

REPORT TO THE  
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**A Performance Audit  
of  
Davis Behavioral Health**

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# Digest of A Performance Audit of Davis Behavioral Health

## Chapter I: Introduction

Davis Behavioral Health (DBH or Davis) is the community mental health and substance abuse provider for Davis County. The federal government requires states to provide both mental health and substance abuse treatment on an individual, community basis. In response, the State of Utah contracts with Davis County and then Davis County contracts with DBH to provide this opportunity for treatment. The majority of funding for these services comes from public sources, with other revenues coming from patient fees and insurance.

DBH's activities to fulfill this mission are primarily overseen by DBH's nine-member Board of Trustees. The Davis County Commission has one seat on this board and one of the three county commissioners is a board member. Additional oversight comes from DBH's independent auditors, by the Division of Substance Abuse and Mental Health (DSAMH or division) in the Department of Human Services, and by the Division of Health Care Financing (HCF) in the Department of Health and others. In its recent audits of DBH, the division expressed concerns that several affiliated corporations created and funded by DBH had become a financial liability and that procurement policy was not followed in awarding the IT system contract. These concerns, along with other legislative issues, led a legislator to request and the audit subcommittee to approve this audit.

## Chapter II: Creation and Operation of Independent Corporations Was a Poor Use of Limited DBH Funds

**Corporate Reorganization Was Costly for DBH.** In 2004, DBH was looking for a way to increase their funding for basic services and react to a changing service environment, so they decided on a new corporate structure that included five new corporations. Instead of generating profits, the creation and operation of the new corporations cost DBH about \$850,000 in additional expenses, increased DBH's complexity, and decreased its efficiency. In 2007 DBH decided to dissolve the corporations and return their responsibilities to DBH. This indicates it was not necessary to create the independent corporations because DBH could assume all of their functions.

DSAMH and Davis County's clerk-auditor question this use of DBH funds. It does not appear that there was a need to go to the expense of

privatizing activities that were already being done or could have been done by DBH. Creating separate corporations increased the administrative costs for the overall operation. DBH has decided to continue to operate Diversified Employment Opportunities (DEO) and Daybreak as divisions of DBH. If they are to continue with these functions, additional refinement of these operations is necessary to improve service delivery and control costs.

**DEO Hampered By A Slow Start and Poor Execution.** During its three years as an affiliated entity, DEO did not create employment for DBH clients by creating any independent small businesses or winning any federal government contracts. Instead, DEO's employment program only employed clients to do work for DBH, thus increasing DBH's costs. DEO, while offering limited therapeutic benefits, was not financially viable and relied almost exclusively on DBH for jobs for clients and for funding. DBH dissolved DEO in June 2007 and it became a division of DBH. As of the date of this report, 56 clients are employed at DBH. It is conceivable that DEO could provide employment services to more clients, at a lesser cost, by developing jobs in the community and getting outside contracts and outside funding. We recommend that DEO develop plans on how they will get outside funding and outside job placements for clients.

**Daybreak Duplicated Existing Services.** DBH created an affiliated corporation, Daybreak, to provide mental health services for people with insurance. Leasing a separate facility to serve people with insurance duplicated existing internal functions. The corporation was not financially viable and relied on DBH for financial support. It was dissolved in June 2007. Daybreak, now as a division of DBH, is still not financially viable and continues as a stand-alone facility that serves select clients. Other Utah mental health centers care for insurance clients in their clinics. They have not created separate clinics to care for insurance clients. We recommend that DBH reassess the mission and goals of the Daybreak program to determine if it should remain a stand-alone facility.

### **Chapter III: IT Provider Relationship Has Caused Concerns**

**ITX Media's Dual Role Creates Potential Conflict of Interest.** The owner of ITX Media (ITX) is both DBH's chief information officer (CIO) and their primary information technology (IT) provider. This relationship creates a potential conflict of interest. Conflict of interest is further increased by the contract between ITX and DBH, which requires little documentation. DBH's selection of ITX for IT service provision has

caused lingering questions that can only be remedied with pending contract amendments. Despite these questions, the products and services provided by ITX to DBH and the Health Data System Consortium are proving useful and are gaining user acceptance. We recommend that DBH take steps to clarify IT oversight and further examine contract amendments.

**Chapter IV:  
Implementing an  
Integrated IT  
System Has Been  
Difficult**

**The Profiler System Has Improved.** Nationally, health care providers are moving toward electronic information systems integrating both billing and clinical information. DBH's IT integration process follows that national trend and has been slow to implement and gain acceptance. The integration process is not easy; most organizations, including DBH, encounter user-acceptance, training, and error problems. Initial selection and start-up problems fueled staff's hesitance to accept the unfamiliar system. Development has also been hampered by documentation and training problems. It appears that the system is now gaining acceptance as problems are being resolved. We recommend that DBH take steps to improve communication and training regarding the Profiler system, and also talk to agencies with concerns about their data.

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# Chapter I Introduction

Davis Behavioral Health (DBH or Davis) is the community mental health and substance abuse provider for Davis County. The federal government requires that individuals have the option of receiving both mental health and substance abuse treatment on an individual, community basis. In response, the State of Utah contracts with Davis County and then Davis County contracts with DBH to provide this opportunity for treatment. The majority of funding for these services comes from public sources, with other revenues coming from patient fees and insurance.

In 2004, DBH created and funded affiliated entities in an attempt to generate additional funds to fulfill the mission of DBH. That mission is:

To provide comprehensive, quality behavioral health services to individuals, families and our community through: effective clinical practice with evidence-based outcomes provided in a fiscally responsible manner to ensure client/family, community and staff satisfaction.

DBH's activities to fulfill this mission are primarily overseen by DBH's nine-member Board of Trustees. The Davis County Commission has one seat on this board and one of the three county commissioners is a board member. Additional oversight comes from DBH's independent auditors, by the Division of Substance Abuse and Mental Health (DSAMH or division) in the Department of Human Services, and by the Division of Health Care Financing (HCF) in the Department of Health, and others. In its recent audits of DBH, the division expressed concerns that several affiliated corporations created and funded by DBH had become a financial liability and that procurement policy was not followed in awarding the IT system contract.

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**Davis County created DBH as a nonprofit organization to provide mental health and substance abuse services to county residents.**

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## **DBH Has a Contract to Provide Community Mental Health Services**

DBH is a nonprofit organization that contracts with Davis County to provide mental health and substance abuse services. The federal



government requires the state to provide behavioral health services to its citizens. In answer to this charge, the State of Utah designated counties as local mental health authorities (LMHA) in charge of providing behavioral health services for the people of their county. Davis County, as a LMHA, elected to deliver services by creating DBH as a nonprofit corporation and then contracting with DBH to be the county's service provider. Federal, state, and county funding flows through the LMHA to DBH. DBH also receives some additional funding from private sources.

### **DBH is Required to Provide Mandated Services by Federal, State, and County Governments**

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**DBH is required to provide 10 mandated services.**

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Federal regulation of the U.S. mental health system has evolved through a series of legislative changes. In 1999, the Supreme Court ruled that “states are required to place persons with mental disabilities in community settings rather than in institutions.” This is a result of the move beginning in 1955 toward community-based mental health.

The State of Utah has legislated that the county is the LMHA, as well as the local substance abuse authority. Counties are required every year to submit an annual plan “for mental health funding and service delivery,” as well as plans for treatment of substance abuse. The following mental health services as found in *Utah Code* 17-43-301(4) are mandated:

1. Inpatient care and services
2. Residential care and services
3. Outpatient care and services
4. 24-hour crisis care and services
5. Psychotropic medication management
6. Psychosocial rehabilitation, including vocational training and skills development
7. Case management
8. Community supports, including in-home services, housing, family support services, and respite services
9. Consultation and education services including case consultation, collaboration with other service agencies, public education, and public information
10. Services to persons incarcerated in a county jail or other county correctional facility

Substance abuse authorities are required under *Utah Code* 17-43-201 to submit a plan with “provisions for services, . . . for adults, youth, and

children, . . . and primary prevention, targeted prevention, early intervention, and treatment services.”

In order to fulfill the requirements of this legislation, Davis County created, then contracted with DBH to “provide and perform the . . . mental health services to and for all persons, including adults, youth, and children, within Davis County.” This contract specifies that DBH will provide all of the services listed above from *Utah Code* 17-43.

**The Majority of Financing for DBH Comes from Governmental Sources**

DBH is financed mainly through governmental sources, but also from patient fees and private insurance. In the last two years DBH has generated revenue from extraordinary, one-time property transactions. DBH’s total budget for fiscal year 2008 is \$15,011,733. Figure 1.1 shows the historical revenues and the sources of that revenue as per DBH.

The majority of DBH’s funding comes from federal, state, and county sources.

**Figure 1.1 DBH Revenues Have Continually Increased Each Fiscal Year.** In fiscal year 2007, DBH received 84 percent of their revenue from public sources.

Revenue Category	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007
Federal (Medicaid) <sup>1</sup>	\$ 7,002,448	\$ 7,027,194	\$ 7,846,366	\$ 8,067,641
State Funds <sup>2</sup>	4,021,495	4,030,623	4,156,610	4,443,560
County Funds <sup>3</sup>	785,278	834,483	826,930	853,465
<b>Public Total</b>	<b>\$11,809,221</b>	<b>\$11,892,300</b>	<b>\$12,829,906</b>	<b>\$13,364,666</b>
Patient Fees, Insurance	977,511	941,770	1,126,352	776,125
Other <sup>4</sup>	250,283	349,683	1,356,590	1,736,597
<b>Total</b>	<b>\$13,037,015</b>	<b>\$13,183,753</b>	<b>\$15,312,848</b>	<b>\$15,877,388</b>

1 Primarily directed toward Medicaid and chronically ill client needs.  
 2 Including the required state match of federal funds.  
 3 Including the required county match of federal funds.  
 4 Includes rental fees, property transactions and other.

DBH's total revenue has increased about 22 percent from fiscal year 2004 to fiscal year 2007. Funding from public sources—intended to serve clients on Medicaid, those who cannot afford services anywhere else, and other Davis county residents—has increased each year for a total increase of about 13 percent.

The most marked increase is in the “other” category of revenue. This increase is not expected to be ongoing revenue but are extraordinary (one-time) revenue items. For example, in 2006, DBH had major property transactions. They sold buildings and property, purchased property and received a \$395,000 donation from the seller of a building they purchased.

In fiscal year 2007, DBH also had extraordinary revenues from property that DBH acquired from Davis County valued at \$945,000. According to DBH's Chief Executive Officer (CEO) these were properties used in DBH operations that were intended to be deeded to DBH years before when DBH had completed the payments on Municipal Bonds that had been issued by the County to buy property and build facilities. The transfer of the property's title was completed on December 29, 2006.

DBH's revenues are used to treat clients in various clinical programs as well as administrative expenses. Figure 1.2 shows the breakdown of where the revenues detailed in Figure 1.1 are spent.

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**Program services spending, as a percentage of revenues, has decreased.**

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**Figure 1.2 Program Services Spending, As A Percentage of Revenues is Decreasing.** Program services spending as a percentage of total revenue has decreased from 83.8 percent to 81.7 percent.

Expense Category	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007
MH Intensive	\$ 2,917,482	\$ 3,078,400	\$ 3,370,679	\$ 4,005,341
MH Out-Patient	4,254,397	4,904,244	5,005,642	5,328,694
SA Intensive	1,319,947	1,238,673	1,518,783	1,369,766
SA Out-Patient	1,623,778	1,548,682	1,576,361	1,487,866
Prevention & Education	673,014	674,947	519,006	442,846
HUD Project	136,642	145,141	148,392	335,749
<b>Total Program Expenses</b>	<b>\$10,925,260</b>	<b>\$11,590,087</b>	<b>\$12,138,863</b>	<b>\$12,970,262</b>
Management Expenses	1,693,741	1,641,473	2,009,275	1,963,344
Other Expense <sup>1</sup>	0	0	598,143	485,603
<b>Increase (decrease) in net assets</b>	<b>418,014</b>	<b>(47,807)</b>	<b>566,567</b>	<b>458,179</b>
<b>Total</b>	<b>\$13,037,015</b>	<b>\$13,183,753</b>	<b>\$15,312,848</b>	<b>\$15,877,388</b>

Source: DBH audited financial statements.

1. Includes expenses for the non-profit corporations and the DBH property expenses.

Actual dollar program services spending increased 18.7 percent from fiscal year 2004 to fiscal year 2007. However, when looking at program services spending as a percentage of total revenue there was a decrease from 83.8 percent to 81.7 percent. Similarly, actual management expenses increased 15.9 percent from fiscal year 2004 to fiscal year 2007. However, management expenses as a percentage of total revenues decreased slightly, from 13 percent to 12.4 percent, from fiscal year 2004 to fiscal year 2007. These decreases allowed for the payment of the non-profit corporation's losses and for net asset increases.

In fiscal year 2006 DBH's increase in net assets (profit) of \$566,567 primarily came from \$402,175 of one-time transactions. In fiscal year 2007, DBH received land and buildings from Davis County valued at \$945,000. It appears that without the \$945,000 donation, DBH would have shown a

decrease in net assets (loss) in their operations of \$486,821. DBH's gains in the sale of property and donations of property have offset operating losses. This is a concern because operating funds generation has not been covering DBH expenditures.

Although the above figure shows that DBH had increased net assets (profit) in fiscal years 2006 and 2007, the majority of the increase came from extraordinary one time transactions. If DBH had not had these extraordinary transactions, they would have shown a loss in their operations in 2007.

## **Audit Scope and Objectives**

The Legislative Audit Subcommittee requested this audit of DBH. This audit has three objectives:

1. Examine the concerns identified by DSAMH in their November 2006 audit of DBH.
2. Examine all financial and other resources devoted to the spin-off affiliated entities and determine if such expenditures are efficient and effective.
3. Determine if all entities have adequate governance and board oversight.

We reviewed the operation of the affiliated entities mentioned as concerns in the DSAMH audit from their creation in 2004 until their dissolution on June 29, 2007. This audit provides ways for DBH to increase the efficiency and effectiveness of two of the entities as DBH has decided to continue providing services from these entities as divisions within DBH. Further concerns with these companies and their continuing functions are addressed in Chapter II.

DBH, along with four other community mental health centers (CMHCs), entered into a consortium of computer users and hired ITX Media (ITX) as their IT service provider. The division audit expresses concern about the contract between Davis and ITX. DSAMH is concerned that the contract was not bid through an appropriate procurement process and believes DBH should rebid the contract. These concerns are addressed

in Chapter III. The consortium of CMHCs uses Pro-Filer, a software product from Uni/Care, to provide both clinical and billing electronic records. Staff concern with Pro-Filer is addressed in Chapter IV.

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## **Chapter II**

# **Creation and Operation of Affiliated Entities Was A Poor Use of Limited DBH Funds**

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**DBH reorganized in 2004 by creating five new corporations. In 2007, they put all of the corporations back together under DBH.**

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Davis Behavioral Health (DBH) reorganized in 2004 and created five affiliated corporations with the dual purposes of generating funds that could be passed through to DBH to care for the unfunded and reacting to a changing therapeutic services environment. Instead of generating funds for DBH, the creation and operation of the new corporations cost DBH approximately \$850,000, increased the complexity of the organization, and decreased its efficiency. On June 29, 2007 DBH dissolved the affiliated corporations and put the functions back under DBH. The State Division of Substance Abuse and Mental Health (DSAMH or division) and Davis County's clerk-auditor question the use of DBH reserves to provide funding for the new affiliated entities.

It does not appear that there was a need to go to the expense of privatizing activities that were either already being done or could have been done by DBH. Although DBH dissolved all the affiliated entities, they continue to provide services using Diversified Employment Opportunities (DEO) and Daybreak—as divisions of DBH which adds to DBH's costs that need to be paid with state and county funds. Additional refinement of these operations is necessary to improve service delivery and control costs.

### **Reorganization Was Financially Costly to DBH**

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**DBH spent approximately \$850,000 to reorganize and operate affiliated entities.**

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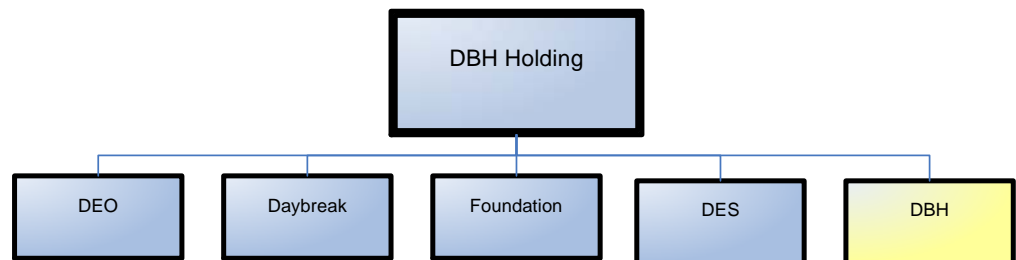
DBH's Chief Executive Officer (CEO) and board decided to follow an out-of-state center's organizational structure and reorganized DBH in 2004. The total cost for the reorganization and the services provided by the affiliates was approximately \$850,000.

The affiliated entities increased the complexity of DBH and created additional expenses for DBH. For example, DBH paid attorneys and staff to create the new corporations. These expenses were not isolated and charged to the affiliated entities; they were paid by DBH. None of the additional administrative burdens or additional expenses were clearly visible because the affiliated entities were removed from DBH board oversight and accountability.



Specific information for each affiliated corporation, including the corporation's type and purpose, governance, and initial and ongoing funding sources, is detailed in Appendix A. A visual of the corporate restructuring is shown in Figure 2.1.

**Figure 2.1 DBH Created Five New, Affiliated Entities in 2004 and Then Dissolved Them in 2007. DEO and Daybreak Continue as Divisions Within DBH. Prior to 2004 and after 2007, DBH was the main corporation.**



DBH specifically set up the five new corporations so they would not be part of DBH. To accomplish this, DBH created DBH Holding corporation as an umbrella corporation and then created the other four corporations to be under DBH Holding. The five corporations shown in blue above were created in 2004—three service entities (DEO, Daybreak, and the Foundation) with the specific purpose of generating funds that could be passed back to DBH and two entities (DBH Holding and DES) to provide support services to the service entities.

1. **Diversified Employment Opportunities (DEO)**—set up on 7/29/04 to create employment for DBH clients by operating in-house businesses or winning federal janitorial contracts
2. **Daybreak Behavioral Medicine (Daybreak)**—set up on 7/14/04 to provide services to people with insurance
3. **Family Well Being Foundation (Foundation)**—set up on 7/14/04 to solicit charitable contributions
4. **DBH Holding**—set up on 7/14/04 as a pass-through corporation to receive and distribute funds

- 5. **Davis Employment Services (DES)**—set up on 3/4/05 to provide the employment and payroll functions for DEO and Daybreak employees.

DBH, shown in yellow, was the original corporation prior to 2004 and is the only one that remained after the five new corporations were dissolved on June 29, 2007. From an organizational and financial standpoint, the five new corporations were to be independent and were not to be included in DBH's audited financial statements. While the corporations were independent on paper, in reality they received financial and administrative support from DBH. Some of the actual work was performed by DBH staff. Additionally, DBH provided the initial start-up funds and some ongoing funding. Figure 2.2 demonstrates this relationship.

**DBH spent about \$850,000 creating and operating five new corporations.**

**Figure 2.2 DBH Spent Approximately \$850,000 Creating and Supporting the Three Affiliated Entities from Fiscal Years 2003 to 2007.** DBH provided start-up funds, paid client wages, and paid fees to consultants.

	DEO	Daybreak	Foundation	Total
<i>DBH collateral provided</i>	\$250,000	\$225,000	\$25,000	\$500,000
Reserve for write-down of collateral –FY 2006	232,469	158,800	0	391,269
Additional collateral write-off by DBH to retire working capital loan–FY 2007	37,358	16,109	0	53,467
Additional DBH support	86,513	51,510	62,257	200,280
Increased cost to DBH for janitorial and food services provided by DEO <sup>1</sup>	127,000			127,000
Consultant fees paid by DBH	90,840			90,840
<b>Total Support Provided by DBH</b>	<b>\$574,180</b>	<b>\$226,419</b>	<b>\$62,257</b>	<b>\$862,856</b>

<sup>1</sup> In addition, DBH paid client wages for services such as office support and building and grounds maintenance. The lack of records prevent us from identifying how much DBH paid for these services prior to DEO. Overall, DBH paid wages to approximately 110 clients

Figure 2.2 shows that DBH spent approximately \$850,000 to create and operate the affiliated entities through June 29, 2007 when they were

dissolved. Sixty-nine percent of the \$850,000 in DBH funds were directed to DEO. In addition to these costs, DBH paid for legal fees and services and DBH staff to provide services to the affiliated entities. The lack of records prevents us from identifying how much DBH administration and staff time was devoted to the affiliated entities. For example, some DBH staff traveled out-of-state to visit other organizations to see their corporate structures and operations; file documents of incorporation; work with the IRS on tax-exempt status issues; set up new accounts; transfer DBH funds; and hire administrators, accountants, and auditors for the new corporations.

DBH's CEO believes that employing clients keeps Medicaid costs down because they are no longer in a Medicaid reimbursed day treatment program. We do not believe that savings would be significant given the low number of therapy sessions for the existing DEO clients.

### **Uncertainty Regarding Nature of Funds**

DBH used a portion of their reserves to provide start-up funds for the new corporations. There are still questions regarding the nature of the funds used. DBH believes they were private funds that they earned from client fees, private insurance and charitable contributions. DBH's board recognized the funds used as privately-generated and authorized the use of \$500,000 to be used as collateral so the new companies could secure working capital in the initial period of operation. However, others believe they were public funds since they were earned by DBH using the infrastructure paid for with federal, state and county funds.

In April 2004, DBH asked the Davis County Commission, the local Mental Health Authority, to approve their reorganization plans. DBH told the commission that the overall purpose of the new corporations was to "become less reliant on revenues from the State Department of Human Services and Medicaid funding through the State Department of Health, and . . . to expand recovery-oriented services." Based on this information, in February 2005 the Davis County Commission voted on and approved DBH's reorganization plan to create new nonprofit corporations and to loan the new corporations an amount not to exceed a cumulative total of \$900,000 of DBH's reserves or to establish a line of credit from a commercial bank for that amount. We interviewed the Davis County Commissioner on the board at the time of the creation of the corporations, and he said it was clear to him that a primary purpose of

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**DBH used a portion of their reserves to provide start-up funds for the new corporations.**

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creating the new corporations was to earn a profit through alternative services that could be put back into DBH.

In March 2005, the DBH board approved the investment of up to \$900,000 of DBH's reserves as start-up funds for the new, affiliated entities. The funds were to be deposited in certificates of deposit at a local bank that secured a line of credit the affiliated entities could use as needed in their operations. Initially, DBH transferred \$500,000—\$250,000 for DEO, \$225,000 for Daybreak, and \$25,000 for the Foundation. The line of credit was to be paid back with interest once the affiliated entities began to generate revenues that exceeded their expenses.

DBH's board believed they could use the reserves based on their attorney's analysis that funds generated from client fees and insurance were private, not public funds. Davis County's clerk-auditor disagrees with the conclusion that client fees and insurance earned in DBH's operations should be considered private funds and could, therefore, be used to start the new corporations. The issue is that DBH earned client fees and insurance using an infrastructure that was primarily funded by federal, state, and county funds. DBH's private funds calculation is detailed in Appendix B.

### **Poor Execution of the Affiliated Entities Resulted in Financial Problems**

DBH did not formulate adequate business plans and cost/revenue forecasts before they created the affiliated entities. Further, DBH lacked the knowledge and expertise necessary to successfully implement the goals of the corporations. DBH only received partially-developed business concepts from outside consultants and others who, in our opinion, produced very general documents that simply stated the affiliated entities could earn profits in a short period of time. DBH hired new staff and tasked them to operate these new entities thereby increasing DBH's expenses.

Other organizations, including the Davis County Clerk-Auditor, were approached about the reorganization plans and were concerned about the use of DBH funds to create and operate the affiliated entities. Although the Davis County Commission approved DBH's reorganization plans, they may not have understood the issues in the reorganization plans. This lack of understanding may be due to the commission's representation on

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**DBH did not need to create the five corporations. All of the functions could have been done by DBH.**

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the DBH board. Only one county commissioner is active on the DBH board at any given time and there was a transition of commissioners during the planning period for the affiliated entities, when the entities operated and when they were dissolved.

We asked Medicaid officials in the Division of Health Care Financing (HCF) in the Department of Health if DBH had to lease a separate facility and create a new infrastructure to treat clients that were not on Medicaid. According to HCF's manager of reimbursement, while Medicaid funding can only be used for persons on Medicaid, that does not mean that centers cannot provide services to people who are not on Medicaid. A center must simply have a valid methodology to allocate expenses for those clients not on Medicaid. In other words, DBH could have isolated the costs using accounting techniques; they did not have to create a new corporate structure or lease a separate facility.

### **DBH Had to Compete with the Newly Created Corporations for Resources**

DBH devoted time and effort to the creation of the affiliated entities because they claimed that “at a time when the demand for services was increasing, government funding for such services was reduced.” In fact, federal, state and county funding did not decrease; it actually increased. The negative funding impact experienced by DBH was not due to decreased funding; it was caused by the Federal Government's decision to prohibit the use of excess Medicaid funds for non-Medicaid clients. DBH had other funding sources and also reserves they could use within DBH.

Once DBH attorneys and staff created the affiliated entities, they devoted their time and attention to hiring staff and leasing office space for the companies. Some DBH staff, administrators, and psychiatrists were shared with the new entities to help them succeed.

DBH was financially supporting the operations of the new affiliated entities at a cost to their own operations. DBH staff were not receiving Cost of Living Increases (COLA), vacant staff positions were not refilled, and staff were told that they could no longer continue to serve unfunded clients. This reduction in services increased DBH's financial problems by reducing their ability to bill for Medicaid services. A lack of clinical staffing at DBH was a serious issue discussed in the 2007 site review conducted by the DSAMH. It was so serious that DBH was placed on

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**DBH financially supported the new entities at a cost to their own operation.**

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corrective action. These vacancies caused both poor documentation and deficient treatment programming.

In summary, DBH had a major reorganization in 2004 that took time, staff, and resources and cost DBH approximately \$850,000. DBH reorganized again in June 2007 when they dissolved the corporations created in 2004. These major reorganizations have created unrest and concern with staff. Staff told us they were told that the purpose of the reorganization was to create profits for DBH yet the opposite occurred. Some staff question the leadership skills and capabilities of management in its direction of the organization away from their core mission to serve Medicaid clients and the indigent and to clients with insurance. Also, staff unrest and turmoil occur when staff see what they perceive to be unnecessary expenses in other areas of the organization.

The five corporations were dissolved on June 29, 2007. At the same time, two of the corporations—DEO and Daybreak—were registered with the State Division of Corporations as Doing Business As (DBA) corporations and now operate as divisions of DBH. Neither corporation is financially viable and DBH continues to support them financially. Now that the corporations are part of DBH, it will be more difficult to isolate their revenues and expenses.

### **DEO Hampered by Poor Focus And Execution**

During its three years as an affiliated entity, DEO did not create employment for DBH clients by creating any external to DEO businesses or winning any federal government contracts. Instead, DEO simply hired a limited number of clients to do work for DBH and then billed DBH for all the hours worked and their administrative costs. DBH dissolved DEO in June 2007 and it became a division of DBH. The clients became DBH employees. DBH could have hired clients to be DBH employees in 2004 without having gone to the expense of creating a new corporation. It is conceivable that DEO could provide employment services to more clients, at a lesser cost, by developing jobs in the community and integrating DEO within DBH.

DEO was incorporated on July 29, 2004 as an affiliated entity to provide supported employment to clients. Supported employment has

demonstrated good outcomes in helping adults with severe mental illness to obtain and sustain competitive employment. According to DBH staff, prior to DEO, DBH's day-treatment program provided similar services to clients. To create DEO, a case manager was moved from the day-treatment program, an executive director was hired, and DBH provided \$250,000 in start-up funds.

DEO made several administrative staff changes in 2005 and 2006. In May 2006, DBH's human resources director became DEO's executive director. He began to hire DBH clients as DEO employees to do work for DBH. The number of clients that can be placed is limited by the number of available jobs and how long each client stays in a given job. From 2004 until its dissolution in June 2007, DEO earned \$508,336 yet spent \$859,370, for a net loss of \$351,034. DEO earned the majority of its revenue by billing DBH for services. DEO only had small contracts to provide janitorial services for DBH affiliated companies such as Daybreak and ITX Media. DBH paid the corporate losses to dissolve the corporation.

### **DEO Has Been Slow to Progress**

DBH's vision was that DEO would provide supported employment for its clients by either starting small business ventures or by winning federal government contracts. DBH's concept paper states: "DBH thinks that supported employment is the single-most important evidence based practice for sustained recovery. Therefore this is our first priority." In addition, their objective was to "phase out day treatment services, long-term individual and group therapy, and other traditional dependent-inducing services."

To provide supported employment, DEO intended to create "an affirmative business" that will use "a consumer co-operative business model, employing a workforce that is 60 percent disabled and 40 percent normalized." The initial business ideas were a recycling business and a pet day care.

The initial business ventures were ideas proposed by a consultant hired by DBH. The first was an aluminum recycling business where clients would pick up recycling products from businesses, government, and residents and sell the recyclables to a recycling vendor. The consultant's proposal for the aluminum recycling business stated "revenues are

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**DEO did not create any businesses or win any federal government contracts.**

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projected to be ‘revenue neutral’ within six months of operation.” The second was a pet day care where clients would provide “doggie day care, exercise, and activities.” Neither venture materialized. According to DBH’s controller, both proposed ventures were capital intensive, and DBH did not have the capital to purchase the needed equipment.

In addition to working in these areas, the plan was for DEO to win federal government contracts, initially in the area of janitorial services. The proposal for janitorial services stated that the objective of the janitorial service was to “turn a profit within one year” and “refine process, labor and equipment such that any new account is profitable within six months.”

DEO was particularly interested in placing clients into janitorial positions at a federal facility in their county. However, another organization had that contract and had been placing DBH clients into jobs since the 1980s. Rather than DBH continuing to refer clients to this other organization for employment, DEO wanted to win contracts and place clients directly.

The DEO director told us he has bid on 15 janitorial contracts but has not won any of the contracts. He said that it was very difficult to win contracts. Our review shows that there are various nonprofit and private sector organizations that do similar work and bid for contracts. DBH may not have taken into consideration the competition in the market or the difficulty of getting outside contracts.

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**DBH was awarded two State of Utah janitorial contracts with potential excess revenue of \$3,100 per year.**

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At the end of 2007, DEO was awarded two contracts with the State of Utah to provide janitorial services in state buildings. One contract is for approximately \$496,000 over five years, effective February 1, 2008, and the other is for \$44,000 over five years, effective December 1, 2007. Together the two contracts provide approximately \$108,000 per year, and DEO can employ 4.2 full-time equivalents. DEO plans to use one full-time and seven part-time clients to do the work. Although there is not a lot of excess revenue available from these two contracts—only about \$3,100 per year—this outside funding will help employ some staff and bring in outside funding for DBH. While getting these two contracts is a step in the right direction to get outside funding, DBH continues to be the main employer for clients.



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**DBH is DEO's primary client and funding source.**

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## **DBH is DEO's Primary Funding Source**

Unable to get sufficient outside contracts or effectively start businesses, DEO hired DBH clients to provide services to DBH. DEO billed DBH for the wages of all the clients and the administrative costs of this separate program with an administrator, a business manager, and office staff. These positions did not exist prior to DEO. While DEO was an affiliated entity, there was little oversight of DEO's invoices to DBH. DEO's business manager simply billed DBH for all the hours employees worked and an additional \$1.50 per-hour overhead.

As the number of clients DEO hired increased, the amount DEO billed DBH increased. After the initial start-up, DEO's monthly bill to DBH increased from about \$23,000 per month to \$37,000 per month. According to the business manager, the goal of the program was to employ clients, not to have them working efficiently and effectively. DBH therapists question this approach, wondering how employees will be ready to work in outside organizations if they never learn to work efficiently and effectively. As of the date of this audit report, there were 56 clients employed at DBH. These expenses are not isolated in the DEO program budget but are spread out in the budgets of other DBH programs.

Several DBH staff expressed concern that DEO staff are doing unnecessary work, such as cutting the lawn multiple times during the week. There do not appear to be sufficient controls in place to ensure that the work done and expense charged to DBH are necessary. For example, one client worked overtime for over eight months before her hours were reviewed. We question the attempt to employ clients at any cost to DBH.

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**DBH's janitorial expenses have increased.**

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**DBH's Janitorial Expenses Have Increased.** DBH's total janitorial expense has more than doubled from about \$80,000 per year in fiscal year 2004 to \$175,000 in fiscal year 2007. Prior to DEO, DBH used the services of outside janitorial companies and paid about \$80,000 per year to clean all of their facilities. DBH now pays \$175,000 per year—\$120,000 to DEO and \$56,000 to outside janitorial services and for cleaning supplies. The original idea was that DEO would employ DBH clients to do things that DBH was contracting for, such as janitorial services, and the cost to DBH would be the same. However, that has not happened with the janitorial contract. Taking into consideration DBH's

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**DBH's food and preparation costs have increased.**

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additional office space, DBH is now paying about \$72,000 more to clean their facilities.

**DBH's Food Service Expenses Have Increased.** Prior to DEO, DBH had one staff member establish menus and purchase food for clients and case managers to prepare. DBH provided lunch and dinner for clients. Clients and case managers worked together to provide a learning experience for clients in addition to other skills taught by the case managers. In this way, clients learned life skills by learning to cook, serve, and clean up. Utilizing DEO for food services resulted in food and preparation costs increased from \$80,000 to over \$160,000. Actual food costs increased from \$80,000 to \$105,000 from fiscal year 2004 to 2007, the additional cost of \$55,000 in fiscal year 2007 was the result of wages paid to a supervisor and several clients to prepare and serve the food. These costs do not include the salary and benefits of a food services manager that was paid by DBH.

**Some Other DBH Costs Have Increased.** In an effort to employ more clients, DEO hired clients to provide services to DBH such as building and grounds maintenance, lawn service, snow removal, courier service, and a client shuttle service. Some of these services were provided in prior years by DBH staff, selected DBH clients, or volunteers. While it may be good for clients to be employed, it is also important that DBH can afford these services and that the services provided are completed effectively and efficiently.

For example, prior to DEO, case managers transported clients only when they had no other transportation. In fiscal year 2007, DEO began a client shuttle service that operates for more than 12 hours per day, transporting clients to and from DEO jobs and medical appointments. To provide this service, DEO hired clients to be shuttle drivers and also hired a client shuttle coordinator and bills DBH for all the hours worked. While DEO clients like the shuttle service because they do not have to spend money on transportation, it increases the cost to DBH and may keep clients dependent on DEO. Some therapists have told us that teaching clients to be independent and figure out their own transportation is part of learning responsibility, a component of recovery. We question this additional cost to DBH.

Overall, it appears that DBH's expenses for some basic services have increased because DEO is providing the services and there is another level

of administrative expense that needs to be covered. Some could argue that providing jobs for clients is important and the additional cost is justifiable. However, we believe that DEO and DBH should have a plan to aggressively place clients outside of DBH and to make their operation financially solvent.

### **DEO Should Pursue Outside Funding**

DEO hires clients to provide services to DBH and bills DBH for all client wages. However, some of the services that DEO is providing to clients could be paid for by Medicaid or the State Office of Vocational Rehabilitation (VR). Other centers use Medicaid and VR funding. DBH billed Medicaid and VR for these services before DEO was created.

DEO has not pursued funding from Medicaid or VR. Instead, they simply bill DBH. When we discussed the idea of using Medicaid and VR, the DEO director stated he did not need to because the DWS contract funds his job coach. Our review shows that the DWS contract does not cover the full cost of the job coach. Getting outside funding for allowable services would be beneficial and free DBH funds for other things. For example, DEO only has one job coach who has told us she is overwhelmed and cannot do job coaching. Instead, she uses clients to supervise other clients and provide some job coaching. A DWS official is quite concerned about the job coach's caseload because she has seen her at a breaking point several times. DEO's job coach currently has a caseload of 56 clients. The supported employment best practice recommends that caseloads should only be up to 25. We believe that DEO should pursue outside funding.

**DEO Has Not Used the DWS Contract Effectively.** DEO could receive more funding from the DWS contract if they would help clients get jobs in the community and continue to provide job coaching to those clients. Instead, DEO only provides job coaching for clients they place in DBH jobs. Because DBH has so few jobs for clients, they are not maximizing their contract.

In October 2006, DBH entered into a one-year contract with DWS whereby DBH would be paid to provide job coaching for 20 DWS customers. These DWS customers have mental health barriers to employment and are thereby DBH clients also. The contract is a performance-based contract for which DWS pays DBH an agreed-upon

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**DEO has not pursued funding from Medicaid or VR.**

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amount per quarter as clients are employed, increase the number of hours they work, and stay employed. DEO places clients in jobs within DBH and DBH pays the client wages.

In speaking to the DWS representative over the contract, we learned that DWS pays for job coaching services. The jobs themselves do not have to be at DBH; they can be in the community. We found that DBH has only received \$35,000 through January 2008 on this \$90,509 contract. DBH could maximize the DWS contract by developing jobs in the community, helping clients get those jobs, and then providing job coaching services to the clients.

Placing clients in community jobs would be beneficial for clients, DBH, and outside employers. By developing jobs in the community, clients would have more and varied job opportunities. Additionally, the financial burden on DBH would be lessened because the wages would be paid by outside employers. In talking to the executive director of another program, we were told that employers are eager to employ clients, and there are many job opportunities in the community. They do not hire anyone inside the program; instead, they hire job coaches to go out and find employers that will hire clients. They place most clients in hospitals, nursing homes, and janitorial services. She questioned why DEO staff do not have the time, energy, or training to go out and develop job opportunities in the community.

The DWS contract may actually decrease because of DEO's practice of not helping clients to get jobs in the community or providing job coaching to them. In August 2007, DEO staff and DWS made a presentation to the DBH board regarding their success in placing DWS clients into DEO jobs. At the time of the presentation, the board was told that 16 out of 20 clients were successful at DEO, and DWS was very pleased with the results. However, a few months later, we found that only six of the 20 are employed by DBH and two are employed in the community. The remainder are inactive. Since DEO does not help clients get jobs in the community or provide job coaching if clients get jobs in the community, DEO will not be paid for job coaching services.

**DEO Should Work with Clients to Gradually Increase Their Working Hours.** Although the DWS contract allows clients to gradually increase the number of hours they work, DEO management believes that clients need to work up to 30 hours each week so that they get off of state

assistance. The DWS contract allows clients to gradually increase the number of hours they work, starting at four hours per week, and increasing one hour per week up to 20 hours per week within four months and 30 hours per week within seven months. The goal remains at 20 hours per week for clients with children under five.

DWS' employment specialist told us they wrote the contract to allow clients to gradually increase the number of hours they work, understanding that some clients have not worked in several years. Our concern is that DEO staff may be pushing clients to work increased hours too quickly, based on DEO's needs rather than when the client is ready. In one case, DEO management required a client to work almost 30 hours per week within a month of starting the job. DEO management went against the recommendation of DBH's therapist and the DWS program of gradually increasing the number of hours worked. The client's hours escalated quickly and created a funding bonus for DEO. However, according to the client's psychiatrist and therapist, the way DEO treated the client was detrimental to her mental health.

### **DEO Employment Program Lacks Coordination with Therapy Component**

In 2003, DBH's CEO set supportive employment as DBH's first priority. In addition, their objective was to "phase out day treatment services, long-term individual and group therapy, and other traditional dependent-inducing services." Rather than using a program that integrates treatment and employment to address total client need, DEO created an employment only program where some clients are simply employed by DBH. DEO does not have any clinical oversight and little communication with DBH clinical staff.

The following sections are examples of DEO's lack of integration of employment and therapy.

**The Number of DBH Clients Who Receive Support Is Limited.** Successful supported employment programs hire employment specialists who go into the community and develop jobs for clients in different industries, based on the interests, preferences, and strengths of clients. Consumer preferences play a key role in determining the type of job that is sought. Consumers who obtain work in their areas of interest tend to have higher levels of job satisfaction and longer job tenures.

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**Clients are employed by DBH; they do not try to place clients into community jobs.**

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DEO has only a limited number of DBH jobs for clients to do. The amount of time clients spend in those jobs varies from a few hours to years. About forty percent of the 110 clients worked in their DEO job for less than 100 hours total. On the other hand, some clients remain employed indefinitely because the DEO job is their job of choice. Although DEO has employed 110 clients for some period of time, DBH saw 697 unemployed mental health clients in 2007. In addition, DBH saw over 400 substance abuse clients in 2007, who may also benefit from supported employment.

There are no limits to the amount of time that clients can work for DEO and there is no structured process to move clients into jobs in the community. A review of the records shows that six clients have worked for DEO for two to three years. Therapists and DSAMH staff question the lack of a time limit on the jobs since it affects the number of clients that can be served by DEO. According to DEO management, some clients want to work for DEO indefinitely because that is their job. In fact, one client moved closer to DEO so that he would be “close to his work.” We interviewed two clients who told us they are on Social Security Disability Income (SSDI) and use their DEO wages for spending money. Both clients said they plan to work for DEO indefinitely because DEO works with them so that they do not go over the monthly maximum earnings set by SSDI.

**DEO Is Physically and Administratively Separated from the Treatment Team.** National literature suggests that supported employment works best when employment specialists coordinate plans with the treatment team (e.g., the case manager, therapist, and psychiatrist). DEO does not prepare a written individualized job support plan for clients so it is unclear what the job support plan is for each client. Some DBH staff do not understand the goal of DEO and what the plan is for clients. Some expressed concerns about the lack of protocols at DEO and coordination between DBH and DEO. Regular communication and coordination is important between DEO and the clinical staff and treatment team.

## **Daybreak and Foundation Duplicated Existing Services**

DBH created an affiliated entity, Daybreak, to provide mental health services for people with insurance. DBH created another affiliated entity, the Family Well Being Foundation, to conduct fundraising. Neither task is new to DBH; the two new corporations merely replaced existing internal functions. The new corporations were never financially viable and relied on DBH for financial support. Both corporations were dissolved at the end of fiscal year 2007. Neither was successful in developing additional funding for DBH. Daybreak, now as a division of DBH, is still not financially viable but continues as a stand-alone clinic.

### **The Purpose of Daybreak Was to Serve Clients With Insurance and To Generate Funds For DBH**

The original idea behind Daybreak was to create a for-profit corporation. According to the organizational restructuring narrative prepared by DBH and presented to various groups in 2004, Daybreak would be a for-profit corporation to:

Provide behavioral health outpatient treatment services to individuals, families, and employee assistance programs that are outside the target population for the community mental health system (Local Authority system) who have the ability to pay through private insurance or other private sources.

[The ongoing funding] would be self-sustaining, generating revenues from collections for the behavioral health treatment it provides. Profits would be donated to the Holding Company for distribution to DBH or [DEO] to provide services to unfunded SPMI and SED [Severe and Persistent Mental Illness and Serious Emotional Disturbance] individuals and their families.

Although Daybreak was incorporated as a non-profit for tax reasons, the purpose remained to generate funds for DBH. In a draft letter to the Executive Director of the Department of Human Services, DBH wrote:

Each corporation within the structure exists for the specific purpose of generating profit that can be passed through to DBH to fund treatment for unfunded SPMI and SED patients.

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**Daybreak was incorporated as a non-profit with the specific purpose to generate funds for DBH.**

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To compete for clients with insurance, DBH believed they needed to create Daybreak and operate it in a separate facility and without a sign identifying it as a mental health facility. DBH's attorney stated that clients with insurance would not want to go to a clinic that was marked as being a mental health facility and would not want to go to a clinic with chronically ill Medicaid clients, such as those seen in DBH clinics. Also, it appears Daybreak may have wanted to attract clients from other counties.

According to DSAMH staff it is unclear why DBH, a community mental health center, should be using federal, state, and county funds to create a duplicate facility to compete with the private sector for clients with insurance. DSAMH states that the goal of public mental health funds is not to make a profit; it is to serve those who cannot get service any place else and to provide services to the indigent.

### **Daybreak Creation Increased Cost and Reduced Efficiency**

Daybreak was incorporated on July 14, 2004 to serve clients with insurance. Daybreak became operational on March 1, 2005, in a separate office, with its own office staff and administration. A DBH psychiatrist split his time between DBH and Daybreak, and a DBH therapist was moved to Daybreak. In addition, several part-time therapists were hired.

The goal of Daybreak was to grow this funding source and provide the excess revenues to DBH. Daybreak did earn revenue, but not in sufficient amounts to cover their fixed costs. From March 2005 to June 2007, when Daybreak was dissolved, Daybreak had a cumulative net operating loss of \$226,419.

Daybreak's records show increasing revenues of approximately up to about \$200,000 for fiscal year 2006 and about \$153,000 for the first six months of 2007. DBH continued to serve clients with insurance and also earned approximately \$200,000 to \$300,000 per year from fiscal years 2005 to 2007.

### **Medicaid Regulations Did Not Prohibit DBH From Continuing to Serve People with Insurance**

DBH's CEO claims that they had to create Daybreak because DBH could no longer see clients with insurance. According to DSAMH and HCF staff, nothing in the 2003 Medicaid changes precluded DBH from

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**Daybreak had a net operating loss during its years as an affiliated entity.**

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**Nothing in Medicaid requirements precluded DBH from continuing to serve clients with insurance.**

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continuing to see clients with insurance in their current facilities. Medicaid rules did not change in 2003—Medicaid simply interpreted them differently in an effort to try to save money.

According to staff at DSAMH, prior to 2003, centers got a certain amount of money for the Medicaid-eligible people in their area. If they could serve those people for less, the centers could keep the surplus. In 2003, Medicaid said that its money could only be used for Medicaid clients. While non-Medicaid clients without insurance were affected, according to DSAMH, clients with insurance were not affected by the Medicaid changes. People with insurance could still come into the mental health centers to be served as long as the cost to serve them was not paid by Medicaid funds. According to DSAMH staff, to say that DBH had to create Daybreak so that they could keep accepting private insurance is not accurate.

In fact, Medicaid staff in the Department of Health believe that the use of separate facilities for different types of clients raises the total cost for centers. According to the manager of reimbursement for Medicaid in the Department of Health, while Medicaid funding can only be used for persons on Medicaid, that does not mean centers cannot provide services to people who are not on Medicaid. A center must simply have a valid methodology for allocating expenses appropriately between clients.

Other Utah mental health centers continue to treat clients with insurance in their clinics. They did not create separate clinics to see clients with insurance.

### **Daybreak Was Not Financially Solvent**

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**Daybreak did not earn enough revenue to cover their costs**

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Even though DBH created Daybreak to generate revenues for DBH, Daybreak was not financially viable and relied on DBH for financial support. Daybreak was staffed with part-time clinicians who had permanent jobs elsewhere and just worked at Daybreak for a few hours each week. The part-time clinicians received 60 or 70 percent of whatever revenue they generated, leaving 30 or 40 percent to cover Daybreak's overhead. Since the part-time clinicians were not working many hours, they were not generating enough revenue to cover Daybreak's fixed costs. In addition to the part-time clinicians, Daybreak also had the services of a DBH therapist and psychiatrist.

DBH did not take into consideration the cost of the overhead for a seven-suite office and office support staff, nor did they take into consideration that their model would not cover their expenses. According to a DBH employee, it is unclear how DBH could have been so naive to think that there were profits to be made in this business.

During their 2006 audit, DSAMH questioned the financial status of DBH and the affiliated entities. According to DBH's former Chief Financial Officer (CFO) he did an analysis that showed Daybreak was not covering its fixed costs—salaries, rent, and other office expenses—because of its use of part-time staff, the sharing of collections, and the lack of sufficient numbers of clients. The former DBH CFO reviewed the projections and made staffing projections of how Daybreak could potentially break even. The former CFO calculated that to break even, Daybreak would need \$755,000 in service income—more than double what Daybreak earned in fiscal year 2007. One of the alternatives presented was to move to a small number of full-time staff who could be more available to clients, thereby potentially increasing revenues. Also, by moving to a limited number of staff, Daybreak might be able to cut down on office expense by leasing the extra office space to others, outside the organization.

With several alternatives to choose from, the CEO decided they would move from several part-time staff who were not seeing enough clients to cover their fixed costs to a limited number of full-time staff. According to the former CFO, even under optimistic assumptions, it would be difficult and challenging to create a positive cash flow from this operation.

According to DBH's former CFO, DBH financially supported Daybreak. As a result of DBH's financial support, the Daybreak board believed Daybreak to be profitable.

At the end of fiscal year 2007 Daybreak was dissolved and became a division of DBH. Around the same time, the CEO required that all clients with insurance be transferred from DBH to Daybreak. Several DBH psychiatrists, and DSAMH staff, question the wisdom of transferring clients. In their opinion moving clients could be detrimental. As many as 10 insured clients were transferred from DBH's Bountiful clinic to Daybreak.

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**DBH cares for clients in separate clinics based on funding source.**

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Therapists were transferred to Daybreak from DBH with little consideration of their duties. A review of records shows that one therapist was seeing between 70 and 130 clients per month at DBH. However, when he was transferred to Daybreak, he was only seeing between 18 and 44 clients per month.

### **DBH's Strict Clinical Structure Is Inefficient**

DBH has created a very strict clinical structure. Only clients on Medicaid can be seen at DBH's central clinics, clients with insurance can only be seen at Daybreak, and unfunded clients can only be seen at the unfunded clinic. The clinics are stand-alone facilities and therefore DBH is paying for redundant infrastructure to operate the separate clinics. Those clients who do not fit into the strict structure are either referred outside of DBH or not seen. According to the business manager of Daybreak, if they cannot see a client with insurance because their specific insurance will not allow the client to go to Daybreak, she must refer the client outside DBH. She said that referring clients back to DBH is not an option for her since her understanding is that DBH can only see clients on Medicaid.

As discussed earlier, DBH can provide services to Medicaid-eligible and non-Medicaid eligible clients in the same facility, provided that revenues and expenses related to these clients are accounted for separately. Services provided to non-Medicaid eligible clients can be paid for with insurance or with appropriate non-Medicaid county and state funds.

We believe that DBH should reevaluate their strict clinical structure and the requirement that clients go to specific clinics based on funding source. It is more important that DBH provide services to its clients in the most cost effective and efficient manner.

Other centers in the state see all of their clients in the same facility regardless of funding source. They keep revenues and expenses separate using accounting methods, not physical location. By not having redundant clinics, they do not have the expense of redundant organizational structures as does DBH.

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**The Foundation raised \$24,686 from various fundraising events and \$60,000 from a real estate broker.**

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## **Creation of a Separate Foundation Was Unnecessary and Unsuccessful**

DBH created the Foundation in order to seek donations from corporations, private charities, and others and then provide this funding to DBH, DEO and Daybreak. However, DBH could have done its own fundraising because it had 501(c)(3) tax-exempt status. In October 2004, DBH initiated a one-year contract with a management consultant, not a professional fundraiser, to provide fundraising services and provided an annual budget of \$74,800 (\$58,000 consultant's fee, \$11,800 promotional materials, and \$5,000 events-conferences/seminars). DBH's board resolved to provide office space, telephone, and the use of excess DBH furniture and equipment to the Foundation. We interviewed the Davis County Commissioner on the board at the time of the creation of the corporations. He said it was his understanding that the fundraiser would be paid based on collections; this was not to be a salaried position.

According to board minutes of February 2005, "an aggressive [fundraising] goal of \$350,000 to \$400,000 by the end of the first year" was set. Although DBH set high goals, the Foundation only raised \$24,686 from their fundraising events. In August 2006, after the fundraiser was gone, DBH received a \$60,000 donation from a real estate broker.

Overall, DBH spent time and resources to set up individual corporations—one to see clients with insurance and another to conduct fundraising. Neither corporation was successful in developing additional funding for DBH. Daybreak was unable to cover their total costs and relied on DBH funding. DBH dissolved Daybreak as an affiliated entity corporation and is operating it as a separate division. The Foundation was not successful in meeting the aggressive goals set and was also dissolved. DBH plans to do fundraising within DBH. We question the time and expense of creating separate corporations when seeing people with insurance and fundraising could have been done by DBH as they were already tax-exempt.

## **Creating Two Support Corporations Was a Duplication**

DBH created two additional corporations—DBH Holding Company (Holding) and Davis Employment Services (DES) to further clarify the independence of DEO, Daybreak, and the Foundation from DBH. DBH Holding was created as an umbrella corporation, and DES was created to handle the administrative and payroll functions for DEO and Daybreak employees.

These corporations assumed the services provided by DBH prior to the reorganization. DBH's board and CEO determined that DBH could not perform the administrative duties of the affiliated entities, so these two additional corporations had to be created. When DEO, Daybreak, and the Foundation were dissolved in June 2007, there was no need for these support organizations, so they were also dissolved. DEO and Daybreak employees simply became DBH employees, and DBH took over the administrative duties.

DBH spent time and resources to set up these individual corporations in 2004 and then dissolved them in 2007. We question the time and expense of creating these separate corporations.

### **Recommendations**

1. We recommend that the Davis County Commission, as the Mental Health Authority, review DBH's mission to make sure it meets the County's mission.
2. We recommend that DBH reassess the DEO program and consider placing it under DBH's clinical director.
3. We recommend that DBH establish budgets and comprehensive policies and procedures for DEO and Daybreak.
4. We recommend that DEO establish a plan to place clients into jobs outside of DBH and to get outside funding to make DEO financially solvent.

5. We recommend that DBH conduct an assessment of its clinics to determine whether they should be consolidated.

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## **Chapter III**

### **IT Provider Relationship Has Caused Concern**

The owner of ITX Media (ITX) is both Davis Behavioral Health's (DBH or Davis) chief information officer (CIO) and their primary information technology (IT) provider. This relationship creates a potential conflict of interest. Conflict of interest is further increased by the contract between ITX and DBH, which requires little documentation. DBH's selection of ITX for IT service provision has caused lingering questions that can only be remedied with pending contract amendments. Despite these questions, the products and services provided by ITX to DBH and the Health Data System Consortium (HDS or consortium) are proving useful and are gaining user acceptance.

#### **DBH Plays Key Role In IT Service Oversight**

The contractual relationship between DBH and ITX began in April 2002. ITX was hired by DBH to help them decide among health information system software options. Together, DBH and ITX chose Pro-Filer software from Uni/Care, and then in September 2003, DBH contracted with ITX to assist with implementation of the selected software. On average, ITX has received \$642,000 a year (not including \$368,000 a year average in Uni/Care software fees) from 2003-2007 for these services—approximately a third of which has been paid by DBH. For further details on these costs, see Appendix C.

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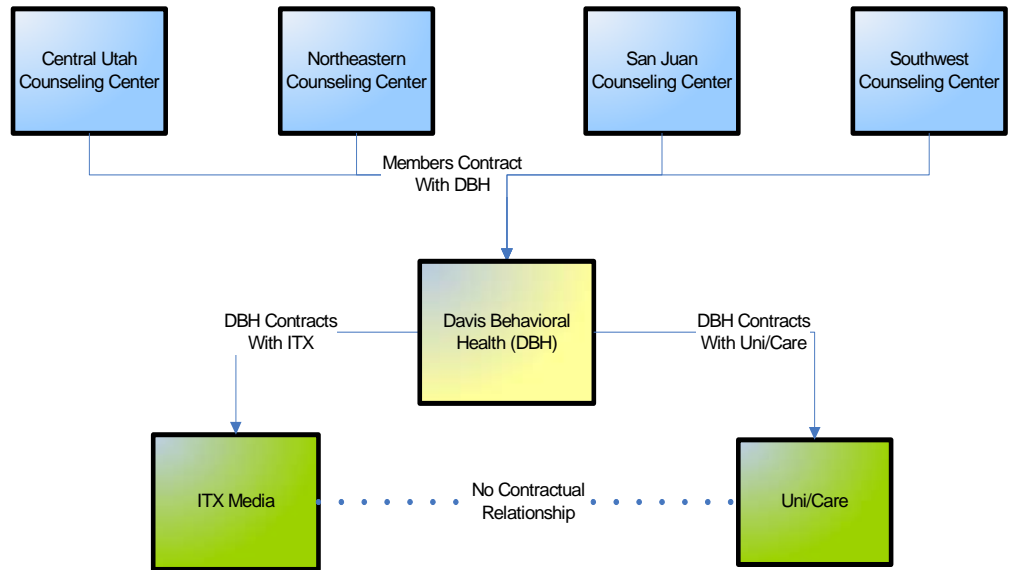
**ITX receives  
\$655,000, per year,  
on average for the  
HDS contract.**

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DBH contracts with other Utah community mental health centers (CMHC) to form HDS. The other consortium members pay the remaining two-thirds of the fees which defrays the cost to DBH of implementing the software. Figure 3.1 shows the relationship among DBH, the other four consortium members, and ITX Media.



**Figure 3.1 DBH Is the Contracting Intermediary Between Other Consortium Members and ITX.** Davis is the contracting agent between HDS and ITX.



**Davis is the consortium's contract oversight provider.**

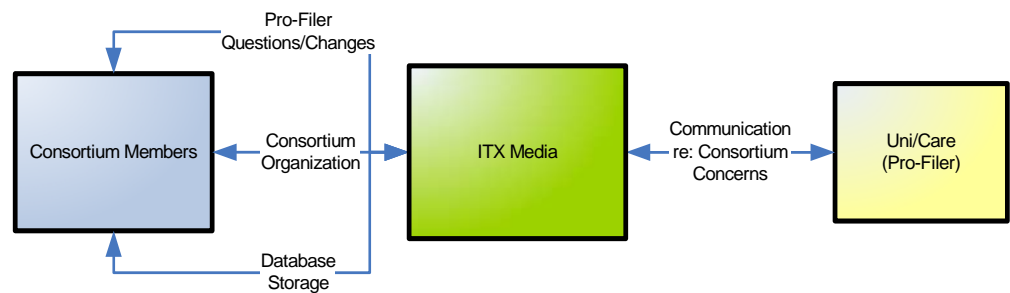
DBH has the intermediary role between the consortium and ITX and, in so doing, is also relied upon by the other consortium members as the consortium's contract oversight provider. ITX Media, as the consultant and service provider, controls communications between Uni/Care and the consortium, but has no contractual relationship with Uni/Care. The contract between Davis and ITX requires ITX to provide the following:

- Management, operation, and maintenance of computer systems and networks
- Training and support of users
- Facilitation of reporting requirements
- Software and hardware usage
- Contract assistance
- Consortium user assistance
- Representation on governing bodies
- Corrective maintenance

The contract between Davis and the other consortium members states that "The contract(s) entered between DBH and any third party pursuant to this Agreement shall provide that the other Members shall be intended third party beneficiaries of such contract." Although DBH is the primary

contractor, ITX is obligated to provide the same services to the other consortium members that it provides to DBH. The contracts are currently being amended to make all HDS members party to the ITX contract. Figure 3.2 shows the relationship among HDS, ITX, and Uni/Care, as well as some of the duties of ITX in relationship to both parties.

**Figure 3.2 ITX Is the Intermediary Between the Consortium and Uni/Care.** The consortium brings most IT questions to ITX, who either deals with the questions themselves or brings them to Uni/Care.



ITX, as the consortium’s IT service provider, works to ensure that Uni/Care and their health information system Pro-Filer meet the data needs of all consortium members. In addition, ITX provides extra services to DBH, acting as their CIO.

### **ITX Media’s Dual Roles Create Potential Conflict of Interest**

The owner of ITX Media is, by many measures, Davis’ CIO, primary IT consultant, and IT goods and services provider. ITX’s multiple roles cause conflict of interest concerns. Davis administration denies there is a problem, as they provide sufficient oversight of their IT operations. We believe that amending the DBH/ITX contract has the potential to alleviate some of the concerns. We also believe that greater internal oversight is necessary.

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**The ITX cost-plus contract authorizes ITX to make purchasing decisions while being paid for the purchases.**

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**The ITX owner is a member of DBH's leadership team.**

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**DBH's use of ITX's owner as their CIO appears to violate their conflict of interest policy.**

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## **There Is Potential for Conflict of Interest Between DBH and ITX**

ITX makes the purchasing decisions for DBH and the consortium. The contract between DBH and ITX requires Davis to reimburse ITX for all “out-of-pocket expenses incurred and paid by ITX in connection with the services provided . . . together with an administrative fee not to exceed five percent.” This agreement not only authorizes ITX to make IT purchases, but also arranges for payment of incidental costs and an administrative fee.

DBH's oversight of these expenses rests with the CIO position. The budget authority and accountability given the CIO is listed in DBH's job description as:

- Cost containment of implementation and consortium costs
- Hardware and software purchases
- Contract budget adherence
- Consulting cost containment to approved budget

This authority is intended to put the CIO in charge of cost containment while still ensuring that DBH has the equipment and knowledge necessary for their data requirements. This position is a member of the Strategic and Leadership Team (SALT Team) for Davis, along with the CEO, the Chief Financial Officer (CFO), legal counsel, and division heads. The SALT Team provides strategic planning.

A variety of sources, including management, organizational charts, DBH staff, and Uni/Care publications identify the ITX owner as the CIO for Davis. The owner of ITX also operates in the CIO position on the SALT Team, and chairs the implementation team charged with managing the day-to-day operations of the organization. Davis staff, including department heads, believe that the ITX owner is charged by DBH management with the duties of CIO.

In contrast, ITX's owner points out that his contract never mentions that title, and despite DBH's decision to call him their CIO, he is merely a contractual employee. This inconsistency has caused additional staff concern with ITX's general role. Davis appears to be violating its policies with this perceived organizational setup. Figure 3.3 shows the DBH's policy regarding conflicts of interest.

**Figure 3.3 DBH Policy Forbids Officers and Employees from Having Conflicting Outside Financial Interests.** DBH may be violating their own policies and procedures in regard to their CIO.

**Equal Opportunity for Contractual Employment Policy**

“No officer, employee, agent representative, or member of any board, committee or council of the agency will have a financial interest in any consulting contract, or have any other conflict of interest.”

**Conflicts of Interest Policy**

“All DBH employees should: . . . not hold investments or any other direct or indirect financial interest in the business of a supplier or client of DBH, or in any enterprise to which financing accommodations are, or may be extended to DBH.”

While ITX’s primary status as a contractor is not a technical violation of DBH’s conflict of interest policy or DBH’s policy to respect the rights of its employees to have outside employment, provided that “such activities do not impair or interfere with the conscientious performance of DBH duties,” it does violate the policies’ intent. A contractor functioning as an integral part of the organization, filling an organizational title, should be held to the same level as an employee.

Of the five consortium members, three do not have a distinct CIO position, but charge other members of management with making the ultimate decisions regarding IT needs. Both Davis and Central Utah Counseling Center have a separate CIO position, with Central’s management making ultimate IT decisions on their CIO’s recommendations. Most members have an IT specialist, but that position has little to no oversight of the IT purchasing practices aside from purchasing individual desktop equipment.

The contract between DBH and the other consortium members requires Davis, as the lead contracting party, to “negotiate terms and conditions of procurement with computer software, hardware and service providers.” ITX is one of the service providers DBH is required to negotiate with on behalf of HDS. If ITX is represented on both sides of the negotiation, in their role on the SALT Team, Davis has failed to provide appropriate oversight for themselves and for HDS as a whole.

**Davis is charged with negotiating the terms of IT contracts for the consortium.**

Despite Davis' lack of oversight, it appears that HDS has some control of the budget. Currently, the consortium members' business managers meet once a month, and ITX presents what they want to do and what equipment will be necessary to do so. This budget proposal is then discussed and rejected or accepted, based on the service levels the consortium wants to meet. Before 2006, the DBH Board alone approved the ITX budget. These reviews provide some oversight by the consortium of ITX's purchases.

**Proposed Contract Amendments  
May Clarify ITX's Role**

DBH and HDS are currently in the process of amending their respective contracts with ITX. These contract amendments have the potential to clarify and limit ITX Media's role in the purchase of equipment. There are four main parts to these amendments. Figure 3.4 details these amendments and their potential effect on organizational concerns.

**Contract amendments could limit ITX's role in purchasing.**

**Figure 3.4 Amendments in the Contract Between DBH, HDS and ITX Have the Potential to Alleviate Concerns.** By making the following changes to the contract, the parties intend to make budgeting more predictable and eliminate concerns of conflict of interest.

Proposed Amendment	Intended Effect
Separate the contract between DBH and ITX and the contract between HDS and ITX	<ul style="list-style-type: none"> <li>• Allows all parties to be satisfied with their own service levels</li> <li>• Clarifies the ITX owner's responsibilities as CIO</li> </ul>
Payment to ITX changes from base fee and expenses plus 5% to a per-user fee	<ul style="list-style-type: none"> <li>• Eliminates conflict of interest concern as purchases will be made for ITX, not DBH or HDS</li> <li>• Reduces need for documentation of purchases</li> <li>• Allows reliable budgeting</li> </ul>
Establish service levels to evaluate ITX Media's performance	<ul style="list-style-type: none"> <li>• Allows DBH/HDS to monitor service levels</li> <li>• Provides a measure of what is being done for the money expended</li> </ul>
Make all consortium members party to the contract with ITX	<ul style="list-style-type: none"> <li>• Eliminates some of DBH's responsibility</li> </ul>

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**Per-user fees would eliminate the incentive to purchase unnecessary equipment.**

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The change to a per-user fee and the separation of the DBH/ITX contract from the HDS/ITX contract could reduce the potential conflict of interest. By making all consortium members party to the contract, responsibility for oversight control rests with all members, not just DBH.

The per-user fees mean that instead of ITX purchasing the equipment on behalf of HDS and being reimbursed, ITX will purchase and own the equipment used by the consortium members at their discretion, in order to meet performance standards. This will eliminate the incentive for ITX to recommend the purchase of equipment not truly needed. Under the existing contract, this risk of excess purchases has been aggravated by lax requirements for documentation of purchases by ITX on behalf of DBH and the consortium.

## **Documentation Requirements are Lacking**

There have been questions about the level of documentation that should be required of ITX for the purchase of equipment under the cost-plus aspect of the contract. Initially, ITX provided no documentation for equipment purchases and reimbursements. The equipment is purchased by ITX, then the consortium reimburses the amount spent, plus a five percent administrative fee. The lack of controls over this process may violate various state, county, and DBH policies. While documentation levels have improved, there are continuing concerns that it is still not enough. The proposed contract amendments reduce the need for documentation, as the equipment will be owned by ITX. Some documentation of cost will still be needed to justify the negotiated user-based fee.

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**Document levels have improved but are still not sufficient.**

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### **There Is No Agreement on the Level of Documentation Required**

The current contract between DBH and ITX does not specify the level of purchase documentation required. Because of this, there have been disagreements between some of Davis' management and ITX. The previous CFO objected to the thin level of documentation provided by ITX in regard to their reimbursed purchases. Due to the dispute about how much documentation should be required, the CFO resigned. He

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**The amount of purchase documentation has continually increased.**

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refused to sign the reimbursement without greater evidence supporting the purchases.

The only contractual limit on purchases is that “prior to incurring any out-of-pocket expenses in excess of the Annual Budget, ITX shall first obtain the advance written approval of DBH.” Because of this requirement, ITX Media is not required to give the detail normally required for state purchasing. The amount of documentation on purchases has continually increased to now include packaging lists, travel receipts, lists of purchased equipment, and, beginning in July 2007, the invoices sent by companies from which equipment was purchased.

### **Undocumented Procurement Violates Various Policies**

Despite not violating the contract, the low level of documentation required by the contract may violate various policies, including state, county, and DBH policy. Figure 3.5 lists the policies that appear to have been violated by this arrangement.

**Figure 3.5 DBH's Lack of Documentation Requirements May Violate Various Policies.** All of the following entities also have requirements for increased documentation and number of bids when the cost of the purchase is greater.

**Utah Administrative Code R33-4**

“Specifications shall be drafted with the objective of clearly describing the purchasing agency’s requirements and of encouraging competition. The purpose of a specification is to serve as a basis for obtaining a supply, service, or construction item adequate and suitable for the purchasing agency’s needs in a cost effective manner. . . . Specifications and any written determination or other document generated or used in the development of a specification shall be available for public inspection.”

**Davis County Procurement Policy**

“Purchase orders are used to encumber budgets for most goods or services. . . . When the goods or services have been satisfactorily received and appropriate property information recorded, the department signs the payment authorization copy of the purchase order, attaches the appropriate invoices, and sends them to the Clerk/Auditor’s office as approved to pay.”

**DBH Procurement Policy**

“The Chief Procurement Officer is responsible for the purchasing of all goods and services by DBH“. In an attempt to document these purchases, “vendor invoices, along with delivery receipts and other proof-of-purchase documentation are to be submitted and matched to the original approval form . . . and sent to the accounting department for payment.”

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**A lack of documentation weakens DBH’s controls.**

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The current contract between Davis and HDS members designates DBH as the “lead contracting party to obtain the goods and services which the parties desire to procure collectively” and requires “that amount which DBH shall assess to each Member shall be shown on statements enumerating: a) the software, hardware, technical support or other services provided; b) the name of the contracting party with DBH; and c) the date that payment is due.” The lack of control Davis has demonstrated weakens the controls of HDS over what is purchased and the amount paid for these purchases.



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**If amendments are signed, further equipment purchases will be made by ITX.**

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### **Contract Amendments Will Reduce the Need for Documentation**

If the contract is amended as proposed, it will reduce the need for cost documentation at the time of purchase and will streamline the approval process. The CFO for Davis explained that when the contract is operated on a fee-per-user/performance standard basis, it will be more like a utility company. It will be up to ITX to decide what equipment they need to purchase in order to meet the performance standards. The equipment will belong to ITX; therefore, there will be no need to provide reimbursement documentation as purchases are made. There will, however, be a need for documentation of costs during rate-setting negotiations.

### **Consortium Members Are Satisfied with Service Despite Contract Flaws**

DBH and the other consortium members are all satisfied to some degree with the services of ITX Media and the resulting products. This is despite paying more, on average, than other CMHCs and oversight bodies' criticisms of the method by which DBH, and by extension, the consortium, acquired the contract with ITX. Specifically, these entities were concerned with the lack of a Request For Proposal (RFP) before contracting with ITX for service provision. There is some dispute within DBH over whether policy was actually broken. It is hoped that the proposed contract amendments will reduce some of the existing concerns.

### **Consortium Members Are Satisfied with ITX's Performance**

When asked, the CEOs of the consortium members were all satisfied with the service provided to them by ITX. A member stated they are too small to be able to afford individual service that would be comparable to what they are getting through ITX. DBH is also satisfied with the services of ITX.

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**Consortium members feel they are getting the most affordable service.**

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The consortium conducted a survey of the community behavioral centers of Utah and found that their IT costs were generally higher than the costs for other non-consortium centers. The proposed contract amendments will further increase the cost gap for Davis. Figure 3.6 shows the results of the consortium's statewide survey.

**Figure 3.6 Consortium Survey Shows Members' IT Costs Are Higher than the Rest of the State.** Both the cost per-user and the percent of total expenses for HDS members are higher on average than non-consortium members costs.

Utah CMHC	Cost Per User	Percent of Total Expenses
<b>Consortium Members</b>		
Northeastern	\$ 5,305	5.1%
Central	5,137	5.7
San Juan	4,939	5.6
Davis	3,741	5.7
Southwest	2,742	5.4
<b>Average</b>	<b>4,373</b>	<b>5.5</b>
<b>Non-Consortium Centers</b>		
Valley	\$ 4,545	4.8%
Weber	5,010	4.9
Bear River	2,637	4.5
Wasatch	2,491	2.1
Four Corners	2,298	3.8
<b>Average</b>	<b>3,396</b>	<b>4.0</b>
<b>State Average</b>	<b>\$ 3,885</b>	<b>4.8%</b>

**HDS members average \$329 more per-year per-user than non-consortium members.**

In comparison to the statewide averages, consortium members pay \$488 more per year per user, and 0.7 percent more for total percent of the budget spent on IT. When comparing the averages of consortium members with averages of non-consortium members, consortium per-user costs are \$977 higher, and percentages of total budget are 1.5 percent higher. The measure of per-user fees is concerning because the definition of a user can vary according to which center is responding. Davis' CFO said that he finds the amount they are spending above average acceptable because they believe they receive a high level of service.

The higher cost does not appear to be explained by a corresponding increase in quality of resulting data. The Division states that while the

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**ITX contract  
amendments are still  
in negotiation.**

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consortium IT system has been steadily improving, its data has been adequate, and comparable to the rest of the state.

There is currently an effort in process to amend the consortium's ITX contract. The proposed amendments are intended to equalize costs between consortium members by switching fee allocation from a percentage basis to a per-user basis. The proposed amendment, supported by DBH, sets the fee for all consortium member organizations at \$160 per user per month. DBH is hoping that the amendment will decrease its fees by as much as \$8,000 per month. The change could also increase the fees paid by the other members. Negotiations are currently in process.

### **The Acquisition of the ITX Media Contract Has Been Faulted**

Multiple sources have criticized the method under which the contract with ITX was procured. A 2003 audit done by the Legislative Auditor General (ULAG), a 2006 audit by the State Division of Substance Abuse and Mental Health (the division or DSAMH), and a follow-up audit all pointed out the flaws in the contract formation. Concern with the cost of IT has been noted by Davis County officials. Figure 3.7 describes what each entity said about this contract procurement.

**Figure 3.7 Two Entities Criticized the Method Under Which DBH Acquired the ITX Contract.** The entities agree that an RFP should have been used in the process.

**2003 ULAG Audit of Utah’s Local Mental Health System**

“One troubling procurement involved hiring a computer consultant who was known to an mental health center (MHC) board member without a competitive procurement process. We found no evidence that an RFP was sent out. . . . it remains clear that the process does not meet the requirements of a publicly announced, competitive procurement.”

**2006 State Division of Substance Abuse and Mental Health Audit**

“Procurement policy was not followed in the awarding of one contract. . . . Even after disclosing this significant deficiency, no action was taken to correct the problem. Consideration should have been given to terminate the contract and then follow proper procurement procedures to ensure the best use of public funds for these requested services.”

The two resulting recommendations were that DBH “ensure state and/or DBH guidelines are adhered to when creating contracts,” and “perform a detailed review on ITX Media and the services it provides.”

**2007 State Division of Substance Abuse and Mental Health Follow-up Audit**

“The report listed two separate recommendations regarding this finding. While DBH adequately responded to the first recommendation listed, no response was provided as to the course of action DBH will take to sufficiently address the second recommendation. We feel this recommendation is an important element in providing both Davis County and DSAMH reasonable assurance that funds are being used appropriately.”

DBH administration sent a letter to the division in the course of the 2003 ULAG audit from the chief procurement officer stating, “It has come to my attention that Davis Behavioral Health, in the process of contracting with ITX Media, did not follow all of the procurement rules to enter into this contract.” It then goes on to express that, despite this, it is in the best interest of DBH and the consortium to continue the contract. Later, the opinion of DBH changed, with the CEO stating that because ITX responded to two RFPs before they were contracted, DBH considered those RFPs still in force. This statement directly contradicts the findings of the 2003 audit, which were not contested by DBH, that no RFP for an IT contract exists.

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**The contract allows ITX to decline to extend the contract, but not DBH.**

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While the division audit recommends that Davis consider rebidding the contract, it appears that they cannot end their relationship with ITX until September 2014. It was entered into in September 2003 for an initial period of five years, with ITX having the option for two renewals for three years each. The State IT Department said that this provision in an IT service provider contract is not normal, but it is not unheard of. They also noted that the terms of this contract are not in favor of DBH, but ITX.

### **Flawed Initial Contract Is Being Amended**

This initial contract, while flawed, is being amended. As previously mentioned, the amendments will accomplish three things: 1) elimination of “cost plus” and conversion to a per-user fee, 2) establishment of service levels for ITX’s performance, and 3) making all consortium members a party to the contract. In addition, the ITX owner’s duties will be separated between the consortium and DBH. It is hoped that these amendments will reduce some of the concerns brought on by DBH’s initial failure to follow their own policy, as well as state policy, in procuring the ITX contract. We also recommend contract amendments be included to allow Davis, along with ITX, to decide whether they will renew the ITX contract.

### **Recommendations**

1. We recommend that DBH either appropriately fill its CIO position, or empower a DBH employee or member of management with oversight of IT activities.
2. We recommend that DBH further study the costs caused by the proposed contract amendments and decide whether the expense is justified.
3. We recommend that if the proposed amendments are not signed, the contract be amended to require appropriate documentation.
4. We recommend DBH strengthen and follow its procurement policy for both new and renewal contracts.

## **Chapter IV**

# **Implementing an Integrated IT System Has Been Difficult**

Nationally, health care providers are moving toward electronic information systems integrating both billing and clinical information. Davis Behavioral Health's (DBH or Davis) IT integration process follows that national trend and has been slow to implement and gain acceptance. The integration process is not easy, with most organizations, including DBH, encountering user-acceptance, training, and error problems. Initial selection and start-up problems fueled staff's hesitance to accept the unfamiliar system. Development has also been hampered by documentation and training problems. It appears that the system is now gaining acceptance as problems are being resolved.

### **The Pro-Filer System Has Improved**

In January 1999, DBH began the process of selecting an electronic health record (EHR) that would integrate its billing and clinical electronic records. A committee of employees and users was charged with choosing a system. DBH management rejected the committee's selection and directed different staff to continue the search. They explored multiple software possibilities that were not chosen. After several false starts, DBH contracted with ITX Media to help the committee choose a system. Through a committee ranking system, they chose the Pro-Filer software through Uni/Care, the provider. ITX stated that while Pro-Filer is not the system they would have chosen, it has worked out all right. Figure 4.1 is a time line of the deployment of Pro-Filer.

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**DBH had several IT false starts before Pro-Filer was chosen.**

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**Figure 4.1 The Pro-Filer Project at Davis Began in 2002.** Improving the existing system will be an ongoing process.

August 2002	Pro-Filer selected by the committee
November 2002	Uni/Care software installed on the DBH server
May 2004	Pro-Filer “goes live” (begins to be in operation)
October 2004	Phase I (Administrative operation) of Pro-Filer rollout in progress
August 2005	Phase II (Clinical operation) of Pro-Filer rollout in progress
2005	Centerwide Pro-Filer training begins
November 2007	Rollout of screening and assessment tool, the final aspect of Phase II

The process comprises at least a five-year effort, with the “go live” date occurring approximately two years after purchase of the system. This does not appear to be out of line with other agencies. A National Council for Community Behavioral Healthcare (NCCBH) publication states:

For Center for Behavioral Health, the implementation and training started about a year and a half prior to the “go live” date; for Heritage Behavioral Health, it took significantly longer, in part because of the extensive re-engineering. . . . A caveat for CEOs: driving an implementation too fast is arguably more dangerous than taking too long.

As a result of the process discussed above, DBH now has an operable system, which includes both billing and clinical components. This five-year roll-out has been difficult and trying for staff. Current nationwide trends for electronic health records show that the industry, on the whole, has been slow to accept change.

A 2005 U.S. Government Accountability Office (GAO) study of electronic health records in the healthcare industry as a whole, states:

Respondents to two recent surveys reported that only 31 percent of physician group practices and 19 percent of hospitals use fully operational EHRs. . . . Approximately 13 percent of solo

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**DBH’s IT system is operable in both billing and clinical records.**

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**Community behavioral health providers have a low rate of EHR implementation.**

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physicians have adopted some form of EHR, while 57 percent of large group practices . . . have adopted an EHR.

The statistics for community behavioral health providers appear to be even lower. An NCCBH publication on EHRs states:

A September 2006 . . . poll of community behavioral health providers across the country indicates that just under eight percent have implemented the EHR with clinical components fully functioning, while 32 percent have implemented the EHR with billing components in place. Another 11 percent of providers are in the process of installing an EHR.

### **Staff IT System Dissatisfaction is Decreasing**

The Pro-Filer system was rolled out using an unfamiliar appearance and operation called the tree format, and staff members disliked the number of mouse clicks necessary to get to a given screen. The tree system has now been replaced with a more familiar, windows-based platform, and ease of use is improving along with this change. Some DBH staff have been dissatisfied with both the Pro-Filer system and the use of computers in a clinical environment. Other staff members recognized the need for change but question the process of change selected by their management.

### **The Initially Difficult Platform of Pro-Filer Is Being Modified**

The appearance and operation of the Pro-Filer system was different from the button-based windows format that most people are used to. The tree format that Pro-Filer initially used required a separate mouse click for every area of increasing detail, as opposed to the windows format, where one click takes you directly to the specific screen. The tree format required excess time and effort to get to the desired screen, thus causing staff to be dissatisfied with the system as a whole.

This tree format has been continually modified from the initial rollout of Pro-Filer to more closely resemble the more familiar windows format. The main improvement is the addition of an initial screen called

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**The initial appearance and operation of Pro-Filer was difficult for staff.**

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**While Pro-Filer is improving, staff feel it has taken too long.**

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Navigator, which provides direct buttons for the screens clinicians need and use most. Each clinician's Navigator screen shows only the buttons for the tasks they specifically desire. This new screen, in addition to increased familiarity with the system, has been noted by trainers and staff of DBH and the Health Data System (HDS or consortium) as improving the ease of use. While some staff say that this improvement has taken too long, it is generally agreed that the ease of use of Pro-Filer is improving.

Other computer-savvy staff complain that while Pro-Filer is improving, there really was no need to wait for these improvements. These employees note that there were other software options available but not accepted as an option at the time of Pro-Filer's purchase.

DBH management states that when advertising for a system they had asked for a tree format, not realizing exactly what that entailed. The CEO said that since they had never started an IT program before, they did not know exactly what they were looking for, and so they have had to work with what they got. They have attempted to make the modifications necessary to reform the system in a more user-friendly way. Davis' CEO also stated that at this point in their progression, she would never ask staff to start over and learn a new program.

It has not been uncommon for community behavioral health centers to struggle with standards and requirements for IT systems. An NCCBH study pointed out that "regardless of the due diligence conducted during the evaluation phase, the project team is likely to discover that there were some misperceptions about the capabilities of the products selected." This appears to be what occurred at DBH.

### **Resistance to Platform Has Diminished**

On the whole, staff system satisfaction seems to be improving as the system evolves. Despite this, staff have been resistant to change processes they know, which increases difficulty of use. When changes are made to improve the programs, some of the staff use the changes, and some stick with the old way they already know, or mix the two methods. Because of this, the programs get increasingly difficult, and for some, satisfaction goes down.

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**System changes are not always accepted by staff.**

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**Staff resistance is a problem nationwide.**

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**The division IT specialist hears complaints about IT throughout the state.**

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This resistance to change applies not only to changes made to Pro-Filer, but also to the computer system as a whole. Some clinicians have voiced the concern that computers should not have a place in the clinical environment. Their concern is that it creates a barrier between the clinician and the patient. Although this is a concern, one of the trainers believes that as soon as the new clinical records screening tool has been around for enough time for clinicians to get used to it, this concern will not be an issue, as has happened for other IT applications.

According to the NCCBH, most software implementations are difficult, but vital. An NCCBH newsletter devoted to EHR states, “Staff resistance is one of the most difficult aspects of EHR implementation and should be considered every step of the way.” This staff resistance is generally acknowledged. Later in the newsletter, NCCBH states:

We know of some organizations that are on their second implementation of an EHR and are still not successful—the problems are not related to the vendor but to the leadership of the organization. Staff resistance that is not dealt with effectively will extend the implementation process.

These reports acknowledge that the way to overcome staff resistance is to continue on the course. The IT specialist for the state Division of Substance Abuse and Mental Health (the division or DSAMH) said that she hears consistent complaints about IT systems throughout the state, but this will always be the case. In her opinion, clinicians like to have their hard-copy charts, and so the biggest reason that IT systems fail is because it is very difficult to manage staff reactions.

NCCBH advises that “the cultural change and its effect on clinicians was enormous, but was quickly overcome, mostly because there was no choice. . . . ‘Include them, train them, support them, but don’t give them any choice.’” While it appears DBH clinicians have had no choice in the use of this program, training methods need improvement.

## **Pro-Filer Training and Operating Documentation Need Improvement**

Despite the complicated nature of Pro-Filer, staff are not provided with a continually updated training manual. Also, when staff are trained,

they are provided with individually created staff cheat sheets, but these are neither updated when changes are made, nor organized in a usable fashion. Frequent changes are made to the Pro-Filer system but not adequately documented or communicated to all staff. This makes the training process inconsistent and less effective.

### **Systemwide Training Manual Is Not Given to Staff**

Consistent training is vital for new staff. Before staff members are given personal access to Pro-Filer, they go through initial training. There is some concern that this training varies in both extent and content. The new staff training covers proper use of the system to address the basic information areas that must be completed for each client. Training does not follow a particular order and takes approximately one hour.

After this hour of new staff training, staff are permitted to use the Pro-Filer system. There is no staff training/reference manual given to staff, although the trainer has been tasked with preparing one this year. Instead of receiving a training manual, staff are given a collection of “cheat sheets” that have been created by other staff members and explain how to do specific tasks. There is no order to these cheat sheets, and there is no way to update them with changes in Pro-Filer, as everyone may have different collections of sheets.

An NCCBH publication states “train early, train during, and train after—training never stops.” Staff must be trained on the most updated system operation. A CEO contributing to an NCCBH publication added that at his center, “all employees had to pass a competency exam on the test database before they would be given a log-on to the real database. . . . The reality is that you can’t have part of your staff using an EHR and the other half doing something else.” DBH needs to make both initial and continuing training coherent and consistent, so Pro-Filer data entry can be coherent and consistent.

### **Documentation Regarding Pro-Filer Is Inconsistent**

Because of the continually evolving nature of Pro-Filer, it is vital that changes made in the operation of the system are adequately communicated to staff. While DBH believes they have a method for communicating these changes, this method does not effectively reach all

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**Staff training varies in both extent and content.**

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**NCCBH advises, “Train early, train during, and train after—training never stops.”**

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staff. Figure 4.2 shows the process in place to disseminate IT process changes.

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**Figure 4.2 Multiple Avenues Are Used to Inform Staff of System Changes.** None of these methods of communication occur in a staff-wide setting.

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ITX designs/becomes proficient at the new process.

ITX trains one or both of DBH's staff trainers.

DBH staff trainers train the team leaders/supervisors.

Team leaders/supervisors train the staff as a whole.

The Clinical Director sends out screen shot emails detailing the old way and then the new method.

One training manual per center is updated with the changes.

An occasional newsletter is sent out by ITX, which includes details on the changes.

While these steps are an attempt to get the Pro-Filer changes out to the staff, there is no mechanism which documents the system changes, and no system to ensure that all staff are trained. The use of email disseminates the information, but it does not show if the intended message is appropriately received, nor does it aid in training the appropriate user. Staff told us that training emails are deleted without being read.

A goal of the staff trainer this year is to begin a program under which there are mandatory staff meetings at each of DBH's separate centers to refresh training on selected Pro-Filer functions. For the trainer, this represents a better setting to train all center staff at once on IT system changes. This level of communication assures that all staff are given consistent levels of training.

## **Data Quality Assessments Have Been Mixed**

Officers at the Division of Health Care Financing in the Department of Health have expressed concern with some of the encounter data that comes from DBH's Pro-Filer system. In addition, employees and

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**A new training goal is to refresh IT training at staff meetings.**

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supervisors at Davis have expressed concern that the data may not be accurate. In contrast, DSAMH states that client data from DBH and the rest of the HDS Consortium is comparable in quality to data from the rest of the state centers.

### **Some Parties Express Concern With the Quality of Pro-Filer Data**

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**Officers in the Department of Health Care Financing in the Department of Health expressed concern with the quality of some DBH data.**

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Officers in the Division of Health Care Financing in the Department of Health expressed concern with some encounter data that comes from Davis to set Medicaid rates. According to the reimbursement officer, many data items DBH submits have been rejected, such as the number of hospital admissions. Frequently, Davis cannot match the data that was sent in, and sometimes the numbers are out of the realm of possibility.

ITX responded to these concerns by saying that they and Uni/Care are going through a learning curve in state reporting requirements. He also said that they are improving, but part of the problem is that Davis cannot see the numbers in the system before they are submitted. ITX is working on that problem, which will make reporting much more accurate.

In addition to this criticism from outside the organization, staff at DBH have criticized Pro-Filer data. Some concerns, aside from the difficulty of use, appear to be misunderstandings about definitions and uses of various system fields within the Pro-Filer program. Another concern is that it is difficult to get reports and information out of Pro-Filer after data has been entered.

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**DBH staff do not have confidence in Pro-Filer data.**

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Davis responds that they believe the data is improving, and in the past, the data coming out is only as good as the data going in. In order to improve the quality of the data entered, they run reports, both as an organization and individually, to point out errors. After an organizational report is run, it is determined where the error originates, and those errors are sent back to that party to fix the problem. DBH has also begun weekly meetings at which both clinicians and the billing department are represented. At these meetings, they attempt to settle differences and figure out how to record and bill for services more seamlessly and with fewer errors.

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**The division says DBH data is comparable to the rest of the state, but no better.**

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### **The Division Says Pro-Filer Data Quality Is Comparable**

DSAMH reports that the quality of data from DBH and the rest of the consortium is comparable to that from other centers, but no better. This is an improvement from March 2002, when the division requested a corrective action plan regarding their data submission because of the poor quality of data. DBH responded that they would have an EHR in place by summer 2002. They were able to install the system by November 2002 but were not able to use it until 2004. The IT programmer for the division said that, currently, the data is good. She also said that the systems across the state are all different, but they are of good quality.

### **Recommendations**

1. We recommend that DBH have an open discussion with staff regarding their difficulties/suggestions for the improvement of Pro-Filer.
2. We recommend that DBH assess Pro-Filer's staff training program to identify areas needing improvement.
3. We recommend that DBH create, disseminate, and maintain a Pro-Filer training manual for all staff members.
4. We recommend DBH clearly communicate to staff the changes made to Pro-Filer as well as the reason for the changes.
5. We recommend that DBH work with its oversight agencies to remedy Pro-Filer data concerns.

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## **Appendices**



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# **Appendix A**

## **Affiliated Entities' Formation Details**

### **DBH Holding Company**

*Type of Corporation:* A new, nonprofit, tax-exempt corporation.

*Purpose:* To promote behavioral health treatment and recovery services, through the work of its subsidiaries: DEO, Daybreak, DBH, and the Foundation.

*Governance:* The board of directors that currently exists for DBH.

*Initial Funding Source:* Private funds received by DBH through a donation or loan to the Holding Company and/or loans of public funds from DBH.

*Ongoing Funding:* From donations to the Holding Company or the Foundation or profits from Daybreak.

### **Diversified Employment Services (DEO)** **(Initially named Recovery Works)**

*Type of Corporation:* A new, nonprofit, tax-exempt corporation.

*Purpose:* To promote recovery through employment of individuals with Serious and Persistent Mental Illness (SPMI) in a work environment that also employs non-SPMI workers and has a management structure that has specialized training in supervising workers with SPMI. DEO would provide employment by starting independent small businesses that provide a product or service to the general public or through special federal government contracts set aside for handicapped employment.

*Governance:* The board of directors, that has some members in common with the current DBH board.

*Initial Funding Source:* Private funds received by DBH through a donation or loan to DEO and/or loans of public funds from DBH.

*Ongoing Funding:* Would be as self-sustaining as possible, generating revenues from the business enterprises or contracts it enters into. Additional funding would be from donations to the Holding Company of the Foundation and/or profits from Daybreak distributed by the Holding Company.

## **Daybreak Behavioral Health (Daybreak)** **(Initially named Francis Peak Family Counseling Center)**

*Type of Corporation:* A new, nonprofit, tax-exempt corporation.

*Purpose:* To provide behavioral health outpatient treatment services to individuals, families, and employee assistance programs that are outside the target population for the community mental health system who have the ability to pay through private insurance or other private sources. (Non-SPMI adults or Seriously Emotionally Disturbed Children (SED)).

*Governance:* An independent board of directors that may include some members of the current DBH board, but the majority of the members would not be DBH board members.

*Initial Funding Source:* Private funds received by DBH, and through the assignment of DBH's employee assistance contracts, and/or loans of public funds from DBH.

*Ongoing Funding:* Daybreak would be self-sustaining, generating revenues from collections for the behavioral health treatment it provides. Excess revenues would be donated to the Holding Company for distribution to DBH or DEO to provide services to unfunded SPMI and SED individuals and their families.

## **Family Well Being Foundation**

*Type of Corporation:* A new, nonprofit, tax-exempt corporation.

*Purpose:* To promote behavioral health treatment and recovery services through the work of its sister corporations: DEO, Daybreak, and DBH.

*Governance:* The board of directors, whose members may have members in common with the current DBH board.

*Initial Funding Source:* Private funds received by DBH and/or loans of public funds from DBH.

*Ongoing Funding:* Direct donations or through fundraising efforts. The donations received would be distributed to DBH or DEO to provide services to unfunded SPMI and SED individuals and their families.

## **Davis Employment Services**

*Type of Corporation:* A new, nonprofit corporation

*Purpose:* To provide payroll and administrative services to the other corporations.

*Governance:*

*Initial Funding Source:*

*Ongoing Funding:* Fees charged to the other corporations.

## Appendix B

**DBH Private Funds Calculation.** DBH calculated that they had \$1.2 million in private funds they could use to fund the new, nonprofit organizations.

Fiscal Year	Fees & Ins	Net Income	Medicaid Capitation Surplus	Private Funds	Dedications
1986	114,600	-1,166		0	-1,166
1987	344,349	242,594		242,594	
1988	317,265	147,660		147,660	
1989	309,687	236,735		236,735	
1990	266,092	-5,382		0	-5,382
1991	272,173	154,777		154,777	
1992	252,171	-36,694		0	-36,694
1993	280,344	394,435		280,344	
1994	324,627	441,641		324,627	
1995	322,452	56,947		56,947	
1996	356,508	970,150	970,150	0	
1997	505,952	374,704	270,088	104,616	
1998	604,320	481,547	176,112	305,435	
1999	552,514	396,764	424,097	0	-27,333
2000	735,035	184,555	8,339	176,216	
2001	518,123	-178,294	356,358	0	-534,652
2002	564,161	808,181	715,570	92,611	
2003	786,165	751,212	1,502,291	0	-751,079
<b>Balances at Start-Up</b>	<b>7,426,538</b>	<b>5,420,366</b>	<b>4,423,005</b>	<b>2,122,562</b>	<b>-1,356,306</b>
2004	727,616	418,014	1,661,979		-1,243,965
2005	703,149	-47,807	-59,844		12,037
2006	1,017,933	566,567	-350,000		916,567
2007	764,482	682,227	181,510	500,717	
<b>Total 2007</b>	<b>10,639,718</b>	<b>7,039,367</b>	<b>5,856,650</b>	<b>2,623,279</b>	<b>-1,671,667</b>
Less coverage for net income loss and Medicaid Surplus			-1,671,667		
Plus Trust			52,102		
Less amount used for coverage of entities			-635,847		
DBH Private Funds as of 6/30/07			\$ 868,584		

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## Appendix C

### Consortium IT Project Expense Details

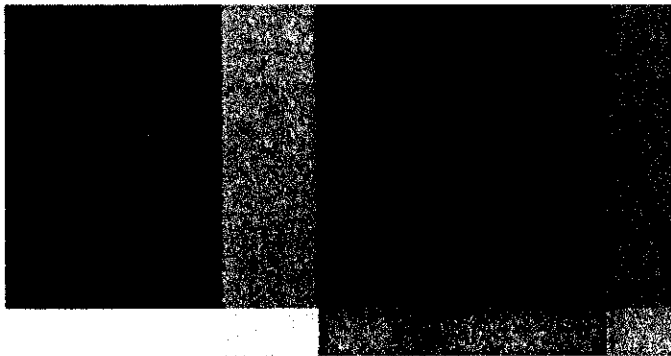
<b>Fiscal Year</b>	<b>Uni/Care Costs</b>	<b>ITX Costs</b>	<b>Other Costs</b>	<b>Total IT Costs</b>
2003	\$ 543,865	\$ 549,571	\$ 37,359	\$ 1,130,796
2004	583,542	412,575	73,080	1,069,198
2005	384,535	618,240	58,541	1,061,316
2006	201,100	757,475	95,028	1,053,603
2007	125,173	935,745	5,909	1,066,828
<b>Average</b>	<b>\$ 367,643</b>	<b>\$ 654,722</b>	<b>\$ 53,983</b>	<b>\$ 1,076,348</b>

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## **Agency Response**

Note: The entire response, including exhibits, is available by request at the Office of the Legislative Auditor General





Response of  
**DAVIS BEHAVIORAL HEALTH, INC.**

to

**LEGISLATIVE AUDIT REPORT No. 2008-06**

June 11, 2008



June 11, 2008

Mr. John Schaff, CIA  
Office of the Legislative Auditor General  
W315 State Capitol Complex  
Salt Lake City, UT 84114



Dear Mr. Schaff,

This letter is to register the strong objection of the Board of Directors of Davis Behavioral Health, Inc. ("DBH"), to your refusal to permit the Board to see a copy of Legislative Audit Report No. 2008-06 (the "Report"), which makes findings and recommendations regarding decisions of the Board and actions taken by management pursuant to those decisions. Although you have asked DBH to prepare a formal response to the Report, your audit manager, Tim Osterstock, informs us that we cannot see a copy of the Report, even though Utah law specifies that "all corporate powers shall be exercised by or under the authority of, and the business and affairs of the nonprofit corporation managed under the direction of, the board of directors." (Section 16-6a-801, Utah Code Annotated). Mr. Osterstock cites you as the source of that prohibition.

We know of no way that we can discharge our duties to the corporation whose affairs we have been elected to govern if you require that we be kept in the dark regarding the findings and recommendations to which you have asked DBH to respond. Furthermore, we can see no legitimate reason why DBH management must go on the record in response to the Report without the guidance and direction of the body that is legally responsible for such direction. Although as a matter of principle we would be inclined to withhold a response to the Report until the Board has had an opportunity to read it and to participate in preparation of the response. We are informed that Mr. Osterstock has said that the Report will go to press on June 11, and that if no response is received by that date, the Report will reflect that DBH did not reply to the findings. Unfortunately, this could be interpreted by some to constitute a tacit admission by DBH of the allegations contained in the Report.

Therefore, we have reluctantly authorized the CEO of DBH to present a response in the preparation of which the Board has had no participation. The Board reserves the right to file a supplemental response once the Report has been released and we have had an opportunity to review it. In the meantime, we would appreciate the courtesy of a personal response from you explaining your decision not to allow the Board access to the Report.

Very truly yours,

  
Dr. James O. Mason, Chairman  
DBH Board of Directors

cc Sen. John Valentine

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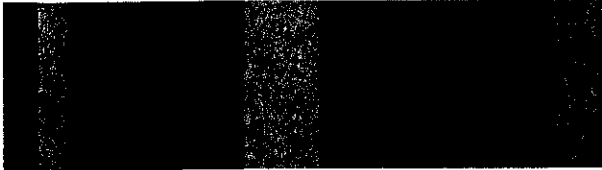
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## INTRODUCTION

The management of Davis Behavioral Health, Inc. ("DBH") has carefully reviewed the findings and recommendations of Legislative Audit Report No. 2008-06 (the "Report"), which is a product of the audit that began in June, 2007. The Report focuses on three subjects: (1) the affiliated non-profit corporations formed in 2004 to support the mission of DBH; (2) a computer services contract entered into by DBH in 2003 on behalf of a consortium of Utah community mental health and substance abuse treatment centers; and (3) the implementation of the electronic medical records and billing system that is the product of the computer services contract.

DBH accepts the recommendations of the Report and has begun implementing them. In general, we believe the recommendations will be helpful as we seek to improve our organization and its services. The audit team members spent considerable time at our facilities and among our staff. Their third-party viewpoint of our operations is a useful complement to our ongoing efforts to review and fine-tune our operations. As with any such third-party effort, the report is still a view from outside. Consequently, there exists the likelihood that some level of misunderstanding will inevitably occur due to the outsider's lack of direct participation in the establishment of company policy or in the execution of day-to-day implementation of directives.

DBH has no significant disagreement with the findings and narrative contained in Chapters I, III and IV of the Report, which are well-reasoned and clearly stated. However, Chapter II, which criticizes the formation and operation of sister non-profit corporations that provided supportive employment to DBH clients with disabilities, mental health services to those who were not eligible for Medicaid, and fundraising support for DBH's charitable activities, is troubling for several reasons:

1. The over-riding criticism of the auditors is that the affiliated non-profit charities did not make a profit, and that DBH used a portion of its private fund reserves to support the formation and operation of these entities. We believe that the use of private reserves to fund mental health services and evidenced-based recovery programs is appropriate and consistent with the charitable mission of DBH.
2. Financial and other information contained in this Chapter is inaccurate.
3. The Report discusses the alleged cost of the affiliated entities, but is largely silent on the benefits generated by those expenditures. It ignores the fact that the two non-profit entities focused on in Chapter II, Diversified Employment Opportunities, Inc., and Daybreak Behavioral Healthcare, provided significant clinical and support services to their clients. These services were provided using evidence-based practices at a reasonable cost, and produced high consumer satisfaction.

4. The standards used for evaluating the affiliated entities are not stated. Unlike the authorities cited in Chapter IV of the Report, there are no references to national behavioral health organizations, best practices or industry standards.
5. The findings in Chapter II are not supported by the quality of evidence customary for audit reports. Much of the "evidence" is anecdotal, consisting of opinions and statements of unnamed staff members or officials that are inconsistent with contemporaneous documents and other credible evidence that suggest a different conclusion.
6. Many of the comments in Chapter II are to the effect that DBH or its affiliates could have used a different structure, model or practice in the activities they conducted. To say that something *could* have been done differently is not a particularly helpful observation. A more meaningful conclusion is that it *should* have been done differently, which conclusion is customarily supported by credible evidence and the weight of authority. Unfortunately, some of the ways in which the auditors said things *could* have been done would constitute Medicaid fraud. Other suggestions would result in much higher costs to state and county government while producing less favorable outcomes.
7. Finally, Chapter II of the Report largely ignores the regulatory and funding environment in which DBH's board of directors and management made decisions relating to the creation and operation of the affiliated non-profit corporations. The correctness of a decision to choose action over inaction, to address new challenges in a particular way instead of continuing the status quo, can only be properly evaluated in light of the context of the time, and of the information available to the decision-makers at the time the decisions were made. DBH's Response to the Audit Report, below, begins with a discussion of that context and environment.

DBH recognizes that evaluating a mental health and substance abuse service provider as it tries to keep pace with clinical advances in today's complex funding and regulatory environment can be challenging. The advantages of an outsider's perspective in the audit process are inevitably accompanied by the disadvantages of limited familiarity with the clinical subject matter and the regulatory environment in which decisions were made. We at DBH appreciate the opportunity to clarify and provide proper context to matters addressed. To this end DBH has prepared the attached response in an effort to clarify facts and circumstances that it believes have been inaccurately represented in Chapter II of the Report.

Respectfully submitted,



Maureen Womack, CEO

## DBH'S RESPONSE TO CHAPTER II OF THE AUDIT REPORT

On June 18, 2001, President George W. Bush signed an Executive Order promoting community-based alternatives -- rather than institutions -- for individuals with disabilities. This Executive Order directed key federal agencies to work closely with states to ensure full compliance with the Supreme Court's ruling in the case of *Olmstead v. L.C.*, 527 U.S. 591 (1999), and the Americans with Disabilities Act. In the *Olmstead* case, the United State Supreme Court ruled that Title II of the Americans with Disabilities Act requires states, whenever possible, to place qualified individuals with mental disabilities in community settings rather than in institutions. The Supreme Court called on the states to develop "comprehensive, effectively working plans" to provide services to individuals with disabilities in the most integrated settings possible.

On April 29, 2002, President Bush announced the appointment of the New Freedom Commission on Mental Health, and charged the commission "to study the mental health service delivery system, and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities." The Commission's twenty-one members had broad experience in relevant fields, including medicine, private and public mental health services, higher education, public health policy, governmental regulation, the legislative branch and the judiciary.

The New Freedom Commission on Mental Health presented its report to the President on July 22, 2003 with the following comment:

After a year of study, and after reviewing research and testimony, the Commission finds that recovery from mental illness is now a real possibility. The promise of the New Freedom Initiative—a life in the community for everyone—can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

The time has long passed for yet another piecemeal approach to mental health reform. Instead, the Commission recommends a fundamental transformation of the Nation's approach to mental health care. This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life's challenges. Too often, today's system simply manages symptoms and accepts long-term disability. Building on the principles of the New Freedom Initiative, the recommendations we propose can improve the lives of millions of our fellow citizens now living with mental illnesses. The benefits will be felt across America in families, communities, schools, and workplaces.

The Commission's report noted that, while mental illness is estimated to cost society \$78 billion dollars a year (most of it in lost productivity), access to mental health care is complicated by limited private insurance coverage, as well as public services and funding that are fragmented among multiple programs with disparate objectives and requirements. The report noted that "too many of those funding streams are tightly restricted in how they can be used and for whom."

Among the report's recommendations for facilitating the integration of those recovering from mental illness into the community are housing and employment programs. The report urges promotion of evidence-based practices such as supported employment "rather than pay for ineffective day treatment programs that do not support employment." In other words, there are progressive clinical reasons for changing the approach to treating individuals with mental health challenges.

Supportive of the recommendations of the Commission report were guidelines and resources developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the federal government. Beginning in 2003, SAMHSA's Center for Mental Health Services sponsored a nationwide initiative to promote the widespread adoption of six evidence-based practices (EBPs) -- treatments that have consistently proven to generate positive outcomes for adults with serious mental illness -- and published resource kits for implementation of these practices. The six evidenced-based practices were:

- Assertive community treatment
- Illness management and recovery skills
- Standardized pharmacological treatment
- Family psycho-education
- Supported employment
- Integrated treatment for co-occurring mental illnesses and substance use disorders

As community mental health and substance abuse treatment centers throughout the country began to implement the recommendations of the Commission report and the six evidenced-based practices, centers in Utah learned of a major change in Medicaid policy that would dramatically affect their ability to provide services. The Utah Department of Human Services announced that the state could no longer use excess Medicaid funds accumulated through program efficiencies to pay for services other than "medically necessary" services to Medicaid enrollees. Other services, including mental health support services to the indigent and underinsured to help them avoid the need for more intensive and costly treatments, could no longer be paid for with Medicaid funds. To add to the problem, state budgets for mental health services were also being reduced.

These developments were of such concern that the Board of the State Division of Substance Abuse and Mental Health published a white paper outlining the anticipated reductions in funding. The white paper stated that "with a projected loss of **\$7,000,000** as a result of

Medicaid changes, in addition to a **\$7,038,400** cut in state funds, and **\$520,800** in federal funds, the impact is a loss of **\$14,559,200, or an 8.8%** reduction in revenues to the system.” [Emphasis in original] The impact on community health centers was expected to be profound: “Large numbers of clients will be discharged -- as many as a few hundred in some rural mental health centers, many hundreds in some urban centers.” The Division expressed concern about the effects of these cuts on the community. The anticipated cuts in service “present a significant risk to public safety and to the well being of our citizens, our communities and our families.” The white paper goes on to say: “The impact on clients who will no longer be able to access services will be tragic. Impacts could be felt in hospital emergency rooms, primary care doctor’s offices, jails and juvenile detention facilities, families and mostly the clients themselves, who could be relieved of the consequences of mental illness with treatment. Additionally, the use of Medicaid dollars to subsidize contracts with state agencies (Juvenile Justice Services and Child and Family Services) will no longer be possible.” (A copy of the white paper, entitled “White Paper: Current and Emerging Issues in Public Substance Abuse and Mental Health” is attached to this response as Exhibit A.)

As predicted in the white paper, several centers discontinued services to non-Medicaid clients, including many who had been in treatment for years. As the Board of Directors and management of Davis Behavioral Health considered how to meet the new funding challenges, they concluded that there were only two realistic alternatives: (1) downsize its operations by reducing or terminating services to non-Medicaid clients, or (2) create alternative growth opportunities. DBH was cognizant of its charge from the local mental health authority to provide “mental health services to and for all persons, including adults, youth, and children, within Davis County” and did not feel that it should abandon the care of its clients, many of whom had serious mental illnesses. Therefore, the Board determined to develop a plan that would continue the implementation of evidenced-based practices in the care of its clients and seek new opportunities for growth.

As DBH was in the process of implementing the recommendations of SAMHSA and the New Freedom Commission on Mental Health in 2003, the Office of the Legislative Auditor General released Report No. 2003-05, “A Performance Audit of Utah’s Local Mental Health System.” The report criticized one mental health center for engaging in “untraditional practices” that “extend beyond traditional mental health services. ... This involvement raises concerns about the best use of scarce public funds, a determination that should be made by the LMHA [local mental health authority], not its contractor.” The report also stated that “Mental health oversight authorities should set policy on MHC [mental health center] involvement in outside activities and should be more involved in the oversight of such projects.”

In light of the findings of the 2003 audit mentioned above, and in the absence of any policies by state or county oversight bodies concerning activities such as supported employment (one of the evidence-based practices touted by SAMHSA and the New Freedom Commission, but viewed as “untraditional” by the auditors), DBH resolved to include all relevant state and county

government bodies in the development of the plan to establish a supported employment program and seek new opportunities for growth.

As DBH considered the best legal structure for providing clinical services to non-Medicaid clients (including those covered by private health insurance and those treated on a fee-for-service basis) and supported employment services to its clients with disabilities, it retained outside corporate and tax counsel and reviewed how such services were being provided by other non-profit organizations. Several alternatives were discussed over a period of several months, with the Board eventually approving the structure recommended by counsel, which had the following characteristics:

- Three new operating entities would be created: one to operate the supported employment program, another to provide clinical services to non-Medicaid clients, and a third to solicit charitable contributions for DBH and the new affiliates.
- The operating entities would be Utah non-profit corporations. The limited-liability nature of each corporation would help insulate DBH and the affiliated corporations from potential tort liability arising out of the activities of the entities. Using separate entities with separate bank accounts and accounting records would also facilitate the tracking of funds and avoid the commingling of public and private funds.
- The new non-profit corporations would apply for charitable status under Section 501(c)(3) of the Internal Revenue Code. In addition to the tax advantages available to charitable organizations, this would facilitate the distribution of any excess revenues among the affiliated entities, as needed.
- A non-profit holding corporation would be created to govern the new DBH affiliates, and the board of directors of the holding corporation would be identical to that of DBH. This structure was designed to prevent mission drift in the new entities, and to ensure that they were always operated so as to complement and support the mission of DBH.

### **Consultations with State and County Officials**

During the process of formulating the proposed structure and creating the new legal entities, DBH management consulted extensively with county and state regulatory and oversight bodies, including:

- Davis County Commission (the local mental health authority)
- Davis County Attorney's Office
- Davis County Clerk/Auditor
- Division of Health Care Financing of the Utah Department of Health



- Division of Substance Abuse and Mental Health of the Utah Department of Human Services
- Office of the Legislative Auditor General

These bodies were provided detailed information about the purposes of the new entities, their legal structure and the proposed sources of their funding. State and county officials were invited to comment on and make suggestions about the proposal. A member of the Davis County Commission was a member of the DBH Board of Directors, and was involved in all meetings and had access to all information regarding the formation and operation of the proposed entities. As the plan evolved, a detailed letter was sent to various officials explaining the structure, funding and proposed operations of the affiliated entities. (A copy of the letter sent to the Davis County Clerk/Auditor is attached hereto as Exhibit B.)

The director of the State Division of Substance Abuse and Mental Health, Randy Bachman, and then-State Legislative Auditor General, Wayne Welsh, reacted positively to the proposal, congratulating DBH for its effort to expand funding for behavioral health services. (Mr. Welsh had previously indicated that he could not formally approve the proposal, since his office might be involved in auditing DBH in the future.) In their meeting with the Chairman of the Board of DBH, the Davis County Commissioner serving on the DBH Board, and DBH's corporate secretary, Mr. Welsh and Mr. Bachman mentioned precautions that should be taken in the formation of the affiliated entities, including ensuring "that accounting and expenses for each entity are completely separate," that "staff time used to develop and manage the entities can be separated and reimbursed from appropriate funding sources," and "that there is Local Authority oversight for the use of public funds and compliance with State and County contract requirements."

The proposed structure and operations of the new affiliated non-profit entities were included in the Davis County Local Authority's Substance Abuse and Mental Health Area Plan for FY 2005, which was approved by the State Division of Substance Abuse and Mental Health. Michael Deilly, Director of the Division of Health Care Financing of the Utah Department of Health, wrote in a letter to DBH's CEO, Maureen Womack, that "[y]our formation of separate legal entities is a positive step in preventing questions or concerns about the appropriate usage of Medicaid dollars and other public funds."

### **Formation of New Entities & County Commission Approval of Operations**

After several months of study and discussion with various stakeholders, DBH created the affiliated non-profit corporations in July, 2004, which immediately applied to the I.R.S. for 501(c)(3) status. Following a series of meetings with the Davis County officials to conduct a detailed analysis of DBH's private funds and a review and certification by outside tax counsel that DBH's accounting of private funds was correct, DBH submitted a proposal to the Davis

County Commission as local mental health authority to approve the initiation of operations by the affiliated non-profit corporations. (A copy of the written proposal submitted to the commission, entitled "A Proposal to Meet the Demand for Community Mental Health and Substance Abuse Services in an Environment of Reduced Federal Funding and More Restrictive Medicaid Rules" is attached hereto as Exhibit C.)

In its meeting of February 2, 2005, the Davis County Commission formally approved the operation of the new affiliated entities and authorized the use of up to \$900,000 of DBH's reserves to finance the operations of the new entities. Mindful of the counsel to separate the accounting and expenses of the affiliates from those of DBH, separate bank accounts for the new entities were set up at a different bank than that at which DBH had its accounts. A certified public accountant was engaged by the entities on an hourly basis to maintain their financial books and records. Start-up funding for the new operating entities was obtained through commercial lines of credit in the total amount of \$500,000, which were secured by a portion of DBH's private fund reserves, as authorized by the Davis County Commission.

### Measuring Costs & Benefits

The audit report concludes that "reorganization was financially costly to DBH." However, the Report fails to distinguish between the costs of reorganization (i.e., the "form") and the operational costs of delivering the services the new entities were created to perform (i.e., the "substance"). Formation of the corporate structure recommended by outside legal counsel for the proposed non-profit activities was not particularly costly, and was based on sound legal and tax considerations. A major deficiency in the Report is that it fails to assign any value to the services provided to the residents of Davis County by the new operating entities. The real issue is not whether an activity cost something, but rather whether the benefits resulting from those costs justified the expenditure.

The Chief Financial Officer of DBH had several discussions with the auditors about the figures presented in support of their conclusion that "DBH spent about \$850,000" on the non-profits. Since the presentation chosen by the auditors was to represent an *increase* in expenditures occasioned by the existence of the sister non-profit corporations, they should not have considered those costs that were simply shifted for accounting presentation but not *increased* in amount. Examples of such stable but partially allocated costs are for liability insurance and some DBH executive salaries. The figures suggested by the CFO for inclusion in Figure 2.2 of the report made appropriate adjustments. The auditors have chosen to disregard the data provided and the CFO's suggestions in this matter. The effect of that choice is to inappropriately and significantly overstate the quantity of funds invested by DBH in start-up costs and the providing of services by DEO and Daybreak.

Figure 2.2 further contains a significant numerical error – probably due to an inadvertent misreading by the auditors. The figure shown as "Additional Support by DBH" for the Foundation is shown as a positive rather than a negative number. At the time that the

companies were assimilated into DBH, the net asset balance for the Foundation showed an accumulated *earnings surplus* of approximately \$62,000 rather than a loss of that amount as represented. This error alone results in *overstatement by the auditors of \$124,500* in the total funds expended by DBH.

The Report's discussion of costs concludes with the following bit of peculiar analysis on page 12: "DBH's CEO [says] that employing clients keeps Medicaid costs down because they are no longer in a Medicaid-reimbursed day treatment program. We do not believe that savings would be significant given the low number of therapy sessions for the existing DEO clients."

The "low number of therapy sessions" for DEO clients cited by the auditors in fact demonstrates what DBH therapists have consistently observed: that individuals recovering from mental illness require fewer day treatment services (at a corresponding reduction in cost) when they participate in meaningful employment such as that provided by DEO's supported employment program.

#### **Nature of the Funds Used to Support the Affiliated Non-Profits**

The Report states that there are still questions about whether DBH's accumulated reserves of \$1.2 million from fees paid by consumers, payments from private health insurance and charitable donations constitute "public" or "private" funds. Neither the Report nor individuals quoted in it cite any authority for the proposition that these are public funds.

Even though the Utah Legislature has provided a clear statutory definition of "public funds," DBH consulted with county and state officials, and also engaged outside tax counsel to conduct an independent review of the accounting before the affiliated non-profit entities were created or funded. The tax attorney's opinion stated in relevant part as follows:

*Section 17-43-203(1)(a) [of the Utah Code] defines public funds for purposes of county human services. It provides that public funds are "(i) federal money received from the department or the Department of Health; and (ii) state money appropriated by the Legislature to the department, the Department of Health, a county governing body, or a local substance abuse authority for the purposes of providing substance abuse programs or services; and (b) includes that federal and state money: (i) even after the money has been transferred by a local substance abuse authority to a private provider under an annual or otherwise ongoing contract to provide comprehensive substance abuse programs or services for the local substance abuse authority; and (ii) while in the possession of the private provider."*

*Section 62A-15-102 defines public funds for State Department of Human Services purposes. It provides that public funds are "those federal and state monies that have been transferred by a local substance abuse authority or a local mental health authority to a private provider under an annual or otherwise*

*ongoing contract to provide comprehensive substance abuse or mental health programs or services for the local substance abuse authority or local mental health authority. Those monies maintain the nature of 'public funds' while in the possession of the private entity that has an annual or otherwise ongoing contract with a local substance abuse authority or a local mental health authority to provide comprehensive substance abuse or mental health programs or services for the local substance abuse authority or local mental health authority."*

*We reviewed the incomes and expenses of Davis Behavioral Health for a number of years. We determined which funds during those years were received as a result of Medicaid and related contracts. These funds clearly fall into the definition of "public funds." We also determined the amount of expenses associated with those funds. We noted that Davis Behavioral Health receives additional funding as a result of court programs. While these funds come from individuals in the form of restitution payments and not through federal or state budgets or programs, we conservatively elected to treat those funds as "public funds" because of the court involvement with the transfer of these funds from individuals to Davis Behavioral Health. We then reviewed other sources of funding, such as individual charitable bequests and individual payments for services rendered and the expenses associated therewith. These sources of funding are clearly not "public funds."*

*Based on my review of the state and federal statutes governing the funds received by Davis Behavioral Health, it is my opinion that the calculations performed in determining the amount of "public funds" received by Davis Behavioral Health complies with the letter and intent of the law. Further, it is my opinion that determining the amount of such public funds and the expenses associated therewith, and treating those funds as "earmarked" funds is desirable for both Davis Behavioral Health and the regulatory agencies involved. Davis Behavioral Health will be able to easily demonstrate to governmental auditors the sources and uses of its funds.*

*I have further recommended to Davis Behavioral Health that activities which are outside the scope of governmental funding be performed by "sister" entities. Doing so would not only provide entity level segregation of funds but would also provide entity level protection to further ensure that public funds are used only for required public purposes.*

In a policy adopted by the Davis County Commission on August 16, 2005, entitled "Davis County Local Substance Abuse Authority and Local Mental Health Authority Policy Regarding Public Funds" (the "Policy"), reference is made to DBH and its affiliated non-profits:

*Davis County, through the "Commission" acting in its capacity as the Authority, contracts with Davis Behavioral Health, Inc., a private non-profit corporation, ("Contract Provider") to provide those services and passes the federal and state funds received under the federal and state contracts and grants to the Contract Provider.*

*Davis County also allocates funds from the Davis County General Fund to the*

*Contract Provider for the purpose of meeting the substance abuse and mental health needs of the residents of Davis County.*

***In addition to public funds, the Contract Provider also receives funding from private sources, including donations, bequests and fees from individuals and legal entities for services rendered. The Contract Provider identifies such private funds in its books and records, which are audited each year by an independent auditing firm. [Emphasis added]***

The Policy goes on to give a definition of "public funds" on page 3:

*For the purposes of this policy and subject to any future change in applicable federal or state law, administrative rules or regulations, "public funds" means any funds defined as public funds by:*

- (a) Sections 17-43-203 and 17-43-303 of the Local Human Services Act.*
- (b) Any contracts between the Utah Department of Human Services, Utah Department of Health, or other or federal state agency and the Authority.*
- (c) Any grant requirements for federal and state grants received either by the Authority or the Contract Provider for the provision of substance abuse and mental health services to the residents of Davis County.*
- (d) Any administrative rules or regulations adopted, issued, or implemented by the Utah Department of Human Services, Utah Department of Health, or other state or federal department or agency relevant to the provision of substance abuse or mental health services to the residents of Davis County.*
- (e) All funds allocated and paid from the Davis County General Fund to the Contract Provider pursuant to the services contract between the Authority and the Contract provider.*

Although the auditors obviously concluded that the perceived "uncertainty" about whether charitable donations and fees paid by consumers and private health insurance companies for services are public funds warranted an audit "finding," both the Davis County Attorney's Office (which drafted the Policy) and the Davis County Commission (which adopted it by unanimous vote) determined that the clear and unambiguous language of the relevant provisions of the Utah Code provided the appropriate standard.

### **Allegation of "Poor Execution" and "Financial Problems"**

The Report does not say what constituted the "poor execution" or "financial problems" mentioned in this finding. The "partially-developed business concepts from outside consultants" referred to in the Report were early discussion documents developed in 2003 and presented to the DBH board in January 2004, nearly six months before the affiliated entities were created and more than a year before they began operations. They described commercial activities that

could be considered for the proposed supported employment entity (Diversified Employment Opportunities) to provide vocational training and employment opportunities to DBH clients. The DBH Board of Directors did not approve these proposals because of the overhead expense required. Instead, the initial services provided by DEO were janitorial and courier services, followed shortly thereafter by landscaping and catering services.

Employees hired for the new operating entities (Daybreak Behavioral Healthcare and Diversified Employment Opportunities) were paid by those entities from their own budgets and bank accounts. This did not increase DBH's expenses, although some of DBH's private fund reserves held in certificates of deposit were used to collateralize the commercial lines of credit used to provide start-up capital for the new entities. Interest on the lines of credit was paid by each entity in full and on time, and the lines were open and in good standing at the time they were voluntarily closed in 2007. None of the lines was ever in default nor did the bank at any time seek to accelerate payment of the loans. The auditors' conclusion that there were "financial problems" appears to be based solely on the fact that DEO and Daybreak did not generate operating surpluses during their first three years of existence. This is not unusual for non-profit, social service organizations. In fact, the supported employment program that won the national award for excellence did not reach the break-even for five years.

No evidence is cited for the Report's suggestion that the Davis County Commission, which approved the proposal for funding and operation of the affiliated entities, "may not have understood the issues in the reorganization plan." The Report speculates that "[t]his lack of understanding may be due to the commission's representation on the DBH board." One would think that being a board member with full access to all business records and information, the right to attend and participate in all board and executive committee meetings, and the opportunity to ask questions and request additional information from staff and other advisors, would be the ideal way to be informed on the issues.

The Report further suggests that perhaps a lack of understanding resulted from the fact that "[o]nly one commissioner is active on the DBH board at any time and there is frequent turnover of commissioner representation." The number of commissioners to serve on the board is specified in the mental health and substance abuse services contract prepared by the county. The commissioner who fills that board position is assigned by the commission itself. The county commissioner who served on the DBH board during the time decisions were made regarding the creation of the affiliated entities was a board member during his entire four-year term as commissioner. He left that position when he failed to receive his party's nomination for re-election to his commission seat. His predecessor as commission representative on the DBH board served in that capacity for six or more years. It is difficult to understand how the auditors concluded that this long and extensive involvement in DBH's governance was the basis for the Commission's alleged "lack of understanding."

The Report says that auditors "asked the Department of Health if DBH had to lease a separate facility and create a new infrastructure to treat clients that were not on Medicaid." The Report

then concludes that “DBH could have isolated the costs using accounting techniques; they did not have to create a new corporate structure or lease a separate facility.” DBH has never suggested that it “had” to lease a new facility to treat non-Medicaid clients. The leasing decision was made for clinical and business reasons, including the fact that there was no available space in existing DBH facilities for the clinicians hired to staff Daybreak Behavioral Healthcare. The legal infrastructure created for the operation of the new entities was suggested by outside corporate and tax attorneys for a variety of legal reasons, including limitation of liability, segregation of private and public funds, eligibility for participation in certain restricted programs, and compliance with IRS rules relating to charitable organizations. The DBH board of directors considered various structures, including those used for similar non-profit operations in other states, and decided to follow the advice of its outside counsel.

### **Was There a Decrease in Public Funding in 2004-2005?**

The Report states that “[t]he negative funding impact experienced by DBH was not due to decreased funding; it was caused by the Federal Government’s decision to prohibit the use of excess Medicaid funds for non-Medicaid clients.” This is a distinction without a difference. The fact that Utah was informed that it could no longer use excess Medicaid funds for non-Medicaid clients and services meant that community mental health centers would experience an immediate loss in usable revenue for existing programs and services. (Under Utah’s Medicaid plan, centers receive a funding allocation based on the number of Medicaid-eligible individuals residing in their county, but the funds can only be used to provide Medicaid-approved services to individuals enrolled in Medicaid.)

The State Division of Substance Abuse and Mental Health notified community mental health and substance abuse centers of the dramatic changes that would result from the new clarification of Medicaid policy. “Previously, savings accrued through program efficiencies have developed system capacity and services statewide, have provided expanded services to underinsured/indigent clients, have provided continuity of care during periods of client Medicaid disqualification, and have provided client support services keeping them out of more intensive and costly services. That appears no longer possible using Medicaid funds.”

Although perhaps viewed as inconsequential by the auditors, this change was seen as monumental by other state officials and by the affected community mental health and substance abuse treatment centers that would no longer be able to use surplus Medicaid funds to help pay for services to the unfunded. The decision by DBH’s Board of Directors to use a portion of its private fund reserves to start the new supported employment entity (DEO) and the clinic for the mentally ill who were not funded by Medicaid (Daybreak) was a reflection of the Board’s determination not to abandon the implementation of evidence-based practices or the care of non-Medicaid clients in the face of announced reductions in public funding.

## Alleged "Competition" by DBH with New Entities for Resources

The Legislative Auditor's conclusion that DBH was financially supporting the operations of the new affiliated entities at a cost to its own operations is erroneous. Davis Behavioral Health provided the following information to the Legislative Auditor.

Davis Behavioral Health annually submits a budget to the Davis Behavioral Health Board of Directors for approval. This annual budget is a list of all planned expenses and revenues for the upcoming fiscal year. The budget is comprised of the following components:

1. An **operating budget**, which is an annual budget of activity stated in terms of budget classifications, functional categories and cost accounts. It contains estimates of the total value of resources required for the performance of our operations including the reimbursable work and services of staff. It also includes estimates of workload in terms of projected numbers of consumers to be served and the services they will receive. The biggest expense in the operating budget is employee salaries and benefits (approximately 80%).
2. A **capital budget**, which is the annual budget for projects that helps maintain or improve DBH's assets and infrastructure. To be included in the DBH Capital Budget, a project must meet one of the following criteria:
  - It is a new construction, expansion, renovation, or replacement project for an existing facility or facilities.
  - It is a purchase of major equipment (assets) costing \$5,000 or more.
  - It is a major maintenance or rehabilitation project for existing facilities with an economic life of at least 10 years.
3. A **reserve budget**, which is comprised of funds that are earmarked by DBH from its retained surplus for future use to cover write-offs or as seed money for the mission-based enhancement of clinical care.

The funds used to secure the lines of credit of the affiliated non-profit corporations came from DBH's **reserve budget** and had no impact on its **operating budget**. As noted previously, the period of 2004-2005 was one of uncertainty because of unanticipated changes in the restrictions on the use of surplus Medicaid funds and reductions in state allocations for services to the unfunded population. The state estimated the cumulative impact of these changes on community mental health and substance abuse treatment facilities in Utah to be a \$14 million reduction in funds for operations.

In light of these projected reductions, DBH's management and Board made two preliminary decisions regarding its operations: (1) clients currently in services would be allowed to continue in treatment until they could be safely and therapeutically discharged; and (2) employees would not be subjected to layoffs to reduce staff.

In the meantime, management began an evaluation of the key issues related to cost analysis:



- What are the evidenced based services that DBH needs to provide to meet our mission and promote recovery?
- How many staff do we need to provide these services (a capacity analysis)?

DBH did not increase staffing ratios, salaries, or give cost-of-living increases during this period of uncertainty and evaluation until a determination could be made as to whether the operating budget could sustain these increases. This period did create anxiety among the staff and management of DBH in spite of the realization that change is inevitable and that the current healthcare funding environment requires organizations to adapt to sudden and unanticipated changes. (As several national experts in the field have noted, the changes required by a recovery-oriented approach to mental health treatment can be expected to generate some internal opposition among employee clinicians who feel threatened by change, who have spent much of their careers in a different treatment model, or who believe that recovery is not possible for people with mental health problems.)

DBH disagrees with the Legislative Auditor's implication that it should have used its reserve budget for operations, including hiring of staff and salary increases. DBH believes this to be a bad management practice that could quickly consume cash reserves with no prospect of replenishment. The Board's decision to proceed with its plan to fund the affiliated non-profits was a reasoned and prudent step that permitted a continuation of services to the residents of Davis County, implementation of a key evidenced-based practice, and the establishment of service entities with the potential to eventually become financially self-sufficient.

**██████████ Diversified Employment Opportunities' Alleged "Lack of Vision and Poor Execution" ██████████**

Diversified Employment Opportunities ("DEO") has provided training and supported employment services to more than 100 clients of DBH who are recovering from mental illness and/or addictions. Many of these individuals had been unemployed and in day treatment programs for years, and were living on government disability and support payments. Initially, DEO provided janitorial services to DBH, replacing outside vendors. While the Report criticizes DEO for providing services to DBH, replacement of outside vendors is the first step recommended by experts in the supported employment field. Services provided to mental health centers by outside vendors are the "low-hanging fruit" that is the easiest to harvest. Why pay money to outside for-profit companies when those funds can provide employment opportunities for the center's own disabled clients who are looking for work? As the DEO work force has grown and its employees have gained enough experience to be able to supervise their peers, additional contracts have been obtained for services to outside customers, including the State of Utah and Weber State University. DEO has been commended by outside customers for the high quality of its services, and the State of Utah recently contacted DEO to ask if it would be willing to take

over a \$500,000.00 janitorial services contract awarded to a company that has failed to provide a level of service comparable to that of DEO.

The Report alleges that DEO performed unnecessary services to DBH in an “attempt to employ clients at any cost to DBH.” This is simply not true. The Report’s “evidence” for this allegation is the fact that payments for janitorial and food services were higher in fiscal year 2007 than in 2004. The Report ignores, however, the fact (disclosed to the auditors during their field work and in meetings to comment on the draft Report) that the square footage of office space being cleaned by DEO is much larger than the space cleaned in 2004 by outside vendors. For example, daily janitorial services are provided to the Kaysville Clinic, a 27,000 square foot medical office building acquired by DBH in January, 2006, and occupied by DBH and other health care providers, that has been cleaned by DEO since its acquisition, but no mention of this additional space is mentioned by the auditors, even though they included the cost of this service in the FY 2007 costs.

Similarly, costs of food services are compared for fiscal years 2004 and 2007 with no mention of the fact that *five times as many meals* were served to DBH clients in 2007 than in 2004, including three meals per day, seven days per week to residents of the 16-bed Crisis Recovery Unit. Furthermore, the auditors used the cost of *food only* for the 2004 figure, but ignored the costs of DBH case managers who provided meal preparation services. The implication in the Report that the pre-DEO practice was preferable fails to recognize two important facts: (1) that the Davis County Health Department found that the way food was previously stored and prepared by DBH staff and clients violated multiple health department regulations, and (2) that food preparation work performed by case managers cannot properly be billed to Medicaid or other public funding sources on a continuing basis. Properly trained and licensed DEO food service personnel prepare and serve meals to DBH clients and other customers that are of high quality, nutritious (menus prepared by registered dieticians) and in full compliance with applicable laws and regulations. DEO’s disabled employees have learned skills and professional standards of food preparation and catering that have permitted the organization not only to serve the needs of DBH, but also to successfully cater events for non-DBH customers in Davis County.

After discussing DEO’s janitorial, food preparation and transportation services, the Report states that DEO “bills DBH for all client wages.” This is incorrect. DEO bills all its customers, including DBH, the fair-market value of its services. As with any service provider, employee wages are part of the cost of services, which also include the cost of materials, equipment and overhead.

The Report also states that “some of the services that DEO is providing to clients could be paid for by Medicaid or the State Office of Vocational Rehabilitation.” Although we are not sure how the auditors came to this conclusion, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services has declared that billing Medicaid for services such as “client vocational training, including staff discussion of client employment options, or

assistance provided to clients to locate employment” and “client transportation in circumstances where the transportation was the primary service” are not services that can properly be billed to Medicaid. (“Office of Inspector General Review of Medicaid Community Mental Health Provider Services in Illinois”, September 2006) To knowingly charge Medicaid for such services would constitute fraud punishable by civil and criminal penalties. DBH is not aware of any services currently provided by DEO that could be billed to Medicaid.

If the State Office of Vocational Rehabilitation (“VR”) were to contract with DEO to provide vocational training to clients referred by VR, DEO could certainly bill VR for those services. However, no such referrals have been received from VR and DEO’s small administrative staff is being kept extremely busy training, supervising and managing its current roster of 56 employees, as well as additional clients that will be referred to DEO under the current contract with the Department of Workforce Services (“DWS”). As DEO continues its growth and has both the contracts and the supervisory personnel to justify adding additional employees to its payroll, it will certainly do so.

The auditors’ finding that “DEO has not used the DWS contract effectively” suggests a lack of understanding about the contract and of the types of clients referred to DEO by DWS. The DWS contract is for job coaching of 20 clients per year, and has limits on the amount of time that DEO can provide services to these clients. The clients referred by DWS are those whom DWS has been unable to place in employment with businesses in the community for various reasons, including scheduling conflicts with essential mental health therapy, child care issues and inability to pass a BCI criminal background check. DEO is, in effect, an employer of last resort for these individuals. There is no reason to believe, as the Report suggests, that if DBH were to limit its services to attempted placement of these clients in jobs in the community it would be any more successful than the efforts by DWS itself. The success and value of the DEO model is that it permits these clients with significant barriers to traditional employment to work in jobs and with an employer that will accommodate their special needs and support them in their recovery. The flexibility of the DEO model is a significant factor in producing the results that DWS has described as “staggering” and that have caused DEO’s program to be cited favorably in national studies of supported employment.

DEO has no control over the number of clients who come into its program from DWS. The number and frequency of referrals are determined by DWS. In some months there may be five referrals; in others only one or two. Clients who complete the program or leave for other reasons prior to completion are not necessarily immediately replaced by other referrals from DWS. Thus, the Report’s statement that at one point there were sixteen DWS clients in DEO and a couple of months later there were only two is not an indication of program deficiencies, but rather the normal result of the irregular timing of the arrival and departure of DWS clients.

The fact that only a portion of the contract budget was drawn down by DEO in 2007 is not the result of a lack of success with the contract, but rather of a delay in submitting billings to DWS

for certain services. Because of its satisfaction with DEO's services, DWS carried unused 2007 funding into 2008. Perhaps the best indication of the quality of DEO's work under the DWS contract is the language DWS itself used in renewing the contract for an additional year:

The results of the contract after the first year are staggering. Four customers dropped out of the program not at the fault of DBH/DEO or DWS. The remainder has been successful. All customers have increased work hours. Two in three have achieved thirty (30) or more work hours per week for four (4) or more consecutive weeks. Every participant has achieved work stability. Over a third have been promoted. Over half are, or have, counted toward the federal TANF/FEP participation rate. Just under half have successfully closed their TANF/FEP cases due to increased earnings. At least three customers have successfully moved into outside employment.

These results justify the continuation of the contract from October 1, 2007 to September 30, 2008. (*Attachment E "Work Statement" to DWS Contract 076089 Amendment #2*)

Another finding of the Report that seems to reflect a lack of understanding of DWS procedures is that "DEO should work with clients to gradually increase their working hours." The Report says, "Our concern is that DEO staff may be pushing clients to work increased hours too quickly, based on DEO's needs rather than when the client is ready." The fact, however, is that a DWS client's work hours are set by DWS, not by DEO. DWS prepares for each client a written Employment Plan that is completed and signed by the DWS employment counselor after consultation with the client and the client's therapist, and then signed by the client. This written Employment Plan, which specifies the number of hours the client is to work, is then sent to DEO, which makes work assignments in accordance with the plan.

The Report cites a specific case in which it alleges that "DEO's management required a client to work almost 30 hours per week within a month of starting the job." The Report states that the "client's hours escalated quickly and created a funding bonus for DEO" and that this was done "against the recommendation of DBH's therapist." In fact, DEO required no such thing. The initial DWS Employment Plan for this client, dated June 14, 2007, and signed by the client and her DWS employment counselor, specified 4 to 8 hours of work per week. The next Employment Plan, dated August 30, 2007, and signed by the client and her counselor, specified 16 hours of work per week. The last Employment Plan sent for this client by DWS and dated September 10, 2007, specified 30 hours per week. The work assignments made by DEO for this client followed the specifications of the Employment Plans issued by DWS.

The performance goals of a certain number of hours of work per week are not set by DEO, but by DWS. The DWS contract states in the section entitled "Outcome Measures" that "The Department's customers are expected to be working **20 hours a week within four** months of the initial referral, and **30 hours a week within 7 months.**" [Emphasis in original] The contract says nothing at all about a gradual increase in hours worked by the clients. If DWS and the

client desire a gradual increase, they can so specify in the Employment Plan prepared by DWS. DEO simply provides job coaching and employment opportunities to the clients in executing the plan developed by them and DWS.

DEO's supported employment model was cited approvingly as one of nine initiatives with "promising practices" by Mathematica Policy Research, Inc. ("MPR") in its 2008 report to the U.S. Department of Health and Human Services entitled "Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment." MFR, an outside contractor engaged by the Department of Health and Human Services to conduct a study of state and local efforts to promote employment among disabled recipients of Temporary Assistance for Needy Families, also cited DEO's model in a series of practice briefs produced for program administrators to provide information about "potentially promising practices to promote sustained employment for TANF recipients living with disabilities." Copies of the MPR report and practice briefs (*Conducting In-Depth Assessments, Creating Work Opportunities, Creating TANF and Vocational Rehabilitation Agency Partnerships, and Providing Specialized Personal and Work-Based Support*) were provided to the auditors, who chose not to mention them in their Report.

#### **Daybreak Behavioral Healthcare**

Daybreak Behavioral Healthcare leased space next to DBH's executive offices in Farmington and began operations with clinical services being provided on a part-time basis by two psychiatrists, two advanced practice registered nurses, a psychologist and two licensed clinical social workers. Clinicians were paid a percentage of collections, thereby eliminating overhead costs of salaries and benefits for everyone except one full-time support staff member. Daybreak provided Davis County residents with access to the only psychiatrists in private practice in Davis County at a time when waiting lists to see psychiatrists in Salt Lake and Weber counties were backed up more than six months. During its first three years of operations, Daybreak served more than 1,100 individuals, many of whom were suffering from serious mental illnesses. At least forty-four of these consumers would have required hospitalization and expensive inpatient treatment had they not obtained the assistance provided at Daybreak.

Daybreak clinicians were of excellent quality and included professional staff from the University of Utah and Weber State University. Daybreak has received referrals from primary care physicians, LDS Family Services and other community sources. The greatest challenge faced by Daybreak has been recruiting and retaining a sufficient number of prescribers to meet the demand for services. Some of the original part-time clinicians who intended to transition into full-time positions decided to pursue advanced degrees or left to accept more lucrative offers outside Davis County. The recent addition of an experienced full-time psychiatrist, Dr. Kay Phillippi, will help meet the demand for prescriber services while increasing the revenues of the clinic.

The Report contains the inaccurate statement that “DBH’s CEO claims that they had to create Daybreak because DBH could no longer see clients with insurance.” The reason for shifting to Daybreak clients whose primary funding source was private insurance, as well as those who sought treatment on a fee-for-services basis, was in order to improve efficiency and reduce costs. Because DBH has a large number of clinicians, it is expensive and time-consuming to go through the empanelling process for every clinician and every insurance company used by DBH clients. Furthermore, DBH was carrying significant accounts receivable for services to self-pay and insured clients as a result of difficulties with private sector billing and collection procedures. Daybreak’s clinicians were already empanelled with the major insurance companies and its support staff was experienced in insurance billing and collection. As a result, Daybreak’s aged accounts receivable during the time it existed as a separate legal entity were almost non-existent.

The Report criticizes DBH’s clinical structure (specifically the use of Daybreak to see clients with private funding sources) as being “inefficient.” The auditors’ standards for judging efficiency are not identified, but it should be noted that Daybreak has served more than 1,100 clients at a per-encounter cost lower than that of DBH.



#### **Criticism of Two Support Corporations as a “Duplication”**



The Report criticizes the creation of two support entities, DBH Holding Corporation and Davis Employment Services, as a duplication of functions that could have been performed by DBH. However, for DBH to have performed these functions for the affiliated non-profit operating entities (DEO and Daybreak) would have been contrary to the directions given by state and county officials, who made it clear that the accounting and funds of the affiliates should be kept “completely separate” from those of DBH.

DBH Holding Corporation was not an operating entity and consumed no funds. The only function it performed was to control the makeup of the boards of the affiliated non-profit corporations through its power of appointment. The board of directors of the holding corporation was identical to that of DBH. The purpose of this structure was to prevent mission drift by ensuring that the activities of the other non-profits were consistent with and supportive of those of DBH.

Davis Employment Services was a non-profit, closed group employee leasing company that was officially the employer of DEO and Daybreak personnel so that those employees could qualify for group rates on health insurance. Its services were provided to DEO and Daybreak “at cost” and added no expense to the operations of either of these entities or to DBH.

## **SUMMARY & CONCLUSION TO CHAPTER II FINDINGS**

During the years 2003-2004, mental health centers throughout the United States were undergoing major

changes in response to directives from the federal government that urged a new approach to treating mental illness. Emphasis in the future was to be on recovery: a process leading to a restoration of self-esteem and identity, and an attainment of meaningful roles in society. Traditional approaches to mental health treatment, including government support payments to individuals who spent their lives in day treatment programs of perpetual duration, were determined to be less desirable than programs using evidence-based practices such as supported employment that helped the mentally ill develop a feeling of self-worth and a degree of financial independence. Two major barriers to re-integration of the mentally ill into society, access to affordable housing and employment, were identified by a presidential commission as priorities that needed to be addressed by the nation's mental health systems.

Unfortunately, rules governing the use of public funding for mental health services did not change in harmony with the new directives regarding implementation of the recovery model and use of evidence-based practices. For example, Medicaid funds, which account for more than 70% of the revenues of most community mental health centers, could not be used for vocational education or supported employment programs, which were considered essential to recovery. In Utah, the situation was made more difficult by an announcement from the State that excess Medicaid funds accumulated through program efficiencies could no longer be used to pay for non-Medicaid services such as mental health treatment to unfunded consumers. The State Division of Substance Abuse and Mental Health predicted that this change in interpretation of Medicaid rules would require that community mental health centers terminate services to hundreds of clients at each center who had been receiving treatment. The loss to the State system was estimated at over \$14 million, and was described as a "significant risk to public safety and to the well being of our citizens, our communities and our families."

As centers were attempting to come up with programs to implement recovery model treatment programs in the face of a projected sharp decline in revenues, the situation became even more uncertain in July of 2003, when the Office of the Legislative Auditor General issued a report on its audit of Utah's local mental health system that criticized the use of public funds for support of what the auditors called "untraditional activities". The criticized activities included affordable housing and supported employment programs, two of the initiatives that were being encouraged by the federal government as essential to recovery.

In this environment of new treatment directives, projected decreases in funding, and uncertainty as to what public funds could be used for, the Boards of Directors and management of DBH

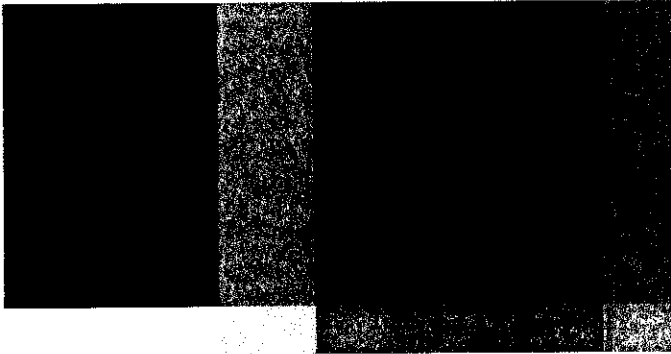
began work on finding ways to implement evidenced-based practices in mental health and substance abuse treatment, meet the increasing demand for services in Davis County, and comply with the more restrictive interpretation on the use of Medicaid funding. During this process, DBH consulted extensively with county and state oversight bodies, obtained opinions from outside legal counsel with expertise in corporate and tax issues, and drew on the experience of community mental health centers in other states that had successfully implemented similar programs. After considering various alternatives of a period of more than a year, DBH created three new non-profit operating entities and two support entities to complement and support the mission of DBH in providing mental health and substance abuse treatment services to the residents of Davis County, including those who were not eligible for Medicaid assistance.

The affiliated non-profit entities have, for the most part, fulfilled the charitable purposes for which they were created. The mental health clinic has served more than 1,100 clients at a per-encounter cost lower than that of DBH. The supported employment entity has provided vocational training and employment to more than 100 disabled clients of DBH, and currently has contracts for services totaling several hundred thousand dollars. DBH clients who participated in the supported employment program have been able to earn money for their own support, reduce their dependence on government support payments, and reduce their need for mental health therapy. Most importantly, they have consistently expressed satisfaction in being able to successfully perform meaningful work and become more self-sufficient. The foundation formed to solicit charitable contributions raised more than \$85,000 in its first year of operation, but its activities were suspended by its board in 2006 in light of the difficulty of obtaining donations for mental health services.

DBH believes that the decision made by its Board of Directors to use a portion of its private fund reserves was both reasonable and prudent in that it permitted the implementation of a supported employment program that has received both local and national recognition for accomplishments in helping the mentally disabled obtain and keep meaningful employment, a key element of recovery. It also provided funding for the establishment of an efficient, high-quality psychiatric clinic that has provided mental health services to more than 1,100 residents of Davis County who are not eligible for Medicaid. At a time when there are no other psychiatrists in private practice in Davis County, and when obtaining an appointment to see a psychiatrist in adjoining counties usually requires a wait of at least six months, Daybreak Behavioral Healthcare was able to save many of its patients from serious mental breakdowns that would have required hospitalization at great expense to public funding sources.

As evidence-based practices such as supported employment gained acceptance among Utah regulatory bodies and were no longer viewed with suspicion as "untraditional activities," Davis Behavioral Health was able to dissolve its affiliated non-profit corporations in 2007 and fold their operations into DBH. However, its mission of providing high-quality mental health and substance abuse treatment services leading to recovery remains unchanged.





“There are risks and costs to a program of action.  
But they are far less than the long-range risks and  
costs of comfortable inaction.”

John F. Kennedy



Exhibit A  
Response of Davis Behavioral Health, Inc.  
To  
Legislative Audit Report No. 2008-06

**UTAH DIVISION OF SUBSTANCE ABUSE  
AND MENTAL HEALTH BOARD**

**WHITE PAPER:  
CURRENT AND EMERGING ISSUES IN PUBLIC  
SUBSTANCE ABUSE AND MENTAL HEALTH**

January 2005

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## *INTRODUCTION*

The Utah State Board of Substance Abuse and Mental Health in the Board meeting in May 2004 commissioned a white paper on current and emerging issues that impact public substance abuse and mental health in Utah. Subsequently, the following individuals met to review the process of developing a white paper that would describe these issues:

Marie Christman, Deputy Director, Utah Department of Human Services

Randall Bachman, Director, Utah Division of Substance Abuse and Mental Health

Rob Johnson, Business Manager, Bear River Mental Health

Dr. James Ashworth, Chairman, Utah Board of Substance Abuse and Mental Health

Jack Tanner, Executive Director, Utah Behavioral Healthcare Network

Patrick Fleming, Director, Salt Lake County Division of Substance Abuse Services

The white paper outlines the background, history, current and emerging issues in substance abuse and mental health. It provides a synopsis of recent history and issues of public substance abuse and mental health services in Utah, and makes recommendations to policymakers for the delivery of future services.

On August 10, 2004, Robin Arnold-Williams, Executive Director of the Utah Department of Human Services, called a meeting of local authority and state officials and other stakeholders to address recent changes in Medicaid policy that have created significant changes in the financing and the services to clients in the public mental health system, as well as clients in other systems. A similar meeting was held on August 24, 2004 to address current issues in substance abuse. Recommendations from both forums are incorporated in this paper.

It is our hope that this white paper will assist everyone concerned about the state of substance abuse and mental health services in Utah by providing information and perspectives that will inform all stakeholders, including elected officials, advocates, government agencies, the non-profit sector, and others who care about the individuals and families we serve.

--Randall W. Bachman, M.Ed., Director, Utah Division of Substance Abuse and Mental Health

**UTAH STATE DIVISION OF SUBSTANCE ABUSE  
AND MENTAL HEALTH BOARD MEMBERS:**

James Ashworth, M.D., Chairman

Michael Crookston, M.D., Vice-Chairman

Nora B Stephens, M.S.

Paula Bell

Cameron Cuch, M.Ed.

Joleen Meredith

Darryl Wagner, R.Ph.

**THE FOLLOWING INDIVIDUALS ASSISTED WITH THE  
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Randall Bachman  
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Acknowledgement is also given to the DSAMH research, financial, and support staff who provided information and support to this project, as well as to UBHN members who assisted.

## ***EXECUTIVE SUMMARY***

Recent developments in substance abuse and mental health have challenged our ability to maintain the current system of publicly funded services in Utah. From state budget cuts beginning in Fiscal Year 2002, to changes in Medicaid policy that have a fundamental impact on the way mental health services are structured and delivered in the community, dramatic changes have forced a re-examination of our entire system.

The following white paper outlines current and emerging issues and recommendations. It also contains background information on substance abuse, mental health, and Medicaid. From this analysis, and recent meetings to address strategies to address the current challenges in substance abuse and mental health, the following recommendations are offered:

1. Reaffirm Utah's commitment to effective substance abuse and mental health prevention and treatment.
2. Reaffirm that public expenditures for the delivery of effective substance abuse and mental health prevention and treatment services are a wise use of resources.
3. Reaffirm Utah's commitment to the seriously mentally ill and addicted who are indigent and most needy.
4. Support the coordination of funding and services.
5. Increase funding for critical services.
6. Support the goals of the President's New Freedom Commission on Mental Health; including the statement that services must be consumer and family- driven.
7. Engage the primary health care providers.
8. Develop and expand the use of appropriate technology.
9. Support the implementation of effective evidence-based practices based on the best available science.
10. Promote efforts to overcome the stigma of addictions and mental illness.
11. Promote parity in health care for substance abuse and mental health services.
12. Develop a comprehensive statewide plan for the delivery of public substance abuse and mental health services.

It is our hope as the citizens appointed to the Utah Board of Substance Abuse and Mental Health that this white paper will assist everyone who cares about individuals and families with substance abuse and mental disorders in Utah to work together to meet our current challenges and build a life in the community for all who need our assistance.

## **PART 1**

### **OVERVIEW OF CURRENT AND EMERGING ISSUES AND RECOMMENDATIONS**

Since 2001, a downturn in the nation's economy has created significant shortfalls in state budgets. Utah is no exception. Due to these state budget shortfalls and an increase in demand for service, due in part to population increases and an increase in awareness of the need and effectiveness of substance abuse and mental health services, access to and availability of services have been significantly affected. The following synopsis illustrates the impacts in both substance abuse and mental health.

### **SUBSTANCE ABUSE**

On the positive side, there is a growing awareness of the effectiveness of substance abuse prevention and treatment in Utah and throughout the United States. In particular, the impact of substance abuse on the child welfare and justice systems has been well documented. The effectiveness of Drug Courts and similar treatment and intervention programs has been established. Substance abuse prevention programs in Utah are working, as evidenced by a significant reduction in the number of students using alcohol and other drugs in Utah over the last twenty years.

However, an increase in demand for treatment and recent budget cuts has resulted in significant waiting lists. The face of the "typical" substance abuser has changed from a middle-aged male alcoholic to male and female young adults involved in street drugs, particularly methamphetamine, who are also involved in the legal system.

State budget cuts have impacted the access to and the availability of services to those in need of substance abuse treatment. To illustrate, in Fiscal Year 2004 there was:

- A **\$75,000** reduction in statewide substance abuse services
- A **\$494,400** reduction in funding to local substance abuse centers
- Due to these reductions, the state also stands to lose **\$335,000** in federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars due to a Maintenance of Effort failure unless funds are restored or a waiver is granted.

Finally, the **Drug Offender Reform Act (DORA)** is an initiative that is designed eventually to provide assessment and treatment to all who need it in the corrections system. The cost for this initiative will start at **\$6.3 million** the first year, **\$12.1 million** the second year, and **\$17.3 million** at the end of the third year, with the hope to sustain that level of funding on an ongoing basis. While this is a significant investment of state dollars, the proponents project a substantial cost avoidance in slowing the increasing need for prison beds.

## **MENTAL HEALTH**

A positive development, as with substance abuse, is a growing awareness of the effectiveness of appropriate mental health treatment, including early identification and intervention. From the 1999 Surgeon General's Report, to the 2003 President's New Freedom Commission on Mental Health, there is an increased realization, not only in mental health circles, but also among primary health care providers and the general public, about the reality of mental illness and the promise of effective interventions and treatment.

State budget cuts and changes in Medicaid policy have resulted in cuts in service for those in the public mental health system, particularly for those who are uninsured. To illustrate, recent state and federal cuts have resulted in:

- A reduction of **\$3,039,400** to the Utah State Hospital. This reduction made it necessary to cut **56** beds, including **26** forensic beds. *(Note: As of this writing, the Division and the State Hospital have been given permission to restore these beds effective December 1, 2004. However, ongoing funding to maintain these beds and to meet the increasing demand of the justice population with mental health issues will continue to be a challenge.)*
- A **\$1,262,700** cut in funds to the community mental health centers.
- A **\$1,441,300** decrease in funding for state-paid community services, which includes cuts in the Families, Agencies, and Communities Together (FACT) Program.
- Corresponding federal and state funding reductions of **\$820,800**, including **\$300,000** in state General Fund one-time appropriations, and **\$520,800** to community mental health centers and community services.
- Since state and local dollars can be used to match federal Medicaid dollars at a rate of nearly three federal dollars for each state and local dollar, cuts in state and local funding represent a **three-fold loss of Medicaid funds**.
- A pending loss of **\$745,000** in federal Mental Health Block Grant funds due to Maintenance of Effort (MOE) failure unless funds are restored or a waiver is granted.
- Recent changes in Medicaid re-basing of rates for the Prepaid Mental Health Plan (Capitation) are projected to impact the budgets of the community mental health centers by a rate reduction of approximately **\$3.2 million dollars**. The combined rate reduction and corresponding loss of ability to use Medicaid savings to fund the uninsured result in a loss of approximately **\$7 million dollars**, a projected caseload reduction of **4,332 clients cut from service**, and a reduction of **107 staff positions**. *(For further elaboration, see Parts 3 & 4 of this document.)*



## ***IMPACTS ON BOTH SUBSTANCE ABUSE AND MENTAL HEALTH***

The merger of the Division of Substance Abuse and the Division of Mental Health in September 2002 was a significant event. While the rationale was that the merger of the divisions could result in administrative savings, and perhaps a better integration of substance abuse and mental health services, particularly for those with dual diagnoses, advocates for both groups expressed concerns about whether the needs of both target groups would be short-changed. Notwithstanding the merger, there were budget impacts on both systems, including:

- A **\$22,000** cut to information technology
- A **\$555,900** cut in administration

These cuts impact not only the state's ability to provide technical assistance, training and support; they also increase the difficulty of providing proper oversight. A recent legislative audit raised concerns about the governance of the community mental health centers and the role of the state and local county governments in providing proper oversight.

Overall, the State General Fund cuts to both the substance abuse and mental health systems have been **\$7,038,400** since Fiscal Year 2002.

Revenues from all sources for community mental health centers were **\$131,527,251** in 2002; revenues for community substance abuse were **\$33,566,656**, for a total of **\$165,093,907**. *Source: Utah Behavioral Healthcare Network report.* With a projected loss of **\$7,000,000** as a result of Medicaid changes, in addition to a **\$7,038,400** cut in state funds, and **\$520,800** in federal funds, the impact is a loss of **\$14,559,200**, or an **8.8%** reduction in revenues to the system. Nearly all revenues in the public sector, whether provided by state or local government directly, or contracted to a private non-profit organization, are dedicated to support expenditures for programs and services to eligible target groups. Programs are allowed reasonable administrative costs, and are required to have fund balances to assure program viability in the event of revenue shortfalls or extraordinary client expenditures.

## ***HISTORY OF FUNDING***

### **Mental Health**

*The following information is from State Profile Highlights from the National Association of State Mental Health Program Directors Research Institute (NRI), June, 2004:*

Nearly two-thirds of the funding for public mental health services (63%) was spent for state hospitals in the United States in 1981. By 1993, that trend began to reverse so that only 49% was spent for state hospitals. By 2002, over two-thirds of the funding for public mental health services (67%) was spent on community mental health programs,

and only 30% on state hospitals. Clearly there has been a major change in the way public mental health services have been delivered in the past two decades—from a focus primarily on state hospitals and institutional care to community and family-based treatment approaches. During that same period of time, 1981-2002, state mental health agency controlled spending went from \$6.1 billion dollars to \$24.9 billion dollars. However, in inflation-adjusted dollars, the increase was from \$6.1 billion dollars to \$7.2 billion dollars. While the majority of funding (57%) still comes from the state government taxes, most of the recent increase in funding has come from Medicaid.

According to the most recent figures available comparing Utah to other states and the national averages, in Fiscal Year 2002, Utah spent a total of approximately \$159 million dollars on public mental health services, which includes state, local, federal block grant and Medicaid expenditures. Of that \$159 million, \$41 million was spent on the state hospital, and \$118 million on community-based mental health.

Utah spent about \$69 per person on state controlled mental health services on a per capita basis in Fiscal Year 2002, which includes Medicaid mental health expenditures. The national average was \$87. Utah ranked 30th in per capita expenditures. These data are based on expenditures prior to the most recent round of budget reductions.

Funding for state mental health systems is complex. For example, funding for mental health services can come from a variety of payers, including state and local revenues, Medicaid, Medicare, the Health Resources Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA) and its divisions, Housing and Urban Development (HUD), Education, the Social Security Administration, the National Institute of Mental Health (NIMH), and other federal agencies.

### **Substance Abuse**

Unlike mental health, Medicaid and other third party insurance is a small portion of substance abuse funding. The majority of funding for substance abuse prevention and treatment comes from federal and state sources. Local substance abuse authorities are required to match 20% of the state General Fund pass-through dollars for substance abuse. The Substance Abuse Prevention and Treatment (SAPT) Block grant is a major source of federal funding for substance abuse prevention and treatment, currently \$17.9 million a year. Twenty percent of the Block Grant must be utilized for prevention services.

Public funding for substance abuse prevention and treatment rose from \$22.8 million to \$33.6 million from 1997 to 2002. (*Source: UBHN Report: Funding History, Community Mental Health Centers, Local Substance Abuse Programs, 1997-2002*). However, for Fiscal Year 2003, total funding had declined to \$32.1 million, and for Fiscal Year 2004, to \$30.3 million. The main reason for the decrease was the loss of TOPPS II federal grant money for infrastructure development as well as other federal grants. (*Source:*

*DSAMH records).*

There has been a marked shift in the "typical" substance abuse treatment client in the last decade. This shift has been from the adult male alcoholic to the adolescent and young adult involved in street drugs, particularly methamphetamine. There has been an increase as well with individuals involved in the criminal justice system or the child welfare system. Consequently, funding for the justice population has increased, through federal grants and tobacco settlement dollars for drug courts. Over the past five years, \$8.5 million dollars has been allocated to drug courts and drug boards.

### **DOLLARS AND SENSE**

Studies have demonstrated the wisdom of investing in prevention and treatment of addictions and mental disorders. For example, advocates for Utah's Drug Offender Reform Act (DORA) project a cost offset and avoidance of approximately \$5.60 for every dollar spent on treatment for individuals in the criminal justice system based on a study in Oregon: (*Source: Finigan M. "Societal Outcomes of Drug and Alcohol Treatment in the State of Oregon", Oregon Office of Alcohol and Drug Abuse Programs, 1996.*) In prevention, based on a California study, every dollar spent on substance abuse prevention and treatment resulted in a cost avoidance of approximately \$7.00. (*Source: CALDATA, California Department of Alcohol and Drug Programs, 1994.*)

Dollars spent on effective prevention and treatment in both mental health and substance abuse will help offset costs in:

- Criminal justice
- Law enforcement
- Child protection and child welfare
- Primary health care
- Domestic violence
- Education, including special education
- Unemployment
- And finally, the immeasurable costs of family disruption and instability

### **IMPACT/STRATEGY MEETINGS**

Robin Arnold-Williams, immediate past Executive Director of the Utah Department of Human Services, called state officials, local mental health authorities and their providers, and other stakeholders to an "Impact/Strategy" meeting on August 10, 2004. The purpose of the meeting was to address the current issues in mental health, particularly the impact of Medicaid policy changes on the system. From that meeting, follow up task groups and objectives were developed. The input was synthesized into five overall recommendations:

1. Reassess who is the public client, and review current laws, rules and policies.
2. Reexamine service delivery models to mitigate the impact of reductions on

- clients and families.
3. Educate the public and legislature about the impacts of reduced services.
  4. Address the funding issues.
  5. Promote Collaboration.

Representative task groups have been organized to address each of the areas above, except #5, Promote Collaboration. The recommendation was to use existing forums and affiliations to continue to promote and enhance effective collaboration.

A similar meeting was held on August 24, 2004 to address critical issues in substance abuse, and the following recommendations were made:

#### Prevention

1. Make prevention a priority.
2. Promote best practices.
3. Address workforce issues.
4. Promote public education.
5. Increase coordination and integration of services.

#### Treatment

1. Provide adequate funding.
2. Promote best practices.
3. Address workforce issues.
4. Promote integrated treatment.
5. Collaborate with justice programs.

#### Crosscutting and Other Issues

1. Reduce stigma through public education.
2. Re-design the system to make it more user-friendly.
3. Integrate the categorical funding.
4. Review the infrastructure.
5. Promote local planning.

### **RECOMMENDATIONS**

The State Board of Substance Abuse and Mental Health makes the following recommendations as we move forward to meet the current and future challenges of the system:

1. Reaffirm Utah's commitment to effective substance abuse and mental health prevention and treatment.

More than enough data exist to support the cost-effectiveness of prevention and treatment. Whether in avoiding expenditures in child welfare, health, education, corrections, law enforcement or business, the evidence is irrefutable: *Prevention and treatment work!* We no longer need to "prove it". We need to act on it.

2. Reaffirm that public expenditures for delivery of effective substance abuse and mental health prevention and treatment are a wise use of resources.

Whether it is the fact that every dollar spent on prevention saves seven dollars, or demonstrating the common sense of treatment as an alternative to incarceration, we must continue to promote effective prevention and treatment as a wise investment.

3. Reaffirm Utah's commitment to the seriously mentally ill and addicted who are indigent and most needy.

The current law for mental health requires the system to prioritize services to adults who are seriously and persistently mentally ill and indigent, and children who are seriously emotionally disturbed. In substance abuse, federal requirements determine service priorities, including pregnant drug abusers and women with dependent children. Funding should be aligned to assure those who are most needy are served.

4. Support the coordination of funding and services.

Expenditures for substance abuse and mental health can be found in a variety of public agencies' budgets as well as private insurance, third party payments, client fees and other sources. Identification of possible funding streams and their coordination will assure the cost-effective delivery of services.

5. Increase funding for critical services.

Funding for substance abuse and mental health treatment has not kept pace with demand. Increased funding for critical services should be seen as a wise investment and good public policy.

6. Support the goals of the New Freedom Commission, including the statement that services must be consumer and family driven.

We need to support existing partnerships with consumers and families, and promote new alliances with them. Effective models of consumer involvement have been developed and refined. The system must move toward consumer and family support and engagement. With only one of four or five persons in need of treatment receiving it, we must think outside the professional delivery models and develop and encourage consumer and family directed systems of support.

7. Engage primary health care providers.

Substance abuse and mental health prevention and treatment are public health issues. No longer can primary care physicians, nurses, and other medical professions afford to not address substance abuse and mental illness in their practices. Professionals in the field of substance abuse and mental health must reach out to primary care providers and share their knowledge and expertise in support of the patient.

8. Develop and expand the use of appropriate technology.

Goal six of the New Freedom Commission on Mental Health envisions that technology is used to access mental health care and information, and the same could apply to substance abuse. Not only can technology be used to access care and information, it can be used to creatively connect those in need of care and support, and to help someone manage or recover from his or her disease. Technology could be used in prevention to help families and communities understand the best way to prevent alcohol and other drug abuse, to identify and intervene in the early stages of mental illness, and to promote healthy communities.

9. Support the implementation of effective evidence-based practices based on the best available science.

Professionals must be held to a standard that supports continuous, rigorous, ongoing training and education in the effective delivery of services. Organizations must provide sufficient management and support to assure the delivery of quality services. We should reinforce what works through funding, training, and technical assistance, and abandon approaches that are outdated or ineffective.

10. Promote efforts to overcome the stigma of addictions and mental illness.

Addictions and mental illnesses are some of the most common, yet most treatable illnesses. Stigma hinders the effective intervention, prevention and treatment of these diseases. We must promote the notion that being clean and sober and mentally healthy is essential to overall health, and fight the stereotypes and the prejudices that characterize these illnesses.

11. Promote parity in health care for substance abuse and mental health services.

Addictions and mental illness must be recognized and treated as diseases. Without insurance parity, the primary cost of both illnesses will be borne by the taxpayers.

12. Develop a comprehensive statewide plan for the delivery of public substance abuse and mental health services.

We believe we are currently in a crisis that threatens the infrastructure of our system. However, crisis creates an opportunity to transform and improve the way we do business. Funding to help support the transformation of the public substance abuse and mental health system will be available from the Substance Abuse and Mental Health Services Administration (SAMHSA) in the near future. We should take advantage of that support, and use it as an opportunity to develop a blueprint for what we want the system to be in the future.

## **CONCLUSION**

The recent crisis in substance abuse and mental health funding has presented significant challenges, not only to enhance and expand effective services to those who need them, but also to just maintain and build on what we have. Unfortunately, service cuts in some areas, particularly to those who are uninsured, present a significant risk to public safety and to the well being of our citizens, our communities and our families. New advances in effective prevention, early intervention, and treatment demonstrate that investing in programs that promote healthy lifestyles and provide science-based treatment really do pay dividends in the long run. Utah should use this crisis as an opportunity to not only transform the current system, but also promote and preserve what we have and what we know works.

## *PART 2*

### *Substance Abuse Services in Utah - 2004*

Substance abuse is the misuse, abuse, or dependence on alcohol and other drugs that are both legal and illegal. Abuse and dependence are often not understood to be diseases; however, those who enter treatment for their disease, struggle to overcome and recover from it just like patients with other illnesses. Substance abuse is often thought of as a condition of the “weak-willed” or “immoral”, a factor that may cause discrimination and ostracism, both of which impede recovery. Overcoming the social stigma of substance abuse and increasing the public’s understanding of treatment and recovery are goals in both Utah and the United States.

Almost 95,000 adults and youth in Utah are in need of treatment for substance abuse, but the current capacity for treatment in the public treatment system is only about 18,000 slots (see chart below). Only 19% who need treatment in Utah receive it.

The best strategy for reducing substance abuse is to prevent it. Prevention research has shown that the longer the onset of substance use is delayed, the lower the chance that a person will develop an addiction. Utah has been a leader in implementing science-based strategies to prevent and delay the use of alcohol and other drugs among youth.

Alcohol has been and still is the most widely abused drug in both the United States and Utah, but both illegal and legal drugs are also used and abused. Methamphetamine is the most common drug of choice among Utah women, which can have devastating impacts on the family and community. Youth are more likely to abuse marijuana, which often leads to harder alcohol and other drugs in later years.

Crime and substance abuse are strongly linked with more than half of all treatment referrals coming from the courts and law enforcement. This takes a toll on those non-offenders who need treatment but are unable to access it because treatment slots are unavailable. Lack of treatment resources for offenders also leads to recidivism and increased costs for both the justice system and community. Substance abuse is one of the major aggravating health care issues in both the United States and in Utah today even though it can be successfully prevented and treated.



## Utah Statewide Need For Treatment Survey Results

District	Adults (18 years +)			Youth (12-17)		
	% Need Treatment	# Need Treatment	Current Capacity	% Need Treatment	# Need Treatment	Current Capacity
Bear River	4.1%	3,747	1,148	5.0%	804	153
Central Utah	5.9%	2,542	143	9.3%	772	73
C Davis County	3.3%	5,115	1,121	4.1%	1,158	152
Four Corners	5.7%	1,583	595	15.4%	693	106
Northeastern	7.7%	2,024	239	8.0%	407	68
San Lake County	5.7%	35,514	5,343	9.2%	8,354	1,379
San Juan County	4.2%	367	134	3.4%	65	52
Southwest Center	5.1%	4,339	582	7.3%	1,229	125
Summit County-VMH	7.5%	1,365	257	20.5%	818	43
Tooele County-VMH	6.4%	1,695	293	13.1%	585	68
Utah County	4.1%	9,365	1,402	2.5%	1,095	205
Wasatch County	5.4%	541	32	7.4%	127	9
Welder Human Services	5.9%	7,005	2,110	9.9%	2,121	251
<b>Total:</b>	<b>4.9%<sup>a</sup></b>	<b>75,703</b>	<b>15,367</b>	<b>7.3%<sup>b</sup></b>	<b>18,029</b>	<b>2,889</b>

<sup>a</sup> Taken from the 2000 State of Utah Telephone Household Survey / Treatment Needs Assessment Project  
<sup>b</sup> Taken from the 2003 State of Utah Prevention Needs Assessment Survey

### Understanding Substance Abuse

Biological, medical, psychological, emotional, social, and environmental factors all contribute to substance abuse and dependence. It is a "bio-psycho-social" disorder that is *progressive, chronic, and relapsing*. Substance abuse often dominates an individual's life with negative impacts both to the individual and to those around him or her (SAMHSA, Changing the Conversation, 2000). As addiction develops and progresses, compulsive use continues regardless of negative consequences experienced by the addict. The ability of an addict to "reason" a way out of addiction and to "will" abstinence becomes more difficult. The compulsion to abuse substances lies partly in the configuration of the human brain. The neocortex provides the individual with the ability to reason and to make complex decisions; however, drugs affect the neocortex in ways that disrupt reasoning and distort judgment. (Daryl S. Inaba, Pharm.D, in "Uppers, Downers, All Arounders").

### Strategies Used To Impact Substance Abuse

The two major strategies used to mitigate the impact of substance abuse in the United States are prevention of use/abuse and treatment of addiction. The National Institute for Drug Abuse reports that substance abuse is a preventable behavior and addiction is a treatable disease.

### Prevention Science: Delaying Use Reduces Risk of Abuse

Historically, substance abuse prevention has included a vast array of interventions from total prohibition, to temperance, to harm reduction. Currently, skill building, resiliency programs and other science-based strategies are considered the most effective ways to prevent substance abuse. These programs focus on training in self-esteem, developing coping skills and teaching parenting and peer leadership.

The following statistics were collected from patients receiving substance abuse treatment services in Utah in 2003:

1. 36% of patients reported using alcohol or other drugs between the ages of 12 and 15.
2. 42% of clients started using their primary substance of abuse before the age of 16.
3. 59% reported first use occurring before the age of 18.

Prevention research has demonstrated that the longer the onset of alcohol and other drug use is delayed, the lower the chance that a person will begin to use and/or become dependent on that use. Risk and protective factors build on natural resistive strengths that people have, such as supportive friends, family, community, school and church. Researchers Steven Glenn, Ph.D., and Richard Jessor, Ph.D., present four antecedents or predictors of future drug use in children by age 12, that differentiates future abusers from future non-abusers. They are:

1. **A strong sense of family participation and involvement by age 12** - Children who feel that they are significant participants in and valued by their families are less prone to substance abuse in the future.
2. **An established personal position about alcohol, other drugs, and sex by age 12** - Children who have a position on these issues and who can articulate how they arrived at their position, how they will act on it, and what effect their position will have on their lives are less likely to develop alcohol or other drug problems.
3. **A strong spiritual sense and community involvement by age 12** - Young people who feel that they matter, who contribute to their community, and who have a sense of role and purpose in society are less likely to develop significant alcohol or other drug problems.
4. **Attachment to a clean and sober adult role model other than parents by age 12** - Children who can list one or more non-drug using adults for whom they have esteem and to whom they can turn for information or advice are less prone to develop drug abuse problems. These positive role models, often persons like a coach, a teacher, activities leader, minister, relative, neighbor, or family friend, play a critical role in the formative years of a child's development.

Utah, a leader in applying the science of prevention services, has adopted the risk and protective factor model as the basis of its substance abuse prevention services since 1990. Utah also conducts regular Student Health and Risk Prevention Surveys (SHARP) that indicate the level of substance use in the youth population. Lifetime alcohol use among high school students in Utah has decreased from 64% in 1997 to 37% in 2003. Lifetime marijuana decreased from 41% to 19% during the same period, and other drugs (including cigarettes) decreased similarly.

## Intervention and Treatment: A Client Focused Model

Treatment of substance abuse in Utah is effective and is based on the best science and practices developed over the last 30 years. Treatment is defined as “the broad range of primary and supportive services—including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up, provided for persons with alcohol and/or other drug problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or other drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems” (Institute of Medicine, 1990).

The most effective treatment planning is based on an individual's needs and responds to changes in need throughout the stages of treatment. A client focused treatment model comprises these four elements:

1. Screening and assessment to identify treatment needs.
2. Intake, clinical evaluation and placement in an appropriate level of care.
3. Treatment planning, engagement and retention in treatment.
4. Continuing care.

Utah has adopted the American Society of Addictions Medicine's Patient Placement Criteria (ASAM-PPC) as a guideline to place a person in the appropriate level of care/treatment. The severity of substance related disorders varies like other disorders and may range from misuse to addiction, thus, interventions must be matched to the level of severity of the disorder. Simple misuse may require only a brief educational intervention, whereas a diagnosis of substance abuse or dependence may require some level of treatment ranging from outpatient to intensive outpatient (IOP) to partial hospitalization (day treatment) to residential treatment and/or detoxification. Effective treatment addresses multiple factors in preparation for self-management of addiction. The maintenance phase of treatment and recovery is a lifelong process that may or may not require professional treatment services.

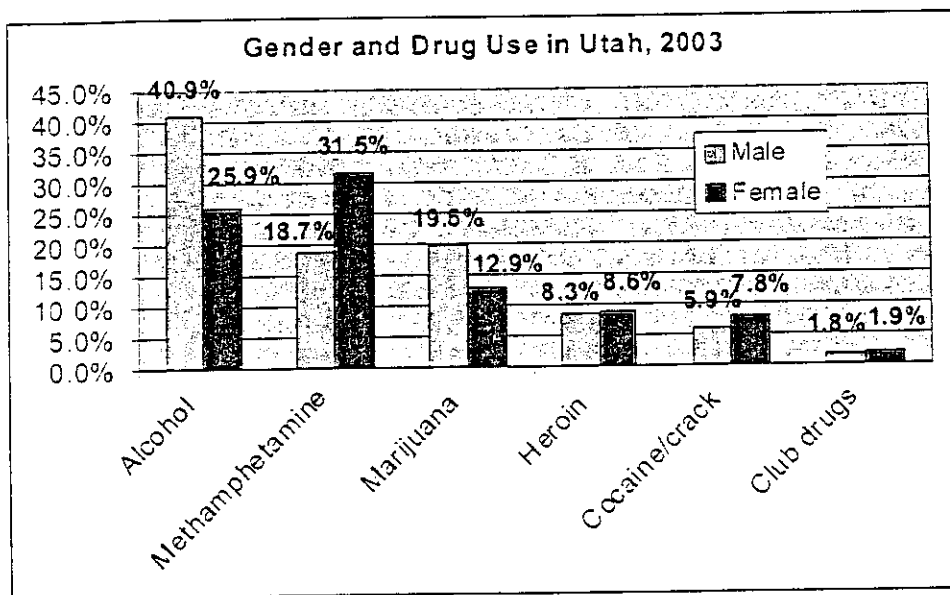
### Drugs of Abuse in Utah

In 2003, alcohol was the most commonly abused drug (36.36%) followed by methamphetamine (23.76%). Others included marijuana (17.87%), heroin (8.73%) and cocaine/crack (6.78%). In almost every other state in the nation, marijuana is second to alcohol, which highlights the severity of methamphetamine abuse in Utah. Methamphetamine use moved ahead of marijuana in Utah in 2001 and has continued its upward trend since then.

Currently, males represent two-thirds of the treatment population. In 1991, males represented 82% of the treatment population, and since then the number of women entering treatment has doubled. In 1991, 83% of the admissions in Utah were for alcohol, but in 2003 only 37% of admissions were primarily for alcohol. Treatment for abuse of other drugs has almost tripled in the past 13 years.

### Women More Likely to Abuse Drugs Other Than Alcohol

Gender differences in drug use are significant in Utah. The following chart demonstrates that the number of females in treatment exceeds the number of males in only two categories: methamphetamine and cocaine. Heroin and club drug abuse are approximately equal between men and women. The most drastic differences are in alcohol and methamphetamine use. In Utah, men are more likely to abuse alcohol and women are more likely to abuse other drugs. The women who abuse methamphetamines are typically between 18 and 35 and 68% have young, dependent children.



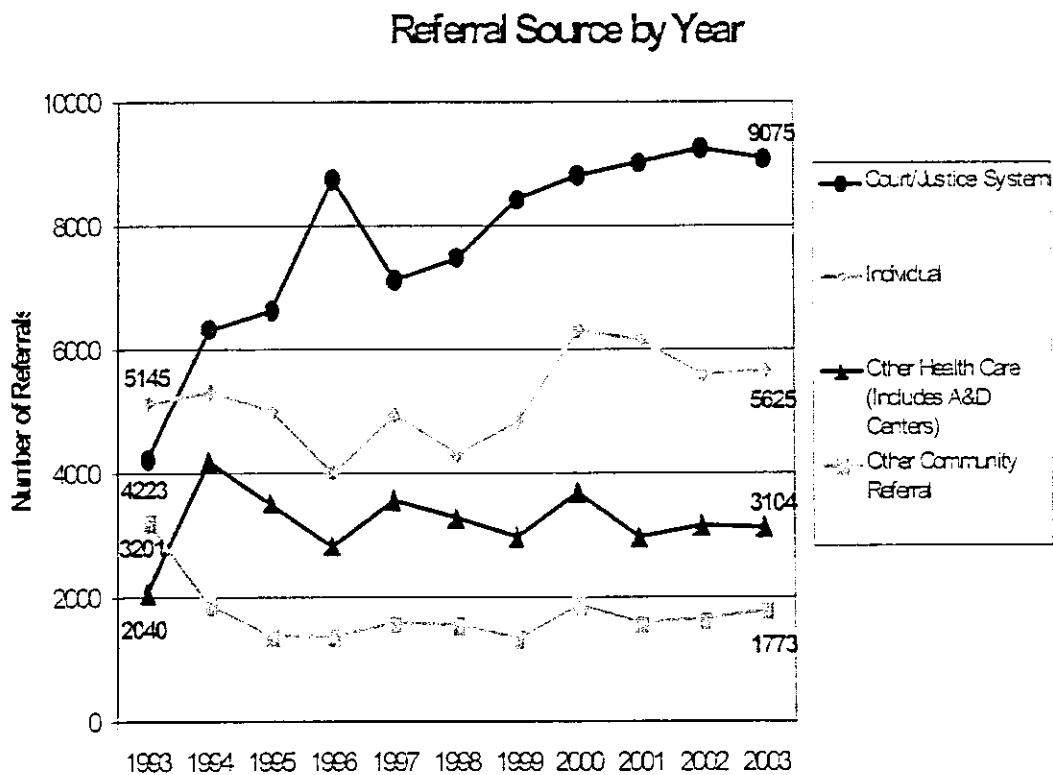
### Marijuana is Drug of Choice for Youth

Youth, under the age of 18, are more likely to abuse marijuana than alcohol or any other drug. By maturity, 18–24 years of age, the drugs of choice, almost equally, are alcohol and methamphetamine. Methamphetamine becomes the number one drug of choice for ages 25 to 34. By age 35 and up, alcohol becomes the most commonly abused drug. Prevention and intervention are keys to keeping youth from using and abusing substances.

## Treatment System is Dominated by Criminal Justice Patients

The courts and criminal justice system are significant contributors of substance abuse treatment referrals. Since 1994, referrals from the criminal justice system have trended steadily upward, currently reaching more than one-half of all treatment referrals. Utah has concentrated resources and energy on the criminal justice population because of the impact this population has on the community and state. Approximately 70% of prison inmates in Utah have a diagnosable substance abuse problem and would qualify for treatment. Even more are "involved" in alcohol and other drugs, but don't meet the criteria for abuse or dependence.

Referrals also come from individuals (self-referrals), health care providers and other community sources such as employers and religious leaders.



## Most Offenders Needing Treatment Don't Receive It

Simply locking up offenders does little to reduce the risk of recidivism so treatment services are provided within the prisons. Ninety-five percent of all inmates are released into their communities upon completion of sentences. The Utah Department of Corrections estimates. However, that only about one-

third of those who need services are able to access treatment. Many of these individuals are among the most chronic users. If the 70% who need substance abuse treatment do not receive it in prison, and if county-based substance abuse treatment resources are not sufficient to meet the need, the adverse impact on their communities is significant. Without readily available community treatment, additional burdens are placed upon courts, county jails, and local law enforcement agencies.

### **Treatment Works In Utah**

Data collection from treatment patients in Utah shows that treatment leads to reduction in use of substances, and often total abstinence. Those completing treatment are able to live independently, stay employed and contribute to their families and communities.

In 2003:

1. 58% of patients completing treatment were abstinent or had decreased use.
2. Homelessness had decreased by 33%.
3. Employment rose by 19%.
4. Criminal activity and arrests were reduced by 69%.
5. Medical visits associated with drug use declined by 50%.

Another Utah study of follow-up data showed that 66% of patients were abstinent after 6 months and employment among them had risen from 37% at admission to 65% at follow-up.

### **Treatment is Cost Effective**

Research on the cost offset for treatment services indicates that for every \$1.00 spent on treatment, \$7.00 in the costs of crime, healthcare, employment, and social impacts are saved. Investment in substance abuse services keeps families together, keeps people employed, and keeps communities safe. Nationally, substance abuse accounts for over \$81 billion in associated social, legal, and health related problems. In the criminal justice system, substance abuse increases costs for police and courts and for incarceration and supervision of offenders. Victimization costs of property replacement, medical expenses and insurance premiums are also impacted. Workplace accidents, absenteeism, and healthcare services used are also impacted.

The cost of treatment is much less than the cost of incarceration. An evaluation of the Washington County Drug Court found that it costs 45% less for an offender to participate in drug court for one year than to place an offender in jail

for 90 days. Because many substance abusers are non-violent offenders, community treatment is a viable way to preserve community safety while saving tax dollars. The following estimate shows the cost to incarcerate a female drug abuser with two dependent children.

**Treatment Preserves the Family**

Perhaps the greatest costs are to families. Children who grow up with adults or older siblings who abuse substances stand a greater chance of becoming abusers themselves. These children may also be neglected, not receiving the appropriate care for their nutritional, educational and nurturing needs.

<b>Incarceration</b>	<b>Treatment</b>
Incarceration for mother = \$26,000/year	Treatment services for family = \$14,500/year
Foster Care for young child = \$35,200/year	
Foster Care for infant = \$35,200/year	
<b>Total = \$96,400</b>	<b>Total = \$14,500</b>

**Recommendations**

1. **Parity in health care insurance for substance abuse services**  
 Substance abuse must be recognized and treated as a disease. Until substance abuse treatment is required coverage under health insurance plans it will continue to be funded primarily by taxpayers.
  
2. **Treatment vs. Incarceration**  
 Once community safety is assured, treating substance abusing offenders in community settings saves tax dollars and is more effective. The Drug Offender Reform Act (DORA), considered in the 2004 legislative session and proposed for action in 2005, would accomplish this.
  
3. **Insist on a science-based approach to prevention and treatment that yields successful outcomes**  
 All substance abuse services, whether publicly or privately funded, should be based on proven, science-based approaches that meet or exceed best practice standards and yield the following outcomes:
  1. Abstinence from Alcohol/Other Drug Use.
  2. Increased Employment/Education
  3. Decreased Crime and Criminal Justice Services
  4. Sound Family and Living Conditions

4. **Keep families together, keep people employed, and keep communities safe**  
Healthy families, wherein all of its members are free of alcohol or other drug abuse, are integral to a health society. A healthy society is more productive and more economically stable. Healthy communities and families promote a safer environment and decrease crime.



## *PART 3*

### *MENTAL HEALTH SERVICES - 2004*

Prior to 1992, a traditional fee-for-service model existed in Utah for community-based mental health services. Payment for inpatient care was the responsibility of the state and both inpatient and outpatient services could be provided by any approved provider. This multiple provider model resulted in a fragmented service system with no accountability for outcomes, no flexibility for effective treatment options, no coordinated patient follow-up and no stable housing options for persons with mental illness. The financial risk for the provision of mental health services resided with the payer (the state and federal governments), making cost effectiveness a low priority for providers.

Under the leadership of the Utah State Department of Health and with the involvement and direction of the Governor and Legislature, a new model of service delivery for mental health Medicaid recipients was developed. The new model placed responsibility for all mental health services with a single provider in each established catchment area of the State. It was expected that approaches to services and treatment would be reinvented and any savings occurring would be used as incentives to the provider for developing the capacity and services of the mental health system throughout the state.

Services were reinvented. In 1992, Southwest Center, Valley Mental Health and Four Corners Behavioral Health tested the new model and the "Utah Capitation Experiment" began. Under this new capitated system, these centers were paid a monthly premium for each eligible Medicaid member. All required services were to be provided within the total premium paid. These test centers created annual service data upon which rates were established specific to each center's experience in providing services and treatment. This new model pooled all funding sources together (federal, state and local), integrated and coordinated all client care appropriate to individual client needs, provided a full continuum of care from intensive inpatient to outpatient services, and developed new systems to support treatment including subsidized housing, supported employment, and educational and vocational supports. The model shifted financial risk from the payer to these providers with each center at full risk for any cost overruns. However, financial incentives existed for effective management of costs and for the use of creative solutions by which the need for expensive inpatient care could be reduced. The result was that previous growth rates in state Medicaid expenditures for mental health declined and savings through effective management of care were reinvested to provide expanded treatment program options including services to uninsured/indigent clients with no other funding resources.

The model was expanded to all centers across the State except Northeastern and San Juan Counseling Centers in 1995. Northeastern Counseling changed from fee-for-service to the capitation model in 2001, and later, Heber Valley Counseling was separated from Wasatch Mental Health as a fee-for-service program. Capitated centers were grouped into three categories for the purpose of structuring rates: Rural, Urban

and Valley Mental Health. Rate setting was done by what is now the federal Center for Medicaid Services (CMS) from rates submitted by the Utah Department of Health based upon a review of cost information provided by the capitated mental health centers to the Utah Department of Health. Annual adjustments to Medicaid rates were made to accommodate inflationary factors and program changes. Medicaid revenues also grew in proportion to increases in Medicaid eligibility.

The Federal Balanced Budget Act, effective August 14, 2003, changed the procedures for setting Medicaid rates. Certification of rates by an independent actuary was required. The Utah Department of Health contracted with Pricewaterhouse Coopers for that purpose. To comply, center-specific data was provided to the actuaries for certification. Through these new procedures, rates would now be based on the actual cost of services provided.

The actuaries reported that a comparison of Medicaid revenue to cost, together with elimination of previously eligible services, would reduce Medicaid mental health revenue across the State. The impact of these changes has threatened the continuation of Utah's effective management of care and costs because risk factors would be too great. Medicaid contracts require that all medically necessary services exist in all counties. However, the rates to be provided and the risks associated may affect the ability of some mental health centers to both bear the risk and meet the obligations of the contract in the future. Some mental health centers, if financially unable to bear the risk, may have to abandon the managed care/cost model and revert back to a fee-for-service system with its potential proliferation of high cost treatment placements. Thus, the rule changes by Medicaid, instead of saving money, may have the reverse impact of actually increasing Medicaid costs. The actuaries, concerned about this possibility and to help mitigate the impact of the loss, recommended to the Center for Medicaid Services (CMS) a one-year transitional rate cutting the impact by one/half. No action on this proposal has occurred as of this writing.

These changes will not only adversely impact the mental health systems in many states but will also leave them unable to address recommendations of the Report of the President's New Freedom Commission on Mental Health. Utah will be no exception. Previously, savings accrued through program efficiencies have developed system capacity and services statewide, have provided expanded services to underinsured/indigent clients, have provided continuity of care during periods of client Medicaid disqualification, and have provided client support services keeping them out of more intensive and costly services. That appears no longer possible using Medicaid funds.

The impact on clients who will no longer be able to access services will be tragic. Impacts could be felt in hospital emergency rooms, primary care doctor's offices, jails and juvenile detention facilities, families and mostly the clients themselves, who could be relieved of the consequences of mental illness with treatment. Additionally, the use of Medicaid dollars to subsidize contracts with state agencies (Juvenile Justice Services and Child and Family Services) will no longer be possible.

Medicaid services have been provided for FY 2004 based upon signed contracts, even though rates have not yet been established, and even after the conclusion of the year. The services provided were based on the contractual obligation to provide all medically necessary and appropriate covered services including additional or alternative services (creative interventions) that meet the needs of clients if they are equally effective and result in improved outcomes. Funds provided under the capitation model are expended in providing those services. No funds exist for a retroactive reconciliation even though rates for the year concluded on June 30, 2004 have not yet been established. CMS has been unable to conceptualize its current strategy, to create appropriate reimbursement rates, to reconcile implementation problems, to provide for any meaningful transition and to effectively resolve policy issues with the State. The Mental Health Centers, however, are expected to continue providing services for the next year based upon "good faith relationships" with CMS even though rates for FY 2005 are also not set.

The President's New Freedom Commission on Mental Health produced a superb document calling for a transformation of mental health systems in the nation. Its goals to achieve community living; to provide access to the most current treatments and best support services; to benefit from advances in treatments, support services, research, technology and understanding; and to promote access by clients to accurate information promoting learning, self-monitoring and accountability seems more remote than ever. This is because of the disconnection between these goals and the counter-restrictions of the principal funding source, Medicaid.

The impact of these actions by CMS, coupled in some cases by funding losses due to state funding formula changes, affect different mental health centers in different ways. In anticipation of these impacts, mental health centers have initiated the following actions as cited in actual written communication to clients and agency partners:

1. (Rural) Only clients with Title XIX (Medicaid) eligibility will be served.
2. (Rural) Roles in emergency services to unfunded clients will be limited to funds available.
3. Large numbers of clients will be discharged – As many as a few hundred in some rural mental health centers, many hundreds in some urban centers.
4. (Urban) Cases will either be closed for clients ineligible for Medicaid or they will be referred to other mental health service providers in the community.
5. (Urban) All clients receiving mental health services will be evaluated for Title XIX eligibility.
6. (Urban) Treatment Priority for Uninsured Applicants:
  - Priority #1: Individuals in need of involuntary hospital services and those who are court committed.

- Seriously and Persistently Mentally Ill (SPMI), Seriously Emotionally Disturbed (SED), or Severely Mentally Ill (SMI) individuals who are in acute distress.
7. (Urban) Admission Criteria for Uninsured Applicants:
    - May be treated only to the extent that state dollars are available – no Medicaid dollars may be used.
    - All uninsured individuals requesting services will first complete an application for Medicaid.
    - Applicants admitted to services will first qualify for Medicaid unless they fall within the established treatment priorities.
    - Individuals approved for treatment will receive crisis stabilization services not to exceed 45 days.
    - Those who meet spend-down criteria, and are Medicaid approved, will be treated.
  8. (Rural) Each clinic will have a quota for discount fee clients of 12% of total caseload.
  9. (Rural) We will no longer be able to serve you with a discounted fee as of June 30.
  10. (Rural) If you are receiving medications, primary care physicians may be able to prescribe for you.
  11. (Rural) We are no longer allowed to subsidize services to non-Medicaid clients with Medicaid funds.

These changes require new approaches, different service delivery models and organizational structures that will meet the needs of clients and that will help them recover and become resilient as they face the challenges of mental illness.

## **PART 4:**

### **MEDICAID ISSUES—CURRENT STATUS**

The rate certification process has recently concluded, and the net impact on community mental health centers of the rate adjustment process is a reduction of **\$3.2 million**. The rate reduction and the corresponding prohibition of using Medicaid savings to fund uninsured clients will have a projected impact of **\$7 million** on Utah's community mental health system. We are now required to transfer any savings into a Community Reinvestment Fund that will be administered by state Medicaid. These funds can only be used to benefit the Medicaid client.

**Use of Medicaid Revenue on Non-Medicaid Clients** – Statements by CMS on this issue clearly indicate that Medicaid funds cannot be used on indigent/uninsured (non-Medicaid) clients that are not Medicaid eligible.

**Program Needs and System Capacity Development** – Program and system capacity needs that are funded with Medicaid dollars will not be available to non-Medicaid clients. Further, proposals for new development with Medicaid dollars must be provided from a Medicaid Reinvestment Account that would be established from savings in providing Medicaid services (an example might be expanding work related skill development for the chronically mentally ill served by Medicaid). It is possible that Medicaid Reinvestment Accounts would be determined from cost settlements and that all plans for use of the account must be approved by CMS. Two factors should be noted: (1) rules for these accounts do not yet exist, (2) if rates for succeeding years are set on the basis of actual cost of services in the previous year, then for each year that there are savings, the succeeding year's rates would be lowered. If costs were higher, there would be insufficient Medicaid revenue to pay for the services.

**Risk** – A three percent risk factor will be incorporated into the approved rates that will not be included in calculations for Reinvestment Accounts.

**Data Issues** – Significant discrepancies still exist between service data provided by the state to the mental health centers upon which services are provided and with that data accepted by actuaries justifying Medicaid costs. Two factors may contribute to this problem: (1) Data system conversions by the state, (2) Changes in eligibility categories for individual clients that occur between the time service is provided and the time compensation for those services occurs due to retroactive eligibility. Other unknown factors may also exist.

It should also be noted that problems with the capacity, quality, and collection of data on a local level by the Community Mental Health Centers has been a factor as well.

**Transitional Rate** - Conflicting messages on the likelihood of a blended/transitional rate have been received, one from the CMS Regional Office, the other from the national office.

Finally, it should be noted that there is still uncertainty regarding the final implications of the decisions made at the federal level at the Center for Medicaid and Medicare services and the Office of Management and Budget.

## PART 5

### LANDMARKS IN MENTAL HEALTH AND SUBSTANCE ABUSE

#### LANDMARKS IN PUBLIC MENTAL HEALTH:

In recent years there have been two major landmark reports on public mental health, the 1999 Surgeon General's Report, and the 2003 Report on the President's New Freedom Commission:

##### **Mental Health: A Report of the Surgeon General**

In 1999, David Satcher, M.D., Ph.D., the Surgeon General of the United States, issued a report on Mental Health. This report emphasized that mental health and physical health are inseparable, and that we must move from the stigma associated with mental illness and addictions to viewing these afflictions in the same light that we view physical illnesses.

The report outlined a vision for the future, which included a commitment to:

- Continue to build the science base
- Overcome stigma
- Improve public awareness of effective treatment
- Ensure the supply of mental health services and providers
- Ensure the delivery of state of the art treatments
- Tailor treatment to age, gender, race and culture
- Facilitate entry into treatment, and
- Reduce financial barriers to treatment

##### **The President's New Freedom Commission on Mental Health**

In April 2002, President George W. Bush announced the creation of the New Freedom Commission on Mental Health, stating: "Our country must make a commitment. Americans with mental illness deserve our understanding and they deserve excellent care." The commission was charged with the responsibility to make recommendations that would enable individuals with mental illness to live, work, learn and participate fully in their communities. It rejected a piecemeal approach to mental health reform, and instead issued recommendations to fundamentally transform the Nation's approach to mental health care. Thus, the report that was released in July 2003 was entitled: *Achieving the Promise: Transforming Mental Health Care in America*. This transformation is captured in the Vision Statement:

*“We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community.”*

The Commission proposed six broad goals in a transformed system:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

In Utah, the belief was that same compelling vision and the goals stated to transform the mental health system could be applied to substance abuse as well.

## **LANDMARKS IN SUBSTANCE ABUSE**

### **LANDMARKS IN SUBSTANCE ABUSE PREVENTION**

- Early 1980's: Began development of Utah's K-12 Alcohol, Tobacco and Other Drug Prevention Education Program, a scoped and sequenced curriculum for students in kindergarten through high school (later named “Prevention Dimensions”). Program is a partnership between the Utah State Office of Education, Division of Substance Abuse and Mental Health, and Department of Health, along with local school districts, substance abuse authority agencies, and health departments.
- 1983: Utah Legislature passed beer tax increase. \$2 million of new tax revenue was appropriated to the Division for the establishment of school- and community-based prevention programs, including teacher in-service training for the K-12 Program.
- 1983: Establishment of a statewide network of Substance Abuse Prevention Specialists with new revenue from beer tax.



- 1983: Governor Scott Matheson created the Governor's Youth Council (GYC – now the *Governing* Youth Council) to provide a meaningful way for youth to be involved in combating substance use/abuse among their peers. The Division supported the GYC for years; it now has a multi-agency support structure, involving several state departments and agencies (DSAMH, CCJJ, Public Safety/Highway Safety Office, Education, Health, Utah Council for Crime Prevention).
- 1985: Utah Federation for Drug-Free Youth (UFDY) established. Provided a means for parents, volunteers, and others to become involved in substance abuse prevention.
- 1985: Established a full-time position for a Substance Abuse Education Specialist at the Utah State Office of Education.
- 1986: Federal Drug-Free Schools and Communities Act enacted by Congress and signed into law by President Ronald Reagan.
- 1987: Utah receives first year appropriation of federal Drug-Free Schools and Communities Act funding. Eighty percent (80%) is appropriated to the Utah State Office of Education, 90 percent of which is allocated to Utah's 40 school districts. Twenty percent (20%) is appropriated to the Governor's Office for programs targeted at high-risk youth.
- 1989 or 1990: Federal Block Grant requirement of 20% set-aside for prevention enacted.
- 1990: Utah Legislature created the Utah Substance Abuse Coordinating Council (in 1994 added an anti-violence component and was renamed the Utah Substance Abuse and Anti-Violence Coordinating Council/USAAV). The Council included a Prevention Subcommittee.
- 1993: Risk and Protective Factor Model of Substance Abuse Prevention adopted by the Utah State Board of Substance.
- 1997 to Present: Utah participation in several multi-state consortium projects with the Center for Substance Abuse Prevention (CSAP), National Institute on Drug Abuse (NIDA), and the University of Washington Social Development Research Group (SDRG) to test the Risk and Protective Factor framework.
- 2000: CSAP awarded a State Incentive Cooperative Agreement (SICA/SIG) to Utah. Award was for \$2.9 million per year for three years (total of \$8.7 million). Purpose was to implement science-based prevention programs targeting 12-17 year olds.

- 2002: Merger of DSA + DMH = DSAMH
- 2003: DSAMH began development of a "Pro-Vention" Model for promoting mental health, based upon successful substance abuse prevention models.
- 2003 CSAP awarded a State Incentive Enhancement Grant (SIG-E) to Utah. Award was for \$750,000 per year for three years (total of \$2,250,000). Purpose is to implement extend the SICA model (science-based prevention programs) to 18-25 year old college students.

### ***NATIONAL LANDMARKS IN SUBSTANCE ABUSE TREATMENT***

1. Adoption of National Institute of Drug Abuse (NIDA) Principles of Effective Treatment (1999)

The Principles of Effective Treatment highlight the need to replace program-driven treatment with client-driven treatment; tailor length of stay to address individual clinical needs rather than fit persons with varying needs to a prescribed length of stay; manage an individual's care throughout an entire continuum of services and menu of services; improve performance monitoring and outcome analysis and promote scientific proven treatment services.

2. Access to Recovery (2003)

President George W. Bush announced in his State of the Union Address in January 2003, a new substance abuse treatment initiative, Access to Recovery (ATR). The purpose of ATR is to increase consumer choice, including faith-based programmatic options, increase treatment capacity and allow clients to access a comprehensive array of clinical treatment and recovery support services through the use of vouchers to pay for a range of effective, community-based substance abuse services. ATR is outcome-oriented and supports "best practice" models. In the fall of 2004, \$100 million dollars was distributed to 14 states and one tribal organization in three-year grants.

### ***UTAH LANDMARKS***

1. Adoption of ASI and ASAM (2001)

DSAMH requires the use of the Addiction Severity Index (ASI) as a common assessment instrument, which provides consistent information for each adult client entering treatment with local authorities. The required use of the American Society of Addiction Medicine (ASAM) Uniform Patient Placement Criteria Second Edition-Revised

has resulted in more effective and appropriate treatment placements and has reduced length of stays in more costly services. The adoption of these tools places emphasis on client-driven treatment rather than program-driven treatment and on variable lengths of services rather than fixed length.

## 2. Completion of Substance Abuse Treatment Practice Guidelines (2003)

DSAMH staff and representatives from local substance abuse providers developed these guidelines. The practice guidelines are based on the most recent scientific and clinical knowledge available from the literature and from outcome research.

## ***NATIONAL LANDMARKS IN SUBSTANCE ABUSE TREATMENT OF THE JUSTICE POPULATION***

### 1. Explosion in Illicit Drug Use

The segment of society using drugs between 1950 and 1970 expanded with the crack cocaine epidemic of the mid-1980's, and the number of drug arrests skyrocketed. Initial legislation redefined criminal codes and escalated penalties for drug possession and sales. These actions did little to curtail the illicit use of drugs and alcohol. As law enforcers redoubled their efforts, America's prisons were filled, compromising Federal and State correction systems' abilities to house violent and career felons. Some States scrambled to "build out" of the problem, spending hundreds of millions of dollars on new prisons, only to find that they could not afford to operate or maintain them.

### 2. The Nation's First Drug Court established in Miami in 1989.

The first drug court was implemented in 1989 in Miami, Florida when Judge Herbert M. Klein, troubled by the disabling effects that drug offenses were wreaking upon Dade County courts, became determined to "solve the problem of larger numbers of people on drugs." The court became a model program for the Nation.

## ***UTAH LANDMARKS***

### 1. Dramatic increase in the number of individuals referred from the criminal justice system

The number of referrals to Utah's public substance abuse programs from the criminal justice system has risen dramatically over the past 10 years, from 5145 to 9075, nearly 1/2 of the 19,577 referrals to the system. At the same time, the number of inmates who need substance abuse treatment services has also risen to 70% of all incarcerated state prisoners.

### 2. In 2001, methamphetamine became the primary illicit drug of choice

After alcohol (36.36%), methamphetamine is the most commonly abused drug among Utahans who entered treatment in 2003 (23.76%). Methamphetamine was followed by marijuana (17.87%), heroin (8.73%) and cocaine/crack (6.78%). In almost every other

state in the nation, marijuana is the highest drug after alcohol, which highlights Utah's problem with meth. Methamphetamine surpassed marijuana in Utah by 2001, and has continued an upward trend since then.

Methamphetamine continues to be the drug of choice among Utah women of childbearing age who use and abuse illegal drugs. Of particular concern is the fact that two-thirds (68%) of these women have young, dependent children. It is estimated that about 70% of males and 81% of females are at risk of abuse or dependence on alcohol or drugs upon entering the Salt Lake County Metro Jail (2002). In addition, 58% of males and 74% of females test positive for an illicit drug at the time of arrest. This does not include alcohol intoxication (ADAM, 2002).

### 3. Utah's First Drug Court Established in 1996

In 1996, the first Drug Court in Utah was established in Third District Court (Salt Lake). Designed as an alternative for non-violent drug offenders, it provides intensive drug treatment and monitoring as opposed to traditional sentencing and incarceration. During 1997, Third District's Drug Court has begun to see the fruits of its labor with the first graduates of the program. According to the U. S. Department of Justice, the recidivism rate of drug offenders sent to prison can be more than 60% with recidivism among drug court participants ranging from 5% to 28%.

### 4. Tobacco Settlement Funding for Utah's Drug Courts

This new law, effective in 2000, expanded existing drug court programs and created the criteria for participation in drug court programs. In total, \$1,646,867 million dollars of Tobacco Settlement funds were used to create a statewide Drug Court and Drug Board program. Sixteen drug courts and 2 drug boards are funded through this program.

### 5. 2000, creation of the Collaborative Interventions for Addicted Offenders (CIAO) Program

CIAO program was created in 2000 to address substance abuse among parolees and probationers in Utah. This program provides a continuum of evidence based treatment services in the community. CIAO is the result of a partnership between the Division of Substance Abuse and Mental Health and the Utah Department of Corrections. CIAO is funded with \$755,000 of Federal Substance Abuse Block Grant funds.

(Ms:dsamh: white paper final 1.22.05jrb)

November 19, 2004

Steve Rawlings  
Davis County Clerk/Auditor  
Davis County Courthouse  
P.O. Box 618  
Farmington, UT 84025

Re: Davis Behavioral Health Designation and Use of Private Funds

Dear Mr. Rawlings

The purpose of this letter is to bring you up-to-date on DBH's corporate restructuring and how private funds were defined by the Board and will be used in the restructuring process. To ensure that you have a full understanding of DBH's restructuring and the reasoning behind this effort, this letter is divided into three sections: first, the goals or motives for the restructuring; second, a summary of the new corporate structure and the reasons why this particular corporate structure was selected; and third, how the restructuring process will be funded.

I. Goals/Motives

1. To continue to provide mental health treatment to unfunded SPMI and SED patients in Davis County, while implementing changes in federal funding regulations and being good stewards of State and County funds.
2. To promote "recovery" in DBH patients, to normalize their lives, and to eliminate dependency on the public human services systems for sustaining their quality of life.
3. To fill a gap in mental health services for individuals who are not within the target population served by the public mental health system in a manner that provides a continuum of care that is similar to the continuum provided in the public system

## II. Summary of the New Corporate Structure

The DBH restructuring is based upon the creation of four 501(c)3 private, non-profit corporations. One corporation will be structured as a holding corporation (DBH Holding Corporation) which will become the parent company of DBH and three new subsidiaries of DBH Holding Corporation which are sister corporations to DBH (Francis Peak Family Counseling Center, Diversified Employment Opportunities, and the Family Behavioral Health Foundation). Non-profit corporate structures were selected because non-profit companies are restricted in their ability to pay dividends or profits to only other non-profit corporations and not individuals or for-profit organizations. Therefore, each corporation within the structure exists for the specific purpose of generating profit that can be passed through to DBH to fund treatment for unfunded SPMI and SED patients. Specifically, Francis Peak Family Counseling Center, Inc. is a private behavioral health clinic that will provide services to non-SPMI and non-SED patients with the ability to pay through private insurance, cash, employee assistance programs, or other private sources. After the clinicians and overhead expenses are paid, a portion of the profits will be passed through the DBH Holding Corporation to DBH to assist in funding treatment.

Diversified Employment Opportunities, Inc. (DEO) is an "affirmative business" which is a private business that will have a mixed work force of traditional employees (approximately 60%) and DBH patient employees (approximately 40%). The DBH patient employees will be hired in positions at all levels of the business that maximize their skills and potential for growth. These jobs are designed as permanent jobs that patients can work at until they are able to secure other employment. DEO will begin work in a custodial business and aluminum recycling business. DEO has also been qualified as a federal "NISH" provider which makes it eligible for federal set-aside contracts awarded to companies that employ disabled individuals in their workforce. After the workforce and overhead expenses are paid, a portion of the profits will be passed through the DBH Holding Corporation to DBH to assist in funding treatment.

The Family Behavioral Health Foundation, Inc. will be focused on fund raising and public awareness of how behavioral health issues impact the family. The fund raising efforts will be in the form of special events and donations from private foundations, individuals, and businesses. After the staff and overhead expenses are paid, a portion of the profits will be passed through the DBH Holding Corporation to DBH to assist in funding treatment.

The DBH Holding Corporation is designed simply as a pass-through corporation to initially receive and distribute private funds that DBH has accrued over the year and to distribute profits from DBH sister corporations back to DBH to assist in funding treatment.

### III. Determination and Use of Private Funds

When the DBH Board of Directors began planning the corporate restructuring, they made two commitments to ensure the corporate restructuring process would hold up to public and legislative scrutiny. First, the Board is committed to full disclosure to DBH's public funding sources (Davis County, the Department of Human Services (DHS), and the Department of Health (DOH)) regarding the planning, funding and implementation process. Second, the Board is committed to statutory and contractual compliance regarding the use of public funds. These commitments led to the following steps to accomplish full disclosure and full contractual and statutory compliance:

1. The Local Mental Health and Substance Abuse Authority has been a full participant in the planning process and represented by Commissioner Cragun as a non-voting member of the DBH Board of Directors. During Board meetings the corporate restructuring was reviewed and approved. In addition, the Board gave a directive to define and segregate DBH's private funds for use in the development of the new corporate structure. This directive included the mandate that the segregation of private funds could not jeopardize the 60-day operating cash balance required in the Medicaid contract with DOH.
2. On April 5, 2004 and April 15, 2004, I met with Pattie Christiansen, outside counsel DBH retained to assist in the development of the new non-profit companies, to provide a legal analysis on the definition of private funding using State and County contracts and State statutes.
3. On April 9, 2004, the DBH Board Chair, Commissioner Cragun, and I met with Randy Bachman, SAMH Division Director, Wayne Welch, Legislative Auditor and other members of the Legislative Auditor's staff. The purpose of the meeting was to fully disclose DBH's planning process to the Legislative Auditors and DHS.
4. On April 15, 2004, Ray Johnson, DBH, CFO, and I met with Davis County Commissioner Michael Cragun; Gary McKean, Deputy Davis County Attorney; and Steve Rawlings, Davis County Clerk/Auditor. The purpose of the meeting was to review the new corporate structure and review the definitions and calculations of DBH private funding that would be used to develop the new corporate structure.
5. On April 19, 2004, the Davis County Mental Health and Substance Abuse 2005 Area Plan was submitted to the Local Authority for review. The Area Plan contained an overview of the new corporate structure in Part IV: Brief Descriptions of Other Services Offered.

6. On April 26, 2004, a letter drafted by Pattie Christiansen was sent to Gary McKean. The letter contained an analysis of how DBH defined and calculated the amount of private funds.
7. On April 27, 2004, the Davis County Commission, in its role as the Local Mental Health and Substance Abuse Authority, approved the 2005 Area Plan.
8. On April 28, 2004, the Davis County Area Plan was submitted to the State Division of Substance Abuse and Mental Health for approval.
9. On June 17, 2004, Maureen Womack, DBH President met with Mike Dielly and Karen Ford, DOH Division of Health Care Finance. During the meeting, Maureen reviewed the new corporate structure.
10. On July 1, 2004, I met with Gary McKean, Deputy Davis County Attorney and a staff member from the Clerk/Auditors office. During the meeting, Mr. McKean requested more analysis be added to the April 26, 2004 letter.
11. On July 5, 2004, a revised private funds analysis letter was sent to Gary McKean.
12. On July 13, 2004, the Local Authority received a conditional letter of approval for the Area Plan from the State Division of Mental Health and Substance Abuse. The approval was conditioned on submission of some clarifying information, none of which was related to the new corporate restructuring.
13. On September 17, 2004, I had a phone conversation with Gary McKean. During the call, Mr. McKean stated he was satisfied with the analysis in the private funds letter and requested that a meeting be arranged between the DBH CFO and the County Clerk/Auditors staff to ensure the calculations of private funds matched the definitions contained in the private-funds analysis letter.
14. On September 17, 2004, Ray Johnson DBH CFO, met with you and other members of the Auditors staff who confirmed the calculation of private funds matched the definition in the private funds analysis letter. From that meeting Ray report your office need to complete further analysis of the calculations.

From our meeting yesterday, the following concerns were noted for resolution, prior to the private fund determination can made and approved by the county.

1. Private funds generated from the third party payments (private insurance, co-payments and fees) shall only be counted as private funds profits after the expenses incurred by DBH for the services which generated the third party



Mr. Steve Rawlings  
November 19, 2004  
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payments have been deducted. (Third Party Payment – cost of clinical service – cost DBH overhead to support the clinical service = Available private funds)

2. The DBH private fund calculation must be amended to reflect the calculation shown above and resubmitted to the County for analysis and approval.

Please let me know if you have any questions (801) 726-8709. Thank you for your time and consideration.

Sincerely,

Abel C. Ortiz  
General Counsel, DBH Board of Directors

ACO:lj

**A PROPOSAL TO MEET THE DEMAND FOR COMMUNITY MENTAL  
HEALTH AND SUBSTANCE ABUSE SERVICES IN AN ENVIRONMENT OF  
REDUCED FEDERAL FUNDING AND MORE RESTRICTIVE MEDICAID  
RULES**

Background

In response to recent changes in Medicaid funding rules that have significantly reduced the resources available to community mental health centers in Utah, the Board of Trustees of Davis Behavioral Health, Inc. ("DBH"), has recommended the formation of three non-profit corporations to support and supplement the services that DBH can provide under the new funding rules. These entities, which will be sister organizations of DBH, will permit behavioral health services to be provided to a broader cross-section of the community than DBH can service under the new Medicaid guidelines. One of the new entities will be for the specific purpose of providing vocational training and employment opportunities to DBH clients who are trying to transition from hospitalization or other intensive treatment programs back to social and economic independence. Although supportive employment programs such as this have been strongly encouraged by SAMHSA (the federal Substance Abuse and Mental Health Services Administration) as an evidence-based practice that is an essential component of community mental health services, they cannot be financed with Medicaid funds.

In addition to providing a vehicle to provide our community with behavioral health, substance abuse and family counseling services that cannot be provided to the general public under the new Medicaid rules, another benefit of the new organizations is that any surplus funds generated by their activities (above what is required for the development and operation of their programs) will be available to Davis Behavioral Health to help offset the losses DBH has experienced due to cut-backs in governmental funding. It is proposed that the initial operating expenses of the new entities be financed through loans from either of the sources described in the proposal below.

Outside legal counsel, as well as community mental health centers in other states that have established successful programs of this type, have recommended that separate legal entities be used to provide these services, in order to facilitate the auditing of income and expenditures, and to protect DBH from any uncertainty as to whether its Medicaid funds are being used to subsidize DBH services that are not eligible for reimbursement by Medicaid or that are being provided to individuals who are not eligible for Medicaid benefits.

Proposals

DBH requests that the Davis County Commission, acting in its capacity as the local mental health authority, approve the following proposals:

1. That Diversified Employment Opportunities, Inc. ("DEO"), a non-profit corporation, be authorized to provide vocational training and transitional employment opportunities to clients of Davis Behavioral Health who are completing mental health

and/or substance abuse treatment programs. The initial training and employment program will be in the area of janitorial services. DEO has been certified as a NISH program provider, which will give it priority for government contracts within its field of service.

2. That a non-profit family counseling center be authorized to provide mental health, substance abuse, and family counseling services on a fee-for-services basis to individuals who are not eligible for treatment from Davis Behavioral Health under state and federal assistance guidelines.

3. That a non-profit charitable foundation be authorized to seek donations from corporations, private charities and other funding sources to provide supplemental funding to Davis Behavioral Health, DEO, and the family counseling center.

4. That the initial operating expenses of DEO, the family counseling center and the foundation be funded from one of the following sources (as the County Commission may direct):

- a. A loan from DBH's contingency reserve (This fund, which consists of surplus private funds that the Board of Trustees has directed be set aside for capital expenses, special projects or other contingencies.); or
- b. A line of credit from a commercial bank.

DAVIS BEHAVIORAL HEALTH, INC. BOARD OF TRUSTEES

By: \_\_\_\_\_  
REX T. WILLIAMS, CHAIRMAN

**The exhibits are available by request  
at the Office of the Legislative Auditor General**

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## **Auditor's Comments Regarding the Agency Response**

We have reviewed the audit response letters submitted by the Davis Behavioral Health (DBH) Board Chairperson and by the organization's management and, due to the depth of their criticism, have deemed it necessary to formally reply to their comments. Such a response is not a typical practice of the Office of the Legislative Auditor General, but it is called for in this case and follows performance audit standards established by the United States Governmental Accountability Office (GAO).

### **Board Response**

The DBH Board Chairperson's objections to and negative characterizations of how our audits are released are unfortunate but understandable, given his lack of understanding of the audit process due to his exclusion from the process by DBH management. DBH management has been involved in previous legislative audits that have followed the same exit process. In past audits, DBH management and key members of DBH's board have been involved in the audit, from beginning to completion. However, the audit process does not include the entire board of any audited organization. For this audit, DBH management attended the exit conferences and elected not to have board participation.

This audit began with an entrance conference that included the past DBH Board Chair and one other board member. The audit's completion process was discussed at that time, including the level of board participation and the organization's option to respond. DBH board officers changed during the course of the audit and, apparently, were not informed of the audit process by the prior board members or DBH management.

As the completion of the audit drew near, we began our exit process. We offered initial drafts to DBH management, who could have shared the drafts with one or two key board members. DBH management requested copies for three administrators, and they received these copies on April 22. On May 8, we met with DBH and discussed this draft. A second draft was provided to, and discussed with, DBH administrators on May 13. DBH received a final draft on May 20, and at the request of DBH management, we provided an additional copy for the board chair.

On June 3, DBH's executive director informed us that the board chair wanted all board members to review the draft document in a late June board meeting and that board and agency responses would not be possible until sometime in July. We informed DBH that it is not our

practice to widely distribute draft reports to entire boards, and that a response was needed by June 11 if one was to be included in the bound report. This response time (over one and a half months) is substantially longer than what we typically give auditees. Several attempts to contact both the board chair and vice chair regarding their concerns with the exit process were unsuccessful.

Inclusion of an agency response is not an agency's right; it is a courtesy offered by our office. The GAO book of audit standards states that conducting audit exit conferences with agencies and allowing a response to the audit is an important part of developing "a report that is fair, complete, and objective." Taking these steps, although they increase the time and cost of an audit, is worthwhile. However, the inclusion of an agency response does not dictate when and how an audit is released.

The Legislative Audit Subcommittee has addressed this exit process over the years, and the current subcommittee is comfortable with the existing method. In this case, the subcommittee chairs were informed of DBH concerns and agreed that the current exit process appropriately accommodated DBH.

## **Agency Management Response**

During the audit exit process, we reviewed the information in the DBH response letter or alluded to as ignored by the auditors, and found it insufficient and/or unsupported.

The information we included in this report, as in all other reports from this office, represents the most accurate documentation available during the audit process. Most of the base financial information in the report comes directly from either DBH's finance and accounting departments or their audited financial statements. Much of the information in the report was verified by the past CFO, who resigned during the audit process, and DBH's controller. The numbers presented after the audit process by DBH's current CFO were, in our opinion, developed solely to refute both the audit and past DBH information.

DBH's criticism that the auditors do not recognize that the affiliated entities provided a service which resulted in benefits for the increased costs, misdirects the intent of Chapter II. In fact, the \$850,000 value cited in the report is the additional cost required to establish the infrastructure of those businesses, not the cost of therapeutic activities. It is also important to note that the affiliated entities serve a very limited number of clients at a higher cost than previous programs.

The agency response neglects to explain why the entities that DBH claims had to be separated from DBH for federal accounting purposes, are now functioning as divisions of DBH. During

the exit process and in their response, DBH stated that the problem was not the need for federal accounting separation, but a need to separate out private insurance that was losing billings due to poor accounting procedures.

The purpose for creation of the affiliated entities needs to be clarified. DBH is critical of the report's focus on the profitability of the entities, yet it continues to emphasize the support it gained from its oversight agencies. The two go hand in hand. State and county oversight bodies were sold the concept of separate affiliated entities with the benefits of 1) separation of private and public funds, and 2) profitability that could be utilized to augment DBH's public funds. The original articles of incorporation identify the affiliated entities' profit motive "to provide financial support to existing 501(c)(3) organizations." Service delivery, as a component of the incorporation papers, was added two years later and was not a major part of the presentation to the oversight agencies.

Finally, the Office of the Legislative Auditor General wishes to clarify that it never expressed support or opposition to the development of the private businesses. On numerous occasions, DBH contacted both the current and past Auditors General in an attempt to obtain support for its plans to privatize some businesses. Our answer was that we would neither support nor oppose their plans with the caveat that our 2003 mental health report found problems with another center's affiliated business, and caution was advised. DBH's use of quotes from oversight agencies where it implies inclusion of the Office of the Legislative Auditor General is inaccurate and simply not true. We have worked with all of the oversight agencies throughout this audit, and all have expressed serious concerns with DBH management's support of the affiliated businesses.