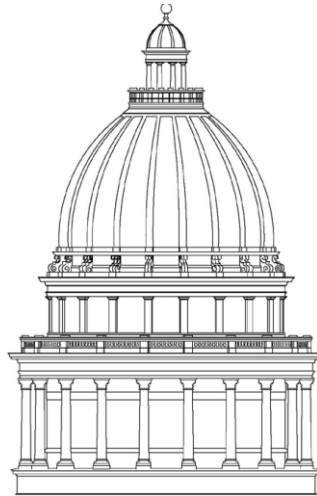


REPORT TO THE
UTAH LEGISLATURE

Number 2017-13



**A Performance Audit of the
Division of Family Health and Preparedness**

November 2017

Office of the
LEGISLATIVE AUDITOR GENERAL
State of Utah



STATE OF UTAH

Office of the Legislative Auditor General

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Audit Subcommittee of the Legislative Management Committee

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Senator Gene Davis • Senator Ralph Okerlund • Representative Brian S. King • Representative Brad R. Wilson

JOHN M. SCHAFF, CIA
AUDITOR GENERAL

NOVEMBER 14, 2017

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report, **A Performance Audit of the Division of Family Health and Preparedness** (Report #2017-13). A digest is found on the blue pages located at the front of the report. The objectives and scope of the audit are explained in the Introduction.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

A handwritten signature in black ink that reads "John M. Schaff" with a stylized flourish at the end.

John M. Schaff, CIA
Auditor General

JMS/lm

Digest of A Performance Audit of The Division Of Family Health and Preparedness

The Division of Family Health and Preparedness (FHP or Division) within the Department of Health administers programs, that according to their mission, promote “optimal health outcomes for Utah’s most vulnerable populations.” Vulnerable populations include women, infants, children, the disabled, the elderly, those needing emergency services, low-income individuals, and populations facing health disparities. The Division employs approximately 270 individuals among six bureaus. Many bureaus oversee operational programs that partner with or support local health departments and community organizations to deliver services throughout the state (FHP provides few direct services). Most bureaus are funded through a combination of state and federal funds, resulting in a broad spectrum of stakeholders. The Division’s fiscal year 2016 budget was \$122 million, which is largely comprised of federal funds.

Chapter II Child Care Licensing Underutilizes Sanctions in Addressing Noncompliance

Child Care Licensing Should Clarify Policies to Ensure Consistent, Effective Sanctions. Child care providers, in some circumstances, violate rules established to protect the health and safety of children with minimal repercussions, leaving children at risk. When child care providers violate a rule, licensors follow internal protocols to determine the appropriate sanction to impose. While Child Care Licensing (CCL) has broad statutory authority to enforce compliance through a variety of sanctions, we found that some of these sanctions are rarely used due to insufficient policies. Our survey of surrounding western states identified policies and procedures CCL should consider in reviewing how sanctions are used. Additionally, policies on sanctions would benefit from enhanced transparency and consistency as demonstrated by the high-quality inspections we observed at center-based and home-based facilities.

Child Care Licensing Needs Better Policies Directing the Appeals Process. CCL currently does not increase monitoring of providers who operate during the appeals process. Providers have the right to appeal any sanctions imposed by CCL, but the appeals process needs both clarity and additional monitoring requirements to protect children in care. We found that CCL relies on other entities instead of exercising its own authority, resulting in unnecessary delays. Additionally, we compared CCL’s current appeals process to best practices established by national organizations as well as other states’ policies and found Utah needs clear, publicly available policies outlining the appeals process. Specifically,

CCL should consider revising appeal time frames, imposing immediate sanctions even when a provider files an appeal, and clarifying the relationship between CCL and other investigating entities such as law enforcement and Child Protective Services.

Chapter III

Infrequent Reviews, Screening Delays Expose Health Facility Residents to Risk

Assisted Living Center Oversight Can Improve with More Frequent Reviews.

Health Facility Licensing (HFL) has struggled to keep up with industry growth in providing timely reviews of facilities they are charged to oversee; however, recent trends show some improvement. The time between assisted living center (ALC) surveys has doubled, leaving residents exposed to greater risk. Correspondingly, surveyors are identifying more deficiencies, including more critical offenses within surveyed facilities. Utah lags behind other states in the number of surveyors and time between surveys. As the elderly population is projected to nearly double by 2050, solutions are needed to provide protections to vulnerable aging adults.

Health Facility Licensing Needs Efficiencies, Oversight Standards, and Improved Practices. Facility growth has been a primary cause of long survey time frames over the last few years. To address the infrequent survey rate, HFL should adopt efficiencies that include technological upgrades, survey team restructuring, and cost-benefit analysis of multiple surveyor locations. Because no mandate exists for the quality or duration between surveys, HFL should work with the Legislature to develop an oversight standard, so that resources can be allocated to maintain that standard. Additionally, HFL needs to improve practices by posting survey results online and better utilizing statutory sanctions.

Health Facility Licensing Has Not Sufficiently Screened Health Facility Staff.

Although HFL has a sophisticated system for clearing individuals applying to work in health facilities (initial screening) and those individuals already working in health facilities (ongoing screening), operational weaknesses expose health facility residents to unnecessary risk. The initial background screening process for new employees, which went online in May 2012, contains three operational weaknesses. First, some providers are not submitting the names of all new hires into the screening system. Second, a portion of the screening system is not automated, contributing to year-long delays. Finally, important appeals policies are lacking. In addition to initial screening concerns, weaknesses in the ongoing screening process include HFL's inability to triage new criminal activity notices (or "hits") based on severity and splitting time manually clearing low-risk individuals instead of focusing on high-risk hits already in the system.

Chapter IV

Improved Monitoring and Data Needed for Baby Watch Early Intervention Program

On-Site Monitoring Not Occurring, Key Indicators Show Program Performance Declining. On-site monitoring of the Baby Watch Early Intervention Program (BWEI) is not occurring, creating challenges for validating the quality and duration of the services provided. Simultaneously, key indicators show a downward trend in program performance since 2009. In the absence of on-site monitoring, it is difficult to evaluate what is driving this trend. Additionally, BWEI needs clear policies to improve processes.

Better Cost Data Needed to Allocate Resources and Enhance Transparency. The current funding formula and associated metrics offer insufficient data on some program costs. Costs associated with the type and duration of a service are not known. This information is valuable for the effective utilization of limited resources. Additionally, while providers already track and collect data relating to duration and type of services, BWEI does not use these data points. With a total budget of \$28 million and an average cost of \$5,207 per child, BWEI should better protect taxpayer investments by enhancing transparency via detailed data reporting.

Some Other States Effectively Collect Data and Use Private Insurance to Fund Early Intervention. Some other states have found alternative funding mechanisms that appear to provide a more reliable source of ongoing funds. Specifically, some states have maximized their Medicaid funds and 24 states have leveraged private insurance to help pay for a portion of their early intervention programs.

Placement of Baby Watch Early Intervention Program Is Appropriate. We were also asked to evaluate the appropriateness of the BWEI program's placement within the Department of Health. Based on its alignment with other programs in its current bureau as well as the feedback we received, we concluded that BWEI's current placement is appropriate.

Chapter V

FHP Can Improve Performance Management

Better Strategic Planning and Performance Metrics Are Needed. FHP should develop a division-level strategic plan and performance metrics based on outcomes. We documented that as of October 2017, the Division has begun this process, setting action items and deadlines necessary to draft a strategic plan. Additionally, in the absence of a division strategic plan, it is unclear how program, bureau, division, and department missions fit together to optimize the health of Utah citizens.

Poor Monitoring and Accountability Led to Undesirable Outcomes. While strategic planning with meaningful performance metrics is a critical part of performance management, FHP must also incorporate ongoing evaluation to ensure long-term goals are met. Failure to adequately monitor a contract with the University of Utah led to a gap in services for some children with special health care needs. The Division should use performance data to guide future management decisions.

REPORT TO THE UTAH LEGISLATURE

Report No. 2017-13

A Performance Audit of the Division Of Family Health and Preparedness

November 2017

Audit Performed By:

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Chapter I

Introduction

The Division of Family Health and Preparedness (FHP or Division) within the Department of Health (DOH) administers programs that, according to their mission, promote “optimal health outcomes for Utah’s most vulnerable populations.” Vulnerable populations include women, infants, children, the disabled, the elderly, those needing emergency services, low-income individuals, and populations facing health disparities. The Division employs approximately 270 individuals among the following six bureaus:

- Child Development
- Children with Special Health Care Needs
- Emergency Medical Services and Preparedness
- Health Facility Licensing
- Maternal and Child Health Care
- Primary Care

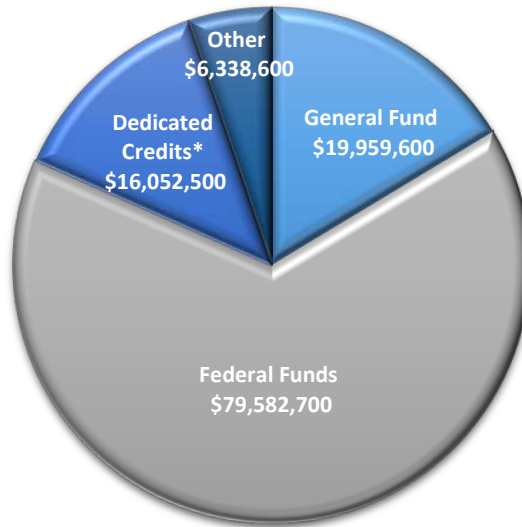
Many bureaus oversee operational programs that partner with or support local health departments and community organizations to deliver services throughout the state (FHP provides few direct services). Most bureaus are funded through a combination of state and federal funds, resulting in a broad spectrum of stakeholders.

The Division’s fiscal year 2016 budget was \$122 million, which is largely comprised of federal funds. Figure 1.1 illustrates the high level of federal funding FHP expends to care for vulnerable populations.

The Division of Family Health and Preparedness promotes optimal health outcomes for Utah’s most vulnerable populations.

FHP’s overall FY 2016 budget was \$122 million and includes federal and state funds.

Figure 1.1 FHP Utilizes State and Federal Funds. 65 percent of FHP's \$122 million budget is comprised of federal funds.



Source: Legislative Fiscal Analyst Compendium of Budget Information 2016.
*Dedicated Credits according to **Utah Code** 63J-2-102 are "revenues from collections by an agency that are deposited directly into an account for expenditure on a separate line item and program."

Our Review Focused on Programs That Serve Vulnerable Populations

This performance audit coincides with an in-depth budget review of DOH. Our review focuses specifically on FHP because we were asked to review two programs within the Division, the Baby Watch Early Intervention Program (BWEI) and oversight of air ambulance services. Due to the vulnerable populations that the Division protects and serves, we reviewed, assessing for risk, all six bureaus within FHP. Ultimately, we focused our review on three main areas: Child Care Licensing, Health Facility Licensing, and BWEI. These programs were selected because they impact the safety of individuals, have a large taxpayer investment, and are important to DOH's overall mission of improving the health of Utah's citizens.

Child Care Licensing Regulates Providers To Protect the Health and Safety of Children

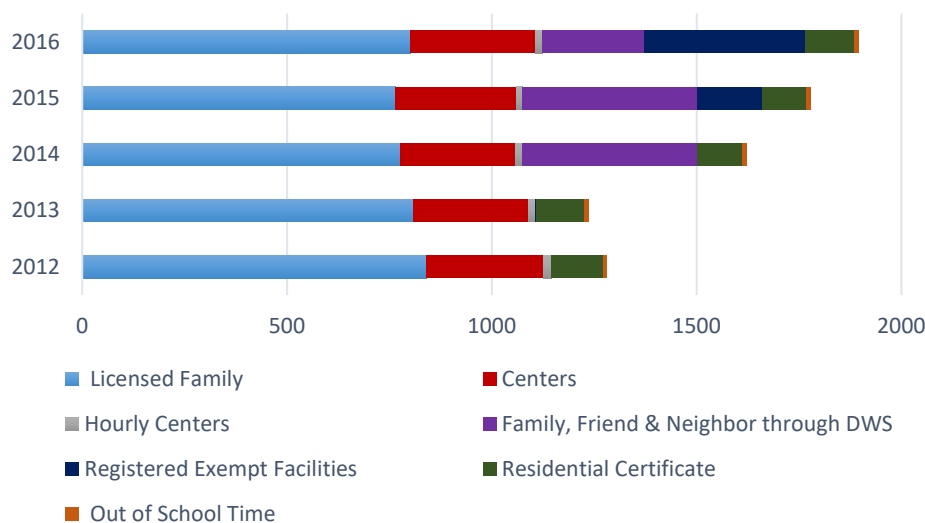
Child Care Licensing (CCL) is charged with protecting children's common needs for a healthy and safe environment. To do so, they determine the requirements for licensure of child care facilities, develop rules that child care providers must follow, and enforce these

Three bureaus were selected for our review based on risks to vulnerable populations and the large taxpayer investment.

rules. CCL’s administrative rule requires two annual inspections for each fully licensed provider: a comprehensive announced inspection that evaluates compliance with all rules, and an unannounced inspection focused on health and safety violations. Licensors completed an average of 2,468 inspections annually over the last five years—90 percent of the inspections required by rule. Differing levels of oversight apply depending on the type of child care facility. While there are a variety of child care facility types, as shown in Figure 1.2, our audit focused on the two types of fully regulated child care establishments: home-based and center-based.

CCL inspects child care provider homes and facilities and enforces rules intended to protect children in care.

Figure 1.2 Number of Child Care Facilities Is Increasing. While the total number of child care facilities has increased over the past five years, the two types that are fully regulated by CCL—licensed family homes and centers—have been consistent.



Source: Data provided by Child Care Licensing administrator.

Health Facility Licensing Provides Critical Oversight of Vulnerable Populations

The Bureau of Health Facilities Licensing and Certification (HFL or Bureau) oversees the quality of care for vulnerable populations that include the elderly, the terminally sick, pregnant women, and people with intellectual disabilities. The Bureau oversees federally certified and state-licensed health care facilities and providers, as shown in Figure 1.3.

HFL provides oversight and regular on-site inspections of state licensed and federally certified health facilities.

HFL’s process ensures the protection and appropriate care of vulnerable adult and other populations.

Figure 1.3 HFL Oversees Federal and State Facilities.* This report focuses on state-licensed operations and efficiencies.

State-Licensed Facilities	Federally Certified Facilities
Assisted Living Centers—Multiple Types	Hospitals—Multiple Types
Personal Care Agencies	Home Health Agencies
Birthing Centers	Hospice Care
Abortion Clinics	Organ Donation Centers
Mammography Centers	Nursing Facilities—Multiple Types
Hospitals—Psychiatric	Intermediate Care for Individuals with Intellectual Disabilities

*Source: Director of the Bureau of Health Facility Licensing.
 *Facilities are surveyed to varying standards based on each facility function and oversight entity.
 Note: Many federally certified facilities are also state licensed. Though intermediate care facilities are federally certified, they are surveyed by the state licensing team.*

The Bureau oversees approximately 870 health facilities: 411 state and 459 federal. HFL staff are tasked with oversight activities, which include inspecting facilities, staff, and residents; and reviewing files to ensure adequate protections are in place.

Baby Watch Serves Families of Young Children with Developmental Delays

BWEI provides support and services to families with children from birth to three years of age who have developmental delays or disabilities. The program uses a family coaching model to help parents address their child’s individual needs.

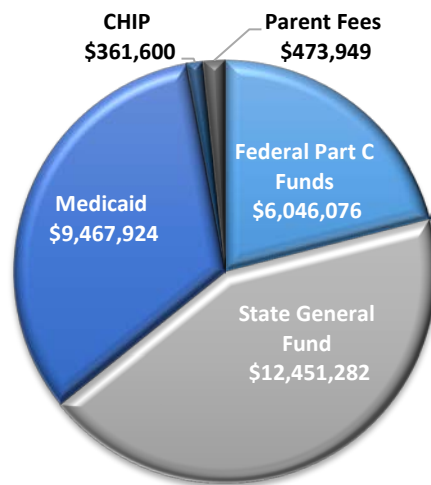
Providers work with families in the child’s natural environment, most commonly the home, and incorporate services such as speech pathology, occupational therapy, and physical therapy to improve functioning in the following areas: cognitive development, motor development, communication development, social/emotional development, and adaptive behavior.

Along with early intervention programs in the other 49 states, BWEI is governed by the federal regulations created under the Individuals with Disabilities Education Act (IDEA) Part C. These regulations require that BWEI serve all children in the state who are found eligible according to the criteria set by the state. While all states are required to serve severely delayed children, states can choose to extend eligibility to children with moderate, mild, and at risk delays. Utah serves children with severe and moderate delays. Federal regulations do not allow EI programs to put children on waiting lists.

Federal regulations require BWEI to serve children with developmental delays who meet Utah’s eligibility requirements.

Federal regulations also guide how EI programs use various sources of funding, such as the federal funds they receive through IDEA Part C. Additionally, states may choose to collect parent fees but cannot deny services if a family is unable to pay. Utah collects parent fees, which make up only two percent of program revenue. Figure 1.4 shows the sources of funding for BWEI.

Figure 1.4 Funding for Baby Watch Early Intervention Program Is a Combination of State and Federal Funds. Nearly half, 43 percent, of the program’s revenue in fiscal year 2016 came from Utah’s general fund.



Source: Family Health and Preparedness financial data. Note: While a significant part of BWEI's budget, the Medicaid money shown here is not included in FHP's \$122 million budget.

With a budget of \$28 million and an average cost per child of \$5,207, BWEI is an important taxpayer investment, not to mention a vital program to the children that it serves.

Finally, this next section, which discusses air ambulance costs, was part of our review but was limited in scope. Because we were specifically asked to review this topic we have included this limited review here.

Air Ambulance Balance Billing Concerns Remain Unresolved

We were asked to review oversight of air ambulance services and determine whether service charges, such as those resulting from balance billing practices, are appropriate. Balance billing occurs when

With a budget of \$28 million and an average cost per child of \$5,207, BWEI is an important taxpayer investment

Balance billing occurs among Utah's air ambulance providers, but controlling this practice is difficult.

an air ambulance company, which provides services for patients needing to be airlifted for medical care, does not have a contract with the patient's insurance company. After the insurance plan pays the air ambulance company the allowable amount for the service, the air ambulance company bills the patient for the remainder. If a patient does not have insurance and is left responsible for the full amount of the bill, this is also balance billing.

Balance billing occurs in Utah, as evidenced by a review of complaints filed with the Utah Insurance Department as well as the widespread practice of private, for-profit air ambulances selling "memberships" to safeguard payees from balance billing. An individual can buy a membership from a specific air ambulance company for an annual fee. A member who is transported by that company will pay no additional cost. However, it is important for the public to know that memberships offer limited protections because patients in an emergency have little control over which air ambulance company transports them. Thus, individuals could have memberships with one company but be transported by another air ambulance that later balance-bills them.

Federal law preempts states from regulating aviation rates, routes, and services.

While Utah has not experienced balance billing concerns to the extent that other states have, recent national trends indicate that this practice may be growing and there is nothing preventing this from occurring. This is because federal law preempts states from regulating aviation rates, routes, and services. Without congressional action, state oversight of air ambulance billing is very limited. Because of these barriers to state action, we did not complete a full review of FHP's oversight of air ambulance services. However, we identified issues with current data on costs of air ambulance services.

In response to S.B.95 passed in the 2017 Legislative Session, an air ambulance committee was formed and will compile a report to the Legislature on air ambulance charges. However, the source of the data available to the committee, the All Payer Claims Database (APCD), has significant limitations that hinder accuracy in reporting on the prevalence of balance billing in Utah. Specifically, we found the following information is not included in the APCD:

- Charges that were not submitted to an insurance company
- Insurance companies that cover fewer than 2,500 Utah lives and are not subject to federal risk adjustments

- Fee-for-service Medicare
- Denied claims

Additionally, because of the way this data is collected, it shows only the amount of patient responsibility and does not indicate if the charges are a result of balance billing. Thus, we can identify cases in which a patient must pay a large amount but cannot determine whether the charge is appropriate or whether balance billing occurred. Due to the data's limited value, any conclusion drawn from the data should be regarded with caution.

Audit Scope and Objectives

- Chapter II reviews Child Care Licensing's enforcement of statute and rules to protect children in care.
- Chapter III reviews Health Facility Licensing's infrequent review of health facilities and provides solutions to provide better oversight.
- Chapter IV reviews the Baby Watch Early Intervention Program's effectiveness and funding structure.
- Chapter V reviews performance management at the division level.

Any conclusions drawn from the All Payer Claims Database should be regarded with caution.



Chapter II

Child Care Licensing Underutilizes Sanctions in Addressing Noncompliance

According to the program’s website, the mission of Child Care Licensing (CCL) is “to support working parents by protecting the health and safety of children in child care programs”. We reviewed many CCL functions and found several concerning cases where providers continually violated rules but did not receive penalties or conditional status (i.e. the license holder receives increased monitoring and pays the costs associated with the additional oversight). These cases occur because CCL has not adequately established policies and procedures that guide the use of statutorily allowed sanctions. Consequently, application of CCL’s authority is not always consistent, resulting in ineffective sanctions. We also found the appeals process improperly delays the use of sanctions, allowing child care providers continued access to children even in a confirmed case of child abuse. We are concerned that current policies for sanctions and appeals leave children at risk. While our review revealed numerous concerns, site visits to child care facilities validated that inspections are occurring as required and are efficient and effective.

Child Care Licensing Should Clarify Policies to Ensure Consistent, Effective Sanctions

Child care providers, in some circumstances, violate rules established to protect the health and safety of children with minimal repercussions, leaving children at risk. When child care providers violate a rule, licensors follow internal protocols to determine the appropriate sanction to impose. While CCL has broad statutory authority to enforce compliance through a variety of sanctions, we found that some of these sanctions are rarely used due to insufficient policies. Our survey of western states identified policies and procedures CCL should consider in reviewing how sanctions are used. Additionally, policies on sanctions would benefit from enhanced transparency and consistency, which are demonstrated in the high-quality inspections we observed at center-based and home-based facilities.

A review of Child Care Licensing operations revealed weaknesses in enforcing provider compliance, program policies, and delays in the appeals process, leaving children at risk.

Underutilization of Available Sanctions Leaves Children at Risk

Due to weak policies, half the providers we reviewed exhibited a pattern of non-compliance that sanctions did not remedy.

Providers who continually violate rules designed to protect the health and safety of children do not always receive monetary penalties or conditional status. This is because CCL's policy for applying sanctions does not adequately address patterns of noncompliance. To understand how CCL utilizes sanctions, we reviewed all cited and repeat cited findings in the last two years (a total of 724 for center-based and 850 for home-based providers). From this, we selected a sample of 20 providers who had cited findings in at least three inspections. We reviewed the public records of these providers to assess whether the providers exhibited patterns of noncompliance and, if so, whether sanctions applied by CCL were sufficient to address these patterns. We found that half of the providers had a pattern of noncompliance that sanctions did not remedy, which is unsurprising due to the weak policies currently in place.

The extensive amount of time required to fully review each case limited the size of our sample. We completed an additional in-depth review of four providers with patterns of repeat noncompliance or singular egregious violations and then examined how CCL sanctioned these providers. Our findings from the four selected cases are summarized below.

- **CCL Imposed No Sanctions for Confinement of a Child.** At an unannounced inspection for home-based Provider 1, a licensor found a child confined in a port-a-crib covered with a trampoline inside a laundry room. The licensor called Child Protective Services, indicating that this violation posed a serious threat to the children in care. CCL cited and publicly recorded the finding but took no further action. A review of the provider's history indicated that the provider had 14 cited findings and 16 repeat cited findings of the most severe level of violation during a four-year period. Stronger CCL sanctions on these early violations may have prevented the child confinement violation.
- **Provider Left Children Unsupervised Three Times in One Year Without Consequences.** Licensors cited center-based Provider 2 for leaving children unsupervised nine times over a period of two and a half years, including during a field trip. During one inspection, the complaint

During an inspection, CCL cited a provider for a serious threat to a child in care, but took no further action.

investigator found four children unsupervised in the infant and toddler room. An older child entered the room and covered a toddler in a crib with a soft activity center, pushing the object onto the younger child. The CCL inspector intervened in this case to protect the toddler, but subsequent findings of unsupervised children in this provider's care indicate compromised child safety is an ongoing concern. Despite the provider's pattern of noncompliance since 2014, CCL imposed no sanctions in FY 2017 for three incidents in which children were left unsupervised. Current policies do not call for the issuing of sanctions unless violations occur in consecutive inspections or accumulate to 15 in one year. This case illustrates our concern that current applications of sanctions have not corrected patterns of violations.

- **Three Individuals Lived in Provider's Home with No Background Checks for Five Months After Initial Citation.** Home-based Provider 3 repeatedly violated rules requiring background checks for all individuals living in the home where care is provided. Three people who did not have background checks lived in the provider's home and had access to children. In February 2017, a licensor identified the problem, but it was not resolved for nearly five months. CCL imposed civil money penalties (CMPs) for this violation only three times during that period, with the last CMP dated two months before the violation was resolved. Between February and the end of June, CCL did not perform any on-site inspections, a step they should have taken to protect the children in care. The provider violated this same rule in 2015, when an individual lived in the home for one year without a background check. Given this history, CCL's delayed approach to enforcement is cause for concern. The absence of clear policies and procedures to address this situation is unacceptable, given the critical role background checks play in ensuring the safety of children in care.
- **When Three Unsupervised Toddlers Left the Provider's Premises, CCL Imposed No Sanctions.** In contrast to the other three cases we examined, home-based Provider 4 did not have a pattern of noncompliance. However, this

CCL identified four unsupervised children during an inspection after the provider had already been cited multiple times.

CCL did not perform any on-site inspections for five months after identifying that three adults in the home had not submitted background checks.

Records indicate that three unsupervised children under age two left the premises and were returned by a police officer, but CCL did not sanction the facility.

provider received no sanction for an egregious incident. Three children, ages two and younger, were left unsupervised in the yard and left the premises. Police officers found them and returned them to the provider's home. CCL did not impose conditional status or monetary penalties for this violation that resulted in child endangerment because their policies fail to adequately address sanctions for serious first-time offenses.

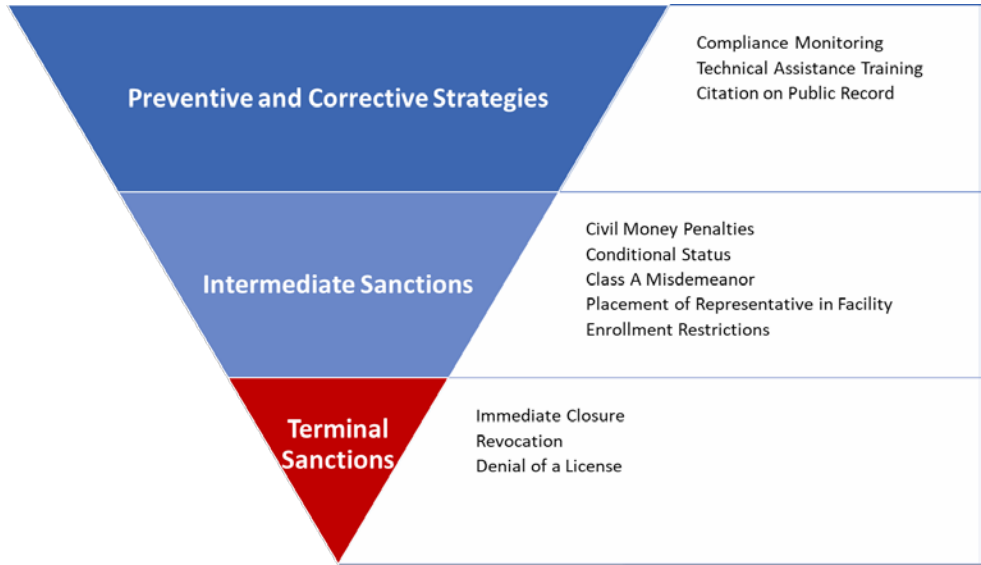
The risk to children evident in these cases demonstrates the need for clear, fully developed policies governing the use of monetary penalties and conditional status.

Child Care Licensing Applies Sanctions Using A Narrow Definition of Repeat Noncompliance

To promote provider compliance and protect children, CCL uses two primary sanctions: placing a provider's license on conditional status with increased monitoring, and imposing CMPs, although other intermediate sanctions are available. We are concerned that CCL defines repeat noncompliance narrowly and has unclear policies regarding the use of both conditional status and CMPs. For example, current CCL policies dictate that providers will not incur CMPs unless they violate the same rule in at least two consecutive inspections. Figure 2.1 shows the progression of sanctions recommended by the National Center on Child Care Quality Improvement.

We are concerned that CCL defines repeat offenses narrowly and has unclear policies on how they use sanctions.

Figure 2.1 Best Practices Call for a Variety of Progressively Severe Sanctions to Address Noncompliance. CCL should more closely align their policies to well-researched strategies for intermediate sanctions.



Source: Office of the Legislative Auditor General
Note: The National Center on Child Care Quality Improvement does not list Class A misdemeanors or placement of a department representative in a facility as possible sanctions; however, these are available to CCL through statute and fit the definition of intermediate sanctions.

While statute authorizes the use of additional sanctions, such as placement of a department representative in a facility and referral of code violations for prosecution as Class A misdemeanors, we found such sanctions are rarely used. CMPs were used most often. Figure 2.2 illustrates CCL’s practice for applying CMPs.

CCL has underutilized sanctions that could protect children such as placing a department representative in a facility.

Figure 2.2 Use of Civil Money Penalties by Severity. CCL imposes penalties only when violations of the same rule recur in at least two consecutive inspections.

Severity	1 st Violation	2 nd Consecutive Violation	3 rd Consecutive Violation	4 th Consecutive Violation
Level 1	CMP warning on public record	\$100 CMP* on public record	\$100 CMP on public record	\$100 CMP on public record
Level 2	Not on public record	CMP warning on public record	\$75 CMP on public record	\$75 CMP on public record
Level 3	Not on public record	Not on public record	CMP warning on public record	\$50 CMP on public record

Source: CCL Rule Interpretation Manual; CCL Protocols: Processes and Procedures

*Note: Four types of violations can incur higher CMP amounts but are still well below amounts listed in statute and rule. For example, violations of direct supervision incur \$100 per unsupervised child.

Licensors complete at least two inspections of each facility annually: one announced and one unannounced. The first time they identify a Level 1 violation during an inspection, the cited finding is posted on the provider’s online record, which is publicly available. CCL then imposes CMPs for repeat violations.

We reviewed CCL’s policies for imposing CMPs and found numerous weaknesses:

- CMPs are imposed only when a provider receives the same citation in at least two *consecutive* inspections, as shown in Figure 2.2. We are concerned that this practice allows a provider to violate a rule, come into compliance for the subsequent inspection, and then violate the same rule again with no consequence other than a cited finding on the public record.
- The penalty amount does not increase with repeat violations.
- Statute allows CMPs of up to \$5,000 per day for noncompliance (see Figure 2.3), but actual fees assessed are much lower (see Figure 2.2).
- Information detailing the dollar amount of CMPs imposed for various violations is not publicly available, although CCL

We found several weaknesses in CCL’s policies for assessing civil money penalties.

reports the new rule enforcement manuals will include this information and be available to the public.

- Home-based and center-based providers pay the same CMP amount without regard to the size of their operation or amount of income generated.

We are concerned that children are not adequately protected when CCL fails to impose sanctions, available to them in statute, that could promote improved provider compliance.

For Determining Conditional Status, CCL Considers Only Violations that Have Occurred in the Last 12 Months. According to current policy, CCL may place providers on conditional status when they accrue 15 Level 1 violations in a 12-month period. When a provider is placed on conditional status, licensors perform additional inspections and charge the cost of those inspections to the provider (\$253 per inspection for centers and \$245 per inspection for licensed family homes).

While we documented that providers are paying the costs associated with increased oversight, the formula used to determine conditional status is problematic for two reasons: it weighs repeat violations the same as initial violations, and it considers only one year of behavior. Thus, the formula is inadequate for assessing ongoing patterns of noncompliance, as demonstrated by Provider 1, who was not placed on conditional status until June 2017, despite numerous cited findings including substantiated complaints of fraud.

Administrative Rules Need Clarification To Allow for Effective Use of Sanctions

When providers fail to comply with licensing requirements in code or administrative rule, CCL has statutory authority to use a variety of sanctions. Statute also gives CCL the ability to promulgate rules for disciplinary actions “and other procedural measures to encourage and assure compliance with statute and rule.” We found that some of these statutory sanctions are not utilized. Figure 2.3 shows the enforcement mechanisms available to CCL.

The criteria CCL uses to identify providers who should be placed on conditional status does not account for repeat violations and only considers one year of behavior.

Figure 2.3 Sanctions Authorized in Statute and Rule. CCL does not use the sanctions in red due to unclear rules.

Utah Code	Administrative Rule
CMPs from \$50-\$1,000 for risk of harm, \$1,050-\$5,000 for actual harm	CMPs up to \$5,000 per day per rule
Placement of a department representative in a facility	Conditional status
Referral of code violations for prosecution as class A misdemeanors	Immediate closure in cases of clear and present danger to children
Denial or revocation of a license	Denial, revocation, or refusal to renew license

Source: *Utah Code 26-39-601 and Administrative Rule 430*

Administrative rules are not clear enough to allow prosecution of providers with serious offenses.

According to the Child Care Licensing administrator, CCL almost never refers violations of code for prosecution as class A misdemeanors and has never placed a department representative in a facility, even though statute specifies they may assess the cost of this additional monitoring to the provider. CCL’s administrator stated there have been some situations in which management considered referral for prosecution, such as the incident in which a provider altered her child care license to receive additional funds from the Child and Adult Care Food Program. However, administrative rules were not clear enough to allow prosecution. Department representatives are not placed in facilities because CCL believes conditional licenses are more effective.

License revocations, which are sanctioned in both statute and administrative rule, occur but are not common. This is not surprising, since revocations are a terminal sanction, which best practices dictate should be used sparingly. We are concerned, however, that intermediate sanctions allowed by statute have not been used to address noncompliance. As of September 2017, CCL has drafted new rules that eliminate past barriers to prosecution. These draft rules do not include information on how CCL identifies the amount of CMPs they impose for various violations.

We recommend CCL incorporate referral of code violations for prosecution as class A misdemeanors into their enforcement practices and revise rules to provide clarity on how they plan to utilize monetary penalties and licensing restrictions. According to the federal Office of Child Care in the Administration for Children and Families Office of Child Care, “Having an array of intermediate sanctions, including but not limited to civil fines, reducing admissions or capacity, and stipulated consent agreements, or increased inspections, gives States

options and flexibility to respond to varied circumstances.” CCL should review policies and determine, when appropriate, how they can better utilize available statutory penalties.

Other States Define Patterns of Noncompliance More Broadly and Use Additional Sanctions

We reviewed western states and found potential improvements to Utah’s CCL policies for utilizing sanctions:

- Colorado requires licensing specialists to discuss recommendations of adverse licensing action with their supervisors and identify situations in which these actions would be appropriate. According to Colorado’s standard operating procedures, these situations include “consistent violation of regulations on 2 or 3 licensing visits within the last five years.”
- Washington, in a new set of rules expected in 2018, plans to identify specific dollar amounts of civil penalties based upon history of repeated noncompliance within three years.
- Idaho considers prosecuting certain violations as misdemeanors, such as operating without a basic daycare license or failing to complete required background checks for family day care homes.

We recommend CCL revise policies and administrative rules to better address patterns of noncompliance and use available statutory sanctions when necessary to protect the health and safety of children. Specifically, CCL should consider expanding licensing restrictions beyond conditional status and impose CMPs when a provider repeatedly violates the same rule, regardless of whether the violations occurred in consecutive inspections.

Unclear Policies Have Given Management Broad Discretion, Leading to Inconsistent Sanctions

We recommend that after CCL revises policies and rules, this information should be made available online to both providers and the public. Broad administrative discretion, which guides the use of sanctions, causes a lack of transparency. While some discretion is valuable, we are concerned that the broad discretion we documented interferes with consistent application of sanctions and clarity. Neither administrative rule nor other publicly available documents clarify the

We recommend CCL consider other states’ utilization of sanctions and then revise policies to address patterns of noncompliance.

factors to be considered and steps to be taken to determine an appropriate sanction.

Some Key Functions Are Performed Consistently and Transparently. In contrast to CCL’s lack of consistency and transparency in their use of sanctions, we found that other key functions performed by CCL are consistent and transparent. Our review of inspection processes and observations of several site visits of licensed facilities revealed that sufficient controls are in place to ensure efficient and effective inspections of child care facilities. Licensors regularly inspect both center-based and home-based child care facilities and follow a clear process to assess providers’ compliance with statute and rule.

In recent years, CCL has taken steps to improve both efficiency and consistency in the inspection process. Their use of electronic systems streamlines inspections and provides accessibility to all relevant information for licensors in the field. Additionally, CCL coordinates with other regulatory agencies such as fire marshals and local health departments to avoid duplication of efforts in their inspections. Publicly available information on CCL’s website (e.g. interpretation manuals, online records of completed inspections, and cited findings) enhances transparency. We recommend CCL incorporate this focus on consistency and transparency into their enforcement practices.

Child Care Licensing Needs Better Policies Directing the Appeals Process

CCL currently does not increase monitoring of providers who operate during the process of appealing a sanction. Providers have the right to appeal any sanctions imposed by CCL, but the appeals process needs both clarity and additional monitoring requirements to protect children in care. We found that CCL relies on other entities instead of exercising their own authority, resulting in unnecessary delays. Additionally, we compared CCL’s current appeals process to best practices established by national organizations as well as other states’ policies and found Utah needs clear, publicly available policies outlining the appeals process. Specifically, CCL should consider revising appeal time frames, imposing immediate sanctions even when a provider files an appeal, and clarifying the relationship between CCL

CCL has taken steps to ensure inspections of child care facilities are efficient and effective.

and other investigating entities such as law enforcement and Child Protective Services.

Child Care Licensing Delays Implementation Of Sanctions, Deferring to Other Agencies

CCL allows providers to continue operating during the appeals process if another entity, such as law enforcement or Child Protective Services, is involved, regardless of the risk posed to children. For example, an in-home provider and her husband were both charged with child abuse in December of 2016. CCL’s complaint investigator substantiated the complaint of child abuse, stating “there were several instances in which children in care were subjected to physical and emotional abuse.” CCL decided to revoke the license but gave the provider 30 days’ notice instead of implementing an immediate closure. At the time, the police officer investigating the case told CCL he was “worried for the safety of the other children as they have an open case for child abuse,” yet CCL chose not to close the facility. The provider and her husband continued providing care without restrictions or enhanced supervision. Clearer policies could better direct CCL’s actions in cases like this.

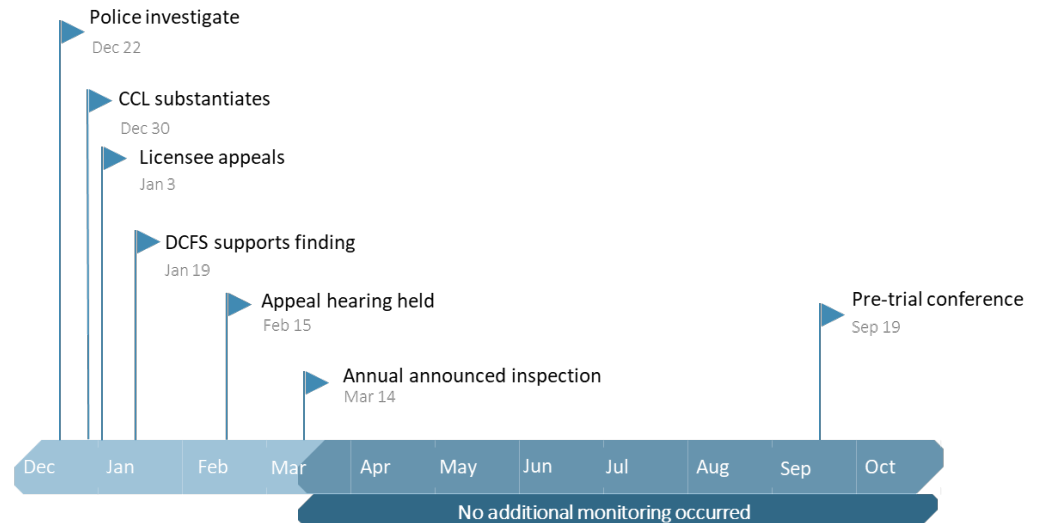
After conducting an appeal hearing, CCL granted the provider permission to continue operating until the criminal court proceedings have concluded, although no new children could enroll in the facility. In the interim, CCL did not utilize other available sanctions, such as increased monitoring, although providers can be charged for the costs associated with additional inspections. The CCL administrator cited several factors in this decision, including parental support for the provider and the fact that the charges rested on testimony from one witness. Due to these factors, the administrator stated, the courts were unlikely to find the provider and her husband guilty.

Also of concern is the length of time in which the provider operated without any additional monitoring, as shown in Figure 2.4.

Providers who are in the appeals process are allowed, in some cases, to continue operating despite the risk to children.

In one instance a licensed provider was permitted to work throughout the appeals process without additional monitoring.

Figure 2.4 Timeline of Appeal for In-Home Provider Accused of Child Abuse. CCL performed no additional monitoring during the appeal process.



Source: Child Care Licensing and Child Protective Services case files

This case demonstrates that CCL relies on other entities, such as law enforcement, to act in cases where a provider harms a child. The case also provides an example of CCL exercising administrative discretion without clear guidelines. We recommend development and publication of an appeals policy to address this problem.

Administrative Rule and Policies Need Clarity to Protect Children’s Safety and Providers’ Rights

Although administrative rule and policies help determine when CCL can impose the most severe sanctions, such as revocation, the process is unclear. Specifically, the steps necessary to meet due process requirements during an appeal are omitted from rule and policies. These policies, including providers’ and CCL’s responsibilities, should be clearly written and made publicly available.

We consulted with the executive director of the National Association for Regulatory Administration (NARA), to obtain an expert opinion on delaying a final decision regarding an appeal until the conclusion of a related criminal trial. He emphasized the importance of monitoring during the appeals process:

As long as the health and safety of the clients is ensured, possibly through increased monitoring and additional

The appeals process for a provider accused of child abuse is still pending after eleven months.

Steps for due process are unclear and are not found in policy or rule.

measures, which could include specific sanctions, during this criminal trial and appeals process, then it would be aligned with the intent of the best practices.

As demonstrated in Figure 2.4, CCL does not have a policy requiring increased monitoring or other sanctions during the appeals process to ensure the health and safety of the children in care. We recommend CCL incorporate monitoring during the appeals process to remedy this issue.

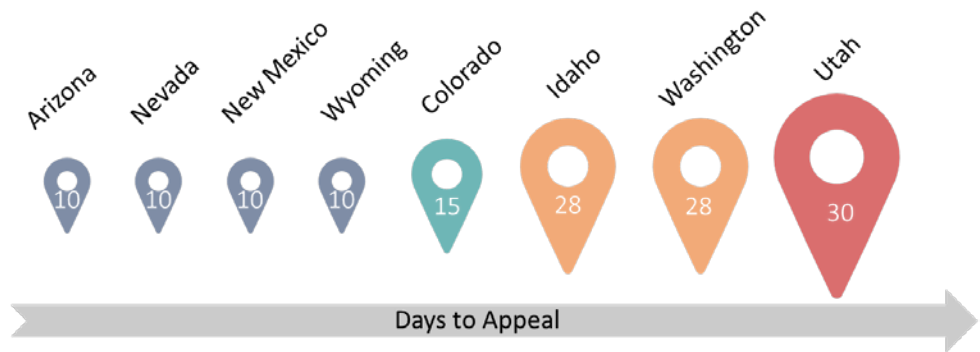
Surrounding States Have Clearer Appeals Processes

We surveyed licensing offices in surrounding states to compare their appeals processes to those in Utah and found the following:

- The state of Washington has publicly available policies and procedures that clearly outline circumstances requiring revocation of a license as well as the necessary steps and staff members involved to ensure the due process rights of the provider. Washington’s licensing office imposes sanctions immediately, but providers can petition for a stay hearing in many cases to freeze imposition of the sanction until a full hearing can take place.
- According to Idaho’s Daycare Licensing, Idaho Code and rules governing standards for child care licensing allow the “denial, suspension, revocation, non-renewal of a license or completion of a plan of correction prior to the completion of an appeal process.”
- New Mexico imposes sanctions immediately if the health and safety of children are at risk; when sanctions are appealed, the sanction stays in place until the decision is either upheld or overturned. This policy is in their office’s administrative rules and thus is publicly available.

We also compared the number of days Utah gives providers to file an appeal to the length of time other states allow. In the in-home provider’s case (Figure 2.4), the appeal hearing occurred six weeks after CCL substantiated the complaint of child abuse. Figure 2.5 shows how the time allowed for filing appeals in Utah compares to what is allowed by surrounding states.

Figure 2.5 Number of Days to File an Appeal. Of the western states, Utah has the longest time frame for filing an appeal, contributing to delays in the implementation of sanctions.



Source: Legislative Auditor General

Note: For states that have different filing deadlines for different sanctions, this figure shows the number of days allowed for the most severe actions taken by the Child Care Licensing office.

Utah's length of time to file an appeal is among the longest of the western states.

Utah has a uniform time frame for filing an appeal regardless of the violation. Arizona and Wyoming adjust the filing deadline based on the action taken. Additionally, New Mexico commits to holding the appeal within five days when sanctions take effect immediately, offering prompt due process to providers whose business interests are substantially affected by a sanction. A prompt process is beneficial to both the protection of children as well as providers' due process rights and should, therefore, be adopted.

Recommendations

1. We recommend Child Care Licensing develop clear policies regarding use of sanctions to address patterns of noncompliance.
2. We recommend Child Care Licensing clarify policies and procedures for the appeals process after consultation with their legal counsel, including a process for increasing monitoring during appeals.
3. We recommend policies for sanctions and appeals be made publicly available online.

Chapter III

Infrequent Reviews, Screening Delays Expose Health Facility Residents to Risk

The Bureau of Health Facility Licensing and Certification (HFL or the Bureau) oversees the quality of care for vulnerable populations that include the elderly, the terminally sick, pregnant women, and people with intellectual disabilities. This chapter focuses primarily on the oversight of the elderly in assisted living centers (also known as assisted living facilities or ALCs), which make up 55 percent of the facilities HFL regulates. Industry growth, which is fueled by a growing elderly population, and limited resources for oversight have led to concerns. Specifically, this chapter discusses the following concerns:

- Growth in ALCs has led to infrequent regulatory reviews, or surveys. In 2012, ALCs were surveyed every 35 months and by 2016 the duration doubled to 70 months.
- While HFL can increase efficiencies, facility growth will likely necessitate additional funding. Other states have adopted standards on survey frequency and tied funding to facility growth. HFL should first improve efficiency and then work with the Legislature to determine a standard for oversight and benchmark funding to that standard.
- HFL has not sufficiently screened health facility providers. This is because the screening process is mired by low-risk clearances and fails to triage criminal cases by severity, thereby creating undue risk to residents.

Our concern is that state liability and potential harm to residents could continue as unmitigated risks if these issues remain unresolved.

Assisted Living Center Oversight Can Improve with More Frequent Reviews

HFL has struggled to keep up with industry growth in providing timely reviews of facilities they are charged to oversee; however, recent trends show some improvement. The time between ALC surveys has

The Bureau of Health Facility Licensing is charged with licensing and inspecting health facilities throughout the state.

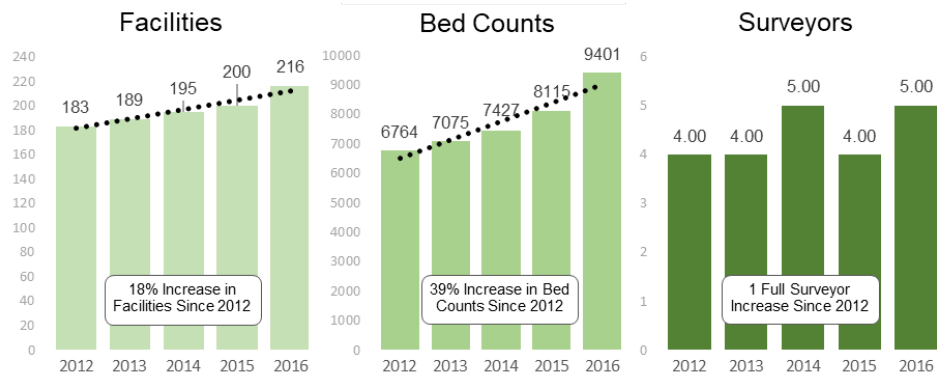
doubled, leaving residents exposed to greater risk. Correspondingly, surveyors are identifying more deficiencies, including more critical offenses within inspected facilities. Utah lags behind other states in the number of surveyors and time between surveys. As the elderly population is projected to nearly double by 2050, solutions are needed to provide protections to vulnerable aging adults.

The State Health Facility Industry, Particularly ALCs, Saw Major Growth in the Last Five Years

The health facility industry in Utah is expanding in two major ways. First, the number of ALCs has grown 18 percent over five years. Second, ALC facility bed counts have increased 39 percent in that same period, as shown in Figure 3.1.

The number of new health facilities and bed counts has shown strong growth over the last five years, but the number of HFL surveyors may not be keeping pace.

Figure 3.1 Assisted Living Center Bed Counts Are Expanding. Facilities are increasing while surveyors appear to be insufficient.



Source: HFL with auditor analysis
 Note: To accurately compare Utah's data with that of other states we listed the number of surveyors as a head count, not an FTE number. These surveyors also perform complaint investigations, in addition to inspecting ALCs, Intermediate Care Facilities for the Intellectually Disabled, and other facility types.

Figure 3.1 demonstrates industry growth in ALCs. HFL processes require a review of residents and staff charts as a proportion of facility totals. Therefore, larger facilities, which require more reviews, hinder HFL's ability to visit all facilities in a timely manner. An increase of one surveyor, while a large relative increase, may not be sufficient to keep pace with growth. Other states have experienced similar growth and report efforts to obtain more surveyors to regulate that growth.

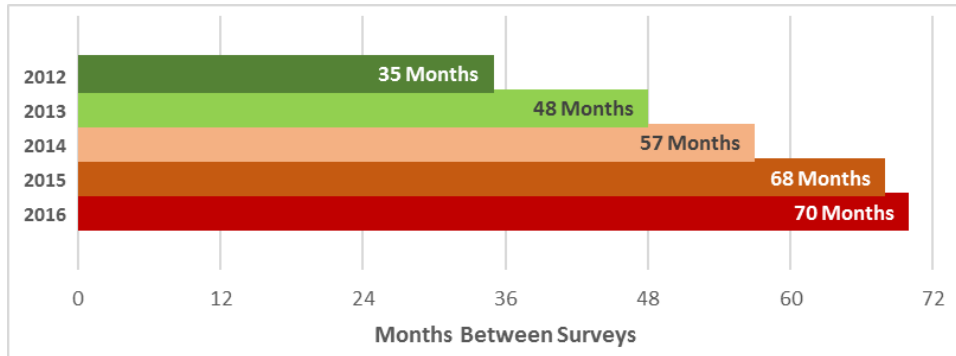
Health Facilities Industry Boom Leads to Longer Time Between Surveys

HFL survey time frames for some facility types are expanding and, in some cases, have doubled over the last five years. Figure 3.2 shows

HFL reviews a proportion of charts based on resident and staffing counts, thus larger facilities require more review.

that the longest duration between ALC surveys increased from 35 months in 2012 to 70 months in 2016.

Figure 3.2 The Longest Time Frame Between ALC Surveys Doubled from 2012 to 2016. However, time between surveys do not now appear to be increasing as rapidly.



Source: HFL records

Note: Historic survey time frames are based on a calendar year and could not be recreated to match fiscal year data.

HFL calculated durations in Figure 3.2 by selecting the facility with the longest time between surveys. We were told HFL prioritizes reviews of these facilities. Because average time between surveys has not been collected until recently, we recommend HFL calculate and track average time between surveys for all facility types to better understand their workload.

To address the increased workload that is evidenced by longer time periods between surveys, HFL streamlined their survey process (fiscal year 2015) and added a surveyor (fiscal year 2016) through ongoing and nonlapsing funds to increase the number of surveys they perform. Though HFL has seen improvements, we are concerned that funding additional surveyors using temporary funds is not sustainable, resulting in increased risk to residents as survey durations lengthen.

Increased Number of Deficiencies and Weakened Provider Compliance Coincide with Delays in Survey Time Frames

Surveyors inspecting facilities for safety and environmental risks are finding more deficiencies as time between surveys expands, including more serious offenses. Increased time between surveys may not be the only explanation for increased deficiencies; however, other western states that have mandated surveys every one to two years report no major increases in deficiencies. Figure 3.3 demonstrates a five-year increase in ALC cited deficiencies.

To address longer time frames between surveys, HFL streamlined their process in FY 2015 and added a new surveyor in FY 2016.

Surveyors inspecting facilities for safety and environmental risks are finding more deficiencies, including more serious offenses, as time between surveys expands.

Figure 3.3 Expanded Survey Time Frames Correspond with Increased Citations. HFL is identifying more Class I (serious) violations than in prior years.

Fiscal Year	2012	2013	2014	2015	2016
ALC Facility w/ Longest Duration (Months) Between Surveys	35	48	57	68	70
ALC Class I Citations	9	28	18	8	35
ALC Class II Citations	339	403	327	156	711

Source: HFL documents with auditor analysis

Note: Class I citations are serious violations of statute and/or administrative rule that presents imminent danger to a resident or hazards to the public health. Class II citations are issued for other immediate health or safety concerns in the facility.

The overall pattern in Figure 3.3 reveals that citations increase with the expansion of survey time frames; however, fiscal year 2014 and 2015 show a departure from the trend. HFL reports this is primarily the result of fewer surveyors in those two years, though HFL data does not entirely support this explanation for FY 2014 (see Figure 3.1).

In an effort to mitigate risks in health facilities, HFL’s survey process reviews resident and staff charts and environmental factors within facilities. Frequent facility reviews, therefore, help providers to better understand state laws and protect residents. To assess risk, the following cases were brought to our attention because they are serious in nature and resulted in an investigation. We do not suggest that HFL’s infrequent surveys led to the serious concerns in these cases. HFL, however, provides vital oversight for the protection of vulnerable populations, and therefore needs to provide frequent surveys to hold providers accountable and reduce resident risk. The following three cases illustrate the need for more frequent surveys:

Facility 1—Since 2010, this ALC was cited on three occasions (complaint investigations included) for issues with medication distribution. The year following the last survey (five years and nine months between relicensure surveys), a complaint was filed where a staff member mixed up a resident’s medication and administered a higher-than-prescribed dose. The resident was found unconscious and later died. HFL’s follow-up investigation again identified issues with medication distribution. HFL reviews a facility’s incident reports and medication logs during their regular surveys, which is important for correcting medication errors.

HFL’s survey process provides important protections for vulnerable populations and is key to holding providers accountable.

Facility 2—In 2015, a resident left this locked facility and was found deceased in the courtyard from apparent exposure during the night hours in late November. After this incident occurred, a complaint was filed. HFL surveyors review whether staffing levels meet individuals’ needs and found that in this case, the facility failed to monitor the resident or investigate the resident’s death. Prior to this incident, this ALC’s most recent in-depth relicensure survey was in 2010.

Facility 3—In 2015, HFL received a report that a resident had died due to being locked outside the facility all night. HFL later found that a staff member ignored facility policy and failed to monitor the resident. This facility had not been surveyed since 2010, nearly a six-year time span.

Increased time between surveys weakens provider accountability and expands risk to vulnerable residents, especially given high staffing turnover in the health care industry.



























Reviewing Other Operational Practices Provides Insight into the Need for More Surveyors

Even with a slight increase in surveyors, HFL continues to inspect ALCs at longer durations and with fewer surveyors than other western states. HFL also lacks mandated time frames between surveys, which is the practice in most states we reviewed, as shown in Figure 3.4.

Increased time between HFL surveys weakens provider accountability and expands risk to vulnerable residents of health facilities.

HFL continues to inspect ALCs at longer timeframes and with fewer surveyors than other western states we reviewed.

Figure 3.4 Other States Vary in Survey Frequency, Resources.
Utah has fewer surveyors per facility than other states.

	Frequency of Surveys	Mandated Timeframe	Surveyor to Facility Count
Nevada	 1 Yr.	✓	 : 21
Arizona	  1 Yr. [†]	✓	 : 71
Washington	  1.5 Yrs.	✓	 : 20
Oregon	  2 Yrs.	✓	 : 34
Idaho	   1.25-3 Yrs. [‡]	✓	 : 40
Colorado	    3-5 Yrs.		 : 73
Utah	     5+ Yrs.		 : 84

Source: Health facility licensing professionals in western states.

Note: Some states, such as Arizona and Idaho, struggle to keep up with industry growth and have exceeded their mandates. Both are wishing to hire more surveyors to catch up with growth. Also note that Nevada's surveyors include clerical staff and Washington's are calculated FTEs.

[†] In Arizona if no deficiencies are identified, surveyors may skip the following year's survey. Also, facility counts are inclusive of all facility types, including federally certified facilities.

[‡] In Idaho, surveys are required within a 15-month time frame until the facility attains two consecutive surveys with no core deficiencies. Under this provision, surveyors must then visit a facility at least every three years.

The four states with the most frequent time frame did not report an increase in identified deficiencies, while states with longer time frames did.

Figure 3.4 suggests that facility oversight becomes increasingly difficult when fewer surveyors are available. With more surveyors, HFL could inspect facilities more frequently and better manage risks. For example, the four states with the most frequent survey time frames, which also experienced growth, did not report an increase in the number of identified deficiencies during our audit. States with longer time frames reported increased deficiencies. Utah does not mandate an average survey time frame for state-licensed facilities.¹ However, the nearly 100 in-state federally certified nursing and skilled nursing facilities are required to be surveyed within a 15-month time frame, though more surveyors (17) are utilized to meet this requirement. The challenge is balancing limited resources with better resident protections that result in shorter survey time frames.

Given recent and future health facilities' growth, we are concerned that oversight inadequacies will persist if HFL maintains the status

¹ Abortion clinics and federally certified facilities (listed in Chapter I) are the only facilities HFL regulates that have statutorily mandated survey time frames.

quo. However, solutions to this problem are available and will be discussed in the following section.

Health Facility Licensing Needs Efficiencies, Oversight Standards, and Improved Practices

Facility growth has been a primary cause of long survey time frames over the last five years. To address the infrequent survey rate HFL should adopt efficiencies that include technology upgrades, team restructuring, and cost-benefit analysis of multiple surveyor locations. Because no mandate exists for the quality of or duration between surveys, HFL should work with the Legislature to develop an oversight standard, so that resources can be allocated to maintain that standard. Additionally, HFL needs to improve practices by posting survey results online and better utilizing statutory sanctions.

HFL Should Consider Adopting Efficiencies Found in Other States

During our review of other states' health facility licensing practices, we found several actions that, if HFL adopted, could lead to greater efficiencies. We recommend HFL adopt the following:

Technology Upgrades. HFL surveyors currently use a paper-based process when surveying a health facility. Other states have migrated their survey processes to more efficient, electronic formats. Washington reports great efficiencies gained by utilizing technology upgrades during their survey process. The Centers for Medicare and Medicaid Services (CMS), which regulates federally certified facilities in Utah, is also requiring states move to an electronic process to review all federally certified facilities.

States such as Colorado and Washington have also created forms to electronically input health facility complaints into the CMS system. In contrast, HFL staff manually type complaints into the system. By streamlining this process, HFL could become more efficient, freeing staff to address their backlogs. Large upfront costs may be necessary to adopt new technologies, but doing so could provide enhanced efficiencies and cost savings over time.

Survey Team Restructuring. Washington routinely utilizes one surveyor for smaller facilities (between 6 and 100 bed counts). We

Best practices in other states could promote greater efficiencies if adopted in Utah.

observed cases where teams of four HFL surveyors were sent to review a health facility. An HFL manager explained that sending two surveyors, rather than one, helps insulate against provider influence and assists in writing correct citations. While we are not determining the optimal number on a survey team, we question whether smaller teams could be used to more effectively utilize state resources.

Multiple Surveyor Locations. Arizona, Colorado, Nevada, Oregon, and Washington all have health facility surveyors operating from multiple strategic locations within their states. HFL operates exclusively from Salt Lake County. We were told an HFL surveyor office was located in St. George, but it was closed during the recession. HFL should conduct a cost-benefit analysis to determine if greater efficiencies and oversight are attainable with two locations.

More Frequent Reviews Could Be Achieved with Mandated Time Frames and Adequate Funding

As the aging population increases, it is important for HFL to keep up with facility growth in the industry. We are concerned that without a mandated time frame or corresponding funds to survey ALCs and other state-licensed facilities, oversight may become inadequate. For example, HFL's current ongoing funding may not support survey time frames of three years or fewer. We believe HFL should first improve efficiencies within the Bureau, then work with the Legislature to determine a time-frame standard for oversight and benchmark funding to meet that standard. Determining an oversight standard for both quality and survey duration is a policy question to be considered by the Legislature, with input from HFL. Idaho has gone through this process and has calculated the number of surveyors required to support their statute's 15-month to three-year mandate.

In addition to HFL lacking a survey mandate, their funding is not tied to growth, and the ability to regulate that growth, in the health facility industry. Two of six states we reviewed, Arizona and Nevada, have funding models that are more closely tied to market growth and may provide a more sustainable funding model.

- Arizona places 90 percent of licensing revenues into an investment fund, with the remaining 10 percent going to the state general fund. All monies derived from civil money penalties (CMPs), instead of going to a restricted account as is the case in Utah, go into the state general fund.

Utah does not have a mandated time frame or funding for a specified oversight standard; however, Idaho set a standard and calculated funding required to meet it.

- Nevada assesses fees to providers based on adjusted actual costs to survey health facilities and a provider’s ability to pay the fee (smaller facilities find it difficult to pay). Fees are reviewed by their board of health and, once approved, generally do not require major adjustments from year to year.

Abortion clinics, unlike other Utah facilities, are indexed to growth, because they are required to pay an annual license fee that covers the costs of surveying. Statute authorizes these funds “to pay for the cost of the licensing . . . and . . . inspecting abortion clinics.” ALCs also have licensing fees, but these funds do not directly fund surveys. We recommend HFL adopt efficiencies to streamline their process, then work with the Legislature to set an appropriate oversight standard for quality and survey duration and benchmark funding to that level.

To Further Improve Their Process, HFL Can Better Hold Providers Accountable in a Variety of Ways

HFL can also improve their process by better holding providers accountable. HFL should promote provider compliance by posting survey findings publicly and utilizing statutory sanctions that maximize state resources.

Post Survey Findings Online. HFL can do more to promote provider compliance. For example, although statutorily required, HFL has not publicly posted completed surveys, including critical violations. Instead, survey findings are available solely through the formal request process of the Government Records Access and Management Act (GRAMA).

The requirement to publicly post information promotes provider accountability and is a practice already employed by CMS and Child Care Licensing. Child Care Licensing (which regulates child care facilities within the Department of Health) has a detailed system that posts survey findings online. Their publicly accessible records include the cited offense (including if it was a repeat offense), severity level, detailed explanation of findings, and dates of investigation and correction. Although statute requires HFL survey findings be public record, it does not require they be posted online; however, many states are doing this.

Funding models indexed to market growth can be found in other in-state licensed facilities and in other states.

HFL should post findings from facility inspections online, a practice utilized by Child Care Licensing, other states, and CMS.

A recent national study found that Utah was among the 10 worst states for public accessibility to basic health facility information. We spoke with Arizona, Colorado, Idaho, Nevada, Oregon, and Washington (most of which had “exceptional” scores for information access) about their transparency, including whether they post their surveys publicly. All but one of these states reported publicly posting surveys online. For example:

- Idaho (intermediate rating) used this study to drastically change their online content. Their changes include the development of a new web-based portal which allows for more transparency, including posting findings online. As a result, Idaho reports seeing positive changes in provider compliance.
- Colorado (exceptional rating) reported that their survey findings have been publicly posted for five years. They believe doing so has brought a level of accountability to providers and has benefitted the public.

We are uncertain of the cost required to post surveys online, but we believe doing so would add value to the surveys HFL is already performing. We recommend HFL review the cost required, then post their survey findings online. Doing so would promote better provider accountability and transparency to the public.

Better Utilize Enforcement Mechanisms. *Utah Code 26-21-11* authorizes HFL to assess various penalties for violations of statute or rule. However, HFL reported that they have not utilized many of these enforcement mechanisms, and those they have used could be more consistently applied. Other states report that CMPs are their primary mechanism to bring providers into compliance with state law. While HFL utilizes CMPs, more effective options may exist. For example, one nursing facility administrator reported that the publicly available rating system for federal facilities is more effective than a CMP to incentivize compliance. HFL should utilize available statutory sanctions to promote provider compliance and maximize state resources.

Barriers have kept HFL from consistently holding some providers accountable. For example:

- HFL has not adopted a formal CMP policy that fines providers based on the severity of citations issued. HFL is hesitant to

HFL reported that they have not utilized many sanctions authorized in statute.

adopt a policy because fines issued to smaller facilities could be passed on to the residents they are required to protect. While recognizing this constraint, we recommend HFL thoughtfully adopt CMP policies that can be consistently applied.

- HFL administrative rules are out of alignment with current survey practices. For example, administrative rule sanctions are based on an outdated survey practice of “three or more violations of a single licensing rule...occurring within a 12-month time period.” However, as facilities are infrequently reviewed, up to 70 months between surveys, enforcement is unlikely and limited based on this definition. We recommend HFL amend and utilize this rule to align with current survey practices.

Health Facility Licensing Has Not Sufficiently Screened Health Facility Staff

Although HFL has a sophisticated system for clearing individuals applying to work in health facilities (initial screening) and those individuals already working in health facilities (ongoing screening), operational weaknesses expose health facility residents to unnecessary risk. The initial background screening process for new employees, which went online in May 2012, contains three operational weaknesses. First, some providers are not submitting the names of all new hires into the screening system. Second, a portion of the screening system is not automated, contributing to year-long delays. Finally, important appeals policies are lacking.

In addition to initial screening concerns, weaknesses in the ongoing screening process include HFL’s inability to triage new criminal activity notices (or “hits”) based on severity and splitting time manually clearing low-risk individuals instead of focusing on high-risk hits already in the system.

Initial Background Screening Technology Is Hindered by Three Operational Weaknesses

Though HFL has developed advanced initial and ongoing screening technology, these advances are inadequate when human review is limited. Increased staffing, along with fixes to system weaknesses, may assist HFL in keeping up with screening pressures.

Some providers are not submitting the names of some new hires into the HFL background screening system.

Some Providers Are Not Properly Recording Some New Employees into the Direct Access Clearance System (DACs).

When employees are not recorded in DACs, they are not properly screened. For example, in fiscal year 2017 HFL issued 71 citations to providers that had not followed background screening protocols. This problem is not easily corrected when surveyors visit facilities for in-depth surveys once in a five-year window. Additionally, we reviewed the rosters of three health facilities against DACs records and found that one of the facilities had 19 employees who had not been properly screened. The other two facilities had a total of 10 employees who were not entered into at least one element of the screening system.

Due to delays in initial background screenings for new applicants, some facilities have reportedly contracted with private screening companies. However, screenings that are performed in place of HFL's clearance process may violate *Utah Code 26-21-206*, which requires all providers to be cleared by the state. These background screening services do not have authority to clear employees working in health facilities and HFL is concerned the services are limited and do not access the same criminal databases as HFL. Thus, providers' private screenings are potentially giving a facility and its residents a false sense of security.

HFL must find a way to keep up with screening demands and better hold providers accountable for screening employees. Although providers hold a share of blame, risk still exists that must be mitigated. One solution is to require provider training in proper background screening processes. For example, Arizona requires some managers of health facilities to complete continuing education training every two years before they can be relicensed. We recommend HFL continue to work with providers to become compliant with screening rules.

Manual Review Is Creating a Screening Backlog. Although DACs is automated with criminal databases, HFL manually checks new applicant records against the Department of Human Services' (DHS) SAFE database. This has contributed to a queue of records for HFL staff to review and has placed them a year behind in reviewing new incoming criminal hits for their ongoing screening system.²

² The federal grant which facilitated upgrades to HFL's screening process, required HFL to move from screening "direct care" persons (i.e. nurses and aides) to screening "direct access" persons (nurses, kitchen staff, custodial, etc.) in health facilities, creating an increase in records HFL must review.

HFL clearances are delayed due to large queues of records waiting to be reviewed.

In July 2017, HFL staff reviewed ongoing screening hits from July 2016. Tracking the average queue size between July and August 2017 showed the following:

- 16,840 records were in queue for processing for some element of background screening.³
- 3,015 records were in queue from hits during the ongoing criminal background screening.⁴
- 126 records were in queue for people HFL denied clearance to work in a health facility who are still potentially working for a provider.⁵

Several facility administrators we spoke with were frustrated with delays in the initial screening system, though they were generally pleased with HFL survey teams. Some administrators explained that delays in screening are exposing their residents to risk. For example, we spoke with one administrator who hired and continuously employed an individual for one year before terminating this person for administering medication via needle without a license. The administrator reported that at least one year after the employee had been fired (two years after the employee's application), HFL determined that the individual was not fit to work in a health facility because of a similar offense they performed in a prior facility. Another administrator explained that with high staff turnover, a screening (which often takes six to eight months according to the administrator) may not be returned until after an employee has already quit working with a facility. We agree with these administrators and further believe that delays in the screening system not only present risk to residents but also place a liability on the state.

Because SAFE data (which includes Adult Protective Services and Child Protective Services records) is, as DHS reports, limited because of incomplete data, full automation may be difficult. However, HFL

Some facility administrators reported that delays in the HFL's screening process exposes residents to risk.

³ This number includes demands for HFL to check juvenile records (under age 18), the SAFE database, or the applicant's need to receive fingerprinting.

⁴ This number includes fingerprint results revealing initial checks against criminal and juvenile record, ongoing FBI Rap-Back hits, or fingerprint rejections.

⁵ This number includes individuals who HFL determined were ineligible to work, were working without completed screenings, or were terminated without updating records.

and DHS both believe DACS and SAFE could be better integrated to speed up the screening process. During the close of this audit, HFL and DHS were working together to better match the two databases. We understand complexities exist in sharing data and recommend HFL continue to work with DHS to reduce records in the queue.

No Formal Policy Exists to Determine Appropriate Reasons For HFL Staff to Overturn a Deniable Offense. HFL administrative rule is explicit on what criminal behaviors prevent an applicant from working in a health facility. However, because no formal policy for overturning that ruling exists in the first level of the HFL appeals process, HFL relies on human judgment to make determinations. This practice could potentially lead to inconsistent judgments that do not appropriately account for risk. We acknowledge it may be difficult to account for every human risk factor, but believe a formal policy could promote more consistency. We recommend HFL adopt a policy that promotes consistent appeals decisions and properly accounts for risk.

Ongoing Screening Criminal Hits Are Not Triaged by Severity of Offense

HFL's ongoing screening process is delayed when low-risk clearances take time from the high-risk criminal queues. Once HFL fingerprints a new employee of a health facility, FBI Rap-Back screening technology delivers near real-time feedback to HFL when a new arrest, warrant, or conviction occurs. However, the hit goes into a queue, where HFL reviews the oldest criminal record and initial screening records needing to be cleared. As a result, HFL is one year behind in determining whether each ongoing hit disqualifies employees from working in a health facility. Because of this backlog, potentially dangerous people are working in health facilities that the technology has identified but HFL is too overburdened to address. For example, we sampled HFL's screenings of individuals with criminal hits on one day in July 2017. During that sample, we found that of the five individuals with concerning records, one had a third-degree felony and was still working in a health facility. We recommend HFL address identified screening weaknesses and continue to work with DHS to integrate their two systems.

HFL is one year behind in determining whether an employee that has been flagged with a background screening concern should work in a health facility.

Recommendations

1. We recommend the Bureau of Health Facility Licensing calculate and track the average time between surveys for each facility type to better understand their backlog.
2. We recommend the Bureau of Health Facility Licensing adopt efficiencies such as implementing an electronic surveying process, restructuring survey teams, and performing a cost-benefit analysis on multiple surveyor locations.
3. We recommend the Bureau of Health Facility Licensing improve efficiencies, then work with the Legislature to set an oversight standard for quality and survey duration and benchmark funding to that level.
4. We recommend the Bureau of Health Facility Licensing publicly post their survey findings online.
5. We recommend the Bureau of Health Facility Licensing utilize statutory enforcement mechanisms that promote provider compliance and maximize state resources.
6. We recommend the Bureau of Health Facility Licensing thoughtfully adopt formal civil money penalty policies that can be consistently applied among providers.
7. We recommend the Bureau of Health Facility Licensing, along with the Health Facilities Committee, amend their administrative rules to align with current survey practices and utilize them to better enforce compliance.
8. We recommend the Bureau of Health Facility Licensing continue to work with providers to ensure their compliance with *Utah Code* 26-21-206.
9. We recommend the Bureau of Health Facility Licensing work closely with the Department of Human Services to better integrate DACS with the SAFE database to reduce background screening queues.
10. We recommend the Bureau of Health Facility Licensing adopt a policy detailing what would allow them to overturn a deniable offense during the first level of the appeals process.



Chapter IV

Improved Monitoring and Data Needed for Baby Watch Early Intervention Program

Utah’s Baby Watch Early Intervention (BWEI) program delivers services to children from birth to age three with developmental delays. We were asked to assess the efficiency and effectiveness of BWEI and found several areas in need of improvement. First, the program does not perform on-site quality monitoring, which is needed to ensure high-quality services are provided in the child’s natural environment as federally required. Because high-quality services result in larger developmental gains for children in early childhood than for their older counterparts, quality monitoring is critical. Second, the program does not use data on service duration and service type to more accurately allocate resources and enhance transparency. Third, other states effectively collect data and have identified funding sources, such as private insurance, to help improve the effectiveness of their early intervention programs. Finally, we were asked to review the placement of BWEI program within the Department of Health and found that it is appropriate.

On-Site Monitoring Not Occurring, Key Indicators Show Program Performance Declining

On-site monitoring of BWEI is not occurring, creating challenges for validating the quality and duration of the services provided. Simultaneously, key indicators show a downward trend in program performance since 2009. In the absence of on-site monitoring, it is difficult to evaluate what is driving this trend. Additionally, BWEI needs clear policies to improve processes.

On-Site Monitoring Is Essential to Determine Quality of Baby Watch Early Intervention Services

On-site monitoring is not occurring despite a policy requiring it since 2013. In fact, documentation submitted by the Division of Family Health and Preparedness to the Governor’s Office of Management and Budget (GOMB) in June 2016 shows that on-site monitoring was supposed to start by July 1, 2016; however, it is still not occurring. On-site monitoring includes file reviews, interviews,

Utah’s Baby Watch Early Intervention Program delivers services to children from birth to age three with developmental delays.

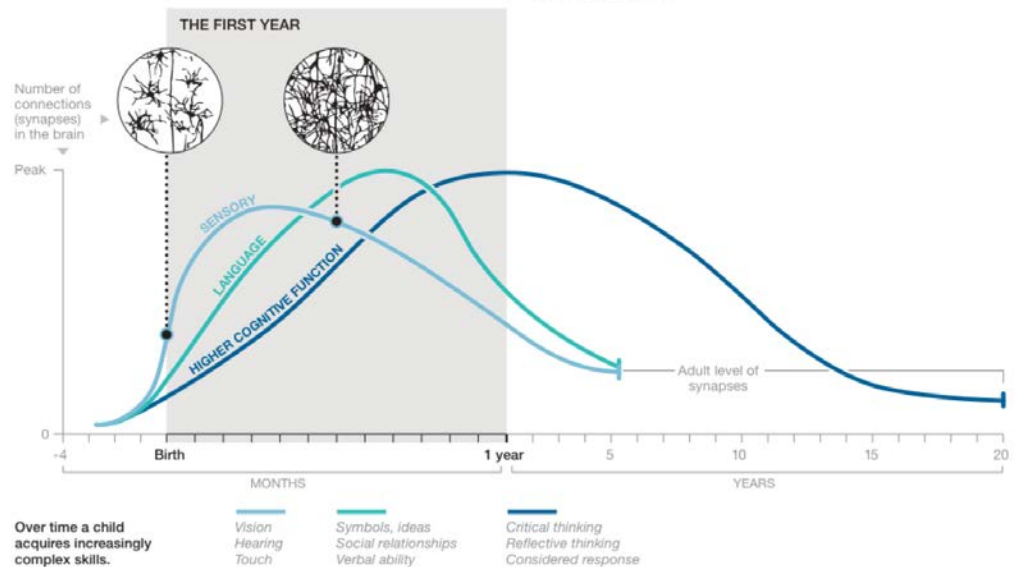
BWEI has not followed its policy for performing on-site monitoring.

observations, and follow-up monitoring visits. It is important for validating that high-quality early intervention services are delivered to children and their families in a home or community setting. Federal regulations require that states monitor their early intervention programs.

According to the National Early Childhood Technical Assistance Center, “Intervention is likely to be more effective and less costly when it is provided earlier in life rather than later.”

According to the National Early Childhood Technical Assistance Center, high-quality early intervention programs can reduce the incidence of future problems in learning, behavior, and health and are more cost-effective when provided earlier in life rather than later. These findings are backed by research on the human brain indicating that the brain is most plastic, or able to change, early in life, as shown in Figure 4.1.

Figure 4.1 The Brain Is Most Flexible During Early Childhood. The first year of a child’s life sets the foundation for future learning abilities.



Source: Lawson Parker, based on Charles Nelson, Harvard Medical School; Pat Levitt, Children’s Hospital, Los Angeles. Synapse drawing based on Golgi Stain Preparations (1939-1967) by J.L. Conel.

According to Harvard University’s Center on the Developing Child, “Neural connections for different functions develop sequentially,” and “early experiences determine whether the circuits are strong or weak.” Although no studies have calculated the return on investment specifically for early intervention programs serving the birth to three population, studies measuring the benefit of other early childhood programs consistently show a return. The Center on the Developing Child found that for every dollar spent on early childhood,

there is a \$4 to \$9 return on investment to taxpayers realized through reductions in the cost of crime, special education, and welfare.

Therefore, ensuring BWEI services are high quality via monitoring is critical. The BWEI program manager acknowledges the importance of monitoring and recently filled a position to perform this function. Additionally, BWEI providers report that they are not receiving appropriate technical assistance from the program, which is a requirement of the program’s policies.

Key Indicators Show Some Providers Not Meeting State Targets

A lack of monitoring may have contributed to the recent decline in BWEI program performance. Federal regulations require states to report on all compliance and results indicators; of these, Utah has selected *improvement in positive social-emotional skills at the exit of the program* as an area of improvement. This indicator, as well as the other two federally required indicators of child outcomes, has declined in the last five years, which is concerning. Figure 4.2 shows performance on these indicators for federal fiscal years 2014 and 2015, the most recent years for which data is available.

BWEI’s performance on key indicators of child outcomes has declined.

Figure 4.2 Performance on Child Outcome Indicators Declining. Fewer providers met state targets in federal fiscal year 2015 than in 2014.

Outcome Indicator	State Targets Met Overall?		Number of Providers Meeting State Target (Total = 15)		
	2014	2015	2014	2015	Change
Percentage of infants and toddlers who demonstrate improved:					
Positive social-emotional skills	✓	✓	10	8	↓
Acquisition and use of knowledge and skills	✓	✗	7	6	↓
Use of appropriate behaviors to meet their needs	✓	✗	9	8	↓

Source: Program profiles from FFY2014 (reporting on July 1, 2014 – June 30, 2015) and FFY2015 (reporting on July 1, 2015 – June 30, 2016). Program profiles from FFY2016 will not be available until 2018.

Without on-site monitoring, it is unclear why some providers are performing better than others.

While some providers are exceeding state targets, other providers are not meeting these targets as shown in Figure 4.2, contributing to a reduction in state performance overall. Variability among providers on these indicators suggests the quality of services may not be uniform. Without monitoring in place, however, it is difficult to determine the cause for the decline. In 2015, the Office of Special Education Programs began utilizing child outcome data as part of their state determinations; thus, performance on these indicators is key to the sustainability of the program. We recommend implementation of on-site quality monitoring to ensure high-quality intervention services are provided throughout the state.

Baby Watch Early Intervention Program Needs Clear and Complete Policies

Providers report a lack of clarity in the BWEI program's current policies. Specifically, program policies do not address key expectations for both providers and the state BWEI office regarding background checks and data management. While other states require background checks for providers,⁶ Utah's BWEI policies do not address the use of background checks. The current program manager confirmed that background checks are not required but could not identify the rationale for this. In some cases, providers require background checks for their employees, although they cannot access state databases to complete them. Technology to support background checks already exists within Family Health and Preparedness (FHP). Other programs within FHP, such as Child Care Licensing and Health Facility Licensing, have statutory requirements to conduct background checks on all adults who have access to the vulnerable populations they serve. Legislative action is necessary to establish similar requirements for BWEI. Therefore, we recommend that the Legislature consider requiring background checks in the BWEI program and that BWEI develops administrative rules and policies supporting their use.

There are no existing policies that address the process for making changes to the Baby and Toddler Online Tracking System (BTOTS), the state-run data management system. The BTOTS includes information on all children in the program, their Individual Family Service Plan, their assessments, and the services they receive. This is

⁶ Arizona, Idaho, Illinois, Kentucky, Missouri, Nevada, and New Jersey are among the states included in our review that require background checks.

BWEI does not require background checks for providers.

problematic because providers do not receive notification when system changes are made. This practice of changing the data system with no standardized procedure calls into question the validity of the data when changes occur. Additionally, the reports the BWEI program uses may not accurately represent what is happening in the providers' organizations, since these reports are not shared with the providers for accuracy validation.

Providers report that in general, policies need clarification and that in some instances, state policies exceed federal requirements, which poses challenges for providers. For example, federal regulations allow children to be served in groups in some cases while the state office required providers to visit children individually. Additionally, some policies are not followed. A failure to implement on-site monitoring as required in policy exemplifies this concern. Due to the number of policies in need of revision as well as the lengthy approval process required by federal oversight, we recommend BWEI review all policies, utilizing stakeholder input, and submit a revised policy manual in full.

Better Cost Data Needed to Allocate Resources and Enhance Transparency

The current funding formula and associated metrics offer insufficient data on some program costs. Costs associated with the type and duration of a service are not known. This information is valuable for the effective utilization of limited resources. Additionally, while providers already track and submit data relating to duration and type of services, the BWEI program does not use these data points to allocate resources. With a total budget of \$28 million and an average cost of \$5,207 per child, the BWEI program should better protect taxpayer investments by enhancing transparency via detailed data reporting.

Current Funding Formula Is Limited by Insufficient Cost Data

BWEI provider funding is not working effectively due to cost data limitations. In FY 2017, the BWEI program implemented a new formula that allocates state general funds and federal funds based on the total number of visits providers deliver plus administrative costs. This formula does not include the duration of the visits or the type of

Providers report current policies are unclear.

BWEI implemented a new funding formula in FY 2017, but it is not working effectively.

service delivered (speech pathology, physical therapy, etc.), two factors that impact cost. The direct service rate varies based on the geographic region: urban providers are reimbursed at \$168 per visit, rural providers at \$180 per visit, and frontier at \$219 per visit. In addition, each provider's contract includes funding for administrative costs.

For Medicaid-eligible children who are active in the program (defined by receiving at least one visit in the month), this funding formula does not apply. Instead, providers bill Medicaid for a monthly bundled rate of \$473.22 which includes both direct service and administrative costs. In contrast to the state-paid formula that is differentiated by geographic region, this rate applies to all providers in the state. Neither the Medicaid nor the state-paid rate reflects service type or duration of visit.⁷ Consequently, provider billing is inaccurate because it does not report service type or duration. As a result, FHP cannot track program costs.

The Current Medicaid Bundled Rate Needs Review to Ensure It Is Cost-Beneficial. The bundled rate for Medicaid is problematic because it is based on service delivery estimates from 1996 (adjusted for inflation over the years). Due to the variation of needs among children in the BWEI program and the individualized approach to meeting those needs, bundled rates may not align with the actual costs incurred by providers to deliver services. Program managers and providers report that bundled rates may be cost-beneficial, but without doing an analysis of provider visits based on type and duration, they cannot know if this is true. Additionally, Medicaid regulations require supporting documentation showing the date of service, service type, service duration, and place of service, indicating that this data should already be collected by BWEI. Monthly bundled rates present challenges to providing this information. We contacted the Centers for Medicare and Medicaid Services for information on bundled rates. They reported:

States should also be aware that not all provider types would warrant a monthly rate given the variation in frequency and intensity of the services. If there is such

Variations in frequency and intensity of services among children presents challenges to using a monthly rate.

⁷ The rate per visit applies to all direct services that are part of the child's Individualized Family Service Plan, such as speech pathology, occupational therapy, and physical therapy.

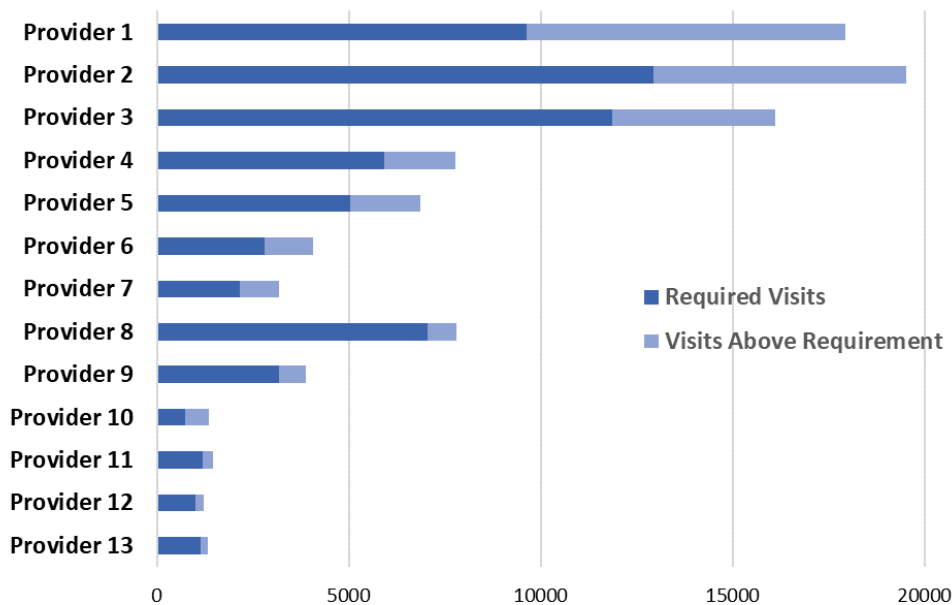
variability, we have advised states to use a smaller unit of service when setting the payment rate.

Therefore, we recommend the Division review data by service type and duration and determine if the current bundled rate for Medicaid is optimal.

Providers Report Current Funding Formula for State-Paid Children Contributes to Budgetary Uncertainty. Although fluctuations in the number of Medicaid-eligible children in a provider’s region occur, the current funding structure cannot adjust to these changes. For example, if a provider has more state- or federally paid children than expected, the provider may deliver more visits than contracted and will not be reimbursed for these visits. Federal regulations obligate states to offer services to all eligible children and prohibit capping the number of services a child receives or putting children on a waiting list, further exacerbating this problem. Figure 4.3 shows that some providers exceeded contract requirements.

Federal regulations do not allow BWEI to put children on a waiting list or cap the number of services children receive.

Figure 4.3 Number of Visits That Exceed Contract Requirements by Provider. Some BWEI providers are delivering services to state-paid children that exceed the number of required contracted visits.



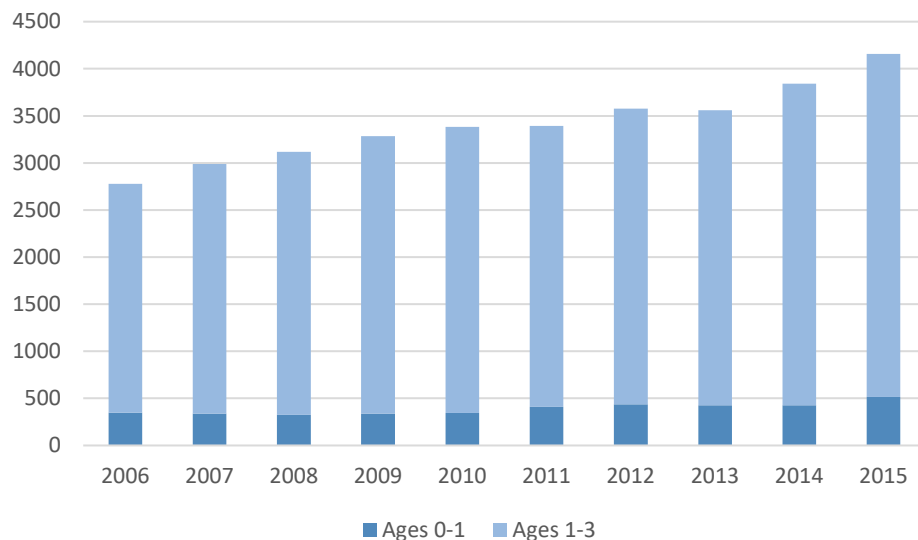
*Source: Monthly expenditure reports from FHP Finance Manager
 Note: Contract requirements are based on 2015 visit estimates. Two providers who did not perform visits above contract requirements are not included here.*

Providers did not lose any funding when BWEI implemented the new formula.

As Figure 4.3 demonstrates, most providers are providing more visits (light blue) than they are contracted to provide (dark blue). This indicates that the current funding formula is not working effectively. In fact, more than 25 percent of the visits delivered by BWEI providers to state-paid children in 2017 exceeded contract requirements. Of the 15 BWEI providers, 13 exceeded their contracted number of visits to state-paid children, delivering a total of 27,791 visits that exceeded contract requirements. The number of visits contracted with each provider was based on the estimated number of visits conducted in 2015, allowing each provider to maintain level funding from 2016 to 2017. Hence, provider funding may be adequate, but is inaccurately reported in the funding formula. Alternately, it is possible that some providers are not adequately compensated and may be providing lower quality services to stretch their limited funding and still provide services to all eligible children.

At the same time, the BWEI program has experienced growth in the number of children served overall. Figure 4.4 shows the number of children served over the past 10 years.

Figure 4.4 Children Served by the BWEI Program Over Last 10 Years. Since 2006, the number of children served has increased by almost 50 percent.



Source: Utah Annual Performance Report for federal fiscal year 2015

While providers have expanded their outreach efforts over the past 10 years, they now report a reduced capacity for child-finding activities, indicating that some eligible children may be unserved.

Providers report reduced capacity to identify children in need of early intervention services.

Caseload data provided by program management indicates that the number of children receiving services every month did not grow as expected in 2017, suggesting that the program has reached its maximum capacity. BWEI currently serves 2.75 percent of the age 0-3 population in the state, well below the national baseline of 4.97 percent. This data, coupled with growth expected in Utah's early childhood population, raises questions about program sustainability.

The current funding formula is not equipped to address either the concern of capacity associated with growth or the need for better data on service type and duration. The formula was developed without adequate attention to guidance from GOMB and without ensuring that providers and BWEI program staff understood how it would operate. Thus, the BWEI program should consider implementing changes to resolve these issues.

To do this, we recommend that FHP collect and analyze submitted provider data to determine the costs associated with providing services by type and duration. This information can then be used to improve the funding formula. Progress should be reported to the Legislature annually. We expect this could take some time, but it will ultimately result in more effective utilization of funds and enhanced transparency.

Data Submitted by Providers Can Be Used to Understand Costs and Allocate Resources Effectively

BWEI currently cannot track the total hours of service delivered by a provider. However, each time providers conduct early intervention visits, they enter the type and duration of the service into the BTOTS data management system. Unfortunately, this data is only used to track a child's record and has not been analyzed to evaluate program performance or costs. It is housed separately from financial data used to pay providers. Since the data is collected but not utilized, program managers have insufficient information to assess providers' performance and to understand the costs associated with delivering early intervention services. By utilizing provider-submitted data to track the duration and type of services delivered, the BWEI program can compare current allocation of resources to actual costs and adjust as needed. Improved data would enhance transparency by providing better information to both the state office and to taxpayers; the state office could use the data to make better funding decisions, and taxpayers would have more information about how the funds are being used.

There was no increase in the overall caseload for BWEI in 2017, suggesting the program does not have the capacity to grow.

BWEI requires providers to submit information on service type and duration but does not use it to understand program costs.

Other states track the number of hours of service children receive, but Utah counts only visits.

Tracking data on duration of services is helpful for comparing performance across states and is a better indicator of service quality than number of visits, which BWEI currently uses. Prior to adoption of the visit metric, Utah participated in a 2015 survey of the Individuals with Disabilities Education Act (IDEA) Part C early intervention programs. Twenty-five states reported their average number of delivered service hours per child per month, ranging from 0.9 to 12 with a median of 4.3. At 1.4 hours of service per month in 2015, Utah dedicated far fewer service hours to eligible infants and toddlers than other states participating in the survey. Utah's 1.4 hours is based on a one time study, but we were told that hours are not regularly tracked. Therefore, the basis for comparison with other states is currently limited. We recommend that BWEI develop a report function in BTOTS that allows for analysis of service type and duration to estimate costs of services by type and to compare service hours with other states.

Some Other States Effectively Collect Data and Use Private Insurance to Fund Early Intervention

Utah's BWEI program relies on building block requests as a primary funding source. Given the competitive nature of building blocks, we are concerned that they are not a reliable source of ongoing funds. Some other states have found alternative funding mechanisms that appear to provide a more reliable source of ongoing funds. Specifically, some states have maximized their Medicaid funds, and 24 states have leveraged private insurance to help pay for a portion of their early intervention programs. In fact, securing funding is a federal requirement. IDEA Part C regulations hold states responsible for "the identification and coordination of all available resources for early intervention services within the State, including those from Federal, State, local, and private sources." Given the importance of the program as well as the significant taxpayer investment, we recommend FHP study successful changes other states have made in funding their early intervention programs and determine if Utah should adopt similar changes.

Other States Use Fee Schedules for Medicaid To Capture Service Type and Duration

Utah's BWEI program needs better data reporting on duration and type of services provided to assess past expenditures and inform

BWEI relies on building block requests to the Utah legislature to secure new funding.

resource allocation. Other states use a billing structure differentiated by type of service and billed in 15-minute increments, allowing for detailed data on the costs of service delivery and comparison of those costs across providers. These fee schedules allow states to pay for actual services rendered and can also provide consistency across funding streams. In contrast, Utah’s providers receive \$473 per month for Medicaid-eligible children and are reimbursed by visit for state-paid children.

Connecticut Is Shifting from a Bundled Rate to a Fee Schedule. In 2011, CMS informed Connecticut that it must change its Medicaid early intervention payment rates. According to the executive director of the Infant and Toddler Coordinators Association, bundled rates can lead to possible fraud. Connecticut designed the new rates in the fee schedule to ensure the transition will not increase costs. The new fee schedule allows for billing in 15-minute increments with rates differentiated by service category. This approach does not assign a rate to each specific service (speech pathology, occupational therapy, etc.), allowing latitude in the type of provider, an approach that avoids pitfalls other states have experienced. Figure 4.5 shows Connecticut’s fee schedule.

Fee schedules allow states to pay for the actual services children receive instead of using a bundled rate.

Figure 4.5 Connecticut’s Fee Schedule. These rates and limits apply to all funding sources.

Service Category*	Rate (per 15-Minute Increment)	Time Allowed in One Day	Annual Limits
Assessment	\$30	2 hours	2 hours
IFSP Meeting	\$30	10 hours	10 hours
Treatment: Professional	\$30	1.5 hours	None
Treatment: Para-professional	\$21	1.5 hours	None
Treatment: Professional, High Utilization	\$24	No limit	None
Treatment: Para-professional, High Utilization	\$12	No limit	None

Source: Chart of proposed services, rates, and limits, August 2017, from Connecticut’s Birth to Three website
**Evaluations are an additional service category but are not billed in 15-minute increments, thus they are excluded from this table.*

While all other functions of the program can be billed in 15-minute increments, evaluations have no time limit and are billed as a whole. Additionally, the inclusion of categories for high-utilization services allows flexibility in addressing individual children’s needs. Connecticut is also revising language in its Medicaid state plan to ensure all EI services are covered under the Early and Periodic

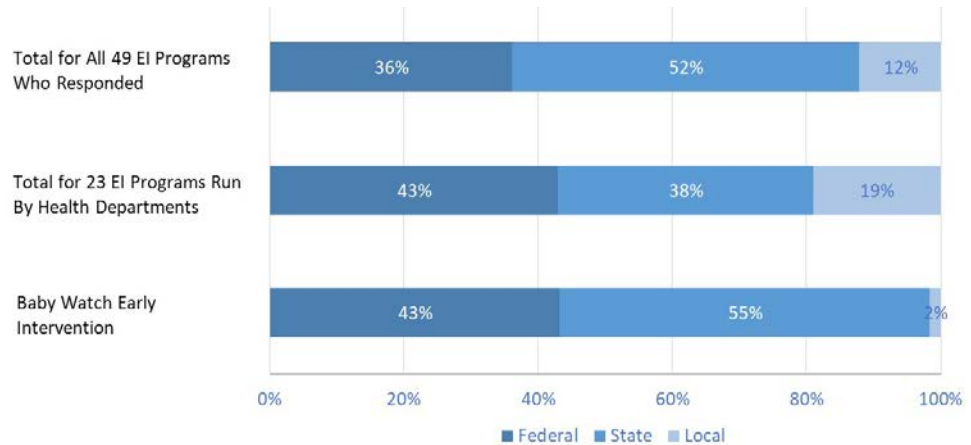
In addition to implementing a fee schedule, Connecticut revised language in the Medicaid state plan.

Screening, Diagnostic and Treatment (EPSDT) benefit and to maximize federal Medicaid dollars. After a six-year process, these changes took effect November 1, 2017. Other states have also opted to safeguard their early intervention services under Medicaid by revising the EPSDT language.

Many States Leverage Private Insurance to Fund Their Early Intervention Programs

States utilize a variety of funding sources for IDEA Part C Early Intervention programs, many exceeding the number of sources BWEI uses. Additionally, we are concerned that the program addresses funding needs solely by seeking new funds from the Legislature. Figure 4.6 shows how Utah’s funding breakdown compares with the 23 other EI programs housed in their state’s Department of Health and with national totals.

Figure 4.6 Funding Sources for Early Intervention Programs. Utah’s BWEI program currently receives small amounts of local funding, the category that includes private insurance, as compared to programs in other states.



Source: Infant and Toddler Coordinators Association Finance Survey 2017 and BWEI budget information from the FHP Finance Manager

Figure 4.6 demonstrates Utah’s lack of local funding sources. Parent fees comprise the two percent listed here. There are also local sources that support providers through in-kind contributions, such as free building space, which are not represented in the figure. Below are the largest sources of local funds used by other states in order of the amount they contribute nationwide to EI programs:

BWEI’s local funding comes from parent fees.

The six states surrounding Utah all use private insurance to support their EI programs for the birth to three population.

- County tax levies—7 states
- Funding from local education agencies—8 states
- Private insurance—24 states, including all 6 surrounding Utah

We focused on private insurance because of its widespread use nationwide. According to a 2017 survey, the average amount each state received annually from private insurance billing is \$2.5 million, based on 14 states reporting this number.⁸ We surveyed five states that utilize private insurance as a funding source for their IDEA Part C early intervention programs.⁹ While there is diversity in how they incorporate private insurance, most surveyed states report that additional resources outweighed the additional administrative burden. For example:

- Massachusetts first began accessing private insurance for its EI program in 1991. It is now the second largest funding source for the program, exceeded only by Medicaid.
- Colorado reported generating \$3.2 million annually in the centralized trust from insurance companies that deposit a set rate per covered child receiving EI services.

Based on information from other states, we expect that utilizing insurance effectively will require legislative involvement. New Mexico and Massachusetts enacted statute that ensures families will not pay co-pays or deductibles for early intervention services; Massachusetts included co-insurance as well. This statutory model provides EI programs with a viable funding source in which the revenue generated outweighs the associated administrative costs.

States Can Adopt Centralized Billing Models to Administer All Funding Streams. Centralized billing holds promise for reducing uncertainty at the provider level by removing the distinction between state paid and Medicaid paid child allocations. Of the states we contacted, Indiana, Kentucky, and Missouri have successfully implemented centralized billing offices with an outside contractor who manages their comprehensive data and claims system, and Idaho has a

⁸ Some states do not track private insurance revenue because providers bill insurance companies directly. Massachusetts was eliminated from the calculation because with \$50,507,530 in insurance revenue, it was an outlier.

⁹ States include: Massachusetts, Colorado, Missouri, Indiana, and Kentucky.

States that pass legislation regarding the use of private insurance for EI programs report success.

Some states use outside contractors to manage their comprehensive data and claims systems.

centralized revenue unit. As FHP considers adding a funding stream, they should also determine the appropriateness of the centralized billing model for Utah's BWEI program.

Placement of Baby Watch Early Intervention Program Is Appropriate

We were also asked to evaluate the appropriateness of the BWEI program's placement within the Department of Health. We found that states vary considerably regarding the placement of their early intervention programs. In 23 states including Utah, EI programs reside within state health departments. Thirteen programs are housed in the department of education, and programs in the remaining states are in other departments or offices. The BWEI program serves children who benefit from access to additional programs within the Department of Health's Bureau of Children with Special Health Care Needs. BWEI works with these programs to ensure referrals, avoid duplication of services, and participate in workgroups focused on specific issues affecting children. Based on these factors as well as the feedback we received, we concluded that BWEI's current placement is appropriate.

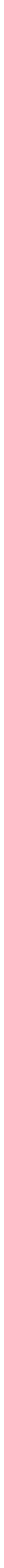
In summary, improved monitoring, clarified policies, better data, and a cost study of program funding is needed to make the BWEI program more effective. These improvements are critical for ensuring that Utah's youngest and most vulnerable children continue to receive high-quality early intervention services.

Recommendations

1. We recommend that the staff of Baby Watch Early Intervention perform on-site monitoring of contracted providers to ensure quality of services.
2. We recommend that Baby Watch Early Intervention update and clarify policies, utilizing stakeholder input throughout the process. Policy changes should include, but are not limited to, the use of background checks and data system changes.

BWEI works closely with other programs in its current bureau that serve children with special health care needs.

3. We recommend that the Legislature consider statutory changes to require background checks for Baby Watch Early Intervention providers.
4. We recommend that Baby Watch Early Intervention track and utilize data on service hours and service types for all program participants.
5. We recommend that the Division of Family Health and Preparedness develop and implement a plan to improve funding for Baby Watch Early Intervention and report annually their progress to the Social Services Appropriations Committee. This plan should include:
 - a. A cost-benefit analysis to determine if a fee schedule would be an improvement over the current bundled Medicaid payments,
 - b. a cost-benefit analysis of private insurance utilization, and
 - c. if private insurance is deemed cost-effective, the development of statutory language supporting private insurance billing.



Chapter V

FHP Can Improve Performance Management

This final chapter focuses on opportunities for the Division of Family Health and Preparedness (FHP or Division) to improve performance management, which is important for improving organizational effectiveness. Through documentation reviews, observations, and discussions with FHP staff, we identified weaknesses in the Division's current performance management framework. Specifically, we found that FHP should strengthen strategic planning practices and adopt meaningful performance metrics focused on outcomes rather than outputs. We also found that insufficient accountability mechanisms led to negative child outcomes, as children did not receive adequate clinical services due to weak contract monitoring. Thus, ongoing performance monitoring is needed to improve management's decision making.

Department of Health (DOH or Department) management agrees performance management is an area in need of improvement and has selected the following strategic priority for 2017-20:

Foster a culture of performance management—emphasize quality outcomes, focus on performance improvement, including standard operating procedures and processes that adopt ongoing improvements.

We support this priority and recommend several improvements to how FHP management can foster a culture of improved performance management.

Better Strategic Planning and Performance Metrics Are Needed

FHP should develop a division-level strategic plan and performance metrics that are based on outcomes. We documented that as of October 2017, the Division has begun this process, setting action items and deadlines necessary to draft a strategic plan. Additionally, in the absence of a division strategic plan, it is unclear how program,

FHP should strengthen strategic planning and adopt meaningful performance metrics focused on outcomes.

bureau, division, and department missions fit together to optimize the health of Utah citizens.

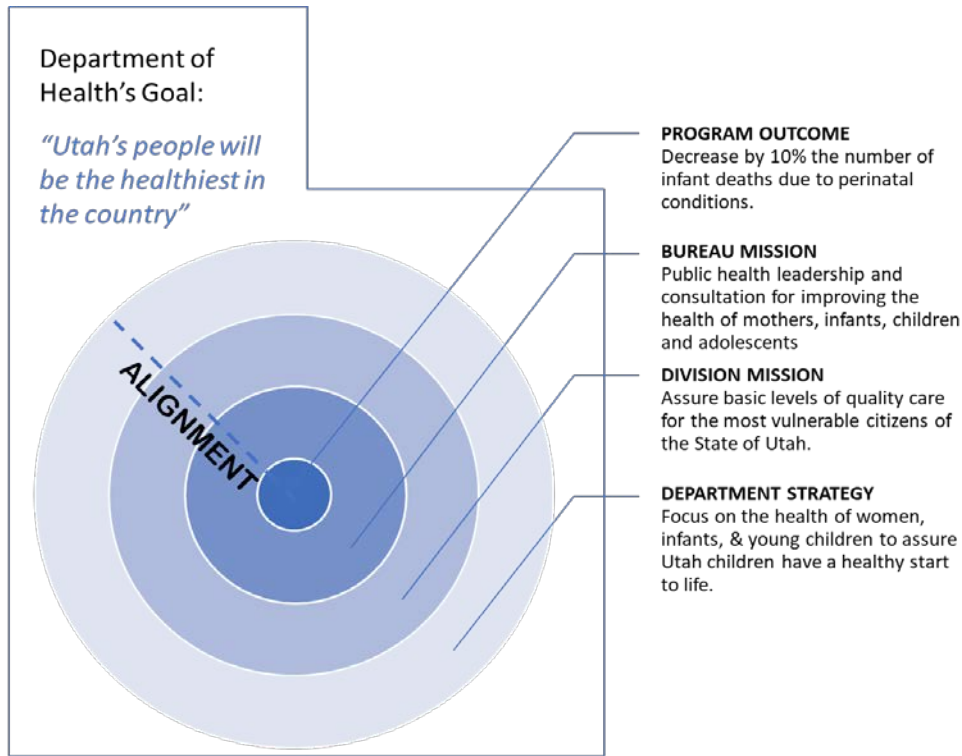
FHP Should Integrate Its Strategic Plan with DOH's Mission

FHP should adopt a division-level strategic plan and integrate this plan with DOH. Additionally, the Bureau of Child Development does not have a strategic plan and should develop one. While the remaining five bureaus within FHP have strategic plans, they were outdated when we received them in April 2017. This conclusion is based on our review of the bureaus' strategic plans as well as discussions with Division management. For example, we found that the Bureau of Children with Special Health Care Needs (CHSCN) restructured and incorporated new programs over the past three years but did not update their strategic plan until August 2017. Until this recent update, five programs had not been integrated into the CHSCN Bureau's overall strategy. Although it takes time to make such changes, programs added in 2015 should have been represented in the CHSCN Bureau's strategic plan much sooner.

Since FHP lacks a division-wide strategic plan, it is difficult to determine how strategic plans for the bureaus and the FHP plan align to meet DOH goals. This lack of planning is a departure from DOH's internal strategic planning documents, which underscore "a new way of doing business in public health that emphasizes agency-wide practices to realize outcomes in contrast to relying solely on program specific delivery." Figure 5.1 illustrates this department-wide alignment.

FHP lacks a division-wide strategic plan.

Figure 5.1 Department-Wide Alignment of Strategic Plans. For successful performance management, strategic plans should align from the program level to the department level.



Source: Office of the Legislative Auditor General

FHP should align the strategic plans and goals from the department level to the program level.

Organizational integration requires alignment across an entire department. Unfortunately, this alignment needs to be strengthened within FHP. This weak alignment results in the following problem, identified during the Department's 2012 strategic planning process:

The UDOH consists of many health programs/services with specific sources of funding and performance requirements...These conditions lend to a silo effect within the agency where programs can develop a singular focus on grant requirements.

FHP has not sufficiently adopted the Department-level practices designed to improve public health outcomes in Utah, resulting in siloed programs with limited alignment to larger organizational goals. Alignment with organizational goals is a best practice. According to *Best Practices in Performance Measurement*:

Alignment with organizational goals is crucial for successful performance measurement systems. Top leaders

Alignment with organizational goals is crucial for successful performance measurement systems.

should convey the organization's vision, mission, and strategic direction to employees and external customers clearly, concisely, and repeatedly. Organizations can achieve this by developing conceptual frameworks that include balanced measures, target setting, and benchmarking.

To be meaningful, Division outcome metrics must connect to the overarching goals set by the Department.

Performance Metrics Lack Focus on Outcomes

Our review of bureau strategic plans indicated that outcome metrics are not tracked for half of the programs. When performance metrics are tracked, the bureau typically uses federal requirements rather than DOH objectives to drive selection of metrics. While federal requirements are beneficial, they are insufficient; strategic planning also needs to be driven by internal practices.

FHP's assistant division director stated that performance metrics have been of secondary importance historically, often created solely to satisfy either legislative or federal grant requirements, and have not been used to guide FHP's operations or business decisions. Management acknowledges that this is a weakness and has indicated a commitment toward improving their performance metrics. Additionally, the performance metrics currently in place focus on inputs (resources placed into programs) and outputs (services delivered) rather than outcomes (impact of the resources and services). While inputs and outputs are easier to measure, FHP bureaus need outcome metrics to ensure effectiveness and to track improvement.

In 2013, DOH employees participated in a workshop entitled "Building a Performance Management System." The workshop included guidance on developing outcome metrics and recommended selection of at least one outcome metric per program; however, it does not appear this occurred. Of the 38 programs within FHP, only half have a performance measure that tracks outcomes. The Bureau of Health Facilities Licensing, which we reviewed in detail, has no outcome metrics for any of its programs. The Bureau of Child Care Licensing also tracks only output rather than outcome measures. While outputs are often easier to measure than outcomes, output-focused measurements can lead organizations to pursue activities that

FHP has not tracked outcome metrics for half of the programs.

Current metrics focus on inputs and outputs, rather than outcomes.

improve performance on easily quantifiable metrics while neglecting activities that create meaningful change.

Without strategic plans that include meaningful performance metrics, there is a risk that goals set in federal grant proposals do not align with a bureau's goals. This is important because 65 percent of the Division's funding comes from federal grants. In fact, the most recent proposal for the Maternal and Child Health (MCH) federal grant reflected reduced objectives related to children with special health care needs, despite the ability to meet higher goals. When asked why the goals were lowered, the bureau director of MCH, who was responsible for the grant, was unable to provide a reason. Lowered standards may ensure short-term goals are met but do not promote long-term improvement in public health outcomes.

Without strategic plans that include meaningful metrics, there is a risk that goals set by federal grants will not align with bureau goals.

Poor Monitoring and Accountability Led to Undesirable Outcomes

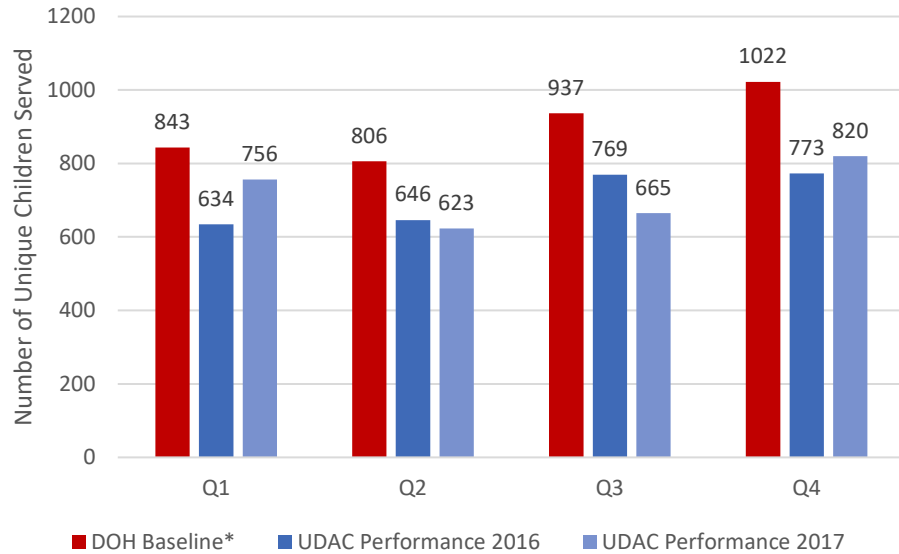
While strategic planning with meaningful performance metrics is a critical part of performance management, FHP must also incorporate ongoing evaluation to ensure long-term goals are met. Failure to adequately monitor a contract with the University of Utah led to a gap in services for some children with special health care needs. The Division should use performance data to guide future management decisions.

One FHP Contract Designed to Serve Vulnerable Children Failed to Meet Contract Objectives

FHP contracted with the University Developmental Assessment Center (UDAC) from July 1, 2015, until June 30, 2017, to provide evaluation services to children throughout Utah who have developmental disabilities or are at risk for developing them. Throughout this two-year agreement with FHP, UDAC failed to meet contract objectives for numbers of children served. Figure 5.2 compares the numbers of children served in 2013, used as the baseline, with the actual numbers served by UDAC in both years of the contract.

UDAC failed to meet contractual objectives, decreasing the number of children served with developmental disabilities.

Figure 5.2 Comparison of UDAC Performance to Historical Performance. UDAC served fewer children than UDOH served historically, despite commitments to increase the number served by five percent.



Source: UDAC quarterly reports submitted to UDOH
 *DOH used actual numbers from 2013 as the baseline.

Children in rural areas were affected more by the decrease in services.

The decrease in services affected children in rural areas more than those in urban areas: in 2016, UDAC served 29 percent fewer rural children than UDOH served in 2013.

Despite this ongoing performance issue, FHP did not sufficiently hold the contractor accountable. In fact, DOH management disagreed on how to address contract deficiencies, ultimately instructing personnel overseeing the partnership to overlook agreed-upon outcome measures. By overlooking these measures, FHP was not timely in identifying and addressing barriers to meeting contracted objectives, such as the increased cost of sending providers to rural areas. As a result, fewer rural children were served.

When DOH attempted to renegotiate the contract in April 2017, UDAC did not sign a contract for the current fiscal year, leaving children with special health care needs in many parts of the state with no access or limited access to developmental clinics until for some time. We believe this gap in services resulted from poor monitoring from the beginning of the contract. Instead of negotiating a new contract after the first year with a revised set of expectations, FHP

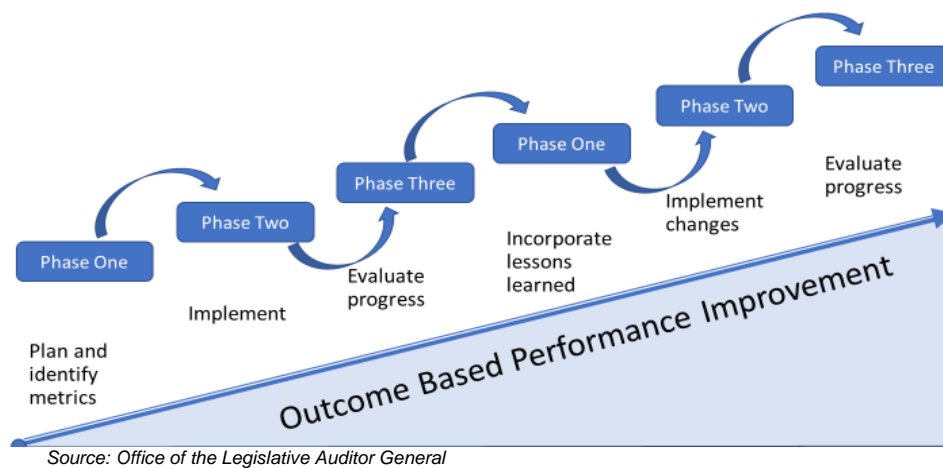
extended the initial contract for a second year, further exacerbating the problem.

Documentation from a 2014 DOH internal audit demonstrates that contract monitoring is an ongoing concern. According to the internal audit, “UDOH Division Directors have been informed of the importance of and their responsibility for, creating and maintaining contract/grant monitoring and reporting.” By implementing a system of ongoing performance monitoring with clear accountability measures, FHP may have avoided gaps in services for some children served by the UDAC contract.

Ongoing Performance Monitoring Can Improve Decision-Making

In the case of the UDAC contract, FHP had performance data but did not utilize it effectively. Best practices outlined by the Office of the Legislative Auditor General indicate organizations should evaluate performance data and make needed interim changes to meet goals and objectives as part of a recurring three-phase cycle of performance management, outlined in Figure 5.3.

Figure 5.3 Phases of the Performance Management Process. Best practices include evaluating progress, a key step FHP omitted in oversight of the UDAC contract.



FHP management acknowledged other situations in which decision-making was not guided by strategic planning or performance monitoring. According to DOH’s deputy director, management operated in “crisis leadership mode and not strategic management mode.” For example, they elected to move programs among bureaus

Past internal audits demonstrate contract monitoring is an ongoing concern.

“Crisis leadership,” rather than strategic planning, was utilized to make important programmatic moves.

The GAO Green Book recommends information be communicated “across all levels of an entity” to best meet an entity’s objectives.

without sufficiently gathering information from key program personnel, such as program managers, before implementing these significant changes. This decision, based on misconceptions about program operations, led to disruption for some programs that collaborated closely with others in their respective bureaus. After recognizing the problem, leadership moved two programs back to their original places within the Division.

In contrast, management’s decision to move the Baby Watch Early Intervention Program from the Bureau of Child Development to the Bureau of Children with Special Health Care Needs improved the program’s ability to collaborate with other programs serving similar populations, according to feedback from both providers and personnel within FHP.

The U.S. Government Accountability Office Green Book standards offer best practices that could prevent unproductive situations in the future. They recommend that information should be communicated “to all levels of the entity” to “enable personnel to perform key roles in achieving objectives, addressing risks, and supporting the internal control system” and to allow “personnel to help management achieve the entity’s objectives.” By following this guideline, FHP’s management can improve the quality of the information they use when making decisions.

Recommendations

1. We recommend that the Division of Family Health and Preparedness develop a strategic plan and align this plan with updated Department and Bureau-level strategic plans.
2. We recommend that the Division of Family Health and Preparedness ensure all bureau strategic plans include meaningful and measurable outcome metrics.
3. We recommend that the Division of Family Health and Preparedness implement ongoing performance evaluations of all programs to ensure outcomes are achieved.

Agency Response



State of Utah

GARY R. HERBERT
Governor

Spencer J. Cox
Lieutenant Governor

Utah Department of Health

Joseph K. Miner, MD, M.S.H.P.
Executive Director

Division of Family Health and Preparedness

Paul R. Patrick
Division Director

November 7, 2017

Mr. John M. Schaff, CIA
Legislative Auditor General
315 House Building
P.O. Box 145315
Salt Lake City, Utah 84114-5315

Dear Mr. Schaff,

I appreciate the opportunity to review and respond to the legislative report "A Performance Audit of the Division of Family Health and Preparedness" (Report Number 2017-03)

I realize the work done by you and your staff in the review of our Division was thorough and in depth and covered most of our programs. Your staff conducted themselves in a polite and professional manner as they interacted with our staff and stakeholders. I commend their efforts as this performance audit resulted in 21 recommendations designed to improve our abilities to serve the most vulnerable populations in Utah.

I accept all the recommendations and a response to each is included with this letter. I look forward to working with your office to ensure that implementation strategies are consistent with the intent of the recommendations.

Sincerely,

Paul R. Patrick
Division Director, Family Health and Preparedness
Utah Department of Health

Recommendations and Response to Performance Audit of the Division of Family Health and Preparedness (FHP) Report # 2017-03

Chapter II - Child Care Licensing (CCL)

Recommendation #1: *We recommend Child Care Licensing develop clear policies regarding use of sanctions to address patterns of noncompliance.*

FHP Response:

We concur with this recommendation. Our program managers have met to discuss this recommendation and started developing clear policies regarding the use of consistent, higher, and effective sanctions that will provide adequate protection for the children. We have identified a list of noncompliance issues that, based on severity and not facility type, will result in immediate, mandatory civil money penalties. We have also identified the need for a stronger policy and higher sanctions for repeat violations. In addition, we will be increasing the length of time our database will track noncompliance patterns and violations in order to identify and address any possible repeat noncompliance. This will lead to a faster identification of the need for a conditional license.

To implement these improvements, we will present the proposed policy changes to our licensing committees for feedback, make the proper adjustments to our database system, train our staff, and make policies and procedures available to the public using our rule interpretation manuals to improve transparency, provider compliance, and consistency in enforcement.

Contact: Simon Bolivar, Child Care Licensing Administrator, 801-803-4618, sbolivar@utah.gov

Implementation Date: March 1, 2018.

Recommendation #2: *We recommend Child Care Licensing clarify policies and procedures for the appeals process after consultation with their legal counsel, including a process for increasing monitoring during appeals.*

FHP Response:

We concur with this recommendation. In consultation with legal counsel, we are in the process of revising and clarifying our Child Care Licensing policies and procedures for the appeal process. This will include shortening time frames for the appeal process, conducting monitoring inspections during the appeal, and making rule changes to address these issues. Additionally, we will provide online public access to our appeal policies and procedures, as well as implement monitoring processes so that children are still protected during appeals.

With these improvements, the procedures for writing statements of noncompliance will be expedited. This will give providers quicker access to inspection outcomes and the opportunity to decide if an appeal request is warranted. This will also help to verify compliance and make inspection findings available to the public in a shorter time period.

Contact: Simon Bolivar, Child Care Licensing Administrator, 801-803-4618, sbolivar@utah.gov

Implementation Date: March 1, 2018.

Recommendation #3:

We recommend policies for sanctions and appeals be made publicly available online.

FHP Response:

We concur with this recommendation. As stated in our previous responses, we will bring the proposed policy changes to the Advisory and Center Committees for feedback. As these policies and procedures are finalized,

we will make them publicly available using our website and by giving written notice to all current providers of this information. The rule interpretation manuals will be updated to include all newly adopted policies and procedures or changes thus making it available to the public through our website.

Contact: Simon Bolivar, Child Care Licensing Administrator, 801-803-4618, sbolivar@utah.gov

Implementation Date: March 1, 2018.

Chapter III - Bureau of Health Facility Licensing (HFL)

Recommendation #1: *We recommend the Bureau of Health Facility Licensing calculate and track the average time between surveys for each facility type to better understand their backlog.*

FHP Response:

We concur with this recommendation. HFL currently calculates and tracks the average time between surveys for assisted living centers. We will expand this process to personal care agencies, birthing centers, and other types of health facilities that receive licensure surveys.

Contact: Chris Turner, Senior Business Analyst, 801-273-2811, christurner@utah.gov

Implementation Date: June 30, 2018.

Recommendation #2: *We recommend the Bureau of Health Facility Licensing adopt efficiencies such as implementing an electronic surveying process, restructuring survey teams, and performing analysis on the benefits and costs of multiple surveyor locations.*

FHP Response:

We concur with this recommendation. While HFL currently makes use of a federal electronic data system that tracks state surveys and that must be used for certification of Medicare/Medicaid facilities, this system does not perform electronic surveys. HFL will thoroughly research electronic survey programs nationwide to identify and implement appropriate electronic surveying.

HFL will re-evaluate the size and composition of survey teams to increase efficiency and reduce time between surveys, while maintaining survey quality.

In addition, HFL will conduct a cost-benefit analysis of adding locations for survey staff, locating HFL staff within other offices, and re-establishing previously closed locations.

Contact: Joel Hoffman, Bureau Director, 801-273-2804, jhoffman@utah.gov

Completion Date: December 31, 2018.

Recommendation #3: *We recommend the Bureau of Health Facility Licensing improve efficiencies, then work with the Legislature to set an oversight standard for quality and survey duration and benchmark funding to that level.*

FHP Response:

We concur with this recommendation. The HFL will continue to seek more efficient processes, independent of the increasing number of health facilities in the state noted by the audit. The Department will work with the Legislature to determine a standard time frame for licensure surveys and seek appropriate benchmark funding to meet those levels.

HFL has requested building blocks for staffing during recent years and will continue to seek financial support for this growing program. Currently, licensing funds are deposited into the general fund; no additional financial allocation is provided to HFL to account for the growth and increase in survey and licensing workload. Therefore, HFL will also work toward financing survey costs with licensing fees, as recommended by the audit.

Contact: Joel Hoffman, Bureau Director, 801-273-2804, jhoffman@utah.gov

Implementation Date: Legislative session May 31, 2019.

Recommendation #4: *We recommend the Bureau of Health Facility Licensing publicly post their survey findings online.*

FHP Response:

We concur with this recommendation. Posting survey findings online would be a valuable tool for consumers seeking services from health facilities. We will research options, including sources for expertise in this area (such as Child Care Licensing), to improve public accessibility in a cost-efficient manner.

Contact: Angela Anderson, Program Manager, 801-273-2810, aanderson1@utah.gov

Completion Date: December 31, 2019.

Recommendation #5: *We recommend the Bureau of Health Facility Licensing utilize statutory enforcement mechanisms that promote provider compliance and maximize state resources.*

FHP Response:

We concur with this recommendation. HFL will analyze the different methods of sanctioning providers to ensure that the most effective methods are being used to promote provider compliance, as appropriate to provider facility size and assets, and in keeping with revised CMP policies to be developed (see Recommendation #6 response, below).

Contact: Carmen Richins, Licensing Manager, 801-273-2802, carmenrichins@utah.gov

Implementation Date: July 1, 2019.

Recommendation #6: *We recommend the Bureau of Health Facility Licensing thoughtfully adopt formal civil monetary penalty policies that can be consistently applied among providers.*

FHP Response:

We concur with this recommendation. While HFL currently has a flow chart of how civil money penalties can be applied in different situations, HFL does not have a formal written policy. We will analyze our current standards for imposing penalties and adopt a formal civil monetary penalty policy. This policy will outline amounts and how the civil money penalties are applied to providers of all sizes and in differing circumstances.

Contact: Carmen Richins, Licensing Manager, 801-273-2802, carmenrichins@utah.gov

Implementation Date: September 30, 2018.

Recommendation #7: *We recommend the Bureau of Health Facility Licensing, along with the Health Facility Committee, amend their administrative rules to align with current survey practices and utilize them to better enforce compliance.*

FHP Response:

We concur with this recommendation. The current administrative rules that apply to HFL are found in Utah Administrative Code R432. HFL will review the survey sections of these rules (R432-2 and R432-3) and work with the Health Facility Committee to organize and amend these rules.

Contact: Joel Hoffman, Bureau Director, 801-273-2804, jhoffman@utah.gov

Implementation Date: June 30, 2019.

Recommendation #8: *We recommend the Bureau of Health Facility Licensing work with providers to ensure their compliance with Utah Code 26-21-206.*

FHP Response:

We concur with this recommendation. HFL will provide training at association meetings for nursing facilities, assisted living facilities, home health and hospice agencies, and personal care agencies to consistently and accurately submit information for required background checks. We will also continue to cite deficiencies to facilities that do not meet background screening requirements.

Contact: Joel Hoffman, Bureau Director, 801-273-2804, jhoffman@utah.gov

Implementation date for training: October 31, 2018.

Implementation for citations for non-compliance: ongoing.

Recommendation #9: *We recommend the Bureau of Health Facility Licensing work closely with the Department of Human Services to better integrate the DACS with the SAFE database in an effort to reduce background screening queues.*

FHP Response:

We concur with this recommendation. The DACS database is an upgraded background screening system that automatically checks the OIG Registry, DOPL database, CNA Registry and criminal records through public safety. These automatic checks save time so staff do not have to manually check these databases. One of the last parts of the system to upgrade is the Human Services database that stores information from Adult Protective Services and Child Protective Services. Since the completion of the audit, HFL has been working with Human Services to implement a link that will allow DACS to automatically check their database for background hits. Some pieces of the link have been established and a testing mechanism will be ready in the near future. Once this link is implemented, we expect a significant reduction in background screening queues.

Contact: Chris Turner, Senior Business Analyst, 801-273-2811, christurner@utah.gov

Implementation Date: June 30, 2018.

Recommendation #10: *We recommend the Bureau of Health Facility Licensing adopt a policy detailing what would allow them to overturn a deniable offense during the first level of the appeals process.*

FHP Response:

We concur with this recommendation. Current practice for HFL for a denial of a background check is to allow a person to submit information to appeal the denial. This can be done through a request for reconsideration of the facts or through a formal appeal with a hearing officer.

HFL will draft a formal policy that includes guidance from Utah Code 26-21-2 and Utah Administrative Code R432-35. The policy will clarify the factors used by presiding officers in deciding requests for reconsideration and formal adjudications to ensure uniformity in appeals of deniable offense determinations.

Contact: Carmen Richins, Licensing Manager, 801-273-2802, carmenrichins@utah.gov

Implementation Date: June 30, 2018.

Chapter IV - Children with Special Health Care Needs (CSHCN) - Baby Watch Early Intervention Program (BWEIP)

Recommendation #1: *We recommend the staff of Baby Watch Early Intervention Program perform on-site monitoring of contracted providers to ensure quality of services.*

FHP Response:

We concur with this recommendation. In October of 2017 the program hired a Compliance and Monitoring Specialist who will focus on monitoring quality statewide. Duties for this position include the following:

- conduct onsite child file reviews for each local program
- create an audit evaluation form for the BWEIP to ensure consistency
- conduct audits of early intervention service delivery, procedures, processes and compliance at each local program
- provide education to local programs through on and off site reviews
- conduct onsite, face-to-face, quality monitoring visits to local programs that ensure alignment with federal and state regulations
- assist with quality improvement activities for the local programs
- evaluate program data from the Baby & Toddler Tracking System (BTOTS) database

Contact: Lisa Davenport, Program Manager for BWEIP, 801-584-8209, lisadavenport@utah.gov

Implementation Date: January 2018

Recommendation #2: *We recommend that Baby Watch Early Intervention update and clarify policies, utilizing stakeholder input throughout the process. Policy changes should include, but are not limited to, the use of background checks and data system changes.*

FHP Response:

We concur with this recommendation. BWEIP and the Division have started strategic reviews and are implementing changes to ensure that policies and procedures are appropriate, effective, and satisfy federal regulations. These efforts involve various stakeholders, including the Interagency Coordinating Council (ICC), providers, and others.

BWEIP is evaluating the BTOTS data system to improve monitoring and data reports. BWEIP plans to create policies and procedures for standardizing changes to the database system and notifying providers of data changes. In addition, BWEIP holds a BTOTS User Group meeting (BUG) at least monthly for all BTOTS users to discuss suggestions and proposed changes to make the system more responsive to all stakeholders' needs.

BWEIP supports implementing a requirement for background checks for all direct service staff hired by the fifteen Early Intervention programs. The CSHCN Bureau is currently working with the Department and the Division to develop and implement standardized policy and procedure for background checks, including any required technological support

Contact: Lisa Davenport, Program Manager for BWEIP, 801-584-8209, lisadavenport@utah.gov

Implementation Date: December 2018

Recommendation #3: *We recommend that the legislature consider statutory changes to require background checks for Baby Watch Early Intervention providers.*

FHP Response:

We concur with this recommendation.

Recommendation #4: *We recommend that Baby Watch Early Intervention track and utilize data on service hours and service types for all program participants.*

FHP Response:

We concur with this recommendation. BWEIP management will implement reporting of Early Intervention service hours and type within BTOTS. This will allow the Division to more closely track costs and ensure that queries of the system will pull the necessary reporting measures.

Contact: Lisa Davenport, Program Manager for BWEIP, 801-584-8209, lisadavenport@utah.gov

Implementation Date: December 2018

Recommendation #5: *We recommend that the Division of Family Health and Preparedness develop and implement a plan to improve funding for Baby Watch Early Intervention Program and report annually their progress to the Social Services Appropriations Committee. This plan should include:*

- a. A cost benefit analysis to determine if a fee schedule would be an improvement over the current bundled Medicaid payments,*
- b. a cost benefit analysis of private insurance utilization, and*
- c. if private insurance is deemed cost effective, work with the legislature to develop statutory language supporting private insurance billing.*

FHP Response:

We concur with this recommendation. BWEIP will research funding methods to simplify the tracking of costs and state reimbursement payments. We will work directly with Medicaid to methodically analyze the current Medicaid bundled rate to determine whether the rate is congruent with provider practices and appropriately funds the needs of children receiving Early Intervention services.

BWEIP is also re-examining billing private insurance in light of other states' viable models for capturing additional funding as part of refining our billing model. We will work with the legislature as needed by any identified funding methods that require changes to statutory language. Together, these changes are intended to reduce uncertainty for providers, support effective programs for children and families, and ensure regulatory compliance.

Contact: Lisa Davenport, Program Manager for BWEIP, 801-584-8209, lisadavenport@utah.gov

Implementation Date: December 2018

Chapter V - Division Family Health and Preparedness (FHP)

Recommendation #1: *We recommend that Family Health and Preparedness develop a strategic plan and align this plan with updated department and bureau-level strategic plans.*

FHP Response:

We concur with this recommendation. FHP has already begun the process of comprehensive strategic planning in the Division, in conjunction with the Department of Health's 2017-2020 Strategic Plan. This will include a review of every program, bureau, and Division-level performance measure currently used and creating new performance measures where none currently exist.

We will also examine the quality of all performance measures and the data used to measure them, making improvements when needed. The result will be a comprehensive strategic plan for the Division and for each bureau. Throughout the process, we will work to assure that plans are aligned across the bureaus, the Division, and the Department.

Our process will engage staff at every level of the Division in the strategic planning process. While such broad staff involvement will take longer, it will significantly increase staff buy-in and follow-through on the strategic plans that result from the process.

Contact: Curtis Burk, Deputy Division Director, 801-419-4963, cburk@utah.gov

Implementation Date: October 1, 2018

Recommendation #2: *We recommend that Family Health and Preparedness ensure all bureau strategic plans include meaningful and measurable outcome metrics.*

FHP Response:

We concur with this recommendation. As part of the current Division-wide strategic planning already underway, Division leadership will review all outcome program, bureau, and Division-level metrics to ensure they are meaningful and measurable, and make improvements where needed.

Contact: Curtis Burk, Deputy Division Director, 801-419-4963, cburk@utah.gov

Implementation Date: October 1, 2018

Recommendation #3: We recommend that Family Health and Preparedness implement ongoing performance evaluation of all programs to ensure outcomes are achieved.

FHP Response:

We concur with this recommendation. The Division will implement quarterly performance reviews of each program in the Division. We will also implement an annual performance report for the Division and for each bureau. These annual and quarterly reports will be written and reviewed at the monthly Division Leadership Meetings with all bureaus and provided to the department.

Contact: Curtis Burk, Deputy Division Director, 801-419-4963, cburk@utah.gov

Implementation Date: April 1, 2018