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Lieutenant Governor

Department of Health & Human Services

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Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

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Deputy Director

NATE WINTERS
Deputy Director

Date: May 1, 2024

Commissioner Paul Cozzens
Iron County Commission
68 South 100 East
Parowan, Utah 84761

Dear Commissioner Cozzens:

In accordance with Utah Code Annotated 26B-5-102, the Office of Substance Use 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. OSUMH 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 (May 6, 2024 08:02 MDT)
Brent Kelsey
Director

Enclosure
cc: Wade Hollingshead, Beaver County Commission
Gil Almquist, Washington County Commission
Celeste Meyers, Kane County Commission
Jerry Taylor, Garfield County Commission
Michael Deal, Southwest Behavioral Health

Utah Department of
Health & Human Services
Integrated Healthcare

Site Monitoring Report of

Southwest Behavioral Health Center

Local Authority Contract # A03083

Review Date: March 19, 2024

Final Report

Table of Contents

Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 26B-5-102, the Office of Substance Use and Mental Health (also referred to in this report as OSUMH) conducted a review of Southwest Behavioral Health Center (also referred to in this report as SBHC or the Center) on March 19, 2024. 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; OSUMH 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	1	7
Combined Mental Health Programa	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	12-13
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	15-16
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	1	21

Governance and Fiscal Oversight

The Office of Substance Use and Mental Health (OSUMH) conducted its annual monitoring review of the Local Authority, Southwest Behavioral Health Center (SBHC). The Governance and Fiscal Oversight section of the review was conducted on March 19, 2024 by Kelly Ovard Administrative Services, Auditor IV.

The site visit was conducted 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. State licensing and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Employee 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 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 OSUMH 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 OSUMH 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, 2023 and submitted it to the Federal Audit Clearinghouse on February 22, 2024. The CPA firm Hafen Buckner Everett & Graff, PC performed the Center's audit and issued a report dated January 29, 2024. 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 Block Grant for Prevention & Treatment of Substance Abuse & Mental Health Services was selected for additional testing. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2023 Audit:

There were no findings in the FY23 Audit.

Findings for Fiscal Year 2024 Audit:

FY24 Major Non-compliance Issues:

None

FY24 Significant Non-compliance Issues:

None

FY24 Minor Non-compliance Issues:

None

FY24 Deficiencies:

1) **Subcontractor audit monitoring tool**: Each of the three subcontractors, selected for the audits, had monitoring tools that were uploaded from prior years. Annual monitoring occurs, but the reports are only generated during in person audits which do not occur each year. Article 1.16 (a),(c) and Administrative Rule Section R523-2-6 (6-7) states: that there should be an annual audit and audit report.

County's Response and Corrective Action Plan:

Action Plan: SBHC has provided annual monitoring, but did not have the written checklists/monitoring tools to show OSUMH staff. We will ensure that, moving forward, we are completing an annual monitoring checklist, as required, to demonstrate the completed activity. We do currently have two different monitoring tools in place: one for an on-site premises visit to ensure that the building and facilities are in compliance; and, secondly, an additional Clinical Audit Form for documentation and record review completed regularly throughout the year. The Clinical Auditing Form was not provided to the OSUMH during the review process. The on-site visit does not occur annually, but the Clinical Audit does, and an audit report will be documented and provided as required and requested annually.

Timeline for compliance: Already being completed before the end of FY24.

Person responsible for action plan: Wendy King, CIS Director and Mike Sherratt, Clinical Director

Tracked at OSUMH by: Kelly Ovard

FY24 Recommendations:

1) The **disaster/emergency plan** audit team appreciates your participation in the regional HCC. Please review Appendix A for any recommendations.
    a) We want to call your attention to the **radio checks** and offer assistance ensuring your program is meeting the requirements for 75% participation as outlined in division directives.
    b) It can be noted that the programs in **Washington and Garfield have not been responsive to any radio checks**. We would love to connect with you to ensure that your radios are in functioning condition and assigned to the right program and staff.

FY24 Division Comments:

1) **Thank you** to Mike Deal and the entire staff at Southwest Behavioral Health for the timely upload of documents for the audit, enthusiasm for their work and for the great services they provide to the clients in their 5 county catchment area!

Mental Health Mandated Services

According to Utah Code 26B-5-102, 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 (6)(a)(ii) each local authority is required to "annually prepare and submit to OSUMH 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 OSUMH 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 OSUMH is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Mental Health Programs

The Office of Substance Use and Mental Health (OSUMH) conducted its annual monitoring review at Southwest Behavioral Health Center (SBHC) on March 19-20th, 2024. The monitoring team consisted of Leah Colburn, Program Administrator; Cody Northup, Program Administrator; Heather Rydalch, Peer Support Program Manager, and Amy Campbell, Program Administrator. The review included the following areas: record reviews, internal agency chart review, discussions with clinical supervisors, management teams, peer support, and case staffings. During the discussions, the site visit team reviewed the FY23 Monitoring Report; statistics, including the mental health scorecard; area plans; adult and youth outcome questionnaires (OQs/YOQs); OSUMH Directives, and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Combined Mental Health Programs

Findings for Fiscal Year 2023 Audit

There were no findings for the FY23 audit.

Findings for Fiscal Year 2024 Audit:

FY24 Major Non-compliance Issues:

None

FY24 Significant Non-compliance Issues:

None

FY24 Minor Non-compliance Issues:

None

FY24 Deficiencies:

None

FY24 Recommendations:

1) **Scorecard Data:** OSUMH would like to recommend that SBHC work with the OSUMH data team to explore and address the identified data concerns. During the onsite review SBHC reported that the agency implemented a new documentation system (Axiom) on July 1st, 2022 which had a significant number of bugs and system errors that needed to be worked out, including not being able to enter pertinent tracking information relevant to scorecard data. These concerns are believed to be leading to underreported data on both the Adult and Youth FY23 Scorecards. Based

on the monitoring discussion, the primary data concerns revolve around the decrease in unfunded clients served (youth served decreased by 98% and adults served by 73.6%), case management for both adults (-19%) and youth (-48%), youth respite numbers (-98%) and jail services for adults (FY22:101; FY23:0). Prior to the end of the monitoring visit, SBHC was linked with the OSUMH data team to further discuss and address the concerns.

FY24 Division Comments:

1) **Employment Stabilization:** OSUMH would like to acknowledge the stabilization in employment over the past year as was noted by SBHC during the onsite review. It was mentioned that several teams are fully staffed or just completing hiring final positions on various teams. SBHC reportedly has been able to maintain steady staff numbers for some time, specifically with regards to clinicians on the adult and youth teams, but also with non-professionally licensed staff as well.

2) **Community Partners:** OSUMH commends SBHC on their commitment to building and maintaining positive and strong relationships with community partners. During the onsite visit, the OSUMH monitoring team had the opportunity to participate with a panel of community partners to explore relationships and each of the panel agencies praised the collaboration with SBHC in their respective areas. Noted phrases during the discussion were: "*a foundational relationship*," "*fantastic relationship*," and "*I feel like we have the best partnerships in the state*." These partners included local law enforcement, multiple community resource centers and emergency shelters, a youth care and crisis center, and an agency that specializes with individuals with intellectual and/or developmental disabilities.

3) **Mobile Crisis Outreach Team (MCOT) Services:** SBHC meets with OSUMH crisis administrators monthly to go over the MCOT dashboard data, and appreciates working with SBHC crisis managers. SBHC MCOT has built a strong relationship with their Public Safety Answering Point, and now individuals in crisis are diverted from law enforcement involvement to MCOT for face to face support and stabilization. It was also noted by the OSUMH crisis team that no receiving center services were provided in FY23, and data for FY24 services has not yet been provided. OSUMH continues to encourage and support SBHC to submit MCOT data in a timely manner.

Child, Youth and Family Mental Health

Follow-up from Fiscal Year 2023 Audit

FY23 Deficiencies:

1) ***Youth Outcome Questionnaire (YOQ):*** FY22 internal charts were not provided for youth mental health and were unable to be reviewed for this monitoring cycle. The FY23 internal mental health charts provided did demonstrate that the documentation of YOQ as an intervention continues to be inconsistently done by clinical teams. Office Directives state "*Data from the Outcome Questionnaire (OQ) or Youth Outcome Questionnaire (YOQ) shall be shared with the client and incorporated into the clinical process, as evidenced in the chart (excluding children aged five and under).*" Use of the YOQ is a useful indicator in treatment and can be used to identify reduction of clinical symptoms. SBHC should review with clinical teams the impact of using the YOQ measures as part of the clinical treatment process for youth and families. It is recommended that SBHC review Combined Mental Health Recommendations related to internal chart review process and training to increase use of the YOQ as part of the clinical intervention.

   This finding will remain a deficiency, see FY24 Deficiencies #1, due to scorecard data showing a decrease in YOQ administration and chart reviews continuing to show inconsistent results of the YOQ being used as an intervention.

Findings for Fiscal Year 2024 Audit

FY24 Major Non-compliance Issues:

None

FY24 Significant Non-compliance Issues:

None

FY24 Minor Non-compliance Issues:

None

FY24 Deficiencies:

1) ***Youth Outcome Questionnaire (YOQ):*** The FY23 youth scorecard indicates a decrease in percentage of clients participating with the YOQ (FY22: 87%; FY23: 58%). As noted in the combined mental health recommendation section, this data may be inaccurate and OSUMH has requested that SBHC work with the OSUMH data team

on reported scorecard numbers. YOQ administration and utilization will remain a deficiency due to a possible decrease in YOQ usage numbers, as well as the chart reviews continuing to show inconsistent YOQ use as an intervention. As noted in the FY23 deficiency, Office Directives state "*Data from the Outcome Questionnaire (OQ) or Youth Outcome Questionnaire (YOQ) shall be shared with the client and incorporated into the clinical process, as evidenced in the chart (excluding children aged five and under).*" OSUMH does want to acknowledge that SBHC has identified this as an area of focus and has a plan in place to further address this deficiency going forward, including having the front desk staff notify the clinician that the YOQ has been completed and clinical supervisors following up with clinicians through individual chart reviews. Additionally, it was noted that SBHC has requested additional training with the YOQ.

County's Response and Corrective Action Plan:

Action Plan: The Clinical Director will then explore YOQ research and training in order to provide Therapists an understanding of the YOQ along with how they can use it as an intervention. The goal of this is to gain buy-in which will help them to incorporate it into treatment. Research by the Clinical Director will complete by June 30, 2024. Previous to the Site Visit, Clinical Director has discussed with a Program Manager the plan of having him provide training for the YOQ if OSUMH does not have the resource of YOQ training. This training will be conducted no later than October 1 st 2024. We are also looking into our EHR system's ability to have a link in the note screen to provide easy of accessing the YOQ

Timeline for Compliance: Jan 1, 2025. We suspect an immediate increase as Program Managers focus on this objective.

Person responsible for action plan: Mike Sherratt, Clinical Director

Tracked at OSUMH by: Cody Northup

FY24 Recommendations:

1) **Working with Other Youth Serving Systems:** OSUMH applauds the efforts of SBHC in working with the other local youth service providers in the area and would like to recommend a continued focus on finding ways to improve collaboration with these agencies. During the on-site review it was reported that SBHC has relationships and ongoing communication with both Juvenile Justice and Youth Services (JJYS) and Division of Child and Family Services (DCFS), and all agencies are currently working on ways to enhance that communication. Additionally, all three agencies are continuing to work on maintaining confidentiality and addressing any privacy concerns with regards to mutual clients.

FY24 Division Comments:

1) **Family Peer Support Specialists (FPSS):** OSUMH staff met with two FPSS supervisors during the onsite review and were able to explore their perspectives. Additionally, a review of the FY23 youth scorecard shows an increase in FPSS services over the previous year (FY22: 1; FY23: 10). The supervisors noted that each of them have been certified for the last two years, expressed great enjoyment in what they do, and reported on the value that FPSS brings to the clients that they work with. OSUMH would like to acknowledge and show appreciation for SBHC's commitment to FPSS and the value that it brings to clients.

2) **Engaging Parents in Youth Treatment:** OSUMH commends SBHC and the St. George office on placing a focus to help parents engage with their children's treatment. It was reported during the onsite visit that the agency has developed and completed an "orientation to therapy" video for parents to view at the onset of treatment to help them recognize the importance of their involvement in the change process with their children. SBHC is currently identifying the most effective way of showing the video to parents. Additionally, SBHC has started a parent support group each week that provides further guidance for parents and ways they can more effectively connect with their children.

Adult Mental Health

Follow-up from Fiscal Year 2023 Audit

There were no findings in the FY23 audit.

Findings for Fiscal Year 2024 Audit

FY24 Major Non-compliance Issues:

None

FY24 Significant Non-compliance Issues:

None

FY24 Minor Non-compliance Issues:

None

FY24 Deficiencies:

1) **Outcome Questionnaire (OQ)**: A review of the FY23 adult scorecard shows a decrease in clients participating with the OQ (FY22: 83.5%; FY23: 40.2%) and as noted above, during the onsite monitoring visit there may be some concerns with the data being underreported due to a new documentation system being implemented July 1st, 2022. SBHC mentioned a concern that the OQ link in the new documentation system was producing an error and couldn't be utilized for a number of months, which is believed to be where the data is pulled from and causing the decrease in numbers. Exploration of the internal 2023 and 2024 chart reviews show that the OQ is being administered and utilized as a clinical tool on a regular basis. Additionally , SBHC has identified this as an area of focus for the agency and has outlined the following plan: Complete OQ as intervention training by April 3rd, 2024. Program manager will conduct monthly reviews on every therapist to determine if OQ was referenced as intervention (begin March 3rd). Work with the front desk to ensure completion of OQ when due (start March 13th). OSUMH would like to additionally recommend that SBHC work with the OSUMH data team to explore the decrease in OQ data and where it is pulled from within their new system.

County's Response and Corrective Action Plan:

Action Plan: The Clinical Director will explore OQ research and training in order to provide Therapists an understanding of the OQ along with how they can use it as an intervention. The goal of this is to gain buy-in which will help them to incorporate it into treatment. Research by the Clinical Director will complete by June 30, 2024. Previous to the Site Visit, Clinical Director has discussed with a Program Manager the plan of having him provide training for the OQ if OSUMH does not have the resource of OQ training. This training will be conducted no later than October 1 st 2024. We are also looking into our EHR system's ability to have a link in the note screen to provide ease of accessing the OQ.

Timeline for Compliance: Jan 1, 2025. We suspect an immediate increase as Program Managers focus on this objective.

Person responsible for action plan: Mike Sherratt, Clinical Director

Tracked at OSUMH by: Cody Northup

FY24 Recommendations:

None

FY24 Division Comments:

1) **Day Program Success (Elev8 and Oasis House):** During the onsite review, the OSUMH team was able to visit SBHC Clubhouse-like programs in both St. George (Elev8) and Cedar City (Oasis House). It was reported that both programs have been strong resources for clients, with an average of 45 individuals on a daily basis per facility. Elev8 is working toward accreditation and has been successful in implementing a client lead approach, including identifying meals and prepping meals, creating a schedule of activities, volunteering for various daily chores, applying for Clubhouse jobs such as employment coordinator, and participating in weekly wellness groups. Oasis House has members that have been going for many years and there is a sense of community with the members helping out with daily chores and meal prep.

2) **Peer Support Services (PSS):** OSUMH applauds SBHC's efforts on bolstering PSS for clients. A review of the FY23 adult scorecard shows a significant increase in services offered (FY22:62; FY23:149; 140%). SBHC reported that a large portion of the increase is due to a focus on training and education regarding specific roles for peer support and case management, as well as working with the case managers to recommend peer support if it is believed that a client could benefit from the services. SBHC mentioned that they have been focusing on getting individuals certified in peer support, including staff who lead DBT and dual diagnosis groups in

addition to holding peer support connection groups monthly. At the time of the review, SBHC had at least 5-6 certified peers in St. George and 5-6 in Cedar City.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review for Southwest Behavioral Health on March 19, 2024. The annual monitoring review was held virtually. The review focused on the requirements found in State and Federal law, Office 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 2023 Audit

FY23 Deficiencies:

1) The **Synar Compliance Check** rate decreased from 91.1% to 80.1% from FY21 to FY22 respectively, which does not meet OSUMH Directives. The standard for Synar Compliance Checks is to have a 90% compliance rate. It is recommended that SBHC work with the Health Department to increase the Synar compliance check rate.

   This issue has been resolved. The **Synar Compliance Check** rate moved from 80.1% to 92.4% from FY22 to FY23 respectively, which meets OSUMH Directives.

Findings for Fiscal Year 2024 Audit

FY24 Major Non-compliance Issues:
None

FY24 Significant Non-compliance Issues:
None

FY24 Minor Non-compliance Issues:
None

FY24 Deficiencies:
None

FY24 Recommendations:

1) The **Eliminating Alcohol Sales to Youth (EASY) checks** decreased from 24 to 22 checks from FY22 to FY23 respectively, which does not meet OSUMH Directives. The number of EASY Compliance Checks should increase by one check each year. It is recommended that SBHC continue working with law enforcement to increase the number of EASY compliance checks each year.

FY24 Division Comments:

1) **Youth State Leadership Training:** The Youth State Leadership Training continues to be a prominent event for youth around the state of utah. There were 200 youth around the state of Utah that attended the event at Bryce Canyon this past year with a goal to have 250 youth attend in the upcoming year. The Community Anti-Drug Coalitions of America (CADCA) provided a full day training for this event.

2) **Suicide Prevention - Washington County:** The Washington County Prevention Coalition (WCPC) has focused on various efforts, including addressing shared risk and protective factors to allow the coalition to not only address substance use disorder, but also suicide prevention. WCPC has been working on accessing resources in the community to further suicide prevention efforts, including partnering with the Live On campaign. The Live On campaign has been a primary focus at the Washington County Fair, which has brought attention to suicide prevention. They also focus on doing policy work on suicide prevention during the legislative sessions each year and provide training for the Hope Squads for every county. WCPC's efforts on suicide prevention have made a positive difference in their community.

3) **Parowan Valley Prevention Coalition:** The Parowan Valley Coalition (PVC) is the newest and strongest coalition. They recently completed a parent survey and collected a total of 82 surveys, which is significant since Parowan only has a community of 600 people. The survey showcased parental beliefs on alcohol use, community readiness for alcohol use prevention, a reduction of alcohol consumption in Parowan for overall lifetime use, and a slight increase in 30 day alcohol use, which was a result of the 12th grade responses. Parowan has been able to develop a plan to focus on methods of reducing alcohol use in their community through the recent data they gathered.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Southwest Behavioral Health on March 19, 2024. The annual monitoring review was held virtually. The review focused on compliance with State and Federal law, OSUMH contract requirements, and OSUMH Directives. Clinical practices and documentation were evaluated by reviewing SBHC's Internal chart review and discussing current practices. Adherence to Drug Court, Justice Reinvestment Initiative (JRI) 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 2023 Audit

FY23 Minor Non-compliance Issues:

1) **The Consumer Satisfaction Survey Shows:**

    a) 8.8% of **Youth (Family) Satisfaction Surveys** were collected in FY22, which does not meet OSUMH Directives.

    This issue has been resolved. 11.3% of **Youth (Family) Satisfaction Surveys** were collected in FY23, which meets OSUMH Directives.

    b) 9.6% of **Adult Satisfaction Surveys** were collected, which does not meet OSUMH Directives. There needs to be at least 10% of surveys collected to obtain accurate data results.

    This issue has been resolved. 12.1% of **Adult Satisfaction Surveys** were collected, which meets OSUMH Directives.

FY23 Deficiencies:

1) The Treatment Episode Data Set (TEDS) shows that the number of **old open admissions (old charts that should be closed)** was 9.7%, which does not meet OSUMH Directives. There needs to be less than 4% of old charts that can be open at any given time.

    This issue has not been resolved; see Deficiency #1.

Findings for Fiscal Year 2024 Audit:

FY24 Major Non-compliance Issues:

None

FY24 Significant Non-compliance Issues:

None

FY24 Minor Non-compliance Issues:

None

FY24 Deficiencies:

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

   a) **Old Open Admissions:** The Treatment Episode Data Set (TEDS) shows that the number of old open admissions (old charts that should be closed) was 13%, which does not meet OSUMH Directives. There should be less than 4% of old charts that should be open at any given time.
   b) **Completion of Services for Youth:** There were 0 clients under the age of 18 that were discharged from SUD treatment at SBHC in FY23 for any reason (completion, termination, drop out, etc.) In FY22, there were 416 completed SUD episodes and in FY23 only 76 were reported, which could account for not having youth in their data. Midyear for FY24, there were 0 discharges submitted from SBHC, which leads to showing that their SUD Treatment data is questionable for FY23.

County's Response and Corrective Action Plan:

Action Plan: SBHC is reviewing the number of old open admissions. It appears that a number of the open admissions are from services that SBHC submitted from Court Support Services and they were not notifying SBHC when a client was closed. We will work to close these old open admissions with the data team. Court Support Services is now using our Electronic Health Record (EHR) system to open, close and record services. This will ensure that they are being closed in a timely manner and also give us a better way to track and follow up on the open admissions in the system. We also believe that some of the old open admissions are due to the change in our EHR system and clients that should have been closed came over as open in the new system and have not been closed. SBHC will review and submit closures to get to the required 4% of old charts. In addition, SBHC data staff will review the Youth discharge questions to ensure data is tracked and reported correctly if there are errors.

Timeline for compliance: To be completed by July 1, 2024.

Person responsible for action plan: Wendy King, CIS Director

Tracked at OSUMH by: Becky King

FY24 Recommendations:

1) **TEDS Shows:**
    a) SBHC's rate of suicide deaths (26/100,000) is higher than the state overall (22/100,000) and has been increasing, similar to the state pattern.
    b) Youth need for Alcohol and Drug (AOD) treatment has been lower than the state, but in 2021 and 2023 it was slightly higher than the state.
    c) Clients who were Black, Indigenous, and People of Color (BIPOC) were less likely to drop out of treatment but more likely to be terminated than clients who were white, not Hispanic.

    It is recommended that SBHC review their data for accuracy or look into methods of reducing suicide deaths, reducing the need for AOD treatment for youth and reviewing reasons why BIPOC may be terminated in treatment more than white clients.

FY24 Division Comments:

1) **TEDS Shows:**
    a) SBHC and the state have a similar pattern and rate of drug overdose deaths (20/100,000 in 2018-20).
    b) SBHC has a rate of successful completion of SUD treatment that is higher than both the state and rural averages. This rate increased steeply between FY2022 and FY2023.
    c) SBHC has a high rate of clients abstinent from drugs at discharge but a low rate of clients abstinent from alcohol at discharge.
    d) SBHC has a high percentage of clients (93% overall) who completed at least 90 days in treatment at the end of an episode. In FY2022, this number was 52%. The state and rural averages in FY2023 were 56% and 53%, respectively.
    e) SBHC has an excellent rate of clients using social recovery support at discharge.
    f) SBHC has a greater decrease in tobacco / nicotine use than both the state and rural averages.
    g) SBHC clients have lower rates of criminal justice involvement at both admission and discharge in 2023.
    h) SBHC has higher completion and termination rates and lower dropout rates than the state and rural averages.

2) **Suicide Prevention and Quality Treatment Services:** SBHC continues to focus on Suicide Prevention that includes suicide prevention trainings agency wide. Their goal is to train all staff to be able to respond to anyone that may be experiencing a

suicidal crisis. Their Zero Suicide Grant has been utilized to train staff in Crisis Response Planning (CRP). All providers are trained in this model and SBHC now has their own trainer on staff. SBHC also utilizes this grant opportunity to train clinicians on Brief Cognitive Behavioral Therapy (BCBT). They are also working on increasing their ability to treat psychosis by continuing Cognitive Behavioral Social Skills Training (CBSST) groups, training on Cognitive Behavioral Therapy for Psychosis (CBTp), and through monthly consultation with a specialist at the Utah State Hospital.

3) **Crisis Services / Receiving Center:** SBHC received funding to build a Receiving Center, which opened in September 2023. Most of the referrals for the Receiving Center from law enforcement and the state crisis line. The remaining 10% of referrals come from other sources. SBHC offers crisis services 24/7 and they are using the Mobile Crisis Outreach Team (MCOT) to do outreach as needed. SBHC has a dedicated MCOT Team to provide crisis outreach. The Receiving Center and crisis services provided by SBHC have been valuable for their community.

Section Two: Report Information

Background

Utah Code Section 26B-5-102 outlines duties of OSUMH. Paragraph (2)(c) states that the OSUMU 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 OSUMH 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. OSUMH 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 OSUMH 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 Office of Substance Use and Mental Health

Prepared by:

Kelly Ovard _____ Date 05/01/2024
Administrative Services, Auditor IV

Approved by:

Kyle Larson _____ Date 05/01/2024
Administrative Services Director

Pam Bennett _____ Date 05/01/2024
Assistant Division Director

Eric Tadehara Eric Tadehara (May 1, 2024 10:06 MDT) Date 05/01/2024
Assistant Division Director

Brent Kelsey Brent Kelsey (May 6, 2024 08:02 MDT) Date 05/06/2024
Director

Attachment A

OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY24

Name of Local Authority: **Southwest Behavioral Health Center**

Date: **March 6, 2024**

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		Need confirmation of the plan's official status (i.e. signature page)
Record of changes (indicating dates that reviews/revisions are scheduled/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
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 (HCC) . Participated in a minimum of three of the four yearly DHHS radio checks		X		SWBC has five radios, one for each county. It is strongly suggested that all counties participate in these checks. We appreciate SWBC's participation in their regional healthcare coalition. Beaver participated in 2 checks in the past year Iron participated in all checks this past year Kane participated in all checks this past year Washington did not participate in the radio checks Garfield did not participate in the radio checks
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
Procedure for protection of healthcare information systems and networks	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			
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.

OSUMH Southwest FY24 Audit Final Report

Final Audit Report 2024-05-06

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