SB155: Initial 988 Mental Health Assistance Report

Behavioral Health Crisis Response Commission, 2021

utah department of human services

TABLE OF CONTENTS

** SB155 Requirements have been italicized and the corresponding Behavioral Health Crisis Response Commission recommendations have been emboldened.*

SB155: 988 Mental Health Assistance Report

The History of Utah's Crisis System, the Behavioral Health Crisis Response Commission and 988

In November of 2020, The National Suicide Hotline Designation Act (NSHDA) was signed into law, setting precedent to establish 988 as the ubiquitous number for behavioral health crises nationwide. This landmark legislation requires all telecom providers to activate the 988 number within their networks by July 16, 2022. Efforts initiated by Utah's Senator Daniel Thatcher in 2014, and carried forth by U.S. Representative Chris Stewart through the National Suicide Hotline Improvement Act of 2018 resulted in Senator Cory Gardner sponsoring NSHDA, a bi-partisan, watershed opportunity, to transform the way the American people interact with both emergency services and the behavioral health system as a whole. Utah remains steadfast to its commitment to crisis intervention and suicide prevention, as established by legislative precedent, and continues to maintain suicide prevention as a critical and premier initiative. The state heralds the support of providing quality crisis response to every individual: anytime, anyplace, and anywhere.

In preparation for the landmark transition to 988 from the National Suicide Prevention Lifeline's ten digit number, Utah's Senator Daniel Thatcher and Representative Steve Eliason sponsored SB155 (2021), *988 Mental Health Crisis Assistance,* creating the Statewide Behavioral Crisis Response Account, amending the membership and duties of the Behavioral Health Crisis Response Commission (BHCRC) and requiring the Commission to study and make and submit recommendations on matters contained within the bill. The BHCRC, before December 31, 2021, shall present an initial report on the matters described herein to the Executive Appropriations Committee. A second and final report shall be presented to the legislature before December 31, 2022.

The BHCRC is a legislatively mandated commission of multidisciplinary, interagency, and community representation. The Commission works closely with the Utah Department of Human Services Division of Substance Abuse and Mental Health for consultation with regard to the standards and operation of the statewide crisis line, statewide warmline, and related crisis resources. Historically, the BHCRC has been tasked through SB0037 (2017) and HB0032 (2020) with integrating historically localized mental health crisis lines; establishing and implementing a statewide mental health crisis line and a statewide warm line; identifying a statewide phone number or other means for an individual to easily access the statewide mental health crisis line and warm line; studying and identifying how to ensure there is a supply of qualified behavioral health professionals to staff both the crisis and warm line; exploring funding mechanisms to operate the statewide crisis and warm lines; coordinating with local mental health authorities; supporting a supply of qualified mental and behavioral health professionals

and certified peer support specialists for both the statewide crisis and warm lines; establish a funding mechanism to operate and maintain the statewide mental health crisis and warm lines; and coordinating with local mental health authorities in fulfilling commissions duties; recommending standards for crisis worker certifications. As part of preparing for the 988 Mental Health Assistance Report, the BHCRC offered a legacy review of history and context in outlined legislation and standards and found that they are in line with Substance Abuse and Mental Health Services Administration (SAMHSA) outlined crisis best practices and yielded no recommendations changes or improvements (SAMHSA, 2020).

With SB155, the BHCRC was tasked with studying and making recommendations regarding the following: crisis line practices and needs regarding quality and timeliness of service; service volume projections; statewide crisis line staffing needs and required certifications; statewide assessment of technology needs; duties of crisis line workers to include coordination or re-distribution of secondary duties performed by crisis line workers, including responsibilities of responding to non-emergency calls; establishment of a 988 statewide hotline; opportunities to increase operational and technological efficiencies and effectiveness between 988 and 911; statewide standards, models, projected needs, quality and timeliness of services; hospital and jail diversions, staffing and certifications of Mobile Crisis Outreach Teams; current models and projected needs and quality and timeliness of Resource Centers (also referred to as Stabilization Centers and Receiving Centers); policy considerations related to whether the state of Utah should manage, operate, and pay for complete behavioral health system; whether the state should create partnerships with private industry; sustainable funding source alternatives for the crisis system to include possible charging of a 988 fee, utilizing general fund appropriations, other government funding options, grants, insurance partnerships, or other funding resources.

In preparation for the transition of the 10-digit National Suicide Prevention Line to the 3-digit 988, Utah's BHCRC has offered a robust evaluation of the state's crisis system as required by SB155. Commission membership is as follows:

Commission members:

Ross VanVranken – Chair, Huntsman Mental Health Institute

Doug Thomas – Co-Chair, Utah Division of Substance Abuse and Mental Health, Department of Human Services

Ric Cantrell – Utah Attorney General's Office

Deondra Brown – Representative of the public

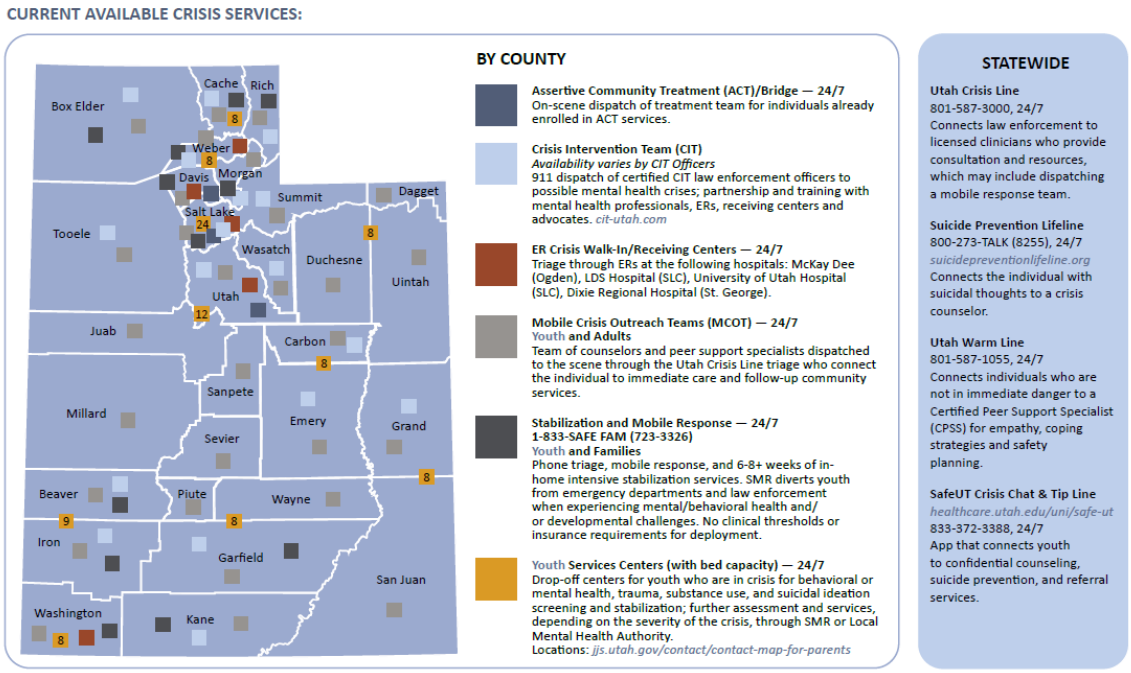
Dr. James Ashworth – Mental/Behavioral Health Clinician, University of Utah Health

Tim Whalen – Mental/Behavioral Health Clinician, Salt Lake County Behavioral Health

Aimee Winder Newton –Representative of County of the First or Second Class, Utah

Association of Counties, Salt Lake County Council
Melissa Huntington –Melissa Huntington – Representative of County of the Third, Fourth, or Fifth Class, Four Corners Behavioral Health
Steve Eliason – Utah House of Representatives
Jennifer Daily-Provost, Utah House of Representatives
Paul Ray, Utah House of Representatives
Daniel Thatcher – Utah Senate
Evan Vickers, Utah Senate
Luz Escamilla, Utah Senate
Jordan Sorenson – Utah Hospital Association
Emma Chacon – Representative of an Accountable Care Organization, Division of Medicaid and Health Financing
Dr. Mark Foote—Representative of Integrated Health Care Systems, Medical Director Behavioral Health, Intermountain Healthcare
Mary Jo McMillon – Individual with Lived Experience, Utah Recovery Community Organization, USARA
Chief Jeff Carr –Law Enforcement, Chief of Police Association
Kevin Rose – 911 Call Centers, 911 Committee, Weber 911
Kira Slawson – Rural Telecommunications, Blackburn & Stoll, Legal Counsel for Utah Rural Telecom Association
Chief Kevin Ward – Emergency Medical Services, Layton Fire Department
Shawn Guzman – Utah League of Cities and Towns, City of St. George
Jennifer Somers – Voiceover Internet Protocol and Landline, Century Link
Tara Thue – Mobile Wireless, AT&T
Nate Talley- Governor's Designee, Governor's Office of Planning and Budget
Deondra Brown, Staff to the Commission, Attorney General's Office

Utah's Cumulative Crisis System

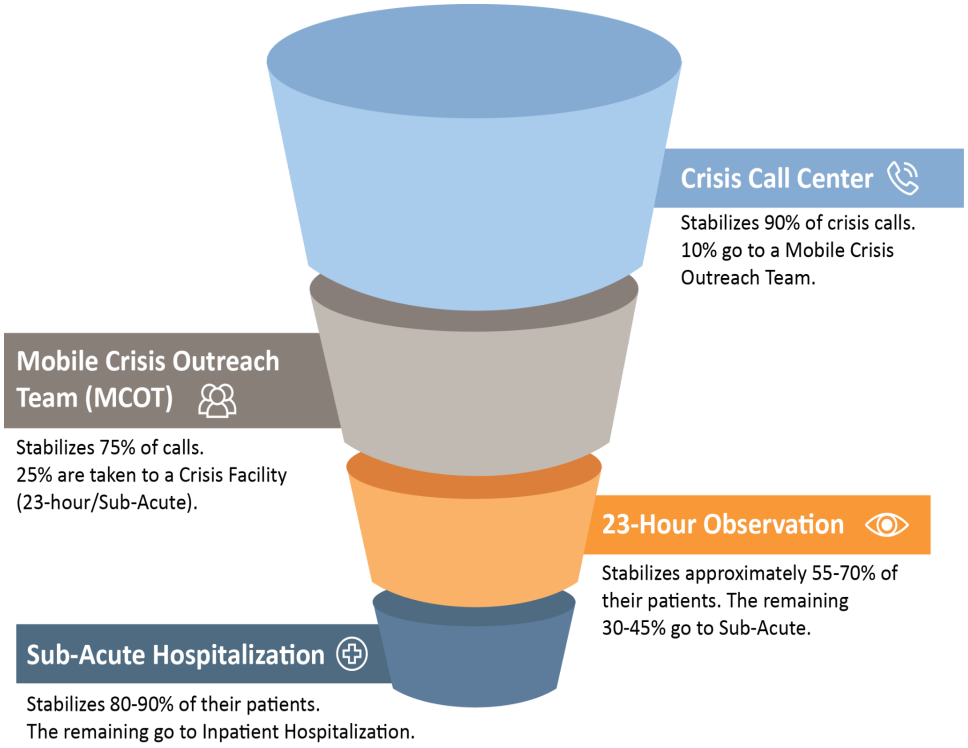


Best Practice Standards of Care

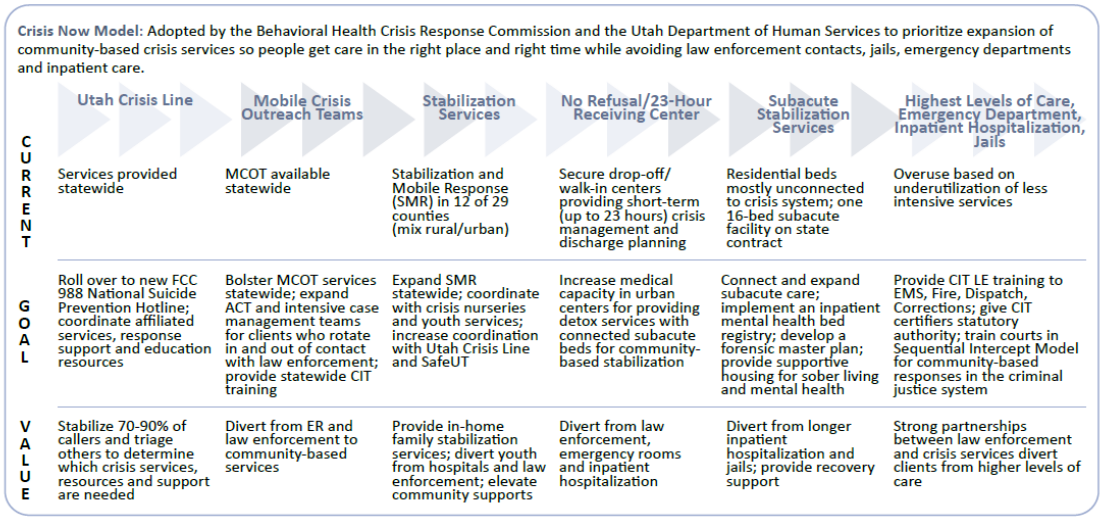
Quality crisis care is a complete care delivery system in which care is provided anytime, anyplace, anywhere. Wherein persons experiencing behavioral, substance, and mental health related distress and crises are able to always have qualified, competent, caring professionals to call, can assess via a mobile response when needed, and be offered a safe place to go to access quality, trauma-informed specialized crisis stabilization when indicated. Crisis care, when delivered in alignment with best practice standards as outlined by SAMHSA, is a key component, is an individualized approach, represents a strategy for suicide prevention, offers reduction of psychiatric bed overuse, decreases psychiatric boarding in emergency departments and unnecessary law enforcement involvement, and is widely accepted as a preferred intervention by persons in distress with mental health and substance use crises. A robust crisis care delivery system is well posed to address the fragmented nature of the overall behavioral health system as detailed in the Kem C. Gardner Policy Institute and Utah Hospital Association report on Utah's Mental Health System, which highlights the historical and inadequate over-emphasis and over-reliance on Utah's emergency departments and law enforcement to provide crisis services and poses short-term crisis services and Receiving Centers as a solution. These recommendations strongly align with above mentioned SAMHSA recommendations wherein the core elements of a crisis system include:

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis;

3. 23-hour crisis receiving and stabilization programs; and
4. Essential crisis care principles and practices.



In addition to their reliance on SAMHSA, Utah's Behavioral Health Crisis Response Commission (BHCRC) has historically aligned initiatives with the Crisis Now Model, a national model for comprehensive community-based crisis continuum. The model draws parallels with SAMHSA best practice and components include technology-enabled regional or statewide call centers, 24/7 mobile response in the community, and Crisis Receiving Centers. The model also dictates that services should be delivered in a way that the user is not refused care because of the presenting crisis, there is an emphasis on recovery and trauma informed care, suicide prevention principles are applied, and there is collaboration with law enforcement. The following image, the result of landscape analysis, offers a visual of the current and ideal systems with potential valuable outcomes within Utah.



Crisis Now Model: Adopted by the Behavioral Health Crisis Response Commission and the Utah Department of Human Services to prioritize expansion of community-based crisis services so people get care in the right place and right time while avoiding law enforcement contacts, jails, emergency departments and inpatient care.

	Utah Crisis Line	Mobile Crisis Outreach Teams	Stabilization Services	No Refusal/23-Hour Receiving Center	Subacute Stabilization Services	Highest Levels of Care, Emergency Department, Inpatient Hospitalization, Jails
CURRENT	Services provided statewide	MCOT available statewide	Stabilization and Mobile Response (SMR) in 12 of 29 counties (mix rural/urban)	Secure drop-off/ walk-in centers providing short-term (up to 23 hours) crisis management and discharge planning	Residential beds mostly unconnected to crisis system; one 16-bed subacute facility on state contract	Overuse based on underutilization of less intensive services
GOAL	Roll over to new FCC 988 National Suicide Prevention Hotline; coordinate affiliated services, response support and education resources	Bolster MCOT services statewide; expand ACT and intensive case management teams for clients who rotate in and out of contact with law enforcement; provide statewide CIT training	Expand SMR statewide; coordinate with crisis nurseries and youth services; increase coordination with Utah Crisis Line and SafeUT	Increase medical capacity in urban centers for providing detox services with connected subacute beds for community-based stabilization	Connect and expand subacute care; implement an inpatient mental health bed registry; develop a forensic master plan; provide supportive housing for sober living and mental health	Provide CIT LE training to EMS, Fire, Dispatch, Corrections; give CIT certifiers statutory authority; train courts in Sequential Intercept Model for community-based responses in the criminal justice system
VALUE	Stabilize 70-90% of callers and triage others to determine which crisis services, resources and support are needed	Divert from ER and law enforcement to community-based services	Provide in-home family stabilization services; divert youth from hospitals and law enforcement; elevate community supports	Divert from law enforcement, emergency rooms and inpatient hospitalization	Divert from longer inpatient hospitalization and jails; provide recovery support	Strong partnerships between law enforcement and crisis services divert clients from higher levels of care

Crisis Line *Service Volume Projections*

Using Erlang Model Projections, informed by Vibrant Emotional Health and state service trends of call volume and duration, the BHCRC expects a difference of 197,856 and 174% increase in call volumes for the Utah Crisis Line from the base call volume of Fiscal Year (FY) 2021. To accommodate these increases, base clinical staffing of the crisis line is projected to increase from 35.53 full time employees (FTE) to 85.40 FTE. Complete system projections can be found here: BHCRC Legislative Workgroup Projections.

Calls	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
Projected Change in Volume from Prior Year	14%	26%	48%	13%	14%	14%
Crisis Line + Lifeline Received & Outbound	113,685	143,473	211,793	239,121	273,281	311,541
Total Cost Projections	$4,702,454	$8,929,750	$15,143,226	$15,290,716	$18,040,538	$21,025,861

Preparing for 988: Utah's Crisis Line Standards and Needs

Towards *establishing a statewide 988 hotline, the* BHCRCfound, and recommended, that no "establishment" would be needed. The 988 number represents only a transition from a 10-digit National Suicide Prevention Lifeline number to a 3-digit number. Given the ease of accessibility, Utah anticipates substantial volume increases and additional requests for crisis services across the continuum. And though the DHS Division of Substance Abuse and Mental Health maintains and oversees Utah Crisis Line services as

outlined in R523-17, all 988 calls will be routed through the National Suicide Prevention Lifeline's affiliates. Thus, Utah's 988 calls will be routed to the National Suicide Prevention Lifeline affiliate, the Utah Crisis Line, as operated by Huntsman Mental Health Institute where calls are responded to by trained personnel who provide or arrange acute mental health intervention, crisis outreach, and stabilization services. The National Suicide Prevention Lifeline Designation Act requires that all telecom providers offer this number to their clients by July 16, 2022. As of fall 2021, 95% of telecom providers have activated the number. This number must continue to operate in congruence with National Suicide Prevention Lifeline Standards, and adhere to federal confidentiality standards as outlined by Health Insurance Portability and Accountability Act of 1996 (HIPAA) CFR -Title 42.

The 2017 Utah General session with SB0037, offered provisions related to the creation of a statewide crisis line and further purveyed the delivery and terms of such service. Complete Utah State Crisis Line *quality and timeliness of service standards* are within Administrative Rule R523-17, outlining that a statewide crisis line must provide 24/7 state-wide crisis line coverage, provide collaboration and coordination of care for persons accessing crisis services with local authorities. Key standards include existing answer rate requirements within five rings or 30 seconds, no greater call abandonment rate than 5% of the total calls, and 90% of in-state National Suicide Prevention Lifeline (NSPL) calls be answered by the statewide crisis line. National standards as offered and maintained by the NSPL are congruent with Utah's expectations, but do not hold expectations for call abandonment rates. **In review, the BHCRC found that current standards are in line with SAMHSA best practice, yet this alignment could be maintained while adjusting standards to reflect 911 answer rates and recommends adjusting administrative rules to reflect this**. Relevant 911 standards are maintained by the Utah Communications Authority and are also codified in state statute in section 2 of 63H-7a-304.5

In exploration of the required *statewide assessment of staffing needs, including required certifications*, Utah reviewed the state's requirements of Crisis Worker Certification as outlined in Administrative Rule R523-17, which establishes a standardized set of care, practices, and skill development for all crisis workers across the state, to include crisis line professionals delivered over a 40-hour curriculum. This certification was put in place in anticipation of 988 becoming a reality. Crisis line professionals may be: Peer Professionals, persons with lived experience related to mental illness or substance use; mid-level case managers; Social Service Worker (SSW); or other qualified mental health professional who holds a Crisis Worker Certification. Persons whom do not maintain independent licensure must have supervisory staff available during all times of operation for consultation and supervision of the clinical interventions provided for persons who may be at imminent risk for suicide or other high-risk behaviors. **CBHCRC members, noting the absence of national and state standards within crisis line services for cultural and linguistic competency, recommended exploring and establishing cultural and linguistic competency standards for the crisis line and the larger crisis continuum.**

Clinical services comprise the *primary duties* performed by crisis workers. They include providing active engagement and rapport building to promote caller's collaboration in securing the person's own safety, and providing clinically indicated and least restrictive interventions, resourcing life-saving interventions, and active rescue or prompting involuntary commitment as a last resort only. The crisis line, in addition to currently stabilizing 86% percent of calls via phone, must act as a care facilitator, providing warm hand-offs and complex resource facilitation to stabilize crisis situations. Furthermore, the state crisis worker must be well versed in crisis resources and readily deploy mobile crisis outreach teams and generate referrals to facility-based stabilization services to include Receiving Centers, Resource Centers, Access Centers, Detoxification Units, and Emergency Departments. **When evaluating both *primary duties* and possible *coordination or redistribution of secondary duties performed by crisis line workers, including responding to non-emergency calls,* the BHCRC found that all standards were in line with SAMHSA best practices and review of history in this regard recommended no mandatory changes.** Secondary duties often include providing follow-up services to include check-in contacts, resource facilitation like arranging outreach and stabilization services when clinically indicated; however, further exploration of follow up procedures regarding threshold, frequency, and required content is an area to be further explored by the DHS Division of Substance Abuse and Mental Health and its contractor.

When evaluating the *technological needs*, the BHCRC evaluated national requirements as offered by National Suicide Prevention Lifeline (NSPL), currently administered through Vibrant Emotional Health. The NSPL is a network of independently operated and funded local and state call centers and this national network ensures that persons accessing 988 will have their calls answered, and answered quickly, with linkages to relevant local services, and in accordance to best practice guidelines and standards in suicide prevention and crisis care. Routing into the NSPL/988 allows routing to a local center based on area code, and should a local center not be available, the call is then routed to the backup network of 9 back up call centers through the NSPL. Routing based on physical location, a function of geo-location services, has not been approved for the 988-phone number as of fall 2021. The NSPL also operates a Spanish sub-network and works in confluence with the Veterans Crisis Line. In the next two years, explorations to create a national "Unified Platform" are underway where all centers within the 988 NSPL network would access a shared Contact Center System (CCS), Customer Relationship Management System (CRM) and Network Resource Center (NRC). This cloud-based network is expected to be operated through the mobile network. Also, not yet approved by the FCC is the text/chat function to 988. Currently text and chats to the NSPL utilize a national "bucketing system", where text/chats are answered by a small network of centers who maintain coverage for all text and chats regardless of location. States are not able to elect to receive only their own text/chats. **The BHCRC recommends to not assume text/chats from 988 and the National Suicide Prevention Lifeline until Utah is able to elect to accept only its own texts and chats without assuming responsibility of other states overflow through national bucketing system.**

The Commission also *explored opportunities to increase operational and technological efficiencies and effectiveness between 988 and 911, utilizing current technology*, and found that at this time, there are no outlined possible efficiencies between 911 and crisis lines to include the NCPL's 988 number. The numbers, 988 and 911, represent two parallel and unique systems with unique data reporting, needs, practices that serve distinct needs with some small expected area of overlap. 911 utilizes the ESInet and 988 will utilize a broadband based connection with a platform technology that will continue to be cloud based. **The BHCRC found it would be incredibly costly and inefficient for the systems to merge 911 and 988 systems. 911 and 988 will continue to collaborate, but structural, operational and technical changes or efficiencies are not recommended. BHCRC members recommended supporting the additional costs associated with the purchase of dispatch radios used by 911 to MCOT teams to support 911 efficiency and safety.**

With the provision of a *statewide assessment of technology needs* related to the crisis line and with evaluation of *opportunities to increase operational and technological efficiencies and effectiveness between 988 and 911, utilizing current technology* the Commission found that incorporation of 988, or crisis calls, texts and chats to ESInet or PSAP network would yield both financial and operational in-efficiencies. **BHCRC recommendations include the following: (1) re-evaluation of interoperability and geolocation requirements based on FCC recommendations, (2) further expansion of remote workforce across the state to support capacity building with both phone and crisis continuum services (3) Improve deployment and tracking capabilities between MCOT and crisis line personnel to mirror best practice air traffic control standards (SAMHSA, 2020) (4) explore potential needs to support crisis line in preparing for Unified Platform to include possible expansion of their Electronic Health Record (EHR) (5) explore potential needs to support crisis line in preparing for text/chat capability when it is activated by the FCC and the NSPL.**

In addition to exploring operational and technological efficiencies and technological needs, the BHCRC also explored the *needs for interoperability partnerships and policies related to 911 call transfers and public safety responses,* to include researching and exploring the existing partnership between Salt Lake City's Public Safety Answering Point (PSAP), were on average 150 calls per month are transferred to the Utah Crisis Line for disposition and potential deployment of Mobile Crisis Outreach Teams. However, Utah maintains 30 PSAPS spread across the state, and capacity limitations with the Utah Crisis Line present a primary barrier for expansion of these models. **The BHCRC recommends that projections for statewide calls from 911 to the crisis line be expanded to include all PSAPs, and that a matrix and decision trees should be developed to map call transfers and workflows between 988, 911, and United Way's 211 line.** The Commission will continue to explore these processes and how best to ensure seamless transitions between 911 and 988 as appropriate.

Mobile Crisis Outreach Teams: Current Models and Projected Needs

In exploration of the *standards for statewide mobile crisis outreach teams to include current models, and quality and timeliness of service, hospital and jail diversions, and staffing and certification,* the BHCRC met with multiple Mobile Crisis Outreach providers and reviewed the states requirements of Mobile Crisis Outreach Teams (MCOT) as outlined in Administrative Rule R523-18, which created statewide standards of certification care and practice using an Mobile Crisis Outreach model of care as outlined by SAMHSA in their National Guidelines for Behavioral Health Crisis Care- Best Practices Toolkit. In this model and administrative rule, MCOT requires the makeup of a Mental Health Therapist, who is a certified crisis worker, and another Certified Crisis worker who is preferably a person with lived experience with mental health or substance use concerns (a peer support specialist or a family-resource facilitator). Other individuals, including a Certified Case Manager or a Social Service Worker (SSW), may be utilized to fulfill this requirement. Should a need for an exception be required to the above referenced rule, the DHS Division of Substance Abuse and Mental Health director or designee shall determine if an agency is granted an exception to any of the above requirements, and obtain certification based on that agency's submitted plan. Frequently exceptions are offered for rural areas, or in other areas where access to mental health therapists or qualified mental health professionals may present a barrier. Currently, Utah maintains 15 MCOT teams that are routinely deployed by the Utah Crisis Line, local police departments, and the MCOT providers themselves. Ideally, these teams would offer a “first responder”model of deployment, where there would be a resource available for deployment regardless of geographic area or time of call. However, the teams, seven in urban areas and eight in rural areas, offer limited capacity service delivery and it is frequently reported that both the crisis line and police departments cannot access the service due to the teams being occupied on another call.

In 2018, Utah utilized acclaimed and vetted RI International as a consulting partner to examine its crisis system and formulate recommendations around ongoing implementation. The result was a candid look at the inadequacies and successes of Utah’s crisis system. The report outlined the following challenges facing Utahns in regard to access to crisis care: discrepancies between rural and urban care, lack of critical and consistent components of a crisis system to include an “Air Traffic Control Hub”crisis line (developed and implemented since), lack of robust mobile crisis outreach teams (developed in limited capacity since), lack of access to receiving centers and subsequent sub-acute stabilization beds. Due to these inadequacies, RI International determined that Utah has a historical reliance on emergency departments (ED) and law enforcement as its de-facto crisis response. Such reliance has contributed to the overutilization of costly private and state psychiatric facilities. RI International posits that should these elements be rectified, and crisis response be delivered in a comprehensive manner that includes access to a state/regional air traffic control model of crisis line, the state could yield $97,608,075 in savings to payers funding inpatient psychiatric beds. The BHCRC employed the “Crisis Now Calculator”, an algorithmic tool to formulate

recommendations for MCOT teams. Complete system projections can be found here: BHCRC Legislative Workgroup Projections.

MCOT	FY22	FY23	FY24	FY25	FY26
Urban Teams	5	18	18	18	18
Rural Teams	5	8	8	8	8
Total Cost	$8,000,000	$20,800,000	$20,800,000	$20,800,000	$20,800,000

**Local counties often leverage additional resources to expand teams outside of the funded model, reflecting in the figure detailed in the paragraph above of 15 total MCOT teams*

The BHCRC finds that current models are in alignment with best practice standards, and supports the current use of exceptions as approved by the Director of the DHS Division of Substance Abuse and Mental Health or designee; the availability of such services in a "first responder capacity" is found to be lacking. The BHCRC shall continue to explore MCOT development as modeled by projections detailed herein to support the needed 26 MCOT teams statewide. Furthermore, the BHCRC shall continue to explore the number of times MCOTs could have been deployed if available through PSAP data. Furthermore, the DHS Division of Substance Abuse and Mental Health in collaboration with the Crisis Line, shall amass data on the volume of MCOT deployments not completed due to the MCOT provider being unavailable due to being on another call.

In addition, the BHCRC also recommended that they should continue to evaluate what models could supplement and support Mobile Crisis Outreach Teams to include the use of telehealth in rural areas, and the development of Behavioral Emergency Service Technicians as detailed in SB53.

Resource Centers: Current Resources and Opportunities

In exploration of *Resource Centers to include current models and quality and timeliness,* the BHCRC met with the provider of the Davis County Receiving Center and hospital based Intermountain Health Care's Access Centers, reviewed the states requirements of Receiving Centers (or Resource Centers) as outlined in Administrative Rule R523-21, which created statewide standards of certification, care and practice for Behavioral Health Receiving Centers that align with SAMHSA in their National Guidelines for Behavioral Health Crisis Care-Best Practices Toolkit. The BHCRC found that Receiving and Resource Centers operated in community settings offer strong law enforcement jail diversion and treatment retention rates, 72% and 82% respectively, but availability statewide is lacking. Furthermore, currently, the programs serve only adults. Utah currently has available to its community two Receiving Centers in Davis and Utah Counties, each able to accommodate up to 16 individuals with ability to refer rapidly to subacute care. In addition, two additional Receiving Centers, in Salt Lake and Washington Counties, are anticipated to open in FY23. Challenges with smaller

commercial payers reimbursing Receiving Center services were identified by the Commission as an area of future exploration.

In addition, the state maintains a series of Youth Service Centers and Crisis Nurseries, but the programs do not meet crisis standards: presenting concerns served, and hours of operation are limited and varied. These programs often provide little clinical intervention and are frequently not integrated in the care continuum resulting in a siloed delivery of services.

Hospital and Emergency Department-based Access Centers are available in four counties of the state to include Weber, Salt Lake, Utah, Washington. The programs typically admit between 50-55% of their clients to an inpatient level of care. However, availability of the service statewide presents a significant challenge as the programs with 24/7 staffing requirements of multidisciplinary teams are costly to build and operate. Other challenges identified included the inability of access centers functioning in a siloed care setting, with expressed difficulty accessing outpatient and inpatient services contributing to recidivism and psychiatric boarding.

The Commission recommends further exploration of the bed registry tool to supplement and aid siloed care in all settings, assuring that persons accessing these elevated levels of care are able to transition to adequate and appropriate providers and settings, and to explore payment considerations for persons using commercial insurance. The Commission also recommends further exploration and expansion of the Receiving Center model in additional areas of the state. Complete system projections can be found here: BHCRC Legislative Workgroup Projections.

Additional Policy and Financing Considerations

When *evaluating policy considerations related to whether the state should manage, operate and pay for a complete behavioral health system and/or create partnerships with private industry, a review of current investments, partnerships, and costs related to system development and private payer contract*, the **BHCRC found that the state should continue to pursue a private and public partnership that leverages all resources. The BHCRC offers the recommendation to continue with the DHS Division of Substance Abuse and Mental Health oversight with operations contracted by public and private providers, seeking all possible resources.**

Following a robust exploration of projections and funding options, the following total system projections were drawn and include Medicaid penetration and payment assumptions when appropriate:

	FY22	FY23	FY24	FY25	FY26
Total Funding Needed from All Items	$27,229,710	$39,945,473	$44,184,574	$43,200,419	$43,805,431
Current Appropriation Distributed	-$27,400,703	-$37,999,062	-$35,656,350	-$34,856,350	-$34,856,350
Needed Funding	-$170,993	$1,946,411	$8,528,224	$8,344,069	$8,949,081
If Technology, text/chat/MCOT dispatch approved	$231,007	$4,347,789			
Of the appropriation above, DSAMH will use the following to administer the program:					
DSAMH Cost Allocation Plan Cost	$544,594	$798,909	$883,691	$864,008	$876,109
The costs above support the administration and oversight of the program. The amount is determined by the federally negotiated Cost Allocation Plan DSAMH has with the federal government and is currently approximately 2% of all DSAMH annual revenue.					

Complete system projections can be found here: BHCRC Legislative Workgroup Projections.

In exploration of *sustainable funding source alternatives including: charging a 988 fee, including a recommendation on the fee amount; General Fund appropriations; other government funding options; private funding source; grants; insurance partnerships, including coverage for support and treatment after initial call and triage; and other funding resource,* **the BHCRC recommends full legislative funding for the crisis system, and, absent adequate funding, the Commission shall recommend pursuing other funding options including a 988 telecom fee. Utah shall continue to pursue all relevant funding opportunities and relevant funding options as described herein.**

In addition, the BHCRC has identified the following areas for future exploration prior to the final report:

- Civil commitment and the crisis system
- Receiving Center licensing
- Children and youth crisis services and Stabilization and Mobile Response Programming
- Crisis services for persons with substance use and misuse
- Serviceable populations and inequities in service delivery
- Workforce development
- Upstream crisis services
- Rapid appointments/Walk-in clinics and bridge services for Medication Assisted Treatment
- Technology expansion to mirror SAFEUT chat functions, rapid appointment questionnaire, and telehealth access in crisis situations and follow up services
- The role of Behavioral Emergency Service Technicians (as detailed in **SB53**) in the crisis continuum