



State of Utah

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Department of Human Services

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Division of Substance Abuse and Mental Health
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Director

January 26, 2021

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,


Doug Thomas (Jan 26, 2021 16:54 MST)

Doug Thomas
Division Director

Enclosure

cc: Commissioner Kent Wilson, Emery County Commission
Jaylynn Hawks, Grand County Council
Karen Dolan, Director of Four Corners Community Behavioral Health

Site Monitoring Report of

Carbon County and
Four Corners Community Behavioral Health

Local Authority Contracts #160135 and #160136

Review Date: November 3, 2020

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 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 3, 2020. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

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

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

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	11
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	14
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	17
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 1	19-20 20

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 3, 2020 by Kelly Ovard Auditor IV and Kyle Larson, Division Administrative Services Director.

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, 2019. The auditors issued an unmodified opinion in their report dated September 8, 2020 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 November 10, 2020 with no findings for the year. The finding from the June 30, 2019 audit has been resolved.

Follow-up from Fiscal Year 2020 Audit:

FY20 Minor Non-compliance Issues:

- 1) *Carbon County - Independent Audit Findings:* Carbon County has received a repeat finding in their financial statement audit, Finding 2018-002 Cash Allocation Reconciliations. Certain cash allocations had not been reconciled to the general ledger. Cash transactions are interrelated to other accounts. Potential misstatements may not be identified or corrected in a timely manner; the objective of safeguarding assets may not be achieved. The County partially resolved the issue, but received this finding for two consecutive years.

This Finding was not stated as a finding in Carbon County's single audit for 2019. This finding has been resolved.

- 2) *Carbon County - Federal Awards Policy:* Carbon County does not have a written federal awards policy. 2 CFR 200 requires non-federal entities to have written policies regarding the management of their Federal award funds. The Carbon County Federal Awards Policy was included.

Carbon County provided its Federal Awards Policy adopted in the latter part of 2019. This finding has been resolved.

- 3) *Four Corners Community Behavioral Health - Independent Audit Findings:* FCCBH received two findings in their single audit. 2019-01 No Written Federal Awards Policy. 2 CFR 200 requires non-federal entities to have written policies regarding the management of their Federal award funds. FCCBH resolved this issue prior to the site visit and provided a copy of their new Federal awards policy.

FCCBH has included its written Federal Awards Policy adopted in the latter half of 2019. The policy was provided for the audit. This finding has been resolved.

2019-02: No independent review of payments made on clients behalf. FCCBH policy requires that payments made on behalf of clients be reviewed by an independent employee. The auditors discovered that at one location, the case worker establishes the budget and pays bills for a specific client with no independent review of these payments. There were not any questioned costs as a result of this finding, but it is important that FCCBH ensures that all staff are following policy and internal controls.

The audit report for the year ending June 30, 2020 noted this had been corrected. This finding has been resolved.

Findings for Fiscal Year 2021 Audit:

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

FY21 Deficiencies:

None

FY21 Recommendations:

- 1) The FCCBH emergency plan was reviewed by Robert Snarr, Program Administrator as part of the site visit. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that FCCBH review these suggestions and update their emergency plan accordingly. **Please pay attention to the matter of “Record of Changes” that was not-compliant in the report.**

FY21 Division Comments:

None

Mental Health Mandated Services

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

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

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

Consultation and Education Services

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

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

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

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

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Four Corners Community Behavioral Health (FCCBH) on November 3 and 4, 2020. Due to COVID-19, the annual monitoring review was held virtually. The monitoring team consisted of Leah Colburn, Program Administrator; 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 FY20 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Resource Facilitation (Peer Support), High Fidelity Wraparound, 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 2020 Audit

FY20 Minor Non-compliance Issues:

- 1) *Youth Outcome Questionnaire*: FCCBH does not administer the Youth Outcome Questionnaire (YOQ) at the required frequency of once every 30 days. Through records reviews, seven of the ten charts had YOQs that were not administered at the required rate of at least once every 30 days. Eight of the ten charts reviewed did not meet the criteria of using the YOQ in treatment. The Division Directives state “*the Youth Outcome Questionnaire (OO/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).*” FCCBH will need to evaluate the process of administering and utilizing the YOQ in treatment.

This finding has been partially resolved due to a lesser number of charts with concerns, and the identification of a system-wide delivery barrier resulting from COVID-19. See Deficiency #1,

FY20 Deficiencies:

- 1) *Objectives*: The recovery plan objectives were not measurable or achievable within the charts. Objectives in eight of the ten charts reviewed were vague and difficult to achieve (e.g. the “client will trust in others,” and the client “will improve self worth”). The Division Directives state, “*The current version of the approved Utah Preferred Practice Guidelines shall be the preferred standard for assessments, planning and treatment*” which state that “*objectives [should be] measurable, achievable and within a timeframe.*”

This item has been resolved with eight of ten charts reviewed meeting requirements. See recommendation #1.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

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.

Center’s Response and Corrective Action Plan:

Action Plan: Administration of the YOQ is difficult for a variety of reasons; parents not attending appointments, lack of compliance from youth, youth with limited understanding, minimal time allowed during school based sessions, etc. In addition, FCCBH (as well as many other LMHAs) were not adequately prepared for the COVID-19 pandemic, which made acquiring the YOQ difficult with telehealth and phone visits. However, it is the understanding of FCCBH that DSAMH is partnering with the LMHAs to find a solution to getting an online YOQ completed from a clients home, in the event of another pandemic or situation that would warrant online teletherapy in the future. This would also aid in compliance from acquiring YOQs from parents who do not attend sessions or for kids being seen in a school based setting. FCCBH values the YOQ and appreciates the outcome data it provides and will continue to train staff in order to gain greater compliance around administration.

Timeline for compliance: 6 months

Person responsible for action plan: Melissa Huntington

DSAMH Tracking by: Leah Colburn

FY21 Recommendations:

- 1) *Objectives:* FCCBH has made significant progress with their documentation of SMART goals and objectives with eight out of ten charts meeting this requirement. It is recommended that FCCBH continue to strengthen training on objectives to ensure that all goals and objectives meet preferred practices guidelines specifically related to timely and measurable outcome measures especially as they onboard new clinicians.
- 2) *Holistic Approach to Health:* During the review of their assessments there is minimal documentation identifying a client's primary care physician and supporting conversations about physical health wellbeing. Ensuring that youth have an identified provider and access to physical healthcare is a key metric in ensuring a child's overall health and wellbeing. It is recommended that FCCBH provide training to staff to include the documentation of this type of information, including during assessment and case management activities to encourage conversation about healthcare access and appropriate linkages to physical health care providers, including dental and vision, for children.
- 3) *Services to Youth and Families:* FCCBH continues to provide quality services for youth and families in their catchment area. It is recognized that there have been a number of system changes with local child serving agencies which has decreased the number of youth referred to their programs. This decrease is noted in the FY20 Youth Scorecard with youth served dropping (FY19 499/FY20 442) and those served who are SED (Seriously Emotionally Disturbed) (FY19 238/FY20 131). These system changes have directly impacted FCCBH referral networks for youth, thus decreasing the number and the overall acuity of the youth they serve. It is recommended that FCCBH engage with other LMHAs and DSAMH to discuss these referral pathway changes to develop strategies to increase children and youth in their services.

FY21 Division Comments:

- 1) *Unfunded Clients:* FCCBH has begun a process to better identify those clients who are served through unfunded funds, to determine if these clients could qualify for Medicaid. They are reviewing all current clients and are strengthening their process when clients are new to their services. They are hopeful that this will allow for greater sustainability of care for their clients and allow FCCBH to reserve unfunded dollars for those who do not have any access to insurance or who are underfunded.
- 2) *Family Resource Facilitation and Family Peer Support:* FCCBH family peer support numbers have remained consistent (FY19 15 families, FY20 15 families). It is encouraged to review this service to identify and rectify barriers to increase access to this service for youth and families. It is also encouraged to review referral pathways both internally and with community partners. It is also recommended that FCCBH continue partnering with local interagency groups to ensure collaboration for family peer support continues in the rural areas.

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 November 3 and 4, 2020. Due to COVID-19, the annual monitoring review was held virtually. The monitoring team consisted of 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 FY20 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 2020 Audit

FY20 Minor Non-compliance Issues:

- 1) *Administration and Use of the Outcome Questionnaire (OQ)*: FCCBH does not administer the Outcome Questionnaire (OQ) at the required frequency of once every 30 days. Record reviews demonstrated that seven of the ten charts had OQs that were not administered at the required rate of at least once every 30 days. Seven of the ten charts reviewed did not meet the criteria of using the OQ in treatment. The Division Directives state “*the 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*”. FCCBH will need to evaluate the process of administering and utilizing the OQ in treatment.

This finding has been partially resolved, due to identification of a system-wide delivery barrier resulting from COVID-19. See Deficiency #1.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

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 “*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*”.

The lack of administration of 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. 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 OQ with telehealth-provided services.

Center’s Response and Corrective Action Plan:

Action Plan: As indicated in the Youth Action plan response, FCCBH (as well as many other LMHAs) were not adequately prepared for the COVID-19 pandemic, which made acquiring the OQ difficult with telehealth and phone visits. However, it is the understanding of FCCBH that DSAMH is partnering with the LMHAs to find a solution to getting an online OQ completed from a clients home, in the event of another pandemic or situation that would warrant online teletherapy in the future. FCCBH values the OQ and appreciates the outcome data it provides and will continue to train staff in order to gain greater compliance around administration.

Timeline for compliance: 6 months
Person responsible for action plan: Melissa Huntington
DSAMH Tracking by: Pam Bennett

FY21 Recommendations:

- 1) *Documentation and a Holistic Approach:* A review of FCCBH charts indicated that documentation did not include evidence of education on improving physical health in five of ten charts reviewed or the identification of the primary care physician (five of ten charts). It is apparent that FCCBH is closely engaged in client support around physical health. Therefore, DSAMH recommends training staff to include the documentation of this type of information, including during assessment and case management activities.

FY21 Division Comments:

- 1) *Provision of Peer Support Services:* DSAMH Peer Support Program Manager, Heather Rydalch, met with Peer Support Specialists (Adult Peer Support and Family Resource Facilitators/FRFs) and supervisors. FCCBH reported that PSS have been particularly beneficial in the Clubhouse-like programs. Both individual and group PSS are offered. As the PSS program expands, clear definitions of Adult PSS, Family PSS, FRFs and System of Care (SOC) Wraparound to delineate roles will be helpful.

- 2) *Suicide Prevention*: FCCBH has recently completed a Suicide Prevention grant from DSAMH, and continues to work on a Federal grant to address suicidal crises in adults aged 25 and older. The internal suicide prevention committee ("Safe Squad"), created as part of the grants, will be maintained within the agency, making recommendations for prevention, intervention and postvention improvements. DSAMH commends FCCBH for responding to need within the First Responder community by creating rapid access appointments for those responding to deaths by suicide. In addition, FCCBH has created a media campaign to decrease behavioral health stigma and address First Responder burnout - "Your first response gave me my second chance!"
- 3) *Supported Employment (SE)*: In addition to Clubhouse-like programs that focus on a work-ordered day, FCCBH has made efforts to include elements of Individual Placement and Support for First Episode Psychosis within the agency Supported Employment program. FCCBH is encouraged to continue training with DSAMH for SE skill development such as job coaching, job development, employer engagement and placement of clients shared with Vocational Rehabilitation.
- 4) *Integration*: FCCBH and community health agencies appear to partner at Level 3 of the six levels of Collaboration and Integration (Substance Abuse and Mental Health Services Administration). Behavioral and physical health providers are co-located at the Price clinic, with partnerships at the Federally Qualified Health Clinics (FQHCs) in East Carbon and Moab, and the local clinic in Emery County. FCCBH and community partners use the Columbia Suicide Severity Rating Scale (C-SSRS) and Patient Health Questionnaire-9 (PHQ-9) screening tools. Electronic health records (EHRs) are separate. Communication is scheduled regularly and driven by the need for consultation and coordination for clients receiving medication-assisted treatment, in addition to addressing specific patient issues.
- 5) *Participant Feedback*: DSAMH Peer Support Program Manager, Heather Rydalch, met with Clubhouse-like program members virtually. Individuals stated that they "do much better" with Peer Support. Several mentioned that one of the goals that they are working on is exercise. They attend a member-led group called "Healthy Half Hour" that includes activities such as meditation and yoga. One member mentioned that they are having trouble getting places and that FCCBH provides reliable transportation so they can make it to "Club". One member mentioned that she received a lot of help with housing and is now in "the best apartment in all of Price". She said it took a while but it was worth it. Staff and friends from the clubhouse will check on her to make sure she is doing okay.
- 6) *Cultural and Linguistic Responsivity*: FCCBH has submitted a Cultural Competency Plan to DSAMH. The plan includes a broad overview of Administrative, Human Resource, and Clinical activities, in addition to Macro Systems goals, without inclusion of details or plans for quality assessment. A Quality Assurance Performance Improvement (QAPI) plan for the 2020 calendar year has been developed.
- 7) *Nicotine Cessation*: A review of the charts demonstrated that nicotine cessation is being addressed and documented during the evaluations. FCCBH is integrating cessation into other groups rather than hold groups strictly for nicotine cessation, as cessation groups have

not been well-attended. The Clubhouse-like programs have discussions around nicotine cessation monthly at house meetings and provide referrals for individuals indicating interest in ending use.

- 8) *Meeting Participant Needs:* The FY20 Adult Mental Health Scorecard provides evidence of agency efforts to meet participant needs. Supported housing placement numbers have jumped from 5 (FY19) to 23 (FY20). FCCBH has also used diversion beds and transitional placements to manage crises in the community. Emergency numbers have decreased from 451 (FY19) to 375 (FY20), and inpatient stays have dropped from 33 (FY19) to 19 (FY20).
- 9) *Mental Health Court:* DSAMH staff met with Judge Thomas to review the Mental Health (MH) Court and FCCBH. The Judge reviewed the MH Court criteria and process, and described FCCBH as a strong, collaborative partner. It is a comparatively young program, and they are seeing successful participant change.

Substance Use Disorder Prevention

Becky King, Program Administrator, conducted the annual prevention review of Four Corners Community Behavioral Health on November 3rd, 2020. 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 2020 Audit

No findings were issued in 2020.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

FY21 Deficiencies:

- 1) FCCBH did not complete EASY Compliance checks in the FY21, which does not meet Division Directives. Local Authorities are required to conduct one more EASY check each year.

Center's Response and Corrective Action Plan:

Action Plan: Complete at least one more EASY compliance check than the year prior.

Timeline for compliance: Already completed. Two EASY compliance checks were completed in October 2020.

Person responsible for action plan: Alexandria Anderson

DSAMH Tracking by: Becky King

FY21 Recommendations:

- 1) **Grand County Coalition** - Grand County is in the early stages of discussing the formation of a coalition in their local area. It is recommended that FCCHB continue to work with Grand County to assist with the development of this new coalition.

- 2) **Local Authority Assessment** - FCCBH has collected and analyzed from the 2019 SHARP data to start working on the development of their Local Authority Assessment. It is recommended that FCCBH continue to work on collecting data from various sources to develop their Local Authority Assessment.

FY20 Division Comments:

- 1) **Community Partnerships:** The Communities that Care Coalitions (CTC) (C.A.R.E and CHEER) have seen community board membership expansion. Their coalition messages have been reaching more people in the community than ever before. FCCBH has also been able to build community partnerships by continuing to encourage and support new coalitions. Another way FCCBH has strengthened community partnerships is through partnering with other agencies and coalitions to host events, advertise, and work together to accomplish shared goals.
- 2) **Coalitions:** FCCBH has been working on developing new coalitions in their community, including: (1) Emery County PROSPER Team. This coalition was developed with the support of Claire Warnick and Christine Jensen from the Utah State University (USU) Extension. (2) Grand County - FCCBH's Prevention Coordinator has been involved in conversations around starting a SUD/ Prevention Coalition in Grand County. These conversations are in the early stages amongst key leaders. (3) The CHEER Coalition in Green River was founded in 2008. Encouraging CHEER to adopt CTC has been an ongoing effort.
- 3) **Evidence-Based Practice (EBP):** FCCBH has implemented the following EBP's in their community: (1) WhyTry - Which has been implemented at Mont Harmon Middle School, all 5th Grade classes in Carbon County, CHEER coalition Pirates Den Teen Center (2) Two Communities That Care Coalitions (2) One Prosper operated coalition (3) Second Steps - Which is in all elementary schools in Carbon County.

FCCBH ensures fidelity for their EBP's in the following manner: (1) The WhyTry teacher and teacher assistants at Mont Harmon Middle School are WhyTry trained and teach the classes to fidelity. (2) WhyTry lessons taught at Pirates Den Teen Center are taught by the coalition coordinator who is also WhyTry trained. (3) Coalition members receive various CTC throughout the year; orientation training, workgroup training, key leader bored training. (4) The prevention coordinator regularly checks in with the teacher administering these lessons and will occasionally sit in on a class.

- 4) **Scorecard:** FCCBH multi county area has shown a 4 year trend decrease in "Percentage of youth prescription drug misuse within the past 30 days"

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the monitoring review of Four Corners Community Behavioral Health on November 3rd, 2020. The review focused on compliance with State and Federal laws, Division Directives, Federal Substance Abuse Treatment (SAPT) Block Grant requirements, Drug Offender Reform Act (DORA), 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 2020 Audit

FY20 Minor Non-compliance Issues:

1) *Treatment Episode Data Set (TEDS)*: Criminogenic risk data was not collected for 27.4% of all clients involved with the criminal justice system, which does not meet Division Directives.

Criminogenic risk data was not collected for 26.4% 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 the Deficiency #1 below.

Findings for Fiscal Year 2021 Audit:

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

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.

Center's Response and Corrective Action Plan:

Action Plan: Our data manager is planning to review open admits and determine which charts should be closed. He will continue to review this quarterly to improve compliance around this.

Timeline for compliance: 6 months
Person responsible for action plan: James Jewkes
DSAMH Tracking by: Becky King

2) The Consumer Satisfaction Survey Results showed:

a) General satisfaction for youth surveys declined from 83% to 61% from the FY19 to FY20 respectively, which does not meet Division Directives.

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

Center's Response and Corrective Action Plan:

Action Plan: FCCBH is currently collecting Consumer Satisfaction surveys and will monitor this weekly throughout this process. In addition, FCCBH will implement qualtrics to help families more easily access surveys.
Timeline for compliance: 4-6 months
Person responsible for action plan: James Jewkes
DSAMH Tracking by: Becky King

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.

Center's Response and Corrective Action Plan:

Action Plan: Since our FY21 monitoring visit, the FCCBH data manager is frequently monitoring the percentages around criminogenic risk to ensure collection rates are sufficient for Division Directives. In addition, the data manager will review this compliance need monthly with Program Directors. The Program Directors will then discuss this compliance mandate with their staff during weekly staff meetings.
Timeline for compliance: 4-6 months
Person responsible for action plan: James Jewkes
DSAMH Tracking by: Becky King

FY21 Recommendations:

- 1) Services:** East Carbon has seen many people relocate from Salt Lake to their area, including homeless individuals, which has required restructuring of services to meet the needs of their community. FCCBH has also struggled with separating risk populations in their groups, but are doing it. They started to stagger the group time to help alleviate the congestion in the waiting room. FCCBH reported that it was an easy task to stagger 47 groups with a small staff. FCCBH is also planning to open their family clinic in early 2021 which will separate the SUD adults from the youth populations in different buildings. It is recommended that FCCBH continue to seek ways to continue serving the unique needs of the individuals in their community.

FY20 Division Comments:

- 1) COVID-19 Pandemic:** FCCBH has continued to provide services virtually and on site during the COVID-19 Pandemic. The virtual groups have been helpful to individuals that live far from the clinic, have transportation or child care issues. Some clients have missed the human connection, so FCCBH has ensured that there are services still being provided on site as well. Clients and staff are required to wear masks at the clinic and wash their hands frequently.
- 2) Medication Assisted Treatment (MAT):** FCCBH has experienced great success with Operation Recovery in Carbon County, which has provided MAT services through their psychiatric doctors who are also Suboxone certified or provided through the county hospital addiction specialists. Operation Recovery has remained open during the COVID Pandemic. Dr. Lauren Prest (Addiction Psychiatrist) spends twelve hours a week at the Moab Clinic providing MAT. FCCBH has also been able to provide MAT by referring their clients to the Federally Quality Health Care Center (FQHCs) in every county.
- 3) FCCBH's Strengths:** FCCBH has new ideas, strong efforts in MAT and is always piloting new ways to help retain and sustain SUD clients in treatment and long-term recovery. FCCBH's agency is small, which makes it difficult to accomplish goals at times, but they always seem to find a way to achieve them. FCCBH has been able to expand MAT services through partnerships with the hospital in Grand County and secure transportation in Carbon and Emery county. While there are still barriers for clients attending treatment and in Grand County, FCCBH continues to seek ways to work through these barriers.

Section Two: Report Information

Background

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

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

Non-Compliance Issues, Action Plans and Timelines

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

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

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

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

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

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

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

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


Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of 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 Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health

Prepared by:


Kelly Ovard  Date 01/26/2021
Auditor IV


Approved by:

Kyle Larson  Date 01/26/2021
Administrative Services Director

Eric Tadehara 
Eric Tadehara (Jan 27, 2021 17:20 MST) Date 01/27/2021
Assistant Director Children's Behavioral Health

Kimberly Meyers 
Kim Myers (Jan 29, 2021 08:46 MST) Date 01/29/2021
Assistant Director Mental Health

Brent Kelsey  Date 01/28/2021
Assistant Director Substance Abuse

Doug Thomas 
Doug Thomas (Jan 26, 2021 16:54 MST) Date 01/26/2021
Division Director

Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY21

Name of Local Authority: Four Corners Community Behavioral Health

Date: November 10, 2020

Reviewed by: Robert H. Snarr, MPA, LCMHC
Geri Jardine

<i>Compliance Ratings</i>				
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.				
Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)		X		Plan needs to be signed
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)	X			
Record of changes (indicating when changes have been made and to which components of the plan)			X	Need to include a note of changes made to previous plans.
Record of distribution (individual internal and external recipients identified by organization and title)	X			
Table of contents	X			
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan	X			
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.				

List of essential functions and essential staff positions	X			
Identify continuity of leadership and orders of succession	X			
Identify leadership for incident response	X			
List alternative facilities (including the address of and directions/mileage to each)	X			
Address recovery and maintenance of client records	X			
Communication procedures with staff, clients' families, the State and community	X			
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
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.)		X		Need to identify who is on the planning team and representing which department(s).
The planning team has identified requirements for disaster planning for Residential/Housing services including: <ul style="list-style-type: none"> • 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 		X		Need to specify how these functions will be provided in the event of an emergency/disaster.

DSAMH is happy to provide technical assistance.












Four Corners Final Audit FY21

Final Audit Report

2021-01-29


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