

**OFFICE OF QUALITY AND DESIGN**

2019 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: Jon Hawkins**

Senate Sponsor: Wayne A. Harper

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**LONG TITLE**

**General Description:**

This bill creates the Office of Quality and Design within the Department of Human Services.

**Highlighted Provisions:**

This bill:

- ▶ creates the Office of Quality and Design within the Department of Human Services;
- ▶ establishes the powers and duties of the Office of Quality and Design;
- ▶ deletes provisions relating to the Office of Services Review; and
- ▶ makes technical changes.

**Money Appropriated in this Bill:**

None

**Other Special Clauses:**

None

**Utah Code Sections Affected:**

AMENDS:

**62A-1-105**, as last amended by Laws of Utah 2016, Chapter 300

**62A-4a-202.6**, as last amended by Laws of Utah 2018, Chapter 415

**62A-16-102**, as enacted by Laws of Utah 2010, Chapter 239

**62A-16-201**, as last amended by Laws of Utah 2011, Chapter 343

**62A-16-204**, as last amended by Laws of Utah 2013, Chapter 445



28 **62A-16-301**, as last amended by Laws of Utah 2011, Chapter 343

29 ENACTS:

30 **62A-18-101**, Utah Code Annotated 1953

31 **62A-18-102**, Utah Code Annotated 1953

32 **62A-18-103**, Utah Code Annotated 1953

33 **62A-18-104**, Utah Code Annotated 1953

34 **62A-18-105**, Utah Code Annotated 1953



35  
36 *Be it enacted by the Legislature of the state of Utah:*

37 Section 1. Section **62A-1-105** is amended to read:

38 **62A-1-105. Creation of boards, divisions, and offices.**

39 (1) The following policymaking boards are created within the Department of Human  
40 Services:

- 41 (a) the Board of Aging and Adult Services;
- 42 (b) the Board of Juvenile Justice Services; and
- 43 (c) the Utah State Developmental Center Board.

44 (2) The following divisions are created within the Department of Human Services:

- 45 (a) the Division of Aging and Adult Services;
- 46 (b) the Division of Child and Family Services;
- 47 (c) the Division of Services for People with Disabilities;
- 48 (d) the Division of Substance Abuse and Mental Health; and
- 49 (e) the Division of Juvenile Justice Services.

50 (3) The following offices are created within the Department of Human Services:

- 51 (a) the Office of Licensing;
- 52 (b) the Office of Public Guardian; ~~and~~
- 53 (c) the Office of Recovery Services~~[-];~~ and
- 54 (d) the Office of Quality and Design.

55 Section 2. Section **62A-4a-202.6** is amended to read:

56 **62A-4a-202.6. Conflict child protective services investigations -- Authority of**  
57 **investigators.**

58 (1) (a) The ~~[division]~~ department, through the Office of Quality and Design, shall

59 ~~[contract with]~~ conduct an independent child protective service ~~[investigator from the private~~  
60 ~~sector]~~ investigation to investigate reports of abuse or neglect of a child that occur while the  
61 child is in the custody of the division.

62 ~~[(b) The executive director shall designate an entity within the department, other than~~  
63 ~~the division, to monitor the contract for the investigators described in Subsection (1)(a).]~~

64 ~~[(c) Subject to Subsection (4), when]~~

65 (b) When a report is made that a child is abused or neglected while in the custody of  
66 the division:

67 (i) the attorney general may, in accordance with Section 67-5-16, and with the consent  
68 of the division, employ a child protective services investigator to conduct a conflict  
69 investigation of the report; or

70 (ii) a law enforcement officer, as defined in Section 53-13-103, may, with the consent  
71 of the division, conduct a conflict investigation of the report.

72 ~~[(d)]~~ (c) Subsection ~~[(1)(c)(ii)]~~ (1)(b)(ii) does not prevent a law enforcement officer  
73 from, without the consent of the division, conducting a criminal investigation of abuse or  
74 neglect under Title 53, Public Safety Code.

75 (2) The investigators described in Subsections ~~[(1)(c) and (d)]~~ (1)(b) and (c) may also  
76 investigate allegations of abuse or neglect of a child by a department employee or a licensed  
77 substitute care provider.

78 (3) The investigators described in Subsection (1), if not peace officers, shall have the  
79 same rights, duties, and authority of a child protective services investigator employed by the  
80 division to:

81 (a) make a thorough investigation upon receiving either an oral or written report of  
82 alleged abuse or neglect of a child, with the primary purpose of that investigation being the  
83 protection of the child;

84 (b) make an inquiry into the child's home environment, emotional, or mental health, the  
85 nature and extent of the child's injuries, and the child's physical safety;

86 (c) make a written report of their investigation, including determination regarding  
87 whether the alleged abuse or neglect was substantiated, unsubstantiated, or without merit, and  
88 forward a copy of that report to the division within the time mandates for investigations  
89 established by the division; and

90 (d) immediately consult with school authorities to verify the child's status in  
91 accordance with Sections 53G-6-201 through 53G-6-206 when a report is based upon or  
92 includes an allegation of educational neglect.

93 [~~(4) If there is a lapse in the contract with a private child protective service investigator  
94 and no other investigator is available under Subsection (1)(a) or (c), the department may  
95 conduct an independent investigation.~~]

96 Section 3. Section 62A-16-102 is amended to read:

97 **62A-16-102. Definitions.**

98 (1) "Committee" means a fatality review committee, formed under Section 62A-16-202  
99 or 62A-16-203.

100 (2) "Qualified individual" means an individual who:

101 (a) at the time that the individual dies, is a resident of a facility or program that is  
102 owned or operated by the department or a division of the department;

103 (b) (i) is in the custody of the department or a division of the department; and

104 (ii) is placed in a residential placement by the department or a division of the  
105 department;

106 (c) at the time that the individual dies, has an open case for the receipt of child welfare  
107 services, including:

108 (i) an investigation for abuse, neglect, or dependency;

109 (ii) foster care;

110 (iii) in-home services; or

111 (iv) substitute care;

112 (d) had an open case for the receipt of child welfare services within one year  
113 immediately preceding the day on which the individual dies;

114 (e) was the subject of an accepted referral received by Adult Protective Services within  
115 one year immediately preceding the day on which the individual dies, if:

116 (i) the department or a division of the department is aware of the death; and

117 (ii) the death is reported as a homicide, suicide, or an undetermined cause;

118 (f) received services from, or under the direction of, the Division of Services for People  
119 with Disabilities within one year immediately preceding the day on which the individual dies,  
120 unless the individual:

- 121 (i) lived in the individual's home at the time of death; and
- 122 (ii) the director of the Office of [~~Services Review~~] Quality and Design determines that
- 123 the death was not in any way related to services that were provided by, or under the direction
- 124 of, the department or a division of the department;
- 125 (g) dies within 60 days after the day on which the individual is discharged from the
- 126 Utah State Hospital, if the department is aware of the death; or
- 127 (h) is designated as a qualified individual by the executive director.

128 Section 4. Section **62A-16-201** is amended to read:

129 **62A-16-201. Initial review.**

130 (1) Within seven days after the day on which the department knows that a qualified

131 individual has died, a person designated by the department shall:

- 132 (a) complete a deceased client report form, created by the department; and
- 133 (b) forward the completed client report form to the director of the office or division
- 134 that has jurisdiction over the region or facility.

135 (2) The director of the office or division described in Subsection (1) shall, upon receipt

136 of a deceased client report form, immediately provide a copy of the form to:

- 137 (a) the executive director; and
- 138 (b) the fatality review coordinator or the fatality review coordinator's designee.

139 (3) Within 10 days after the day on which the fatality review coordinator or the fatality

140 review coordinator's designee receives a copy of the deceased client report form, the fatality

141 review coordinator or the fatality review coordinator's designee shall request a copy of all

142 relevant department case records regarding the individual who is the subject of the deceased

143 client report form.

144 (4) Each person who receives a request for a record described in Subsection (3) shall

145 provide a copy of the record to the fatality review coordinator or the fatality review

146 coordinator's designee, by a secure method, within seven days after the day on which the

147 request is made.

148 (5) Within 30 days after the day on which the fatality review coordinator or the fatality

149 review coordinator's designee receives the case records requested under Subsection (3), the

150 fatality review coordinator, or the fatality review coordinator's designee, shall:

- 151 (a) review the deceased client report form, the case files, and other relevant

152 information received by the fatality review coordinator; and

153 (b) make a recommendation to the director of the Office of [~~Services Review~~] Quality  
154 and Design regarding whether a formal fatality review should be conducted.

155 (6) (a) In accordance with Subsection (6)(b), within seven days after the day on which  
156 the fatality review coordinator or the fatality review coordinator's designee makes the  
157 recommendation described in Subsection (5)(b), the director of the Office of [~~Services Review~~]  
158 Quality and Design or the director's designee shall determine whether to order that a formal  
159 fatality review be conducted.

160 (b) The director of the Office of [~~Services Review~~] Quality and Design or the director's  
161 designee shall order that a formal fatality review be conducted if:

162 (i) at the time of death, the qualified individual is:

163 (A) an individual described in Subsection 62A-16-102(2)(a) or (b), unless:

164 (I) the death is due to a natural cause; or

165 (II) the director of the Office of [~~Services Review~~] Quality and Design or the director's  
166 designee determines that the death was not in any way related to services that were provided  
167 by, or under the direction of, the department or a division of the department; or

168 (B) a child in foster care or substitute care, unless the death is due to:

169 (I) a natural cause; or

170 (II) an accident;

171 (ii) it appears, based on the information provided to the director of the Office of  
172 [~~Services Review~~] Quality and Design or the director's designee, that:

173 (A) a provision of law, rule, policy, or procedure relating to the deceased individual or  
174 the deceased individual's family may not have been complied with;

175 (B) the fatality was not responded to properly;

176 (C) a law, rule, policy, or procedure may need to be changed; or

177 (D) additional training is needed;

178 (iii) the death is caused by suicide; or

179 (iv) the director of the Office of [~~Services Review~~] Quality and Design or the director's  
180 designee determines that another reason exists to order that a formal fatality review be  
181 conducted.

182 Section 5. Section 62A-16-204 is amended to read:

183 **62A-16-204. Fatality Review Committee proceedings.**

184 (1) A majority vote of committee members present constitutes the action of the  
185 committee.

186 (2) The department shall give the committee access to all reports, records, and other  
187 documents that are relevant to the fatality under investigation, including:

188 (a) narrative reports;

189 (b) case files;

190 (c) autopsy reports; and

191 (d) police reports, unless the report is protected from disclosure under Subsection  
192 [63G-2-305](#)(10) or (11).

193 (3) The Utah State Hospital and the Utah State Developmental Center shall provide  
194 protected health information to the committee if requested by a fatality review coordinator.

195 (4) A committee shall convene its first meeting within 14 days after the day on which a  
196 formal fatality review is ordered under Subsection [62A-16-201](#)(6), unless this time is extended,  
197 for good cause, by the director of the Office of [~~Services Review~~] Quality and Design.

198 (5) A committee may interview a staff member, a provider, or any other person who  
199 may have knowledge or expertise that is relevant to the fatality review.

200 (6) A committee shall render an advisory opinion regarding:

201 (a) whether the provisions of law, rule, policy, and procedure relating to the deceased  
202 individual and the deceased individual's family were complied with;

203 (b) whether the fatality was responded to properly;

204 (c) whether to recommend that a law, rule, policy, or procedure be changed; and

205 (d) whether additional training is needed.

206 Section 6. Section **62A-16-301** is amended to read:

207 **62A-16-301. Fatality review committee report -- Response to report.**

208 (1) Within 20 days after the day on which the committee proceedings described in  
209 Section [62A-16-204](#) end, the committee shall submit:

210 (a) a written report to the executive director that includes:

211 (i) the advisory opinions made under Subsection [62A-16-204](#)(6); and

212 (ii) any recommendations regarding action that should be taken in relation to an  
213 employee of the department or a person who contracts with the department;

214 (b) a copy of the report described in Subsection (1)(a) to:  
215 (i) the director, or the director's designee, of the office or division to which the fatality  
216 relates; and  
217 (ii) the regional director, or the regional director's designee, of the region to which the  
218 fatality relates; and  
219 (c) a copy of the report described in Subsection (1)(a), with only identifying  
220 information redacted, to the Office of Legislative Research and General Counsel.  
221 (2) Within 20 days after the day on which the director described in Subsection (1)(b)(i)  
222 receives a copy of the report described in Subsection (1)(a), the director shall provide a written  
223 response to the director of the Office of ~~Services Review~~ Quality and Design and a copy of  
224 the response, with only identifying information redacted, to the Office of Legislative Research  
225 and General Counsel, if the report:  
226 (a) indicates that a law, rule, policy, or procedure was not complied with;  
227 (b) indicates that the fatality was not responded to properly;  
228 (c) recommends that a law, rule, policy, or procedure be changed; or  
229 (d) indicates that additional training is needed.  
230 (3) The response described in Subsection (2) shall include a plan of action to  
231 implement any recommended improvements within the office or division.  
232 (4) Within 30 days after the day on which the executive director receives the response  
233 described in Subsection (2), the executive director, or the executive director's designee shall:  
234 (a) review the plan of action described in Subsection (3);  
235 (b) make any written response that the executive director or the executive director's  
236 designee determines is necessary;  
237 (c) provide a copy of the written response described in Subsection (4)(b), with only  
238 identifying information redacted, to the Office of Legislative Research and General Counsel;  
239 and  
240 (d) provide an unredacted copy of the response described in Subsection (4)(b) to the  
241 director of the Office of ~~Services Review~~ Quality and Design.  
242 (5) A report described in Subsection (1) and each response described in this section is a  
243 protected record.  
244 (6) (a) As used in this Subsection (6), "fatality review document" means any document



245 created in connection with, or as a result of, a fatality review or a decision whether to conduct a  
 246 fatality review, including:

- 247 (i) a report described in Subsection (1);
- 248 (ii) a response described in this section;
- 249 (iii) a recommendation regarding whether a fatality review should be conducted;
- 250 (iv) a decision to conduct a fatality review;
- 251 (v) notes of a person who participates in a fatality review;
- 252 (vi) notes of a person who reviews a fatality review report;
- 253 (vii) minutes of a fatality review;
- 254 (viii) minutes of a meeting where a fatality review report is reviewed; and
- 255 (ix) minutes of, documents received in relation to, and documents generated in relation  
 256 to, the portion of a meeting of the Health and Human Services Interim Committee or the Child  
 257 Welfare Legislative Oversight Panel that a fatality review report or a document described in  
 258 this Subsection (6)(a) is reviewed or discussed.

259 (b) A fatality review document is not subject to discovery, subpoena, or similar  
 260 compulsory process in any civil, judicial, or administrative proceeding, nor shall any individual  
 261 or organization with lawful access to the data be compelled to testify with regard to a report  
 262 described in Subsection (1) or a response described in this section.

263 (c) The following are not admissible as evidence in a civil, judicial, or administrative  
 264 proceeding:

- 265 (i) a fatality review document; and
- 266 (ii) an executive summary described in Subsection [62A-16-302\(4\)](#).

267 Section 7. Section **62A-18-101** is enacted to read:

268 **CHAPTER 18. OFFICE OF QUALITY AND DESIGN**

269 **62A-18-101. Title.**

270 This chapter is known as the "Office of Quality and Design."

271 Section 8. Section **62A-18-102** is enacted to read:

272 **62A-18-102. Definitions.**

273 As used in this chapter:

- 274 (1) "Director" means the director of the office.
- 275 (2) "Office" means the Office of Quality and Design.

276 Section 9. Section **62A-18-103** is enacted to read:

277 **62A-18-103. Office of Quality and Design -- Creation.**

278 (1) There is created within the department the Office of Quality and Design.

279 (2) The office is under the administrative and general supervision of the executive

280 director.

281 Section 10. Section **62A-18-104** is enacted to read:

282 **62A-18-104. Director of the office -- Appointment -- Qualifications.**

283 (1) The executive director shall appoint a director of the office.

284 (2) The director shall have a bachelor's degree from an accredited university or college,

285 be experienced in administration, and be knowledgeable about human services programs.

286 (3) The director is the administrative head of the office.

287 Section 11. Section **62A-18-105** is enacted to read:

288 **62A-18-105. Powers and duties of the office.**

289 The office shall:

290 (1) monitor and evaluate the quality of services provided by the department including:

291 (a) in accordance with Title 62A, Chapter 16, Fatality Review Act, monitoring,

292 reviewing, and making recommendations relating to a fatality review;

293 (b) overseeing the duties of the child protection ombudsman appointed under Section

294 [62A-4a-208](#); and

295 (c) conducting internal evaluations of the quality of services provided by the

296 department and service providers contracted with the department;

297 (2) conduct investigations described in Section [62A-4a-202.6](#); and

298 (3) assist the department in developing an integrated human services system and

299 implementing a system of care by:

300 (a) designing and implementing a comprehensive continuum of services for individuals

301 who receive services from the department or a service provider contracted with the department;

302 (b) establishing and maintaining department contracts with public and private service

303 providers;

304 (c) establishing standards for the use of service providers who contract with the

305 department;

306 (d) coordinating a service provider network to be used within the department to ensure

307 individuals receive the appropriate type of services;  
308           (e) centralizing the department's administrative operations; and  
309           (f) integrating, analyzing, and applying department-wide data and research to monitor  
310 the quality, effectiveness, and outcomes of services provided by the department.