UNIVERSITY NEUROPSYCHIATRIC INSTITUTE

Community Health Needs Assessment
Implementation Plan & Completion Report
2014–2017
BACKGROUND

University of Utah Neuropsychiatric Institute (UNI) is dedicated to the de-stigmatization of mental illness through excellence and compassionate clinical care, collaborative research, and education related to behavioral and mental health. UNI is committed to patient-centered care and an approach that addresses all aspects of the individual—biological, psychological, social and spiritual—essential to achieving balance in mental health. UNI treats patients of all ages and stages of life, providing child, adolescent, adult and geriatric psychiatric care and substance abuse treatments.

UNI provides care in a 170-bed inpatient facility that is designed to offer a safe and healing environment where personal insight and recovery begins. The University of Utah School of Medicine’s Department of Psychiatry is located onsite and provides patients with expertise and advanced care not available elsewhere in the Intermountain West. In addition to an inpatient unit, UNI operates a significant outpatient practice. UNI physicians are actively engaged in teaching and research, activities that enhance their ability to provide the latest advances in psychiatry.

COMMUNITY NEED AND COMMUNITY BENEFIT

University of Utah Health strives to identify and address the health and wellbeing-related needs of our immediate and regional communities through multiple approaches.

- UNI holds to the strong belief that essential mental healthcare services should be accessible to all residents of the community it serves, without regard to race, religion, gender, national origin, physical or mental disability, veteran status or ability to pay. UNI has established a financial assistance policy to ensure this takes place for those insured and underinsured and uninsured alike. Discounts of up to 100% of charges are offered on a sliding scale. This is based on income as a percentage of the Federal Poverty Level guidelines, available liquid assets, and charges for services rendered. The charges associated with patients who meet UNI’s guidelines to qualify as charity care are not pursued. The total of this charity care is approximately $7.7 million annually. Additionally, UNI writes off approximately $6.7 million in bad debt.

- Although UNI incurs shortfalls between its established charges for services and amounts paid by several state and federal programs, these shortfalls are not included as charity care. Additionally, UNI provides a number of services that are not self-supporting for which collections are less than the costs required to provide the services. These negative margin services greatly benefit uninsured and low-income patients as well as the broader community and are provided as a part of the UNI mission.

- UNI maintains a self-pay discount program in which self-pay patients automatically receive a discount on total charges. This program reduces uninsured patients’ liabilities to a level more equivalent to insured patients. The self-pay discounts are approximately $1.3 million annually.

- UNI provides direct service to residents with special health-related needs and those living in under-served communities. Details of these programs are discussed later in this report.
The Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, requires each nonprofit hospital to conduct a Community Health Needs Assessment (CHNA) every three years. After identifying and prioritizing unmet needs, each hospital is required to develop a three-year implementation strategy to address one or more identified community health need. This report documents the process through which UNI conducted the CHNA, the key findings, the identified priorities, and the implementation strategies, and fulfills the requirement to make results of the CHNA available to the public.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

The focus of the CHNA was on Salt Lake County (SLCo); however, some of the implications and strategies address a broader region, including rural areas beyond SLCo.

The CHNA process was led by UNI leadership and staff, and supported by a consulting team with public health and health policy expertise from Stamats Healthcare Marketing.

The multi-faceted CHNA process, conducted from March–August 2014, encompassed:

1. Epidemiological and socio-demographic analysis. This intensive data analysis drew on multiple national, state, and county public data sources. Health risks, behaviors, and access to health care services for SLCo residents were compared with those of Utah, the U.S., and Healthy People 2020 goals. Relative risk and relative rates of mental illness calculations helped identify the greatest gaps for the SLCo population.

2. Qualitative interviews. Consultants conducted interviews with ten community business and government agency leaders, as well as UNI Board members. These interviews provided perspectives on current and emerging health issues, as well as emerging community and environmental situations that may affect health and quality of life.

3. Focus groups. All segments of the community were represented through a series of six focus groups, including four groups with the leadership of community agencies that work directly with underserved populations, and two groups with clinical and non-clinical staff who serve the community, manage outreach programs, and interact daily with community members. The community agency focus groups represented (1) agencies serving specific ethnic and cultural segments; (2) agencies that provide health services to the individuals and communities in need; (3) agencies that provide support counseling for a wide range of health-related needs (including behavioral health, rape recovery, addiction recovery, and others); and (4) education, youth services, and wellness agencies. A total of 57 individuals participated in the six focus groups.

4. Priority setting. Potential priority health risks and gaps in access to care were identified from the summary of the three stages of research (identified above). These lists were narrowed down and the final priorities selected in two internal team meetings. Criteria for priority-setting included:
• Severity of the issue, as represented by some or all of the following: highly acute, affects a large number of people, has significant economic and/or opportunity costs that are growing or worsening over time

• Availability of known feasible interventions, with measurable impact that are likely to achieve results and improve the community’s quality of life and health in a reasonable time frame

• Unaddressed or under-addressed issue: no/few organizations or (insufficient) resources focusing on it effectively at present

• UNI synergies: special expertise, strategic priority, and/or programs in place to serve as building blocks

5. Development of implementation strategies. Implementation strategies were outlined with the participation of UNI clinical and administrative leadership. Each of the implementation teams included representatives of relevant community agencies, as well as UNI clinicians and staff.

KEY FINDINGS OF THE ASSESSMENT

The areas with the highest relative risks in comparison with the state of Utah, the US as a whole, and/or Healthy People 2020 goals included:

• Environmental factors: air quality, crime rate
• Health indicators: suicide, poisonings
• Maternity: infant mortality, low birth weight
• Disability: age 18–64
• Infectious conditions, including Sexually Transmitted Diseases (STD)
• Asthma, other respiratory conditions
• Various cancers: incidence, mortality
• Diabetes: incidence, mortality
• Senior frailty: falls, Parkinson’s
• Binge drinking
• Low rate of childhood immunizations
• Low use of preventive dental care

In addition, the assessment identified population dynamics and access issues that may affect health status and wellbeing, such as:

• High rate of youth and young adult population growth
• Rapidly growing ethnic and cultural diversity, including growth of the immigrant and refugee populations – affecting English language proficiency as well as cultural literacy and ability to navigate the health system
• High percentage of adults ages 18–64 who are disabled
• STD and infectious disease rates
• Lower-than-average percentage of mothers who received first trimester prenatal care
• Lower rates of health care coverage and higher rates reporting cost as a barrier to obtaining health care vs. reference populations
• Limited access to behavioral health services – particularly ongoing care, appropriate placement, and medication access for those with chronic or long-term conditions – among individuals facing financial, access, and other barriers to care

The qualitative research identified ways in which these health risks and access barriers affect specific population segments. In addition, the qualitative research delineated culture- and community-specific barriers to health maintenance, access to and use of health care services, and effective communication with health care providers.

PRIORITY SELECTION

Priorities for community health enhancement were determined after weighing the severity of each area of heightened relative risk, the availability of known and effective interventions, determination that the area was un-addressed or under-addressed by existing resources, and synergies with other UNI initiatives. Three-year implementation plans have been outlined and implementation teams identified for each of the priorities.

One of the overall goals for our behavioral health services includes addressing the behavioral health needs of patients, and others, where they present within the UNI system, minimizing long-term individual, family and social costs associated with untreated or late-treated mental health issues in the UNI patient population. We plan to address this goal through the following three methods:

1. Expand outreach efforts to underserved areas in Salt Lake Valley, which partially also benefits rural Utah communities

2. Assist Salt Lake Valley and rural Utah communities in closing the behavioral health care gap within the continuum of care

3. Create behavioral health education and resource opportunities for Salt Lake Valley and rural Utah communities

HISTORICAL DATA

Utah is in the middle of what some experts call the “suicide belt.” Utah has one of the highest per capita suicide rates in the nation, often ranking between the 5th and 7th highest states in the nation on a per capita basis. Currently, suicide is the leading cause of death for 10-17-year-olds in Utah. The overall suicide rate for Utah in 2015 was 24.5 per 100,000, which is considerably higher than the national average of 13.3. The data on the next page from the Utah Department of Health shows how this preventable cause of death has been increasing over the past 17 years. One of the primary goals for behavior health outreach and crisis intervention services is to reduce the rate of death by suicide, suicide attempts and the need for admission to a hospital for a behavioral health crisis.
### Number of Suicide Deaths by Age Group and Rate of Suicide Deaths

Ages 10+ per 100,000 Population, Utah, 1999–2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Ages 10-17</th>
<th>Ages 18-24</th>
<th>Ages 25-64</th>
<th>Ages 65+</th>
<th>Total Ages 10+</th>
<th>Overall Suicide Rate Ages 10+ per 100,000 Population</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>12</td>
<td>51</td>
<td>186</td>
<td>33</td>
<td>282</td>
<td>15.8</td>
<td>(14.0–17.8)</td>
</tr>
<tr>
<td>2000</td>
<td>16</td>
<td>49</td>
<td>193</td>
<td>35</td>
<td>293</td>
<td>15.9</td>
<td>(14.1–17.8)</td>
</tr>
<tr>
<td>2001</td>
<td>17</td>
<td>46</td>
<td>218</td>
<td>33</td>
<td>314</td>
<td>16.7</td>
<td>(14.9–18.7)</td>
</tr>
<tr>
<td>2002</td>
<td>22</td>
<td>39</td>
<td>239</td>
<td>36</td>
<td>336</td>
<td>17.6</td>
<td>(15.8–19.6)</td>
</tr>
<tr>
<td>2003</td>
<td>17</td>
<td>63</td>
<td>212</td>
<td>43</td>
<td>335</td>
<td>17.3</td>
<td>(15.5–19.3)</td>
</tr>
<tr>
<td>2004</td>
<td>18</td>
<td>49</td>
<td>273</td>
<td>37</td>
<td>377</td>
<td>19.2</td>
<td>(17.3–21.2)</td>
</tr>
<tr>
<td>2005</td>
<td>11</td>
<td>54</td>
<td>247</td>
<td>32</td>
<td>344</td>
<td>17.1</td>
<td>(15.3–19.0)</td>
</tr>
<tr>
<td>2006</td>
<td>11</td>
<td>49</td>
<td>254</td>
<td>43</td>
<td>357</td>
<td>17.3</td>
<td>(15.6–19.2)</td>
</tr>
<tr>
<td>2007</td>
<td>10</td>
<td>60</td>
<td>263</td>
<td>35</td>
<td>368</td>
<td>17.4</td>
<td>(15.6–19.2)</td>
</tr>
<tr>
<td>2008</td>
<td>16</td>
<td>62</td>
<td>274</td>
<td>32</td>
<td>384</td>
<td>17.7</td>
<td>(16.0–19.6)</td>
</tr>
<tr>
<td>2009</td>
<td>16</td>
<td>53</td>
<td>342</td>
<td>32</td>
<td>443</td>
<td>20.0</td>
<td>(18.2–21.9)</td>
</tr>
<tr>
<td>2010</td>
<td>21</td>
<td>55</td>
<td>340</td>
<td>50</td>
<td>466</td>
<td>20.6</td>
<td>(18.8–22.6)</td>
</tr>
<tr>
<td>2011</td>
<td>17</td>
<td>60</td>
<td>359</td>
<td>55</td>
<td>491</td>
<td>21.3</td>
<td>(19.5–23.3)</td>
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<tr>
<td>2012</td>
<td>22</td>
<td>63</td>
<td>404</td>
<td>56</td>
<td>545</td>
<td>23.3</td>
<td>(21.4–25.3)</td>
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<tr>
<td>2013</td>
<td>31</td>
<td>62</td>
<td>413</td>
<td>64</td>
<td>570</td>
<td>23.9</td>
<td>(22.0–25.9)</td>
</tr>
<tr>
<td>2014</td>
<td>33</td>
<td>74</td>
<td>370</td>
<td>78</td>
<td>555</td>
<td>22.9</td>
<td>(21.0–24.8)</td>
</tr>
<tr>
<td>2015</td>
<td>44</td>
<td>73</td>
<td>438</td>
<td>54</td>
<td>609</td>
<td>24.5</td>
<td>(22.6–26.6)</td>
</tr>
<tr>
<td>Preliminary 2016</td>
<td>33</td>
<td>85</td>
<td>445</td>
<td>75</td>
<td>638</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Pending 2016</td>
<td>*</td>
<td>*</td>
<td>72</td>
<td>10</td>
<td>*</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Preliminary 2017 YTD</td>
<td>30</td>
<td>59</td>
<td>285</td>
<td>51</td>
<td>425</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Pending 2017 YTD</td>
<td>*</td>
<td>22</td>
<td>284</td>
<td>32</td>
<td>*</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Data Notes: *Data is suppressed due to counts less than five or the total can be used to calculate a cell with counts less than five. Rate is per 100,000 population. Pending totals represent all cases where the cause of death is yet to be determined for the age group specified. Data Sources: Utah Death Certificate Database, Utah Medical Examiner Database, US Census Bureau. Last Update: September 12, 2017.
IMPLEMENTATION STRATEGIES
Priority #1: Behavioral Health Access

Goal

- Expand outreach efforts to underserved areas in the Salt Lake Valley and rural Utah communities

Performance Measures

- Measure #1: Increase number of tele-behavioral health and tele-crisis affiliations
- Measure #2: Increase number of psychiatric consultations in the primary care setting through the GATE program

Strategies/Tactics

- Expand services to hospitals and clinics interested in tele-behavioral health capabilities for their patients
- Develop a stronger partnership with community clinics and the University of Utah School of Nursing to increase access to behavioral health services within primary care clinics
- Maintain/expand current diversion program efforts to avoid behavioral health patients awaiting psychiatric services in the emergency department

Measure #1

This performance measure tracks the number of behavioral health outreach visits performed using tele-medicine via phone or internet-related technologies (e.g., crisis text). The primary outreach method is the 24/7 CrisisLine, which is an affiliate of the National Suicide Prevention Lifeline. The SafeUT app was rolled out as a free community resource for students in partnership with the Office of the Utah Attorney General and the Utah State Board of Education. UNI also provides free crisis response and hospital diversion programs that aim to keep individuals safe and divert them from an emergency department, if possible. The community crisis service programs are designed to provide community members with a full range of options to help solve the crisis in the best setting possible. Our team of professionals are highly trained in mental health crisis management and suicide prevention.

Our licensed clinicians provide prompt and compassionate crisis intervention, suicide prevention, information and referrals as well as follow-up services, emotional support, and assistance to individuals experiencing emotional distress or psychiatric crisis.

We also operate a “Warm Line.” This line is for individuals who are not in immediate crisis, but are seeking support, engagement, or encouragement. Certified Peer Specialists offer support and empower callers to resolve problems by fostering a sense of hope, dignity, and self-respect. Callers may speak with peer specialists daily 9 a.m. to 10 p.m.

During the three-year period covering our initial Community Health Needs Assessment, the combined calls and text communications increased each year in accordance with the baseline goal to expand outreach services. It is important to note that these services are offered at no cost to the community. In 2015 the volume increased 12.2%; in 2016 it increased 11.5%; and in 2017 it increased an incremental 5.5%. As more individuals used the Warm Line and Crisis Chat options we saw the volume to the traditional CrisisLine drop in 2017, after three years of increased utilization.
Crisis Calls, Warm Line Calls & Crisis Texts

<table>
<thead>
<tr>
<th></th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Calls</td>
<td>43,793</td>
<td>49,946</td>
<td>53,102</td>
<td>46,445</td>
</tr>
<tr>
<td>Warm Line Calls</td>
<td>6,111</td>
<td>6,070</td>
<td>8,376</td>
<td>9,815</td>
</tr>
<tr>
<td>Crisis Text Conversations</td>
<td>-</td>
<td>-</td>
<td>994</td>
<td>9,617</td>
</tr>
<tr>
<td>Total Crisis Contacts</td>
<td>49,904</td>
<td>56,016</td>
<td>62,472</td>
<td>65,877</td>
</tr>
<tr>
<td>% Increase</td>
<td>n/a</td>
<td>12.2%</td>
<td>11.5%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>
One of the exciting emerging crisis intervention services has been the crisis chat option that has been made available primarily to K-12 students via the SafeUT app. The SafeUT Crisis Text and Tip Line is a statewide service that provides real-time crisis intervention to youth through texting and a confidential tip program from a smartphone. Licensed clinicians in our 24/7 CrisisLine call center respond to all incoming chats, texts, and calls by providing supportive or crisis counseling, suicide prevention and referral services. UNI’s goal is to help anyone with emotional crises, bullying, relationship problems, mental health, or suicide related issues.
Nearly 1,000 students utilized the service in FY 2016 when it was first introduced. In 2017 there was a nearly 10-fold increase in its utilization. The graph and chart below show the dramatic increase in crisis communications since the app’s inception. This service is being rolled out to all of Utah’s 41 K-12 school districts and is being rolled out to students at the University of Utah in late 2017 on a pilot basis. If the pilot program works as expected it will be made available to all of the institutions of higher education in the State of Utah.
SAFE UT: TELE-CRISIS APP RESULTS

The following chart shows the number of crisis communications by type and month for calendar 2016 and early 2017:

Triaged through the CrisisLine, UNI Mobile Crisis Outreach Teams (MCOT) provide a free, prompt, face-to-face response to any resident of Salt Lake County who is experiencing a behavioral health crisis. MCOT teams are typically comprised of a Licensed Clinical Social Worker as well as a Peer Mentor with a lived experience. Youth and adult services teams are available 24/7 and offer consultation and support to individuals, families, schools, treatment providers and first responders. Follow-up services provide ongoing support, including referrals to health care providers and to community-based mental health services.
Measure #2

The goal for our second measure was to increase the number of psychiatric consultations in the primary care setting through the GATE program. The ultimate goal is to provide better onsite behavioral health access thereby reducing the need for outside consultations. Over the past three years, we have made tremendous progress on both clinical interventions.

For years, we have heard frustration from primary care physicians about the lack of access to mental health specialists and poor communication and follow-through when patients are finally seen. There is an unfortunate division that exists between “medical” and “mental” health treatment. There is growing evidence that treatment of mental health disorders in the primary care setting is associated with improved overall health outcomes and the potential for cost savings. Unfortunately, implementation of mental health integration projects nationwide has been moving slowly. We are also aware that training on mental health issues during primary care residencies is variable and “on the job” experience is how most primary care physicians obtain knowledge on treating mental health disorders, usually with very little outside help from psychiatrists. To address these issues, UNI has been on the leading edge of providing primary care physicians with access to a team of on-demand psychiatrists through the GATE Program as well as making great strides in the integration of behavioral health professionals into the primary care setting.

The Gate Program is a novel, web-based consultation model aimed at extending mental health services to children and adults through patient-centered consultations between primary care physicians and psychiatric specialists. GATE is an acronym that stands for Giving Access To Everyone. Our goals are to improve access to mental health services for
children and adults, improve collaboration between primary care physicians and mental health professionals, and enhance knowledge of how to manage mental health conditions in the primary care setting. As opposed to the traditional psychiatric clinic, we believe we can influence the greatest number of people with the GATE Program by providing high quality care to families and children, while at the same time lowering costs and maintaining the majority of the treatment in the medical home.

The number of GATE consultations has increased from zero in 2014 to more than 100 consults per year for the past two years. The decrease in consultations from 2016 to 2017 is primarily due to the integration of Clinical Social Workers that have been embedded in our primary care clinics. This has been a great benefit to both providers and patients as it allows a patient needing more in-depth mental health services to be seen at the time of their visit to the clinic without the short delay that is experienced by patients being treated via a GATE consultation. The following chart shows the utilization of the GATE consults over the past four years.

<table>
<thead>
<tr>
<th>GATE Consultations</th>
<th>FY 2014 TOTAL</th>
<th>FY 2015 TOTAL</th>
<th>FY 2016 TOTAL</th>
<th>FY 2017 TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations</td>
<td>-</td>
<td>56</td>
<td>171</td>
<td>107</td>
</tr>
<tr>
<td>% Change</td>
<td>-</td>
<td>-</td>
<td>205%</td>
<td>-37%</td>
</tr>
</tbody>
</table>
The following chart shows the significant increase in community clinic integration visits by Licensed Clinical Social Workers (LCSWs) and psychiatric residents embedded in our primary care clinics. We will continue to pursue this effective integration strategy and expect the numbers will continue to increase.

<table>
<thead>
<tr>
<th></th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>-</td>
<td>-</td>
<td>9,359</td>
<td>10,805</td>
</tr>
<tr>
<td>% Change</td>
<td>-</td>
<td>-</td>
<td>n/a</td>
<td>15%</td>
</tr>
</tbody>
</table>
Priority #2: Behavioral Health and the Continuum of Care Goal

Goal

- Assist Salt Lake Valley and rural Utah communities in closing the behavioral health care gap within the continuum of care

Performance Measures

- Measure #1: Increase number of patients seen within the UNI HOME program
- Measure #2: Increase residential treatment access to the Girls Transition Center. These are children in custody referred to UNI by the Division of Child & Family Services.
- Measure #3: Increase capacity for Teen Scope and Kidstar day treatment programs

Strategies/Tactics

- Develop a respite program for UNI HOME members to provide a less restrictive level of care than inpatient hospitalization
- Develop a residential treatment program for boys in DCFS custody that mirrors the Girls Treatment Center
- Develop additional Teen Scope day treatment programs throughout the Salt Lake Valley

Background & Outcomes

- The mission of the UNI HOME Program is to optimize the quality of life of the people we serve by providing excellent, compassionate, and integrated health services throughout the lifespan. The UNI HOME Program is committed to the following values:
  - Excellence - We adhere to the ‘good to great’ philosophy by aiming for the highest possible clinical standards in treating and supporting our clients and the community.
  - Compassion - We believe in having a service attitude and in providing lifelong and person-centered services to our clients. We believe in supporting and appreciating each person, and we desire to help them identify and reach their potential.
  - Integrity - We believe in conducting ourselves in a professional and ethical manner and treating everyone with dignity and respect. We believe in being responsible with the limited resources available to us.
  - Teamwork - We believe that we can help our clients most effectively by working and collaborating as partners with them, their caregivers, our staff, and other agencies.
  - Communication - We value open, constructive communication and believe in listening to our clients, their caregivers, and our employees.
  - Advocacy - We believe in promoting the civil rights of our clients and supporting their access to the best possible care and community services.
  - Education - We believe in constant professional growth for our employees and sharing our expertise with caregivers, future professionals, and the community. We also believe in contributing to treatment knowledge through our own research.
Measure #1

The UNI HOME program is a coordinated health care model and center of excellence for meeting the medical and mental health needs of people with developmental disabilities. We provide these services to children and adults:

- Annual physical exams and well-child checks
- Behavior management services
- Case management
- Crisis management
- Dietician/nutritional counseling
- Individual and group counseling
- In-house billing and insurance support
- Medication management
- Primary medical care
- Preventive care
- Psychiatric evaluations
- Psychology services (testing)
- Specialty care referral

Our providers have training and experience working with the medical and mental health issues faced by people with developmental disabilities. Many of our patients have impairments in their intellectual and/or social functioning that is a result of other developmental problems such as genetic disorders, birth trauma, autism spectrum disorders, and brain injuries.

The UNI Home Program has seen steady enrollment increases over the past three years, in accordance with the goal in the initial CHNA. There has been a 20.4% average annual increase for 2015–2017 over fiscal year 2014.
Measure #2

The Girls Transition Center (GTC) is an intermediate, secure residential treatment program for adolescent females ages 12–17 years. Patients enter the program through a Division of Child & Family Services (DCFS) or Juvenile Justice Service referral. The average length of stay is four to six months. The GTC program has experienced robust growth over the past three years in accordance with the CHNA goal to increase capacity, as shown in the table below:

<table>
<thead>
<tr>
<th>Girls Transition Program Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 2014</strong></td>
</tr>
<tr>
<td>Enrollment</td>
</tr>
<tr>
<td>Growth</td>
</tr>
</tbody>
</table>
Measure #3

The Kidstar Day Treatment Program is for children 5–12 years old. The Teenscope program is for adolescents. Both programs assist in a clarifying diagnosis, resolving family issues, and providing treatment for all mental health issues. When appropriate, we also address chemical dependency issues.

The treatment team includes board-certified child/adolescent psychiatrists, psychologists, social workers, expressive therapists, an education specialist, as well as an addiction specialist, when appropriate. Together, with the patient and their family, the care team creates an individualized treatment plan. The adolescents are evaluated for medication needs and participate in a psychoeducational assessment and additional psychological testing to provide the best course of treatment. Teen Scope includes a fully accredited education program allowing patients to earn credit toward graduation. The education specialist serves as a liaison to the patient’s school and provides advocacy and coordination when the student returns to their school. Teen Scope now has two locations: Research Park and South Salt Lake. Adolescents will be assessed and placed in the program location that best meets their clinical needs.

Kidstar is a daily treatment program for children 5–12 years of age that assists in clarifying the diagnosis of children with emotional and behavioral challenges. The treatment team includes board-certified child/adolescent psychiatrists, psychologists, social workers, expressive therapists, and an education specialist. Together they create an individualized treatment plan for each child. Treatment includes a psychiatric evaluation, individual and family therapy, psychological and educational evaluations, school recommendations, and social skills training.

Measure #3 was to increase capacity for the Teen Scope Day and Kidstar Treatment Programs. In accordance with our CHNA goal we have increased capacity on average about 7% each year over the past three years. See the table to the right:

<table>
<thead>
<tr>
<th>Teen Scope &amp; Kidstar Treatment Programs</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td>5,504</td>
<td>5,619</td>
<td>5,446</td>
<td>6,596</td>
</tr>
<tr>
<td>Growth</td>
<td>-</td>
<td>2.1%</td>
<td>-3.1%</td>
<td>21.1%</td>
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Priority #3: Behavioral Health Community Education

Goal
• Create behavioral health education and resource opportunities for Salt Lake Valley and rural Utah communities

Performance Measures
• Increase community behavioral health education opportunities through community presentations and presence at community health fairs
• Increase the number of families educated about behavioral health services provided by the community in Salt Lake Valley and the State of Utah
• Reduce the stigma associated with mental illness to improve the quality of life of individuals with mental illness

Strategies/Tactics
• Increase number of behavioral health community presentations at UNI and surrounding behavioral health agencies to increase awareness of mental illness
• Develop partnerships with community agencies to create a resource guide for behavioral health services
• Continue working with the State of Utah as it develops a statewide crisis line

The University Of Utah Neuropsychiatric Institute (UNI) has been very active in reaching out to the Salt Lake Valley and rural Utah communities. During the period of 2015–2016, UNI held at least 70 events promoting mental health awareness intended to help reduce the stigma associated with such disorders. The events ranged from employee health fairs to school suicide awareness events to the Utah Comic Con event. See Exhibit A for details of the outreach events.

UNI has developed numerous partnerships with community agencies, including the various groups listed in Exhibit A. One of the most successful collaborative agreements has been with the Utah State Board of Education and the development and management of the SafeUT app. The app has been deployed to nearly every public school in the State of Utah and is also being rolled out to students at the university level.
UNI has hosted several outreach booths at the semi-annual Comic Con Convention in Salt Lake City. During 2017, the Executive Director of UNI, Ross VanVranken chaired the Crisis Line Commission. The Commission completed its work in late 2017 and reported to a legislative interim committee regarding the committee’s recommendations, which can be found at: https://le.utah.gov/interim/2017/pdf/00004125.pdf

If implemented, UNI will play a key role in marketing and providing clinical services to a statewide crisis line. Currently, UNI receives all calls from the National Suicide Prevention Lifeline as the Utah affiliate. The recommendations of the committee are that the national Lifeline number serves as the statewide crisis number.
Exhibit A

UNI Outreach Events FY15–FY17

FY15 – Quarter 1
- University of Utah Health’s Be Well Utah
- AFSP Out of the Darkness Walk
- Utah National Alliance on Mental Illness (NAMI) NAMI Walk
- Utah Support Advocates for Recovery Awareness (USARA) Recovery Day
- University of Utah Employee Appreciation Day

FY15 – Quarter 2
- Critical Issues Conference
- NAMI Conference
- DCFS Provider Fair

FY15 – Quarter 3
- KUED Super Reader Party
- Utah Psychiatry Association Conference
- Generations Conference
- Discovery Gateway with KUED Autism Fair
- Paper Tigers Film Host at Bryant Middle School

FY15 – Quarter 4
- Utah Pride Festival
- Catholic Community Services Health Fair
- Refugee Health Fair
- Pre-Autism Conference in Utah

FY16 – Quarter 1
- Wilderness Therapy Symposium
- University of Utah Health’s Be Well Utah
- American Foundation for Suicide Prevention (AFSP) Out of the Darkness Walk
- Utah Comic Con
- Utah NAMI Walk
- Utah Fall Substance Abuse Conference
- USARA Recovery Day
- University of Utah Employee Appreciation Day
- Safety Safari Salt Lake City
- KUED Teen Suicide Film Host

**FY16 – Quarter 2**
- Critical Issues Conference
- NAMI Conference
- Utah Division of Child Family Services (DCFS) Provider Fair
- Clearlink Employee Health Fair
- Resilience Film Host at Bryant Middle School

**FY16 – Quarter 3**
- KUED Super Reader Party
- Utah Psychiatry Association Conference
- Generations Conference
- Discovery Gateway with KUED Autism Fair
- Salt Lake Performing Arts Family Night
- American Foundation for Suicide Prevention Conference

**FY16 – Quarter 4**
- Utah Pride Festival
- West Fest
- Health and Safety Fair at Morningside Elementary
- Davis School District Wellness Fair
- Annual Elder Abuse Conference
- Salt Lake County Building Healthy Communities Event
- Granger High School Suicide Awareness

**FY17 – Quarter 1**
- Wilderness Therapy Symposium
- West Valley City Night Out – Family Safety and Health
- University of Utah Health’s Be Well Utah
- AFSP Out of the Darkness Walk
- Utah Comic Con
- Utah NAMI Walk
- Take 5 to Save Lives Draper Event
- Utah Fall Substance Abuse Conference
- USARA Recovery Day
- University of Utah Employee Appreciation Day

**FY17 – Quarter 2**
- Boys and Girls Club Health Fair in Salt Lake City
- Critical Issues Conference
- NAMI Conference
- DCFS Provider Fair

**FY17 – Quarter 3**
- Davis School District Transition Fair
- KUED Super Reader Party
- Alliance House Film Festival
- Utah Psychiatry Association Conference
- Generations Conference
- State of Utah Crisis Summit
- Discovery Gateway with KUED Autism Fair
- Queer Prom with Utah Pride Center

**FY17 – Quarter 4**
- Promising Youth Conference
- Utah Pride Festival
- Mental Health Awareness Month Social Media Campaign