Date: January 27, 2022

Commissioner Lorene Miner Kamalu  
Davis County Commission  
PO Box 618  
Farmington, UT 84025

Dear Commissioner Kamalu:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of Local Authority, Davis County and Davis Behavioral Health, its contracted service provider; 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 at 385-310-5118.

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

Sincerely,

Brent Kelsey  
Assistant Director Substance Abuse  
Interim Division Director

Enclosure

cc: Commissioner Bob Stevenson, Davis County Commission  
Commissioner Randy Elliott, Davis County Commission  
Brandon Hatch, Director of Davis Behavioral Health
Site Monitoring Report of

Davis Behavioral Health

Local Authority Contract #A03091

Review Date: December 7, 2021

Final Report
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Section One: Site Monitoring Report
Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Davis County and their contracted service provider, Davis Behavioral Health (also referred to in this report as DBH or the Center) on December 7, 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.

The Center is required to respond in writing within 15 business days of this draft report with a plan of action addressing each non-compliance issue and the Center employee responsible to ensure its completion.
## Summary of Findings

<table>
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<th>Programs Reviewed</th>
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<th>Number of Findings</th>
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<td></td>
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</table>
Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of the Local Authority, Davis County, and its contracted service provider, Davis Behavioral Health (DBH). The Governance and Fiscal Oversight section of the review was conducted on December 7, 2021 by Kelly Ovard, Financial Services Auditor IV.

A site visit and review was conducted remotely, due to current DSAMH policy, with DBH as the contracted service provider for Davis County. Davis County also provided documentation for their annual review of DBH. 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, DBH 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.

The Local Authority, Davis County received a single audit as required. The CPA firm Carver Florek & James, completed the audit for the year ending December 31, 2020. The auditors issued an unmodified opinion in their report dated June 23, 2021. The SAPT Block Grant was not selected for specific testing as a major program. **There was a significant deficiency in the county audit which will be addressed in the findings.**

Davis Behavioral Health, the contracted service provider for Davis County, also received a single audit. The CPA firm Litz & Company completed the audit for the year ending June 30, 2021. The auditors issued an unmodified opinion in their report dated October 27, 2021. The SAPT Block Grant and Substance Abuse and Mental Health grants were tested as major programs.
Follow-up from Fiscal Year 2021 Audit:
No findings were issued for FY21.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:

1) Section III - Federal Awards Findings: County Year Ending 12/31/20 audit.
   a) Criteria: Schedule of Federal Awards Preparation: The County should have proper controls in place over the preparation of the Schedule of Federal Awards (SEFA) to ensure accurate reporting of Federal awards.
   b) Condition: Auditors found that the SEFA prepared by the county reported amounts used by the County’s Health Department as expenditures passed through to subrecipients. Furthermore we found a few instances where amounts reported on the SEFA did not agree to the underlying accounting records of the county.
   c) Cause: The County’s procedure for evaluating federal expenditures improperly recorded amounts utilized by the County Health Department as passed through to subrecipients. Furthermore, the County’s procedure for preparing the SEFA did not detect the few instances where amounts did not agree with the underlying accounting records of the County.
   d) Effect: The preliminary SEFA overstated amounts passed through to subrecipients and overstated total SEFA expenditures.

County’s Response and Corrective Action Plan:

<table>
<thead>
<tr>
<th>Action Plan:</th>
<th>Davis County recognizes the need to accurately report federal funds received by county departments, including those passed through to subrecipients. To better accomplish this, a project accounting financial system was implemented in 2019 to capture this information at the time of data entry. Internal processes are routinely reviewed and updated, and training is provided by the Clerk/Auditor’s office to departments engaging in grant activity. Improvements to the annual SEFA report preparation process are currently being implemented, and include a more stringent supervisory review of report data and calculations as well as a final review by the Clerk/Auditor or Chief Deputy in advance of audit submission. Report preparation for 2021 will begin approximately four weeks ahead of previous year end schedules to allow time for additional review and correction, if necessary. In addition, key staff responsible for report preparation attended online SEFA training through the Government Finance Officers Association (GFOA) on July 20, 2021 as well as in-person training hosted by the Utah State Auditor’s Office on December 22, 2021. Both trainings identified areas where processes may be improved, including report formatting and program administration.</th>
</tr>
</thead>
</table>

Utah Department of Human Services, Division of Substance Abuse and Mental Health
Davis County/ Davis Behavioral Health
FY2022 Monitoring Report
Timeline for compliance: New process will be implemented during the 2021 SEFA preparation (January-March 2022).

Person responsible for action plan: Curtis Koch, County Auditor

Tracked at DSAMH by: Kelly Ovard

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Section IV - Utah State Compliance Findings: County Year Ending 12/31/20 audit.

a) Criteria: Deficit Fund Balance: In accordance with Utah State statute, for any fund that has a deficit unassigned/unrestricted fund balance in the year under audit, the subsequent budget year, the County must have appropriations to retire the deficit of an amount equal to or greater than 5% of the funds total actual revenue of the year under audit.

b) Condition: We found that the CDBG/SSBG fund balance at the end of the year had a deficit balance, which exceeded 5 percent of the total actual revenues. The County did not make any budget appropriations, nor did they make any ensuing budget amendments in the subsequent budget year to retire the deficit amount.

c) Cause: The County did not foresee a budget deficit in the fund upon submission of the approved budget to the State. Furthermore, the County did not monitor the deficit in the fund balance at year-end and amend the subsequent year budget in a timely manner.

d) Effect: A violation of Utah State statute.

County’s Response and Corrective Action Plan:

**Action Plan:** Davis County recognizes the significance of the reported CDBG/SSBG fund balance deficit resulting from timeliness of draw requests from HUD. As a result, the Davis County Auditor’s office established additional internal procedures and oversight of the responsible department in July of 2021 (see Attachment A). The new process ensures that draw requests are verified by both the requesting department and the Auditor’s office before payment is remitted to the subrecipient.

In addition, the Davis County Auditor’s office continues to assist the responsible department with budget monitoring and technical assistance. In accordance with state Statute, a budget hearing was held on December 21, 2021 to recognize additional program revenues and expenditures, with the anticipated impact of resolving the deficit fund balance at the close of 2021.

Timeline for compliance: Completed.

Person responsible for action plan: Curtis Koch, County Auditor

Tracked at DSAMH by: Kelly Ovard
FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None

FY22 Recommendations:

1) The DBH emergency plan was reviewed by Nichole Cunha, Program Administrator II 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 DBH review these suggestions and update their emergency plan accordingly. In review of last year's tool, the areas remarked as non-compliant resulted in recommendations not addressed. In discussion with Kim Myers, Nichole Cunha and Geri Jardine, you will have a 90-day window to resolve non-compliant areas. Should the non-compliance not be resolved, at that time, a finding could be issued. We would like to emphasize that Technical Assistance is available to the DBH team during this time. We are here to support and develop a plan with their team.

2) There was one I9 that was missing the hire date. Please review I9 forms for missing information.

FY22 Division Comments:
1) Thanks to the DBH staff for timely access and data uploads. It was very helpful in making the audit go as smoothly as possible.
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 Davis Behavioral Health (DBH) on December 7, 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 Division Comments:

1) Cultural Responsivity: During the recent DSAMH health needs assessment, DBH was found to be more likely than their peer agencies to have items identified as important to LGBTQ+ workgroups observable in their public spaces. Additionally, DBH had the highest response score with 88% of clinicians surveyed responding to the question about reducing disparities with actionable ideas across the youth in transition (YIT) age spectrum. DBH had the highest score in state on the technical aspects of their website, including ease of use and intuitive nature for people with disabilities to navigate.

2) Access to Care: DBH is committed to ensuring that individuals have access to services in a timely manner, ensuring that individuals engage in the appropriate level of care to meet their clinical goals while being cognizant of the ongoing need to address the workforce capacity within their agency. DBH is exploring alternatives to direct individual psychotherapy to meet recovery goals for clients, including skills-based groups, aftercare groups, and crisis skills groups for individuals. DBH notes that this approach is timely in that many new clients are recognizing they need mental health support, but may not be able to fully engage in individual psychotherapy. The clients are still able to make gains through early intervention programming options such as groups. DBH leadership has stated, "If people are brave enough to call and ask for help, then we want to help." DSAMH commends DBH for enlisting new approaches to meet both the clients needs while being aware of workforce capacity.
Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Davis Behavioral Health on December 7, 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, record reviews, program visits, and allied agency visits. During the discussion the team reviewed the FY21 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Peer Support, school based behavioral health 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
No findings were issued for FY21.

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) **Respite:** The FY21 scorecard indicates that DBH experienced a slight increase in the provision of respite services from the prior year (FY20, 4.3% to FY21, 4.9%), however PRS is still below the urban average of 7.1%. DBH noted that this service was impacted by the ongoing impacts of COVID-19 on programming. It is recommended that DBH monitor this service to ensure access through their service continuum while also continuing to build referral pathways to identify families in need of this important service in their community.

2) **Psychosocial Rehabilitation Services (PRS):** The FY21 scorecard indicates that DBH provided this service at a rate lower than the urban average (DBH 6.3%, Urban 12%). DSAMH recommends that DBH review how this service is referred to within their agency to ensure that youth have access to this service when clinically indicated. DBH may want to consider how PRS can be used in conjunction with psychotherapy to support clinical care and client goals as part of their plan to respond to agency capacity needs.
FY22 Division Comments:

1) **Family Peer Support Services (FPSS):** DBH leadership has a strong understanding of the value and role of FPSS to support youth and families in finding success. The FY21 scorecard indicates there was a decrease in families served, however DBH noted that the decrease is due to FPSS turnover. With the closure of Allies with Families, DBH will need to ensure they have a plan to capture FPSS data for services provided through school based early intervention programming. DSAMH encourages DBH to explore opportunities to expand FPSS services and increase the number of certified FPSS at their agency. Technical assistance is available as requested.

2) **Community Collaboration:** DBH continues to demonstrate a strong commitment to partnering with other agencies in their community to provide individuals with the best care and resources. DBH has a strong partnership with the health department and Davis School District in supporting early mental health screening nights and ensuring a referral pathway for families who are seeking services. DBH has also developed relationships with early childhood providers to support mental health and behavioral needs for youth who attend daycare. DBH is continually working to promote programming which meet the needs of their community, through the work at Farmington Bay Receiving Center to their new program, PRAXIS, to support the needs of youth in transition to build life skills.
Adult Mental Health

The Division of Substance Abuse and Mental Health Adult Mental Health team conducted its annual monitoring review at Davis Behavioral Health (DBH) on December 7, 2021. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Mindy Leonard, Program Manager; Leah Colburn, Program Administrator; Pam Bennett, Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, program visits, and allied agency 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 Clinical Use of the Outcome Questionnaire (OQ):** Division Directives require at least 50% administration rate to clients served. The FY21 Adult Mental Health Scorecard indicates that administration rates have decreased to 49.5%, falling below the required rate for the third time in five years. Division Directives also state that “data from the OQ or YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart.” Eight of the nine charts reviewed did not demonstrate use of the OQ as a clinical tool. Of note, one of the nine charts was for a client receiving medication management only. DBH has indicated that OQ administration and clinical use will be a clinician initiative moving forward.

Not including the OQ in telehealth sessions is a concern due to lack of measurable outcomes. This may be an overall concern within the Local Mental Health Authority system as there are more sessions held through a virtual platform. It is recommended that DBH work in conjunction with other clinical directors and DSAMH to develop a process for administering and documenting the use of the OQ with telehealth-provided services.

This item has been partially resolved as evidence of the use of the OQ was seen in the chart review and during clinical staffing.
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) **Data Collection of the Outcome Questionnaire (OQ):** Division Directives require at least a 50% administration rate to clients served. The FY22 Adult Mental Health Scorecard indicates that administration rates were 35.2% for all adult mental health clients and 33.4% for adults with serious mental illness (SMI). This reflects the 1,796 clients who received the OQ of 4,984 clients that could receive the OQ, as reported in the raw data from OQ Measures. This data is in contrast to eight of nine charts that included evidence that the OQ had been administered. Division Directives also state that “data from the OQ or YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart.” The OQ was used as a clinical tool in five of nine charts, potentially related to a notation that a data issue was impacting the ability of therapists to see the OQ results. DSAMH encourages DBH to address and rectify data issues impacting the recording of the OQ and the ability of clinicians to access results for clinical use.

**County’s Response and Corrective Action Plan:**

<table>
<thead>
<tr>
<th>Action Plan:</th>
<th>During the Covid-19 pandemic we discontinued OQ administrations for several months. We have now resumed OQ’s and the amount of administrations should improve as time goes on. In addition, we have tested to ensure that members of the clinical team are able to view the OQ results with clients during the treatment session. That issue has been resolved.</th>
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<tr>
<td>Timeline for compliance:</td>
<td>Jan 1, 2022</td>
</tr>
<tr>
<td>Person responsible for action plan:</td>
<td>Andrea Hamala</td>
</tr>
<tr>
<td>Tracked at DSAMH by:</td>
<td>Mindy Leonard</td>
</tr>
</tbody>
</table>

**FY22 Recommendations:**
None
FY22 Division Comments:

1) **Growth of Clientele and Penetration of the Adult SMI Population:** The FY22 Adult Mental Health Scorecard reflects the most dramatic increase in population served between FY20 and FY21 for adults served (23.43% increase) and adults with serious mental illness (20.4% increase). DBH also saw an expansion in the number of unfunded adults served (14.7%), with accompanying increases in supportive services (psychosocial rehabilitative services-29.1%; case management-9.8%; peer support-11.1%). DBH staff are commended for managing this growth in demand during the pandemic.

2) **Peer Support Services (PSS):** Heather Rydalch, Peer Support Program Manager, met with the substance use disorder (SUD) Director, two Peer Support supervisors, and five Certified Peer Support Specialists (CPSS). DBH CPSS work collectively with a team approach to wellness, and they have seen a decrease in hospitalization from those that are receiving PSS. A Peer Support supervisor said, “**Our peers are in a unique role. They are actively engaged seeing each person [client] where they are and it is interesting watching the difference it makes with the client**”. One of the CPSS mentioned “**Everyone was very creative in ways to keep folks connected during the pandemic.**” The Director said “**We are super lucky at DBH, our Peers and supervisors are really strong and they reach lives in a really meaningful way.**” There is a waiting list for PSS at DBH and the agency is in the process of hiring another full-time CPSS.

3) **Participant Feedback:** Heather Rydalch, Peer Support Program Manager, met with the Journey House Director and seven members. The Director expressed gratitude that they are able to meet in person again. Prior to the pandemic, average daily participation at Journey House included 20-25 members per day. This has increased to 30-35 members per day since the Clubhouse started to meet in person again. During the pandemic, the Clubhouse was delivering up to 80 meals per day. Members expressed appreciation for the opportunity to be involved in Journey House. One member said “**[the Director] is wonderful and has made my recovery better. In my recovery I appreciate everyone here.**” Another member said “**Before I started coming here, I was watching too much TV and now I work in the kitchen and I am really enjoying it.**” One of the members mentioned that he “**helped to spearhead planting a garden this last year that included a couple pumpkins, and they planted flowers.**”

4) **Housing 101:** DBH is working to streamline and simplify housing access by hosting a class that includes the local housing application and DBH housing. Through this process, the agency is able to assist with more efficient case management, and to determine those applicants that are most engaged in the housing process.
Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Davis Behavioral Health on December 7, 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 the Fiscal Year 2021 Audit

FY21 Deficiencies:

1) The EASY Compliance checks decreased from 117 to 58 from FY19 to FY20 respectively, which does not meet Division Directives. Davis County is required to increase the number of EASY Compliance Checks by one check each year.

The EASY Compliance checks increased from 58 to 83 checks from the FY20 to FY21 respectively, which 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) Data Entry: The FY21 prevention scorecard shows that the compliance rate for data entry in the DUGS system decreased from 100% to 58% from the FY20 to FY21 respectively. It is recommended that DBH check the data for accuracy or train staff on data entry if needed. Technical assistance can be provided by the DSAMH Prevention Regional Director as needed.
FY22 Division Comments:

1) **Increased Capacity:** There has been a significant growth in staff and coalitions over the past year. DBH now has four coalitions and will be starting a fifth one in January 2022. They also went from two to thirteen cities engaged in prevention efforts. Eleven of the thirteen communities in Davis County have been engaged on some level with the Communities that Care (CTC) operating system. The remaining two communities, Farmington and Fruit Heights will start this process in January 2022. Davis County currently has the following coalitions: (1) North Davis CTC (2) Layton CTC (3) South David CTC (4) Woods Cross CTC (5) Central Davis CTC, which will be starting in January 2022.

2) **Learning to Breathe:** DBH implemented the Learning to Breathe program which has been successful in the schools. DBH has been training school counselors and teachers on the Learning to Breathe curriculum. Some of the teachers and counselors are using it in groups while others are implementing it throughout all school grades. The strategy for the upcoming year will be to get all the 6th grade classrooms trained on this model. DBH did a few pilot projects on the Learning to Breathe program where the students responded well. This curriculum is specifically geared toward the developed brain of adolescents.

3) **Mindfulness Based Stress Reduction (MBSR)** - DBH has been teaching MBSR since 2014. The outcomes have shown a significant reduction in stress, anxiety and a feeling of being able to manage life better. There are currently one male and twelve females in this group this year. The male participant was experiencing high anxiety where the sessions were beneficial to him; in fact, he showed significant changes in his life over the past two months. DBH has three additional instructors completing the MBSR training this year. This training will include two male teachers who will start teaching MBSR in January 2002, which will be focused on men, individuals in the military and those experiencing chronic pain. DBH also discovered that men are more inclined to participate in the gender specific group for men.
Substance Use Disorders Treatment

Becky King, Program Administrator conducted the monitoring review on December 8, 2021. The review focused on compliance with State and Federal laws, Division Directives, Federal Substance Abuse Treatment (SAPT) block grant requirements, JRI, DORA, Drug Court, 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, and the Consumer Satisfaction Scorecard.

Follow-up from Fiscal Year 2021 Audit

FY21 Minor Non-compliance Issues:

The Substance Use Disorder Outcome Measures Scorecard shows:

1) **The percentage of clients using social recovery supports** decreased from 17.0% to 9.4% respectively from FY19 to FY20, which does not meet Division Directives.

The percentage of clients using social recovery supports increased from 9.4% to 113.1% from FY20 to FY21 respectively, which meets Division Directives.

*This issue has been resolved.*

The Consumer Satisfaction Survey Report shows:

2) **The Adult Consumer Satisfaction Survey Report** shows that only 7.8% of these surveys were collected, which does not meet Division Directives.

The Adult Consumer Satisfaction Survey Report shows that 15.3% of these surveys were collected, which meets Division Directives.

*This issue has been resolved.*

3) **The Youth Satisfaction (Family) Survey Report** shows that only 6.2% of these surveys were collected, which does not meet Division Directives.

The Youth Satisfaction (Family) Survey Report shows that 11.0% of these surveys were collected, which 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:

1) **Old Open Admissions:** There were 8.8% of old open admissions (charts that should be closed), which does not meet Division Directives. There should be less than 4% of old charts that can be open at any given time.

County’s Response and Corrective Action Plan:

<table>
<thead>
<tr>
<th>Action Plan:</th>
<th>DBH will close old open charts.</th>
</tr>
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<tbody>
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<td>Timeline for compliance:</td>
<td>March 1, 2022</td>
</tr>
<tr>
<td>Person responsible for action plan:</td>
<td>Maggie Arave</td>
</tr>
<tr>
<td>Tracked at DSAMH by:</td>
<td>Rebecca King</td>
</tr>
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FY22 Recommendations:

1) **Community Correction Checklist (CPC):** The University of Utah Social Research Institute (U of U SRI) conducted an evaluation with DBH on services provided to justice involved clients. The outcome of this evaluation showed lower scores in the following areas: Treatment Characteristics and Quality Assurance. DBH has already started working on these areas through the following measures:

(a) **Treatment Characteristics** - DBH is creating a consumer handbook for each level of care. They have updated the handbooks for their higher levels of care and Drug Court and are still working for general outpatient services.

(b) **Quality Assurance** - The U of U SRI has been helping DBH identify low cost and free screeners for Substance Use Disorder (SUD) treatment screening and evaluation and came up with a few options. It is recommended that DBH continue to work with the U of U SRI on efforts to improve treatment characteristics and quality assurance for their justice programs.
FY22 Division Comments:

1) **Nicotine Replacement Therapy (NRT) / Dimensions Program:** DBH is piloting a nicotine pilot project for Nicotine Replacement Therapy. They have done a great job in implementing the NRT treatment protocol, evidenced-based practices and using the Fagerstrom tolerance questionnaire. They have offered NRT’s in the form of patches, gums and lozenges. DBH also has a clinical staff overseeing the monitoring of the outcomes for this program. DBH added the Dimensions program for screening and treatment for nicotine cessation, which is available agency wide. The Dimensions program is a group that provides emotional, information and social support for tobacco reduction and cessation. Since this program was implemented in 2021, DBH has administered over 257 boxes of NRT’s to 185 clients. Clients receive 12 weeks of NRT’s while they are participating in the Dimensions Program. DBH has also made progress in diagnosing clients with nicotine use and asking them what their interest level is in quitting nicotine. DBH has seen a reduction in nicotine use with the population that has been referred for NRT, which is reflected in their data.

2) **Safe Haven Recovery:** DBH is licensed to treat 20 clients at Safe Haven Recovery, which is a co-ed substance use disorder (SUD) for men and women. This program recently moved into a new building in Farmington. DBH recently hired a therapist to provide gender specific programming for men and women. Safe Haven Recovery is a beautiful facility, which is peaceful and serene. Safe Haven hasn’t reached a waitlist for men, but has a small waitlist for women. This program currently has a male therapist, recovery support specialist and a tech. They also have access to a Security Guard since this program is connected to the Receiving Center. Safe Haven Recovery also has access to nursing services and a psychiatrist.

3) **Receiving Center:** DBH reports that things are going well with the Receiving Center, which is always busy. The majority of law enforcement drop offs to the Receiving Center comes from the south end of the county. DBH received funding from DSAMH, which they will be using to convert half of the residential support living and adding a small Receiving Center in the north end of Davis County. This center will have access for both south and north law enforcement and will be closer to the hospital. The programming hasn’t changed for the Receiving Center since it opened. The COVID pandemic has created an issue with staff recruitment. However, there is a therapist available for the Receiving Center 24 hours a day, 7 days a week, where the crisis team also responds to crises in the community as needed. They provide detoxification services and there is rapid access to SUD and mental health services through the Receiving Center. DBH reports that they do an excellent job of triaging the right level of care for clients. There is also a Psychiatrist that participates in daily rounds and meets with clients.
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...
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.

**Corrective Action Requirements:** It is the responsibility of the Local Authority to develop a corrective action plan sufficient to resolve each of the noncompliance issues identified. These corrective action plans are due within 15 working days of the receipt of this report. The Division of Substance Abuse and Mental Health may be relied upon for technical assistance and training and the Local Authority is encouraged to utilize Division resources. Each corrective action plan must be approved by Division staff and should include a date by which the Local Authority will return to compliance. This completion date and the steps by which the corrective action plan will return the Local Authority to contract compliance must be specific and measurable.

Submit the corrective action plan inside of the provided box after each finding or deficiency. Please do not make any edits outside of these boxes.

**Steps of a Formal Corrective Action Plan:** These steps include a formal Action Plan to be developed, signed and dated by the contractor; acceptance of the Action Plan by the Division as evidenced by their signature and date; follow-up and verification actions by the Division and formal written notification of the compliance or non-compliance to the contractor.

**Timeline for the Submission of the Action Plan:** This report will be issued in DRAFT form by the Division of Substance Abuse and Mental Health. Upon receipt, the Center will have five business days to examine the report for inaccuracies. During this time frame, the Division requests that Center management review the report and respond to Kelly Ovard if any statement or finding included in the report has been inaccurately represented. Upon receipt of any challenges to the accuracy of the report, the Division will evaluate the finding and issue a revision if warranted.

At the conclusion of this five day time frame, the Center will have 10 additional business days to formulate and submit its corrective action plan(s). These two time deadlines will run consecutively (meaning that within 15 working days of the receipt of this draft report, a corrective action plan is due to the Division of Substance Abuse and Mental Health).

The Center’s corrective action plan will be incorporated into the body of the report when issued.
We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Davis 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 at 385-310-5118.

The Division of Substance Abuse and Mental Health

Prepared by:

Kelly Ovard  Administrative Services Auditor IV

Date 01/27/2022

Approved by:

Kyle Larson  Administrative Services Director

Date 01/27/2022

Leah Colburn  Children’s Behavioral Health

Date 01/27/2022

Kimberly Myers  Assistant Director Mental Health

Date 01/27/2022

Brent Kelsey  Assistant Director Substance Abuse

Interim Division Director

Date 01/27/2022
### Preface

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<tr>
<th>Monitoring Activity</th>
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<tr>
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<td>made by whom, and date of change</td>
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<td>board, etc.)</td>
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### Basic Plan

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<td>Planning assumptions</td>
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<td>Conditions under which the plan will be activated</td>
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<td>Procedures for activating the plan</td>
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<td>Methods and schedules for updating the plan, communicating changes to staff, and</td>
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<td>Need to identify the methods for updating the</td>
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<tr>
<td>training staff on the plan</td>
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<td>plan, communicating changes and how staff are</td>
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<tr>
<td></td>
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### Functional Annex: The Continuity of Operations (COOP) Plan to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.

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<td>Identify continuity of leadership and orders of succession</td>
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<td>Need to identify continuity of leadership and orders of succession (i.e., include org chart)</td>
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<td>Identify leadership for incident response</td>
<td>X</td>
<td>Need to identify incident response</td>
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<tr>
<td>List alternative facilities (including the address of and directions/mileage to each)</td>
<td>X</td>
<td>Need to include alternative facilities available, if needed</td>
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<td>Communication procedures with staff, clients' families, the State and community</td>
<td>Need to identify coordination efforts with the State, community and clients' families.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Procedures that ensure the timely discharge of financial obligations, including payroll.</td>
<td>Need to address financial backup procedures</td>
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**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.)

Need to identify who is on the disaster planning team and who represents which area.

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

Need to specify how these functions will be provided in the event of a disaster

DSAMH is happy to provide technical assistance.
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