



State of Utah

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Governor

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Lieutenant Governor

DEPARTMENT OF HUMAN SERVICES

ANN SILVERBERG WILLIAMSON
Executive Director

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

DOUG THOMAS
Director

September 18, 2017

The Honorable Ben McAdams
Mayor, Salt Lake County
2001 South State St., #N2100
Salt Lake City, UT 84190

Dear Mayor McAdams:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of Salt Lake County Division of Behavioral Health Services and the Salt Lake County Health Department, the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental services, substance abuse treatment and prevention services, and general operations.

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by Salt Lake County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Chad Carter (801)538-4072

We appreciate the cooperation and assistance of the staff and look forward to a continued professional relationship.

Sincerely,

A handwritten signature in blue ink that reads "Doug Thomas".

Doug Thomas
Division Director

Enclosure

cc: Jeff Smart, SUD Prevention Bureau Manager, Salt Lake County Health Department
Gary Edwards, Executive Director, Salt Lake County Health Department
Tim Whalen, Director, Salt Lake County Division of Behavioral Health Services
Karen Crompton, Director, Salt Lake County Human Services



Site Monitoring Report of

Salt Lake County
Division of Behavioral Health Services and
Health Department

Local Authority Contracts #160237 and #160424

Review Dates: February 28th, 2017

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Salt Lake County Division of Behavioral Health Services (also referred to in this report as SLCo or the County) on February 28th, 2017. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the County's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the County's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 2	14 - 15 15 - 17
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 3	19 - 20
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	1 None 1 1	23 - 24 24 - 26 26

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of Salt Lake County Division of Behavioral Health Services (SLCo) and Salt Lake County Health Department Prevention. The Governance and Fiscal Oversight section of the review was conducted on February 28th, 2017 by Chad Carter, Auditor IV and Kyle Larson, Administrative Services Director. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Client fees were reviewed for consistency and adherence to approved fee schedules. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Board minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided by the governing board and/or the contracted County.

As part of the site visit, the most recent version of the Medicaid Cost Report was reviewed. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter.

Mental health and substance use disorder services are contracted to outside providers. SLCo must ensure that subcontractors comply with all provisions identified in the DHS Contract with Local Mental Health Authority. SLCo does conduct regular monitoring reviews on their subcontractors. The Governance and Oversight section of the review was extended to include some contracted providers to test compliance. Site visits were done on Clinical Consultants, Asian Association and House of Hope. The visits included a review of insurance, code of conduct, conflict of interest, licensing, invoices and training.

SLCo's independent financial statement audit was reviewed as part of monitoring. The CPA firm Squire & Company completed the audit of Salt Lake County for the year ending December 31, 2015 and issued a report dated June 30, 2016. The auditors' opinion was unqualified and no deficiencies were identified during the audit of the financial statements.

Follow-up from Fiscal Year 2016 Audit:

FY16 Significant Non-compliance Issues:

- 1) SLCo conducted their annual audit on OptumHealth, but the report has not yet been completed. In speaking with SLCo, they will repeat their finding on Optum for insufficient subcontractor monitoring. The action plan submitted last year by Optum for this finding stated that they would conduct at least six audits per quarter. Optum has participated in some of SLCo's monitoring visits, but have not done the additional monitoring on their own as

stated in their action plan. SLCo is proactively following up on this issue, but Optum must be able to provide reasonable assurance that its contracted providers are meeting performance standards and are in compliance with the DHS contract.

This issue has been resolved. SLCo will not repeat this finding in their most current Optum audit, Optum has increased their subcontractor monitoring and meets SLCo requirements. DSAMH will be following up with Optum directly this year to review their monitoring process to ensure it meets the requirements listed in the DHS Contract.

FY16 Minor Non-compliance Issues:

- 1) During the review of subcontracted providers, it was found that Volunteers of America (VOA) was not in compliance with conflict of interest provisions of the DHS contract. VOA was aware of several therapists that either had their own practice or were providing the same services with other employers. The subject was being communicated within the organization, but was not being documented. The contract requires that all potential conflicts are disclosed in writing and updated annually.

This issue has been resolved. SLCo addressed this issue with VOA directly. Three different subcontracted providers were selected for a contract compliance review this year. No issues were found in these reviews and the subcontractors stated that SLCo is doing a good job of communicating contract requirements.

Findings for Fiscal Year 2017 Audit:

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

None

FY17 Deficiencies:

None

FY17 Recommendations:

None

FY17 Division Comments:

- 1) FY17 Division Directives require that each Local Authority conduct a walk-through testing of their adherence to access standards prior to their scheduled site visit. SLCo has monitored access, customer service and ease of accessibility. The results showed that minimum access standards are being met. The access testing provided an excellent opportunity for

improvement. A call was made to a provider for services, the person that answered the phone stated that only one person provided that service and that he had a waiting list of two months. However, upon follow-up with the Program Manager, the tester was referred to a number of people who could attend to this need. The tester was able to provide feedback and SLCo has recommended that all personnel answering the phones are well versed on all services and who could immediately be contacted to provide that service. A follow-up call to the agency was made, the person answering the phone asked all necessary questions and were able to get the tester in for services within a week.

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to “annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract.” This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Child, Youth and Family Mental Health

Youth, & Families team conducted its annual monitoring review at Salt Lake County on February 27th, 28th and 29th of 2017. The monitoring team consisted of Eric Tadehara, Program Administrator; Tiesha Cohen, Program Manager; and Wendy Mair, Family Mentor with the Utah Family Coalition (NAMI Utah). The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, program visits, and feedback from families through questionnaires and a focus group. During the visit, the monitoring team reviewed the FY16 audit findings and County responses; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention funding; juvenile civil commitment; compliance with Division Directives; and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2016 Audit

FY16 Minor Non-compliance Issues:

- 1) *Coordination of care:* Coordination of care within the chart review, such as evidence of communication or coordinated treatment efforts between the contracted providers was lacking.

This finding has been resolved. SLCo has made significant progress working with community partners and coordinating care for youth in the catchment area. There were no concerns seen through partner meetings or chart reviews.

- 2) *Emergency data:* Emergency data reported to DSAMH regarding emergency services is incomplete. For FY15, there was an increase (from four in FY14 to 37 in FY15) in the number of children and youth who were reported to SAMHIS to have received emergency services, however, SLCo is not capturing all of the emergency data.

Based on continued progress, this has been mostly resolved and decreased to a recommendation; see Recommendation #1.

- 3) *Objectives:* During the chart review, objectives in six of the 16 charts were vague, lacked meaning for children, youth and families, and were difficult for a child or youth to achieve. Providing technical assistance/training to the various providers to incorporate these concepts into the recovery planning process will allow for better progress for children and their families.

This finding has been resolved. Through chart reviews, objectives met division directives and were meaningful for children, youth, and families.

- 4) *Juvenile Civil Commitment:* The Juvenile Civil Commitment processes are not compliant with statutory requirements. There was not an effective administrative process to track Juvenile Civil Commitment to ensure that the transfer of physical custody is completed in the time frame and

manner required by statute. Discharge from Commitment forms were not completed for youth discharging from the Utah State Hospital.

This finding has been resolved. SLCo has an effective method to track commitment forms and is utilizing the correct forms for the commitment process.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

None

FY17 Deficiencies:

None

FY17 Recommendations:

- 1) *Emergency data:* SLCo has made improvements in the way it captures emergency data, with FY16 emergency data reported as 158 children and youth receiving these services (an increase of 327% from FY15 data reported).

DSAMH recognizes that data for emergency services through the Mobile Crisis Outreach Team is not accessible at this time. It is recommended that SLCo continue to work with their other providers who provide emergency services to continue to effectively capture this data. Training providers to use the Emergency Modifier for the Event of Service will allow SLCo to capture and report more of the emergency services that are being provided.

FY17 Division Comments:

- 1) *Community Service & Resource Provider:* SLCo has increased the number of clients served by 755 from FY15 to FY16. SLCo has community partnerships with programs such as The Children's Center, Horizonte, and The Family Support Center. These programs offer varying resources for children, youth, and families. The services provided include a therapeutic preschool, school-based behavioral health services, and family oriented resources for families experiencing trauma and domestic violence.
- 2) *Staff Training and Internal Auditing:* SLCo has invested in continually training their staff in an effort to increase adherence to clinical reporting measures. SLCo has shown a vast improvement in the quality of documentation of services being provided by its vast provider network. The recovery plan objectives met the Division Directives criteria for clinical objectives. The Division Directives state, "objectives are measureable, achievable, are meaningful and within a timeframe." Of 19 charts that were reviewed only two contained objectives that lacked two of the four components of a well written objective. It is noted that

SLCo has illustrated vast improvements within their clinical documentation, record keeping, and responsiveness to constructive feedback. Salt Lake County also invests in internal auditing procedures that ensures the services provided are in accordance with the Division Directives. There was also evidence of improved coordination of care with community partners.

- 3) *Family Feedback:* The Utah Family Coalition (UFC) collected feedback from 12 families via survey and four families who participated in a focus group. When asked about the most important things they liked about the SLCo local mental health center, families and caregivers reported “the care they give and the service they provide,” “they do their best,” and “they were patient and prompt.” Families are grateful for the many services provided by SLCo.
- 4) *Wraparound and Family Resource Facilitators:* SLCo is providing High Fidelity Wraparound as defined by the UFC. SLCo Family Resource Facilitators (FRF) are an integral part of the service delivery system in SLCo and maintain a strong emphasis in the Wraparound process on engaging both informal and formal supports. The families who receive FRF services commented that their FRF “helps bring the kids together and works to achieve their goals.” Families shared that the FRF “gave me information that met my needs” and another family shared, “[the] FRF helped get through schooling issues which helped with my needs.”

Adult Mental Health

The Division of Substance Abuse and Mental Health Adult Monitoring Team conducted its annual monitoring review at Salt Lake County on February 28th and 29th, 2017. The team consisted of Pam Bennett, Program Administrator, Robert H. Snarr, Program Administrator, LeAnne Huff, Program Manager and Cami Roundy, Peer Support and Resiliency Program Manager. The review included: record reviews, and discussions with clinical supervisors and management teams, including Salt Lake County Division of Behavioral Health, OptumHealth, and multiple providers and community partnerships throughout the County. Site visits were conducted at Women's CORE II, Volunteers of America Assertive Community Treatment (VOA/ACT) team, Valley Store Front, Valley Behavioral Health Assertive Outreach Team (AOT) staffing, Alliance House, Jordan Valley West Outpatient, University Neuropsychiatric Institute (UNI) Crisis Team members, Salt Lake Behavioral Advisory Council, and Salt Lake Mental Health Court staffing. A focus group was conducted with individuals receiving services in Salt Lake County at Valley Behavioral Health (VBH) North Valley. During the site visit, the team discussed and reviewed the FY16 audit findings; the mental health scorecard; area plan; Outcome Questionnaires; and SLCo's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2016 Audit

FY16 Significant Non-compliance Issues:

- 1) *Documentation of Mandated Outpatient Services:* This finding is continued from FY14 and FY15 as documentation issues continue to be found in the assessment, treatment plans and progress notes, which could result in inadequate treatment. Issues were found related to ongoing assessments, inconsistencies within the progress notes, and missing objectives.

There have been improvements, but this finding has not been fully resolved and will continue in FY17; Minor Non-compliance Issue # 1

FY16 Deficiencies:

- 1) *SLCo/OptumHealth's Provider Charting (Goals/Objectives):* DSAMH provided a recommendation in FY15 regarding short term goals/objectives. In accordance with Division Directives, recovery planning principles state short term goals/objectives are to be measurable, achievable and within a timeframe. One possible option for developing measurable goals is encouraging staff to utilize SMART goals; **S**pecific, **M**easurable, **A**ttainable, **R**elevant, and **T**ime-based.

This finding has been resolved. The review of charts demonstrated significant improvement in the creation of measurable and attainable short term goals and objectives in outpatient charting.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

- 1) *Documentation of Mandated Outpatient Services:* This finding is continued from FY15 to present as documentation issues were found in charts reviewed including assessments, the absence of goals and objectives, and treatment plans that could impact client care. Twenty charts were reviewed. Two charts from VOA did not include an assessment or had a sparse assessment. In addition to not having an assessment, one chart also had no goals or objectives, group notes appeared to be cut and paste, charting was not individualized, and symptoms did not support the diagnosis. Two charts from other agencies did not include treatment plans, although the plans were referenced in the paper chart provided. This finding is moved from a Significant Non-compliance Issue to a Minor Non-compliance Issue due to overall improvement in chart quality and the length of time needed to continue to train providers within the SLCounty system. *This finding also reflects the SLCo FY15 Monitoring Report of OptumHealth.*

Center’s Response and Corrective Action Plan:

Optum Salt Lake County continues to audit the documentation requirements for clinical services including assessments, treatment plans and progress notes during monitoring visits of their in network providers. After the charts are reviewed, the providers are given specific feedback regarding issues identified. If necessary, follow-up meetings and trainings are scheduled to ensure implementation of the mandates. Optum SLCo is using data analysis to select providers and charts for audits, in an effort to help identify those providers who may need support and education to meet Medicaid, DSAMH, Salt Lake County Division of Behavioral Health (DBHS) and Optum SLCo documentation requirements. This was implemented in FY17 and will continue into FY18 with on-going audits.

- 2) *Data collection of Incarcerated Individuals:* Accurate data of incarcerated individuals with severe mental illness served in Salt Lake County has not been collected since FY12. DSAMH recognizes that this data is not collected by SL County Behavioral Health directly, but it is required for SLCo to collect and report the data annually. This finding is a Minor Non-compliance Issue due to the length of time that SL County has been out of compliance with this data finding.

Center’s Response and Corrective Action Plan:

As was noted above, DBHS struggles with complying with this requirement because the Salt Lake County government system has determined that the Salt Lake County Jail would provide these services independent of DBHS. Recently DSAMH reminded our elected officials through written correspondence of their responsibility to provide this data. DBHS will follow-up on this

action and meet with Jail Chief to see if progress can be made.

Salt Lake County has a Mayor/Council form of Government not a Commission. The Council has chosen to directly appropriate county general funds (no SGF) to our independently elected Sheriff for the provision of mental health services in the jail. Our efforts to collect the data have been challenging due to an antiquated electronic health record that the data jail is in the process of replacing.

DBHS' relationship with the jail is excellent. We already have in place a data sharing agreement and as soon as we can we will look to provide the data DSAMH is requesting. However, with the current Rio Grande area crisis and the pressures on our jail, no progress will be made on this goal in the first quarter of SFY18. Our jail is struggling to even be able to keep its commitment to the state regarding the very important competency restoration program.

DBHS does not anticipate making progress on this issue until at least the first part of CY19.

DBHS also has a meeting scheduled with DSAMH leadership about this issue to discuss further.

FY17 Deficiencies:

- 1) *DSAMH Directive on Outcome Questionnaire (OQ) Administration:* SLCo's rate of OQ administration has dropped from 78.5% in FY15 to 35.7% in FY16. Division Directives require at least 50% OQ collection rate to be in compliance. DSAMH recognizes the complexity of providing OQ training to over 200 providers and appreciates SLCo and OptumHealth's efforts in continuing to provide training and guidance to their providers. DSAMH recommends SLCo and OptumHealth continue to provide training and direction on OQ administration to reach the Division Directives requirement of 50%. *This reflects the finding in the SLCo FY15 Monitoring Report of OptumHealth.*

Center's Response and Corrective Action Plan:

Optum SLCo provided six in-person OQ Trainings in 2016, with two conducted in FY17 to increase clinician's knowledge and use of the OQ and Y-OQ questionnaires. In addition, Optum has worked closely with OQ Measures over the past year to provide two additional trainings related to the administrative components related to the OQ Analyst, as well as one-on-one support to address providers' technical issues. Therefore, staff from both, Optum SLCO and OQ Measures, were surprised by the decrease in the rate of administration. After this issue was identified in the exit conference, Optum requested additional information about the algorithms used in the State's calculations. While the FY17 Mid-year Scorecard offered no data related to the percent of unduplicated clients participating, it indicated an increase from the FY16 Scorecard in the percent of clients matching to SAMHIS. However, these numbers did not appear to reflect the efforts to increase questionnaire administration.

Optum provided the scorecard data and algorithm information to the OQ Measures Technical Team who is researching possible barriers to capturing the Optum data. OQ Measures collaborated with DSAMH and has since informed Optum some issues were identified and the data was re-analyzed, indicating an increase to 87.8% of clients matching SAMHIS. No

calculation was made available regarding the percent of unduplicated clients participating, as referenced in this finding. A meeting with representatives from DSAMH, DBHS, Optum SLCO and OQ Measures is pending based on the new analysis, which was released on 7/12/2017. Optum SLCO and DBHS are eager to identify and address issues which may be inhibiting the accurate count of administration of the OQ and Y-OQ questionnaires. Optum will continue to provide both clinical and administrative OQ Trainings in FY18. In addition, during audits, providers who are identified as continuing to use paper forms are offered additional support to start using the OQ Analyst.

DBHS would also request DSAMH's assistance in having the number of unduplicated clients participating re-calculated. Since there was a noticeable increase in matched clients it is anticipated that there were also be an increase in the number of unduplicated clients participating.

As the initial response indicates, many efforts were put forth to educate providers and to increase the administration of the OQ questionnaires. In person trainings were offered on the following dates:

- 3/29/16 (two trainings in one day)
- 3/30/16 (two trainings in one day)
- 10/18/16
- 11/3/16

As additional time is needed for training and implementation into practice, the mid-year FY17 scorecard data was reviewed to determine if there was any improvement noted as a result of the additional trainings and supports. At that time, questions arose regarding the accuracy of the data, and problems with the calculations were identified. When adjustments were made, the updated data reflected improvements in the DBHS scores. Also, the additional research highlighted the volume of client profiles without MRNs in the OQ Analyst, which may contribute to the low administration rate calculation. These issues would be applicable to FY16 and FY17 data. A meeting has been scheduled on September 13, 2017 with DSAMH, DBHS, Optum SLCO and OQ Measures to further discuss the issues with the MRNs and to collaborate on a plan to increase the amount of OQ data for SLCO captured in the DSAMH scorecard calculations. Once all parties are more confident in the accuracy of the administration rate as noted on the scorecard, a plan can be outlined to target specific areas to improve the administrations where necessary.

- 2) *Use of OQ as an Intervention:* Division Directives require that data from the OQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart. Only eight of 20 (40%) charts had evidence of integration of OQ as a tool in therapy sessions. The OQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. It is recommended that SLCO and OptumHealth work with providers to increase understanding of the clinical use of the OQ. *This reflects the finding in the SLCO FY15 Monitoring Report of OptumHealth and a recommendation by DSAMH in FY16.*

Center's Response and Corrective Action Plan:

As previously indicated, Optum SLCo has offered multiple trainings on the use of the OQ Measures Tools in FY17. Subsequently, providers have requested additional training for their clinicians. During Optum's Provider Advisory Committee Meetings and QAPI Meetings, providers suggested trainings be offered via WebEx where agencies may schedule staff meetings and training sessions to accommodate more staff, rather than traveling to an in-person training. Additional Brown Bag Trainings will be offered focusing on incorporating the tools into treatment planning. These will be included in the FY18 Optum training schedule.

FY17 Recommendations:

- 1) *Utah State Hospital (USH) Discharge:* SLCo is working to ensure patients ready for discharge are discharged from the Utah State Hospital within 30 days. However, several patients have exceeded this time-frame. DSAMH recommends SLCo consider the development of more residential beds and/or related resources and supports to help with step down process from USH and toward increased access to treatment based housing and/or permanent supportive housing in the community.

FY17 Division Comments:

- 2) *Salt Lake County DBHS Monitoring Report:* DSAMH reviewed the "Salt Lake County FY15 Monitoring Report of Mental Health Services provided by United Behavioral Health/Optum". The report was thorough, addressing post-stabilization care services, oral interpretation services, outpatient mental health services, and an administrative review. All issues noted by DSAMH had been identified in the DBHS report and are being addressed by OptumHealth.
- 2) *Operation Diversion:* DSAMH commends SLCo in their work on the Operation Diversion Program in Salt Lake County, including the provision of 53 residential beds and Detox for individuals experiencing homelessness who live with mental health and substance use disorders.
- 3) *Programs involving Peer Support Services:* DSAMH Recovery and Resiliency Peer Program Manager Cami Roundy met with the Recovery and Resiliency team at OptumHealth and with the Mobile Crisis Outreach Team members at the University Neuropsychiatric Institute. DSAMH would like to commend both agencies for the excellent work involving the Peer Support Program, Peer Navigator Program, and Peer Support inclusion on the outreach teams and warm-line calls.
- 4) *Assisted Outpatient Treatment:* DSAMH commends the Valley Behavioral Health Assisted Outpatient Treatment (AOT) program for ongoing wrap-around care for those individuals with a history of high service utilization. Staff emphasize both client choice and overall wellness during staffing. OptumHealth has also been able to demonstrate cost-effectiveness for this program.
- 5) *Participant Feedback:* DSAMH Recovery and Resiliency Peer Program Manager Cami Roundy met with a focus group of 20 members at Alliance House. Fifteen of the members expressed that they are doing very well in their treatment, and stated that they feel they create

their own goals. Ten of the members have had help with employment and five of them work offsite. Wellness is addressed at Alliance House including groups on nutrition, weekly walks and exercising. Five of the members said that they have been offered smoking cessation and they have had groups in the past that focused on this. Three of the members have their Peer Support Certification or are working toward it. Several quotes from the members are as follows. “Before I came to Alliance House I was unemployable, un-rentable and did nothing all day. Since I have been coming here, I am employable, rentable and I am starting to like waking up in the morning.” “Coming here is seeing bravery at work.” “Not a single member or staff looks down at anyone, and you never have to feel ashamed.” “My entire life I have lived on the outside looking in, now I am sitting right in the middle.” “I was going to be homeless, and they helped me with a program to get a place to live.”

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review of Salt Lake County Health Department Prevention on November 16th, 2016. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from Fiscal Year 2016 Audit

FY16 Deficiencies:

- 1) SLCo saw a decrease in the number of Eliminating Alcohol Sales to Youth compliance checks that occurred in FY2015.

This finding has not been resolved and will be continued in FY17; see Deficiency #1.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

None

FY17 Deficiencies:

- 1) SLCo saw a decrease in the number of Eliminating Alcohol Sales to Youth (EASY) compliance checks for a third year. In FY16, SLCo had 378 compliance checks completed compared to 476 in FY15.

Center's Response and Corrective Action Plan:

The Eliminating Alcohol Sales to Youth program check numbers decreased in 2016 by 98 checks from 2015. The primary reason for the decrease was Salt Lake City performing zero compliance checks in 2016 when compared to the 77 checks done in 2015. A few other agencies contributed to the decline of EASY checks (Sandy and South Jordan had a larger decline when compared with other cities).

This year, we have been working with the Utah Highway Safety Office to increase checks. Salt Lake City PD has started to perform checks again, and we are working to get new agencies involved with the program trying to recruit at least one new agency quarterly (Taylorsville and West Jordan). We are also encouraging agencies that previously had lower checks in 2016 to

increase their numbers (to the recommended four checks a year). With the increase in compliance checks from Salt Lake City, Taylorsville and West Jordan, we plan on having a much higher number in 2017.

- 2) SLCo saw a decrease in the Synar (Tobacco sales) compliance rate. The rate decreased from 94% in FY15 to 89% in FY16. The goal is to have a 90% compliance rate.

Center’s Response and Corrective Action Plan:

Reducing underage tobacco use through vendor compliance and education is important to us. The Health Department’s goal is for our compliance rates to align with the minimum federal requirement of 80%, but we are always striving for no violations and no sales to our youth. In 2016, we were 4 violations short of our DSAMH contract goal of 90% (581 outlets were inspected and 65 were found in violation). We will continue to educate tobacco outlets and be consistent with our compliance checks with the goal to increase FY2017 beyond 90%.

- 3) SLCo does not have a current Strategic Plan for the LSAA or communities.

Center’s Response and Corrective Action Plan:

Salt Lake County Substance Abuse Prevention has a strategic plan, and incorporates that strategic plan into prioritizing and purchasing prevention services, it’s called the Prevention Services Plan. We will develop a new strategic plan as directed by DSAMH and will update our plan with data and language from our community partners/coalition’s strategic plans.

FY17 Recommendations:

- 1) It is recommended that SLCo increase training opportunities for staff and coalition members. This includes program level training, and attending conferences, summits and workshops. Increasing training opportunities increases the capacity of the community to do effective and evidence based prevention.

FY17 Division Comments:

- 1) SLCo reported that 114 Naloxone kits have been distributed with other grant funding with one reported overdose reversal.
- 2) SLCo is working with four coalitions at this time; Murray, Draper CTC, Salt Lake City Mayor’s Coalition, and Kearns CTC.
- 3) Salt Lake City PD stopped doing EASY compliance checks, but this fiscal year they have started doing the checks again. While the number of checks decreased, more agencies were doing checks than previous years. SLCo staff conducted a survey of agencies on EASY to identify barriers and are working towards fixing the barriers. Taylorsville has stated that they want to come on board to do checks, they previously didn’t participate.

- 4) All new staff (in FY16) were SAPST certified. Last two statewide trainings were primarily SLCo providers.
- 5) The community of Murray had a higher participation rate on the 2017 Student Health and Risk Prevention survey. This will allow the community to have data specific to them for prevention planning.

Substance Abuse Treatment

Becky King, Program Administrator and Holly Watson, Program Manager, conducted the annual review of Salt Lake County Behavioral Health Services on February 28th, 2016. The visit focused on Substance Abuse Prevention and Treatment (SAPT) block grant compliance, compliance with Division Directives and Contracts, SLCo's monitoring of contracted programs and their providers compliance with contract and clinical requirements. Block grant compliance was evaluated through a review of provider contracts, discussions with staff members and a review of SLCo's audit reports. Compliance with Division Directives was evaluated by reviewing SLCo's audit instruments and procedures, reviewing provider contracts, comparing program outcome measures against DSAMH standards and visits with SLCo's agencies' staff members. Monitoring of clinical practices was evaluated by reviewing SLCo's audit reports, audit instruments, procedures and discussions with staff responsible for the audits of contracted providers.

Follow-up from Fiscal Year 2016 Audit

FY16 Major Non-compliance issues:

- 1) Not all of SLCo's agencies were using the Sliding Fee Scale and Fee Reduction Policy submitted by SLCo with their area plan for collection of client fees. SLCo Criminal Justice Services reported in FY14 and FY15 that they had been using a standard fee of \$1,200 for phases 2-4 of Drug Court and clients are required to pay for their Urinalysis Tests at \$12.50 each. Since drug testing is required a minimum of two times per week, this added a minimum of an additional \$1,300 per year to the assessed fees. This process was in conflict with both the requirements outlined in the FY16 Division Directives and the DHS contract for Substance Abuse Services with SLCo.

This issue has not been resolved and will be continued in FY17; see Major Non-compliance Issue #1.

FY16 Minor Non-compliance issues:

- 1) The FY15 Utah Substance Abuse Treatment Outcomes Measures showed:
 - a. The percent of clients reporting alcohol abstinence from admission to discharge increased from 23.6% to 27.3% from FY13 to FY14 respectively. In FY15, the percent of abstinence from alcohol use decreased to 20.6%, which did not meet the Division Directives. In FY16, the percent of abstinence from alcohol use decreased to 13.6%, which still does not meet Division Directives.

This issue has not been resolved and will be continued in FY17; see Minor Non-compliance Issue #1a.

- b. The percent of clients that completed a treatment episode successfully decreased from 47.4% to 45.7% from FY13 to FY14 respectively. In FY15, the percent of clients

completing a treatment episode successfully decreased to 42.5%, which did not meet Division Directives. In FY16, the percent of clients completing a treatment episode successfully decreased to 40.0%, which still does not meet Division Directives.

This issue has not been resolved and will be continued in FY17; see Significant Non-compliance Issue #1b.

- c. The percent of old open admissions for non-methadone, intensive outpatient (IOP) or residential treatment in SLCo was 5% in FY14, which is above the Division Standard of 4%. In the FY15, the number of old open admissions increased to 5.1%, which still didn't meet Division Directives. However,

This issue has been resolved. In FY16, the number of old open admissions decreased to 3.6%, which now meets Division Directives.

- 2) In FY15, SLCo collected 9.5% of the Youth (*Family*) Surveys, which is below the required rate of 10%.

This issue has been resolved. In FY16, SLCo collected 11% of the Youth (Family) Surveys, which now meets Division Directives.

Findings for Fiscal Year 2017 Audit:

FY17 Major Non-compliance Issues:

- 1) SLCo Criminal Justices has not implemented a Sliding Fee Scale or Fee Reduction Policy, which is a repeat finding from FY14, FY15 and FY16. Upon review of the Drug Court Manuals, it was not evident that there was a sliding fee scale. In addition, the Drug Court Manual appears to reflect that clients are required to (1) pay a minimum of \$360.00 to move phases; (2) pay their fees in full prior to graduation; (3) and pay for contested drug test results. This is not in compliance with the National Associations of Drug Court Professionals (NADCP) Best Practice Standards or Division Directives. Clients can only be charged for a contested drug test if the test is confirmed as a positive result. It is recommended that SLCo Criminal Justice Services (1) implement a Sliding Fee Scale; (2) Fee Reduction Policy; (3) follow NADCP Best Practice Standards and Division Directives; (4) and update the Drug Court Policy Manual to reflect the requirements in the Division Directives and NADCP Best Practice Standards.

Center's Response and Corrective Action Plan:

On March 13, 2017, after receiving approval from the County Council, CJS implemented a Sliding Scale Fee for all Drug Court clients (see attached policy). Clients are no longer required to pay a minimum amount to move phases or to graduate. Although the drug testing lab requires a \$12 reduced contested fee, if the result is negative, the lab credits the money back to the clients account. We have updated all our material and manuals to reflect the sliding scale fee policy, including updating the policy manual related sections as it pertains to fees and phase

advancement and that reflects the requirements in the Division Directives and NADCP Best Practice Standards. Copies of these are available upon request.

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

1) The FY16 Utah Substance Abuse Treatment Outcomes Measures showed:

- a) From FY15 to FY16, the percent of abstinence from alcohol use decreased from 20.6% to 13.6% respectively, which does not meet Division Directives.

Local Substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of clients who are abstinent from alcohol from admission to discharge at a rate that is greater than or equal to 75% of the national average. Abstinence from alcohol is defined as no alcohol use for 30 days.

- b) From FY15 to FY16, the percent of clients completing a treatment episode successfully decreased from 42.5% to 40.0% respectively, which does not meet Division Directives.

Local Substance Abuse Authorities will meet or exceed their FY2016 Successful Treatment Episode Completion rates in FY2017 and will work towards achieving a goal of 60%. Local Substance Abuse Authorities whose FY2016 completion rate was over 60% are required to meet or exceed a 60% completion rate in FY2017. Successful Treatment Episode Completion is defined as a successful completion of an episode of treatment without a readmission within 30 days. An episode of treatment is defined in the Treatment Episode Data Set.

- c) From FY15 to FY16, the percent of clients retained in treatment 60 days or more decreased from 73.0% to 65.4% respectively, which does not meet Division Directives.

The Local Substance Abuse Authorities will meet or exceed their FY2016 treatment retention in the FY2017 and will work towards achieving a goal of 70%. Local Substance Abuse Authorities whose FY2016 retention rate was over 70% are required to meet or exceed a 70% retention rate in FY2017. Retention is defined as the percentage of clients who remain in treatment over 60 days.

- d) From FY15 to FY16, the percent of clients employed from admission to discharge decreased from 21.2% to 5.9% respectively, which does not meet Division Directives.

The Local Substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of their clients who were employed full/part time or enrolled as a student from admit to discharge at a rate to or equal to 75% of the national Average.

Center's Response and Corrective Action Plan:

With each of the below areas we would respectfully request that DSAMH run all the statistics anew since there was an issue identified within DSAMH, and since corrected, with the number of clients matched. The number of clients matched within Salt Lake County increased by 10%, but we did not receive updated information if this increased match rate affected the outcome statistics.

- a) This is equally frustrating to DBHS. Despite our training on this issue, through our audits we continue to see that what is written in the progress notes does not always match up with what data is entered. The most common scenario remains that a client enters treatment with an illicit substance identified, and then some time after this it is discovered that they had also been using alcohol. Yet, instead of going back to the enrollment to enter the information, the information is entered at the time the discovery is made making it appear like the client began using alcohol during treatment. Additionally, due to the fact that we contract out with a large network of providers, the provider at the beginning of an episode is not necessarily always the provider at the end of episode. In these instances, the provider at the end of the episode would not have access to the episode admission record and it is not possible to update that with newly discovered information. Due to the detox admission counting as the start of an episode the use of substances listed are usually restricted to those the client reports while intoxicated, and therefore may not reflect the complete condition at admission. This initial report of substances while under the influence may for this reason be minimizing the actual use disorder and/or the number of substances used/abused. However, it is an unfortunate reality that there are some clients who turn to alcohol as a "replacement drug" for whatever drug of choice the client is giving up. This is certainly not encouraged and is addressed accordingly. Salt Lake County will continue to ensure providers address this issue, and also ensure that it is being properly recorded.
- b) Due to Salt Lake County's model of paneling providers versus providing the services in-house, it is a constant training issue to ensure providers are coding any part of the [TEDS NOMS](#) data correctly. Treatment completion is the criteria reviewed during the County's audits of each provider and, if found to be a deficiency, would require corrective action. Based on County audits of providers, we feel this finding is primarily related to data entry and training of clinical staff. Through the County's Navigator and PSCC meetings, as well as the annual audits, we will continue to train staff and address this issue. Additionally, we are now providing our QA/QM team a monthly report of providers' open clients and discharge reasons so that we may take a more proactive approach to addressing this finding and provide more technical assistance in areas where the data indicate it is needed.

This issue was also recently spotlighted during a recent provider meeting (PSCC), and will continued to be addressed during future meetings. Instructions were given to the Directors and Clinical Directors about training their staff. Part of these instructions included that the clinical team should decide if the client completed treatment successfully vs. the individual clinician. DBHS will produce a report monthly and apprise the providers of the current status of "treatment completion".

- c) DBHS does not understand how this became a finding as it contradicts what we have heard anecdotally and what our report indicates. In the SAMHIS SA Outcomes report, for FY16 it shows that 69.9% of clients were retained in treatment 60 days or more. Complicating this is that providers closed 186 cases during FY16 even though none of these 186 clients ever received services in FY16. We know this is a training issue and providers need to indicate when the client ceased receiving services vs. when the provider closed the record physically, but 62 of these specific clients were in services for less than 60 days, which skews the numbers negatively. We have trained, and will continue to train regarding applying the correct date when closing cases, but the numbers we have received via the report would indicate that DBHS met the 70% threshold (i.e., 69.9% before subtracting the number of clients who were closed but did not receive services who had less than 60 days in treatment).
- d) DBHS will provide training to the providers regarding the importance of clients either maintaining or gaining employment, as well as training regarding the data entry of this.

FY17 Deficiencies:

- 1) *Treatment Data Episode Set (TEDS)*: DSAMH requires local authorities to report whether clients have been “compelled” to treatment by the justice system. This is a new requirement in FY17. 31.1% of all SLC’s TEDS submissions for the first six months of FY17 did not include this information. This is required to track outcomes related to the Utah’s Justice Reinvestment Initiative.

Center’s Response and Corrective Action Plan:

We have been working with individual providers to address this issue. We sent out reports on the compelled counts per agency, trained the agency navigators (“Power-users”) to have staff dis-enroll and re-enroll clients with admissions in prior fiscal years that received treatment in FY17 with the correct compelled indicator. Currently we have about 60% of clients counted as compelled during the fiscal year, excluding assessment or detox as of our data in SAMHIS through April 2017.

Valley Behavioral Health has also had issues with their system in collecting and reporting both new admissions and updating existing admissions with the compelled element. They have been working on this issue and responded that it should be working now. We will continue to follow-up with them on this issue.

We would like to have clarification of the 31% or all DBHS’ TEDS submissions for the first six months of FY17. We have been told by DSAMH that if the client has compelled = YES on any admission in the FY it will be “counted” as compelled across all admissions, in other words they are counting the unique clients not the enrollments. Is this accurate? This should also not include assessment or detox as they are not used to report “treatment”.

FY17 Recommendations:

- 1) *Language*: DSAMH recommends additional training for staff on language that furthers public understanding of addictive disorders as a medical issue to reduce stigma and stereotyping. One excellent resource is a fact sheet produced by *The National Alliance for Buprenorphine Treatment (NAABT)* that could be distributed to staff can be found at: https://www.naabt.org/documents/NAABT_Language.pdf. Another excellent resource can be found online at: <https://www.whitehouse.gov/ondcp/changing-the-language-draft>. DSAMH is available to provide technical assistance upon request.
- 2) *Treatment Data Episode Set (TEDS)*: The TEDS submissions for the first six months of FY17 does not identify clients criminogenic risk level. In FY17, there was a non-collection rate of 67.8%. This field is optional for 2017, but it critical to evaluating Utah's Justice Reinvestment Initiative.

FY17 Division Comments:

- 1) *Monitoring*: SLCo and OPTUM have used a shared monitoring process over the past two years which has resulted in positive outcomes. This joint monitoring process has allowed SLCo and OPTUM to identify needs and technical assistance at the time of the audit. This has improved their ability to address deficits in real time rather than several months later when the report is issued to the provider.
- 2) *Medication Assisted Treatment (MAT)*: SLCo continues to encourage the use of Medication Assisted Treatment (MAT), which has improved client and program outcomes. All Drug Court and justice related programs are also required to allow the use of MAT, which has resulted in long term recovery and reduced recidivism rates.
- 3) *Vivitrol Project*: SLCo Behavioral Health continues to experience positive outcomes with the Vivitrol Project. By providing the Vivitrol injection in jail and up to six months of injections for individuals in Salt Lake County Treatment Programs, there has been increased rates of sobriety. This project has made a positive difference in the community.
- 4) *Peer Support Specialists*: OPTUM has been working on increasing the reimbursement rates for the Peer Support Specialists, which will result in increased recruitment and retention efforts. SLCo considers Peer Support Specialists to be an asset to their community and are dedicated to increasing incentives for programs to employ Peer Support Specialists in their programs.
- 5) *Direct Access*: SLCo continues to do an excellent job of referring clients to the appropriate programs and has a system in place to manage their waiting list. Last year, during a DSAMH Direct Access Test with a female volunteer that called the front desk of the Salt Lake County Behavioral Office, the receptionist did not ask this woman if she was pregnant. However, this year, it was noted during the Direct Access Discussion that all women that call in for services are asked if they are pregnant so that they can be served within 48 hours if they are pregnant. SLCo continues to seek methods of improving access and quality of services in their community.

- 6) *Outcome Scorecards*: SLCo had discontinued preparing scorecards for several years, but in the past year, reinstated the scorecard, which has been helpful to providers in measuring and improving outcomes. SLCo continues to seek methods of improving the quality of their services through outcomes measures and innovative approaches.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 10 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 15 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Salt Lake County Division of Behavioral Health Services and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health

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