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Department of Health & Human Services

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Deputy Director

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Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

Date: February 15, 2023

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

Dear Commissioner Kamalu:

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

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

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

Sincerely,

Brent Kelsey
Office Director

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

Site Monitoring Report of

Davis Behavioral Health

Local Authority Contract #A03091

Review Date: December 6, 2022

Draft Report

Table of Contents

Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Office of Substance Use and Mental Health (also referred to in this report as OSUMH or the Division) conducted a review of Davis County and their contracted service provider, Davis Behavioral Health (also referred to in this report as DBH or the Center) on December 6, 2022. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

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

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

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

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	3	9-10
	Minor Non-Compliance	None	
	Deficiency	None	
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	17
Substance Use Disorders Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Substance Use Disorders Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	

Governance and Fiscal Oversight

OSUMH conducted its annual monitoring review of the Local Authority, Davis County, and its contracted service provider, DBH. The Governance and Fiscal Oversight section of the review was conducted on December 6, 2022 by Kelly Ovard, Financial Services Auditor IV.

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

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

The Local Authority, Davis County received a single audit as required. The CPA firm Carver Florek & James, completed the audit for the year ending December 31, 2021. The auditors issued an unmodified opinion in their report dated June 22, 2022. The SAPT Block Grant, Mental Health Block Grant and the OPIOID Response Grants were selected for specific testing as a major program. **There were three significant deficiencies in the audit which will be addressed in the findings.**

DBH, the contracted service provider for Davis County, also received a single audit. The CPA firm Litz & Company completed the audit for the year ending June 30, 2022. The auditors issued an unmodified opinion in their report dated November 10, 2022. The Mental Health Block Grant and State Opioid Targeted Response were tested as major programs. There were no findings in the audit.

Follow-up from Fiscal Year 2022 Audit

FY22 Significant Non-compliance Issues:

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

    This item has been resolved

2) **Section IV - Utah State Compliance Findings:County Year Ending 12/31/20 audit.**
    a) **Criteria: Deficit Fund Balance:** In accordance with Utah State statute, for any fund that has a deficit unassigned/unrestricted fund balance in the year under audit, the subsequent budget year, the County must have appropriations to retire the deficit of an amount equal to or greater than 5% of the funds total actual revenue of the year under audit.
    b) **Condition:** We found that the CDBG/SSBG fund balance at the end of the year had a deficit balance, which exceeded 5 percent of the total actual revenues. The County did not make any budget appropriations, nor did they make any ensuing budget amendments in the subsequent budget year to retire the deficit amount.
    c) **Cause:** The County did not foresee a budget deficit in the fund upon submission of the approved budget to the State. Furthermore, the County did not monitor the deficit in the fund balance at year-end and amend the subsequent year budget in a timely manner
    d) **Effect:** A violation of Utah State statute.

    This item has been resolved.

Findings for Fiscal Year 2023 Audit

FY23 Major Non-compliance Issues:

None

FY23 Significant Non-compliance Issues:

Davis County Audit:

1) County Audit: **Identification of Transportation Sales Tax Receivable** – Significant Deficiency 2021-001
    a) Criteria: The County should have appropriate procedures and controls in place to ensure year end accruals are recorded, therefore revenues and expenditures are reported in the proper period.
    b) Condition: We found that the County did not record year end receivables for transportation sales tax revenues.
    c) Cause: The County's procedure for identifying transportation sales tax receivables at year end was not comprehensive enough to identify this receivable prior to submitting the trial balance for audit.

County's Response and Corrective Action Plan:

Action Plan: The County recognizes the need to accurately report the funds passed through to UTA. The County will add a procedure to the year-end checklist to ensure that twelve months of revenues are accrued in a timely manner.

Timeline for compliance: Was implemented shortly after the deficiency was discovered.

Person responsible for action plan: L. Douglas Stone, CPA

Tracked at OSUMH by: Kelly Ovard

2) **Suspension and Debarment** – Significant Deficiency – 2021-002
    a) Criteria: Prior to enter in subawards and contracts with award funds, the County must verify that such contractors and subrecipients are not suspended, debarred, or otherwise excluded pursuant to 31 CFR § 19.300.
    b) Condition: The County did not conduct an appropriate search for suspension or debarment of vendors/contractors who were performing work under ALN 21.027, prior to entering into a contract to perform services under this award. Questioned Costs: $0
    c) Cause: The County received a large influx of federal funding in response to coronavirus pandemic. The County did not have proper controls in place to ensure that the vendors/contractors hired to perform work under this award are not suspended, debarred or otherwise excluded pursuant to 31 CFR § 19.300.

County's Response and Corrective Action Plan:

Action Plan: The County recognizes the need to abide by federal regulations when expending these funds. The County will implement a procedure for ensuring vendors are registered through SAM.gov prior to expenditure of funds.

Timeline for compliance: Was implemented shortly after the deficiency was discovered.

Person responsible for action plan: L. Douglas Stone, CPA

Tracked at OSUMH by: Kelly Ovard

3) Payroll Costs - **Allowable Costs** – Significant Deficiency – 2021-003
    a) Criteria: The County is required to have procedures in place to assure that federal awards are expended only for allowable costs in accordance with Subpart E – Cost Principles of the Uniform Guidance. Allowable costs are supported by appropriate documentation and correctly charged as to account, amount, and period. 2 CFR 200.430(i) establishes requirements for documentation of personnel expenses. 2 CFR 200.303(a) establishes that the auditee must establish and maintain effective internal control over the federal award that provides assurance that the entity is managing the federal award in compliance with federal statutes, regulations, and the terms and conditions of the federal award.
    b) Condition: During our testing we found five instances where hours used to allocate payroll to the grant differed from actual hours worked and paid. We found one instance where a timesheet was missing an employee signature and the manager's signature. Questioned Costs: $0
    c) Cause: Tracking of grant-related payroll is tedious process that requires additional review internally to ensure necessary paperwork supports the payroll paid.
    Effect: Payroll and related costs were not properly reported by an insignificant amount.

County's Response and Corrective Action Plan:

Action Plan: In late 2021, the County implemented an automated timekeeping system (UKG) for recording and tracking employee time. This system will resolve the insignificant issues listed in this finding.

Timeline for compliance: Was implemented shortly after the deficiency was discovered.

Person responsible for action plan: L. Douglas Stone, CPA

Tracked at OSUMH by: Kelly Ovard

FY23 Minor Non-compliance Issues:

None

FY23 Deficiencies:

None

FY23 Recommendations:

None

FY23 Division Comments:

1) **Emergency Plan updates** for next year. In addition, there have been added a couple of new elements which should be incorporated into your plan for next year's review.
    a) We strongly support and encourage your participation in your regional healthcare coalition and the DHHS quarterly 800 MHz radio checks which will prove vital in the event of an actual disaster/emergency.
    b) We also encourage completion of hazard vulnerabilities, risks, gaps and needs assessment of your emergency plan. As always, we are happy to provide TA if needed to address any of these issues.
2) **Thank you** to the team at Davis Behavioral Health for the timely upload of G&O documentation for the audit.

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 Office of Substance Use 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 Office of Substance Use and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

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Combined Mental Health Programs

The OSUMH team conducted its annual monitoring review virtually with DBH on December 6, 2022. Duplicate findings for Child, Youth and Family and Adult Mental Health have been combined below to provide clarity and avoid redundancy.

Follow-up from Fiscal Year 2022 Audit

There were no findings for FY22.

Findings for Fiscal Year 2023 Audit

FY23 Major Non-compliance Issues:

None

FY23 Significant Non-compliance Issues:

None

FY23 Minor Non-compliance Issues:

None

FY23 Deficiencies:

None

FY23 Recommendations:

None

FY23 Division Comments:

1) **Treatment Tracks:** DBH is targeting increased utilization of evidence based practice (EBP) at their agency. The agency is towards a treatment track model to better connect an individual to the most appropriate EPB for their presenting problem and diagnostic needs. DBH reports the intention is to better address clinical outcomes and access to services. Hopefully, they will also be able to better address workforce capacity through strengthening use of EPBs. OSUMH is encouraged with the intentionality that DBH has to move more toward EBPs at their agency.

Child, Youth and Family Mental Health

The OSUMH team conducted its annual monitoring review virtually with DBH on December 6, 2022. The monitoring team consisted of Leah Colburn, Program Administrator and Mindy Leonard, 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 FY22 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Peer Support, and compliance with Division Directives and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2022 Audit

There were no findings for FY22.

Findings for Fiscal Year 2023 Audit

FY23 Major Non-compliance Issues:

None

FY23 Significant Non-compliance Issues:

None

FY23 Minor Non-compliance Issues:

None

FY23 Deficiencies:

None

FY23 Recommendations:

1) **Family Peer Support Services (FPSS)**: The FY22 scorecard data indicates that DBH provides FPSS at a lower rate than their urban counterparts (DBH 0.9%/ Urban 2.1%). DBH has continued from the prior year to see lower provision of this service. The agency has been actively engaged in technical assistance with OSUMH specific to FPSS over FY22 and FY23 to work towards reviewing their approach with this service with the goal of increasing access. OSUMH appreciates the commitment and willingness of DBH to engage in creative ways to grow and improve quality to meet their agency goals with this service. It is recommended that DBH continue to engage in technical assistance until DBH finds stability in this service.

FY23 Division Comments:

1) **Youth in Transition Programming:** DBH has worked to strengthen programming for transition aged youth in their community. The PRAXIS program is designed for youth ages 16-22, who would benefit from additional mental health community based support as they transition into adulthood. A continuum of services and supports offered within the

program allow for youth to engage in a meaningful and individualized way to meet their goals. DBH is working to better engage with youth serving agencies in their community to ensure that youth who would benefit from this programming have access. OSUMH will be continuing to follow this engagement model as it is unique across the local mental health authority system.

Adult Mental Health

The OSUMH team conducted its annual monitoring review virtually with DBH on December 7, 2022. The monitoring team consisted of Mindy Leonard, Program Manager; Leah Colburn, Program Administrator; Pam Bennett, Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, program visits, and allied agency visits. During the discussion, the team reviewed the FY22 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 for the Fiscal Year 2022 Audit

FY22 Deficiencies:

1) **Data Collection of the Outcome Questionnaire (OQ):** Division Directives require at least a 50% administration rate to clients served. The FY21 Adult Mental Health Scorecard indicates that administration rates were 35.2% for all adult mental health clients and 33.4% for adults with serious mental illness (SMI). This reflects the 1,796 clients who received the OQ of 4,984 clients that could receive the OQ, as reported in the raw data from OQ Measures. This data is in contrast to eight of nine charts that included evidence that the OQ had been administered. Division Directives also state that "*data from the OQ or YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart.*" The OQ was used as a clinical tool in five of nine charts, potentially related to a notation that a data issue was impacting the ability of therapists to see the OQ results. OSUMH encourages DBH to address and rectify data issues impacting the recording of the OQ and the ability of clinicians to access results for clinical use.
   This item has remained with a participation rate below 50% in FY22. See Deficiency #1.

Findings for Fiscal Year 2023 Audit

FY23 Major Non-compliance Issues:
None

FY23 Significant Non-compliance Issues:
None

FY23 Minor Non-compliance Issues:
None

FY23 Deficiencies:

1) **Participation with Outcome Questionnaires (OQs):** The FY22 Adult Mental Health Scorecard indicates that the percent of unduplicated clients participating was 44.1%. This is below the required match of 50%. This is the second year that the participation measurement has fallen below the required minimum. DBH is encouraged to review the collection of OQs to resolve this issue. This remains as a duplication for this review period and will be reviewed next year after statewide adjustments to the denominator of the OQ statistic have been made.

County's Response and Corrective Action Plan:

Action Plan: Upon internal review it appears that those primarily receiving telehealth services have lower OQ participation. As a result DBH provided additional training on manually giving the OQ during a telehealth session. All clinicians were again reminded of the importance of using the OQ as a clinical tool. DBH has also implemented an internal caseload review process with each adult therapist where their clients are reviewed twice a year. One of the added elements of this review will be to monitor and coach around effectively using the OQ.

Timeline for compliance: October 2022

Person responsible for action plan: David McKay

Tracked at OSUMH by: Pam Bennett

FY23 Recommendations:

None

FY23 Division Comments:

1) **Utilization of the Outcome Questionnaire:** The DBH internal chart review demonstrates an improvement from 50% to 75% in the use of the OQ as a clinical intervention. SUMH commends DBH for using the OQ to direct clinical care and track progress with clients.

2) **Peer Support Services:** Heather Rydalch, Peer Support Program Manager, met in person with 1 CPSS supervisor and 3 CPSSs at the DBH office in Layton on December 8, 2022. Two of them have been Peer Support (PS) there for around 6 months, the other PS has been there for for and a half years. One mentioned "*I am giving some hope , encouragement, and validating my peers"* Another PS is a previous client of DBH that is now a CPSS and giving back to others. One of the PS is teaching Dimensions and a Peer Goals Group and he said " *I learn a lot through teaching"* "*Recovery is possible*". He is also working with Mental Health Court and said that since he has been providing PS there the Judge and Public Defender are completely on board with PS. "*It's okay to not be*

okay" I'm not the fixer, I am here to encourage". CPSSs reports that"*All of us have clients that have responded really well with PS*" One PS is working with a client 5 hours a week and it is worth it keeping her out of the USH.

3) **Participant Feedback**: Heather Rydalch, Peer Support Program Manager, met briefly with the Journey House Director, spoke with a few clients in the common area and then met privately with 2 members. One member has been coming here for a long time and loves having Peer support although she mentioned that she does not have a therapist and would like one. While talking about her PS, she stated " *she is amazing, give her a high five. She deserves to be employee of the month"* The other member said that she enjoys coming here and she has many goals that she is working on such as; cleaning house, keeping positive, getting along with others. If she was not coming to Journey House she would be staying in and isolating. They both agreed "*they do a great job here*!"

4) **Supported Employment (SE)**: DBH has maintained Individual Placement and Support (IPS) fidelity. DBH is in the process of hiring a full-time IPS Supervisor. DBH continues to employ two full-time Employment Specialists (ESs). The ESs have moved office locations and continue to be in proximity of clinical staff. The ESs and IPS Clinical Supervisor continue to receive ongoing SE training from the OSUMH IPS trainer. Vocational Rehabilitation (VR) has appointed a liaison specific to the IPS program. DBH is a Community Rehabilitation Provider and continues to provide vendor services with VR. IPS clients are being referred to a VR Benefits Counselor. The Clinical Supervisor will assume the IPS Lead role and provide goal setting as well as manage the weekly Unit Meetings. The ESs are assisting individuals obtain and maintain competitive and integrated employment. The ESs have established long-standing working relationships with employers and community partners. DBH is interested in having an IPS Fidelity Review in 2023.

Substance Use Disorders Prevention

Becky King, Program Administrator for OSUMH, conducted the annual prevention review of DBH on December 6, 2022. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from the Fiscal Year 2022 Audit

There were no findings in the FY22 Audit

Findings for Fiscal Year 2023 Audit

FY23 Major Non-compliance Issues:

None

FY23 Significant Non-compliance Issues:

None

FY23 Minor Non-compliance Issues:

None

FY23 Deficiencies:

None

FY23 Recommendations:

1) **Marketing and Outreach:** DBH has continued their partnership with an outside marketing team and Peachjar, the Davis School District Newsletter which shares information to the community about prevention efforts. Coalitions within Davis County have utilized Peachjar to effectively provide information regarding prevention programming offered in the county. DBH feels like they could do better in providing information on the dates and times that these programs are offered. It is recommended that DBH continue to work with their Marketing Team, coalitions and Peachjar to provide information on dates and times of classes for the community.

FY23 Division Comments:

1) **Learning to Breathe Program:** DBH has continued to focus on the Learning to Breathe program, which has expanded over the past year. They are currently finishing their training on Learning to Breathe with 30 schools and will be training 22 more schools in January. The Director of Social and Emotional Learning (SEL) at the school district has been going to all the classrooms to observe and ensure that teachers and students are engaged. DBH recently met with the Director of SEL who shared that she thought that things were going well and wanted to do another round of instructor training next year.

DBH is working with the University of Colorado to do research on Learning to Breathe. Due to positive results from this research, the University of Colorado is looking into developing a pre and post test for Learning to Breathe. DBH reached around 5,000 kids in one school year. l. The Learning to Breathe Program has been implemented in three High Schools and there will be two other High Schools that implement this program next year.

2) **Circle of Security Parenting:**. This parenting program is based on the theory of attachment, where the best outcomes for kids come from a healthy attachment with their parents. Kids that have healthy attachments with their parents typically have less problems in the future. Evaluations show that parents report having a positive experience in the class, including increase in knowledge. This program is providing a way for parents to approach their child more effectively and tune into their emotional cues, where they are more supportive and nurturing rather than creating wedges between the parent and child.

3) **Strengthening Families Instructor Training:** DBH has been offering the Strengthening Family Program, which has shown positive outcomes. In the past, they offered typically three to four programs a year and are now offering 15 programs this year. DBH is offering this program in North and South Davis, including Layton. They are also focusing on implementing the Strengthening Families Program in Spanish for the first time this year. DBH has a team of eight instructors for this program. The Coalitions are also reaching out more to high risk families in the communities, which has also helped families as well.

Substance Use Disorders Treatment

Becky King, Program Administrator for OSUMH conducted the monitoring review on December 6, 2022 for DBH. The review focused on compliance with State and Federal laws, Division Directives, Federal Substance Abuse Treatment (SAPT) block grant requirements, JRI, DORA, Drug Court, scorecard performance and consumer satisfaction. The review included a document review, clinical chart review, and an interview with the clinical director and other staff members. Consumer satisfaction and performance were also evaluated using the Division Outcomes Scorecard, and the Consumer Satisfaction Scorecard.

Follow-up from Fiscal Year 2022 Audit

FY22 Deficiencies:

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

   There were 1% of old open admissions (charts that should be closed) in the FY22, which meets Division Directives.

This issue has been resolved.

Findings for Fiscal Year 2023 Audit:

FY23 Major Non-compliance Issues:

None

FY23 Significant Non-compliance Issues:

None

FY23 Minor Non-compliance Issues:

None

FY23 Deficiencies:

None

FY23 Recommendations:

1) **The Treatment Episode Data Set (TEDS) Shows:**
   a) DBH's median number of days in treatment is the lowest in the state and they have the lowest percentage of clients engaged for 90 days or more (41% at Davis vs. 67% in the rest of the State).

The low number of days in treatment doesn't seem to affect completion as 58% of DBH's clients successfully completed compared to 40% statewide. Of those who do successfully complete, 40% of DBH's completers remained in treatment for 90+ days. This is different from the rest of the State where 67% of completers remain 90+ days, on average.

b) 50% of DBH's clients have used their primary substance within 30 days of discharge. This is the highest percentage in the State. Of successful completers in FY22, 68% of those using at admission were also using at discharge.

It is recommended that DBH review their data for accuracy and focus on methods of increasing engagement in treatment and looking into why 50% of clients were reported as using their primary substance upon discharge. OSUMH can provide technical assistance and support as needed.

FY23 Division Comments:

1) **The Treatment Episode Data Set (TEDS) Shows:**

   a) In recent years, successful completion of young adults has increased from about 30% to about 60%.
   b) DBH does a good job connecting clients to social supports (40% of Davis clients are connected and 23% of clients from the rest of the state are connected).

2) **Quality Services:** DBH provides quality services and always seeks ways to improve their services. They provide individualized treatment with person centered plans and use evidenced-based practices / Trauma-informed services to ensure that their clients needs are being met. DBH also provides extensive crisis services, outreach, housing options and has good partnerships with community providers. DBH has also focused on increasing access to services by completing the initial evaluation within five days or sooner.

3) **Recovery Support Services:** DBH has exceptional recovery support services, which is a vital part of their program. Their recovery support services are located in all levels of care in the substance use disorder (SUD) and co-occurring SUD and mental health disorder programs. Their Recovery Support team works well together and receives support from administration, which helps them provide effective services. The staff on the Recovery Support Team have lived experiences to help support clients in recovery.

4) **Began Again Recovery Center -** DBH is working on launching a new recovery residence to provide stable housing for individuals in SUD treatment, which they are excited to get started. This recovery residence will be located where the former residential treatment program and Receiving Center were located. This will be a 20+ bed facility recovery residence for men. This

program will also host recovery events at their facility and provide outreach to the community as needed.

5) **Outreach Services:** DBH is working on starting a new outreach program in January 2023. They are partnering with Videra Health, which provides an artificial intelligence (AI) platform to provide outreach for clients. DBH will be using this platform to do outreach for clients discharged from the residential / inpatient programs. DBH reports that this tool will allow them to monitor clients' general health and wellness during a high-risk, post-discharge time frame. DBH currently has an outreach process in place where peer support specialists do outreach with individuals that are discharged from treatment and are at high risk. They have been focusing on providing them with support and ren-engaging them in treatment. DBH reports that the Videra Health program will enhance outreach services that are already being done by Peer Support Specialists by sending phone calls to clients to help re-engage them in treatment and provide them with support as needed.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Office of Substance Use 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.

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

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

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

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

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

The Center's corrective action plan will be incorporated into the body of the report when issued.

Signature Page

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

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

The Office of Substance Use and Mental Health

Prepared by:

Kelly Ovard Kelly J. Ovard Date 02/15/2023
Administrative Services Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 02/15/2023
Administrative Services Director

Amanda Alkema Amanda Alkema Date 02/15/2023
Assistant Director

Eric Tadehara Eric Tadehara (Feb 15, 2023 10:11 MST) Date 02/15/2023
Assistant Director

Brent Kelsey Brent Kelsey Date 02/15/2023
Office Director

Attachment A

UTAH OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY23

Name of Local Authority: Davis Behavioral Health

Date: 12/2/2022

Reviewed by: Nichole Cunha, LCSW
Geri Jardine

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

Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Confirmation of the plan's official status (i.e., signature page, date approved)	X			
Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)		X		Per Brandon Hatch, will submit plan with record of changes in the near future
Method of distribution to appropriate parties (i.e. employees, members of the board, etc.)	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, state and community stakeholders and administration	X			
Describe participation in and coordination with county and regional disaster preparedness efforts, which could include participation in Regional Healthcare Coordination Councils		X		This element is new this year. Please update as needed to address this issue in the SFY24 emergency plan. TA assistance is available if needed.
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
Procedure for protection of healthcare information systems and networks	X			**Please include in the plan the procedure for ransomware attacks. (This is a new element and should be included in next year's plan.)**
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			
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			

SUMH is happy to provide technical assistance.