



Site Monitoring Report of

Tooele County  
Valley Behavioral Health

Local Authority Contracts #160235 and #160236

Review Date: March 27<sup>th</sup>, 2018

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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 27<sup>th</sup>, 2018. 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	None	
	Significant Non-Compliance	2	7-8
	Minor Non-Compliance	1	8-9
	Deficiency	None	
<i>Child, Youth &amp; Family Mental Health</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	12
	Deficiency	1	12-13
<i>Adult Mental Health</i>	Major Non-Compliance	None	
	Significant Non-Compliance	1	15
	Minor Non-Compliance	2	15-17
	Deficiency	3	17-18
<i>Substance Abuse Prevention</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	2	19
<i>Substance Abuse Treatment</i>	Major Non-Compliance	None	
	Significant Non-Compliance	2	22-23
	Minor Non-Compliance	None	
	Deficiency	3	23-24

## **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 27<sup>th</sup>, 2018 by Chad Carter, Auditor IV. 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. Meeting 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 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.

There is a current and valid contract in place between the Division and the Local Authority. Tooele County met its obligation of matching a required percentage of State funding.

As required by the Local Authority, Tooele County received a single audit for the year ending December 31<sup>st</sup>, 2016 and submitted it to the Federal Audit Clearinghouse. The firm Ulrich & Associates, PC completed the audit and issued a report dated June 15<sup>th</sup>, 2017. The auditors' opinion was unqualified stating that the financial statements present fairly, in all material aspects, the financial position of Tooele County. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on internal control over financial reporting and compliance for each major Federal program. No findings or deficiencies were reported in the audit.

The CPA firm Tanner LLC completed a single audit of Valley Behavioral Health for the year ending December 2016. The auditors issued an unqualified opinion in the Independent Auditor's Report dated May 31, 2017. A finding was identified in their review of Federal Awards, see Minor Non-compliance Issue # 1 for more details.

### **Follow-up from Fiscal Year 2017 Audit:**

#### **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.

**This issue has been resolved. The independent auditors followed up on this issue in their most recent audit and found that Valley was able to substantiate their Federal grant billings with actual expenses. As part of the DSAMH site visit, services and expenditures were also analyzed to ensure that billing amounts were substantiated. Valley was able to justify their billed amounts in all Federal and State categories.**

- 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.

**This issue has not been resolved and will be continued in FY18; see Significant Non-compliance Issue #1.**

#### **Findings for Fiscal Year 2018 Audit:**

##### **FY18 Major Non-compliance Issues:**

None

##### **FY18 Significant Non-compliance Issues:**

- 1) *Conflict of Interest:* During the review of personnel files, it was found that one sampled employee was missing a current conflict of interest form. The last one completed was signed in 2015 and did state that a potential conflict of interest did exist. The DHS Contract requires that any potential conflict of interest is declared in writing and reviewed no less than annually. The same issue was found in the previous year and has been moved to a Significant finding due to the level of non-compliance.

##### **Center's Response and Corrective Action Plan:**

Attached is the current Conflict of Interest (COI) for the employee N.H. Moving forward, Valley's Regulatory Oversight and Compliance (ROC) Department has designated its Lead Compliance Auditor to track and monitor COIs. This individual will be responsible for ensuring every employee receives and completes a COI form every year. Also, this person will ensure each COI gets reviewed by Valley's Senior Business Director. In addition to that, this person will create a tracking mechanism to monitor staff completion and any potential conflicts. ROC will conduct monthly follow ups to ensure staff's COI's are filed within the personnel file.

- 2) *Executive Travel:* As a part of monitoring, travel packets are selected for executive officers as they have a higher standard for compliance and because Utah Code Title 62A-15-110-(1)(b)(i) addresses the Division's responsibility to specifically audit executive travel or other expenses. Travel packets were reviewed for executive officers of Valley Behavioral Health

to ensure that Valley’s travel policy was being adhered to and that no personal benefit was gained from travel reimbursements. Two types of issues were found during the review:

- *Insufficient Documentation* – Three credit card receipts, without a list of items purchased, were found to be submitted and approved for meal reimbursements. VBH’s Travel Expenditure Report states, “*Attach all original and itemized receipts. Credit card receipts are unacceptable.*” If itemized receipts are not required for reimbursement approval, it would be difficult to prevent reimbursement for prohibited purchases such as personal items or alcohol.
- *Insufficient Approval* – Three Travel Expenditure Reports were found with no documented approval. This includes a travel packet submitted by the company’s CEO. VBH’s travel policy states “*Upon return, all employees will submit a completed Travel Expenditure Report to the Administrative Services Travel Coordinator within 10 days of their return; this form must be reviewed and signed by the appropriate Program Manager/ Associate Director.*” Internal Revenue Code defines exempt organization corporate officers as employees; it would be appropriate to hold the CEO to the same approval standards.

In previous years, travel reimbursements for managers of VBH have been reviewed. These same issues have been found previously in the Summit travel packets specifically, but the review of Valley executives shows that this is a company-wide issue. There is a need to strengthen controls and approval practices before reimbursements are paid. This finding has been raised to a Significant Non-compliance Issue.

**Center’s Response and Corrective Action Plan:**

Attached is Valley’s form for “Request for Travel and Allowance” and its corresponding policy on “Expense Reimbursements”. Moving forward, all Valley employees must produce itemized receipts in order to be reimbursed. No one will be exempt from this. Company executives will get the final approval by Valley’s Chief Executive Officer. Travel requests for the Chief Executive Officer will be approved by Valley’s Chief Financial Officer. Valley Accounts Payable Manager will be responsible for monitoring this, and ensuring there is sufficient approval and documentation for Valley employees.

**FY18 Minor Non-compliance Issues:**

- 1) *Written policies and procedures for Federal awards:* A deficiency was reported in the single audit for Valley Behavioral Health. Uniform Guidance 2 CFR 200 requires that entities that receive and manage Federal awards maintain written policies, procedures, and standards of conduct regarding federal awards. Valley Behavioral Health did not have these in place and is out of compliance.

**Center’s Response and Corrective Action Plan:**

Valley has a policy addressing Federal Awards that was last effective 10/17. Please see

attachment “ Federal Awards Policy”.

**FY18 Deficiencies:**

None

**FY18 Recommendations:**

- 1) It is recommended that the VBH Board of Directors assess the travel policy and periodically review travel reimbursement expenditures to ensure they are reasonable and necessary for business travel. Some of the submitted reimbursements included high dollar amounts and some receipts showed multiple guests (examples of dinner reimbursements: \$71.94, \$73.77, \$124.86-(2 guests), \$138.56, \$805.27-(12 guests)). Reimbursed meals for multiple guests may have a legitimate business purpose (business meeting, client dinner, etc...), but there was no documentation or explanation provided. It is recommended that the board considers setting dollar amount limits on meal reimbursements and include controls to ensure that meals unrelated to business are not reimbursed (e.g. spouse meals, etc...). Utah Code Title 62A-15-110-(1)(b)(i) states “...the division: shall prescribe guidelines and procedures, in accordance with those formulated by the state auditor pursuant to Section 67-3-1, for auditing the compensation and expense of officers, directors, and specified employees of the private contract provider, to assure the state that no personal benefit is gained from travel or other expenses”. The VBH travel policy states “Valley will reimburse its employees for all actual, reasonable and necessary business and travel expenses incurred while on Valley business.”

**FY18 Division Comments:**

None

### **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 Tooele County – Valley Behavioral Health on March 27, 2018. The monitoring team consisted of Eric Tadehara, Program Administrator; Mindy Leonard, 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 2017 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 2017 Audit**

#### **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.

**This finding has not been resolved and is continued in FY18; see Minor Non-compliance Finding #1.**

#### **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.

**The emergency data went from 27 total children in FY16 to 63 children in FY17. This finding has been resolved.**

### **Findings for Fiscal Year 2018 Audit**

#### **FY18 Major Non-compliance Issues:**

None

#### **FY18 Significant Non-compliance Issues:**

None

**FY18 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. Charts reviewed showed a lack of regular consistency with regard to administration of the YOQ. Of the ten charts that were reviewed only one chart had the required administration of the YOQ.

**Center’s Response and Corrective Action Plan:**

Analytics recently created a Clinical Key Performance Indicator Report. This report tracks clinical documents that are crucial to provide good quality care. This report tracks Assessments, Care Plans, Safety Plans, Care Plan Adherence, and has the potential to integrate OQ/YOQ administration frequency & scores. ROC will work with the Analytic Department to include this component. Additionally, Tooele will post reminder signs around the building to remind staff and clients to do their YOQ’s and to ask their therapist about them. Additionally, this is be an ongoing training issue in staff meetings and supervision. Clinical trainings will be completed by Sarah Debois by July 31, 2018. Tooele will monitor the Clinical KPI report and address any OQ/YOQ deficiencies in staff meetings, individual 1:1’s, and MRR (Peer Review) completions. This will also be a focus with chart audits. Finally, these scores have been added to criteria for pay for performance bonus for staff.

**FY18 Deficiencies:**

- 1) *Community Engagement and Outreach*: Community partners voiced concerns regarding Tooele-VBH's ability to continue to nurture the partnerships because of recent policy changes within Tooele-VBH. Community partners stressed the importance of Tooele-VBH having a strong presence in the community, as well as the vital role Tooele-VBH plays in the community as the County mental health center. In order to provide the level of oversight and coordination as required by Utah Code 62A-15-608 and DSAMH Division Directives, it is critical that Tooele-VBH continue to cultivate their community engagement and outreach. Local staff at Tooele-VBH have built relationships with their community partners, and community members appreciate that Tooele-VBH staff has had a history of responsiveness and commitment to community engagement.

**Center’s Response and Corrective Action Plan:**

Valley places great importance on its relationships with community partners. Policies surrounding the Pay-for-Performance(PFP) have been adjusted since its initial roll-out. Staff community trainings and approved PTO requests do no negatively impact staff’s productivity hours for PFP. Last year, Valley implemented individual 1:1’s in which employees are encouraged to complete a “Career Development Plan.” This plan includes a section for development opportunities ( trainings, outreach). Valley has been focused on improving staff communication this year by implementing daily huddles with teams and creating SLACK Q&A’s where employees can ask leadership questions and address any concerns.

VBH-Tooele has contacted our community partners to ensure satisfaction with services. Frequency of meetings has been increased to once monthly in necessary areas. VBH – Tooele will continue to engage our community partner’s relationships, and ask what is needed of VBH during the Advisory Council that occurs once a month. During this meeting there are representatives from many of the community partners. VBH – Tooele will continue to nurture these relationships and when a need is identified – respond in an efficient, timely manner. There are a number of counsels throughout the county where a VBH staff is available to hear and respond to the community needs. For example: the Council on Aging, CJC Multi-Disciplinary Team and Advisory Board, DCFS, monthly team meeting and law enforcement and JRI meetings where VBH-Tooele is able to hear and respond to community partner.

**FY18 Recommendations:**

- 1) *Peer Support Services:* Tooele-VBH showed a small increase in Peer Support Services (PSS) for youth and families in FY17. Tooele-VBH went from reporting 30 families receiving PSS in the Substance Abuse and Mental Health Information System (SAMHIS) in FY16 to 34 families receiving these services. The number of youth and families who received Family Resource Facilitation (FRF) services in FY17 was 221 total. It is recognized that not all of these FRF services can be reported to SAMHIS as PSS, however it is recommended that Tooele-VBH continue to build and report PSS as appropriate for the children and youth who are opened clients. It is also recommended that Tooele-VBH work with the Utah Family Coalition (UFC) mentor, Brenda Chabot, to work on this reporting.

**FY18 Division Comments:**

- 1) *Family Feedback:* The UFC collected feedback from seven families via survey and two families who participated in a focus group. When asked about the most important things that they liked about the Tooele-VBH local mental health center, families and caregivers reported “The people are very helpful. The programs are very helpful.” Families also reported that Tooele-VBH “are very helpful” and “understands our needs.” Families are grateful for the many services provided by Tooele-VBH.
- 2) *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 county. The families who receive FRF services commented that “Wraparound has made me stay sane and not lose it taking on the six kids we have.” It is evident that Tooele-VBH FRFs are effective and are seen as a helpful resource to the families they serve. One family stated ‘She is a great asset to the Crisis team, helping families who are in crisis. She understands the family point of view and can help advocate for them when needed. Families like her and value the work she is doing for and with them.’”

## Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Tooele County – Valley Behavioral Health on March 27<sup>th</sup>, 2018. The team included Pam Bennett, Adult Mental Health Program Administrator 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, New Reflections Clubhouse, Tooele County Emergency Management and Tooele County Jail. During the discussions, the team reviewed the FY17 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 2017 Audit

#### **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.

**Nine of nine charts reviewed in FY18 contained assessments, objectives, and original, client-centered notes. Eight of nine charts included treatment plans. This portion of the finding has been resolved. Four of nine (44%) charts reviewed in FY18 did not have measurable goals. This issue is not resolved and will be continued in FY18; see Minor Non-compliance Issue #1.**

- 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.

**The administration rate of the OQ increased from 39.6% to 84.5%; this portion of the finding has been resolved. However, only three of nine (33%) charts reviewed in FY18 included review and incorporation of the OQ into the clinical plan. This issue is not resolved and will be continued in FY18; see Minor Non-compliance Issue #2.**

## **Findings for Fiscal Year 2018 Audit**

### **FY18 Major Non-compliance Issues:**

None

### **FY18 Significant Non-compliance Issues:**

- 1) *Safety Planning:* During the chart reviews, safety plans were present in five of the nine charts reviewed (56%). All five charts had inadequate safety plans, consisting only of one line stating “client will contact 911” or “client will call crisis”. The lack of a meaningful safety plan appears to be a pervasive, on-going issue that could have serious consequences for client safety. DSAMH Division Directives require that records contain a safety/crisis plan when clinically indicated. At a minimum, safety plans should include warning signs, coping strategies, specific identified support people, and methods to keep the environment safe. The Stanley Brown Safety Plan is one form that could be used. Added training on safety plan intervention was a recommendation in the FY17 Monitoring Report.

[https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown\\_St StanleySafetyPlanTemplate.pdf](https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_St StanleySafetyPlanTemplate.pdf).

### **Center’s Response and Corrective Action Plan:**

ROC recently completed an internal Safety Plan Audit and shared these concerns at Valley’s Clinical Council Meeting. During this meeting our Chief Clinical Officer tasked clinical leadership to develop a Safety Plan Training. This training will address individualizing key components necessary for a Crises Safety Plan. This training will be rolled out to Tooele staff and would need to be completed by July 15<sup>th</sup>. This will include staff sign in sheets and agendas.

In addition to that, Analytics recently created a Clinical Key Performance Indicator Report that tracks client’s Safety Plan and CSSRS administration. This report will allow clinicians to quickly see Safety Plan administration and necessary review dates. Supervisors will be responsible for reviewing KPI’s in individual supervision meetings. Deficiencies found by Supervisors or auditors in the ROC department will be addressed with individuals in supervision meetings and huddles. Follow up will include further trainings or PIPs as needed.

### **FY18 Minor Non-compliance Issues:**

- 1) *Documentation/Objectives:* Division Directives require that short term goals/objectives are measurable, achievable and include a timeframe. Only five of nine charts (55%) reviewed in FY18 had measurable short-term goals, but had objectives such as “improve my social network” and “learn better coping skills”. One possible option for developing measurable goals is encouraging staff to utilize SMART goals; Specific, Measurable, Attainable, Relevant, and Time-based. DSAMH recommends that Tooele-VBH continue to provide trainings on proper documentation to staff.

This is in contrast to the “*Valley Behavioral Health Internal Audit Report: Care Plan*” (January 2018) that reported 73% of short-term “SMART” goals met a requirement of being “individualized and outcome oriented”. Although measurability is included in the “*Valley Behavioral Health Medical Record Review Audit Tool*” (Short-term goals - Simple, Specific, Measurable, Actionable, Attainable, Reasonable, Time-Specific), objectives do not meet measurability standards. Two of four charts had objectives that listed a duration and frequency of treatment and not a method of measuring progress toward goals. The Division Directives state that objectives should be “behavioral changes that are measurable, short term and tied to the goals.” Valley Behavioral Health is encouraged to review use of the Audit Tool, to ensure that those who are doing reviews understand that measurability should reflect a method to identify treatment progress.

#### **Center’s Response and Corrective Action Plan:**

Valley Behavioral Health works diligently to train all new staff on SMART goals and uses MRR (Medical Record Reviews) monthly tracking to review charts internally. A clinical training on SMART goals will be conducted by Sarah DeBois and will be completed by July 31, 2018. An agenda and attendance sheet will be completed and send to ROC after. Follow up will be addressed in monthly peer reviews at Tooele.

Also, Valley’s Analytics Department is currently working on a report that will allow Valley to extract content from the Care Plan and its author to review. This report will have the capability to look for objective measures for review (OQ, DLA-20, PHQ-9) and review content with the Care Plan. Reviewers will have the ability to quickly pull content from the author’s Care Plan and provide immediate feedback.

- 2) *OQ Use as an Intervention*: 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 two of the nine charts reviewed. One chart stated that the client was discouraged from completing the OQ “due to his state of mind”. In addition, the FY17 scorecard indicates that Tooele-VBH continues to have one of the highest rural measures for percentage of treatment episodes deteriorated. Appropriate use of the OQ as an intervention has been demonstrated to improve treatment outcomes.

Of note, four of five questions related to the OQ in the “*Valley Behavioral Health Medical Record Review Audit Tool*” reviewed whether the OQ is being administered and only question assesses use of the OQ as an intervention. The “*Valley Behavioral Health Internal Audit: Individual Psychotherapy*” (February 2018) report scores the OQ use at 50% for Tooele-VBH.

#### **Center’s Response and Corrective Action Plan:**

A training will be completed by Sarah DeBois by July 31, 2018. The training will address the clinical use of the OQ/YOQ and the need to use as a measure for Care Plans and goal progress. In addition to that, Valley’s Analytics Department recently created a Key Performance Indicator Report that tracks necessary measures needed to monitor and provide good quality to clients. This measure will soon include the ability to track OQ administrations and scores. Clinicians will

have the ability to quickly track client treatment adherence. ROC will be utilizing this report to track internal compliance measures. Deficiencies found will be addressed with staff members in supervision, individual 1:1's, daily huddles, and staff meetings. Further trainings and follow up(PIPS, corrective actions)will be included as needed

**FY18 Deficiencies:**

1) *Community Engagement and Outreach:* Community partners have voiced concerns regarding Tooele-VBH's ability to continue to nurture partnerships because of recent policy changes within Valley Behavioral Health. Community partners stressed the importance of Tooele-VBH having a strong presence in the community, as well as the vital role Tooele-VBH plays in the community as the County mental health center. In order to provide the level of oversight and coordination as required by Utah Code 17-43-301 and DSAMH Division Directives, it is critical that Tooele-VBH cultivate their community engagement and outreach.

**Center's Response and Corrective Action Plan:**

Valley places great importance on its relationships with community partners. Policies surrounding the Pay-for-Performance(PFP) have been adjusted since its initial roll-out. Staff community trainings and approved PTO requests do no negatively impact staff's productivity hours for PFP. Last year, Valley implemented individual 1:1's in which employees are encouraged to complete a "Career Development Plan." This plan includes a section for development opportunities ( trainings, outreach). Valley has been focused on improving staff communication this year by implementing daily huddles with teams and creating SLACK Q&A's where employees can ask leadership questions and address any concerns.

Also, VBH-Tooele has contacted our community partners to ensure satisfaction with services. Frequency of meetings has been increased to once monthly in necessary areas. VBH – Tooele will continue to engage our community partner's relationships, ask what is needed of VBH during the Advisory Council that occurs once a month. During this meeting there are representatives from many of the community partners. VBH – Tooele will continue to nurture these relationships and when a need is identified – respond in an efficient, timely manner. There are a number of counsels throughout the county where a VBH staff is available to hear and respond to the community needs. For example: The Council on Aging, CJC Multi-Disciplinary Team and Advisory Board, DCFS, monthly team meeting and law enforcement and JRI meetings where VBH-Tooele is able to hear and respond to community partner.

2) *Continuity of Care:* DSAMH is concerned about the excessive staff turnover and high caseload size per therapist at Tooele-VBH. This leads to long wait times between appointments, repeated therapist changes and inconsistent care for clients. In addition, the "Valley Behavioral Health Internal Audit: Individual Psychotherapy" (February 2018) reflected that 77.5% of clients reviewed were under-utilizing services.

**Center's Response and Corrective Action Plan:**

VBH-Tooele will hire 3 additional therapists to help manage caseloads. Monetary incentives

have been put in place to aid in retention. (PFP). Although, this finding will be difficult to monitor for compliance without a state turnover rate to measure against.

- 3) *Peer Support Services:* Tooele-VBH does not currently have a Certified Peer Support Specialist (CPSS) for Adult recovery support services. No position has been advertised and no indication was given that another CPSS will be employed. Members interviewed at New Reflection House commented that Peer Support has been a great help and support in the past. Peer Support is a Medicaid State Plan Service and as such must be available to Medicaid Eligible individuals in Tooele County to assist individuals in recovery.

### **Center's Response and Corrective Action Plan:**

Peer Support Specialist has been hired. Date of hire: 21 May 2018.

### **FY18 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. Two charts were reviewed with identified nicotine use, without evidence of referral or offering resources or cessation services in either chart. Division Directives require that tobacco use will be identified in the assessment with resources offered as indicated.

### **FY18 Division Comments:**

- 1) *Participant Feedback:* DSAMH Recovery Resiliency Peer Support Program Manager Cami Roundy met with a group of eight members from New Reflections House in Tooele. One mentioned that they get along like family at New Reflections. Several members commented that they reach out and visit others a lot, and that they enjoy the programs and interacting with others. One member stated that they isolate if they don't come to Clubhouse, and that they appreciate the outreach. All participants agreed that they make their own goals that they are working on. Wellness is addressed with a workout room, a Tuesday wellness class; healthy, well-balanced meals for lunch each day, and a walking group in the summer. Four members have received help with housing, while four others commented that they are waiting for help with housing. They have transportation to and from Clubhouse and six of the members have received help with employment. Members said: "I love it up here." "The activities are fun, and even taking members to appointments is fun." "We are good friends here."
- 2) *Emergency Services System:* Tooele County has invested in a HubLink system, coordinated through the Tooele County 911 Dispatch system. This allows rapid communication between crisis workers, emergency personnel, and law enforcement, and includes mechanisms to avoid safety issues and minimize missed crises calls.
- 3) *Services at Tooele County Jail:* The FY18 Adult Mental Health Scorecard reports that Tooele-VBH has dramatically increased service provision to the Tooele County Jail. This is reflected in a strong community relationship between the two agencies.

## **Substance Abuse Prevention**

Susannah Burt, Program Manager, conducted the annual prevention review of Tooele Valley Behavioral Health on April 2, 2018. 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 2017 Audit**

#### **FY17 Deficiency:**

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

**This finding has not been resolved and will be continued in FY18; see Deficiency # 1.**

### **Findings for Fiscal Year 2018 Audit**

#### **FY18 Major Non-compliance Issues:**

None

#### **FY18 Significant Non-compliance Issues:**

None

#### **FY18 Minor Non-compliance Issues:**

None

#### **FY18 Deficiencies:**

- 1) No Eliminating Alcohol Sales to Youth (EASY) compliance checks were completed during FY17

#### **Center's Response and Corrective Action Plan:**

Intend to continue communication and collaboration with local law enforcement to begin EASY compliance checks in Tooele County.

- 2) Tooele-VBH has not submitted any indicated prevention data during FY18.

#### **Center's Response and Corrective Action Plan:**

Indicated prevention is being done, but was reported incorrectly in our system. Support staff is currently working to correct this and ensure future clients are entered correctly.

**FY18 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.

**FY18 Division Comments:**

- 1) 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.
- 2) Tooele-VBH staff participates on coalitions for Wendover, Tooele City, and Grantsville.
- 3) Tooele County has a Synar Tobacco compliance rate of 93.4%.
- 4) Tooele-VBH offers 100% evidence based strategies according to their strategic plan.
- 5) Tooele-VBH has a strategic plan. The Prevention Coordinator is working with Wendover to develop their strategic plan.

## Substance Abuse Treatment

Shanel Long, Program Administrator, conducted the review of Tooele County - Valley Behavioral Health Substance Use Disorders Treatment Program on March 27, 2018, 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 2017 Audit

#### **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.

**This issue has not been resolved and will be continued in FY18; see Significant Non-compliance Issue #1.**

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.

**This finding has been resolved. In FY17 individuals that completed treatment episode successfully increased from 21.1% in FY16 to 34.4% in FY17 and meets Division Directive requirements.**

- 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.

**This finding has not been resolved and will be continued in FY18; see Significant Non-compliance Issue #2.**

- 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.

**This finding has been resolved. In FY17 individuals that were retained in treatment for 60 days or more increased from 64.2% in FY16 to 77.8% in FY17 and meets Division Directive standards.**

- 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%.

**This finding has been resolved. In FY17 23.1% of youth satisfaction reports were returned and meets Division Directive standards.**

#### **Findings for Fiscal Year 2018 Audit:**

##### **FY18 Major Non-compliance Issues:**

None

##### **FY18 Significant 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. 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.
  - Current and updated documentation: Charts had one ASAM completed at intake and no updated ASAM to justify continued level of care. This should be done frequently to establish appropriate level of care placement.
  - Goals and Objectives: Often times phrases such as “continue to UA” and “Attend groups” are used as goals and objectives as these are general terms and not client specific, completion date, etc. Goals and objectives should be based on individual needs, be measurable with a specified time frame/duration and be frequently updated as a client

completes old goals and new goals and objectives are established. Goals and objectives are not included in the individual or group notes.

- EHRs do not show evidence that health factors have been screened for nor documented. No evidence that individuals are referred or recommended to seek additional health care as needed. No indication that individuals are recommended or referred for MAT if assessment indicated they are a candidate.

**Center’s Response and Corrective Action Plan:**

Health and Wellness factors are part of the PDIE and subsequent individual and group notes. The clinical team will be trained on how to use the check box in the ongoing notes to address health and wellness. There is a check box in this area of NA and the team will be trained in the mental status to include health and wellness.

Tooele will also hold a training to address ASAMs, Care Plan objectives, and health screens. This will be completed by Sarah DeBois by July 31, 2018. Follow up will be completed by monthly MRRs and additional findings will call for additional trainings, 1:1 supervisions, huddles, and staff meetings. PIPs will follow if necessary. Currently our Analytics Department is working on a report that will quickly be able to access the content from these documents and aid clinicians to monitor necessary chart items needed for client care.

- 2) The Utah Substance Abuse Treatment Outcomes Measures Scorecard showed the percent of individuals that were employed prior to admission vs. prior to discharge decreased from - 33.6% in from FY16 to 1.7% in FY17 respectively, which does not meet Division Directives.

**Center’s Response and Corrective Action Plan:**

It has been reported (news) that the economy and job growth has improved in Tooele. This allows the opportunity for employment for those who in the past have not been able to work due to the economy. More efforts will be made on referrals to employment opportunities like Utahjobs.gov, DWS and Division of Rehabilitation. Clients are also employed in supportive employment through the New Reflections House. Will continue to seek opportunities for clients who are looking for work.

**FY18 Minor Non-compliance Issues:**

None

**FY18 Deficiencies:**

- 1) *Criminogenic Screenings:* Division Directives state that all justice involved individuals are to be screened with a criminogenic screenings tools which is to be kept in the EHR. This includes all adults and juveniles involved in the criminal justice system. Evidence of the Risk and Needs Triage Tool (RANT) was found in a portion of the EHRs that should contain a criminogenic screening tool.

**Center’s Response and Corrective Action Plan:**

This has been tracked down and fixed with the State and is now being tracked effective June 1, 2018.

- 2) *Clinical Charts:* Individual and Group notes lacked therapeutic evidence that the client is making progress or not making progress with the therapeutic interventions. Many clinical notes summarized the client's involvement or discussions between client and therapist. Recommended that therapists measure client's progress in groups as well as individual sessions.

**Center's Response and Corrective Action Plan:**

This training will be completed in the weekly staff meeting as an ongoing topic. The client's response to the intervention in the group note is the place indicated to show therapeutic evidence in the box noted as client's response. Training will be provided by Sarah DeBois by the July 31, 2018.

- 3) *Community Engagement and Outreach:* Tooele-VBH has built strong relationships with their community partners. Community partners spoke highly of Tooele-VBH; the community members are appreciative of Tooele-VBH's responsiveness and their commitment to community engagement. Many of the community partners voiced concerns regarding Tooele-VBH ability to continue to nurture the partnerships because of recent policy changes and time requirements for staff. Community partners expressed the importance of Tooele-VBH having a strong presence in the community as well as the vital role Tooele-VBH plays in the community as the County Substance Abuse Authority. It is recommended that Tooele-VBH continue to cultivate their community engagement and outreach.

**Center's Response and Corrective Action Plan:**

Valley places great importance on its relationships with community partners. Policies surrounding the Pay-for-Performance(PFP) have been adjusted since its initial roll-out. Staff community trainings and approved PTO requests do not negatively impact staff's productivity hours for PFP. Last year, Valley implemented individual 1:1's in which employees are encouraged to complete a "Career Development Plan." This plan includes a section for development opportunities ( trainings, outreach). Valley has been focused on improving staff communication this year by implementing daily huddles with teams and creating SLACK Q&A's where employees can ask leadership questions and address any concerns.

VBH-Tooele has contacted our community partners to ensure satisfaction with services. Frequency of meetings has been increased to once monthly in necessary areas.

**FY18 Recommendations:**

- 1) *Court Compelled:* Tooele-VBH has 13.1% of compelled to treatment not being captured. It is recommended a process be developed to ensure that "compelled" individuals are identified

and charts are modified to reflect the correct information as quickly as possible with everyone who presents for SUD treatment.

- 2) *Data Collection- Social Support:* Tooele-VBH showed 0% (zero) change on Social Support Recovery from admit to discharge. This indicates that there is no change from admit to discharge and possibly this information is not being collected at discharge as required as part of the Treatment Episode Data Set (TEDS). It is recommended that Tooele-VBH train staff on the collection of this required data field.
- 3) *Data Collection- Medication Assisted Treatment (MAT):* DSAMH data indicates that Tooele-VBH is not collecting or submitting TEDS data on Medication Assisted Treatment services as required by Division Directives. It is recommended that Tooele-VBH train staff on the collection of this required data field.
- 4) *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](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.

**FY18 Division Comments:**

- 1) Tooele-VBH has increased their Drug Court enrollment in the past year. Evidence indicates they are working hard to utilize the approved Targeted Adult Medicaid and used it to increase their Drug Court enrollment and the slots they have available in their Adult Drug Court.
- 2) Tooele-VBH has Tobacco use as an indicated field on their assessments however there is no evidence that the use of Tobacco is addressed at any other time in the clinical chart. Recommend providing trainings to staff on how to identify tobacco use and then incorporate it into a treatment plan.
- 3) Staff Training is being provided by Sarah DeBois. She has taken on a huge responsibility to provide training to staff by conducting monthly in-services which may include CEU's respectfully. Although this is a great way to keep staff trained in some areas it may not be the best way to ensure staff is receiving most current and effective education on EBP and best practice standards that should be provided by a certified or professional instructor.
- 4) Tooele-VBH continues to have a high rate of staff turnover and role changes which tends to leads to decreased effectiveness of communication and program services. They continue to be understaffed and unable to fill open positions, therapists have large client caseloads which may hinder the effectiveness of services and also causes issues with being unable train staff effectively and efficiently.

- 5) Tooele-VBH continues to expand services further into Wendover, Utah due to a request from that community. Tooele-VBH has recognized the need for services and has been more than willing reach out and provide additional services to that area as indicated by need.

## **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  
Auditor IV



Date July 5, 2018

Approved by:

Kyle Larson  
Administrative Services Director



Date July 5, 2018

Ruth Wilson  
Assistant Director Children's Behavioral Health



Date July 5, 2018

Jeremy Christensen  
Assistant Director Mental Health



Date July 5, 2018

Brent Kelsey  
Assistant Director Substance Abuse



Date July 5, 2018

Doug Thomas  
Division Director



Date July 5, 2018



Policy: 09/2009  
 Effective: 04/2018  
 Procedure Last Approved: 04/2018  
 Procedure Last Revised: 04/2018  
 Procedure Next Review: 04/2019  
 Owner: Benjamin Langley,  
           Corporate Controller  
           FI\_Financial  
 Area:  
 References:

## Expense Reimbursements

### TABLE OF CONTENTS

- A. Travel Requests/Reimbursements:
- B. Mileage Reimbursement:

### POLICY:

Valley Behavioral Health (Valley) will reimburse its employees for all actual, reasonable and necessary business and travel expenses incurred while on Valley business.

### PURPOSE:

This policy and following procedures are intended to ensure there is no personal benefit gained from travel or other expenses

### PROCEDURES:

- A. Travel Requests/Reimbursements:
  - 1. The Executive Leadership Team has responsibility to determine the most appropriate and cost-effective means of transportation consistent with the authorized business purpose of the trip, and considering all associated costs (e.g. employee work time, overnight lodging, meals, mileage).
  - 2. Employees will complete a Request for Travel & Allowance form at least 21 days prior to the anticipated departure date. The form must be approved via signature or email by the Business Director, Financial Manager and appropriate member of the Executive Leadership Team. Upon approval, an executive assistant and/or the Accounts Payable Manager will coordinate airfare or other suitable transportation and hotel arrangements.
    - a. The approved travel schedule may be altered to provide lower rates and/or fees that do not unduly inconvenience the traveling employee.
    - b. Employees will be provided a travel advance of \$50 a day (out-of state) and \$30 a day (in-state).
      - 1. If the employee makes their own travel arrangements, the travel advance can be as much as the expected total cost of the travel and/or training.
      - 2. When an employee requests a hotel different from the conference hotel, expenses will be

paid within a reasonable amount.

- c. The amounts of travel advances outlined in A.2.b may be adjusted periodically upon recommendation of the Executive Leadership Team.
3. Employees requesting use of Company-owned vehicles, private vehicles or rental cars must have such use specifically approved on the request form.
  - a. Reimbursement for the cost of the use of a private vehicle will not exceed an amount which is the monetary equivalent of the lowest available air fare to and from the proposed destination, or an amount determined by applying the prescribed IRS rate, whichever is **less** ("mileage-in-lieu-of-airfare").
  - b. Rental cars shall be obtained, whenever possible, on the applicable state contract in order to ensure that appropriate insurance is carried on the car. When using the state contract, the traveler shall decline insurance coverage as it is already included in the rental car rate. If a different rental car company is used, the traveler shall obtain insurance coverage.
    1. If the employee makes their own rental car arrangements, expenses will be paid within a reasonable amount (prices compared to state rates).
4. Upon return, all employees will submit a completed Travel Expenditure Report (see attached) to the Accounts Payable Manager within 10 days of their return; this form must be reviewed and signed by the appropriate Business Director and Financial Manager.
5. Employees whose actual travel expenses exceed their travel advance will be reimbursed for all reasonable and necessary travel expenses by submitting all paid receipts with a completed Travel Expenditure Report.
6. Employees who received a travel advance larger than actual costs incurred will reimburse the Company within 10 days of their return, and submit a completed, signed and approved Travel Expenditure Report.

**B. Mileage Reimbursement:**

1. Valley Behavioral Health, Inc. will reimburse all employees using their personal vehicles to conduct Company business during working hours for the actual miles driven. Employees will be reimbursed at the then current prescribed IRS rate.

**Attachments:**

Request for Travel & Allowance

**Approval Signatures**

Step Description	Approver	Date
	Emily Harris: Director of Grants, Contracts & Policy	04/2018
Spelling and Grammar Committee reviews all policies.	Namita Nayak: Grants & Contracts, Grants Manager	01/2018
Spelling and Grammar Committee reviews all policies.	Mike Vyfvinkel: Director of Regulatory Oversight	01/2018
	Bret Montgomery: Director of Financial Planning & Analysis	01/2018
	Benjamin Langley: Corporate Controller	01/2018

Step Description	Approver	Date
	Benjamin Langley: Corporate Controller	01/2018

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# Request For Travel & Allowance

(Instructions for completing this form are listed below)

Date: \_\_\_\_\_

Unit: \_\_\_\_\_

Name of Seminar, Workshop, Etc.: \_\_\_\_\_

Number of Persons: \_\_\_\_\_

Name and Title of Person(s) Attending:

\_\_\_\_\_  
\_\_\_\_\_

Destination: \_\_\_\_\_

Purpose of Trip: \_\_\_\_\_

Date of Departure: \_\_\_\_\_

Date of Return: \_\_\_\_\_

## I. TRAVEL ADVANCE

Valley Behavioral Health Inc. will provide you with an upfront check to cover any actual and reasonable expenses while on company business travel. Travel Advance is calculated for each night spent out of town while on company business, and half of the advance on the day of return.

Number of days on Company business \_\_\_\_\_ @ (\$50 out of state; \$30 in state) \$ \_\_\_\_\_

## II. TRANSPORTATION

Air \$ \_\_\_\_\_

Company Vehicle – Company gas card or gas reimbursement \$ \_\_\_\_\_

Private Vehicle – Mileage or gas reimbursement \$ \_\_\_\_\_

Rental Vehicle - This is not normally an approved item. \$ \_\_\_\_\_

Justification For Rental Vehicle: \_\_\_\_\_

## III. REGISTRATION

No registration fee required

Reimburse employee for registration fee \$ \_\_\_\_\_

To be paid by Accounts Payable \$ \_\_\_\_\_

**Completed registration form must be attached** \$ \_\_\_\_\_

## IV. HOTEL

Hotel reservations to be made by VBH representative  
\*Name and address of hotel \_\_\_\_\_ \$ \_\_\_\_\_

Employee has already made hotel arrangements  
Confirmation Number: \_\_\_\_\_ \$ \_\_\_\_\_

**Total Cost** \$ \_\_\_\_\_

\_\_\_\_\_  
Program Manager

\_\_\_\_\_  
Program Director

\_\_\_\_\_  
CEO or COO

Our overall VMH Work Plan is focused on Increasing Access Leading to Recovery. Within that overall strategy, our critical priorities are:

- Establish a culture based on our vision and mission
- Establish a mission-based operating plan
- Establish a culture of continued improvement of effective & efficient business processes—both administrative and clinical
- Become an employer of choice

Briefly describe how the training requested fits into the above Company priorities, your unit plan or your own specific career development plan:

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Once the training is complete, describe your plans for implementing the training back at work.

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*Note: Once you return from training, you may be asked to present a workshop summarizing your learning so others can benefit from it as well.*

### **Instructions for completion of this form:**

1. Please complete the entire form as instructed to insure your request is accurately proposed.
2. All requests should be submitted to Accounts Payable, who will then forward the request to the CEO or COO for approval. Requests must be received 15 days prior to departure in order for all travel arrangements to be made in advance.
3. Travel paid by a third party and administrative leave with pay (i.e. requests not involving travel expenses, but only time off to travel) need to be approved by ELT.
4. Unless extenuating circumstances exist requiring more lengthy explanation, you need not submit a cover letter to the Executive Committee accompanying this form.
5. Those receiving a travel advance will also be sent a Travel Expenditure Report. The completed Travel Expenditure Report must be submitted along with all receipts to the Accounts Payable within 10 days from when the traveler returns.



Policy: 10/2017  
Effective: 10/2017  
Procedure Last Approved: 10/2017  
Procedure Last Revised: 10/2017  
Procedure Next Review: 10/2018

Owner: *Emily Harris: Director of Grants, Contracts & Policy*  
Area: *GC\_Grants & Contracts*

## References:

## Federal Awards Policy

### POLICY:

Valley Behavioral Health, Inc., (Valley) will receive Federal Awards from different Federal Agencies that will require Valley to provide services within the contract award. Valley will be using the Uniform Guidance and generally accepted standards when reporting, tracking, and providing services under the Federal Award in accordance with 2 CFR 200, Subpart D & E (Sections 200.300 & 200.400)

### PROCEDURES:

In accordance with 2 CFR 200 subpart D 200.300 Valley will follow the procedures outlined below.

- a. The Federal awarding agency will manage and administer the Federal award in a manner so as to ensure that Federal funding is expended and associated programs are implemented in full accordance with U.S. statutory and public policy requirements: including, but not limited to, those protecting public welfare, the environment, and prohibiting discrimination. The Federal awarding agency will communicate to Valley all relevant public policy requirements, including those in general appropriations provisions, and incorporate them either directly or by reference in the terms and conditions of the Federal award.
- b. Valley is responsible for complying with all requirements of the Federal award. For all Federal awards, this includes the provisions of FFATA, which includes requirements on executive compensation, and also requirements implementing the Act for Valley at 2 CFR part 25 Financial Assistance Use of Universal Identifier and System for Award Management and 2 CFR part 170 Reporting Sub-award and Executive Compensation Information.

In accordance with 2 CFR 200 subpart E 200.400 Valley will follow the procedures outlined below.

The application of these cost principles is based on the fundamental premises that:

- a. Valley is responsible for the efficient and effective administration of the Federal award through the application of sound management practices.
- b. Valley assumes responsibility for administering Federal funds in a manner consistent with underlying agreements, program objectives, and the terms and conditions of the Federal award.
- c. Valley, in recognition of its own unique combination of staff, facilities, and experience, has the primary responsibility for employing whatever form of sound organization and management techniques may be necessary in order to assure proper and efficient administration of the Federal award.

- 
- d. The application of these cost principles should require no significant changes in the internal accounting policies and practices of Valley. However, the accounting practices of Valley will be consistent with these cost principles and support the accumulation of costs as required by the principles, and must provide for adequate documentation to support costs charged to the Federal award.
  - e. In reviewing, negotiating and approving cost allocation plans or indirect cost proposals, the cognizant agency for indirect costs should generally assure that Valley is applying these cost accounting principles on a consistent basis during their review and negotiation of indirect cost proposals. Where wide variations exist in the treatment of a given cost item by the Valley, the reasonableness and equity of such treatments should be fully considered. See [§ 200.56](#) Indirect (facilities & administrative (F&A)) costs.
  - f. When Valleys educates and engages students in research, the dual role of students as both trainees and employees (including pre- and post-doctoral staff) contributing to the completion of Federal awards for research will be recognized in the application of these principles.
  - g. Valley may not earn or keep any profit resulting from Federal financial assistance, unless explicitly authorized by the terms and conditions of the Federal award. See also [§ 200.307 Program income](#).

The delineated procedures will be followed, up to the point where 2 CFR dictates that Valley Behavioral Health, a 501 (c)3 non-profit is not responsible for cost principles.

## Attachments:

No Attachments

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