



Site Monitoring Report of

Tooele County
Valley Behavioral Health

Local Authority Contracts #160235 and #160236

Review Dates: March 14th & 15th, 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 Tooele County – Valley Behavioral Health (also referred to in this report as Tooele - VBH or the Center) on March 14th & 15th, 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 Center'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 Center'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 2 None	8 - 9
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 1	12 12
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 None	15 - 16
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 3	18 - 19
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 5 None	21 - 22

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of Tooele County – Valley Behavioral Health (Tooele-VBH). The Governance and Fiscal Oversight section of the review was conducted on March 14th, 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.

The CPA firm Ulrich & Associates, PC completed an independent audit of Tooele County for the year ending December 2015. The auditors issued an unqualified opinion in the Independent Auditor’s Report dated July 20th, 2016. The auditors also issued a report focusing on compliance with general State compliance requirements. One significant deficiency was identified regarding budgetary compliance. The County had incurred expenditures in excess of their budgeted totals. The County’s response stated that they agreed with the recommendations given by the auditors and will work to improve the timely recording of transactions and the preparation of an adequate budget.

The CPA firm Tanner LLC completed an independent audit of Valley Behavioral Health for the year ending December 2015. The auditors issued an unqualified opinion in the Independent Auditor’s Report dated May 31, 2016. A significant deficiency was identified in their review of Federal Awards, see Minor Non-compliance Issue # 1 for more details.

Follow-up from Fiscal Year 2016 Audit:

FY16 Significant Non-compliance Issues:

- 1) A repeat finding was issued in Tooele County’s financial statement for the second year regarding the County’s involvement in VBH’s provision of mental health and substance use disorder services.

This finding has been resolved. Tooele County has significantly increased their level of involvement and oversight in the services provided by VBH. Tooele County Commissioners hold monthly “Yardstick” meetings with VBH to assure proper oversight, communicate any contract amendment changes and to discuss any issues. Minutes and an agenda for these meetings were provided for review. The County also participates in VBH Advisory Board meetings as well as meetings to discuss the homeless population in Tooele. Tooele County’s most current financial statement audit also shows this issue has been resolved.

- 2) *Billings/Controls:* In FY15, Valley Behavioral Health decided not to implement their plan using Mental Health Early Intervention TANF funds. VBH continued to bill for these funds each month without providing the services and were required to repay it. VBH should have stronger financial controls in place to reconcile their billings with actual services provided.

This finding has been resolved. VBH has started a new process where their accounting department meets with operations to reconcile the services provided with the billings for those services. VBH has not had any similar billing issues in FY16.

FY16 Minor Non-compliance Issues:

- 1) Valley Behavioral Health was issued a finding in their financial statement audit regarding their billings for the PASSAGE grant passed through DSAMH and Tooele County. The audit stated that VBH needs to put policies and procedures in place to ensure that federal grant billings are substantiated by actual expenses.

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

- 2) *Executive Travel Reimbursements:* Executive travel reimbursements were reviewed to ensure they included proper backup, approval and to ensure that no personal benefit is gained from travel or other expenses per Utah Code Title 62A-15-713-(2)(a). Only two executive travel reimbursements were completed in FY15. One of the packets was missing an approval signature for the travel. Tooele-VBH should strengthen their controls to ensure that all travel and reimbursements are approved and documented, particularly for executives.

This finding has been resolved. All reviewed travel packets for FY16 Tooele executive travel included the appropriate documentation and approvals.

- 3) *Admissions and Discharges Data:* In reviewing data for the current year, Tooele-VBH is extremely low in the number of substance abuse admissions and discharges it is submitting into the Substance Abuse Mental Health Information System (SAMHIS). The 2nd quarter of FY16 shows that Tooele-VBH only reached 32% of the prior year’s admission counts, with 3rd quarter (year to date) only at 21% of the prior year. Data for discharges is even lower, showing only 17% of the prior year in 2nd quarter and 10% of the prior year in 3rd quarter. The 1st quarter is also low, showing 45% of discharges compared to the prior year. The low admission & discharges are a concern as it suggests that clients in need of services aren’t receiving treatment. This poses the question as to whether the data isn’t being submitted

correctly or Tooele is actually seeing a decline in the numbers of clients being served or in need of treatment.

This finding has been resolved. Tooele-VBH has made a significant improvement in their data submissions.

FY16 Deficiencies:

- 1) *Year-end Data:* A comparison of year-end data that was submitted to the Division and data reported in SAMHIS showed some significant differences. Tooele-VBH should ensure that the finance team is communicating with their data team to reconcile client counts.

This deficiency has been resolved. Year-end data submitted by Tooele-VBH matched the data submitted in the SAMHIS system in almost every area.

Findings for Fiscal Year 2017 Audit:

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

- 1) Valley Behavioral Health was issued a finding in their financial statement audit regarding their billings of Substance Abuse Block Grant funds passed through DSAMH. The audit stated that VBH needs to put policies and procedures in place to ensure that federal grant billings are substantiated by actual expenses. During the site visit review, VBH was asked to justify allocated amounts by using rates that were calculated from their latest approved Medicaid Cost Report and applying those to services reported in their electronic health record system. VBH had some difficulties initially in justifying these amounts. It was later found that their reports were not capturing all of the necessary services, a request was made through their IT department to include them in their reporting and they were able to justify the amounts. This raises the question of what VBH has been doing in the past to justify their monthly billing amounts. This is a repeat finding, it was not elevated to a Significant Non-compliance Issue because they were able to justify their allocated amounts in each category during the site review. However, it is required that VBH justifies each monthly billing throughout the year with adequate documentation of services and expenditures.

Center's Response and Corrective Action Plan:

In order to pull the data requested during the audit, some minor adjustments needed to be made to our service reports, giving us the ability to isolate the data needed to justify costs for some data elements. We were able to show more than adequate costs to justify the contract funding. We can now use those same reports moving forward to justify costs on a monthly basis prior to billing.

- 2) In reviewing personnel files, it was found that three of the sampled employees were missing current conflict of interest forms. One of these employees had a documented conflict of interest in the previous year. The DHS Contract requires that any potential conflict of interest is documented and addressed annually.

Center’s Response and Corrective Action Plan:

Moving forward RO has designated a staff member to monitor the completion of this document for all active employees. Each new employee is required to fill out a COI form upon hire with Human Resources. After the employee signs the COI form, it is signed by the HR Office Manager and sent to the employee’s department for review. Once the supervisor signs off, the form is sent back to the RO department for filing.

In addition to that, COI’s are required by staff to complete during the first quarter of each calendar year. The COI form is available to each employee through our company’s communication platform SLACK, e-mail, and Share-point—with a reminder attached for all staff to complete before March. Each Office Manager is responsible for collecting all the completed forms and sending them to RO. Then, a RO staff member is responsible for filing these in the employee’s personnel file. RO has been monitoring this by completing a monthly personnel file audit.

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. Tooele – VBH has monitored access, customer service and ease of accessibility. The results have given them opportunities to improve, including updated signage at their Children’s Program, Adult Program and Foodbank. Additionally, they have identified the need for community crisis assessment and response in which they are targeting immediate access for higher acuity populations.

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

Child, Youth, & Families team conducted its annual monitoring review at Tooele County – Valley Behavioral Health on March 14th and 15th of 2017. The monitoring team consisted of Eric Tadehara, Program Administrator; Tiesha Cohen, Program Manager; and Brenda Chabot, Family Mentor with the Utah Family Coalition (Allies with Families). 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 Fiscal Year 2016 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) *Youth Outcome Questionnaire:* The Youth Outcome Questionnaire (YOQ) is not being administered at the required frequency. Division Directives require that the YOQ be administered at a frequency of “every thirty days or every visit (whichever is less frequent)” for each child and youth.

This finding has not been resolved and is continued in FY17; see Minor Non-compliance Finding #1.

- 2) *Juvenile Civil Commitment:* Tooele-VBH needs to strengthen their Juvenile Civil commitment administrative tracking process to ensure that all requirements are completed within the time frames required by statute.

This finding has been resolved. The FY17 review showed evidence of up to date forms being utilized and completed properly.

- 3) *Objectives:* Recovery plan objectives were not achievable or meaningful in five of the seven charts reviewed. The objectives are difficult to achieve and lack meaning for the child, youth, and/or their family. Division Directives state that “short term goals/objectives are measurable, achievable and within a timeframe.”

This finding has been resolved. The FY17 chart review showed evidence of documentation that meets Division Directives standards.

FY16 Deficiencies:

- 1) *Emergency Data*: Data reported to the Division of Substance Abuse and Mental Health regarding emergency services is incomplete.

This deficiency has not been resolved and is 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:

- 1) *Youth Outcome Questionnaire*: The Youth Outcome Questionnaire (YOQ) is not being administered at the required frequency or rate. Division Directives require that the YOQ be administered at a frequency of “every thirty days or every visit (whichever is less frequent)” for each child and youth and at a rate of at least 50% unduplicated yearly. Charts reviewed showed a frequency of six administrations during the previous calendar year and a rate of 39.9% in FY16.

Center’s Response and Corrective Action Plan:

VBH-TC will provide training on the use of the OQ as a clinical tool as well the importance of documentation of its use. The training will highlight the importance of reviewing the OQ in treatment sessions no less than once every 30 days. VBH continues to monitor this through our ROC team and monitor improvement of use on a monthly basis. In addition, ROC is in the process of developing a training specifically for office support staff and office managers on the use of the OQ analyst.

FY17 Deficiencies:

- 1) *Emergency Data*: Data reported to the Division of Substance Abuse and Mental Health regarding emergency services is incomplete. Although emergency services are being provided, they are only being reported minimally on the Substance Abuse and Mental Health Information System (SAMHIS), with 27 total children and youth served for crisis in FY16.

Center’s Response and Corrective Action Plan:

VBH- TC will monitor data on a monthly basis through the SAMHIS submission data to ensure there is not a discrepancy between emergency services provided and reported. VBH- TC will coordinate with RO to provide a training to support direct care providers to enter emergency data with consistency.

FY17 Recommendations:

- 1) *Clients Served*: Tooele-VBH served 110 less children and youth in FY16, a 17.2% decrease from FY15. To note, in FY17 there was a 4.9% decrease in the amount of clients not served,

but in need of treatment. It is evident that Tooele-VBH is capable of serving the community effectively. For FY17 year-to-date data, Tooele – VBH has served 420 children and youth. It is recommended that Tooele-VBH increase opportunities to serve clients in need of treatment.

- 2) *Peer Support Services:* Tooele-VBH provided Family Peer Support services to 192 children and youth and families in FY16, while only 30 were captured in SAMHIS as being served with Peer Support services. While not all of these 192 children and youth are Medicaid eligible and open clients, it is recommended that Tooele-VBH utilize peer support services for each child and youth who is an open client. It is also recommended that Tooele – VBH work with their Family Resource Facilitator (FRF) Mentor to ensure proper training is done with FRFs who are providing peer support services.

FY17 Division Comments:

- 1) *Community Partnerships:* Tooele-VBH has developed partnerships within their community that would benefit from educating the community about the effective services they have to offer. Educational initiatives can enhance the relationships within the community and offer opportunities to increase the communities’ knowledge of the resources Tooele-VBH has to offer.
- 2) *School-Based Behavioral Health:* Tooele-VBH has begun providing school-based behavioral health services within two of the local schools. Tooele-VBH has created a good foundation for partnerships established and has opportunities in place to expand their delivery of school-based behavioral health services throughout the community to address the need for more community based supports.
- 3) *Family Feedback:* The Utah Family Coalition (UFC) collected feedback from 29 families via survey and five families who participated in a focus group. When asked about the most important things they liked about the Tooele-VBH local mental health center, families and caregivers reported “helpful expertise, very nice and caring,” and “they help us through many crisis.” Families appear to be grateful for the many services provided by Tooele - VBH.
- 4) *Wraparound and Family Resource Facilitators:* Tooele – VBH is providing High Fidelity Wraparound as defined by the UFC. Tooele – VBH FRFs are an integral part of the service delivery system in the County. The families who receive FRF services commented that their FRF, “helps mom calm down in a crisis [and] gave me support when needed.” One family commented that the FRF “spent a lot of time checking on resources and services that we were unable to get on our own, like school and SSI.” It is evident that Tooele-VBH FRFs are effective and are seen as helpful resource to the families they serve.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Tooele County – Valley Behavioral Health on March 14th, 2017. The team included LeAnne Huff, Adult Mental Health Program Manager and Cami Roundy, Recovery and Resiliency Peer Program Manager. The review included the following areas: Discussions with clinical supervisors and management teams, record reviews, site visits to administrative offices, the outpatient clinic, and New Reflections Clubhouse. During the discussions, the team reviewed the FY16 audit; statistics, including the Mental Health Scorecard; area plans; Outcome Questionnaires 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 Significant Non-compliance Issues:

- 1) *Data Submission Regarding Incarcerated Individuals:* According to the FY15 Mental Health Score Card, Tooele-VBH provided emergency jail services to zero (0) individuals. Year-to-date FY16 also report emergency jail service to zero (0) individuals. Services provided are not accurately reflected by the data submitted to the DSAMH as mandated by the Division Directives. Data submission of jail services on the Mental Health Score Card have been under-reported since prior to FY11.

This finding has been resolved. FY16 scorecard shows the numbers went from 0 in FY15 to 65 in FY16.

- 2) *Documentation/Objectives:* Division Directives require that short term goals/objectives are measureable, achievable and within a timeframe. A review of documentation also revealed deficiencies which could impact the quality of care that clients receive.

This finding has not been resolved, however improvements were noted during current chart reviews, so this finding will continue as a joint finding with Substance Abuse in FY17; see Minor Non-Compliance issue # 1.

FY16 Minor Non-compliance Issues:

- 1) *Consumer Satisfaction Surveys:* DSAMH reporting requirements include a minimum consumer satisfaction survey rate of 10% of the number of annual unduplicated clients served for the prior year. Tooele-VBH returned an insufficient number of surveys for FY15 (7.8%) and FY16 (0.9%).

This finding has been resolved. The FY16 scorecard for Tooele-VBH shows that consumer satisfaction survey rate is at 12.1%, exceeding the minimum standard of 10%.

FY16 Deficiencies:

- 1) *Access to Care:* Excessive staff turnover and low staff numbers have resulted in long periods of time between appointments and repeated therapist changes. While time to first intake has been resolved, the number of adult mental health clients served continues to drop (31.5% decrease since 2010) while the County population increases. DSAMH encourages Tooele-VBH to explore methods to improve staff retention.

This finding has been resolved. The number of adult mental health clients remained consistent during FY16.

- 2) *Outcome Questionnaire (OQ) as an Intervention:* DSAMH recognizes the increased administration of the OQ at Tooele-VBH. However, 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.

This finding has not been resolved and will continue in FY17; see Minor Non-compliance issue # 2

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/Objectives:* Division Directives require that short term goals/objectives are measurable, achievable and include a timeframe. Six of the eleven (55%) charts reviewed did not have measurable goals. Two (18%) of the charts reviewed did not have an assessment in the electronic health record, and one of the charts with no assessment also did not have objectives or a treatment plan. In three (27%) of the charts, progress notes were cut and pasted. DSAMH recognizes and appreciates Tooele-VBH's effort over the last year in improving documentation, and improvements are noted. DSAMH recommends that Tooele-VBH continue to provide trainings on proper documentation to staff.

Center's Response and Corrective Action Plan:

VBH-TC will facilitate training on the development of quality care plans that are able to clearly outline the use of the treatment planning tool as a fluid document that is used throughout the course of treatment to outline and prescribe the appropriate level of care. In addition, it will continue to remain a high level initiative for the VBH-TC to complete annual assessment updates as well as no less than quarterly treatment plan reviews depending on the level of care the client is participating. VBH-TC will utilize the Medical Record review process as well as the use of internal audits through our ROC team to show evidence of improvement. This process will also provide a continuous feedback look for areas that may be lacking in this area of the record.

- 2) *OQ Administration/Use as an Intervention*: Division Directives require that OQ administration be at 50% and FY16 score card shows the Tooele-VBH rate has dropped to 39.6%. In addition, the Division Directives require that data from the OQ be shared with the client and incorporated into the clinical process, as evidenced in the chart. The use of the OQ as an intervention was only evident in one of the eleven charts reviewed. In addition, the FY16 scorecard indicates that Tooele-VBH had the highest rural measure for percentage of treatment episodes “deteriorated” and the highest state measure for percentage of discharged episodes “not recovered”. Appropriate use of the OQ as an intervention has been demonstrated to improve treatment outcomes.

Center’s Response and Corrective Action Plan:

In an effort to address the finding of the highest rural measure for percentage of treatment episodes “deteriorated” and the highest state measure for percentage of episodes “not recovered” VBH-TC will provide training in conjunction with the above discussed training on the use of the OQ as a clinical tool as well as the importance of documentation of the use and review of the OQ in treatment sessions no less than once every 30 days. VBH continues to monitor this through our ROC team and we monitor improvement of use on a monthly basis. In addition, ROC is in the process of developing a training specifically for office support staff and office managers on the use of the OQ analyst and the need to utilize this tool with accurately assigning clients to the program as well as discharge from the program showing an accurate reflection of discharge status.

FY17 Deficiencies:

None

FY17 Recommendations:

- 1) *Recovery Plus*: Recovery Plus is an initiative to promote health and wellness in people with mental illness and/or substance use disorders. Smoking cessation classes are not a provided service at Tooele-VBH, and charts reviewed identified nicotine use without evidence of referral or offering resources or cessation services. Division Directives require that tobacco use will be identified in the assessment with resources offered as indicated.
- 2) *Safety Planning*: During the chart reviews, five of the eleven (45%) charts reviewed had vague safety plans, such as “know how to cope” and “when I have thoughts they linger”. One safety plan did not have an emergency contact number. The purpose of the Safety Planning Intervention is to provide people who are experiencing suicidal ideation with a specific set of concrete strategies to use in order to decrease the risk of suicidal behavior. This intervention is a collaborative and empowering effort between a clinician and a client. DSAMH recommends that Tooele-VBH staff receive training on Safety Plan Interventions. A Patient Safety Plan template can be found at:
http://suicidepreventionlifeline.org/wpcontent/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf.

FY17 Division Comments:

- 1) *Utah Behavioral Health Planning and Advisory Council (UBHPAC) membership*: Utah’s

Public Behavioral Health System is funded in part by two federal block grants: the Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant. Federal law 102-321 (the Public Service Act) requires any state receiving funding from these block grants to support a Planning and Advisory Council with peer/consumer representation. UBHPAC is a group of individuals who support and advocate for services for consumers of public behavioral health services by planning and advising the Division of Substance Abuse and Mental Health. DSAMH commends the efforts of Certified Peer Support Specialist (CPSS) Kevin Foote and Renee Chipman from Tooele who have consistently attended UBHPAC over the last few years. They have also actively recruited other Peers so the Peer voice is heard on the Council.

- 2) *Participant Feedback:* DSAMH Recovery and Resiliency Peer Program Manager Cami Roundy met with a focus group of five individuals in recovery at New Reflections House. All five individuals stated that their treatment is going well, and that they decide what their treatment goals are and what they would like to work on. Members said that “coming here has helped me a lot”, “it’s about the friends that you make here, the people that back you up”, “we have a family here - they will fight for you”, “I am doing great here, and haven’t been hospitalized in over a year”, and “having a job helps with my self-esteem.”
- 3) *New Reflection House:* DSAMH commends Tooele-VBH for Recovery Support Services offered through New Reflection House. All individuals report that they are given help with employment, housing and transportation as needed. Exercise groups and healthy meals are offered. Two of the individuals reported that they are receiving CPSS Services, and one said that the CPSS had helped them to get an eye exam and free glasses. One individual stated that they would like to have more free activities. One member mentioned that he was a smoker and said he had not been offered tobacco cessation.
- 4) *Peer Support Services:* DSAMH Recovery and Resiliency Peer Program Manager Cami Roundy met with the CPSS and supervisor at New Reflections House. Documentation and use of the recovery story was reviewed, and the documentation template that DSAMH supports was provided. The Division appreciates the extensive resource list provided by the CPSS for placement on the DSAMH Peer Support Specialist webpage.

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review of Tooele County – Valley Behavioral Health on March 14th, 2017. 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

No findings were issued in FY16.

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) Tooele-VBH did not complete a Strategic Plan for FY16.

Center's Response and Corrective Action Plan:

Strategic Plan was submitted on May 1, 2017.

- 2) No EASY compliance checks were completed during FY16. This is a decrease from 27 in FY15.

Center's Response and Corrective Action Plan:

We will provide education to local law enforcement about the benefits of doing EASY compliance checks, and how it benefits them (financially and personally) and the community.

- 3) The percent of evidence based strategies offered by Tooele-VBH was 66.7%. The goal is to offer 90% evidence based strategies.

Center's Response and Corrective Action Plan:

We will add the work our coalition is doing to our logic models that includes guiding good

choices and compliance checks. We will also look for additional programs our coalitions can support on Blueprints.

FY17 Recommendations:

- 1) It is recommended that Tooele-VBH look for ways to increase capacity of agency staff, administration, and community partners. This may include travel to training and conferences.
- 2) It is recommended that Tooele-VBH incorporate components from existing Tooele County coalitions' community action plans or strategic plans into the LSAA strategic plan.
- 3) It is recommended that Tooele-VBH Prevention staff work with their Regional Director and the DSAMH Contractor to complete necessary paperwork for additional grants.

FY17 Division Comments:

- 1) Tooele-VBH has increased the communities in which it provides direct service. They provide direct prevention services within Dugway, Grantsville and Wendover in addition to Tooele City.
- 2) Tooele-VBH has partnered with multiple agencies to help develop the first bi-state coalition in Wendover Utah/Nevada. This endeavor has increased the support and buy in of prevention services from community members on both sides of the state line.
- 3) Tooele-VBH staff participates on coalitions for Wendover, Tooele City, and Grantsville.

Substance Abuse Treatment

Christine Simonette, Program Manager and Thomas Dunford, Program Manager, conducted the review of Tooele County - Valley Behavioral Health Substance Use Disorders Treatment Program on March 14, 2017, which focused on Substance Abuse Treatment (SAPT) Block Grant Compliance; Drug Court; clinical practice and compliance with contract requirements, and DORA program compliance. Drug Court was evaluated through staff discussion, clinical records, and the Drug Court Scorecard. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to SAPT Block Grant requirements and contract requirements were evaluated by a review of policies and procedures by interviews with Tooele County staff. Treatment schedules, policies, and other documentation were viewed. The Utah Substance Abuse Treatment Outcomes Measures Scorecard results were reviewed with Tooele County staff. Client satisfaction was measured by reviewing records and Consumer Satisfaction Survey data. Finally, additional data was reviewed for Opiate Use, Year-end reports, suicide rates, and Driving under the Influence (*DUI*) rates in Tooele County.

Follow-up from Fiscal Year 2016 Audit

FY16 Significant Non-Compliance issues:

- 1) Tooele-VBH continues to allow Drug Court Phases to determine level of care. All clients are required to start with a specified number of groups per week and the phases of drug court determine the level of treatment. Changes in treatments levels should always be based on a clinical assessment of the clinical assessment of ASAM criteria, not time in drug court or completion of drug court requirements.

This issue has been resolved. The Risk And Needs Triage (RANT) assessment was implemented and additional assessments are being completed when levels of care are changed.

FY16 Minor Non-compliance issues:

- 1) *Documentation:* Tooele-VBH has several factors demonstrating failure to meet Division Directives regarding proper documentation in their electronic health record. Documentation should be current, person centered, updated regularly, and have measurable goals and objectives showing client involvement. In charts reviewed most are lacking valid releases of information, and no consent-to-treat or Privacy statement notice forms. The American Society of Addiction Medicine (ASAM) is a check-box form, which does not list the dimensions or objectives; and the ASAM is not uniquely identifiable in any of the assessments. Group notes do not tie back to client goals and objectives. Tobacco, Medication Assisted Treatment (MAT), and other health factors (high priority risk factors such as HIV/Hep B&C/ TB) are not screened for, nor documented in the charts. Family involvement is not documented correctly under appropriate family services.

This issue has not been resolved and will be continued as a joint finding with Adult Mental Health in FY17; see Minor Non-compliance Issue #1.

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:* Tooele-VBH has several factors demonstrating failure to meet Division Directives regarding proper documentation in their electronic health record. Documentation should be current, person centered, updated regularly, and have measurable goals and objectives showing client involvement. The American Society of Addiction Medicine (ASAM) form is completed, but at times it appears that scoring of the dimensions is not consistent with documentation in the file. The recovery plans do not show client participation in the creation of the plans. Group notes do not tie back to client goals and objectives. Tobacco, Medication Assisted Treatment (MAT), and other health factors (high priority risk factors such as HIV/Hep B&C/ TB) are not screened for, nor documented in the charts.

Center’s Response and Corrective Action Plan:

VBH-TC has had many new employees in the last 12 months. The Adult/SUD Team will focus on providing consistent training that illustrates the importance of documentation standards as they apply to our current EHR. The training will outline that documentation should be current, person centered, updated regularly, and have measurable goals and objectives showing client involvement. The training will be thorough in its review of the use of the ASAM and will ensure that the ASAM form is completed, with scoring in the dimensions that are consistent with the documentation in the file. The client’s recovery/treatment plans will show client participation in the creation of the plan. A training on group notes will be completed to show the importance of the notes tying back to the client goals and objectives. Lastly, the training will illustrate the importance of screening and documenting the screening of Tobacco, Medication Assisted Treatment (MAT), and other health factors (high priority risk factors such as HIV/Hep B&C/ TB) in client charts. VBH-TC will work in collaboration with the ROC team to complete chart reviews of the Adult/SUD charts in order to close the feedback loop and provide consistent measurement of improvement or lack of improvement. The reviews will also identify individuals that may require additional training and monitoring.

The Utah Substance Abuse Treatment Outcomes Measures Scorecard showed:

- 2) The percent of individuals that completed a treatment episode successfully decreased from 35.8% to 21.1%, from FY15 to FY16 respectively, which does not meet Division Directives.

Center’s Response and Corrective Action Plan:

VBH-TC had a strong push on chart cleanup. We believe that this has contributed to the drastic change in numbers. In an effort to continue monitoring on this initiative we will include an SUD admission and discharge portion of the training in the training outlined above.

- 3) The percent of individuals that were employed prior to admission vs. prior to discharge decreased from 11.1% to -33.6%, from FY15 to FY16 respectively, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

VBH-TC had a strong push for chart cleanup. We believe that this has contributed to the drastic change in numbers. In an effort to continue monitoring on this initiative we will include an SUD admission and discharge portion of the training in the training outlined above.

- 4) The percent of individuals that were retained in treatment for 60 days or more decreased from 67.4% to 64.2% respectively, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

VBH-TC had a strong push for chart cleanup. We believe that this has contributed to the drastic change in numbers. In an effort to continue monitoring on this initiative we will include an SUD admission and discharge portion of the training in the training outlined above.

- 5) Only 7.9% of the adult consumer satisfaction reports, and only 5.7% of the youth satisfaction reports were returned, which does not meet the minimum of 10%.

Center's Response and Corrective Action Plan:

VBH has implemented many changes in the collection and tracking related to the adult consumer satisfaction report. We have an agency goal of 20% and monitor this weekly. VBH expects that this metric will be met.

FY17 Deficiencies:

None

FY17 Recommendations:

- 1) *Clinical Charts:* In some charts, family, group and individual therapy notes lacked specificity that allowed the reader to understand where the client was in completing the goal and the therapist's plans to help move the goal towards completion. It is recommended that notes reflect the client's progress towards goal completion and the therapist's next steps or plan to support client efforts in completion of the goal.
- 2) *The National Alliance for Buprenorphine Treatment (NAABT):* 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 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.

- 3) *Court Compelled:* Tooele-VBH may not be capturing all the individuals that are court compelled in their data. It is recommended a process be developed to ensure that “compelled” individuals are identified and charts are modified to reflect the corrected information as quickly as possible with everyone who presents for SUD treatment.
- 4) There is no written Policy and Procedure for on-site drug testing given to clients for their review or records. It is recommended that a policy and procedures document be written and a hard copy be given to all clients at intake or as soon as possible thereafter. Per FY16 Division Directives, section C, subcategory vii, it is stated as follows:

c. Required Written Policy and Procedures: All DSAMH programs, contractors, subcontractors and providers who perform drug testing shall have written policies and procedures that address:

1. *Selection of participants to be tested (hereinafter participants)*
2. *Frequency of testing*
3. *Screening and confirmation methodologies*
4. *Collection and handling of specimens*
5. *Procedure for verifying integrity of sample that includes checks for tampering, adulteration and dilution*
6. *Chain of custody procedures*
7. *Documentation standards*
8. *Training requirements for all direct service staff that includes training on principles of trauma informed care*
9. *Disclosure of results or other information related to drug screen participation*
10. *Potential consequences for testing positive*
11. *The participant’s right to request confirmation testing*
12. *Procedures to ensure the physical and emotional safety of staff and participants*
13. *All policies and procedures are subject to review and approval by the Department of Human Services (DHS).*

FY17 Division Comments:

- 1) Tooele-VBH could benefit from housing, including after care housing for clients.
- 2) Tooele-VBH could benefit from trainings on offering and documenting Evidence Based Practices and MAT services.
- 3) Sarah DeBois has implemented several changes in the way therapists view their roles, conduct evaluations and track needed documentation. She has provided training and technical assistance, and her efforts are starting to take hold. This approach should be noted and commended.

- 4) Tooele-VBH has significantly increased the number of group provided since the FY16 site visit.
- 5) Tooele-VBH has conducted a records review and modification process that has resulted in correcting the majority of Electronic Health Record (EHR) errors that have existed in the past. This process was long and costly but has resulted with great improvements.
- 6) Tooele-VBH has made critical advances with Adult Probation and Parole (AP&P) to have more collaboration and agency support of the JRI efforts within their communities and currently has a strong and functioning JRI committee that is comprised of all the key community partners.
- 7) Tooele-VBH provides critical crisis services in the jail by providing treatment groups, screenings and assessments and re-entry services.

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 Tooele County – Valley Behavioral Health 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

Prepared by:

Chad Carter  Date July 10, 2017
Auditor IV

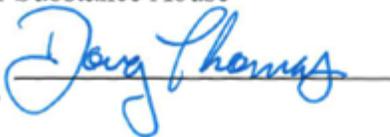
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