Date: 12/16/21

Commissioner Larry Jensen
Carbon County Commission
751 E 100 N
Price, Utah 84501

Dear Commissioner Jensen:

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

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Kelly Ovard (385)310-5118.

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

Sincerely,

Brent Kelsey
Interim Division Director

Enclosure

cc:  Commissioner Kent Wilson, Emery County Commission
     Gabriel Woytek, Grand County Council
     Melissa Huntington, Director of Four Corners Community Behavioral Health
Site Monitoring Report of

Carbon County and
Four Corners Community Behavioral Health

Local Authority Contract #A03807

Review Date: November 2, 2021

Draft Report
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Utah Department of Human Services, Division of Substance Abuse and Mental Health  
Carbon County - Four Corners Community Behavioral Health  
FY22 Monitoring Report
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 Carbon County and its contracted service provider, Four Corners Community Behavioral Health (also referred to in this report as FCCBH or the Center) on November 2, 2021. 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

<table>
<thead>
<tr>
<th>Programs Reviewed</th>
<th>Level of Non-Compliance Issues</th>
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Utah Department of Human Services, Division of Substance Abuse and Mental Health
Carbon County - Four Corners Community Behavioral Health
FY22 Monitoring Report
Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of the Local Authority, Carbon County, and its contracted service provider, Four Corners Community Behavioral Health (FCCBH). The Governance and Fiscal Oversight section of the review was conducted on November 2, 2021 by Kelly Ovard Administrative Services Auditor IV.

Carbon County conducted its annual monitoring of FCCBH and provided a copy of their completed monitoring tool. The County also provided a copy of their written procurement policy.

A site visit and review was conducted remotely with FCCBH as the contracted service provider for Carbon, Emery and Grand 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, the most recent version of the Medicaid Cost Report was reviewed. 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. FCCBH provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report.

The Local Authority, Carbon County received a single audit as required. The CPA firm Squire & Company, PC completed the audit for the year ending December 31, 2020. The auditors issued an unmodified opinion in their report dated September 3, 2021 and stated that the financial statements present fairly, in all material respects, the respective financial position of the governmental activities, the business-type activities, the aggregate discretely presented component units, each major fund, and the aggregate remaining fund information of Carbon County.

Four Corners Community Behavioral Health received a single audit, completed by CPA firm Wiggins & Co. P.C. for the year ending June 30, 2020. The report was completed on September 27, 2021 with no findings for the year.
Follow-up from Fiscal Year 2021 Audit:

None

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None

FY22 Recommendations:
1) There was one employee whose I9 was signed by the organization 9 days after the reported start date. Federal regulations give the organization no more than 3 working days to have this completed.
2) The financial audits for the years ending June 30, 2020 and June 30, 2021 were not yet been uploaded to the Federal Audit Clearinghouse at the time of the audit. Jeannie Willson noted that the outside agency that does this for FCCBH has been notified and is working on this issue. As of November 29, 2021 the audit for June 30, 2020 was uploaded, but the audit for the year ended June 30, 2021 has not yet been uploaded.

FY22 Division Comments:
1) A great deal of thanks go out to Melissa Huntington, Jeanie Willson, Chad Carter and Kara Cunningham for their help in putting the data together.
2) There was a note in the financial report regarding the absence of monitoring of 2 subrecipients for a total of $103,203. This was for Northeastern and San Juan counseling centers. Please note that FCCBH is welcome to use the posted audits on the DSAMH website for these providers as their monitoring tool.
3) The emergency plan was reviewed by Nichole Cunha and Geri Jardine. There were no issues and they commended FCCBH on the quality of their emergency plan.
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.
Combined Mental Health Programs

The Division of Substance Abuse and Mental Health (DSAMH) Mental Health Team conducted its annual monitoring review at Four Corners Community Behavioral Health (FCCBH) on October 2 and 3, 2021. Due to the current DSAMH policy, the annual monitoring review was held virtually. Duplicate findings for Child, Youth and Family and Adult Mental Health have been combined below to provide clarity and avoid redundancy.

FY22 Deficiencies:

1) Administration and Use of the Outcome Questionnaire/Youth Outcome Questionnaire (OQ/YOQ): Of the ten adult mental health charts reviewed, seven charts had no or infrequent administration or clinical use of the OQ. One of the remaining charts did include regular administration of the OQ, but clinical use was limited to the comment “no critical items to discuss.” Of the ten youth charts reviewed, five did not have evidence of YOQ as an intervention, even when there was evidence of administration. DSAMH would like to note that there was increased evidence of YOQ being administered from the prior year, with only three charts not having evidence of administration.

The Division Directives state “...the OQ/YOQ be given to patients and consumers...at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation”. In addition, “data from the Outcome Questionnaire (OQ) or Youth Outcome Questionnaire (YOQ) shall be shared with the client and incorporated into the clinical process, as evidenced in the chart (excluding children aged five and under).”

County’s Response and Corrective Action Plan:

<table>
<thead>
<tr>
<th>Action Plan:</th>
<th>Four Corners will continue to train staff on how often the OQ has to be completed and how to document the OQ in a meaningful way. We will train on how to use the OQ in a meaningful way during the session as well. Four Corners will have the QAPI team make sure when they are reviewing charts they are specifically looking for OQ scores and meaningful documentation in the charts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeline for compliance:</td>
<td>Training will occur in every clinic before May 2022 and QI will meet monthly and will continue to review charts monthly. They will report to each director. We will train monthly if we see this is still an issue in our charts.</td>
</tr>
<tr>
<td>Person responsible for action plan:</td>
<td>Kara Cunningham Clinical Director</td>
</tr>
<tr>
<td>Tracked at DSAMH by:</td>
<td>Mindy Leonard</td>
</tr>
</tbody>
</table>
FY22 Recommendations:

1) **Consistent Documentation:** Medicaid guidelines require that treatment goals are measurable and related to the problems identified in the psychiatric diagnostic evaluation, and that progress notes document the patient’s progress toward the treatment goal. Seven of ten adult mental health charts reviewed included objectives that were not measurable (e.g. “will pace herself”, “will learn skills”), or included progress notes that did not include information on the client’s response to treatment or progress toward goals. Five of the ten children/youth charts reviewed did not have SMART objectives that link back to the clinical assessment. FCCBH is encouraged to review documentation to ensure that appropriate and accurate assessments, treatment plans and progress notes are present to support cohesive client care and outcomes.

FY22 Comments:

1) **Cultural Responsiveness:** During the recent DSAMH needs assessment, the FCCBH leadership focus group provided responses that were most in line with the ideals of the Developmental Disability workgroup. In addition, FCCBH had the highest percentage of providers indicating that people with disabilities should be treated in a way similar to their same-age peers. DSAMH commends FCCBH for ongoing work to create goals to increase cultural responsiveness.
Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Four Corners Community Behavioral Health (FCCBH) on November 2, 2021. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Leah Colburn, Program Administrator; Mindy Leonard, Program Manager, Tracy Johnson, Wraparound and Family Peer Support Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, and record reviews. During the discussion the team reviewed the FY20 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Resource Facilitation (Peer Support), and 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 2021 Audit

FY21 Deficiencies:

1) Youth Outcome Questionnaire Administration: Of the ten charts reviewed, five charts had no evidence of YOQ being administered. One chart reviewed did not use the YOQ as an intervention, however they only had an assessment and no ongoing services. And one chart indicated that the YOQ was not administered due to using telehealth. The Division Directives state “the Youth Outcome Questionnaire (OQ/YOQ) be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt).”

The lack of administration of the YOQ in telehealth sessions is a concern due to lack of measurable outcomes. This reviewer did not review many telehealth charts in the random chart pull, however, in discussion it was indicated that this may be an overall concern within the agency and LMHA system. It is recommended that FCCBH work in conjunction with other clinical directors and DSAMH to develop a process for administering and documenting the use of the YOQ in telehealth provided services.

This issue has not been resolved and will be continued for FY21; see Combined Mental Health Program Deficiencies #1 above.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None
FY22 Minor Non-compliance Issues:
  None

FY22 Deficiencies:
  See Combined Mental Health Deficiencies above

FY22 Recommendations:
  1) Family Peer Support Services (FPSS): FCCBH continues to ensure that youth and families have access to this vital and impactful service in their catchment. FCCBH is encouraged to continue to offer this service to youth and families, earlier in their treatment process, who could benefit from peer based services. It is recommended to review this service provision as the chart review documentation indicated that services were provided to the youth not the parent/caregiver. Per Medicaid, “With the exception of older adolescents (age 16-18) peer support services are provided to their parents/legal guardians and the services are directed exclusively to the treatment of the Medicaid-eligible child (i.e., toward assisting the parents/legal guardians in achieving the rehabilitative treatment goals of their child.” DSAMH is available for technical assistance if needed.

  2) Psychosocial Rehabilitation Services (PRS): Per the FY21 Scorecard, FCCBH provided this service at a rate of 0.3% (1 client) while the rural average is 5.6%. PRS has had a steady decline in services offered since FY19. This trend should be reviewed by FCCBH, to explore options to increase this service provision. DSAMH recognizes that staffing shortages or programming changes have impacted the ability to provide this, however FCCBH should review the provision of this service as it is one of the ten mandated services as required by Utah Code 17-43-301. PRS can be utilized to support clinical services and symptom reduction for youth. DSAMH can provide technical assistance if requested.

FY22 Division Comments:
  1) Access to Care: Similarly to other LMHA statewide, FCCBH has seen a decrease in youth served per the FY21 scorecard. The team at FCCBH has identified factors related to this decrease in their community due to increased access through other state and community partners. They are working to expand referral pathways from other non-traditional partners in the community, which include early childhood and medical providers, while increasing training for their clinical teams to better support all referral sources. FCCBH is encouraged to continue to build relationships with community partners and to highlight their continuum of clinical care and the agency's value in providing early intervention mental health services.
Adult Mental Health

The Division of Substance Abuse and Mental Health Adult Mental Health team conducted its annual monitoring review at Four Corners Community Behavioral Health (FCCBH) on October 2 and 3, 2021. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Pam Bennett, Program Administrator; Leah Colburn, Program Administrator; Mindy Leonard, Program Manager; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, and program visits. During the discussion the team reviewed the FY21 audit statistics, including the Mental Health Scorecard, Area Plans, Outcome Questionnaires, 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 2021 Audit

FY21 Deficiencies:

1) Administration and Use of the Outcome Questionnaire (OQ): Of the ten charts reviewed, six charts had no or infrequent administration and uses as intervention of evidence of OQ being administered. Of these charts reviewed, it is to be noted that: one did not use the OQ as an intervention as the client only received medication services, one client did not continue services beyond the assessment, and two charts indicated that the OQ was not administered due to using telehealth. The Division Directives state “Questionnaires (OQ/YOQ) be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation”.

This issue has not been resolved and will be continued for FY21; see Combined Mental Health Program Deficiencies #1 above.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:

None

FY22 Significant Non-compliance Issues:

None

FY22 Minor Non-compliance Issues:

None

FY22 Deficiencies:

See Combined Mental Health Deficiencies above.
FY22 Recommendations:

1) **Substance Abuse Mental Health Information System (SAMHIS) OQ Participation Rate**: The percentage of unduplicated clients that participate in the OQ is required to be at least 50%. The FY21 Adult Mental Health scorecard indicates that FCCBH met the required participation rate for all clients (63.7%), but fell below the required rate for adults with serious mental illness (47.9%). FCCBH is encouraged to review OQ administration and data entry for clients with serious mental illness (SMI), to ensure that data requirements are met for the SMI subset.

2) **Nicotine Cessation**: Four of ten charts reviewed indicated that clients endorsed the use of nicotine. None of those charts included documentation that nicotine cessation had been offered. In addition, the activity list for the Clubhouse-like day program includes a regularly scheduled trip for participants to purchase nicotine. This is in contrast to a participant from the program who reported that she is attempting to quit, received assistance from the staff, and has regular support from those around her. DSAMH recommends that FCCBH review practices around nicotine cessation to ensure that clients receive consistent messaging and support regarding the importance of ending nicotine use.

FY22 Division Comments:

1) **Mobile Crisis Outreach Team (MCOT)**: The FCCBH MCOT teams have been in operation through FY21, expanding from partial teams with limited hours to full teams responding 24 hours a day, 7 days a week across all counties. The MCOT teams work closely with community partners, with 48 of 193 mobile responses in FY21 referred to the teams by law enforcement.

2) **Integrated Services**: FCCBH demonstrates an ongoing commitment to providing integrated care to the clients served. Examples include the addition of co-located laboratory services for client convenience, New Heights members describing health-related goals and attendance at wellness groups, and the planned addition of an electronic health record field that details acceptable PRN crisis medications to avoid medication interactions.

2) **Participant Feedback**: Pam Bennett, Program Administrator and Heather Rydalch, Peer Support Program Manager, met with several members of the New Heights program. Participants described the efforts made by staff to ensure that they were engaged and taken care of during the pandemic. This included bringing meals, providing newsletters, doing outreach multiple times a week, providing transportation to appointments, and having an outdoor activity when the social restrictions allowed for it. In addition, there are a wide range of activities regularly scheduled. Individuals create their own goals with support from staff. They report that staff are “awesome”, “we have really good staff here, they have to stay here for eternity”. The members also reported that “the staff provide transportation and make sure we get to our appointments on time”.

Utah Department of Human Services, Division of Substance Abuse and Mental Health
Carbon County - Four Corners Community Behavioral Health
FY22 Monitoring Report
3) *Peer Support Services (PSS):* Heather Rydalch, Peer Support Program Manager met with one FPSS and two supervisors. FCCBH values CPSS (Certified Peer Support Specialist) and the value of the work they do is echoed by the New Heights members they work with. PSS has been identified for both youth/families and adults at FCCBH as such a beneficial supportive service, and the impact is far reaching. It was noted that PSS services have likely “helped reduce hospitalization for [Clubhouse] members”.
Substance Use Disorder Prevention

Becky King, Program Administrator, conducted the annual prevention review of Four Corners Community Behavioral Health on November 2, 2021. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from Fiscal Year 2021 Audit

FY21 Deficiencies:

1) FCCBH did not complete EASY Compliance checks, which does not meet Division Directives. Local Authorities are required to conduct one more EASY check each year.

FCCBH completed two EASY Compliance checks in FY21, which is an increase from last year where they didn’t complete any EASY checks. This meets Division Directives.

This issue has been resolved.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None

FY22 Recommendations:

1) Education and Training: FCCBH reports that they weren’t aware that they could invite non-prevention professionals to the Prevention Conference, which they are planning to do next year. It is recommended that FCCBH encourage non-prevention professionals like coalition members and other individuals in the community to attend the Prevention Conference and other educational events as needed.
2) **Coalition Support:** The area is vast between Castledale to Moab, so FCCBH is planning to hire a coalition coordinator to manage the new coalition in Grand County. They are also considering DSAMH’s suggestion to incorporate a Prevention Ambassador to help support their coalitions. It is recommended that FCCBH continue to move forward in hiring a coalition coordinator for Grand County and work with DSAMH on incorporating a Prevention Ambassador.

**FY22 Division Comments:**

1) **Grand County Coalition:** Community members in Grand County rallied together to propose a new coalition to FCCBH that will be focusing on prevention, treatment and recovery support, which has never been done before. FCCBH has been supportive of this new coalition and is looking into ways to make this type of coalition work. Grand County established three workgroups - Treatment, Prevention and Recovery who are working on separate action plans. They already have a good foundation for this coalition and a considerable amount of manpower to make it a sustainable coalition. The coalition as a whole meets every other month and reports out to their workgroups.

2) **Risk and Protective Factors:** FCCBH’s prevention programs and coalitions address specific risk and protective factors highlighted in their counties’ Student Health and Risk Prevention (SHARP) report. For example, their community is concerned about students’ commitment to school after reviewing the SHARP survey, so they incorporated the “WhyTry Program,” which is aimed to address the risk factor of “low commitment to school.” Another example, the PACT coalition (formerly known as CHEER coalition) addresses low neighborhoods attached by helping teens in the community participate in community events like parades, coalition meetings, and clean up in the community.

3) **Community Partnerships:** The Care Coalition has hosted the “Eat a Dinner As a Family Event,” which is held in September. In the past, the Care Coalition set up a pick up location at the school with Little Caesars. Due to COVID-19 last year, the Care Coalition provided gift cards to Little Caesars to kids in school. This event focuses on how important it is to eat dinner with the family. The Care Coalition is planning to continue hosting this event around September and providing kids and their families with gift cards. This is one of the largest events in Carbon County and a good example of how FCCBH is proactive in developing partnerships to provide effective prevention services for their community.
Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the monitoring review of Four Corners Community Behavioral Health on November 2, 2021. The review focused on compliance with State and Federal laws, Division Directives, Federal Substance Abuse Treatment (SAPT) Block Grant requirements, Justice Reinvestment Initiative (JRI), Bureau of Justice Administration (BJA) Drug Court requirements, scorecard performance, and consumer satisfaction. The review included a document review, clinical chart review, and an interview with the Clinical Director and other staff members. Consumer satisfaction and performance were also evaluated using the Division Outcomes Scorecard, the Consumer Satisfaction Survey, and other data measures.

Follow-up from Fiscal Year 2021

FY21 Minor Non-compliance Issues:

1) FCCBH had 7.9% of old charts that were open that should be closed. This does not meet Division Directives, which requires that less than 4% of old charts can remain open at any given time.

FCCBH had 8.4% of old charts in FY21 that were open that should be closed. This does not meet Division Directives, which requires that less than 4% of old charts can remain open at any given time.

This issue has not been resolved, which will be addressed in Deficiency #1 below.

2) The Consumer Satisfaction Survey Results showed:
   a) General satisfaction for youth surveys declined from 83% to 61% from FY19 to FY20 respectively, which does not meet Division Directives.

   The general satisfaction survey for youth increased from 61% to 73% from the FY20 to FY21 respectively, which meets Division Directives.

   b) FCCBH collected 7% of Youth Family Satisfaction surveys, which does not meet Division Directives.

   FCCBH collected 22.7% of Youth Family Satisfaction surveys in FY21, which meets Division Directives.

These issues have been resolved.
FY21 Deficiencies:

1) Criminogenic risk data was not collected for 26.4% of call clients involved in the criminal justice system, which does not meet Division Directives.

Criminogenic risk data was not collected for 30.3% of all clients involved in the criminal justice system, which does not meet Division Directives.

*This issue has not been resolved, which will be addressed in Deficiency #2 below.*

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:

1) FCCBH had 8.4% of old charts that were open that should be closed. This does not meet Division Directives, which requires that less than 4% of old charts can remain open at any given time.

County’s Response and Corrective Action Plan:

**Action Plan:** FCCBH will put into place having the therapist or a case manager go through the case loads every 30 days to make sure we are staying on top of all of the charts. We will make sure anyone who is not following through with treatment is outreached and closed if there has been no follow through.

**Timeline for compliance:** We will start doing this now and will do this every 30 days with each case load.

**Person responsible for action plan:** Kara Cunningham

**Tracked at DSAMH by:** Becky King

2) Treatment data for 30.3% clients involved in the criminal justice system did not include required criminogenic risk information. This does not meet Division Directives.
**County’s Response and Corrective Action Plan:**

**Action Plan:** FCCBH will be checking charts monthly in the QAPI meetings to make sure we are in compliance with this. We have held a meeting with AP & P and set up an agreement to where they are going to share their LS-RNR documents with us. For anyone not in AP & P we will make sure and place a LS-RNR with all intake packets and make sure those are completed with each assessment. Once those are complete the secretaries will input into the EHR the risk level from the LS-RNR.

**Timeline for compliance:** This is taking place now and will continue to take place.

**Person responsible for action plan:** Kara Cunningham

**Tracked at DSAMH by:** Becky King

**FY22 Recommendations:**

1) *Recovery Support:* Participation in social recovery support from admission to discharge went down from 13.1% in the FY20 to 11.1% in the FY21, which does not meet Division Directives. FCCBH reported that when the COVID Pandemic started, several social recovery support groups stopped running in their community. There are limited recovery support services in the community to begin with, so when the COVID pandemic started, the groups diminished to no groups being held at all. Several of the recovery support groups haven’t returned either. It is recommended that FCCBH consider partnering with the Utah Support Advocates for Recovery Awareness to set up recovery support services in their local area.

2) *Tobacco / Nicotine Cessation:* Tobacco / Nicotine use from admission to discharge moved from 0.3% in the FY20 to -1.2% in the FY21, which does not meet Division Directives. FCCBH reported that they have made efforts to increase the diagnosis of tobacco use over the past several years. Peer audits and the internal quality assurance monitoring (QAPI) was conducted to ensure that tobacco / nicotine was being diagnosed and medication assisted treatment and resources like the Quitline are provided to clients as needed. It is recommended the FCCBH continue to identify tobacco / nicotine use at the time of assessment, and provide MAT / tobacco resources as needed for clients.

3) *Community Program Checklist (CPC):* The CPC Checklist Evaluation scores for FCCBH were lowest for Treatment Characteristics (17.1%) and Quality Assurance (12.5%). FCCBH stated that they don’t have a lot of specific treatment for justice involved clients, which is partially due to not having enough staff or clients to support these types of groups. They also reported that they are not able to provide groups for those who are incarcerated. Since there isn’t a consistent enough population for the jail, this makes it difficult to have consistent programming. FCCBH is already doing more groups than they can handle early and late in the evening. FCCBH would like to
receive recommendations from DSAMH regarding curriculum for justice-involved clients for rural areas. It is recommended that FCCBH follow through in working with DSAMH on finding curriculum for justice-involved clients in rural areas and ideas for quality assurance to continue improving services.

FY22 Comments:

1) Operation Recovery: Operation Recovery currently has 133 clients in the program where there is an ongoing demand for their services. FCCBH has three vans that transport clients for services with Operation Recovery from all three counties. Operation Recovery expanded their building to accommodate the increased amount of clients coming in for services, which has been helpful. FCCBH reports Operation Recovery has been a successful program, where they receive support from the community for ongoing referrals.

2) Staff Recruitment and Retention: FCCBH has been working on recruiting staff by providing various incentives for working for their program. They have also been working on building staff retention through promoting staff morale to help eliminate burnout. Since it is a competitive market, FCCBH has been working on selling the idea that working for their program is a fun, quality place to work. For example, the FCCBH Leadership Team recently went on a retreat to focus on team building and staff morale. FCCBH continues to use the Trauma-Informed Approach in working with their clients and supporting their staff. They recently had Brian Miller train staff on Trauma-Informed Supervision, which they have incorporated in their program as well.

3) Program Expansion in Grand County: FCCBH reported that the building in Moab is halfway built. They have the infrastructure and walls in place and are on track to have the building finished in April 2022. FCCBH is renting this new building until staff are able to move in. They will have outpatient and clinic services in the new building and are considering including a drug testing lab in the clinic. FCCBH will be working on incorporating as much integrated care as possible in this new building.
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.
We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Four Corners Community Behavioral Health and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Kelly Ovard @ 385-310-5118.

The Division of Substance Abuse and Mental Health

Prepared by:

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Kimberly Meyers
Assistant Director Mental Health

Brent Kelsey
Assistant Director Substance Abuse
Interim Division Director
# Emergency Plan Monitoring Tool FY22

**Name of Local Authority:** Four Corners Community Behavioral Health  
**Date:** November 2, 2021  
**Reviewed by:** Nichole Cunha, LCSW  
Geri Jardine

## 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 a suggestion to bring into compliance.  
N = No, the Contractor is not in compliance with the requirements.

<table>
<thead>
<tr>
<th>Monitoring Activity</th>
<th>Compliance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>Y</td>
<td>P</td>
</tr>
<tr>
<td>Cover page (title, date, and facility covered by the plan)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Confirmation of the plan’s official status (i.e., signature page, date approved)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Method of distribution to appropriate parties (i.e. employees, members of the board, etc.)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Table of contents</td>
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## Basic Plan

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<tr>
<th>Monitoring Activity</th>
<th>Compliance</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Statement of purpose and objectives</td>
<td>X</td>
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</tr>
<tr>
<td>Summary information</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Planning assumptions</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Conditions under which the plan will be activated</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Procedures for activating the plan</td>
<td>X</td>
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</tr>
<tr>
<td>Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan</td>
<td>X</td>
<td></td>
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</tbody>
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<thead>
<tr>
<th>Monitoring Activity</th>
<th>Compliance</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>List of essential functions and essential staff positions</td>
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<td></td>
</tr>
<tr>
<td>Identify continuity of leadership and orders of succession</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Identify leadership for incident response</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>List alternative facilities (including the address of and directions/mileage to each)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Communication procedures with staff, clients’ families, the State and community</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Procedures that ensure the timely discharge of financial obligations, including payroll.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Planning Step**

Disaster planning team has been selected, to include all areas (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.)

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 (recovery and maintenance)
- Evacuation procedures
- Isolation/Quarantine procedures
- Maintenance of required staffing ratios
- Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic

DSAMH is happy to provide technical assistance.
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