State of Utah
GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Department of Human Services
ANN SILVERBERG WILLIAMSON
Executive Director

Division of Substance Abuse and Mental Health
DOUG THOMAS
Director

June 9, 2020

Commissioner Lamont Smith
Iron County Commission
76 North Main St.
Kanab, UT 84741

Dear Commissioner Smith:

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 Center; 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 (Jul 10, 2020 17:39 MDT)

Doug Thomas
Division Director

Enclosure
cc: Jerry Taylor, Garfield County Commission

Michael Dalton, Beaver County Commission
Gil Almquist, Washington County Commission
Paul Cozzens, Iron County Commission
Michael Deal, Southwest Behavioral Health

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

Site Monitoring Report of

Southwest Behavioral Health Center

Local Authority Contracts #152258 and #152259

Review Dates: March 24th, 2020

Table of Contents

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 March 24th, 2020. 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)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	9-11
	Deficiency	None	
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	13-15
	Deficiency	1	16
Substance Abuse Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	18-19
Substance Abuse Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	22-23
	Deficiency	None	

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) remotely due to the COVID-19 pandemic. The Governance and Fiscal Oversight section of the review was conducted in March of 2020 by Chad Carter, Auditor IV.

The site visit was conducted remotely with 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, 2019 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 December 6th, 2019. 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.

<u>Follow-up from Fiscal Year 2019 Audit:</u>

FY19 Minor Non-compliance Issues:

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.

This issue has been resolved. Southwest has included a conflict of interest module as part of their Core Training that they require every employee to take online annually. This gives every employee the opportunity to declare any potential conflicts and also meets the contractual requirement of having those with previously declared conflicts complete a new form each year.

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:
None

FY20 Significant Non-compliance Issues:
None

FY20 Minor Non-compliance Issues:
None

FY20 Deficiencies:
None

FY20 Recommendations:
1) The Southwest emergency plan was reviewed by Robert Snarr, Program Administrator and Geri Jardine, Program Support Specialist, as part of monitoring. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that Southwest review these suggestions and update their emergency plan accordingly.

FY20 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 for Southwest Behavioral Health Center (SBHC) in March 2020. Due to the COVID-19 pandemic the monitoring team was unable to complete an in person monitoring visit. A modified remote monitoring was completed by Mindy Leonard, program manager. The review included the following areas: record reviews, and questions completed by the clinical director. The monitoring team reviewed the Fiscal Year 2019 audit; statistics, including the Mental Health Scorecard; Area Plans; 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 2019 Audit

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.

   This issue has not been resolved and will continue to be a finding on the FY20 report; See Minor Non-compliance Issue #1.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 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, seven 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. Six of the charts lacked frequent administration and seven of the ten charts reviewed provided no evidence of the YOQ being used in treatment.

County's Response and Corrective Action Plan:

Action Plan: The following five steps were implemented in the prior year. We will continue to report as outlined:

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 rep01t 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 MR 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 month's % 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 each month with their Program Manager to determine if last month's % 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 previously taken steps, SBHC will take the following additional actions in FY2021 to increase our administration of the OQ/YOQ:

1. The Clinical Director will address Program/Team percentages during his regular meeting with Program Managers; they in turn will do the same with their own staff as they meet collectively and individually.
2. Will time OQ/YOQ to individual staff productivity reporting, so as to generate an additional emphasis on administration of the tool.
3. SBHC will place the effort on the Clinician in office, rather than on the support staff at the reception window. This may also garner greater willingness by the client to participate.
4. Will look this year at how to implement administration of the OQ/YOQ tool among the Center subcontractors. Up until now, we have not required their use of this tool.

Timeline for Completion: This will begin immediately and will be monitored throughout the fiscal year.

Person Responsible for Action Plan: Abel Ortiz, Clinical Director

FY20 Deficiencies:

None

FY20 Recommendations:

None

FY20 Division Comments:

1) *Community Partners*: SBHC has a strong presence throughout the community. They are an active member of coalitions and committees that support the advancement of behavioral health. This has afforded SBHC to be viewed as a collaborative community agency in their catchment area. SBHC is engaged with a number of coalitions and agencies which provide a voice for children, youth, and families including Chrysalis, Cherished Families, the Division of Children and Family Services, local chapters of the National Alliance of Mental Illness (NAMI), local health departments, and Utah Support Advocates Recovery Awareness (USARA). SBHC is also actively engaged in the Alliance project with Intermountain Healthcare to address social determinants of health in their community.

2) *Cultural Responsiveness*: SBHC has created access for youth and families in the Hildale community. SBHC has contracted with local providers who are sensitive to the needs of the families in the plural community to provide behavioral health services. SBHC has been supportive of helping youth and families access appropriate services through contracting for Family Resources Facilitation (FRF). The FRF has been well received in the community and has become a valued link between families and providers.

Adult Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring of charts remotely for Southwest Behavioral Health Center in March of 2020. The monitoring team was unable to do an in person monitoring visit due to the COVID-19 pandemic. The review included the following areas: record reviews, and questions completed by the clinical director. The monitoring team reviewed the Fiscal Year 2019 audit; statistics, including the Mental Health Scorecard; and Area Plans. 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 2019 Audit

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.

   This issue has not been resolved and will continue to be a finding on the 2020 report; see Minor Non-compliance Issue #1.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 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. Seven of the ten charts that were reviewed lacked evidence that the OQ was being administered every 30 days. In nine of ten charts that were reviewed, there was no evidence that the OQ was being used as a clinical tool. 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,

County's Response and Corrective Action Plan:

Action Plan: The following five steps were implemented in the prior year. We will continue to report as outlined:

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 MR 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 month's % 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 each month with their Program Manager to determine if last month's % 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 previously taken steps, SBHC will take the following additional actions in FY2021 to increase our administration of the OQ/YOQ:

5. The Clinical Director will address Program/Team percentages during his regular meeting with Program Managers; they in turn will do the same with their own staff as they meet collectively and individually.
6. Will time OQ/YOQ to individual staff productivity reporting, so as to generate an additional emphasis on administration of the tool.
7. SBHC will place the effort on the Clinician in office, rather than on the support staff at the reception window. This may also garner greater willingness by the client to participate.
8. Will look this year at how to implement administration of the OQ/YOQ tool among the Center subcontractors. Up until now, we have not required their use of this tool.

Timeline for Completion: This will begin immediately and will be monitored throughout the fiscal year.

Person Responsible for Action Plan: Abel Ortiz, Clinical Director

FY20 Deficiencies:

1) *Measurable Objectives:* The recovery plan objectives were not measurable within the charts. Division Directives state, "The current version of the approved Utah Preferred Practice Guidelines shall be the preferred standard for assessments, planning and treatment." The current Utah Preferred Practice Guidelines state, "objectives are measurable, achievable and within a timeframe." Objectives in five of the ten chart reviews were vague and difficult to measure (e.g. the "client wants to be comfortable in their environment and tolerate stress of upcoming wedding.").

County's Response and Corrective Action Plan:

Action Plan: In order to improve our treatment planning SBHC will take the following steps during FY2021:

1. During July a random sample of 15 client files will be reviewed from each program area. An audit will be completed on each of the client files using the peer review evaluation form.

2. The SBHC Clinical Director and Program Managers will review the finding from this internal audit. Based upon these finding the Program Managers will develop an improvement strategy (to include training, implementation and evaluation) for each program area to improve treatment plan development.

3. To monitor these improvement strategies, each month every Program Manager will be provided 10 randomly selected client names that the Program Manager will be review that month. The Clinical Director will select at least two clients from the randomly selected list of 10, to review with each Program Manager in monthly supervision.

4. The Clinical Director will identify Center wide training needs from these monthly supervision meetings to be implemented during the year and Program Managers will identify individual employee training needs to improve each employee's performance.

Timeline for compliance: We will begin immediately and will monitor progress throughout the year.

Person responsible for action plan: Abel Ortiz, Clinical Director

FY20 Recommendations:

1) *Staff Retention:* SBHC has indicated that the agency struggles with staff retention, an issue that is pervasive in the public mental health sector. SBHC, and other local authorities, have not been able to compete with the salary structures in some of the private sector and other community programs. DSAMH recommends that SBHC continue to search for creative ways to retain staff, including sharing ideas and engaging in dialogues with other rural and

frontier local authorities. The ability to retain staff equates to better overall treatment and continuity of services.

FY20 Division Comments:

1) *Evidence Based Practices:* SBHC has been able to provide many treatments to fidelity, these include: Eye Movement Desensitization and Reprocessing (EMDR) is monitored through qualified and trained supervisors. Dialectical Behavioral Therapy (DBT) is measured using DBT fidelity scales and is monitored through DBT consultation groups. Individual Placement and Support (IPS) is reviewed every two years by the DSAMH IPS fidelity team. Wraparound is monitored by a Family Resource Facilitator mentor provided by Allies with Families. SBHC has been able to monitor all of these programs by having experts in the field either internally, or utilizing partners to oversee the programs.

2) *Individual Placement and Support (IPS):* SBHC continues to deliver IPS services to "exemplary" fidelity. The agency has trained multiple other IPS providers in the state, and is a national model for IPS supervision. SBHC has the second highest supported employment numbers in the state, reflecting the commitment to working with clients to build employment recovery capital.

3) *Integration:* SBHC, in partnership with Family Healthcare, has implemented integrated care services using the Cherokee Health Systems model successfully in Washington County as a part of the Utah Promoting Integration of Primary and Behavioral Health Care (UPIPBHC) grant. The two agencies work very well together in order to provide the necessary physical and behavioral health care to the residents of Washington County. The SBHC partnership has the highest number of enrollments in the grant and the early outcomes suggest that the treatment provided is effective.

4) *Cultural Responsiveness:* DSAMH commends SBHC for demonstrated commitment to working with marginalized individuals within their catchment area. The SBHC 2020 Recovery Conference has a focus on increasing understanding and skills related to working with individuals involved in plural communities, Native Americans, and the LGBTQ+ community.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review for Southwest Behavioral Health on March 11th, 2020. 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 2019 Audit

No findings were issued.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:
None

FY20 Significant Non-compliance Issues:
None

FY20 Minor Non-compliance Issues:
None

FY20 Deficiencies:

1) *DSAMH Site Visit Preparation:* SBHC has failed to send the required prevention documents to DSAMH for the Site Visits two years in a row. When asked to provide these documents this year, the Prevention Coordinator included some information and website links for a few documents on the Site Visit Letter itself, but not all of the documents requested. DSAMH requires the following documents are sent to DSAMH a week prior the Site Visit to provide enough time to prepare for the Site Visit:

   - Most recent completed assessment (Reviewed data and report)
   - List of training activities completed by staff and or coalition members. Including attendance/roll of trainings.
   - List of reports that have been shared with stakeholders (meeting dates and report)
   - Full strategic plan for 1) LSAA and 2) any coalitions
   - Monitoring tools for prevention strategies implemented (Block Grant funded)
   - List of all strategies implemented, identify which are evidence based.
   - Most recent annual report and submission date.

- Report the Synar compliance rate.
- Report the Eliminating Alcohol Sales to Youth (EASY) compliance checks completed.
- List of all substance use related coalitions within LSAA. Please include minutes and attendance records for six months.
- DUI youth and adult education class schedule in-house and with contracted providers, number of adults and youth that attended classes over the past year and a proof of purchase of the DUI Workbooks.

County's Response and Corrective Action Plan:

Action Plan: Prevention staff will coordinate the material submission with the Division Prevention staff. Assuming the materials to be submitted are the same as last year, Southwest Prevention will gather the most recent completed assessments from each county and compile it into a digital report. We will gather a list of all training activities completed by staff and coalition members, including attendance and rolls. We will provide a list of reports that have been shared with stakeholders, including meeting dates and a copy of the reports. We will provide the full strategic plans for our LSAA and all of our coalitions, along with monitoring tools for strategies and programs they are implementing. We will request a copy of the most recent SYNAR and EASY compliance reports from the state and include those in our reports. We'll provide a list of all coalitions and a copy of six months worth of their attendance and meeting minutes.

Timeline for Compliance: As the information requested for the site visit will require a lot of work and effort to compile, we request reasonable notice of all that will be required this new year. We need time to gather the information from the individual areas and coalitions. Two months would be preferable. With sufficient notice, we will have it completed two weeks prior to the site visit.

Person Responsible for Action Plan: Logan Reid, Prevention Program Manager

FY20 Recommendations:

1) *Community Gaps:* One of the largest gaps that Southwest's communities face is sustainable prevention services through professional guidance from certified and licensed prevention specialists. Some communities (especially small, frontier towns) have a unique culture and identity that require a specialized insight into the community, constant work to build relationships, and professional and trained employees to continue to train, educate and promote evidence-based strategies. However, SBHC reports that they don't have the funds to sustain a full-time (or in some cases even a part-time) prevention specialist in these communities. As a result, progress comes in waves, as federal grants are used to sustain personnel, and morale is always an issue as employees are never certain of a sustained career. More work is needed to build capacity to sustain continued prevention services in these communities, with professional and sophisticated prevention staff who can instill confidence in key leaders and implement and sustain (with fidelity) evidence-based prevention services.

It is recommended that SBHC continue to work with their Prevention Regional Director to seek methods of building capacity and sustaining prevention services in these communities.

FY20 Division Comments:

1) *Capacity Building and Program Sustainability:* SBHC is continuously working on applying for state and federal grants to expand prevention services in their community. Five of the coalitions have Drug Free Communities Grants and three of the other coalitions are applying for grants. SBHC has also been working with local communities, like Garfield County, where the Commissioners agreed to fund two more Coalition Coordinators for their local area. Iron County received a grant to pay for the initial training for facilitators for the Parenting Program and bought enough materials to run this program beyond five years. There is also always funding available for EASY Compliance Checks with Law Enforcement. All of the coalitions have a sustainability plan that includes methods of sustaining programs beyond the implementation period.

2) *Evidence-Based Programs and Practice:* Through the planning process, SBHC has implemented the following evidence based programs and practices: (1) Community Coalitions (Target Population: Youth & Adults - 5 County Area) (2) Parenting Wisely (Target Population: Parents identified by 5th District Court and DCFS - 5 County Area) (3) Guiding Good Choices (Target Population: Parents in Hildale and Panguitch and Bryce Valley) (4) Personal Empowerment Program (Target Population: Indicated Intermediate and Middle School Youth - Washington, Iron and Beaver Counties) (5) Hope Squad (High School Youth - 5 County Area) (6) Hope For Tomorrow (High School Youth - 5 County Area).

3) *Fidelity Measures and Evaluation:* All programs implemented by SBHC include evaluation, which include the following:

   - Coalitions: All coalitions are required to administer a yearly coalition survey to all members, and the results are analyzed and presented back to the coalition by the executive committee or the data subcommittee. Currently, three coalitions with federal funding are using those funds to hire a professional analyst. Currently, Bach-Harrison does the evaluation for these three coalitions.

   - Personal Empowerment Program: Pre and Post Tests, and Satisfaction Surveys are provided to all participants of the program. This survey was created and updated this year, with help from Bach-Harrison, who does the analysis of the data for SBHC. In addition, surveys are provided to teachers, counselors and principals at each school where pre and post tests are administered.

- Hope Squad & Hope For Tomorrow: All students are provided with a pre and post test. In addition, Hope Squad Members are given pre and post tests for individual training they complete to assess change in knowledge.

- Kid Power: All students are provided with a pre and post test, and all teachers are provided with a survey to assess changes they see in the classroom and provide feedback on the program.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Southwest Behavioral Health on March 17th, 2020. 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 2019 Audit

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).

   This issue has been improved, but will be continued in FY20 as a recommendation; see Recommendation #1.

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

1) The Treatment Outcomes Scorecard shows that tobacco use moved from 0.3% to -2.2% from the FY18 to FY19 respectively, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan: In an effort to address the tobacco use among our clients we have implemented the following changes and additions to our program-

- SBHC paid for an employee to become a certified Dimensions smoke cessation program facilitator-instructor
- Currently we have 6 trained Dimensions facilitators on staff
- Clients are no longer allowed to use tobacco or electronic cigarettes/vape on breaks during treatment
- We have implemented a plan aimed at more accurately capturing smoking/tobacco use at the time of intake

Timeline for Compliance: We will continue on with the work that has already begun in FY20 and will monitor our progress throughout this new fiscal year.

Person Responsible for Action Plan: Rylee Munns, SUD Adult Program Manager

FY20 Deficiencies:

None

FY20 Recommendations:

1) Clinical Charts: SBHC has made good progress on their clinical charts, but still have some areas of improvement, including the following:

   - Recovery Plan Objectives: Some objectives in the clinical charts were measurable and time limited, while others were not. Objectives should be specific, measurable, achievable and time limited.

   - ASAM Goals: ASAM Goals should be included in the Recovery Plan and Review. This should include: (1) identifying the ASAM Dimension that is the issue, (2) identifying the condition or issue that creates a high use / relapse potential (3) and writing the objectives that move the individual towards resolving these issues or conditions *(Chart #'s 130859, 17945, 128438, 1727, 122213, 14360, 35545, 133631, 21463).*

2) *Staff Shortages and Turnover*: SBHC reported that they have experienced staff shortage and turnover over the past year. They also stated that recent attention and funding of behavioral health has created increased demand for behavioral health providers, resulting in shortages and high levels of competition for the limited resources. As a result, SBHC reports that they have dealt with considerable vacancy and increased turnover with staff leaving for higher paying jobs. It is recommended that SBHC continue to seek methods of recruiting and retaining staff.

FY20 Division Comments:

1) *Dedicated and Effective Treatment Team*: SBHC has a Treatment Team dedicated to providing quality services. Their team is comprehensive in scope, which includes specialized teams such as: Case Management / Family Resources Facilitators, Women and Children's Residential (Desert Haven), Mobile Crisis Outreach Team (MCOT) / Stabilization and Mobile Response (SMR), Supported Living (Mount View House, Dixie View and Duplexes), Three Drug Court Teams, Mental Health Court Team, Peer Support in all programs and Supported Employment. The SBHC Clinical Leaders meet weekly to coordinate closely on client services to problem solve and focus on strategies to provide effective services.

2) *Training:* SBHC places an emphasis on the training staff in evidence-based practices, which includes incentives for ongoing participation in Consultation/Supervision. SBHC has focused on the following evidence-based practices over the past year: Clubhouse Model, Eye Movement Desensitization and Reprocessing (EMDR), Seeking Safety, Moral Reconation Therapy (MRT), Medication Assisted Treatment (MAT), School-based mental health and Feedback Informed Treatment. SBHC also evaluates their programs on a regular basis to ensure that the evidence-based strategy is effective and makes changes as needed.

3) *Community Partnerships:* SBHC is invested in their community and has initiated several partnerships in community-based activities, such as the Intermountain Alliance for the Social Determinants of Health, Recovery Day, support of the Hilldale community, community-wide Mental Health First-Aid training, Designated Examiner Training, and participation in the Fall Conference Committee. They have also contracted with a robust panel of service providers (the largest in Utah outside of Salt Lake County), including inpatient programs, SUD residential programs, Intensive Outpatient (IOP) programs, private outpatient therapists, prescribers and trainers.

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 (Jul 9, 2020 16:18 MDT) Date 07/09/2020
Auditor IV

Approved by:

Kyle Larson Kyle Larson (Jul 10, 2020 07:58 MDT) Date 07/10/2020
Administrative Services Director

Eric Tadehara Eric Tadehara (Jul 10, 2020 08:12 MDT) Date 07/10/2020
Assistant Director Children's Behavioral Health

Kimberly Myers Kim Myers (Jul 10, 2020 09:16 MDT) Date 07/10/2020
Assistant Director Mental Health

Brent Kelsey Brent Kelsey (Jul 10, 2020 13:47 MDT) Date 07/10/2020
Assistant Director Substance Abuse

Doug Thomas Doug Thomas (Jul 10, 2020 17:39 MDT) Date 07/10/2020
Division Director

Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool

Name of Agency: **Southwest Behavioral Health Center**

Date: **April 2, 2020**

Compliance Ratings

Y = Yes, the Contractor is in compliance with the requirements.
P = Partial, the Contractor is in partial compliance with requirements; comments provided as suggestion to bring into compliance.
N = No, the Contractor is not in compliance with the requirements.

Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)		X		Need signature on plan
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)		X		No date for when review/revision is scheduled; include statement that indicates when plan will be reviewed (i.e., to be reviewed annually)
Record of changes (indicating when changes have been made and to which components of the plan)			X	Need place to identify changes to the plan, made by whom, and date of change
Record of distribution (individual internal and external recipients identified by organization and title)	X			
Table of contents			X	Need table of contents
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan		X		Need to identify schedule for updating plan.
Functional Annex: The Continuity of Operations (COOP) Plan				
Essential functions and essential staff positions	X			
Continuity of leadership and orders of succession	X			
Leadership for incident response	X			

Alternative facilities (including the address of and directions/mileage to each)	X			
Planning Step				
Disaster planning team has been selected, to include all departments (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)			X	Need to identify who is on the planning team and representing which department(s)
The planning team has identified requirements for disaster planning for Residential/Housing services including: ● Engineering maintenance ● Housekeeping services ● Food services ● Pharmacy services ● Transportation services ● Medical records	X			
The team has coordinated with others in the State and community.	X			