needs, further reduces the ability to integrate physical and behavioral health, and creates a system where more people have to pay out-of-pocket to access necessary services. This limits access to care and leads to additional inequities for populations that are unable to pay cash for services.

Building better bridges or connecting points between these siloed systems can help improve system-level efficiencies and help ensure access to a full continuum of behavioral health services and supports.

**4**

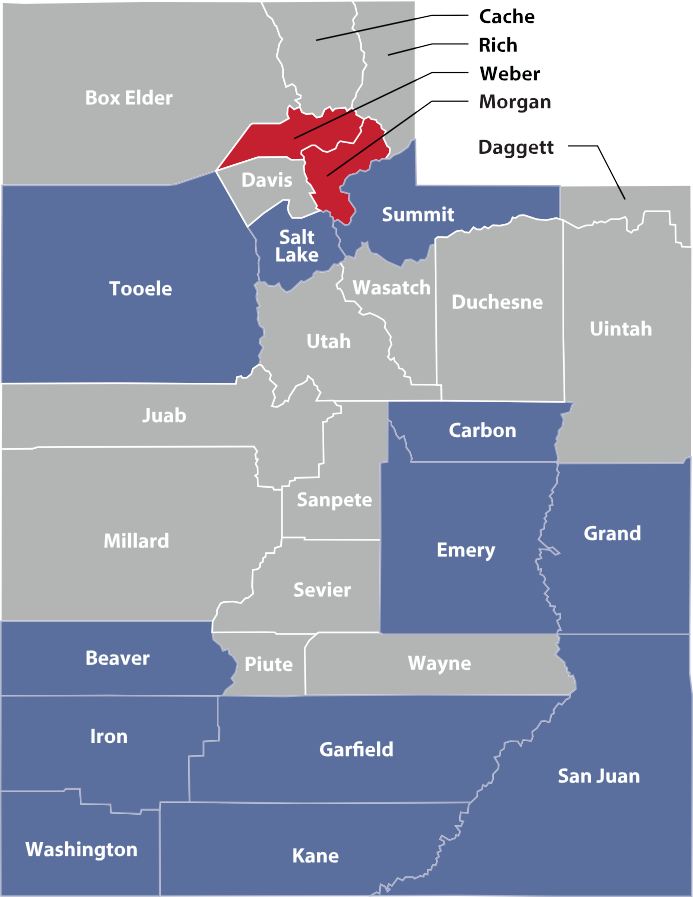
Office of Professional Licensure Review: Behavioral Health Licensure Review

The Office of Professional Licensure Review (OPLR), within the Utah Department of Commerce, is engaged in a comprehensive review of mental and behavioral health licenses in Utah. Key findings from their review align with and support findings from the environmental scan including:

1. Utah has a behavioral health access problem, which partially stems from workforce capacity issues. For example, OPLR found there are about 16,600 licensed behavioral health workers in Utah but given some of these persons are not working, or working outside of Utah, and that around 38% of Utah’s behavioral health workforce is only working part time, this translates to a significant reduction in workforce capacity.
2. OPLR also found that around 38% of behavioral health work hours are not spent in direct patient care, which

**Workforce shortages**

Utah’s ongoing—and growing—behavioral health workforce shortages areas a challenge that is disrupting care across the continuum of behavioral health services and supports. Workforce shortages seem to impact all points along the service continuum, impact all areas of the state (Figure 3), and span all provider specialties. Some areas of particular concern are the limited number of rural, language accessible, and culturally literate behavioral health providers and as well as workforce shortages associated with outpatient care, which impacts the ability to prevent a person’s behavioral health issues from worsening, as well as provide sufficient services to

**Figure 3: Type of Mental Health Care Professional Shortage Area by County (Geographic, High Need, or Low Income), 2022**

further reduces the workforce.

1. Access appears to be worse in outpatient care settings, privately funded care (e.g., commercial insurance and self-pay), and for psychological services. For example, a survey issued by OPLR in 2023 found the average wait time for outpatient behavioral health services in Utah is close to two months, while the recommended guideline is 10 calendar days. The average wait time for inpatient services is slightly less than one month.
2. The proportion of practitioners accepting private health insurance is lower than the proportion of patients or consumers covered by private insurance—and self-pay providers appear to be filling this gap. Full self-pay is accepted by 60% of all behavioral health practitioners in OPLR’s survey and 85-90% of independent practitioners.
3. There are concerns with the quality and safety of Utah’s behavioral health system. Utah ranks poorly (49th relative to other states) on the number of adverse action reports per behavioral health worker, a key measure of safety for behavioral health.

Geographic Shortage Area

Geographic High Needs Shortage Area

Low Income Shortage Area

Note: Mental health shortages are determined across three different domains. (1) Geographic, meaning a shortage of providers for the entire population within a defined geographic area. (2) Geographic High Needs, meaning at least 20% of the population has income below 100% FPL, there is a high ratio of children or elderly in the population, there is a high prevalence of alcoholism, or there is a high degree of substance use disorders. (3) Population groups, meaning there is a shortage of providers for specific population groups within a defined geographic area (e.g., low-income individuals).

Source: Utah Office of Primary Care and Rural Health

discharge people from high-acuity services and link them to community-based care.

As noted above, Utah’s workforce shortages are exacerbated by a lack of system-level coordination, administration burdens, and the creation of siloed and sometimes competing initiatives that may increase access for some populations but decrease access for others. Examples of how workforce shortages are being aggravated by a lack of system-level coordination, disrupting care, and limiting access are included throughout the “Environmental Scan: Detailed Findings” section.

Findings from the environmental scan also point to the need for more provider education and training in evidence-based practices (e.g., engaging and training primary care providers in behavioral health screenings, early intervention, and treatment of mild-to-moderate behavioral health issues); as well as more providers qualified to treat persons with co-occurring behavioral health and other conditions (e.g., homelessness, intellectual or developmental disabilities (ID/DD), and autism spectrum disorder). Findings also point to the need to expand the mental health and SUD health workforce to include more certified or credentialed non-licensed professionals (e.g., peer support specialists, certified case managers, community health workers (CHWs), etc.) as a potential solution to addressing Utah’s workforce shortages.

**Outcome: Limited access to care**

As noted above, a lack of system-level coordination (e.g., multiple behavioral health administrative and service delivery systems, siloed systems, access points, etc.) produces complex, often confusing systems for individuals seeking services. Discussion group participants confirmed that people trying to access behavioral health services and supports often

experience challenges with patient navigation and care transition support, which limits the ability to access the right care at the right place and at the right time. Workforce shortages combined with increased demand results in delays or even an inability to access behavioral health services and supports.

The Utah Behavioral Health Coalition defines behavioral health access as the availability of person-centered, prompt, responsive, affordable, appropriate, and effective (evidence-based) behavioral health services and supports to all individuals across the population lifespan. Access is grounded in equitable and culturally responsive behavioral health promotion, prevention, early identification, and intervention as well as treatment and recovery services.

Effective access to care also attends to regional needs, community culture, and building systems that reduce structural barriers to care and the impact of social determinants of health. It promotes and supports people being active, engaged, and included in their treatment decisions.

Defining Access

Addressing these system-level issues can help alleviate pressures across the continuum of behavioral health services and supports, ensure demand is targeted to the right areas, improve issues with supply, and ultimately increase access.

Findings from the environmental scan indicate there are concerns with access across the continuum of behavioral health services and supports. That said, access issues seem to be more acute in Utah’s rural areas, for certain populations (e.g., culturally and linguistically diverse and marginalized populations), and in certain areas of the continuum (e.g., care for individuals with complex behavioral health needs).

**Sustainable funding**

**5**

Problems that arise from the system-level issues mentioned above are intensified by historically

low funding levels, inadequate reimbursement, a complex patchwork of multiple funding streams with different requirements, and high levels of administrative burden in seeking reimbursement despite improvements in behavioral health care coverage due to federal parity laws. A common theme from

the environmental scan is that many behavioral health services and supports in Utah lack long-term, sustainable funding.

For example, discussion group participants noted there is insufficient funding or reimbursement for prevention and early identification as well as to address the more complex needs of individuals with long-term issues (including reimbursement for stabilization supports and other wraparound services). Stakeholders also noted that current rates do not allow systems and clinics to offer competitive wages, a contributing factor to workforce shortages. Burdensome reimbursement requirements associated with eligible staff and supervision, documentation, service location, and utilization management are additional

components challenging the system.

Finally, many behavioral health providers rely on time-limited grants (each with their own funding terms and restrictions) to sustain and supplement service offerings. Applying for these grants is time and resource intensive and limits the ability to provide consistent services or staffing overtime. Other examples of how sustainable funding is needed to improve access and the provision of behavioral health services are throughout the “Environmental Scan: Detailed Findings” section.

Utah’s Behavioral Health Master Plan

Mission of the Master Plan

Create equitable, aligned, and effective behavioral health systems for all Utahns that provide timely access to high-quality care across the lifespan with a comprehensive continuum of behavioral health services and supports.

### Framework

Utah’s Behavioral Health Master Plan identifies strategic priorities and provides a roadmap for future reform. The Master Plan (Version 1.0) was developed by the Behavioral Health Coalition and is based on the findings from the environmental scan and behavioral health assessment. It utilizes a framework that consists of four areas: (1) guiding principles; (2) strategic priorities; (3) key questions; and (4) focus areas (Figure 4).

**Figure 4: Utah Behavioral Health Master Plan Framework**

|  |  |
| --- | --- |
| **1 Guiding**  **Principles** | Guiding principles for system and programmatic changes. |
| **2 Strategic**  **Priorities** | Strategic priorities for behavioral health system reform. Includes short and long-term initiatives. |
| **3 Key**  **Questions** | Key questions to consider and areas that need further research to fully understand system impact. |
| **4 Focus**  **Areas** | A set of recommended focus areas for programmatic changes with a now, next, and future timeline. |

Source: Leavitt Partners, a Health Management Associates Company

### Guiding Principles

Four principles guide current and continued development of the Master Plan. To correct the system-level issues identified above and ensure an efficient system moving forward, reforms to Utah’s behavioral health system should promote access, alignment, and value.

**Equity:** Reforms should address health disparities and promote equitable access to care for all Utahns that is responsive to the patient voice and considers individual, family, employer, community, and geographic need.

A key part of equity is addressing ***“health disparities”*** or reforms that reduce behavioral health inequities and stigma and advance health equity, diversity, inclusion, and access. [See “Addressing Health Disparities” text box for more information.]

**Alignment:** Reforms should support aligned, efficient, navigable, comprehensive, and sustainable behavioral health services across public and private systems, payers, and sectors.

A key part of alignment is ***“sustainable”*** or ensuring reforms support the right level of payment for different markets, different levels of care, and streamline funding and reimbursement across payers and service types to ensure providers have the resources necessary to engage in reforms.

**Value:** Reforms should encourage investments in effective behavioral health services and initiatives that demonstrate both direct behavioral health cost savings and indirect medical, educational, and social service cost savings.

A key part of value is ***“effective”*** or promoting reforms that are high quality, evidence and outcomes based, and recovery focused. Improving the efficacy of care will lead to improved efficiency of care and the ability to intervene further upstream.

**Access:** Reforms should increase access to available, person-centered, prompt, responsive, affordable, appropriate, and effective behavioral health services and supports to all individuals across the population lifespan.

A key part of access is ***“person-centered”*** or designing reforms that promote and support people being active, engaged, and included in their treatment decisions. Access is grounded in equitable and culturally responsive behavioral health promotion, prevention, early identification, and intervention as well as treatment and recovery services (i.e., culturally and linguistically appropriate services that assist individuals and families working toward recovery from mental and/or substance use problems).

**<<New Text Box>>**

**Addressing Health Disparities**

Health inequities, disparities, and stigma exist across Utah’s entire continuum of behavioral health services and supports. A research team within DHHS conducted a needs assessment in 2022 that identifies needs and obstacles within Utah’s mental health and SUD treatment systems that contribute to health disparities of four target populations.[[1]](#endnote-1) The report also includes a series of system, organizational, structural, and service-level recommendations.

The report’s system-level recommendations are integrated into the Master Plan. The Master Plan also supports the adoption of the report’s organizational, structural, and service-level recommendations as appropriate by state, private, and public sectors, systems, and stakeholders striving to ensure equitable access, reduce health disparities, build systems that reduce structural barriers to care, and create more aligned and effective behavioral health systems in Utah.

Finally, the Master Plan supports working with persons with lived experience and diverse stakeholders in future versions to identify additional focus areas as well as specific objectives, actionable steps, and measurable outcomes for each area of the master plan that impact will health equity and health disparities.

A brief summary of four target populations and their risk factors and outcomes is below. More detailed information can be found in the full report.

***Transition-Age Youth & Young Adults, ages 14-26***. Many transition-age youth are aging out of foster care or juvenile justice systems and are more likely to face suicide as a leading cause of death, have multiple chronic illnesses, and at least one chronic illness. This group often faces disparities in outcomes due to a lack of collaboration between the child and adult systems to ensure seamless transitions of care, among other factors.

***Black, Indigenous, and People of Color (BIPOC).*** Research shows BIPOC have increased rates of mental illness and SUD including higher rates of depression, suicidal ideation, race-related stress, and historical trauma and loss. Despite a higher need for care, BIPOC have reduced accessto care affected by being less likely to receive care from providers even after care is requested, discrimination in health care, a lack of providers who share identities with patients, and lack of provider education around stigma, among other factors.

***LGBTQ+ folks***. People in the LGBTQ+ community experience increased rates of behavioral health issues due to increased risk factors such as poverty, homelessness, domestic violence, hate crimes, stigma, minority stress, and a lack of social support, among other factors. They also experience reduced access to services and often face disparities in outcomes due to a lack of LGBTQ+ specific knowledge and skill among providers and perceptions of marginalization and discrimination, among other factors.

***People with Developmental Disabilities***. People with developmental disabilities face unique challenges that impact their need for mental health and SUD treatment, their ability to access treatment, and their treatment outcomes. Research shows people with developmental disabilities have increased ratesof mental illness including higher rates of anxiety, depression, obsessive compulsive disorder (OCD), suicide ideation, and adverse childhood experiences, among other mental health needs. This group also experiences reduced access to care and disparities in outcomes, which can be exacerbated by a lack of knowledge about appropriate services, among other factors.

**Diversity in Utah’s Behavioral Health Workforce**

As noted above, workforce shortages impact areas of behavioral health services and supports continuum, impact all areas of the state, and span all provider specialties. One area of particular concern, however, is the limited number of language accessible and culturally literate behavioral health providers. White/Caucasian providers continue to make up a disproportionate share of Utah’s mental health workforce compared to the overall population (although slight improvements have been made as the proportion of White/Caucasian providers decreased from 92.5% to 88.5% of the workforce between 2016 and 2021).72

As Utah’s population grows and its demographics change (Figure 16) it is important for the state’s behavioral health workforce to mirror and be able to meet the needs of these diverse populations to ensure appropriate access for all Utahns.

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|  |
| --- |
| Strategic Priorities |
| 1. Expand and support Utah’s behavioral health workforce. 2. Support the continued use, implementation, creation, innovation and of evidence-based interventions. 3. Strengthen behavioral health prevention and early intervention. 4. Integrate physical and behavioral health. 5. Continue to build out Utah’s behavioral health crisis and stabilization systems 6. Improve the availability of services and supports for individuals with complex behavioral health needs. 7. Improve patient/consumer navigation. |

The Master Plan’s guiding principles directed the creation of seven strategic priorities. These priorities are designed to reflect community feedback, achieve the mission of the Master Plan, and improve behavioral health for all Utahns across the state.

The Master Plan also outlines key questions and recommended focus areas for future programmatic changes to achieve the strategic priorities (a top-down and bottom-up approach). It is important to consider these strategic priorities, key questions, and recommended focus areas as a starting point. Future versions will identify specific objectives, actionable steps, and measurable outcomes for select priority areas. As the work begins and systems evolves, key questions and recommended focus areas may change, and more priorities, questions, and focus areas will be identified.

It is also important to note that the key questions and recommended focus areas identified in the Master Plan align with or support multiple strategic priorities, and could therefore be organized by topic, focus area, or how they connect to different portions of Utah’s continuum of behavioral health services and supports (Figure 1). An example of how to organize the information by topic (payment reform) is presented in the “Utah Behavioral Health Master Plan: Payment Reform” text box.

To visualize how the information in the Master Plan can help support specific strategies, this report presents it in a format that outlines strategic priorities, key questions, and focus areas as steps to system reform.

Finally, the Master Plan does not intend to dictate or oversee all activities within or connected to Utah’s behavioral health system. It is meant to serve as a guide for private and public sectors, systems, and stakeholders striving to achieve the mission of ***creating more equitable, aligned, and effective behavioral health systems for all Utahns that provide timely access to high-quality care across the lifespan with a comprehensive continuum of behavioral health services and supports.***

While some of the recommended programmatic changes may result in state-directed or public system reform, the Master Plan is designed to call attention to high-priority areas and help facilitate the development of solutions by other sectors and private systems as well. Involvement of the private sector is important given most people in Utah have employer-sponsored health insurance and access behavioral health services through private systems and providers (Figure 17 and “Utah’s Health Care Coverage Landscape” text box).

A unified approach to system-level reform will help ensure all Utahns have better behavioral health.

**<<New Text Box>> Utah’s Health Care Coverage Landscape**

While Medicaid and the public health system are important payers of behavioral health services, most people in Utah have private health insurance coverage. The majority of Utahns receive health care coverage through their employers (~60%) and Utah has the highest rate of employer-sponsored insurance (ESI) in the country.82

|  |  |
| --- | --- |
| A pie chart with text  Description automatically generated | * *Commercial:* Commercial health insurance is governed by state and federal law and regulated by state insurance departments. Plans are funded by the premiums collected from insured employers and individuals. * *Self-Funded*: Employer-sponsored self-funded health plans are exempt from state regulation under the Federal ERISA statute and are regulated by the Federal Department of Labor. These plans may be funded entirely by the employer or by a combination of employer funds and covered employees’ wages. * *FEHBP*: Federal Employee Health Benefit Plan is an employer-sponsored health insurance program for federal employees, retirees, former employees, family members, and former spouses. * *PEHP:* Public Employee Health Plan is an employer sponsored health plan for public employees in the state of Utah. * *CHIP*:The Children's Health Insurance Program is a state health insurance plan for low-income uninsured Utah children and teens. |

**<<Text Box>> Utah Behavioral Health Master Plan: Payment Reform**

Payment reform is a key component of Utah’s Behavioral Health Master Plan. As noted above, historically low funding levels, inadequate reimbursement, and providers having to navigate a complex patchwork of multiple funding streams intensify Utah’s system-level issues. Payment reform is necessary for ensuring changes to Utah’s behavioral health system are sustainable and support the right level of payment for different markets and different levels of care. Below are a sample of key questions and recommended focus areas related to payment reform pulled from seven strategic priorities.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Payment Reform | | |
| Strategic Priority | Reimbursement | Value-Based Payments | Long-Term Sustainability |
| #1 Support the continued use, implementation, creation, innovation and of evidence-based interventions. |  | Promote risk-based contracts and value-based payment arrangements in both the public and private systems that incentivize and support innovation and outcome attainment. | How to create an infrastructure that supports providers access, utilize, and employ effective, evidence-based interventions across systems, sectors, and geographies (e.g., sufficient reimbursement and other forms of financial support for organizations that provide services to the uninsured/ underinsured)? |
| #2 Strengthen behavioral health prevention and early intervention | Increase reimbursement for primary, secondary, and tertiary prevention services (e.g., behavioral health well-child visits and adult checkups).  Ensure reimbursement for age-appropriate and uniform behavioral health screening across the lifespan (from infants and young children to older adults). |  | How to establish sustainable funding for a broad array of prevention services in both urban and rural geographies? |
| #3 Integrate physical and behavioral health. | Allow providers to bill for physical health, mental health, and SUD services in same day (consider alternative payment models and ways to alleviate unnecessary cost-sharing).  How to address reimbursement disparities between behavioral and physical health? | Incentivize system structures and payments for evidence-based integrated care approaches that address the physical and behavioral health of individuals and families.  How to develop capitated payment models for different populations that include cost savings in and beyond behavioral health to reflect the entire medical cost? | What incentives, funding flows, or other efforts will help increase access to integrated physical and behavioral health care across Medicaid and other public and private markets to make it easier for individuals and families to access care earlier? How to improve parity for these services? |
| #4 Continue to build out Utah’s behavioral health crisis and stabilization systems | Expand private health insurance reimbursement of crisis services (receiving centers, MCOTs, etc.).  Expand private health insurance reimbursement of evidence-based individual and family respite services and supports and other levels of care (psychosocial rehab, psychoeducation, etc.). | Promote bundled payments for crisis services that reflect regional needs. |  |
| #6 Improve the availability of services and supports for individuals with complex behavioral health needs. | Expand intensive outpatient options by adjusting reimbursement models to support sustainability.  Ensure sustainable reimbursement for case management by Medicaid, private insurance, and with other funding for uninsured/ under-insured populations.  Create sustainable funding/reimbursement models that promote the development and expansion of community-based subacute programs and services (consider community-based models, crisis respite homes, individual, family, and crisis respite services, intermediate acuity care models, etc.).  Create sustainable funding/reimbursement models for acute care services and residential care. | Promote bundled payments or global fees for episodes of care to improve reimbursement for community-based individual and family respite services and supports, club houses, recovery supports, supported employment/ education, and other specialized services such as Coordinated Specialty Care (CSC) for psychosis prevention and early intervention. | What type of payment models or levels of reimbursement are necessary to develop, expand, and sustain community-based subacute services and programs for individuals with complex needs?  How to create and promote sustainable reimbursement structures in public and private markets that reflect risk, costs, regional differences, and the complexity of care?  Should public and private markets establish differentiated rates based on risk and outcomes that are appropriate for the population served?  How to create sustainable funding for addiction recovery services?  Determine effective ways to help sustain community-based organizations that provide behavioral health and other safety net and supportive services to the uninsured/underinsured. Funding should be flexible and sustained over time. |
| #7 Expand and support Utah’s behavioral health workforce. | Certified or credentialed non-licensed professionals | | |
| Establish Medicaid reimbursement for CHWs (develop state plan language that is broad enough to encompass behavioral health issues and referral supports).  Expand reimbursement of research-supported recovery-based models that rely on non-licensed professionals, such as peer supports, case management, etc. | Promote use of bundled payments to improve reimbursement for peer supports, CHWs, case management, etc. that reflect regional needs. | What levels of reimbursement, grants, and additional resources are needed to expand peer supports, case managers, CHWs, and other non-licensed care team members? How to equitably distribute these resources to community-based and nonprofit organizations?  Determine effective ways to help sustain community-based organizations that support peer support specialists and other non-licensed providers. Funding should be flexible and sustained over time. |
| Other | | |
| Maintain advancements made to telehealth during the COVID-19 Public Health Emergency (PHE), including ensuring meaningful and equitable reimbursement. |  | Determine effective ways to help sustain culturally literate and language accessible behavioral health providers to meet the needs of Utah’s changing demographics. Funding should be flexible (e.g., SUMH’s multi-cultural affairs grant) and sustained over time. |

Strategic Priorities: Steps to System Reform

**Support continued use, implementation, creation, and innovation of evidence-based interventions.**

**1**

As noted in the environmental scan, discussion group participants feel that messaging around mental health and SUDs needs to focus more on behavioral health conditions being treatable and that “recovery is possible.” Having access to high-quality and evidence-based services can help people achieve recovery. According to the Institute of Medicine, quality health care is “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”19

The Master Plan prioritizes strategies that support the continued use, implementation, creation, and innovation of evidence-based interventions. These strategies will promote a higher standard of care across public and private providers, payers, and systems as they commit to transparent, measurement-based care. Investing in the implementation of science-based frameworks will also help promote and sustain the acceptability, delivery, and implementation of evidence-based prevention, treatment, and recovery services to fidelity—and ultimately produce value for the system.

* **NOW**

#### Key Questions

* What is the role of regulatory agencies in overseeing the use of evidence-based treatments/interventions and monitoring patient outcomes? How will the use of evidence-based intervention be continuously evaluated to make necessary adjustments based on the outcomes? What resources do these regulatory agencies need to accomplish proposed changes to their roles?
* What role does accreditation play in ensuring the use of evidence-based treatments/interventions that reflect the needs of populations being served (e.g., urban vs. rural)?
* How to improve collaboration with higher education, program evaluators, implementation science researchers, training and certification programs, public and private health systems, and payers in identifying and promoting the use of evidence-based treatments/interventions?
* Should the state consider the development of an intermediary organization (or expand that duties of the existing behavioral health licensing board) to evaluate outcome measures and support system-wide adoption of evidence-based practices and a standardized set of quality measures?

#### Focus Areas

* Increase the use of valid/reliable measures that provide transparency into outcomes (e.g., Outcome Questionnaire, Functional Outcome Survey, Brief Addiction Monitor, Substance Use Recovery Evaluator (SURE),20 etc.).
* Promote internal processes for evaluating if changes in care, treatment, or access could help prevent instances of suicide.
* Support research that reflects the patient voice and contributes to the development of assessments, evaluation tools, and evidence-based practices by and for populations with lived experience and populations that experience health disparities.
* **NEXT**

#### Key Questions

* How to create an equitable structure that increases transparency and holds public and private providers accountable for the effectiveness of appropriate services delivered to populations in different sectors and geographies?
* How to create an infrastructure that supports providers access, utilize, and employ effective, evidence-based interventions across systems, sectors, and geographies (e.g., training, sufficient reimbursement and other forms of financial support for organizations that provide services to the uninsured/underinsured, accountability structures, accreditation, etc.)?

#### Focus Areas

* Use science-based definitions of evidence to inform adoption of effective treatments and interventions.
* Develop common methodologies or frameworks for reporting outcomes and performance data across public and private systems and sectors that increases transparency and holds public and private providers accountable for the effectiveness of appropriate services delivered to different populations in different sectors and geographies.
* Promote risk-based contracts and value-based payment arrangements in both the public and private systems that incentivize and support innovation and outcome attainment.
* **FUTURE**

#### Key Questions

* + How best to financially support and sustain behavioral health innovation and the development and implementation of evidence-based interventions over time?
  + How to demonstrate that cost savings from addressing behavioral health impact the entire ecosystem, and these dollars are most effectively reinvested back into behavioral health? (i.e., account for cross-sector savings from addressing behavioral health)

#### Focus Areas

* + Promote existing research, projects, and new initiatives across private and public payers, systems, and sectors that demonstrate overall medical, educational, and social service cost savings to ensure sustainability.

**Strengthen behavioral health prevention and early intervention.**

**2**

Effective promotion, prevention, and early intervention, starting in childhood, is critical to getting ahead of Utah’s growing behavioral health needs, reducing mental health and SUD stigma, and building resiliency and emotional flexibility. This positively impacts children, parents, families, schools, and communities, which can in turn bolster protective factors, reduce risk factors, and increase productivity.

Preventing or delaying the escalation of worsening behavioral health issues will also help improve access by reducing the need for more acute and costly services. This places downward pressure on public and private system costs and reduces costs in other sectors such as education, corrections, criminal justice, housing, and child welfare. The Master Plan supports strategies that promote effective, coordinated, and community-based prevention and early intervention strategies. "We need effective upstream strategies."

 **NOW**

#### Focus Areas

* + Continue to provide mental health and SUD training and technical assistance to communities, providers, and other system stakeholders across the state, including but not limited to:
    - Childcare and preschool providers (e.g., The Children Center Utah’s Infant and Early Childhood Mental Health Training and Teleconsultation Program).
    - School counselors and other K-12 staff (e.g., the Utah School Mental Health Collaborative’s school district technical assistance and training[[2]](#endnote-2)). Training could include education on the roles/responsibilities of school counselors, school-based mental health professionals, and information on how to connect with community mental health providers. See “Environmental Scan: Detailed section for more information.
    - Law enforcement. Training could include education about mental health and SUD episodes and how to interact with individuals with cognitive impairment and high behavioral health needs (e.g., individuals who cycle through the criminal legal system, homeless shelters, and emergency departments).
  + Improve the alignment and sustainability of current programs that help prevent, intervene early, and coordinate efforts to support and address the mental needs of Utah’s most vulnerable child and youth populations in the context of the family (including children served by the Division of Child and Family Services, DCFS). Examples include the Utah Infant Toddler Court Program, Systems of Care, stabilization and mobile response teams, Family Peer Support Specialists, etc.
  + Continue to support schools and other community-based settings by making behavioral health programming available that focuses on normalizing behavioral health discussions, SUD prevention, and mental health promotion and resilience (e.g., SafeUT, the Huntsman Mental Health Institute (HMHI) Brain Health curriculum, Intermountain Health’s “Talk to Tweens”21 emotional well-being program, the University of Utah’s Positive Psychology course and other higher education and K-12 programs, etc.)
  + Leverage the work currently being completed by the Utah Early Childhood Mental Health Working Group to expand awareness of prevention and early intervention services that can be reimbursed by public and potentially private payers (e.g., well-child visits focused on mental health, Early and Periodic Screening, Diagnostic and Treatment (EPSDT); DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; Screening, Brief Intervention and Referral to Treatment (SBIRT), etc.). [See “Meeting the Mental Health Needs of our Infants, Children and Youth” text box for more information.] Consider ways to develop similar reimbursement guides for schools, preschools, and other community or non-clinical settings.
  + Continue to facilitate and support engagement around eliminating stigma, aligning efforts with the collaborative HMHI anti-stigma campaign where appropriate to identify and address structural stigma (laws, regulations, policies), public stigma (attitudes, believes, behaviors), and self-stigma (internalized negative stereotypes). Examples are provided below.

*Structural:* Enact change at the structural level by uniting elected officials, other leaders, and Grand Challenge partners to collaboratively develop platforms with measures to determine areas for change at the public and private policy level.

*Public:* Create measurable change in cultural norms and attitudes to improve the awareness and acceptance of persons with mental health and SUDs.

*Self:* Improve personal awareness, self-acceptance, and understanding in people impacted by mental health and SUDs, providing tools and services that enables them to empower themselves to live full lives.

 **NEXT**

#### Key Questions

* + How to better integrate prevention into Utah’s continuum of behavioral health services and supports?
  + How to establish sustainable funding for a broad array of prevention services in both urban and rural geographies?
  + How to better understand and address the myriad of underlying issues that contribute to risk factors for mental health and SUDs and improve coordination among Utah’s existing prevention systems. Better alignment among groups addressing similar risk and prevention factors could help create more efficiencies within the system.

#### Focus Areas

* + Explore how research and models that support positive childhood experiences and strengthen protective factors can be expanded or adopted across Utah’s behavioral health system to counter the impact of adverse childhood experiences (ACEs) for all Utahns with a specific focus on models by and for Utah’s culturally and linguistically diverse and marginalized populations.
  + Evaluate ways to expand and improve the provision of family-based care for children, youth, and adults (e.g., use of available codes, effective models, individual and family respite services and supports, services and resources for families assisting persons with suicide ideation, etc.).
  + Build systems that promote appropriate screening and identification of need with referral to indicated interventions.
  + Increase funding for primary, secondary, and tertiary prevention services, including reimbursement by public and private payers (e.g., sustainable reimbursement for behavioral health well-child visits and adult checkups).

 **FUTURE**

#### Focus Areas

* + Ensure access to and reimbursement for age-appropriate and uniform behavioral health screening across the lifespan (from infants and young children to older adults), which could also support baseline data creation and monitoring changes in need.

**<<New Text Box>>** **Meeting the Mental Health Needs of our Infants, Children and Youth**

There is a need for early childhood mental health services in Utah. National research shows Utah is among a group of states with the highest prevalence of child and adolescent mental health disorders and the highest prevalence of youth with untreated mental health needs.[[3]](#endnote-3) Early investment improves children’s current and future health, as research shows a link between unmet mental health needs in a child’s earliest years and their lifetime outcomes.

To develop strategies and tactics to strengthen and improve early childhood mental health in Utah, the Children’s Center Utah assembled the Utah Early Childhood Mental Health Working Group in 2021. The working group consists of stakeholders from a variety of early childhood-related professions and backgrounds.

The group is currently working on efforts to: (1) create a baseline estimate of need for early childhood mental health services; (2) increase integration of physical and behavioral health for children by examining financing policies for addressing early childhood mental health needs before they escalate to the point of functional impairment (e.g., expanding awareness of prevention and early intervention services that can be reimbursed by public and potentially private payers); and (3) increase early childhood mental health awareness.

**Integrate physical and behavioral health.**

**3**

Improving Utah’s behavioral health system requires more focus on integrating physical and behavioral health across and within public and private clinics, systems, and payers. Promoting integrated care models and coordinated referrals to behavioral health care expands access to mental health and SUD services, reduces stigma, and helps to alleviate workforce shortages. Research shows integrated approaches address system fragmentation and close care gaps, improve care management, provide a holistic member experience, and are generally cost effective. For example, overall spending on individuals with a behavioral health diagnosis is 2-4 times higher than for individuals without a behavioral health diagnosis.22 Improving integration between physical and behavioral health care can help reduce these costs.23 24

The Master Plan identifies three areas for improving physical and behavioral health integration in Utah:

3a Expand primary care integration models and increase clinical-level coordination between primary care and behavioral health providers.

3b Evaluate ways to reduce barriers and gaps in the delivery of services across public physical and behavioral health systems.

3c Encourage better alignment of integrated behavioral health across public and private payers and systems.

***Expand existing primary care integration models and increase clinical-level coordination between primary care and behavioral health providers.***

Improved detection, effective management, and recovery of mild-to-moderate behavioral health conditions through increased coordination and integration between primary care and behavioral health can help reduce the worsening of behavioral health needs and alleviate pressure on downstream services and supports. Research shows 10–20% of the general population will consult a primary care clinician for a mental health problem in a given year, and that 10–40% of primary care patients have a diagnosable mental disorder.25

Primary care integration and clinical-level coordination is growing in Utah, and the Master Plan supports strategies that continue to increase integration and coordination between primary care and behavioral health. This includes supporting existing, evidence-based primary care integration models; creating regionally based referral networks to support primary care providers with clear pathways to community-based, other outpatient, and specialty behavioral health providers; as well as leveraging certified or credentialed non-licensed professionals (peer support specialists, certified case managers, CHWs, etc.) as integrated care team members to help build the bridge between primary care and behavioral health providers (see strategic priority #7).

The Master Plan also acknowledges that integrated care models vary, and different approaches should be utilized based on providers’ and health systems’ needs. While some specific approaches are mentioned in this report, the Master Plan supports the continued use and development of coordinated, evidence-based, and culturally and regionally appropriate models.

 **NOW**

#### Focus Areas

* + Continue to expand statewide consultation support to primary care providers (e.g., Psychiatric Consultation Program, or CALL-UP).
  + Provide state-supported education, training, and centralized support, resources, and technical assistance to primary care providers across the state to invest in the Collaborative Care Model.
  + Allow providers to bill for physical health, mental health, and SUD services in same day (consider alternative payment models and ways to alleviate unnecessary cost-sharing).
  + Ensure that individuals with alcohol, opioid, and other SUDs have access to primary-care based SBIRT, Medication Assisted Treatment, Office-Based Opioid Treatment, and harm reduction approaches such as naloxone. Focus on eliminating gaps in these services for Utah’s culturally and linguistically diverse and marginalized populations. [See “Total Drug Fatalities in Utah” text box for more information on current trends related to drug-related fatalities in Utah.]
  + Improve integration of tobacco cessation programs in mental health and SUD treatment and provide tobacco cessation training to the behavioral health workforce.

**<<Text Box>> Total Drug Fatalities in Utah**

Total drug-related fatalities in Utah increased in 2020-2021 (Figure 5); however, preliminary data from 2022 show a slight decrease. The main drivers of the 2020-2021 increase were fentanyl and methamphetamine, which was the most common drug involved in fatal overdoses. Deaths from prescription opioids and heroin slightly decreased.26

Utah’s methamphetamine-involved deaths increased nearly 2.5 times from 5.6 per 100,000 adult population in 2015 to 12.2 in 2021.27 American Indians or Alaska Natives have the highest fatal drug overdose rates followed by Black or African Americans.[[4]](#endnote-4)

A graph showing the number of drugs in the u. s.

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**<<Text Box>> Increasing demand for Behavioral Health Services among Utah’s Aging Population**

Utah’s average age remains the youngest, but the state has one of the fastest growing per capita populations of adults age 65+ in the country. Projections indicate that Utah’s older population (ages 65+) will more than triple over the next several decades—from 376,000 people in 2020 to 1.2 million in 2060—which is shifting demand for behavioral health services to older adults.28

While demand for services is increasing, interviewees noted that Utah only has a small number of geriatric psychiatrists in the state (two that work outside of the VA), and that rural-area access is especially limited. There are also few geriatric-trained mid-level practitioners like advance practice registered nurses (APRNs), physician assistants (PAs), social workers, and neuropsychologists.

Expanding the number of behavioral health professionals trained in geriatric care is necessary, but slow. Parallel clinical approaches should include primary-cared based risk prevention and early disease identification to help prevent, delay, and treat the onset of psychiatric and/or dementia symptoms, centralized resource awareness and education, and increased clinical-level coordination between the patient’s existing primary care, care manager, and behavioral health providers. There is also a need for better and more complete communication for hospital discharges and transition of patients to the home or facilities (and vice versa). This requires more extensive behavioral health training in the primary care setting and targeted consultations with specialty behavioral health providers. One participant noted that “primary care docs ***should*** be able to diagnose and treat cognitive decline.”

The Utah Commission on Aging (UCOA) is in the process of developing a Master Plan on Aging that will more comprehensively identify and address the behavioral health needs of older adults among other issues such as preventive care, homelessness, disabilities, family caregiving, etc. It is expected this plan will be complete in November 2023.

*"The excess annual adjusted health care costs of depression, anxiety, and comorbid depression and anxiety reached $27.4, $80.0, and $119.8 million per 1,000,000 elderly population, respectively."[[5]](#endnote-5)*

 **NEXT**

#### Focus Areas

* + Improve the availability of integrated physical and behavioral health services for populations at the beginning and end of the lifespan (infant and early childhood, youth ages 6-12, and the geriatric population) by supporting and sustaining successful, evidence-based primary care integration models and expanding training and technical assistance to pediatricians, medical providers, physicians treating the aging population, and other licensed clinicians across the state. [See “Increasing demand for Behavioral Health Services among Utah’s Aging Population” text box for more information on the behavioral health needs of Utah’s aging population.]
  + Foster systemic connections between primary care providers, outpatient behavioral health providers, and school-based mental health professionals (e.g., encourage primary care providers, local authorities, other community behavioral health providers, and schools to align care needs and ensure referral pathways for patients to access a comprehensive continuum of behavioral health services and supports).
  + Where appropriate, promote training on brief physical health interventions and therapies for behavioral health providers working in integrated settings.

 **FUTURE**

#### Key Questions

* + How to expand and support effective integrated care models utilized in behavioral health outpatient services that create direct linkages back to primary care?
  + How to expand integrated care models across the continuum of behavioral health services and supports so it is not limited to primary care?

#### Focus Areas

* + Develop enhanced, regionally based referral networks to support pediatricians and primary care providers with screening, early identification, and creating connections to behavioral health providers.
  + Incentivize system structures and payments for evidence-based integrated care approaches that address the physical and behavioral health of individuals and families.29
  + Partner with populations with lived experienced and populations that experience health disparities to evaluate gaps in behavioral health programs (across all populations, communities, and geographies) and determine what evidence-based programs, digital tools, and other services could be expanded, supported, developed, and coordinated

to promote behavioral health, wellness, and the management of mild-to-moderate behavioral health concerns.

* Work with Utah’s medical schools to incorporate more training and education on mental health and SUDs in their programs.

***Evaluate ways to reduce barriers in the delivery of services across and within public physical and behavioral health systems.***

The Master Plan supports evaluating ways to reduce barriers in the delivery of services across and within the state's public physical and behavioral health systems.30 This could include evaluating Medicaid beneficiaries’ access to and choice of behavioral health providers as well as any gaps that may exist based on Utah’s changing behavioral health needs and services.

Proposed policy and program changes should take into account safety net behavioral health funding and current services provided to the SMI, uninsured, and underinsured populations by the counties. Changes should also consider the value of the counties’ community-based and region-specific systems, their key partnerships, and the critical wraparound services and systems they provide. [See “Utah’s Uninsured and Underinsured Populations” text box for more information on the need to maintain a focus on uninsured and underinsured populations.]

 **NOW**

#### Key Questions

* + How to streamline the roles of state regulatory agencies to reduce unnecessary administrative complexities for public providers?
  + What are the roles and responsibilities of state and county government with respect to delivering behavioral health services, providing access to care, reducing suicide and overdose deaths, etc. as currently provided and outlined in Utah Code?31
  + How to streamline Medicaid benefits and plan options? How to simplify plans options within Medicaid to reduce disruption when Medicaid members have eligibility changes?
  + How to improve continuity of care in Medicaid? (e.g., establish 12-month continuous eligibility for adults in Medicaid to prevent people from switching programs more than necessary)
  + How to improve Medicaid beneficiaries’ choice of providers and services (especially in rural areas and marginalized communities)? Evaluate network adequacy or freedom of choice waiver 1915(b)?
  + How to define network adequacy? How does network adequacy differ in Utah’s rural and frontier areas? How to ensure these areas have adequate access to equitable, culturally literate, language accessible, and nondiscriminatory services that reflect patient voice?
  + How to improve standardization of services and accountability among Utah’s local authorities?

#### Focus Areas

* + Convene county officials, managed care organizations, community-based providers, nonprofit organizations, patients/consumers, and other relevant groups to discuss and determine appropriate integrated delivery models for each area. Models could include Primary Care Behavioral Health, Collaborative Care, integrated accountable care organizations, or integrated behavioral health care programs.32
  + Harmonize performance metrics and reporting requirements across Medicaid and the Office of Substance Use and Mental Health (SUMH).
  + Simplify and streamline behavioral health related billing, coding, reporting, and other administrative requirements across Medicaid’s ACOs.

**<<Text Box>> Utah’s Uninsured and Underinsured Populations**

The Master Plan supports ensuring comprehensive and sustainable behavioral health services for Utah’s uninsured and underinsured populations, while simultaneously seeking to improve coverage and payment parity. This includes determining effective ways to help sustain community-based organizations that provide behavioral health and other safety net and supportive services to uninsured and underinsured Utahns. Funding should be flexible and sustained over time. If Utah’s uninsured and underinsured residents are unable to access appropriate care in lower acuity settings, their behavioral health conditions may worsen leading them to seek services in emergency departments, hospitals, and other high-acuity, high-cost settings.

About 9% of Utah’s population is uninsured (Figure 17), which translates to just over 300,000 individuals. While Utah expanded Medicaid coverage in 2020 to Utah adults with annual income up to 138% of the federal poverty level (FPL), it is important to note that that segments of Utah’s population remain ineligible for Medicaid, earn too much to qualify for Medicaid and cannot afford marketplace plans or other private insurance, or are uninsured for a variety of other reasons.

The high-cost and limited coverage of some mental health and SUD services, coupled with a growing number of Utahns with high-deductible health plans (HDHPs), also means many families are underinsured when it comes to behavioral health. [See “High-Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)” text box for more information.] Close to 40% of Utahns with family income below $25,000, and 50% of Utahns with incomes between $25,000-$49,999, have employer-sponsored insurance (Figure XX). The federal poverty level is $30,000 for a family of four.[[6]](#endnote-6) Discussion group participants feel that more funding is needed to support these low-income populations and the safety net providers that serve them.

A related concern is that people with private health insurance who run into coverage limits or need additional services may end up in the crisis system and then the public system to receive necessary care. This makes Utah’s publicly funded behavioral health system the de facto payer of behavioral health services in the state. Alternatively, when people move off Medicaid due to increases in their income, they often lose access to a broader array of services (and potentially their behavioral health home).

**Figure XX: Share of Utahns by Family Income Level Covered by Employer Sponsored Health Insurance Plan, 2021**

Notes: A primary source of coverage was assigned for respondents selecting multiple sources of coverage.

Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. 2021.

***Encourage better alignment of integrated behavioral health across public and private payers and systems.***

While it is important to address the integration of physical and behavioral health within Utah’s public health systems, only a fraction of Utah’s population qualify for public services. Most Utahns have employer-sponsored health insurance and access behavioral health services through private systems and providers (Figure 17).

The Master Plan supports strategies to better align integrated behavioral health across public and private payers and systems, including easing administrative complexities for private providers. Such strategies can help improve access to necessary and appropriate behavioral health care for all Utahns, increase parity of mental health and SUD services, and address reimbursement concerns.

 **NEXT**

#### Key Questions

* + How to streamline current behavioral health regulations and administrative requirements across public and private payers and systems to reduce unnecessary administrative complexity for behavioral health providers and consumers?
  + How to address the movement of behavioral health providers from the public/private market to the self-pay or cash-only market (e.g., address administrative burdens, incentivize providers to participate on insurance panels, reduce the barriers to participating in Medicaid, etc.)?
  + What incentives, funding flows, or other efforts will help increase access to integrated physical and behavioral health care across Medicaid and other public and private markets to make it easier for individuals and families to access care earlier in the continuum of behavioral health services and supports? How to improve parity for these services?

#### Focus Areas

* + Improve awareness and use of available behavioral health related codes across public and private payers.
  + Simplify and streamline state licensing, certification, and provider credentialing.
  + Begin to engage with private payers, employers with self-funded health plans, self-pay providers, and other direct-to-consumer market entrants (e.g., Employee Assistance Programs (EAP), online mental health/counseling platforms, etc.) to create a shared vision for a coordinated system. [See “An Unknown: The Impact of a Growing Direct-to-Consumer Market” text box for more information.]

**<<Text Box>> An Unknown: The Impact of a Growing Direct-to-Consumer Market**

The already growing market for direct-to-consumer and digital mental health services expanded during the COVID-19 pandemic.33 These online services and digital tools help create access and can be effective options for individuals with mild-to-moderate mental health needs.

There are some possible concerns to watch for with this growing market, however, which include the efficacy of the services and tools, data privacy and security, connection to a full continuum of local mental health services and supports if higher-acuity services or supports are needed, and ensuring certain populations are not left out as the market transitions to these new models of care (e.g., populations that cannot afford to pay cash for services, populations with low-digital literacy or limited access to broadband services, etc.).

 **FUTURE**

#### Key Questions

* + What are the roles and responsibilities of public and private behavioral health providers, including self-pay providers?
  + How to create equitable access to behavioral health benefits for an increasing number of patients and consumers with HDHPs and employer-sponsored self-funded plans? [See “High-Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)” text box for more information.]
  + Are there essential behavioral health services that private health insurance plans should be responsible for covering?
  + How to improve patient and consumer access and choice across private payers and systems?
  + How to develop capitated payment models for different populations that include cost savings in and beyond behavioral health to reflect the entire medical cost?
  + How to attribute costs to the appropriate payer (both public and private) and avoid cost shifting from the private to the public market?
  + How to address reimbursement disparities between behavioral and physical health? How to better align payment parity between physical and behavioral health providers with similar level of education and training to ensure sustainability and ease the cost of administrative burdens?
  + What type of structure needs to be in place to help align and enforce parity across these different markets? [See “Proposed Amendments and Updates to Mental Health Parity Rule” text box for more information.]

#### Focus Areas

* Consider ways to align private health insurance benefits with Medicaid to better address the needs of the underinsured.
  + Encourage or incentivize private payers to simplify and streamline administrative functions and requirements such as credentialing, billing, coding, reporting, etc.

**<<Text Box>> High-Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)**

Employer and employee education around how to effectively use HDHPs will be important as the number of Utahns covered by HDHPs grows. HSA-qualified HDHPs accounted for 40.1% of Utah’s comprehensive health insurance market in 2021, compared with only 3.0% in 2007.34 These plans have lower monthly premiums, but the higher deductibles require individuals and families to pay more in out-of-pocket costs before their insurance plan begins to cover expenses. Today, HSA-qualified high-deductible family health plans have a minimum deductible of $3,000 with a maximum of $15,000 in out-of-pocket expenses.35 This means that families enrolled in these plans are responsible for paying $3,000 of their covered health care expenses (or more if the deductible is higher) before the insurance company begins to pay a portion of the costs.

While HDHPs may save individuals and families money in the short run through lower monthly premiums, they can deter some individuals from seeking appropriate medical care because of the higher, upfront out-of-pocket costs.36 More than half (63%) of Utahns report delaying or going without healthcare due to cost. Almost a third of this group reports problems accessing mental health services or addiction treatment due to cost. The rate is higher for respondents of color and the Hispanic/Latino population.37

**3%**

**<<New Text Box>> Proposed Amendments and Updates to Mental Health Parity Rule**

On August 3, 2023, the federal government released proposed amendments to the Mental Health Parity and Addiction Equity Act (MHPAEA) that, if adopted, could strengthen implementation of the law by employer-sponsored self-funded health plans and insurers in the group and individual markets.[[7]](#endnote-7)

The proposed amendments establish a framework, based on data collection and analysis, for demonstrating that certain treatment limits on behavioral health coverage comply with the parity law. These regulations could provide a structure to help Utah align and enforce parity across different insurance plans and markets.

**4**

**Improve patient/consumer navigation.**

While it is perceived that that stigma is lessening, the need to improve public awareness of behavioral health is ongoing. This includes increasing behavioral health literacy and providing education that is patient/consumer-informed and outcomes-focused.

A key component of this education is providing behavioral health navigation tools that help patients and consumers understand how to access high-quality behavioral health services and help providers manage and coordinate care.[[8]](#endnote-8)

The Master Plan supports strategies that promote effective behavioral health navigation tools that help reduce time between symptom development, identification of need, and engagement in appropriate care in the least restrictive setting. While existing tools could be better promoted and coordinated,38 it is important to note that the development of future tools should occur after the implementation of major reforms recommended by the Master Plan to account for possible structural changes to Utah’s behavioral health system.

**NOW**

#### Key Questions

* + How best to help employers understand behavioral health coverage and purchase the best plan and services for their employees?

***Focus Areas***

* Continue to promote existing navigation services such as the Behavioral Health Navigation Line (833-442-2211), healthyminds.utah.gov, sumh.utah.gov, etc.
* Continue to support and expand the Utah Parent Center[[9]](#endnote-9) and other central landing pages that provide parenting resources related to prevention services and other evidence-based programming.
  + Partner with patients/consumers to determine ways to better coordinate, align, and enhance existing navigation services and tools across sectors and geographies.
* Provide more education and awareness of the comprehensive continuum of behavioral health services and supports with a priority focus on (1) prevention and early intervention (to address mild-to-moderate behavioral health needs); and (2) crisis and diversion services as receiving centers and mobile crisis outreach teams (MCOTs) are expanded across the state.
* Partner with patients/consumers to develop effective culturally and linguistically appropriate outreach and education materials as well as materials that meet the needs of individuals with low literacy, low health literacy, and limited-English proficiency.
* Support OPLR’s recommendation to empower consumers and regulators to identify and intervene in unprofessional, unlawful, and unsafe conduct by (1) requiring all licensees to immediately report criminal convictions to DOPL (not just to declare them at the time of initial licensure/renewal); (2) requiring all clinicians to be enrolled in the FBI “Rap Back” service for ongoing criminal activity checks; (3) authorizing state licensing agencies to query the National Practitioner Data Bank; and (4) requiring clinicians to provide clients with licensing- and safety-related disclosures.

**NEXT**

#### Focus Areas

* + Encourage employees with HDHPs to contribute more to HSA/flexible spending accounts and provide more education on preventive services available at no cost (e.g., depression screening, some anxiety screening, and some services and items related to diagnosed depression),39 behavioral health access points, and costs related to behavioral health services.
  + Implement, evaluate, and possibly expand the statewide bed registry to show bed availability at inpatient, residential, partial hospitalization, med-detox, social detox, receiving/access centers, crisis respite homes,40 intensive outpatient, and other high-acuity levels of care.
  + Create patient/consumer-informed, consolidated, effective, holistic, transparent, and outcomes-based patient navigation services that help patients and consumers across the population lifespan (infant to geriatric), and in different areas in the state, access a full continuum of behavioral health services and supports (i.e., the right services at the right time and the right place).
* **FUTURE**

#### Focus Areas

* + Develop and leverage digital tools at each level of Utah’s continuum of behavioral health services and supports to help link that level back to a full continuum of care.

**Continue to build out Utah’s behavioral health crisis and stabilization systems.**

**5**

Improving crisis services is a current focus for the state, but more can be done to expand and sustain these initiatives to ensure all Utahns have access to effective and sustainable crisis and stabilization services (including referrals to high-quality, community-based services).

Crisis and stabilization services (like Utah’s community-based behavioral health receiving centers, Intermountain Health's access centers, and MCOTs) prevent behavioral health issues from escalating and help patients more fully engage in treatment and move to self-sustaining recovery. These services can also help people enter treatment earlier on, and at a lower cost, reducing overall costs in the health care system.

Utah's Behavioral Health Crisis Response Commission is in the process of developing a comprehensive coordinated crisis system designed for anyone, anytime, and anywhere. Key goals include better care, hospital diversion, and law enforcement/jail diversion. The Master Plan supports strategies that align with the Commission's recommendations as well as additional strategies that ensure crisis services are expanded and enhanced to reach all Utahns.

**NOW**

#### Focus Areas

* + Ensure crisis/diversion services across the state are fully integrated with law enforcement, jails, courts, and re-entry programs, and are sufficient to meet the needs of the justice and correction systems as they develop effective, coordinated diversion strategies.
  + Ensure law enforcement, justice, and correction systems continue to be trained in best practices for addressing behavioral health issues and coordinate with behavioral health professionals, peer support specialists, certified case managers, and patient/consumer advocates to improve community responses to behavioral health crises.
  + Ensure current crisis services are appropriately funded. Local authorities have limited resources to provide crisis outreach, 24-hour crisis support, and subacute care within their current allocations. Additional funding is needed for Utah’s crisis response infrastructure to ensure individuals in crisis receive appropriate and quality care.
  + Expand access to the crisis call center (with linkages to care), MCOTs, receiving centers and 23-hour observation, and subacute levels of care statewide. Address challenges with expanding rural-area crisis/ diversion services.
  + Expand private health insurance reimbursement of crisis services (receiving centers, MCOTs, etc.).
  + Promote bundled payments for crisis services that reflect regional needs.

 **NEXT**

#### Focus Areas

* + Determine ways to improve coordination between publicly and privately operated crisis/diversion services to maximize availability and access—and improve navigation by patients, consumers, providers, law enforcement, and other sectors and stakeholders across the state.
  + Broaden the behavioral health crisis system to integrate SUD intake and treatment more fully.
  + Ensure crisis services are integrated into a full continuum of behavioral health services and supports across public and private systems and sectors, ensuring equitable access to a comprehensive system for all Utahns.
  + Expand private health insurance reimbursement of evidence-based individual and family respite services and supports and other levels of care (psychosocial rehab, psychoeducation, etc.).

**Improve the availability of services and supports for individuals with serious mental illness and complex behavioral health needs.**

**6**

A critical gap in Utah’s continuum of behavioral health services and supports is the availability of appropriate and effective services for Utahns with SMI, psychosis, anosognosia, and other complex behavioral health needs. While Utah has some providers qualified and willing to treat these populations, access to services is not consistent across different communities, different populations, and different complex behavioral health conditions.

Examples of such services and supports extend from community- to facility-based settings and include assertive community treatment (ACT) teams; caregivers for cognitively impaired older adults; withdrawal management and detox services; residential, partial hospitalization and other intensive outpatient services; community-based recovery services and supports; and subacute care. For purposes of this report, subacute care includes a variety of long-term services and supports provided in a non-acute hospital, facility, or other community-based long-term care setting for people recovering from an acute behavioral health condition. The lack of these “step up” and “step down” services for Utahns moving away from institutional settings (hospitals, prisons, etc.) contributes to capacity issues experienced by inpatient care facilities.

The Master Plan supports strategies to ensure these services reflect the patient voice and are coordinated, expanded, enhanced, and community-based to create a functional and sustainable system to meet the individual needs of all Utahns with complex behavioral health issues.

 **NOW**

#### Key Questions

* + How to expand Utah’s behavioral health workforce qualified to treat SMI, psychosis, anosognosia, and other complex behavioral health needs?
  + How to create and promote sustainable reimbursement structures in public and private markets that reflect risk, costs, regional differences, and the complexity of care?
  + What type of payment models or levels of reimbursement are necessary to develop, expand, and sustain community-based subacute services and programs for individuals with complex needs?
  + Should public and private markets establish differentiated rates based on risk and outcomes that are appropriate for the population served?
  + How to create and determine levels of care? (e.g., clearly articulated “stepped care” approaches; consider using American Society of Addiction Medicine’s (ASAM) criteria)
  + What type of oversight models are effective in managing providers’ concerns with private health insurance plans related to subacute, acute, inpatient, and residential behavioral health care coverage and reimbursement?
  + How to address the mental health “institutions for mental disease” IMD gap? (e.g., modify the Medicaid waiver)
  + What are the current and future needs for civil and forensic beds at the Utah State Hospital?

#### Focus Areas

* + Expand ACT teams across the state and develop a long-term, statewide ACT team plan that includes supporting homeless individuals and individuals involved in the criminal legal system.
  + Partner with people in recovery and their family members to foster health and resilience and improve awareness, connection, and coordination with community-based support groups across the state (e.g., National Alliance on Mental Illness (NAMI), Utah Support Advocates for Recovery Awareness (USARA), faith-based organizations, etc.).
  + Identify specific needs and gaps in Utah’s community mental health system, recovery resources, and other supportive services specific to Utah’s SMI population (across communities and geographies). Evaluate a range of funding, services, and delivery options, along with best practices and models from other states, to help determine what evidence-based programs, tools, and services could be expanded, supported, coordinated, or developed to fill the gaps.
  + Implement autism-spectrum disorder (ASD) services for all populations enrolled in Medicaid as part of the Medicaid state plan (per S.B. 204, 2023).
  + Consider applying for a Medicaid Katie Beckett Waiver to support children with long-term disabilities or complex medical needs (including behavioral health needs) living at home.
  + Expand the HMHI HOME Program.

 **NEXT**

#### Key Questions

* + - How to coordinate with the Department of Workforce Services (DWS) and Utah Homelessness Council to ensure integrated, appropriate, and affordable housing options exist statewide to prevent homelessness and assist near-homeless persons with behavioral health needs? [See “Housing: Utah’s #1 Issue” text box for more information]
    - How to improve funding and coordination with the Division of Services for People with Disabilities (DSPD) to address the affordability of and gaps in services for persons with ID/DD, including subacute, acute, intermediate, and transitional programs for both youth and adults with co-occurring behavioral health needs? Work with Utah’s Institute for Disability Research, Policy & Practice at Utah State University to assess gaps, evaluate why gaps exist, identify best practices, and develop solutions. [See “Mental Health and ID/DD Landscape Analysis” text box for more information.]
    - How to best serve the high-need juvenile justice population?
    - Should the state establish a Utah State Hospital operated long-term care facility?
    - Consider the development of regionally appropriate medical home models for different populations (e.g., create behavioral health homes for SUDs or support the development or expansion of medical home models that provide care to culturally and linguistically diverse and marginalized populations).
    - How to create sustainable funding for addiction recovery services, including improved socialization and standardization of these services?

#### Focus Areas

* Expand intensive outpatient options by adjusting Medicaid and private health insurance reimbursement models to support sustainability.
* Create sustainable funding/reimbursement models that promote the development and expansion of community-based subacute programs and services that that match the right level of care to right level of need and are coordinated with a comprehensive behavioral health continuum of care (consider community-based models, crisis respite homes, individual, family, and crisis respite services, intermediate acuity care models, etc.).
  + Promote bundled payments or global fees for episodes of care to improve reimbursement for community-based individual and family respite services and supports, club houses, recovery supports, supported employment/education, and other specialized services such as Coordinated Specialty Care (CSC) for psychosis prevention and early intervention.
  + Evaluate ways to make programs that support individuals with co-occurring and complex needs affordable (e.g., helping individuals in need pay for treatment through the expansion of subsidies or other assistance programs).
  + Develop or expand reintegration models of care and training for people who are released from prison.
  + Expand the availability of long-term care beds at the Utah State Hospital and other inpatient/residential facilities as needed.
  + Create sustainable funding/reimbursement models for acute care services and residential care.
* **FUTURE**

#### Focus Area

* Ensure access to resources that support the four major dimensions of recovery: (1) health; (2) home; (3) purpose; and (4) community.41 Examples include but are not limited to individual and family respite services and supports, peer support specialists, CHWs, housing, home and community-based services, supported employment/education, transportation, childcare, access to healthy food, and other social supports).

**<<New Text Box>> Housing: Utah’s #1 Issue**

The most frequently mentioned gaps or challenges in Utah’s behavioral health system were affordable housing and housing support services. Nearly all discussion groups noted that there are insufficient housing vouchers, available and affordable housing inventory, and other assistance to address the state’s growing housing needs. And while Utah’s local authorities, community-based behavioral health providers and other service organizations provide critical housing support services, they operate with limited resources in an increasingly expensive housing market with little housing stock. Additionally, Utah lacks the availability of permanent supportive housing to address the needs of its most vulnerable residents who experience homelessness and have additional needs related to behavioral health.

The lack of affordable housing, permanent supportive housing, and housing support services is disrupting care across the behavioral health continuum—impacting patients and providers. For example, the issue:

* + Creates stress and instability that negatively impacts a person’s behavioral health and well-being.
  + Limits the ability for the system to support care transitions along the continuum such as discharging patients from hospital stays or other high levels of care.
  + Increases the number of individuals who experience homelessness and lengths of stay in shelters, community group homes, recovery centers, and other temporary or transitional programs. This exacerbates the challenges related to “step-down” care and the ability to discharge patients from acute/inpatient settings.
  + Prevents people in the criminal justice system from effectively participating in court-ordered treatment.
  + Exacerbates the state’s existing behavioral health workforce shortages. Behavioral health systems across urban and rural areas noted that they are unable to attract talent to their areas due to the lack of homes that are affordable (Figure XX).

**Figure XX: Annual Percent Change in Housing Prices in Utah, 1976-2021**

A graph showing the price of housing prices

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In February 2023, the Utah Homelessness Council released Utah’s Plan to Address Homelessness.[[10]](#endnote-10) The plan includes five goals:

1. Increase accessible and affordable permanent housing opportunities for people experiencing homelessness across the state.
2. Increase access to and availability of supportive services and case management for people experiencing and at risk of homelessness.
3. Expand homeless prevention efforts by increasing coordination, resources, and affordable housing opportunities.
4. Target housing resources and supportive services to people experiencing unsheltered homelessness.
5. Promote alignment and coordination across multiple systems of care to support people experiencing and at risk of homelessness.

The Master Plan supports these goals and working with the Utah Office of Homeless Services during the plan’s implementation process[[11]](#endnote-11) to ensure future versions of the Master Plan (that outline specific objectives, actionable steps, and measurable outcomes) align with Utah’s Plan to Address Homelessness.

The Master Plan also specifically supports the following focus areas:

* Expand and ensure case management is available to diverse populations to address a range of social determinants of health (SDOH) including homelessness and housing. Maintain a sufficient workforce with sustainable reimbursement by Medicaid, private insurance, and other funding for uninsured and under-insured populations—while also reducing unnecessary administrative burdens (see strategic priority #7).
* Develop enhanced, regionally based referral networks to support case managers and other providers with patient/consumer navigation and connect to existing housing resources and supports.
* Expand and sustain integrated permanent supportive housing, scattered-site housing, assisted living, and other community and residential support programs across the state by providing long-term rental subsidies as well as sufficient funding to develop, support, and maintain the housing over time. Models should include community-based, group settings where staff (e.g., ACT teams, peer support specialists, etc.) are available to assist residents with activities of daily living and retain housing throughout the recovery process (including relapse). Models should also align with best practices, including SAMHSA’s Permanent Supportive Housing Evidence-Based Practices Kit[[12]](#endnote-12) and the Corporation for Supportive Housing’s Standards for Quality Supportive Housing Guide.[[13]](#endnote-13)
* Evaluate the possibility of expanding Utah’s Housing Related Services and Supports program (that allows the state to provide housing-related supports and services to the TAM population through its 1115 waiver) to additional Medicaid populations and/or cover additional services and supports such as case management.[[14]](#endnote-14)
* Evaluate the possibility of expanding Medicaid’s presumptive eligibility to people receiving medical services in federally qualified health centers and other community health centers.

**<<Text Box>> Mental Health and ID/DD Landscape Analysis: Utah’s Institute for Disability Research, Policy & Practice**

Utah’s Institute for Disability Research, Policy & Practice at Utah State University is currently engaged in a landscape analysis to evaluate capacity and needs within current systems of care for people with mental health and ID/DD, with a specific focus on the needs of unserved/underserved and culturally diverse populations in Utah.

The purpose of the landscape analysis is to: (1) evaluate the efficacy and impact of the current disability service system with regards to supporting the mental health needs of individuals with ID/DD; (2) identify current gaps in mental health supports for individuals with ID/DD; and (3) identify training needs to help build the capacity of service providers to support the mental health of individuals with ID/DD.

Key recommendations and next steps in the report include:

1. Directly involve individuals with mental health and/or intellectual and developmental disability lived experience, including practitioners and family members/caregivers from diverse backgrounds in the decision-making process regarding allocation and distribution of funds at state and local levels.
2. Provide support (funding, policies, etc.) for improved collaboration between mental health and disability service sectors to facilitate coordinated care.
3. Provide professional development opportunities that support the provision of mental health services for individuals with ID/DD through increasing mental health provider knowledge and confidence.
4. Institutes of higher education and advanced training should review and update their current curricula to reflect specific needs of individuals with IDD in the mental health setting.
5. Value the critical role of direct support professionals in disability service systems through continuing to support competitive wages and providing effective training and ongoing professional guidance. This will enable direct support professionals to identify and address mental health concerns among individuals with IDD within their scope of work.

The results of the landscape analysis should be available in late 2023 or 2024.

**Expand and support Utah’s behavioral health workforce.**

**7**

Utah’s ongoing—and growing—behavioral health workforce shortages are a challenge that is disrupting care across the state and the continuum of behavioral health services and supports. The Master Plan supports strategies to (1) attract, retain, and develop a diverse behavioral health workforce (culturally, linguistically, and from marginalized populations); (2) grow and develop a sustainable behavioral workforce across provider types from prescribers (including primary care providers trained in behavioral health screenings, early intervention, and treatment of mild-to-moderate behavioral health issues), to psychologists, to licensed, certified, and professional/ para-professional; and (3) create supports and incentives for clinicians to work to the top of their license. Many of these strategies are being developed and promoted by the Utah Substance Use Advisory and Mental Health Advisory Council (USAAV+),42 Utah’s Health Workforce Advisory Council,43 and Utah’s Area Health Education Centers (AHEC).44

**Figure 6: Building out Workforce Extenders to Support Utah’s Behavioral Health Workforce**

**A diagram of a health worker's pyramid with Mediterranean Sea in the background

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The Master Plan also includes a specific focus on increasing the use of certified or credentialed non-licensed professionals to extend the current workforce (e.g., peer support specialists,[[15]](#endnote-15) certified case managers, CHWs, etc.) and improve access to community recovery supports (Figure 6). Effective use of certified or credentialed non-licensed professionals as part of an integrated care team can (1) support appropriate task shifting[[16]](#endnote-16) to help licensed providers work more effectively to the top of their license (which helps with provider retention and burn out); (2) promote a clear career ladder within the behavioral health field for individuals who wish to move into different positions; (3) create a workforce that is more inclusive and mirrors individuals served (which helps reduce inequities, disparities, and stigma), and (4) assist with care transitions and patient navigation.

It is also important that certified or credentialed non-licensed professionals have appropriate funding, support, training, supervision, oversight, and experience to be successful, avoid burnout, and ensure the best use of their skills. Training and supervision should be based on best practices as outlined by SAMHSA[[17]](#endnote-17) and other evidence-based resources.

As the state focuses on increasing the use of certified or credentialed non-licensed professionals, it will be important to monitor and respond to potential bottlenecks across the various strata of the workforce (Figure 6). There is no agreement on the optimal mix of non-licensed professionals to licensed professionals. However, some large-scale mental health reform efforts have found value in having a higher proportion of licensed professionals than non-licensed professionals. For example, one effort recommends a workforce mix of 30% low intensity workers, 60% high intensity workers, and 10% senior therapists.[[18]](#endnote-18) If the target population has more severe or complex problems, the percentage of licensed professionals could be higher. Having an insufficient proportion of licensed professionals could create problems with referrals and exacerbate issues with access.[[19]](#endnote-19)

 **NOW**

#### Key Questions

* + How to better streamline and standardize training and certification of the behavioral health workforce?

#### Focus Areas

* + Maintain advancements made to telehealth during the COVID-19 Public Health Emergency (PHE), including ensuring meaningful and equitable reimbursement.
  + Determine effective ways to help sustain culturally literate and language accessible behavioral health providers to meet the needs of Utah’s changing demographics. Funding should be flexible (e.g., SUMH’s multi-cultural affairs grant) and sustained over time.
  + Support OPLR’s recommendation to create a voluntary, entry-level state certification for a “behavioral health technician” (a one-year behavioral health educational certificate) meant to bridge the gap between DHHS certifications and bachelor’s- and master’s-level licenses.
  + Support OPLR’s recommendation to optimize licensure regulation of clinical therapists to allow greater flexibility in supervision and continuing education while maintaining and promoting safe practice.
  + Support OPLR’s recommendation to create a Master Addiction Counselor (MAC) license, which provides a path for existing clinicians to work at their highest level of competence and for prospective clinicians to advance in the substance use disorder counseling (SUDC) subspecialty.
  + Establish Medicaid reimbursement for CHWs (develop state plan language that is broad enough to encompass behavioral health issues and referral supports).
  + Partner with community-based, peer-led organizations to develop effective ways to support, train, sustain, and expand Utah’s certified or credentialed non-licensed professional behavioral health workforce.
  + Provide coordinated training, technical assistance, and education to physical and behavioral health providers, schools, and other sectors and settings on how best to deploy non-licensed professionals as care team members to improve adoption of effective strategies and support coordination and avoid inappropriate use.
  + Improve the certification process and standardize training of non-licensed care team members to help reduce quality differences.
  + Continue to promote and support the training of behavioral health providers working with and providing services to culturally diverse and marginalized populations (see organizational, structural, and service-level reforms outlined in the “Health Disparities in Utah’s Public Mental Health and Substance Use Treatment Systems Needs Assessment for specific recommendations).
  + Support Utah’s behavioral health workforce adopt, expand, or develop models that address stigma (e.g., peer supports within the workforce, encourage help-seeking behaviors, etc.)
  + Support OPLR’s recommendation to enable behavioral health professionals to confidentially seek recovery assistance while maintaining their licensure by expanding the Utah Professionals Health Program (UPHP) to (1) include behavioral health professionals, and (2) cover mental health conditions for all covered professionals.

 **NEXT**

#### Key Questions

* + What levels of reimbursement, grants, and additional resources are needed to expand peer supports, case managers, CHWs, and other non-licensed care team members? How to equitably distribute these resources to community-based and nonprofit organizations?

#### Focus Areas

* + Support OPLR’s recommendation to ensure portability of licensure across state lines so that behavioral health workers moving to Utah can resume practice without interruption, adding to the state's workforce.
  + Promote use of bundled payments to improve reimbursement for peer supports, CHWs, case management, etc. that reflect regional needs.
  + Expand public and private health insurance reimbursement of research-supported recovery-based models that rely on non-licensed professionals, such as peer supports, case management, etc.
  + Determine effective ways to help sustain community-based organizations that support peer support specialists and other non-licensed providers. Funding should be flexible and sustained over time.

 **FUTURE**

#### Key Questions

* + How to create incentives for enhancing the workforce pipeline across all provider types, including increasing diversity (culturally, linguistically, and qualified to treat marginalized populations) across the state (e.g., loan repayment programs)?
  + How to address structural barriers that may prevent persons from participating in Utah’s behavioral health workforce? (e.g., licensure exams that are not culturally responsive or adapted to the experiences of marginalized communities, background checks, etc.)
  + How best to partner with people in recovery and create pathways for them to work in behavioral health fields?
  + What methods are most successful in educating high school students on behavioral health careers to create a more robust future workforce? (e.g., connect with AHEC)

#### Focus Areas

* Support OPLR’s recommendation to create alternative state licensure pathways for clinical therapists, allowing additional qualified applicants, especially from non-traditional backgrounds, into the workforce.
  + Evaluate pathways for upward mobility by developing career ladders through bridge and/or tuition support programs to allow non-licensed professionals to train and obtain certification or licensure to advance into the clinical system.
  + Encourage health plans to demonstrate provider networks that are geographically accessible, offer timely care during convenient hours, and are language accessible, culturally literate, and qualified to treat marginalized populations (could include leveraging telehealth and effective digital tools as well as contracting with a workforce that is grounded in peer recovery, peer support, case management, and community based).
  + Promote statewide public-private partnership service delivery models that offer incentives for providers and public payers to reach underserved areas and populations in Utah.
  + Teach more SUD content and culturally responsive approaches in higher education, training, and certification programs.



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1. <https://le.utah.gov/interim/2022/pdf/00002557.pdf> [↑](#endnote-ref-1)
2. <https://www.u-tteclab.com/utah-smh-collaborative.html> [↑](#endnote-ref-2)
3. Whitney, D., & Peterson, M. (2019, February). U.S. National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatrics [↑](#endnote-ref-3)
4. Presentation by Megan Broekemeier to the Utah Opioid Task Force. (2023 August 30). Utah Fatal Drug Overdose Data Update. Utah Department of Health and Human Services. [↑](#endnote-ref-4)
5. <https://pubmed.ncbi.nlm.nih.gov/23567409/> [↑](#endnote-ref-5)
6. [Poverty Guidelines | ASPE (hhs.gov)](https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines) [↑](#endnote-ref-6)
7. <https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act> [↑](#endnote-ref-7)
8. Reference UCSF's care navigator program that employees a person to be the care navigator for a family dealing with a mental health crisis or issue. It’s called Care Ecosystem. Currently it is being vetted through a grant from NIH. But the results look promising. [↑](#endnote-ref-8)
9. <https://utahparentcenter.org/about/> [↑](#endnote-ref-9)
10. <https://jobs.utah.gov/homelessness/homelessnessstrategicplan.pdf> [↑](#endnote-ref-10)
11. <https://jobs.utah.gov/homelessness/ohsplanrecommend.pdf> [↑](#endnote-ref-11)
12. [Permanent Supportive Housing: Evaluating Your Program (samhsa.gov)](https://store.samhsa.gov/sites/default/files/evaluatingyourprogram-psh.pdf) [↑](#endnote-ref-12)
13. [Standards-for-Quality-Supportive-Housing-Guidebook-final-2022.pdf (csh.org)](https://www.csh.org/wp-content/uploads/2022/11/Standards-for-Quality-Supportive-Housing-Guidebook-final-2022.pdf) [↑](#endnote-ref-13)
14. Several states are piloting programs that provide housing supports through Medicaid. Examples include California, Oregon, and North Carolina. [↑](#endnote-ref-14)
15. <https://sumh.utah.gov/education/certification/peer-support> [↑](#endnote-ref-15)
16. Task shifting and sharing (TS/S) involves the redistribution of health tasks within workforces and communities to increase efficiencies. There is growing research regarding effective frameworks for supporting task shifting in health care settings and what considerations should be made in advance of expanding a workforce and engaging in task shifting to promote success. Examples include: [Task Sharing Approaches to Improve Mental Health Care in Rural and Other Low Resource Settings: A Systematic Review - PMC (nih.gov)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5509535/); [Conceptual framework for task shifting and task sharing: an international Delphi study | Human Resources for Health | Full Text (biomedcentral.com)](https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-021-00605-z); [Mental Health Task-Shifting in Community-Based Organizations: Implementation, Impact, and Cost — Evaluation of the Connections to Care Program | RAND](https://www.rand.org/pubs/research_reports/RR3083.html);

    [Task Shifting - Global Recommendations and Guidelines (unaids.org)](https://www.unaids.org/sites/default/files/media_asset/ttr_taskshifting_en_0.pdf) [↑](#endnote-ref-16)
17. <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers> [↑](#endnote-ref-17)
18. <https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Adult%20IAPT%20Workforce%20Census%202021%20-%20February%202022%20%5BPDF%2C%202.03MB%5D.pdf> [↑](#endnote-ref-18)
19. <https://link.springer.com/article/10.1007/s10488-015-0628-y> [↑](#endnote-ref-19)