



Site Monitoring Report of

Southwest Behavioral Health Center

Local Authority Contracts #122284 and #122285

Review Dates: April 11th, 12th & 13th, 2016

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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 11th, 12th & 13th, 2016. 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; 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	None None None	
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance	None None None	
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance	None None 1	12 - 14
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance	None None None	
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance	None None 3	19 - 21

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review at Southwest Behavioral Health Center (SBHC). The Governance and Fiscal Oversight section of the review was conducted on April 12th, 2016 by Chad Carter, Auditor IV. 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. Client fees were reviewed for consistency and adherence to approved fee schedules. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit had been gained. Detailed service and operating expenditures were examined for proper approval and supporting documentation.

The independent financial statement audits were reviewed for Garfield, Iron, Kane, Washington and Beaver Counties. There were no findings or deficiencies that were specific to the Local Authority contract or the provision of mental health and substance use disorder services.

The CPA firm Hafen Buckner Everett & Graff performed the Center's financial statement audit for the year ending June 30th, 2015 and issued a report dated October 14th, 2015; the auditors' opinion was unqualified. As a part of the review, they examined specific items at the Division's request, including executive travel, personnel and allowability of costs reported. In their opinion these items are accurately presented and no findings or issues were identified.

Follow-up from Fiscal Year 2015 Audit:

No findings were issued.

Findings for Fiscal Year 2016 Audit:

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

None

FY16 Minor Non-compliance Issues:

None

FY16 Deficiencies:

None

FY16 Recommendations:

None

FY16 Division Comments:

- 1) Southwest Behavioral Health Center's client cost for Substance Abuse Treatment is above the state average. SBHC received a finding for this issue in the FY13 monitoring report and provided an explanation for the high costs. Due to demand from the community, SBHC operates three Substance Abuse Residential programs. Providing residential services has a large impact on cost per client, due to the expense of services and a smaller number of clients served. SBHC's residential program has been shown to be a valuable and effective service for many clients. Although SBHC's cost per client is still above the state average, the Division is satisfied with the provided explanation and will not issue a finding for the FY16 monitoring report.

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, and Families team conducted its annual monitoring review at Southwest Behavioral Health Center on April 11th and 12th, 2016. The monitoring team consisted of Eric Tadehara, Program Manager; Dinah Weldon, Program Administrator; and Laura Adams, Utah Family Coalition (New Frontiers for Families). The review included the following areas: record reviews, discussions with clinical supervisors and management, case staff, program visits, and feedback from families through questionnaires. During the visit, the monitoring team reviewed Fiscal Year 2015 audit findings and center responses; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); Wraparound to fidelity; 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 2015 Audit

FY15 Deficiencies:

- 1) *Recovery Plan Objectives:* This is a joint finding of the Substance Use Disorder, Adult Mental Health, and Children's Mental Health Teams: While SBHC has developed a highly flexible electronic health record, recovery plans continue to be static, showing little change over the course of treatment. Objectives are broad and not measurable and do not change over time to show the progress of the client in their recovery. Recovery plans should guide the client through the treatment progress and objectives should represent meaningful steps throughout the recovery process.

This deficiency was partially resolved for the Child, Youth and Family Mental Health review and will be continued in FY16 as a recommendation. Please see Recommendation #1.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

None

FY16 Minor Non-compliance Issues:

None

FY16 Deficiencies:

- 1) *Medication Management*: SBHC does not provide medication management at a rate similar to the state (22.6%) or rural (14.3%) averages. In FY15, SBHC provided medication management to 7.5% (130 total) of the children and youth served. SBHC provided services to 22 more children and youth in FY15 from FY14. SBHC has also made positive efforts to improve collaboration with Primary Care Physicians and local providers to strengthen the care children and youth receive which helps address the limited access to providers.
- 2) *Juvenile Civil Commitment*: SBHC is not using up to date Civil Commitment forms. Civil Commitment Paperwork for juveniles needs to be completed consistent with State statute 62A-15-703 utilizing the proper forms for children's civil commitment procedures located on the DSAMH website at <http://dsamh.utah.gov/provider-information/civil-commitment/>.
- 3) *Youth Outcome Questionnaire*: The Youth Outcome Questionnaire (YOQ) is not being administered at the required frequency. Division Directives require that the YOQ be administered at a frequency of "every thirty days or every visit (whichever is less frequent)" for each child and youth. Charts reviewed had an average of four administrations within the last twelve months.
- 4) *Multi-Agency Coordinating Committees (MACCs)*: SBHC is not fully participating in multi-agency coordinating committees throughout their catchment area. The Division Directives state that "Local Authorities will utilize ... Multi-Agency Collaboration in the provision of services for Children, Youth, and Families." Collaborating with allied agencies which provide services to children and youth (e.g. child welfare, juvenile justice, education, etc.) will strengthen SBHC's partnerships with these agencies and will enable SBHC to better meet the needs of children involved in multiple agencies.

FY16 Recommendations:

- 1) *Recovery Plan Objectives*: In the children and youth charts, improvements in the quality of the objectives was observed, however we recognize that SBHC has continued to work to strengthen the quality of objectives. For example: (1) "Using play therapy client will be able to express his experiences and feelings via therapist facilitation and play. Therapist will teach and facilitate the use of adaptive coping skills specific to client's trauma and internalizing. These will replace the maladaptive skills that have been modeled to him;" and (2) client "will practice basic ignoring and he will practice at school when kids tease him." The first is very broad and difficult for an eight year old youth to understand and achieve. The second lacks meaning and is not measurable. A third objective was not current and had not been updated since 2013. Recovery plans should guide the client through the treatment progress and objectives should represent meaningful steps throughout the recovery process. The Division Directives state that "short term goals/objectives are measurable, achievable and within a timeframe."

FY16 Division Comments:

- 1) *Family Behavioral Contracts*: SBHC's Mobile Crisis Outreach Team (MCOT) develops a Family Behavioral Contract (FBC) with families in order to provide a plan to divert and/or aid during a crisis situation. SBHC meets with families and identifies various house rules, consequences and rewards associated with those rules, and ways each member of the family

can be responsible for their actions in the FBCs. The plan is then monitored by the family and SBHC with more services being provided if necessary. FBC empowers families to proactively approach crisis situations without needing more intensive services. One family who created a plan with MCOT reported afterward that “we feel like we have our child back again as he shows more respect for us and our family rules. ... MCOT is helping him learn to do that [function in society] by empowering us as parents so that we can enforce rules and safety at home.”

- 2) *Family Feedback:* The Utah Family Coalition (UFC) gathered family feedback from 29 families who completed questionnaires. Overall, families believe SBHC and the staff are helpful, caring, and friendly. All 29 families reported being involved in their children’s treatment and recovery planning. Parents and families are happy for the various services provided by SBHC, including the Mobile Crisis Outreach Team and school-based behavioral health services.
- 3) *Wraparound & Family Resource Facilitators:* SBHC is providing Wraparound to fidelity as defined by the UFC in Iron and Washington Counties. The Family Resource Facilitators (FRF) are integral parts of the team and the service delivery system in both counties. It is recommended that SBHC look for opportunities to clarify the role of FRFs and continue to work with staff and clients to understand the role and the importance of Wraparound to fidelity.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Southwest Behavioral Health Center on April 12th and 13th, 2015. The team included Pam Bennett, Adult Mental Health Program Administrator, LeAnne Huff, Adult Mental Health Program Manager, Robert Snarr, Adult Mental Health Program Administrator, and Cami Roundy, Recovery and Resiliency Peer Program Manager. The review included the following areas: Discussions with clinical supervisors and management teams, record reviews, site visits to administrative offices, outpatient clinics, Southwest Supported Employment Services, Elev8 Day Program, Oasis House, Iron County Care and Share, Paiute Tribe, and the Washington County Jail. During the discussions, the team reviewed the FY15 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 2015 Audit

FY15 Deficiencies:

- 1) *Documentation of Outpatient Services:* This is a joint finding of the Adult Mental Health, Substance Use Disorder and Children's Mental Health Teams: While SBHC has developed a highly flexible electronic health record, recovery plans continue to be static, showing little change over the course of treatment. Objectives are broad and not measurable (in six out of eleven Adult Mental Health charts reviewed) and do not change over time to show the progress of the client in their recovery. Recovery plans should guide the client through the treatment progress and reflect changes in objectives and goals as the client completes each new objective. In addition, two of two Adult Mental Health charts from frontier offices were missing several required components including the formulations, recommendations, documentation to justify the diagnosis and coordination between the diagnosis and goal.

This deficiency has not been resolved for Adult Mental Health and will continue in FY16; see Minor-non Compliance Issue # 1.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

None

FY16 Minor Non-compliance Issues:

- 1) *Documentation of Outpatient Services:* A review of documentation demonstrated that six out of eleven (55.0%) charts did not have a current assessment update. Assessment updates are important to identify and document any significant changes in the client's life which may

require a change in treatment planning. In addition, six out of eleven (55.0%) included progress notes that did not contain a plan, reaction of the client to the intervention, or information to assess any progress toward goals and objectives. Six out of eleven (55.0%) did not have measurable objectives. The Division Directives state that objectives should be “behavioral changes that are measurable, short term and tied to the goals.” One possible option for developing measurable goals is encouraging staff to utilize **SMART** goals; **S**pecific, **M**easurable, **A**ttainable, **R**elevant, and **T**ime-based.

Center’s Response and Corrective Action Plan:

Assessment update:

1. SBHC will conduct a Clinical Staff Training:
 - a. Goal: **January 3, 2017**: “100% of clients seen in 2016 have an updated assessment”
 - b. Primary Service Coordinators (PSC’s = Therapists) will be trained and expected to follow the process below.
2. Assessment Update Process:
 - a. Audits of all records will be done to determine records that do not have an assessment update in CY 2016. **July 31, 2016**
 - b. Records without a 2016 update will be added to a spreadsheet for each PSC in each program. The spreadsheet will include: Client Name, ID, Admit date, Date Update Scheduled, Date Update Completed, and Next Update Deadline.
 - c. The reports will be given to the PSC’s. **August 5, 2016**
 - d. **PSCs** will add pertinent update information to the Assessment categories for those records where an update does not exist. The Formulation section of all assessments will be required to include a 2016 update. **August 8- 26, 2016**
 - e. The audits and report will continue to be done each month and provided to each PSC, program manager and the clinical director. **August 31, 2016: (2nd Report created) and distributed September 5, 2016. Process is repeated each month thereafter**
 - f. Program Managers will review the report individually with each clinician each month.
 - g. The Clinical Director will review the reports for each PSC with each Program Manager each month.
3. The Clinical Leadership Team (Program Managers, QI Chair, and Clinical Director) will review overall percentage of ‘updated assessment’ reports to determine if expected improvement in assessment updates is being made and goal will be met. If not meeting expected improvement, the Corrective Action Plan will be modified.
4. The process will be repeated in subsequent years.

Recovery Plan

SBHC had already started a focus on improving Recovery Plans by focusing on having Recovery Plan Objectives meet the SBHC ‘TEAM’ standard. (**T**ime-Framed, **E**asily **E**valuated (measurable), **A**ction/**A**ccomplishment oriented, **M**otivating (to the client)).

1. An initial training reviewing the expectation has been completed within each team.
2. An audit tool for assessing objectives against the TEAM standard has been created.
3. Most teams have completed an initial audit. All teams will be completed **by July 15, 2016**
4. The following process will be completed by **July 31, 2016**
 - a. 5 charts of each PSC selected at random by the Records Specialist and audited using the

- Objectives audit tool.
- b. Audit report is given to each PSC.
- c. PSC reviews the audit, signs and forwards to Program Manager
- d. Program manager and PSC review the audits where improvement is needed.
- e. Program managers review audits with Clinical Director
- 5. The process above (#4) will be completed each month thereafter.
- 6. Program Managers will use weekly team meetings to review objectives and include:
 - a. Identification of a 'Best objective' of the week.'
 - b. Report of the percent of reviewed records that entirely met the TEAM standard.
 - c. Lead discussion on how to improve objectives.
- 7. Each month the Clinical Leadership Team (Program Managers, QI Chair, and Clinical Director) will review overall percentage of audit reports to determine if expected improvement in objectives is being made. If not meeting expected improvement, Corrective Action Plan will be modified.

Goal: By **January 3, 2017**: 90% of all audited objectives will entirely meet TEAM standard.

FY16 Deficiencies:

- 1) *Outcome Questionnaire (OQ) as an Intervention*: DSAMH commends SBHC for an increase in administration of the OQ from 50.6% in FY15 to 53.8% in FY16 of unduplicated clients. However, eight of eleven charts (72.7%) did not document review of the OQ. Division Directives state that data from the OQ or Youth Outcome Questionnaire (YOQ) shall be shared with the client and incorporated into the clinical process, as evidenced in the chart. This outcome measure assists with identification of goals and helps the client and therapist determine therapeutic progress. DSAMH recommends that SBHC train clinical staff to use the OQ as a clinical tool with their clients.

FY16 Recommendations:

- 1) *Data Submission*: According to the FY15 Mental Health Score Card, SBHC provided jail services to zero (0) individuals, despite having a collaborative relationship with jails in the counties. In addition, SBHC has a Supported Employment program, but only 28 individuals are reported as receiving Supported Employment services. These services are not accurately reflected by the data submitted to DSAMH as mandated by the Division Directives. It is recommended that SBHC work with DSAMH to identify and correct data submission issues.

FY16 Division Comments:

- 1) *Recovery-Oriented Culture*: SBHC is commended for building a program that appears to be focused on individual recovery. The concept of Recovery Capital appears to be ingrained in the philosophy of the Center. Discussions and a review of records indicate that treatment is person-centered, strengths-based, and includes an array of recovery support services.
- 2) *Mental Health Courts (MHC) in Iron County*: DSAMH commends Iron County's dedication to starting a mental health court in Cedar City in addition to St. George. DSAMH appreciates being invited to attend the third MHC meeting since they started their programming, and recognizes the value Iron County and SWBC have put on this program. The team is dedicated to helping individuals stay out of jail and lead productive lives.

- 3) *Participant Feedback:* Cami Roundy, Recovery and Resiliency Peer Program Manager, visited with Peers at the Elev8 and Oasis Programs. Peers at the Elev8 Program indicated that they enjoy the programs and activities, and would like to have more activities, groups and classes. Comments included: “Without Southwest, I’d be lost. I would have to stay home. It is a big load off of my shoulders to come here.” Another comment was: “I like that we all get along really well. We don’t have arguments and we have a good time together. An additional comment was: “Part of Recovery is gaining back your own self-worth, and that is what is happening here”. Peers from the Oasis Program enjoy many of the programs that Oasis provides, in particular mentioning recycling and then using the money for trips and other things. They appreciate that their medication can be delivered to them at night. One comment made by a peer at Oasis was: “Groups are great and they keep people occupied.”
- 4) *Peer Support:* SHBC has incorporated Certified Peer Support Specialists (CPSS) in to several programs. CPSS report that they feel supported by leadership and that they are part of the clinical team. Technical assistance regarding CPSS documentation was provided. SBHC is preparing to hold the 3rd Annual “Recovery Conference”, which every employee attends to hear directly about recovery-based services and principles.
- 5) *Suicide Prevention:* DSAMH commends SBHC’s dedication to providing suicide prevention training to their community. The Reach for Hope Suicide Prevention Coalition, in partnership with SBHC, is invested in suicide prevention gatekeeper training including Mental Health First Aid (MHFA) and Question, Persuade, and Refer (QPR). SBHC has a commendable goal of training 50,000 community members in QPR over the course of ten years. They currently have trained 63 QPR trainers, who have trained over 2,500 people as suicide prevention gatekeepers. In addition, SBHC is providing a quarterly QPR newsletter. SBHC has also reached out to First Responders and other community partners to provide MHFA training.
- 6) *Housing Matters:* The housing programming tied to Continuum of Care (COC) funding is meeting individual participant needs. However, it is not meeting the grant requirements. SBHC is working with the local public housing authority to transition participants in the program, and has been working on active participation in coordinated entry processes, as well as key components of evidence-based Housing First and Permanent Supportive Housing.

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review for Southwest Behavioral Health Center on April 12th, 2016. The reviews 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 2015 Audit

No findings were issued.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

None

FY16 Minor Non-compliance Issues:

None

FY16 Deficiencies:

- 1) There was a decrease in the number of Eliminating Alcohol Sales to Youth. For the year, only 42 checks were completed in the LSAA. This is a decrease from 77 the previous year.

FY16 Recommendations:

None

FY16 Division Comments:

- 1) SBHC demonstrated a knowledge and understanding of the trends by preparing a thorough presentation for the site visit.
- 2) SBHC stated that the Substance Abuse Prevention Specialist Training (SAPST) for the Student Resource Officers in Washington County was successful and they are looking to train all SROs in other counties.
- 3) SBHC requires all staff and providers to follow program curriculum, including pre and post tests for all programming. This is monitored by observation as well as checklists.
- 4) SBHC has a strategic plan for the LSAA that incorporates the Action Plans from the coalitions in the five counties.

- 5) SBHC reported that they support six community coalitions throughout the LSAA; five of the coalitions have youth coalition components.
- 6) SBHC identified Provider Lack of Knowledge as a risk factor. SBHC has provided doctor trainings on the Prescribing Guidelines, 80% of the providers who attend state they will change their prescribing practices after the training.
- 7) SBHC is working with BYU to evaluate Kid Power and Personal Power in an effort to increase the number of evidence based strategies provided.
- 8) A recommendation was made at the site visit to put all strategic plans from coalitions online for public view. SBHC complied and put all plans online by the end of April 2016

Substance Abuse Treatment

Shanel Long, Program Administrator, and Heather Lewis, Program Manager, conducted the substance abuse treatment review of Southwest Behavioral Health Center on April 12th, 2016. The review focused on Substance Abuse Treatment (SAPT) Block Grant Compliance, Drug Court Program compliance, clinical practice and compliance with contract requirements. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to SAPT Block Grant requirements, contract requirements and Drug Court requirements were evaluated by a review of policies and procedures, interviews with clients, a discussion with SBHC managers, visits to two Drug Court staff meetings and court sessions, and a review of program schedules and other documentation. SBHC performance was evaluated using Utah Substance Abuse Treatment Outcomes Measures Scorecard and Consumer Satisfaction Survey Data. Client satisfaction was measured by reviewing records, Consumer Satisfaction Survey data and results from client interviews.

Follow-up from Fiscal Year 2015 Audit

FY15 Minor Non-Compliance Issues:

- 1) The FY14 Utah Substance Abuse Treatment Outcomes Measures Scorecard reflects that Increased Alcohol Abstinence rates for SBHC were 25.5% which fell below 75% of the National average, which is the DSAMH minimum standard. The FY15 mid-year Data Manager's report indicates that the percent of increase of abstinence has actually fallen to 21.4% during the first six months of FY15.

This issue has not been resolved and will be continued in FY16; see Minor Non-Compliance Issue #1.

The FY14 Utah Substance Abuse Treatment Outcomes Measures Scorecard reflects that Decreased Criminal Justice Involvement rates for SBHC fell from 38.9% in FY13 to 23.4% in FY14 which is below 75% of the National average, the DSAMH minimum standard. The FY15 midyear Data Manager's report indicates that the percent of Decreased Criminal Involvement continued to fall to 15.4% during the first six months of FY15.

This issue has not been resolved and will be continued in FY16; see Minor Non-Compliance Issue #2.

FY15 Deficiencies:

- 1) This is a joint finding of the Substance Use Disorder, Adult Mental Health and Children's Mental Health Teams: While SBHC has developed a highly flexible electronic health record, recovery plans continue to be static, showing little change over the course of treatment. Objectives are broad and not measurable and do not change over time to show the progress of the client in their recovery. Recovery plans should guide the client through the treatment progress and objectives should represent meaningful steps throughout the recovery process.

This deficiency was resolved for the Substance Use Disorder review.

Findings for Fiscal Year 2016 Audit:

FY16 Major Non-compliance issues:

None

FY16 Significant Non-compliance issues:

None

FY16 Minor Non-compliance issues:

- 1) The FY15 Utah Substance Abuse Treatment Outcomes Measures Scorecard reflects that Increased Alcohol Abstinence rates for SBHC were 26.4% which fell below 75% of the National average, which is the DSAMH minimum standard. Due to the fact that it had increased from FY14, it will remain a minor finding. Last year it was reported that this issue was perhaps a result of improper staff training and documentation and training dates were established, yet it still is not above the average.

Center's Response and Corrective Action Plan:

Alcohol Abstinence

1. Program Managers will (again) train SUD Primary Service Coordinators (PSC) on assessing & documenting alcohol use for every client that enters services. They will also be trained by their Program Managers to complete their part in the following process by **July 31, 2016**:

New Process

2. SBHC Data manager will generate a monthly report listing all current clients who do not have alcohol use listed as one of the 3 primary chemical dependencies, starting **July 15, 2016**
3. Each month, the report will be given to each SUD PSC.
 - a. The PSC will review the report, either confirming that the client has reported not using alcohol, or indicating that they have modified the client's record to include alcohol use.
 - b. The PSC will sign the report and give to their program manager. When needed, the program manager will review the report with the PSC.
4. Each month the Data Manager will generate a report, by team, of the number of discharged clients who report no alcohol use at discharge compared to the number reporting alcohol use at admission or during treatment.

Beginning **August 2nd, 2016**, and each month thereafter the Clinical Leadership Team (Program Managers, QI Chair, and Clinical Director) will review each team's alcohol abstinence reports to determine if expected improvement in alcohol abstinence is being made. If not meeting expected improvement, Corrective Action Plan will be modified.

- 2) The FY15 Utah Substance Abuse Treatment Outcomes Measures Scorecard reflects that Decreased Criminal Justice Involvement rates for SBHC were 29.6% which is below 75% of the National average, the DSAMH minimum standard. Because it had risen from 23.4% in FY14 it will remain a minor finding.

Center's Response and Corrective Action Plan:

Decreased Justice Involvement

1. Southwest Behavioral Health Center believes the Drug Courts in which SBHC is involved utilize incarceration as a sanction at a higher rate than other Drug Courts. SBHC will review the state scorecard to see which drug courts/LSAA's are lowest in criminal involvement. This will be led by the JRI Coordinator and completed by **July 1, 2016**.
2. Outreach will be made to these groups (identified in #1) to determine what they are doing to have the lower criminal justice involvement rates and will consider which strategies can be implemented by SBHC. This will be led by the JRI Coordinator and completed by **July 15, 2016**.
3. In addition to those things learned via strategies 1 and 2, SBHC will implement the following:
 - a. The use of Motivational Incentives. **August 31, 2016**
 - b. When incarceration is being considered for an existing client, SUD and JRI staff will be asked develop two alternatives to be considered for the client in lieu of jail. **August 31, 2016**
 - c. Beginning in **July 2016**, JRI staff will engage with county correctional facilities to implement a pre-release program to assist individuals transitioning from incarceration back to the community to maximize their chances of success. Program aspects to include peer support mentor engagement, education about accessing community services and coordination with meeting this need. The risk and needs assessment will be used to help direct the highest need individuals to accessing ATR/RSS funds to reduce barriers. Review and follow up surveys will be created at intake, 90 days, and 180 days to discuss potential shifts in treatment engagement. In the event a JRI engaged individual is re-incarcerated they will be interviewed by JRI Recovery Collaborators to discover potential missed opportunities for intervention or engagement with recovery.
4. Each month the Data Manager will generate a report, by team, of Criminal Justice Involvement for active and discharged clients in the that month.

Beginning **August 2nd, 2016**, and each month thereafter the Clinical Leadership Team (Program Managers, QI Chair, and Clinical Director) will review each team's Criminal Justice Involvement reports to determine if expected improvement in Criminal Justice Involvement is being made. If not meeting expected improvement, Corrective Action Plan will be modified.

- 3) *Tobacco Cessation:* Division Directives state the Local Substance Abuse Authorities will show that the percent of clients who use tobacco will decrease from admission to discharge by 5%. For SBHC in FY15, the rate of cessation fell from 6.3% to -1.3%. It is recommended that SBHC's initial approach to tobacco cessation as part of overall wellness be re-energized and reinforced.

Centers Response and Corrective Action Plan:

Tobacco Cessation

1. By **July 31, 2016**, the SUD Program Managers will train staff to assess all clients about tobacco recovery. For those clients who express an interest in tobacco recovery, cessation goals and

objectives and assignments will be added to treatment plans related to those cessation goals.

2. By **July 1, 2016**, the Clinical Director will add tobacco cessation to SUD reporting in individual progress notes so changes to tobacco use can be updated more frequently.
3. The Horizon House and St. George SUD programs each recently had a staff member trained in the tobacco recovery program through the state.
 - a. Beginning in **July, 2016**, the Program Managers will assure that initial education will be provided to all SUD groups regarding the recovery value of cessation, including; the importance of tobacco cessation for general wellness, quality & longevity of life and increased likelihood of abstinence from other abused substances.
 - b. By **August 1, 2016**, the Horizon House trainer will begin providing cessation classes to each Horizon House group. And by the same date, the St. George cessation trainer will begin to offer classes for PSCs to refer clients who are interested in cessation.
 - c. By **September 30, 2016**, The trainers will also train/mentor staff or volunteers in the frontier counties who will teach classes in their areas. SBHC staff will also work with the Family Healthcare (FQHC) in providing materials and education to any clients interested in stopping or reducing tobacco use. (all of these last areas will apply to St. George as well).
4. The Program Managers will review with each PSC efforts in tobacco cessation in monthly supervision sessions.
5. The SBHC Data Manager will run quarterly reports to compare and ensure that Tobacco Use is changing from admit to discharge based on those clients reporting cessation.

Beginning **August 2nd, 2016**, and each quarter thereafter the Clinical Leadership Team (Program Managers, QI Chair, and Clinical Director) will review each team's tobacco cessation reports (provided by the Data Manager) to determine if expected improvement in tobacco cessation is being made. If not meeting expected improvement, Corrective Action Plan will be modified.

FY16 Deficiencies:

None

FY16 Recommendations:

- 1) Division Directives identify the need to create a protocol for identification and referral for the screening and treatment of HIV, Hepatitis C, and TB. During discussion, the screening of TB was reported but other diseases are not. It is recommended that SBHC identify and devise a plan with a local health provider or clinic in order to make this testing available during or relatively soon after an assessment is being completed.

FY16 Division Comments:

- 1) *Clinical Documentation:* SBHC has developed a highly flexible electronic health record and in FY16 it is evident staff have worked diligently to improve overall recovery planning and documentation. The "golden thread" is evident throughout client charts. Objectives are clear, concise, and measurable. It is apparent the client had a part in the creation of the plan and that the client made progress throughout the course of the treatment episode. (Chart #s 121512, 125256, 122434, 124527, 124559)
- 2) During client interviews the reporting process to the court was discussed. Several of the Felony Drug Court clients mentioned that they felt communication between treatment staff

members and between staff and drug court team was sometimes lacking. They reported when they arrived at court, oftentimes the drug court team hadn't received any treatment reports so the court staff were not properly informed of treatment status, progress or issues therein. It is recommended that the staff at SBHC discuss this and perhaps offer a training or create a protocol to identify and correct problems with communication.

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 require a formal action plan. 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

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