State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

Date: March 21, 2025
Commissioner Lorene Miner Kamalu
Davis County Commission
PO Box 618
Farmington, UT 84025

Dear Commissioner Kamalu:

In accordance with Section Annotated 26B-5-102, 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 local authority has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. SUMH has approved all corrective action plans submitted by the local authority/county in response to each reported finding, which have been included in the final report. If there are any questions, please contact Kelly Ovard at 385-310-5118.

SUMH appreciates the cooperation and assistance of the staff and looks forward to a continued professional relationship.

Sincerely,

Brent Kelsey (Mar 22, 2025 11:29 MDT)
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

Utah Department of
Health & Human Services
Integrated Healthcare

Site Monitoring Report of

Davis Behavioral Health

Local Authority Contract #A03091

Review Date: December 17, 2024

Final Report

Table of Contents

Section One: Site Monitoring Report

Executive Summary

In accordance with Section 26B-5-102, the Office of Substance Use and Mental Health (also referred to in this report as SUMH) conducted a review of Davis County and their contracted service provider, Davis Behavioral Health (also referred to in this report as DBH) on December 17, 2024. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance use 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; SUMH 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 DBH'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 local authority 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 local authority 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	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Mental Health Programs	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	12-13
Substance Use Disorders Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	15
Substance Use Disorders Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	

Governance and Fiscal Oversight

SUMH 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 17, 2024 by Kelly Ovard, Financial Services Auditor IV.

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. Travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Meeting minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided by the governing board and County.

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 local authority that year. This allows SUMH 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, 2022. The auditors issued an unmodified opinion in their report dated June 28, 2023. The SAPT Block Grant, Mental Health Block Grant and the State Opioid Response Grants were selected for specific testing as a major program.

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, 2024. The auditors issued an ? 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. Due to issues with Medicaid and the PRISM conversion, the financial audit for the year ending June 30, 2023 has not yet been completed as of March 17, 2024 DBH will provide this audit report to SUMH once it has been finalized and will upload the audit to the Federal Audit Clearinghouse.

Follow-up from Fiscal Year 2024 Audit

FY24 Minor Non-compliance Issues:

1) **Documents were not uploaded by the deadline**: Documents for the audit were due on Tuesday November 14, 2023, three weeks prior to the audit. As of Wednesday February 14, 2024, there are still documents that have not been uploaded for the audit. (Payment Justifications for JRI-MH & JRI-SUD, the 2023 financial audit ending June 30, 2023, the Certification of Audit Review and the Grant Match verification for the CHR-P grant)

   This item has been resolved

Findings for Fiscal Year 2025 Audit

FY25 Major Non-compliance Issues:

None

FY25 Significant Non-compliance Issues:

None

FY25 Minor Non-compliance Issues:

None

FY25 Deficiencies:

None

FY25 Recommendations:

1) **Emergency Plan:**. **The plan indicates annual review but does not identify changes**. It is recommended that DBH have a record of changes to the plan. It is strongly encouraged that DBH participates in regional healthcare coalitions if not currently doing so. **(See Appendix A)**
2) **Review Unspent Funding:** SUMH recommends that the Local authority discuss unspent funding with DBH to determine how best to use this funding in future fiscal years.

Program	Service Code	Awarded Amount	Spent Amount	Unspent Amount
MH	EBI - Evidence Based 1st Psychosis	$16,085	$0	$16,085
	EBI - Evidence Based 1st Psychosis	$78,750	$0	$78,750
	PPT - Cert PSS Training	$15,000	$11,400	$3,600
	Total	**$109,835**	**$11,400**	**$98,435**
SUD	PTR - ATR Corrections	$74,379	$35,893	$38,486
	Total	**$74,379**	**$35,893**	**$38,486**
Prevention	PFS2 - Partnerships for Success	$143,200	$70,265	$72,935
	PXP - Prevention Prepared Communities	$233,000	$209,977	$23,023
	SOP2 - State Opioid Prevention	$89,950	$40,092	$49,858
	SOP1 - State Opioid Prevention	$256,500	$250,753	$5,747
	YPX - Youth SUD Prevention Programs	$160,000	$125,040	$34,960
	Total	**$882,650**	**$696,127**	**$186,523**
	Total	**$1,066,864**	**$743,420**	**$323,444**
	Grand Total of LA funding in FY24	**$14,678,051**	**$14,374,607**	**$303,444**
Total Spent/Unspent %			**97.9%**	**2.07%**

FY25 Comments:

1) The FY24 financial audit will be completed at the end of December due to PRISM delays. The **audit** will be provided, uploaded to the **Federal Audit Clearinghouse** and the **Medicaid Cost Report** completed by the end of January.

Mental Health Mandated Services

According to Section 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 (6)(a)(ii) each local authority is required to "annually prepare and submit to SUMH 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 SUMH 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 SUMH is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Mental Health Programs

Cody Northup, Program Administrator, and Heather Rydalch, Peer Support Program Manager, conducted the annual monitoring review for mental health programs at Davis Behavioral Health (DBH) on December 17th, 2024. 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 FY24 Monitoring Report; statistics, including the mental health scorecard; area plans; adult and youth outcome questionnaires (OQs/YOQs); Office Directives, and the Center's provision of the ten mandated services as required by Section 17-43-301.

Follow Up from Fiscal Year 2024 Audit:

FY24 Deficiencies:

Adult Mental Health

1) **Participation with Outcome Questionnaires (OQs):** A review of the FY23 Adult Mental Health Scorecard indicates that the percent of unduplicated clients participating has increased from FY23 (44.1%- 46.1%). This is below the required match of 50% and the third year that the measurement has fallen below the required minimum. During the site visit DBH reported that clients with serious mental illness (SMI) are attending Journey House and family groups. A large portion of the SMI clients are utilizing case management only or medical services, and not going through the front desk where most of the OQs are being administered. DBH reports that case managers may not be doing the OQs, as they are viewed as a clinical tool with effectiveness associated with discussions with a clinician. DBH reported that they will check if Assertive Outreach Team clients are taking the questionnaire and train staff if needed. SUMH encourages DBH to continue to monitor the areas of administration for the OQ, and make adjustments as needed to use the OQ as an evidence-based intervention.

This will remain a finding. ***See FY25 Recommendations, Adult Mental Health #1.***

Findings for Fiscal Year 2025 Audit

FY25 Major Non-compliance Issues:

None

FY25 Significant Non-compliance Issues:

None

FY25 Minor Non-compliance Issues:

None

FY25 Deficiencies:

Adult Mental Health

1) **Participation with Outcome Questionnaires (OQs):** A review of the FY24 adult mental health scorecard shows the number of unduplicated clients participating in the OQ is 45.6% which is below the required match of 75% based on the FY24 Office Directives. During the on site monitoring visit, the SUMH reviewer and DBH were able to discuss this data and noted that DBH has consistently been hovering around the 45% participation rate for the last few years (FY22:44.61%; FY23:46.1%; FY24:45.6%). DBH has not met the required client match, despite using the same process as is used with youth clients, who have a participation rate above 90%. Per the FY24 monitoring report corrective action plan, DBH would ensure that all SMI clients would receive the OQ as indicated in the Office Directives and reported to SUMH that this was occurring during a mid-year follow up. During the on site review, DBH acknowledged that reaching the OQ goal had not occurred and expressed further interest in exploring how to improve this data point going forward. SUMH recommends that DBH work with SUMH to further explore what the barriers may be and ways to achieve the 75% match going forward.

County's Response and Corrective Action Plan:

Action Plan:
Several times per year, DBH will ensure every client who comes to the clinic in that month is given the OQ, regardless of the reason for their appointment. Additionally, we will assign a therapist to be responsible for the administration of the OQ to those clients who primarily receive community based services. The adult team will continue to receive training around administering the OQ via email and with the client during telehealth appointments. We have discussed with OSUMH the possibility of receiving a mid-year report for future years to help us track progress throughout the year.

Timeline for compliance: June 30, 2025

Person responsible for action plan: David McKay, Kim McComas

Tracked at OSUMH by: Cody Northup

FY25 Recommendations:

None

FY25 Comments:

Combined Mental Health

1) **Syracuse Clinic:** DBH mentioned that they opened a clinic in Syracuse, Utah to expand access to services throughout their catchment area. At the clinic they offer mental health and medication management outpatient services to adults, children, and families. It was noted that clinician schedules have been full, particularly on the adult side, and that DBH has received positive feedback from clients about having a facility that is convenient for them. SUMH acknowledges and appreciates DBH's commitment to clients in their catchment area and for meeting their accessibility needs.

2) **Managing Workloads:** During the on site monitoring visit, DBH reported that they have made a number of scheduling adjustments to help with clinician workload, availability of sessions for clients, and opportunities for clinicians to practice new evidence based practices. Clinicians are now limiting their number of scheduled sessions with each client to two appointments at a time which is improving access as well as helping to monitor no shows or late cancellations with existing clients. Another change involves clinicians scheduling open slots for identified clients to receive specific therapeutic services. Clinicians collaborate together on the identifying clients, share progress and challenges. This allows clinicians to be strategic in their scheduling to meet clients' needs, as well as receive needed support and structure to implement newly learned modalities.

3) **Certified Peer Support Specialists (CPSS) and Family Peer Support Specialists (FPSS):** SUMH and DBH reviewed the FY24 youth and adult mental health scorecards and noted a substantial increase in both CPSS and FPSS numbers from the previous year. The adult mental health scorecard shows an increase of 323% (FY23:226; FY24:956) for CPSS clients served and the youth mental health scorecard shows an increase of 177% (FY23:26; FY24:72) for FPSS clients served. DBH attributed the increase in CPSS and FPSS numbers to them being more intentional with utilizing peer support services, having peers attend case management meetings, ensuring proper documentation is matching the services being provided, being assigned to local schools (FPSS), and starting peer groups (CPSS). Group topics focus on Illness Management and Recovery (IMR) and Peer Social Skills. DBH reports they currently have 15 full-time and 4 part-time CPSS and 3 full-time and 3 part-time FPSS. SUMH applauds DBH's focus and intention on utilizing CPSS and FPSS services with their clients and ensuring clients have access to this valuable support.

Children, Youth, and Families

1) **School Based Services:** DBH is currently working in 14 different schools in the area, providing support 2 days per week at 13 schools and 4 days per week at 1 school. The services being provided primarily include individual and family therapy, and the child can be referred back to the main DBH facility if they need more intensive services. DBH is also collaborating with the school counselors, reviewing behavior plans with them, and talking with other community supports to determine the level of need for the kids/families, as well as determining when services are no longer needed.

Adult Mental Health

1) **Services for Older Adults:** DBH mentioned having a number of opportunities in place for the older adult population. The agency has been holding a virtual therapeutic processing group for adults who are 60+ years old. Topics include family relationships, grief, loneliness etc, and the group has reportedly been well attended. Additionally, DBH noted that the agency has clinicians go to local nursing homes to work with adults who may not be able to make it into the main facility, as well as doing educational visits to 3 separate senior centers in the area. SUMH commends DBH's effort and focus with this population, and the many ways they are a supportive partner and presence in the community.

2) **New Housing Facility:** DBH recently purchased 5 acres of land next to their main building which is currently being used as a warming local authority for individuals who are experiencing unsheltered homelessness when a code blue is issued which will remain available throughout the winter months. During spring of 2025, the facility on the property will be torn down and DBH will begin building a 60 unit single bed housing structure to help address the ongoing housing need. DBH currently has 140 beds that they utilize as part of their services, and will add the additional 60 once this new facility is complete. SUMH appreciates DBH's recognition of the need for individuals to have housing and the efforts to continue to build it into their service array.

Substance Use Disorders Prevention

David Watkins, Program Administrator for SUMH, conducted the annual prevention review of DBH on December 17, 2024. The review focused on the requirements found in State and Federal law, SUMH 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 2024 Audit

There were no findings in the FY24 Audit

Findings for Fiscal Year 2025 Audit

FY25 Deficiency:

1) **Data Entry:** During FY24 DBH met the office directives standard of reporting into the Data Users Group System (DUGS) 54% of the time. The Office Directives state "the LA must enter prevention data into the SUMH approved system within 45 calendar days of the delivery of service." At the site visit, DBH mentioned that some of the programs offered are up to 7 or 8 weeks, which is longer than 45 days. DBH has established a process where they enter in all data for a class at the completion of the class rather than after the completion of each session of the class. SUMH recommends that DBH work to establish at least a monthly data entry system instead of at the completion of the program.

County's Response and Corrective Action Plan:

Action Plan:
A new process has been established for monthly data entry. Data is collected during registration, and program managers generate class rolls for instructors. After each class, instructors update the rolls to keep information current. Angie, Jennifer, and Ashley will enter the data into DUGS at least once a month to ensure all classes are recorded within the 45-day timeframe. Each coalition coordinator has a tracking sheet where data (meetings, activities, and events) is kept. Once a month the program managers will enter CTC data into the state reporting system

Timeline for compliance:
As of February 1, 2025 all data should be entered within 45 days of each session.

Person responsible for action plan:
Angie Smith, Jennifer Meyer, & Ashley Desimone

Tracked at OSUMH by: David Watkins

FY25 Recommendations:

1) **Continue process with the Evidence-Based Workgroup (EBW):** DBH offers Circle of Security Parenting, Learning to Breathe, and Catch my Breath programs that don't come from an approved substance use prevention registry. DBH has submitted initial materials to the EBW on the Circle of Security Parenting and the Learning to Breathe programs. SUMH encourages DBH to continue the process by submitting additional research and evaluations of those programs. SUMH also encourages DBH to submit the Catch my Breath program to the EBW.

FY25 Comments:

1) **Partnerships:** At the site visit DBH highlighted the amazing partnerships that have been established throughout the county. In particular DBH has formed a strong partnership with the Davis School District. This partnership has led to classroom implementation of Learning to Breathe and the Catch my Breath programs. It was mentioned that in part due to this relationship, DBH was able to reach more people in the past month with prevention programming than they were in the previous year. This partnership extends outside of school-based programming, one of the reasons DBH is successful at getting parents to attend parenting programs is because the school district advertises for those classes and provides school building space to hold the programs.

2) **Community Coalitions:** SUMH recognizes the work the DBH has done in establishing community coalitions utilizing the CTC framework. To continue to enhance coalition efforts, DBH has focused on providing training and TA to coalition coordinators. To meet the growing needs of coalition coordinators, DBH had them trained in the CADCA Coalition Academy. Recognizing the need coalitions had for more coaching, DBH contracted with CADCA to provide coalition coaching on a merged CTC/CADCA model. This will help coalitions plan to deliver evidence based programs and implement evidence based environmental strategies addressing local conditions.

Substance Use Disorders Treatment

Becky King, Program Administrator for SUMH conducted the monitoring review on December 17, 2024 for DBH. The review focused on compliance with State and Federal laws, SUMH Directives, Federal Substance Abuse Treatment (SAPT) block grant requirements, JRI, Drug Court, scorecard performance and consumer satisfaction. The review included a document review, review of DBH's clinical chart review, and an interview with the clinical director and other staff members. Consumer satisfaction and performance were also evaluated using SUMH Outcomes Scorecard, and the Consumer Satisfaction Scorecard.

Follow-up from Fiscal Year 2024 Audit

FY24 Deficiencies:

1) **The Treatment Episode Data Set Shows:**
   a) DBH has a low median number of days in treatment. For clients who successfully complete treatment, the median number of days at DBH is 64 days, which is roughly half of the state and urban averages (133 and 114, respectively). DBH also has a low percentage of clients who have completed 90 days in treatment at the end of an episode. In FY22, 41% of clients completed 90 days and in FY2023, 44% completed 90 days of treatment. The state and urban averages in FY22 and FY23 were 56% and 53%, respectively.

      This issue has not been resolved, which will be addressed in Recommendation #1 below.

   b) 15% of Criminogenic Risk Data was not collected. SUMH Directives require that there should be less than 10% of data collected at any given time.

      This issue has been resolved. The percentage of justice referred and drug court clients who do not get assessed for criminogenic risk must be below 10%. DBH assessed 100% of justice referred clients in FY24, which meets Office Directives.

2) The Adult Satisfaction Consumer Surveys shows that there were 9.8% of surveys collected, which does not meet SUMH Directives. There needs to be at least 10% of surveys collected to obtain accurate data results.

   This issue has been resolved. The Adult Satisfaction Consumer Surveys shows that there were 20% of surveys collected in FY24, which meets Office Directives.

3) DBH has not submitted any Recovery Support Services (RSS) data since June 2023. It is recommended that DBH work to resolve monthly RSS data submission issues.

This issue has been resolved. DBH submitted Recovery Support Services (RSS) data in FY24, which meets SUMH Directives. DBH provided recovery support services to 808 SUD clients in FY23 and 714 SUD clients in FY24. This represents about 38% of SUD clients served in FY24.

Findings for Fiscal Year 2025 Audit:

FY25 Major Non-compliance Issues:
None

FY25 Significant Non-compliance Issues:
None

FY25 Minor Non-compliance Issues:
None

FY25 Deficiencies:
None

FY25 Recommendations:

1) **Successfully Completing Treatment:** The Treatment Episode Data Set (TEDS) Shows that the percentage of clients who successfully completed SUD treatment at DBH decreased from FY23 (56%) to FY24 (32%). DBH believes this may be a data issue. This issue may also be related to the following factors: (1) The number of individuals who were dropped from Medicaid due to the unwinding who didn't come in for services; (2) DBH was doing screening at the jail, which ended and may have impacted the number of people coming in for services; and (3) DBH transferred a significant number of clients to other providers, which may have been coded incorrectly as an unsuccessful completion.

   It is recommended that DBH examine their data for accuracy and continue to provide training for their staff regarding data entry into the Substance Abuse and Information System (SAMHIS).

FY25 Comments:

1) **TEDS Shows that Davis County is doing well in the following areas:**

   a) The use of medication assisted treatment (MAT) was 45% for SUD clients with opioids as their primary, secondary, or tertiary substance. This is up from 29% in FY23. *(**Please note that last year this was reported as MAT for clients for whom opioids were the primary substance.**)* DBH has placed an emphasis on expanding MAT options for their clients. Individuals coming in for MAT services are evaluated during their initial medical appointment. Individuals being referred by therapists have been assessed for opiate and alcohol use

during their SUD evaluation. All documentation occurs within DBH's electronic health record (EHR), Credible. Medical providers complete a medication management evaluation for MAT. Therapy providers assess MAT through the American Society of Addiction Medicine (ASAM) dimensions 1 and 2, and a referral for MAT is included in the therapy evaluation service. All clients receiving MAT have a medical treatment plan in place with goals toward recovery.

Table 2. Davis SUD Served

Source: TEDS data *(each client is counted only once)*

	FY22	FY23	FY24
Total	2323	2207	1903
Drug Court	104	93	78
MAT (Med. Assisted Tx)	495	371	504
Methadone	137	65	44
Naltrexone	139	100	172
Buprenorphine	245	219	288
Any opioid use	986	904	750
% opioid users receiving MAT	34%	29%	45%
Women	808	767	730
Youth	117	129	100
Justice Referred	784	790	750
Old Open Admissions	1%	0%	0%
Priority Groups			
Pregnant IV Users	10	6	6
Female IV Users	247	282	148
Male IV Users	383	429	217

b) Stable Housing was high at admission (97%) and discharge (98%). DBH owns housing units and is building more apartments to house their clients. These efforts have helped provide more affordable housing for their clients.

c) The percentage of SUD clients employed or in school was higher (46%) than the state (40%) and urban averages (33%) at admission. DBH helps their clients find employment and stay in school while they are in treatment and upon discharge.

d) Consumer satisfaction at DBH has been high (FY20 - 98%, FY21 - 91%, FY22 - 91%, FY23 - 90%, FY24 - 91%) for general satisfaction scores. DBH uses evidence-based methods and individualizes treatment, which helps clients

achieve successful outcomes. They also use a supportive approach, which helps clients feel valued.

2) **Begin Again Recovery Center:** The Begin Again Recovery local authority at DBH offers a range of services aimed at supporting individuals with mental health and substance use challenges. This program is designed to provide comprehensive, compassionate care to help individuals on their path to recovery and mental wellness. Some of the services provided by this local authority include: (1) Crisis Recovery Unit (CRU), which is a short term, crisis stabilization and residential services for individuals with serious mental illness; (2) Individual and Group Therapy; (3) Psychiatric Care and Medication Management; (4) Case Management and Skills Group; and (5) Rehabilitation Programs. The Begin Again Recovery local authority aims to provide a supportive and effective environment for individuals to begin their journey toward lasting recovery and improved mental health.

3) **DBH Receiving Center:** The DBH Receiving local authority provides a range of crisis intervention services to individuals experiencing mental health, substance use, or other behavioral crises. Services that are provided in this program include: (1) 24/7 Crisis Intervention, (2) Crisis Stabilization, (3) Suicide Assessment, (4) Physical Health Screening, (5) Evaluation and Detox Services, (6) Peer Services, (7) Medication Management and Medication-Assisted Treatment (MAT), and (8) Connection to Treatment Programs. After stabilization, clients are connected to ongoing treatment programs and outpatient services. The Receiving Center has helped provide a diversion from emergency rooms and jails and reduced costs related to incarceration and emergency department overuse by diverting individuals to community based treatment. The number of individuals served through the Receiving Center increased from 600 to 800 individuals over the past year, which has been a benefit to the community.

Section Two: Report Information

Background

Section **26B-5-102** outlines duties of SUMH. Paragraph **(2)(c)** states that SUMH 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 SUMH 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 SUMH 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. SUMH 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. SUMH may be relied upon for technical assistance and training and the Local Authority is encouraged to utilize SUMH resources. Each corrective action plan must be approved by SUMH 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 SUMH as evidenced by their signature and date; follow-up and verification actions by SUMH and formal written notification of the compliance or non-compliance to the contractor.f

Timeline for the Submission of the Action Plan: This report will be issued in DRAFT form by SUMH. Upon receipt, the local authority will have five business days to examine the report for inaccuracies. During this time frame, SUMH requests that local authority 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, SUMH will evaluate the finding and issue a revision if warranted.

At the conclusion of this five day time frame, the local authority 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 SUMH).

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

Signature Page

SUMH appreciates the cooperation afforded SUMH 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 03/21/2025
Administrative Services Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 03/24/2025
Administrative Services Director

Pam Bennett Date 03/22/2025
Assistant Director

Eric Tadehara Eric Tadehara (Apr 1, 2025 21:58 MDT) Date 04/01/2025
Assistant Director

Brent Kelsey Brent Kelsey (Mar 22, 2025 11:29 MDT) Date 03/22/2025
Director

Attachment A

UTAH OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY25

Name of Local Authority: **Davis Behavioral Health**

Date: **December 11, 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			
Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)		X		**Plan indicates annual review but does not identify changes. It is recommended that DBH has a record of changes to the plan.**
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				
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			DBH participated in all the radio checks this past year. Thank you! SUMH strongly encourages participation in the Regional Healthcare Coalition if not currently attending.
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.

SUMH Davis Co FY25 Final Report

Final Audit Report 2025-04-02

Created:	2025-03-22
By:	Kelly Ovard (kovard@utah.gov)
Status:	Signed
Transaction ID:	CBJCHBCAABAAR1_-UuEdEXqJOMEzPyomjyt_69p6jU7B

"SUMH Davis Co FY25 Final Report" History

Document created by Kelly Ovard (kovard@utah.gov)
2025-03-22 - 2:51:10 AM GMT- IP address: 207.135.246.161

Document emailed to Kelly Ovard (kovard@utah.gov) for signature
2025-03-22 - 2:53:54 AM GMT

Document emailed to Kyle Larson (kblarson@utah.gov) for signature
2025-03-22 - 2:53:54 AM GMT

Document emailed to Pamela Bennett (pbennett1@utah.gov) for signature
2025-03-22 - 2:53:54 AM GMT

Document emailed to Eric Tadehara (erictadehara@utah.gov) for signature
2025-03-22 - 2:53:55 AM GMT

Document emailed to Brent Kelsey (bkelsey@utah.gov) for signature
2025-03-22 - 2:53:55 AM GMT

Email viewed by Kyle Larson (kblarson@utah.gov)
2025-03-22 - 2:54:02 AM GMT- IP address: 66.249.84.34

Document e-signed by Kelly Ovard (kovard@utah.gov)
Signature Date: 2025-03-22 - 2:54:17 AM GMT - Time Source: server- IP address: 207.135.246.161

Email viewed by Pamela Bennett (pbennett1@utah.gov)
2025-03-22 - 3:50:37 PM GMT- IP address: 66.249.84.34

Document e-signed by Pamela Bennett (pbennett1@utah.gov)
Signature Date: 2025-03-22 - 3:51:42 PM GMT - Time Source: server- IP address: 168.178.201.77

Document e-signed by Brent Kelsey (bkelsey@utah.gov)
Signature Date: 2025-03-22 - 5:29:52 PM GMT - Time Source: server- IP address: 136.60.149.105

Document e-signed by Kyle Larson (kblarson@utah.gov)

Signature Date: 2025-03-24 - 1:23:34 PM GMT - Time Source: server- IP address: 204.113.19.47

Email viewed by Eric Tadehara (erictadehara@utah.gov)

2025-03-25 - 1:07:50 PM GMT- IP address: 66.102.6.168

Email viewed by Eric Tadehara (erictadehara@utah.gov)

2025-03-30 - 7:19:05 AM GMT- IP address: 66.102.6.160

Email viewed by Eric Tadehara (erictadehara@utah.gov)

2025-03-31 - 10:45:31 AM GMT- IP address: 66.249.84.33

Email viewed by Eric Tadehara (erictadehara@utah.gov)

2025-04-01 - 5:07:58 AM GMT- IP address: 66.249.84.35

Email viewed by Eric Tadehara (erictadehara@utah.gov)

2025-04-02 - 3:58:03 AM GMT- IP address: 66.102.6.169

Document e-signed by Eric Tadehara (erictadehara@utah.gov)

Signature Date: 2025-04-02 - 3:58:29 AM GMT - Time Source: server- IP address: 209.147.104.76

Agreement completed.

2025-04-02 - 3:58:29 AM GMT