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Deputy Director
NATE WINTERS
Deputy Director

Date: June 27, 2025

Commissioner Celeste Meyeres - Board Chair
Kane County Commission
76 North Main
Kanab, Utah 84741

Dear Commissioner Meyeres:

In accordance with Section 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 Local Authority; 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 (Jun 30, 2025 10:59 MDT)

Brent Kelsey
Director

cc: Wade Hollingshead, Beaver County Commission
Victor Iverson, Washington County Commission
Paul Cozzens, Iron 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 Local Authority

Local Authority Contract # A03083

Review Date: March 18, 2025

Draft Report

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Section One: Site Monitoring Report

Executive Summary

In accordance with Section 26B-5-102, the Office of Substance Use and Mental Health (SUMH) conducted a review of Southwest Behavioral Health Local Authority (SBHC) on March 18, 2025. 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 Local Authority'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 Local Authority's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Local Authority'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 Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	7-8
Mental Health Programs	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	10-11
Substance Use Disorders Prevention	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
Substance Use Disorders Treatment	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 None	13-14

Governance and Fiscal Oversight

The Office of Substance Use and Mental Health (SUMH) conducted its annual monitoring review of the Local Authority, Southwest Behavioral Health Local Authority (SBHC). The Governance and Fiscal Oversight section of the review was conducted on March 18, 2025 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 Local Authority'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 Local Authority'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 the SUMH to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Local Authority'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 SUMH 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, 2024 and submitted it to the Federal Audit Clearinghouse on January 6, 2025. The CPA firm Hafen Buckner Everett & Graff, PC performed the Local Authority's audit and issued a report dated December 3, 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 2024 Audit:

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.

   This finding 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:

1) **Emergency Plan:** All five counties did not meet the required 75% participation in radio checks as outlined in the office directives. (**Please review the audit in Appendix A**)

County's Response and Corrective Action Plan:

Action Plan:

1. A primary staff member responsible for participating in the scheduled emergency radio test calls in each of the five counties has already been assigned. A secondary staff will now be designated to participate in the event that the primary is unavailable.

2. The SBHC Facility Manager will distribute the State's quarterly calendar and will add the test call to each Primary staff's calendar noting the date and time of the call.

3. The SBHC Facility Manager will send a reminder 24 hours and 1 hour prior to each test call via email or text to all designated staff. The SBHC Facility Manager will log participation by each team as a rollcall is taken on each call.

4. Brief refresher training will be provided on radio protocols and expectations. County teams will review procedures during upcoming staff meetings.

Timeline for compliance: July 1, 2025; Beginning with the next quarterly statewide test call in September, all five counties will implement the above plan to ensure compliance with the 75% participation requirement.

Person responsible for action plan: SBHC Facility Manager, Bill Dudleston.

Tracked at OSUMH by: Kelly Ovard, Geri Jardine

FY25 Deficiencies:

None

FY25 Recommendations:

1) **Unspent Funds:** It is recommended that SBHC discuss internally any unspent funds to optimize the use of the resources provided in this contract.

Program	Service Code	Awarded Amount	Spent Amount	Unspent Amount
MH	RCS - Receiving Local Authority Services	$44,942	$34,949	$9,993
	SPF - Suicide Prevention Firearm Safety	$40,000	$28,912	$11,088
	UPP1 - SAMHSA Int Grant with LA and FQHC's	$76,830	$59,168	$17,662
	UZS - Utah Zero Suicide	$50,000	$49,761	$239
	Total MH	$211,772	$172,790	$38,982
SUD	PTR - ATR Corrections	$56,325	$54,332	$1,993
	SLF - Sober Living Funding	$133,056	$131,117	$1,939
	SOR2 - State Opioid Response	$50,000	$30,923	$19,077
	Total SUD	$239,381	$216,372	$23,009
Prevention	IMC - Intermountain Communities that Care	$77,100	$75,094	$2,006
	PFS2 - Partnerships for Success	$251,600	$100,254	$151,346
	PXP - Prevention Prepared Communities	$404,800	$327,254	$77,546
	SOP2 - State Opioid Prevention	$92,800	$62,903	$29,897
	YPX - Youth SUD Prevention Programs	$212,500	$211,357	$1,143
	Total Prevention	$1,038,800	$776,862	$261,938
	Total Unspent Dollars	$1,489,953	$1,166,024	$323,929
Total Dollars Allocated to Southwest		$15,593,135	$15,277,353	$323,929
Total Spent/Unspent %			97.02%	2.08%

FY25 Comments:

None

Mental Health Mandated Services

According to Section 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 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 conducted the annual monitoring review at Southwest Behavioral Health Local Authority (SBHC) on March 18-19, 2025. 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); SUMH Directives, and the Local Authority's provision of the ten mandated services as required by Section 17-43-301.

Follow-up from Fiscal Year 2024 Audit

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%).

2) ***Youth Outcome Questionnaire (YOQ):*** The FY23 youth scorecard indicates a decrease in percentage of clients participating with the YOQ (FY22: 87%; FY23: 58%).

   These two deficiencies will remain findings for this current fiscal year as FY24 scorecards indicate both the OQ/YOQ are below the 75% administration requirement. The findings have been paired in the combined mental health section below.

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:

Combined Mental Health

1) **Outcome Questionnaire/Youth Outcome Questionnaire (OQ/YOQ):** A review of the adult and youth mental health scorecards show that SBHC's OQ/YOQ scores are below the 75% requirement in the FY24 Office Directives and therefore will be a

deficiency on this fiscal year's monitoring report. Both the OQ and YOQ were deficiencies on the previous fiscal year's monitoring report; this may have been a data concern due to a new electronic health record. Per FY24 scorecards, rates of admission for both OQ (FY23:40%; FY24:69%) and YOQ (FY23:58%; FY24:73%) have improved, but remain below the required rate.

County's Response and Corrective Action Plan:

Action Plan: OQ/YOQ training. We have assessed the barriers of conducting OQ/YOQ and have determined that the largest barrier is understanding and by in on the measures validity. Our action plan is to train out staff in the use, validity, and reporting functions of the OQ/YOQ. SBHC has contacted and arranged training from OQ Measures, the producer of the OQ series of instruments. We are conducting the training in the following three phases:

1. Meet with executive level staff to discuss our barriers with utilizing the measure. This phase was completed on 4/24/25.
2. Conduct an OQ training with Program Managers on the validity and how they can use the measure in monitoring the effectiveness of their program.
3. Conduct an OQ training from OQ Measures to all therapists of SBHC.

Expected outcomes are:

1. Therapists will understand the measure more and utilize it in session.
2. Program Managers will monitor and use it to evaluate the effectiveness of their program.

Timeline for compliance: 12/2025

Person responsible for action plan: SBHC Clinical Director

Tracked at OSUMH by: Cody Northup

FY25 Recommendations:

Combined Mental Health

1) **Data and Outpatient Services:** SUMH recommends that SBHC monitor outpatient service provision and data for both adult and youth populations to ensure appropriate client care. SBHC switched over to a new electronic health record (EHR) system (FY23) and much of their data was not being captured accurately. The impacted data primarily includes unfunded numbers, jail services, youth and adult case management, and youth respite services. While a decrease in service provision continues to be reflected on the FY24 scorecard, each service does show an increase in services from FY23 to FY24.

Children, Youth, and Families

1) **Family Peer Support Specialists (FPSS):** SUMH recommends that SBHC explore ways to implement FPSS into treatment. This service can be a valuable resource for families that could benefit from additional support and advocacy. SBHC employs two staff members with FPSS certifications, but they are not providing FPSS services.

FY25 Comments:

Combined Mental Health:

1) **Family-Centered Approach:** SBHC has reported that they are shifting clinical focus to incorporate a family-centered approach, with the intention of providing quality treatment to their clients. This focus has been manifesting in a variety of ways, including utilizing funds to train clinicians in a family-oriented treatment modality such as Emotional Focused Family Therapy (EFFT), running Dialectical Behavior Therapy (DBT) groups for parents, and revamping the Choices program to an after school program with parent involvement. Additionally, the hospital liaison is working with families through intensive case management services and utilization of outplacement funds to provide additional family support when needed.

Children, Youth, and Families

1) **Stabilization and Mobile Response (SMR):** SBHC experienced a decrease in client count and service volume last year due to staffing changes. They are commended for increasing the number of individuals receiving SMR. SBHC is working to increase both SMR referrals from outside sources and followup visits. OSUMH remains committed to providing ongoing technical assistance and support to SBHC as they rebuild their SMR caseload and continue to deliver high-quality care.

Adult Mental Health

1) Certified Peer Support Specialist (CPSS): Despite a decrease with CPSS services on this fiscal year's adult mental health scorecard (FY23:149; FY24:120), SBHC has recently placed an emphasis on utilizing CPSS services in a variety of settings and is expecting the numbers served to increase in the next fiscal year. This expectation is based on a CPSS being recently added to the adult mental health court team and SBHC has added "peer support productivity and focus" as one of their main clinical goals this year. With this focus they are currently in the process of analyzing their team's roles, responsibilities, and expectations and will then create a plan to increase productivity within these positions.

Substance Use Disorders Prevention

David Watkins, Program Administrator, conducted the annual prevention review for Southwest Behavioral Health on March 31, 2025. 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 2024 Audit

There were no findings for the FY24 audit.

Findings for Fiscal Year 2025 Audit

FY25 Minor Non-Compliance Findings:

1) **Data entry:** Office directives state that prevention services need to be reported into the Data Users Group System (DUGS) within 45 days from the day of service. The LA reached that standard 55% of the time during FY24. It is recommended that the LA increase the consistency of data entry.

County's Response and Corrective Action Plan:

As discussed during the site visit, there was a discrepancy between how the state was tracking compliance with this directive, and how SBHC was stated to have access to this data, but also because we recognize the importance of showing the work we are doing, and the progress we are making toward our goals and objectives. Therefore, we instituted a tracking form with all prevention staff three years ago, where we track the programs and coalitions they are involved with, and their completion of data entry for each. However, we were tracking whether or not they entered the system and added data for their programs/coalitions by the required deadline. Based on that tracking, we showed over 90% compliance. However, what we were not accounting for, were staff adding more data from previous months. For example, staff might log in and add data for January by the February deadline. But when they logged in to add March data, sometimes they added more data for January. Thus, when the OSUMH did a report looking at timestamps, they sometimes saw that data for January had been entered in March, outside of the 45 day window for the directive.

It should be noted here that SBHC does NOT have the ability to run a timestamp report like this, so there was (and is) no way for us to know that we weren't in compliance based on that kind of a review.

Action Plan: When this issue was brought to our attention in July, 2024, we took immediate steps to rectify the situation. We set a new timeline for staff to input ALL data, which is ahead of the 45 day window given by the state. We require them to input data by the first Monday of the month following the service, (creating a minimum of a 35 day

window). This gives us more time to review, and follow up with staff before the 45 day state requirement if they have not entered data. We also explained to them that the state was tracking data by timestamp, (which was not previously known to us), so they can't add data after the 45 day window without being out of compliance. As a result of this, by the time OSUMH came to do our site visit in March of 2025, we had already rectified the issue, and at that time it was acknowledged that SBHC was now in compliance, making this particular finding a non-issue that had already been taken care of.

Our action items are still in place. We require staff to input data by the first Monday of the month following the service provided. We maintain a tracking sheet where we follow their input of data. We will continue to do regular training so they understand how the state is assessing compliance, and understand the 45 day window. We have also requested that OSUMH provide us with a quarterly timestamp report, so we know before the end of the year how we are doing with input, (again, there is no way for us to see that timestamp report, so it's impossible for SBHC to track how we are doing until the state tells us).

Timeline for compliance: SBHC is already in compliance for FY25

Person responsible for action plan: Logan Reid

Tracked at OSUMH by: David Watkins

2) **Reporting:** SUMH collects several prevention reports throughout the year, several of which have deadlines outlined in the office directives or outlined in discretionary grant funding agreements. SUMH has not received the reports or did not receive reports by the deadline specified in the office directives. It is recommended that the LA develops a process to ensure reports are submitted on time. As talked about at the site visit, this could include developing a better communication plan with SUMH to ensure reports have been completed and turned in.

County's Response and Corrective Action Plan:

Action Plan: SBHC has scheduled a quarterly meeting with OSUMH to review all required and upcoming reports, deadlines and submission requirements, to ensure compliance with reporting deadlines.

Timeline for compliance: FY25 Site visit. (The first quarterly meeting is scheduled for July 2, 2025, and will occur on the first Wednesday of every quarter.)

Person responsible for action plan: Logan Reid

Tracked at OSUMH by: David Watkins

FY25 Recommendations:

1) **Evidence-based Programs:** The LA implements a number of programs, some of which do not appear on approved registries. These programs include the PEP Program, Opioids and Athletes, and Overcoming Obstacles. It is recommended that these programs be submitted to the Utah Evidence-Based Workgroup for approval.

FY25 Comments:

1) **Coalition work:** Through the site visit and submitted materials, it is clear SBHC is dedicated to doing prevention work through community coalitions. The LA continues to work really hard to ensure that each coalition has the ability to prioritize risk and protective factors that are known to prevent substance misuse. They are also focused on addressing those factors by identifying the local conditions that lead to those factors in individual communities. SUMH appreciates the hard work the LA puts into running the prevention system they do through community coalitions.
2) **Workforce development:** SBHC is able to have success with community coalitions through their dedication to building up the prevention workforce. SUMH recognizes that building the workforce isn't always easy, and the structure the LA is trying to build can often place a lot of responsibilities on the prevention director. The LA has worked to try and establish a career ladder in an effort to train up and retain prevention workers. They also ensure that the staff that they have received the support and training that they need to do their jobs effectively. At the site visit it was mentioned how difficult coalition work is and the LA's ability to keep coalitions moving forward is related to the training they are able to provide or send each staff member to.

Substance Use Disorder Treatment

Becky King, Program Administrator, and Becky Johnson, Auditor III, conducted the review of Southwest Behavioral Health on March 18, 2025. The annual monitoring review was held virtually. The review focused on compliance with State and Federal law, SUMH contract requirements, and SUMH 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 2024 Audit

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 SUMH Directives.

    This issue has been resolved. In FY24, 0% of clients in the served data are from old open admissions (meaning they have not had any reported events in the past year.) This is an improvement from last year, where there were 13% of old charts that needed to be closed.

    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.)

    This issue has been resolved. In FY24, SBHC increased the number of youth served from 0 in FY23 to 6 in FY24. There were 6 clients under the age of 18 that were discharged from SUD treatment at SBHC in FY24 for any reason (completion, termination, drop out, etc.).

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) **Treatment Episode Data Set (TEDS):** In July 2022, SBHC changed their electronic health record (EHR) from Credible to Axium. Data submitted to SUMH in FY23 and FY24 has been incomplete and inaccurate. While SBHC has been working with the data team to alleviate these concerns, the issues were still present for FY24. It is recommended that SBHC follow these steps: (1) work closely with Axium to ensure the appropriate protocols and submissions are able to be timely and accurately turned in; (2) submit TEDS data on a monthly basis; (3) perform regular quality checks through the SAMHIS website; and (3) work closely with SUMH staff as the need arises.

FY25 Division Comments:

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

    a) The use of medication assisted treatment (MAT) was 50% for SUD clients with opioids as their primary, secondary, or tertiary substance. *(Please note that last year this was reported as MAT for clients for whom opioids were primary.)* SBHC shared that MAT education is part of their annual training curriculum, with a specific emphasis on education for case managers and clinicians. All clients are made aware of the availability of MAT and referred to the appropriate provider when requested by the client or the medical team. Due to these efforts, SBHC has expanded the use of MAT services from 249 clients in FY23 to 337 in FY24.

Table 2. Southwest SUD Served

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

	FY22	FY23	FY24
Total	706	616	972
Drug Court	130	100	127
MAT (Med. Assisted Tx)	246	194	401
Methadone	47	35	55
Naltrexone	61	24	28
Buprenorphine	147	136	318
Any opioid use	287	249	337
% opioid users receiving MAT	73%	52%	50%
Women	321	272	440
Youth	28	42	53
Justice Referred	331	194	180
Old Open Admissions	10%	13%	0%
Priority Groups			
Pregnant IV Users	2	2	2
Female IV Users	111	85	101
Male IV Users	110	86	102

b) SBHC assessed all Drug Court clients and all but 2% of justice referred adults in FY24. SBHC uses the Risk and Needs Triage (RANT) to assess individual risk level and needs to determine the most appropriate interventions based on the risk factors and needs. SBHC works with Court Support Services that administer the Level of Service/Risk, Need, Responsivity (LS/RNR) for individuals in Drug Court, which they send to SBHC. The LS/RNR is a comprehensive assessment tool designed to evaluate the risk of recidivism, rehabilitation needs, and the most effective strategies for supervision and programming. It considers factors like criminal history, substance use, family dynamics, and employment to guide interventions.

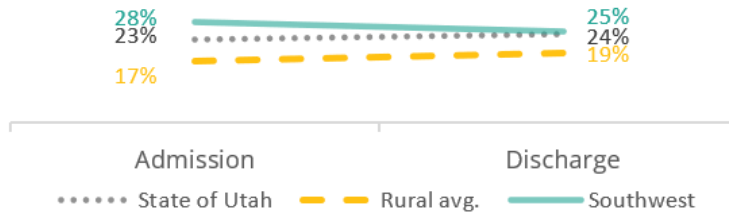
Table 4. Southwest Criminogenic Risk

Source: TEDS data	FY22	FY23	FY24
Justice Referred Adults (non-detox)			
Low risk	10	0	0
Moderate/high risk	209	43	40
Not collected	18	0	1
% not collected	8%	0%	2%
Adult Drug Court			
Low risk	4	0	0
Moderate/high risk	95	26	64
Not collected	5	0	0
% not collected	5%	0%	0%

c) The percentage of clients who attended social recovery support at SBHC was high (28%) at admission. SBHC offers a range of social recovery support for

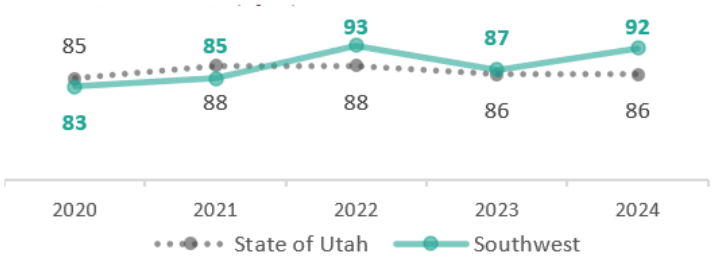
individuals with substance use issues. These services include mentoring and peer support, housing assistance, and case management. They also provide specialized programs for co-occurring mental health and substance use disorders, as well as tailored support for various age groups and communities.

Figure 10. % Using Social Recovery Support
Source: TEDS data, SUD Scorecard



d) Satisfaction with SUD treatment at SBHC was high (92%) in FY24. Client satisfaction at SBHC is attributed to their comprehensive and compassionate approach to care. They provide a wide range of services, including mental health and substance abuse treatment, tailored to meet the unique needs of individuals and families. Their staff is known for being professional, caring, and respectful, which fosters trust and positive experiences. Additionally, their focus on community-based programs and partnerships enhances accessibility and support for clients.

Figure 12. Adult satisfaction with SUD treatment (%)
Source: MHSIP Consumer Satisfaction Survey



2) **Comprehensive and Effective Services:** SBHC has developed a comprehensive and impactive service continuum within their catchment area. This includes a collaborative clinical leadership team, dedicated and effective treatment teams, an emphasis on evidence-based training for staff, and working collaboratively in their local communities. possesses numerous strengths that enable them to deliver comprehensive and impactful services to their community.

Section Two: Report Information

Background

Section 26B-5-102 outlines duties of SUMH. 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 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.

Signature Page

SUMH appreciates the cooperation afforded SUMH monitoring teams by the management, staff and other affiliated personnel of Southwest Behavioral Health Local Authority 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 06/27/2025
Administrative Services, Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 06/27/2025
Administrative Services Director

Pam Bennett Date 06/27/2025
Assistant Division Director

Eric Tadehara Eric Tadehara (Jun 27, 2025 10:25 MDT) Date 06/27/2025
Assistant Division Director

Brent Kelsey Brent Kelsey (Jun 30, 2025 10:59 MDT) Date 06/30/2025
Director

Attachment A

UTAH OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY25

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

Date: **March 11, 2025**

Reviewed by: **Jennifer Hebdon-Seljestad, 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		**Recommend including a place to identify changes to the plan, made by whom, and date of change(s)**
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**			X	**SWBC has five radios, one for each county. Radio checks were conducted 3/7/24, 6/6/24, and 9/5/24. The December check was canceled due to radio reprogramming. It is strongly suggested that all counties participate in these checks.** **Beaver participated in 1 check (6/6/24)**

minimum of three of the four (75%) yearly DHHS radio checks				**Iron participated in 1 check (9/5/24)** **Kane participated in 1 check (9/5/24)** **Washington did not participate in the radio checks** **Garfield did not participate in the radio checks** **SUMH appreciates SWBC's participation in their regional healthcare coalition.**
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.

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