State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Human Services

TRACY S. GRUBER
Executive Director

Division of Substance Abuse and Mental Health
DOUG THOMAS
Director

June 1, 2021

Commissioner Gil Almquist
Washington County Commission
179 East Tabernacle
St. George, UT 84770

Dear Commissioner Almquist:

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

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

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

Sincerely,

Doug Thomas (Jun 1, 2021 10:24 MDT)

Doug Thomas
Division Director

Enclosure
cc: Jerry Taylor, Garfield County Commission
Wade Hollingshead, Beaver County Commission
Andy Gant, Kane County Commission
Paul Cozzens, Iron County Commission
Michael Deal, Southwest Behavioral Health

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

Site Monitoring Report of

Southwest Behavioral Health Center

Local Authority Contracts #152258 and #152259

Review Date: March 23, 2021

Final Report

Table of Contents

Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Southwest Behavioral Health Center (also referred to in this report as SBHC or the Center) on March 23, 2021. Due to Covid-19 the audit was conducted remotely. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

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

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

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	11-12
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	15-16
	Deficiency	1	16-17
Substance Abuse Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	21
Substance Abuse Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	23-24
	Deficiency	None	

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of the Local Authority, Southwest Behavioral Health Center (SBHC) remotely due to the COVID-19 pandemic. The Governance and Fiscal Oversight section of the review was conducted on March 23, 2021 by Kelly Ovard Administrative Services, Auditor IV.

The site visit was conducted remotely with SBHC as the Local Authority and contracted service provider for Garfield, Iron, Kane, Washington and Beaver Counties. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Board minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided.

As part of the site visit, SBHC provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter. Random samples were taken from the backup provided to verify that the listed services qualified for each different service category.

There is a current and valid contract in place between the Division and the Local Authority. SBHC met its obligation of matching a required percentage of State funding.

As required by the Local Authority, SBHC received a single audit for the year ending June 30th, 2020 and submitted it to the Federal Audit Clearinghouse. The CPA firm Hafen Buckner Everett & Graff, PC performed the Center's audit and issued a report dated November 30, 2020. The auditor issued an unmodified opinion, stating that the financial statements present fairly, in all material aspects, the financial position of SBHC. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on internal control over financial reporting and compliance for each major Federal program. The SAPT Block Grant was identified as a major program and was selected for additional testing. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2020 Audit:

No findings for FY20

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 Southwest emergency plan was reviewed by Robert Snarr, Program Administrator and Geri Jardine, Program Support Specialist, as part of monitoring. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. **It is recommended that Southwest review these suggestions and update their emergency plan accordingly and address any partial or non-compliance issues.**

2) There were three **I9's** that were not signed by SBHC within 3 workdays from the date listed as a start date for employment. One start date was blank. Federal requirements state that the employee's start date (first date of paid employment) and the date the organization signs the I9 must be within 3 working days. It is understood that there are employees that work as far away from St. George as Beaver, Panguitch and Kanab. HR has corrected these issues and will continue to verify compliance.

3) Southwest uploaded an employee **Conflict of Interest form for each subcontractor**, but did not have one completed for the vendor itself. The DHS C of I form has been uploaded to SBHC and will be revisited in next year's audit.

FY21 Division Comments:

1) Thank you to the staff at SBHC for the timely submission of data. The data was accurate, organized and provided in a timely manner.

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 Southwest Behavioral Health Center (SBHC) on March 23 and 24, 2021. Due to COVID-19, 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 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 (YOQ):* The frequency with which the YOQ is being administered is below the required guidelines of "every thirty days or every visit (whichever is less frequent)" as described in the Division Directives. In the chart review, seven of the ten charts reviewed did not administer the YOQ at the guideline of 30 days. There is also evidence that the YOQ is not being addressed in the clinical process. Within the chart review, the YOQ was not utilized throughout the treatment process, either in the treatment plan or client notes. Six of the charts lacked frequent administration and seven of the ten charts reviewed provided no evidence of the YOQ being used in treatment.

   This finding will be decreased to a deficiency. See FY21 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) *Youth Outcome Questionnaire (YOQ):* Of the ten charts reviewed, four charts had no evidence of the YOQ being used as an intervention with ongoing services. One chart did not use the YOQ as an intervention, however they had an assessment only and no ongoing services. This is an improvement from FY20 in which seven charts did not use the YOQ as in intervention. Two charts reviewed did not demonstrate administration of the YOQ "every thirty days or every visit (whichever is less frequent)" as described in the Division Directives which is a noted improvement from FY20. While it is recognized that COVID-19 and the move to telehealth may have impacted administration of the YOQ, DSAMH encourages SBHC to review processes to ensure that the YOQ is administered and utilized as a tool in treatment.

County's Response and Corrective Action Plan:

Action Plan:

Youth Outcome Questionnaire (YOQ) -As DSAMH recommends SBHC is going to continue most of the current plans in place to improve our YOQ percentages. They noted that improvements were seen in the Child, Youth and Family Mental Health charts.

In order to continue to improve our YOQ percentages SBHC will take the following steps:

1. The Data Manager will generate four reports:

a. A monthly report is being sent listing all active MH clients who had a therapy service in the last 30 days but have not completed an OQ/YOQ in the same 30 days.

b. A monthly report per team, of the % of clients who received a therapy service in the last 30 days who also completed an OQ/YOQ. This report is now being distributed.

c. A monthly report per clinician, listing all active MH clients who had a therapy service in the last 30 days but have not had an OQ/YOQ reviewed with them in the same 30 days.

d. A monthly report per therapist, of the % of clients who received a therapy service in the last 30 days who also had an OQ/YOQ reviewed with them in the same 30 days.

2. The Office Manager of each MH program office will be responsible for:

a. Making a plan with front desk staff for meeting each monthly goal and reviewing reports to determine that the last month's % of completion met the goal and modifying the plan if the goal was not met.

b. Review OQ #'s in Team Meeting

3. Each MH Program Manager will be responsible for:

a. Reviewing the results of reports (a) and (b) each month with the office manager and reviewing and approving the improvement plan for the next month b. Reviewing the results of reports (c) and (d) each month with each therapist and reviewing and approving their improvement plan for the next month

4. The Clinical Director will:

a. Address Program/Team percentages during his regular meeting with Program Managers.

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

Person Responsible for Action Plan: Shari Lindsey, Clinical Director

DSAMH tracking by: Leah Colburn

FY21 Recommendations:

1) *Family Peer Support Services:* SBHC experienced a drop in family peer support services from FY19 (41 services) to FY20 (21 services). While it is recognized that COVID-19 public health guidelines may have impacted service provision, it is recommended that SBHC review referral pathways, access, and sustainability of this service in their continuum. It is also to be noted that family peer support specialists at this center are utilized to provide a number of other services that are outside the scope of the family peer support role. It is recommended that SBHC review how they utilize staffing patterns to ensure that family peer supports are able to fulfill their roles and responsibilities to provide family peer support to better engage with youth and their families in the community. The DSAMH Children's team is available for technical assistance related to family peer support service provision.

2) *Holistic Approach to Health*: It is recommended that SBHC review their assessment template to encourage conversation about healthcare access and appropriate linkages to physical health care providers, including dental and vision, for children. During the review of their assessments there is no documentation of identifying a client's primary care physician. 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.

FY21 Division Comments:

1) *Youth in Transition (YIT) Programming:* DSAMH was encouraged to learn that SBHC is launching programming specific for the mental health needs of youth in transition. SBHC has identified that this program will target high acuity YIT to establish support for them that is age and developmentally appropriate. DSAMH encourages SBHC to seek technical assistance from the YIT team at DSAMH as they establish this program.

2) *School Based Behavioral Health Service Collaboration:* SBHC has engaged with one of their LEAs to support a stronger partnership to ensure that students have access to mental health services in their community. Through the use of HB373 funding, SBHC and the district developed a mental health assistance program (MHAP) in which students can be referred to mental health services through the LEA and SBHC will screen and refer students to appropriately identified community providers which best meets their needs. This has allowed for greater access to mental health services throughout their catchment area regardless of the students ability to pay.

3) *Agency Resilience and Workforce:* SBHC has experienced changes in clinical leadership in FY20. Throughout these changes, SBHC has continued to provide quality services to their clients while exploring opportunities to develop programming to meet the needs of their clients. SBHC, like other areas in the state, is experiencing a workforce shortage. They are reviewing recruitment opportunities and partnerships with universities to address the increasing need for clinicians and paraprofessionals in their area, especially in recognition that their catchment area is experiencing a population boom.

Adult Mental Health

The Division of Substance Abuse and Mental Health Adult team conducted its annual monitoring remotely for Southwest Behavioral Health Center on March 23 and 24, 2021. The monitoring team was unable to do an in person monitoring visit due to the COVID-19 pandemic. The monitoring team consisted of Pam Bennett, Program Administrator; Mindy Leonard, Program Manager; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: record reviews and questions completed by the clinical director, visits with SBHC staff, a multi-agency system team meeting, Clubhouse, Cherish Families, and Iron County Mental Health Court. The monitoring team reviewed the Fiscal Year 2020 audit; statistics, including the Mental Health Scorecard; and Area Plans. compliance with Division Directives; and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2020 Audit

FY20 Minor Non-compliance Issues:

1) *Administration and Use of the Outcome Questionnaire (OQ*): The frequency the OQ is being administered at is below the required guidelines of "every thirty days or every visit (whichever is less frequent)" as described in the Division Directives. Seven of the ten charts that were reviewed lacked evidence that the OQ was being administered every 30 days. In nine of ten charts that were reviewed, there was no evidence that the OQ was being used as a clinical tool. Division Directives require that the data from the OQ be shared with the client and incorporated into the clinical process, as evidenced in the chart. DSAMH encourages SBHC to have an updated training on the importance of the OQ in the treatment process.

   This finding will remain as a Minor Non-compliance finding. See FY21 Minor Non-compliance #1. Six of ten charts did not include administration of the OQ every 30 days and nine of ten charts did not include evidence of clinical use of the OQ.

FY20 Deficiencies:

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

   This finding will remain as a Deficiency. See FY21 Deficiency #1. Five of ten charts did not include objectives that were measurable.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

1) *Administration and Use of the Outcome Questionnaire (OQ)*: The frequency in which the OQ is being administered is below the required guidelines of "every thirty days or every visit (whichever is less frequent)" as described in the Division Directives. Six of the ten charts that were reviewed lacked evidence that the OQ was being administered every 30 days. In nine of ten charts reviewed, there was no evidence that the OQ was being used as a clinical tool. Division Directives require that the data from the OQ be shared with the client and incorporated into the clinical process, as evidenced in the chart. Although the pandemic and movement to telehealth has impacted OQ administration statewide, this has been a finding in FY18, FY19 and FY20. SBHC implemented an extensive reporting and tracking plan to address this finding in FY20. DSAMH recommends that the plan continue to be implemented, particularly as improvements were seen in the Child, Youth, and Family Mental Health charts.

County's Response and Corrective Action Plan:

Action Plan:

Adult Administration and Use of the Outcome Questionnaire.

SBHC will complete the same steps for OQ as YOQ to increase administration frequency. A significant change this year to increase rates of administration will be the requirement that our contractor providers complete the YOQ and OQ every 30 days with their clients.

In order to continue to improve our OQ percentages SBHC will take the following steps:

1. The Data Manager will generate four reports:

a. A monthly report is being sent listing all active MH clients who had a therapy service in the last 30 days but have not completed an OQ/YOQ in the same 30 days.

b. A monthly report per team, of the % of clients who received a therapy service in the last 30 days who also completed an OQ/YOQ. This report is now being distributed.

c. A monthly report per clinician, listing all active MH clients who had a therapy service in the last 30 days but have not had an OQ/YOQ reviewed with them in the same 30 days.

d. A monthly report per therapist, of the % of clients who received a therapy service in the last 30 days who also had an OQ/YOQ reviewed with them in the same 30 days.

2. The Office Manager of each MH program office will be responsible for:

a. Making a plan with front desk staff for meeting each monthly goal and reviewing reports to determine that the last month's % of completion met the goal and modifying the plan if the goal was not met.

b. Review OQ %'s in Team Meeting

3. Each MH Program Manager will be responsible for:

a. Reviewing the results of reports (a) and (b) each month with the office manager and reviewing and approving the improvement plan for the next month b. Reviewing the results of reports (c) and (d) each month with each therapist and reviewing and approving their improvement plan for the next month

4. The Clinical Director will:

a. Address Program/Team percentages during the regular meeting with Program Managers

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

Person Responsible for Action Plan: Shari Lindsey, Clinical Director

DSAMH tracking by: Pamela Bennett

FY21 Deficiencies:

1) *Measurable Objectives:* The recovery plan objectives were not measurable within the charts. Division Directives state, "The current version of the approved Utah Preferred Practice Guidelines shall be the preferred standard for assessments, planning and treatment." The current Utah Preferred Practice Guidelines state, "objectives are measurable, achievable and within a timeframe." Objectives in five of the ten chart reviews were vague and difficult to measure (e.g. "client will stand up for herself" and "manage symptoms"). The finding remains at a Deficiency as the FY20 plan to resolve the finding may have been impacted by the change in leadership (an integral part of the FY20 plan) and the pandemic.

County's Response and Corrective Action Plan:

Action Plan:

<u>Adult MH Measurable Objectives</u>

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

1. Record Specialists at SBHC monthly will bring an objective from each clinician's chart to be reviewed during their team meeting. Teams will discuss each Objective and how to make it measurable.

2. Training will occur with therapists and Program Managers about using the OQ to make measurable objectives.

Timeline for compliance: These action steps will begin immediately and will be monitored throughout the year. At mid-year, adjustments and additional training will be provided if we are not trending in the correct direction.

Person responsible for action plan: Shari Lindsey, Clinical Director

DSAMH tracking by: Pamela Bennett

FY21 Recommendations:

1) *Peer Support Services (PSS):* The FY20 Adult Mental Health Scorecard indicates that SBHC continues to offer PSS below the state and rural average (FY20-1.3%; State-5.8%; Rural-3.0%). Individuals with lived experience are often hired in positions other than Certified Peer Support Specialists, including case management, therapists, and other staff. In addition to the admirable agency-wide commitment to recovery, DSAMH recommends that SBHC increase PSS that are provided as an evidence-based practice.

FY21 Division Comments:

1) *Mental Health Court:* The SBHC Mental Health Court in Iron County is well-represented by providers. Case managers, Peer Support Specialists, therapists, attorneys, and Judge Matthew Bell were all in attendance. The Peer Support Specialist is a graduate from the Mental Health Court, and she brings a strong presence of advocacy and support to the meetings. Judge Bell is positive and engaged in the process. He is knowledgeable regarding specific client situations and creates a collaborative and supportive environment for clients and staff. The group does very well at setting clear expectations for those who are in the program. They also celebrate the success of the clients and make them feel like an active part of the process.

2) *Growth of Outpatient Services:* The FY20 Adult Mental Health Scorecard indicates that the SBHC outpatient population jumped more than 51% during FY20, a reflection of the rapid

growth of the southwestern counties. In addition, the number of unfunded clients increased from 300 (FY19) to 936 (FY20). DSAMH commends SBHC, and the SBHC staff, for managing an influx of clients, particularly with the added stress of the pandemic and move to telehealth.

3) *Integration:* SBHC and community health agencies appear to partner between Level 3 and Level 4 of the six levels of Collaboration and Integration (Substance Abuse and Mental Health Services Administration). In Beaver, Panguitch, and Kanab, SBHC is co-located with the local Health Department. In Cedar City, SBHC is co-located with Family Healthcare (FHC) and attends monthly coordination meetings. As an active member of the Intermountain Alliance, community health workers from the Alliance attend weekly staffings at SBHC. In addition, the SBHC medical director and FHC APRN speak daily regarding shared clients with complex needs. SBHC and community partners do not have shared screening tools or a shared electronic health record. However, for shared clients, SBHC has a liaison case manager with access to FHC records; FHC has access to SBHC records through a business agreement.

4) *Individual Placement and Support (IPS)/Supported Employment:* The SBHC Employment Team adheres to the IPS model within their agency. SBHC is considered a training base for all Utah IPS sites. SBHC's IPS employment specialists have been ACRE (Association of Community Rehabilitation Educators) certified. SBHC is a local Community Rehabilitation Provider (CRP) vendor for Vocational Rehabilitation, receiving Milestone Payments for their job development, job placement and job coaching services. SBHC's IPS supervisor/lead and employment specialist have recently been trained in Benefits Counseling through Cornell University. They are certified in Work Incentives Planning and Assistance (WIPA) and will provide benefits counseling with SBHC clients, including IPS clients. Recently, SBHC was the recipient of three awards from the Governor's Committee on Employment of Disabilities Golden Key Awards; Lifetime Achievement Award (Michael Cain), Employment Specialist/Advocate of the Year (Emilee Evans) and Employer of the Year (IPS Employer-Brian Head).

5) *Cultural Responsiveness:* SBHC has submitted a Cultural Competency Plan to DSAMH in the FY21 Area Plan. The plan is a component of SBHC's Quality Improvement Policy and Plan. The plan includes a cultural competency scoring grid for record review, as a method to improve cultural competency levels. DSAMH recommends that SBHC consider adding staff courses such as bias sensitivity training.

6) *Nicotine Cessation:* SBHC has completed the DIMENSIONS train-the-trainer program, and offers nicotine cessation classes to both mental health and substance use disorder clients. SBHC has started a Wellness committee that is identifying and implementing strategies for reducing tobacco use in staff, as well as clients.

7) *Oasis House and Participant Feedback:* Members of Oasis House (Cedar City) and staff reported they have been meeting in-person for approximately 2-3 weeks prior to the site visit. During the pandemic, Oasis House staff/CPSSs would provide outreach to Oasis House

members via virtual platforms, phone calls, and text messages. When necessary, Oasis House staff/CPSSs would make in-person visits at safe-social distances. Staff/CPSSs would prepare and deliver meals to members and attempt to keep them engaged. Oasis House reported that all staff are CPSSs, noting, "It's part of our culture!" Oasis House members stated they enjoy participating in Oasis House and community activities. Oasis House offers daily living skills, including the opportunity to use a kitchen for meal prep, cooking and serving. An Oasis House member stated, "I love to use my cooking skills here (Oasis House). I love to make casseroles." Members stated they feel supported and safe at Oasis House. An Oasis House member shared their mental health recovery story and reported, "I have felt better here (Oasis House) than anywhere else in Utah!" The Oasis House members reported they are unemployed (with the exception of work-training within the program). The members indicated they had interest in working outside of Oasis House, mostly desiring part-time employment. Oasis House does not provide employment services within their program; however, they do refer members to SBHC's IPS Employment Team.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review for Southwest Behavioral Health on March 23, 2021. The review was completed remotely due to the Covid-19 pandemic. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the reviews evaluated the services described in the annual prevention area plan and evaluated the data used to establish prevention priorities.

Follow-up from Fiscal Year 2020 Audit

FY20 Deficiencies:

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

   - Most recent completed assessment (Reviewed data and report)
   - List of training activities completed by staff and or coalition members. Including attendance/roll of training.
   - List of reports that have been shared with stakeholders (meeting dates and report)
   - Full strategic plan for 1) LSAA and 2) any coalitions
   - Monitoring tools for prevention strategies implemented (Block Grant funded)
   - List of all strategies implemented, identify which are evidence based.
   - Most recent annual report and submission date.
   - Report the Synar compliance rate.
   - Report the Eliminating Alcohol Sales to Youth (EASY) compliance checks completed.
   - List of all substance use related coalitions within LSAA. Please include minutes and attendance records for six months.
   - DUI youth and adult education class schedule in-house and with contracted providers, number of adults and youth that attended classes over the past year and a proof of purchase of the DUI Workbooks.

     SBHC submitted the required prevention documentation for the site visit this year, which meets Division Requirements.

     This issue 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:

1) The Eliminating Alcohol Sales to Youth (EASY) checks decreased from 129 to 42 checks from FY19 to FY20 respectively, which does not meet Division Directives. The number of EASY Compliance Checks should increase by a minimum of at least one check each year.

County's Response and Corrective Action Plan:

Action Plan:

The SBHC Prevention Team will hold a special planning meeting to discuss how to work with coalitions and police agencies to increase the number of compliance checks each year. We will create a logic model and action plan for our efforts and implement the plan at the start of the new fiscal year. We'd like to note that, as we've mentioned in the past, we think there is a more effective way for DSAMH to assess our efforts with EASY checks rather than, or in addition to, a one check increase per year. We would love to meet with DSAMH leadership to share our ideas about this.

Timeline for compliance: This action step will begin immediately. At the same time, we hope to have discussions with the DSAMH about this particular measure and how to better measure our expected performance, based on actions we are responsible for.

Person responsible for action plan: Logan Reid, Prevention Program Manager

DSAMH tracking by: Rebecca King

FY21 Recommendations:

1) **EASY Compliance Checks:** SBHC reported that there has been resistance with Law Enforcement in small communities in Southwest to complete EASY compliance checks. SBHC shared that some of these small communities have a tradition of not citing sales staff for minor infractions since they have relatives working in these positions. It is recommended

that SBHC continue to educate Law Enforcement and community leadership including mayors and county commissioners on the importance of completing EASY compliance checks in these small communities.

FY21 Division Comments:

1) **Capacity Building:** SBHC continues to help build capacity for their community. They hired new prevention specialists consisting of three full time staff, two part time staff and two Americorp Volunteers over the past year. With the addition of these new positions, SBHC was able to assist in the development of five new coalitions in various communities. SBHC has more than triple the prevention staff than other programs in the State and have increased their coalitions from fifteen to nineteen last year.
2) **Coalition Building:** SBHC reported that Millford is a very small town in Beaver County, which consists of approximately 700 people. They have few services and have their own elementary and secondary school (Kindergarten to 12th grade). SBHC has been working hard with the individuals in Millford for several years to build capacity and readiness to build a coalition. These efforts started with programming in the school through a student assistance program. SBHC also started a youth coalition that was working with the school providing prevention training. Due to the success of the youth coalition, the residents of Millford approached SBHC about starting an adult coalition. As a result of this request, SBHC hired one full time Coalition Coordinator to start a coalition in Millford. SBHC had a five years year plan to build a coalition in Beaver County, which they accomplished this year.

3) **Youth Coalitions:** SBHC shared that their philosophy is that finding the right demographic of youth will lead to the development of effective youth coalitions. They also believe that it is important to give meaningful projects for youth, which they thrive on. The youth coalitions in Southwest have been able to make a significant impact in their communities. When Representative Stewart was working on tobacco legislation he contacted the youth coalition to get their input on this legislation and ended up drafting policy based on their feedback.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Southwest Behavioral Health on March 24, 2021. The audit was completed remotely due to the Covid 19 pandemic. The review focused on compliance with State and Federal law, DSAMH contract requirements, and DSAMH Directives. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to Drug Court, Justice Reinvestment Initiative (JRI) and the Drug Offender Reform Act (DORA) requirements and contract requirements were evaluated by a review of policies and procedures, clinical records and through interviews with Southwest Behavioral staff. Treatment schedules, policies, and other documentation were also reviewed. The Utah Substance Use Disorder Treatment Outcomes Measures Scorecard results were reviewed with staff. Client satisfaction was measured by reviewing records and the Consumer Satisfaction Survey data. Finally, additional data was reviewed for Opiate Use for Washington, Iron, Garfield, Kane, and Beaver Counties.

Follow-up from Fiscal Year 2020 Audit

FY20 Minor Non-compliance Issues:

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

   The Treatment Outcomes Scorecard shows that tobacco use moved from -2.2% to 5.2% from the FY19 to FY20 respectively, which meets Division Directives.

   This issue 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:

1) The Treatment Outcomes Scorecard shows the following:
   a) The percent of clients that were arrested from admission to discharge moved from 35.2% to 18.3% from FY19 to FY20 respectively, which does not meet Division Directives.

b) The number of clients involved in social recovery support decreased from 29.1% to 22.6% from FY19 to FY20 respectively, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan:

Decreased Criminal Justice Involvement – we are seeing in this data that during that time period that there were greater numbers of people coming into our programs when there may have been arrests more than 30 days prior to admit. This may have impacted our eventual rate reported. We are not sure how COVID may have impacted arrest rates as well.

SBHC's SUD Program Manager will review this data with our SUD team and partners, and will reach out to the other LSAA's in the state in search of best practices, while ensuring that reporting is consistent across systems. We will seek to explain and remedy our percentages.

Social Recovery Supports - We have and will continue to encourage our clients to use Social Recovery Support resources. COVID-19, even early on, severely limited the opportunities people had to participate in these activities. We anticipate a return to our previous numbers as more opportunities become available for our clients.

Timeline for compliance: These efforts will begin immediately and will be monitored throughout the year.

Person responsible for action plan: Rylee Munns, SUD Treatment Program Manager

DSAMH tracking by: Rebecca King

FY21 Deficiencies:

None

FY21 Recommendations:

1) **Staff Shortages and Turnover:** SBHC has continued to experience staff shortages and turnover. They are also struggling keeping positions full. It has also been difficult to reimburse staff at a rate that meets the staff member's needs being in a rural area. SBHC shared that recent attention and funding of behavioral health has created increased demand for behavioral health providers, resulting in shortages and high levels of competition for limited resources. As a result, SBHC reports that they have dealt with considerable vacancy and increased turnover with staff leaving for higher paying jobs. It is recommended that SBHC continue to seek methods of recruiting and retaining staff.

FY21 Division Comments:

1) **Tobacco Cessation:** SBHC has implemented a Train the Trainer (TOT) program for the Dimensions tobacco program. Three staff received the TOT training who will be training other staff at Southwest. SBHC is planning to hold Dimensions classes in all programs, including residential treatment. They are also planning to start some classes in person. SBHC has a Wellness Coalition that works on expanding access to tobacco cessation services and guides tobacco free campus policies and implementation. SBHC has continued to provide tobacco quitline information to clients who are requesting help, and clinicians help craft goals and objectives to facilitate change.

2) **Medication Assisted Treatment (MAT):** SBHC continues to provide MAT, which has been going well. They are contracted with Family Health Care and St. George Metro to provide Methadone and other MAT services for clients on Medicaid. SBHC currently has 18 clients at St. George Metro. SBHC is also contracted with True North who is providing Methadone and other MAT services and currently has 11 clients in this program. SBHC currently has a MAT Grant to address the opioid crisis in Iron and Beaver County. The rural areas also have a Health Resources and Services Administration (HRSA) Grant to transport clients to Beaver and Cedar for MAT appointments with Family Health Care. SBHC has also been meeting with the jaios on a regular basis to discuss MAT and start individuals on MAT before they leave the jail. SBHC reports very little resistance in the Beaver County Jail and some resistance in Iron County. SBHC is meeting with the jails regularly to reduce resistance and barriers.

3) **Key Partnership Meetings:** SBHC meets with a myriad of different agencies weekly, monthly, and quarterly to coordinate services for their community. These include: law enforcement (typically through the specialty courts and MAT services), Multi-Agency Coordinating Committees (UROHC). SBHC also meets with the Local Recovery Community on various recovery oriented activities, including Recovery day. The local recovery community is an amalgamation of all the areas of treatment providers, recovery advocates, and fellowships working together to raise awareness, advocacy, and encourage interagency cooperation. SBHC meets with Peer Advocacy Groups (Utah Support Advocates for Recovery Awareness - USARA), the County Attorney's office who works with them on the specialty courts and the Stakeholders board.

Section Two: Report Information

Background

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

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

Non-Compliance Issues, Action Plans and Timelines

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

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

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

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

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

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.
A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

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

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Southwest Behavioral Health Center and for the professional manner in which they participated in this review.

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

The Division of Substance Abuse and Mental Health

Prepared by:

Kelly Ovard Kelly Jay Ovard Date 06/01/2021
Administrative Services, Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 06/01/2021
Administrative Services Director

Eric Tadehara Eric Tadehara Date 06/01/2021
Assistant Director Children's Behavioral Health

Kimberly Myers Kim Myers Kim Myers (Jun 2, 2021 15:19 MDT) Date 06/02/2021
Assistant Director Mental Health

Brent Kelsey Brent Kelsey (Jun 1, 2021 10:56 MDT) Date 06/01/2021
Assistant Director Substance Abuse

Doug Thomas Doug Thomas (Jun 1, 2021 10:24 MDT) Date 06/01/2021
Division Director

Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY21

Name of Local Authority: Southwest Behavioral Care Center

Date: 3/25/2021

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

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

Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)		X		Need signature on plan or confirmation of the plan's official status
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 place to identify changes to the plan, made by whom, and date of change
Record of distribution (individual internal and external recipients identified by organization and title)	X			
Table of contents	X			
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			
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: ● 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			

DSAMH is happy to provide technical assistance.

Southwest FY Final Report

Final Audit Report 2021-06-02

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