



State of Utah

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Governor

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Lieutenant Governor

Department of Human Services

ANN SILVERBERG WILLIAMSON
Executive Director

Division of Substance Abuse and Mental Health

DOUG THOMAS
Director

June 10, 2019

Commissioner Paul Cozzens
Iron County Commission
68 South 100 East
Parowan, UT 84761

Dear Commissioner Cozzens:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of the contracted Local Authority, Southwest Behavioral Health; the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental health services, substance abuse treatment and prevention services, and general operations.

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Chad Carter (801)538-4072

We appreciate the cooperation and assistance of the staff and look forward to a continued professional relationship.

Sincerely,

Doug Thomas

Doug Thomas
Division Director

Enclosure

cc: Jerry Taylor, Garfield County Commission

Michael Dalton, Beaver County Commission
Gil Almquist, Washington County Commission
Lamont Smith, Kane County Commission
Michael Deal, Southwest Behavioral Health



Site Monitoring Report of

Southwest Behavioral Health Center

Local Authority Contracts #152258 and #152259

Review Dates: April 17th, 2018

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Southwest Behavioral Health Center (also referred to in this report as SBHC or the Center) on April 19th, 2019. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	7
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	10-11
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	13-14
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	19-20

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of the Local Authority, Southwest Behavioral Health Center (SBHC). The Governance and Fiscal Oversight section of the review was conducted on March 12th, 2018 by Chad Carter, Auditor IV.

The site visit was conducted at SBHC as the Local Authority and contracted service provider for Garfield, Iron, Kane, Washington and Beaver Counties. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Board minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided.

As part of the site visit, SBHC provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter. Random samples were taken from the backup provided to verify that the listed services qualified for each different service category.

There is a current and valid contract in place between the Division and the Local Authority. SBHC met its obligation of matching a required percentage of State funding.

As required by the Local Authority, SBHC received a single audit for the year ending June 30th, 2018 and submitted it to the Federal Audit Clearinghouse. The CPA firm Hafen Buckner Everett & Graff, PC performed the Center's audit and issued a report dated November 20th, 2018. The auditor's opinion was unqualified, stating that the financial statements present fairly, in all material aspects, the financial position of SBHC. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on internal control over financial reporting and compliance for each major Federal program. The SAPT Block Grant was identified as a major program and was selected for additional testing. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2018 Audit:

FY18 Minor Non-compliance Issues:

- 1) Southwest Behavioral Health Center's client cost for Substance Abuse Treatment is above the state average.

This issue has been resolved. SBHC provided a detailed explanation for their higher cost per client in the FY18 report. This standard was also removed from the Division Directives and will no longer be treated as a finding.

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) During the review of personnel files, three were found with conflict of interest forms that were last completed in 2017. The three in question had declared potential conflicts/secondary employment for several years prior. The DHS Contract requires that employees with potential conflicts complete a conflict of interest form annually. It is required that SBHC tracks employees that declare potential conflicts of interest to ensure they are in compliance.

Center's Response and Corrective Action Plan:

Action Plan: As part of Southwest's annual staff recertification, we will review our current process to ensure Conflicts of Interest/Secondary Employment forms are completed and attached to the Personnel files as appropriate. Generally, the existing, annual process works well, but we will use our new, electronic HR Record to track and report missing forms. This should allow us to highlight missing documentation for follow-up and action.

Timeline for compliance: By July 31, 2019 we anticipate forms completed, reviewed and missing forms sought.

Person responsible for action plan: Barbara Williams, HR Manager

FY19 Deficiencies:

None

FY19 Recommendations:

- 1) Next year DSAMH will be checking for subcontractor monitoring forms. SBHC is able to demonstrate how subcontractor activities and submissions are reviewed and approved in their computer system, but Utah Administrative Rules R523-2-6(g) requires that a monitoring report is available for review. The report should document review activities and the results of the review. It is recommended that SBHC look at their electronic review process and summarize it in a report format for each subcontractor.

FY19 Division Comments:

None

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to “annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract.” This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Southwest Behavioral Health Center on March 18th, 19th, and 20th, 2019. The monitoring team consisted of Mindy Leonard, Program Manager and Laura Adams, Family Mentor with the Utah Family Coalition (Allies with Families). The review included the following areas: record reviews, discussions with clinical supervisors and management, program visits, and feedback from families through questionnaires. During the visit, the monitoring team reviewed the Fiscal Year 2018 audit; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention funding; civil commitment; compliance with Division Directives; and the Center’s provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2018 Audit

No findings were issued.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) *Youth Outcome Questionnaire (YOQ)*: The frequency the YOQ is being administered at is below the required guidelines of “every thirty days or every visit (whichever is less frequent)” as described in the Division Directives. In the chart review, eight of the ten charts reviewed did not administer the YOQ at the guideline of 30 days. There is also evidence that the YOQ is not being addressed in the clinical process. Within the chart review, the YOQ was not utilized throughout the treatment process, either in the treatment plan or client notes. Only two of the ten charts reviewed provided evidence of the YOQ being used in treatment.

Center’s Response and Corrective Action Plan:

SBHC Corrective Action Plan: Increasing Administration and Reviews of OQ/YOQ

1. The Data Manager will generate four reports:
 - a. A monthly report (a) per team, listing all active MH clients who had a therapy service in the last 30 days but have not completed an OQ/YOQ in the same 30 days. This report will begin distribution by June 1.

- b. A monthly report (b) per team, of the % of clients who received a therapy service in the last 30 days who also completed an OQ/YOQ. This report is now being distributed.
 - c. A monthly report (c) per clinician, listing all active MH clients who had a therapy service in the last 30 days but have not had an OQ/YOQ reviewed with them in the same 30 days. This report will begin distribution by June 1.
 - d. A monthly report (d) per therapist, of the % of clients who received a therapy service in the last 30 days who also had an OQ/YOQ reviewed with them in the same 30 days. This report will begin distribution by June 1.
2. The Office Manager of each MH program office will be responsible for:
- a. Reviewing report (a) and identifying the reason for each client not completing an OQ/YOQ that month.
 - b. Setting a goal for each month for the % of OQ/YOQs that be completed. The goals will be reported to their Program Manager and Clinical Director
 - c. Making a plan with front desk staff for meeting each monthly goal.
 - d. Reviewing report (b) to determine the last months % of completion met the goal and modifying the plan if the goal was not met.
3. Each MH Therapist will be responsible for:
- a. Reviewing report (c) and identifying the reason for each client not having an OQ/YOQ reviewed with them that month.
 - b. Setting a goal each month for the % of clients who will have OQ/YOQs reviewed with them.
 - c. Making a plan for meeting the goal they have set and reviewing that plan with their Program Manager.
 - d. Reviewing report (d) each month with their Program Manager to determine if last months % of reviews met the goal and modifying the plan if the goal was not met.
4. Each MH Program Manager will be responsible for:
- a. Reviewing the results of reports (a) and (b) each month with the office manager and reviewing and approving the improvement plan for the next month
 - b. Reviewing the results of reports (c) and (d) each month with each therapist and reviewing and approving their improvement plan for the next month
5. The Clinical Director will be responsible for:
- a. Reviewing the results of all reports with each Program Manager each month and reviewing the plans for improving OQ/YOQ completion and review rates.
 - b. Where progress is not being made towards 100% completion and review of OQ/YOQs, develop a plan with each Program Manager for getting back on track.

In addition to the above, it should be noted that with the approval of HSAG, fidelity implementation of the OQ/YOQ had been selected by SBHC as the next Performance Improvement Project (PIP). Joe Coombs has been identified as the project lead.

Timeline for compliance: The process described above will be fully implemented in June 2019.
Person responsible for action plan: Michael Cain, Clinical Director

FY19 Deficiencies:

None

FY19 Recommendations:

None

FY19 Division Comments:

1) *Family Feedback:* SBHC and the Utah Family Coalition (UFC) collected 54 family feedback questionnaires, with 21 from Iron County and 33 from Washington County. There were many positive comments on the questionnaires. Information shared included comments such as “Using the assistance of a bi-lingual staff has been so very helpful,” and “using the wraparound to fidelity checklist is a very helpful tool showing all the work.”

One of the families mentioned that once they completed services with DCFS, the services they received with the FRF were also terminated. The family was unhappy with this and wanted more time. Examining situations like this and providing additional step-down services to help with the transition for families could alleviate this problem.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Southwest Behavioral Health Center on March 18th, 19th, and 20th, 2019. The team included Mindy Leonard, Program Manager and Heather Rydalch, Program Manager. The review included the following areas: Discussions with clinical supervisors and management teams, record reviews, site visits to administrative offices, Family Health Care, Dixie Regional Medical Center Behavioral Health Unit, and the Iron County outpatient office. During the discussions, the team reviewed the FY18 audit; statistics, including the Mental Health Scorecard; area plans; Outcome Questionnaires and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2018 Audit

No findings were issued.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) *Administration and Use of the Outcome Questionnaire (OQ)*: The frequency the OQ is being administered at is below the required guidelines of "every thirty days or every visit (whichever is less frequent)" as described in the Division Directives. A review of documentation demonstrated that the OQ was not administered in eight of ten charts at the required guidelines. In the ten charts that were reviewed, there was no evidence that the OQ was being used in treatment. Division Directives require that the data from the OQ be shared with the client and incorporated into the clinical process, as evidenced in the chart. DSAMH encourages SBHC to have an updated training on the importance of the OQ in the treatment process.

Center's Response and Corrective Action Plan:

SBHC Corrective Action Plan: Increasing Administration and Reviews of OQ/YOQ

- | |
|---|
| <ol style="list-style-type: none">1. The Data Manager will generate four reports: |
|---|

- a. A monthly report (a) per team, listing all active MH clients who had a therapy service in the last 30 days but have not completed an OQ/YOQ in the same 30 days. This report will begin distribution by June 1.
 - b. A monthly report (b) per team, of the % of clients who received a therapy service in the last 30 days who also completed an OQ/YOQ. This report is now being distributed.
 - c. A monthly report (c) per clinician, listing all active MH clients who had a therapy service in the last 30 days but have not had an OQ/YOQ reviewed with them in the same 30 days. This report will begin distribution by June 1.
 - d. A monthly report (d) per therapist, of the % of clients who received a therapy service in the last 30 days who also had an OQ/YOQ reviewed with them in the same 30 days. This report will begin distribution by June 1.
2. The Office Manager of each MH program office will be responsible for:
 - a. Reviewing report (a) and identifying the reason for each client not completing an OQ/YOQ that month.
 - b. Setting a goal for each month for the % of OQ/YOQs that be completed. The goals will be reported to their Program Manager and Clinical Director
 - c. Making a plan with front desk staff for meeting each monthly goal.
 - d. Reviewing report (b) to determine the last months % of completion met the goal and modifying the plan if the goal was not met.
 3. Each MH Therapist will be responsible for:
 - a. Reviewing report (c) and identifying the reason for each client not having an OQ/YOQ reviewed with them that month.
 - b. Setting a goal each month for the % of clients who will have OQ/YOQs reviewed with them.
 - c. Making a plan for meeting the goal they have set and reviewing that plan with their Program Manager.
 - d. Reviewing report (d) each month with their Program Manager to determine if last months % of reviews met the goal and modifying the plan if the goal was not met.
 4. Each MH Program Manager will be responsible for:
 - a. Reviewing the results of reports (a) and (b) each month with the office manager and reviewing and approving the improvement plan for the next month
 - b. Reviewing the results of reports (c) and (d) each month with each therapist and reviewing and approving their improvement plan for the next month
 5. The Clinical Director will be responsible for:
 - a. Reviewing the results of all reports with each Program Manager each month and reviewing the plans for improving OQ/YOQ completion and review rates.
 - b. Where progress is not being made towards 100% completion and review of OQ/YOQs, develop a plan with each Program Manager for getting back on track.

In addition to the above, it should be noted that with the approval of HSAG, fidelity implementation of the OQ/YOQ had been selected by SBHC as the next Performance Improvement Project (PIP). Joe Coombs has been identified as the project lead.

Timeline for compliance: The process described above will be fully implemented in June 2019.

Person responsible for action plan: Michael Cain, Clinical Director

FY19 Deficiencies:

None

FY19 Recommendations:

None

FY19 Division Comments:

- 1) *Integrated Health Care:* SBHC has implemented four locations to offer integrated health care in partnership with Family Health Care. Provisions include a dental facility and medical care, as well as mental health services. Therapists and doctors work side by side, allowing easy access for case staffing, and providing the best possible care for the clients they serve.
- 2) *Expansion of Services:* As the demand for services has increased, SBHC has utilized subcontracts to meet this need. They have worked with local providers to fulfill their Medicaid contracts in the Washington County Area. SBHC has worked closely with Intermountain Health-Care, developing contracts to provide needs-based services. SBHC also has a close working relationship with Cherished Families in the communities of Hilldale and Colorado City. Cherished Families helps with services for families continuing with, or families exiting from, polygamy.
- 3) *Supported Employment/Individual Placement and Support (SE/IPS):* The FY18 Adult Mental Health Scorecard reflects extremely high supported employment numbers, and SBHC continues to lead the state with SE/IPS services provided at with exemplary fidelity. In addition, DSAMH is grateful for the collaborative efforts and time that SBHC has demonstrated including the provision of time and resources to train other Local Authorities for this evidence-based practice.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review for Southwest Behavioral Health on March 19th, 2019. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the reviews evaluated the services described in the annual prevention area plan and evaluated the data used to establish prevention priorities.

Follow-up from Fiscal Year 2018 Audit

No findings were issued.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

None

FY19 Recommendations:

- 1) *Preparation for DSAMH Annual Site Visit:* SBHC has several things going on in their prevention program, so it is sometimes difficult to get everything ready for the DSAMH annual site visit. They indicated that it might be helpful for the Prevention Regional Director to provide mini site visits quarterly to assist them in reviewing the requirements and prepare for the Site Visit. DSAMH recommends that SBHC work with their Prevention Regional Director to discuss the mini site visits and other ideas to prepare for the DSAMH annual site visits.

FY19 Division Comments:

- 1) *Coalition Expansion and Partnerships:* SBHC currently has 16 coalitions and added another coalition and hired a Coalition Coordinator for the Hilldale Community, which has taken SBHC several years to develop trust with them.
- 2) *Prevention Team Competency and Training:* SBHC's Prevention Team are all trained and competent in prevention services. Within one year of hire, prevention staff at SBHC are required to be (1) internationally licensed as prevention specialists (2) attend the Substance Abuse Prevention Staff Training (SAPST) (3) be certified in the Question, Persuade and Refer (QPR) Suicide Prevention Model and Mental Health First Aid (4) trained in the Communities that Care (CTC) Model (5) attend the Utah Fall Conference each year (6) attend a minimum of three drug prevention seminars/webinars each year (7) Coalition Coordinators need to attend 80% of the monthly Utah Prevention Coalition Academy (UPCA) webinars and the Utah Coalition Summit (8) and attend the Community Anti-Drug Coalitions of America (CADCA) Conferences. SBHC is the only Local Authority in Utah that requires their prevention staff to be internationally licensed as a prevention specialists, which is an asset to their program. Due to the competency of the SBHC Prevention Team, they are able to provide effective evidence-based services to their community.
- 3) *Youth Coalitions:* SBHC has successful youth coalitions due to some changes they made in their coalition structure. In the past, SBHC allowed younger kids in middle schools to participate in coalitions, which created some problems. There were three concerns: (1) Access - middle school kids don't drive, so they couldn't attend the coalition events on their own (2) mixing older kids with younger kids created some problems (3) and the functioning level of younger kids was lower than older kids, which created issues in following through with coalition tasks. SBHC now only allows higher functioning youth in high school (10th - 12th Grade) to participate in coalitions, which has increased the effectiveness of the youth coalitions. SBHC asks the school counselor to invite high functioning youth in high school which don't have extracurricular activities and appear to be interested in getting involved in community efforts. The requirements for the youth coalitions are the same as adult coalitions - both have to create an Action Plan. However, there is more emphasis on training and learning for the youth coalitions. SBHC has included youth in the Community Anti-Drug Coalitions of America (CADCA) Conference and recently took 19 youth to Washington D.C. to meet with Senators and Representatives. They also took the youth to Capitol Hill to provide a presentation to legislative staff. The youth coalitions have become so popular, that SBHC now has a waiting list for youth coalitions and a cap has been set at 60 youth for each coalition. SBHC is a leader in the State of Utah in building successful youth coalitions.
- 4) *Eliminating Alcohol Sales to Youth (EASY) Compliance Checks:* SBHC has been working on increasing the readiness of the law enforcement officers to encourage them do to the EASY Compliance Checks. What they found out was that most police officers in their area were not really concerned about under age drinking, and even felt it was a "right of passage" for

adolescents to drink, which was one of the reasons that the police officers were not doing the EASY Compliance Checks. SBHC invited the officers and sergeants to attend a training they provided that covered the science of prevention and impact of underage drinking. SBHC developed a pre and post test survey to assess the perceptions of police officers on their ability to enforce underage laws. Results from the post test survey indicated an increase of the level of readiness for police officers to complete the EASY Compliance Checks. As a result of these efforts, Beaver County conducted 11 EASY Compliance checks for the first time, which has made a positive difference for their community.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Southwest Behavioral Health on March 19th, 2019. The review focused on compliance with State and Federal law, DSAMH contract requirements, and DSAMH Directives. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to Drug Court, Justice Reinvestment Initiative (JRI) and the Drug Offender Reform Act (DORA) requirements and contract requirements were evaluated by a review of policies and procedures, clinical records and through interviews with Southwest Behavioral staff. Treatment schedules, policies, and other documentation were also reviewed. The Utah Substance Use Disorder Treatment Outcomes Measures Scorecard results were reviewed with staff. Client satisfaction was measured by reviewing records and the Consumer Satisfaction Survey data. Finally, additional data was reviewed for Opiate Use for Washington, Iron, Garfield, Kane, and Beaver Counties.

Follow-up from Fiscal Year 2018 Audit

FY18 Significant Non-compliance Issues:

1) The Utah Substance Abuse Treatment Outcomes Measures Scorecard showed:

- The percent of individuals that completed a treatment episode successfully decreased from 41.6% to 30.7%, from FY16 to FY17 respectively, which does not meet Division Directives. This was a previous finding in FY17.

This issue has been resolved. The percent of individuals that completed a treatment episode successfully increased from 30.4% in FY17 to 47.9% in the FY18 respectively, which now meets Division Directives.

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) *Clinical Charts:* Overall, SBHC does a good job with documentation in their clinical charts; however, the group notes were not individualized. They had general information regarding the group topic, but didn't have information regarding the client's participation in group, progress or lack of progress on recovery goals and didn't include the therapist's clinical observation of the client's progress in treatment. Group progress notes should be individualized, include the client's progress or lack of progress in treatment and therapist's

observation of the client’s progress on recovery plan goals (Chart #'s 52078, 11474, 38361, 25599, 121188, 18743, 2030, 17193, 125035).

Center’s Response and Corrective Action Plan:

Action Plan:

SBHC has taken and will continue to take the following actions to correct the lack of individualization in group notes:

1. Clinicians will use a structure such as “DAP: Data, Assessment, Plan” beginning 5/1/19 to document their group notes, assuring clinicians document the client's participation in group, progress or lack of progress on recovery goals, and the therapist's clinical observation of the client's progress in treatment.
2. Record Specialists will randomly select one chart per clinician per quarter beginning 5/1/19 and complete an audit. Wendy King, the EHR and Quality Manager will be responsible to train the Record Specialists.
3. Program Managers will review random charts with clinicians in their monthly individual RAPs (Review and planning) meetings beginning 6/1/19 to assure documentation standards are being met, including individualization of group notes. Angi Edwards-Matheson, the Assistant Clinical Director, will be responsible for training the Program Managers.
4. Once per month in Washington and Iron counties and once per quarter in the Frontier counties, beginning 6/1/19, each therapist will review one chart with their team, to ensure progress toward this CAP.
5. Program Managers will review progress on individualizing group notes with the Assistant Clinical Director each month in their scheduled RAP meetings beginning 7/1/19.

Timeline for compliance: See above

Person responsible for action plan: Angi Edwards-Matheson

FY19 Deficiencies:

None

FY19 Recommendations:

- 1) *Agency Walk-Through:* It is recommended that SBHC conduct at least one Agency walk-through over the next year to determine whether their agency is meeting the needs of their clients. The knowledge that is gained from the walk-through can help provide an understanding of where the Agency’s priorities should be and what types of changes will ultimately have the largest impact on client perceptions and the budget. More information regarding the Agency walk-through can be found at: [NIATx - How to Perform a Walk-through](#).

FY19 Division Comments:

- 1) *Stabilization Mobile Response Team:* SBHC has combined crisis services for children, adolescents and adults and are now serving all five counties - Washington, Iron, Garfield, Kane, and Beaver Counties. In the Frontier areas, there are great distances to travel, which is a challenge, so SBHC has been working with Allies with Families to assist with mobile crisis

in these areas. They have also been working with the University Neuropsychiatric Institute (UNI) to expand crisis services in their community. SBHC is also looking into using telehealth services to allow therapists to assist with crisis outreach. The Mobile Crisis team consists of 12 individuals, however, due to the workforce shortages in their area, there has been an open position in Iron County since January 2019. SBHC is working hard to ensure that crisis services are covered in all areas of their community, which has made a positive difference in their community.

- 2) *Expansion of Community Partnerships*: SBHC has expanded the number of programs they are partnering with in the community. In the past, SBHC provided most of their services in-house, but came to the realization that increasing partnerships with community programs increases access to services in their community. An example of one of these partnerships is with Cherished Families, a group of individuals that are exiting the plural lifestyle from the Fundamental Church of Jesus Christ of Latter Day Saints. SBHC has been providing support to these families to meet their needs by using Medicaid and Division of Workforce Services dollars to develop group practices to help these families. Through these efforts, SBHC has helped several individuals in their community that would have not been served otherwise if SBHC had not been building trust with them over the past several years. Through these partnerships, SBHC has improved outcomes for clients and their families.

- 3) *Medication Assisted Treatment (MAT)*: SBHC has expanded MAT in their community through increasing partnerships with community partners. Some of these partnerships include St. George Metro Treatment Center, the local Federally Quality Health Care Center and Intermountain Health Care. SBHC assesses individuals with opioid use disorders for MAT and ensures that they receive MAT and additional support to assist them in their recovery efforts. In addition, they are distributing Naloxone Kits to clients and their families to help prevent deaths from overdose. Due to these efforts, SBHC has helped improve outcomes for their clients and families.

- 4) *Data and Training*: SBHC has been providing ongoing training for staff on data entry requirements, which has helped improve their data outcomes. This year, SBHC did not have any data findings and increased the percent of individuals that completed a treatment episode successfully from 30.4% in FY17 to 47.9% in FY18 respectively, which is a significant increase. SBHC is dedicated to providing ongoing training to their staff on data entry requirements and using data to improve services and performance outcomes.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 10 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 15 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Southwest Behavioral Health Center and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health

Prepared by:

Chad Carter Chad Carter Date June 10, 2019
Auditor IV

Approved by:

Kyle Larson Kyle Larson Date June 10, 2019
Administrative Services Director

Eric Tadehara Eric Tadehara Date June 10, 2019
Assistant Director Children's Behavioral Health

Jeremy Christensen Jeremy Christensen Date June 10, 2019
Assistant Director Mental Health

Brent Kelsey Brent Kelsey Date June 13, 2019
Assistant Director Substance Abuse

Doug Thomas Doug Thomas Date June 13, 2019
Division Director

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Document Pages: 28	Signatures: 7
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	kblarson@utah.gov
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