



State of Utah

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Department of Human Services

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Division of Substance Abuse and Mental Health

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Director

August 15, 2019

Commissioner Kendall Thomas
Tooele County Commission
47 South Main
Tooele, UT 84074

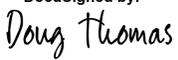
Dear Commissioner Thomas:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of the contracted Local Authority, Tooele County and its contracted service provider, Valley Behavioral Health; the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental health services, substance abuse treatment and prevention services, and general operations.

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

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

Sincerely,

DocuSigned by:

EB71C358FA4D437...
Doug Thomas
Division Director

Enclosure

cc: Gary Larcenaire, Director, Valley Behavioral Health

Marilyn K. Gillette, Tooele County Clerk
Teresa Winn, Valley Behavioral Health
Jeff Coombs, MPH Executive Director, Tooele County Health Department
Alison McCoy, Tooele County Auditor



Combined Special Audit Report and
Annual Site Monitoring Report of
Tooele County / Valley Behavioral Health

Local Authority Contracts #160235 and #160236

Review Date: March 27th, 2018

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Section One: Special Audit Report

Executive Summary

The Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) has conducted a special audit of Tooele County as the Local Mental Health and Substance Abuse Authority, and Valley Behavioral Health (VBH) as their contracted service provider. VBH Tooele staff and services will be referred to as Tooele-VBH. DSAMH received a letter dated March 8, 2019 from Tooele County Health Department requesting a special audit. The letter listed some specific areas of concern and requested that DSAMH do a more in-depth review. Valley Behavioral Health is the contracted service provider for Tooele County; the Division agreed to conduct the expanded review to assess the quality and availability of services provided to clients, but services provided by VBH are ultimately the responsibility of Tooele County. DSAMH conducts an annual site review in accordance with Utah Code Section 62A-15-103, the special audit was conducted in conjunction with the scheduled annual site visit. This is a combined report for the special audit and annual site monitoring review. Any findings that require an action plan are addressed in the Site Monitoring Report.

Special Audit Report

The Division of Substance Abuse and Mental Health (DSAMH) conducted a special audit of Valley Behavioral Health (VBH) at the request of Tooele County. The review was conducted by Chad Carter, Auditor IV; Mindy Leonard, Program Manager and Becky King, Program Administrator. Listed below (*in italics*) are items that were requested for specific review by Tooele County in a letter dated March 8th, 2019. Results of the review are summarized in this report, but any recommendations, deficiencies or findings are addressed in the Annual Site Monitoring Report section.

Review all previous non-compliance issues (Major and Significant Non-Compliance issues) that have been identified over the last four years to see if these deficiencies have been corrected and that previously corrected issues have not returned to the level of non-compliance.

During the last four years of monitoring, Tooele-VBH has received 14 Significant findings and no Major findings. Most of these issues were raised to a level of Significant Non-Compliance because they were repeated over one or more years. Repeated issues include: lack of proper documentation in charts, lack of proper oversight from Tooele County over contracted services, conflict of interest documentation, executive travel documentation and approvals, data submission regarding incarcerated individuals and drug court phases being allowed to determine the level of care for clients. In last year's report, Tooele-VBH received five Significant findings. For the FY19 review, two were found to be resolved and two were reduced to Minor findings. One under Adult Mental Health will be continued as a Significant finding. Please see the Annual Site Monitoring Report section for details.

Review the administrative overhead costs and identify the organizational structure of support that VBH provides to the VBH Tooele Center. Please also review what VBH staff are working outside of Tooele County that are being charged to the Tooele County contract and if their duties and responsibilities to support of Tooele County is adequately reflected in the number of hours actually spent supporting Tooele County.

This is a question best answered by Tooele County during its audit of VBH and compliance to their contract. From DSAMH's special audit it appears that in calculating allocated costs for their annual Medicaid Cost Report, Valley Behavioral Health determined that their administrative overhead rate for FY18 was 29.3%. However, this includes several different expense categories that could be paid by individual cost units but are instead paid at the corporate level for convenience. VBH conducted a separate analysis allocating all expenses to the separate cost units based on their percentage of overall expenses, and determined a true administrative overhead rate of 18.7%.

All payroll for Tooele staff is based on actual services provided to Tooele clients. In FY18 there were two VBH administrative staff that provided work in several different cost units. Their salary is allocated according to the average percentage of time spent in each unit. This is adjusted and budgeted at the beginning of each year. We recommend that this be worked into Tooele County's additional oversight of this contract.

Review if VBH has adequate staffing and how the unusually high turnover rate of VBH staffing is affecting their contract compliance and continuity of care for their patients.

During 2018, Tooele-VBH has had an average count of 76 employees. During this period, they have had 32 employee separations and 29 new hires. Tooele-VBH experienced a 42% turnover rate for 2018. The United States Department of Labor - Bureau of Labor Statistics shows the average separations rate in the United States for Health Care and Social Assistance in 2017 was 33.2%.¹ Turnover for Tooele-VBH is higher than the national average, any effects on services are discussed in the Mental Health and Substance Use Disorder sections.

Review if VBH is meeting all of the objectives and goals of the current Tooele County Area Plan.

This is a function of annual monitoring, please see the Annual Site Monitoring Report section for details.

Review if the length of inpatient services and appropriate out-patient follow-up support for discharged patients is meeting the current access to care standards.

Tooele has a longer period of inpatient stay than other centers and report they anticipate continued trend and significant increase in numbers of adults accessing inpatient services. A case manager is setting appointments for rapid follow-up support upon hospital discharge.

Review if the adult psycho-education, psychosocial rehabilitation and support groups adequately meet the needs of Tooele County residents, including appropriate care plans are being completed and updated at least every 90 days.

The scorecard indicates that the psychosocial rehabilitation is within the parameters of the State mandate. Continued assessment and review of these services and community need and access is recommended.

Review if the children and adolescent psycho-education, psychosocial rehabilitation and support groups, including school support, adequately meet the needs of Tooele County residents.

¹ United States Department of Labor - Bureau of Labor Statistics
<https://www.bls.gov/news.release/jolts.t16.htm>

The scorecard indicates that the amount of psychosocial rehabilitation is within the parameters that is designated by the Division Directives and State mandates. Continued assessment and review of these services and community needs and access to services is recommended.

Review if the number of subcontracted provider entities are adequate and if they are meeting contractual requirements.

This is a question best answered by Tooele County during its audit of VBH and compliance to their contract. From DSAMH's special audit it appears that VBH utilizes subcontracted providers for a variety of services and they are used to extend their reach and when they are not able to provide the services themselves. A review of subcontractor monitoring was conducted and VBH was found to be monitoring their subcontractors appropriately, according to the requirements listed in the DHS contract, but there may be additional requirements in the contract between VBH and Tooele County. With Medicaid expansion it is recommended that community partnerships including subcontractors be continually reviewed for adequacy to manage anticipated growth in service needs and meeting special population needs.

Review if court recommended and/or court mandated behavioral health and substance use programs are meeting the required court timelines and access to care requirements,

Tooele-VBH's court mandated behavioral health and substance use programs are meeting the required court timelines and access to care requirements. In addition, they are meeting Division Directives for Drug Court outlined below:

Substance Use Disorder Need Screening Tool

Tooele-VBH is using the screening tool "UNCOPE," which is built into their assessment to screen for substance use disorders. It also uses seven of the Diagnostic and Statistical Manual Criteria to assist in the determination of the diagnosis for their clients.

Criminogenic Risk Screening Tool

Tooele-VBH is using the Risk and Needs Triage (RANT) Assessment to screen clients that are "high risk and high need" for Drug Court, which is required by Division Directives.

Criminal Risk Screening Kept in Client Charts

Tooele-VBH is including the criminogenic risk screening tool (RANT) and results in their clinical charts, which is required by Division Directives.

Minimum of Two Drug Tests Per Week Documented

Drug Court clients are testing twice a week, unless they are in the maintenance phase, which meets Division Directives.

Drug Court Orientation Manual and Participation Agreement

The DSAMH Criminal Justice Court Program Administrator reviewed the Tooele-VBH Drug Court Manual and Participation Agreement and found it to be in compliance with Division Directives.

No Medication Assisted Treatment (MAT) Prohibitions or Required Taper to Join or Graduate from Drug Court

Tooele County Drug Court Judge and Team support the use of MAT for clients in Drug Court and do not prohibit them from entering or graduating from Drug Court when they are using MAT for their opioid use disorders.

Participant Fee Policy Consistent with Approved Local Authority Fee Schedule

Tooele-VBH charges clients \$5.00 a class in Drug Court. If they can't afford it, they don't have to pay it to receive treatment. Clients are not able to graduate from Drug Court until their payments are complete and the Judge will place them on probation until their fees are paid; however, Tooele-VBH staff help clients find a way to pay their fees if needed. Most clients are on Traditional Medicaid or Targeted Adult Medicaid in Drug Court, so most of the time they are not paying anything while they are in Drug Court.

Each Key Program Member Attends 8 hours of Continuing Education With a Focus on Substance Use Disorders in the Past Year

All Drug Court Team members (Treatment, Judge, Prosecutor, Defense, Case Managers, etc.) attend 8 hours of Continuing Education Credits required by Division Directives. Some of the training has included the State Drug Court Conference and Fall Conference.

Connection to Workforce Services for Medicaid or Health Care Navigators for Other Insurance

Tooele-VBH connects Drug Court clients to Workforce Services for Medicaid or other insurance, which meets Division Directives.

Review if the 24-hour crisis care is meeting patient care standards.

Twenty-four hour crisis care is being offered. The proportion of individuals receiving appropriate follow-up care is unknown. It is strongly recommended that Tooele explore in depth the current crisis care continuum, especially in regards to follow up care, referral to adequate levels of follow up care, safety planning and follow up evidence of safety planning and recommended treatment adherence and outcomes.

Review if adequate case management services are being appropriately provided including acceptable caseload ratios for each case manager.

The case managers are multitasking and providing other services as well. The case loads are quite high at this time. For children and youth, case management services are provided by staff with dual roles of case manager and Family Resource Facilitator. Best practice would indicate that case managers with high needs have a caseload of 5-15 clients and case managers with low needs clients have a caseload of 30-80. Case managers in Tooele have much higher caseloads that comprise both high and low needs clients. High caseloads frequently results in subpar care, increasing need for unnecessary higher levels of care and poor outcomes. It is recommended that Tooele County consistently monitor the outcomes related to inflated case loads and impacts on other parts of the service continuum and service outcomes and make adjustments as needed.

Review if Tooele County based residential programs such as the "Clubhouse model at the New Reflection House" are adequate and appropriately managed.

Tooele does not have any residential programs and subcontracts any need for residential care to other counties. The Clubhouse model is most similar to a day program and is based on a work-ordered day. New Reflections has maintained accreditation (indicating fidelity to the Clubhouse model). There is new leadership within the program. The FY20 Area Plan indicates that funding for the program will remain the same. Leadership transition within the Clubhouse model can be a risky time related to fidelity to the model and related evidence based outcomes and quality of care. It is recommended that appropriate training and additional support and technical assistance be sought for staff and leadership during this transition period.

Review if the services provided to incarcerated patients are adequate and appropriately managed for Tooele County.

Tooele County has had a good relationship with the jail and adult AP and P. Valley is providing adequate services to this population.

Review if the substance use disorder treatment services are adequate and appropriately managed for Tooele County.

Despite staff turnover over the past year, Tooele-VBH has been able to provide substance use disorder treatment and crisis services for clients and their families although there have been complaints about the lack of continuity due to staff turnover. They are providing individual therapy, standard outpatient, intensive outpatient and residential treatment for women and their

children. The number of clients served at Tooele-VBH increased from 458 to 474 from FY18 to FY19 with 96% of the year accounted for. However, the number of admissions has decreased from 256 to 216 from FY18 to FY19 respectively. Tooele-VBH should work on increasing the number of new clients admitted to services in the coming year.

Review if the various age and gender appropriate programs (youth, adolescent, adult, and women's services) are adequate and appropriately managed for Tooele County.

Tooele-VBH's programs are gender responsive and age appropriate and are being provided in their program and at the jail. Tooele-VBH is providing the following groups: Tips for Mental Health and substance use disorders, Mind-Body Bridging - Beginning and Advanced, Mood Management, Life Skills, Anger Management, Cognitive Restructuring, Relapse Prevention, After Care, Recovery Wellness, Recovery Skills, Men's Domestic Violence, Nurturing Parent, Relapse Prevention, Relapse and the Brain, Women's Domestic Violence, Creating Change, Helping Women Recover, Shame Resilience and Interpersonal Relationships.

Despite the challenges that Tooele-VBH has experienced over the past year they made progress on their clinical charts and tracking criminogenic risk and screening for individuals compelled to the Criminal Justice System. Their Clinical Director started focusing on the clinical charts and providing training for staff on Addiction Society of Addiction Medicine (ASAM) and Recovery Plans. Tooele-VBH is also holding a clinical staffing every Thursday. It was recently discovered that many of the staff were not trained in substance use disorders treatment, which Tooele-VBH is focusing on at this time. Another area that they are struggling with is data collection, which they are currently working on. It is recommended that Tooele-VBH continue to train their staff on the clinical charts, ASAM and data collection. DSAMH is available for technical assistance in these areas upon request.

Review that the Family Resource Facilitation program is adequate and includes appropriate wrap around services.

The FRF program did not have any charts that were using High Fidelity Wraparound to complete fidelity that could be reviewed. Often, duties for FRFs are split between case management and FRF services. It is recommended that FRF services be reviewed with Allies with Families, the agency who provides the coaching for the individual FRFs to help improve the High Fidelity Wraparound provided and help clarify FRF tasks from case management tasks.

Review the health needs provided for residents of skilled-nursing facilities, including regular visits are meeting the current needs of local residents.

PASRR reviews the physical and mental health needs of individuals seeking nursing facility admission. The nursing facilities are responsible to monitor and meet the needs of the residents and/or contract out for specific specialized mental health services.

Section Two: 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 27th, 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	1	16-19
	Minor Non-Compliance	1	19-20
	Deficiency	1	20-21
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance	None	
	Significant Non-Compliance	1	24
	Minor Non-Compliance	3	24-26
	Deficiency	1	27
<i>Adult Mental Health</i>	Major Non-Compliance	None	
	Significant Non-Compliance	2	30-31
	Minor Non-Compliance	2	31-33
	Deficiency	2	33-34
<i>Substance Abuse Prevention</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	33-36
<i>Substance Abuse Treatment</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	4	40-42
	Deficiency	1	42

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 27th, 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, Tooele-VBH provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report. 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. Random samples were taken from the backup provided to verify that the listed services qualified for each different service category.

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 31st, 2017 and submitted it to the Federal Audit Clearinghouse. The firm Eide Bailly, LLP completed the audit and issued a report dated November 5th, 2018. The auditor issued an unmodified opinion in all areas, but reported a disclaimer for one discretely presented component unit. The financial statements for the Tooele County Recreation Special Service District were not included as part of the audit on Tooele County’s basic financial statements. 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. As required by the State Compliance Audit Guide they also issued a report on Compliance and Internal Control Over Compliance. Four material weakness issues were reported as financial statement findings:

- 2017-A: Material Weakness in Year-end Financial Closing Process
- 2017-B: Material Weakness in Reconciliation Process
- 2017-C: Material Weakness in Journal Entry Process
- 2017-D: Material Weakness in Cut-Off of Transactions

One material weakness was reported as a State compliance finding:

- 2017-E: Material Weakness in Budgetary Compliance

These issues are addressed in further detail below, see Significant Non-compliance Issue #1.

The CPA firm Tanner LLC completed a single audit of Valley Behavioral Health for the year ending December 2017. The auditors issued an unmodified opinion on the financial statements in the Independent Auditor's Report dated June 7th, 2018. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2018 Audit:

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.

This issue has been resolved. A larger percentage of employee files were reviewed for FY19 and all required documentation was present and current. VBH has made significant improvements in their personnel file documentation.

- 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.

This issue has been resolved. 100% of executive travel packets were reviewed for April - November 2018. Appropriate documentation and approval were found in each of the travel packets reviewed. There were two travel packets found where the traveler did not submit an itemized receipt for meals and these amounts were deducted from the final reimbursement as dictated by their policy. VBH has made significant improvements in their review of travel reimbursements and is adhering to their travel policy.

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.

This issue has been resolved. Valley Behavioral Health finalized a written Federal awards policy and provided a copy to the independent auditors and the Division.

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

- 1) In the single audit conducted for Tooele County, the auditors reported several material weakness issues. Four were reported as financial statement findings:
 - *2017-A: Material Weakness in Year-end Financial Closing Process* - Tooele County does not have an internal control process that is designed to prevent and detect material misstatements.
 - *2017-B: Material Weakness in Reconciliation Process* - Tooele County does not have a formal process to ensure the preparation or accuracy of general ledger account reconciliation. Some reconciliations were not reviewed or approved by management.
 - *2017-C: Material Weakness in Journal Entry Process* - Tooele County did not retain documentation supporting certain journal entries by Tooele County personnel. Journal entries were not reviewed or approved by management.
 - *2017-D: Material Weakness in Cut-Off of Transactions* - Tooele County does not have an internal control process that is designed to ensure the proper cut-off of transactions.
 One material weakness was reported as a State compliance finding:
 - *2017-E: Material Weakness in Budgetary Compliance* - Expenditures exceeded the appropriated budget for multiple funds.

These reported issues for Tooele County are concerning. As a recipient of State and Federal funding, it is essential that the awarding agencies be able to rely on a recipient's internal controls as well as the accuracy of their financial statements. If these issues are not addressed appropriately, the Division will be required to take remedial action, up to and including the withholding of funds. In a telephone conference call with the Tooele County Auditor, it was discussed that the County is nearing completion of their independent single audit for the most recent fiscal year. Please provide a copy of that independent audit as soon as possible when completed. Please also provide a written action plan detailing how Tooele County will bring any new material weaknesses found in the new report back into compliance. The independent auditing report currently underway will need to review the past findings and assure that steps have been taken to resolve these previous findings. DSAMH will work with Tooele County to bring controls into compliance, but these previous findings are of a serious nature and significant steps must be taken in order to avoid remedial action.

Center's Response and Corrective Action Plan:

Action Plan:

On June 18, 2019 Larson and Company, PC issued an independent audit report regarding the financial status of Tooele County for fiscal year 2018. Larson identified three material weaknesses and Tooele County Management issued a response to those findings (attached as "Exhibit A,") Larson's overall opinion of Tooele County was "unmodified", and Tooele County was considered a low-risk auditee.

"Exhibit A"

2018-A: Material weakness in reconciliation process

Criteria: Management is responsible for entity level controls over the reconciliation process. This is a critical component of a good internal control structure.

Condition: During our test work, we noted some sub-ledger accounts were not reconciled to the general ledger at year-end. Reconciliations were not reviewed or approved by management.

Cause: The County did not have control processes in place during 2018 to ensure the preparation, accuracy, review, and approval of account reconciliations in a timely manner.

Effect: There exists a potential for material misstatements in the financial records or financial statements themselves that could go undetected by management. Other potential issues could arise as a result of incorrect financial information caused by the lack of ledger reconciliations.

Recommendation: Best practice internal controls should be identified, implemented, and functioning properly to ensure account balances are reconciled and reviewed frequently throughout the year. This will allow management to have up-to-date and accurate financial information throughout the year, as well as making preparations for the external audit an easier and smoother process.

Management response: Beginning in 2019, sub-ledgers are reconciled monthly and most transactions are charged to accounts at the time they are incurred rather than charged to a general clearing account and allocated later. Asset account is revised semi-annually with the help of departments. Ledgers are reviewed monthly by management and departments to verify accuracy. Commission reviews financial reports at monthly meetings with both the County Auditor and Treasurer present.

2018-B: Material weakness in journal entry process

Criteria: Management is responsible for entity level controls over the preparation, review and approval, and posting of journal entries. Journal entries are a normal part of the accounting function, however, each journal entry posted to the financial records should be reviewed for appropriateness and proper documentation.

Condition: It was noted during our review of significant journal entries, that the County did not retain proper documentation and approval of journal entries recorded by County personnel.

Cause: The County does not have a functioning control process for the review and approval of journal entries.

Effect: There exists a potential for material misstatements and/or fraudulent activity in the financial records or financial statements themselves that could go undetected by management.

Recommendation: Best practice internal controls should be identified, implemented, and functioning properly. Internal controls over journal entries should contain at a minimum, a review process of all journal entries made by someone in a management position and is not the same individual as the one recording the journal entry, the journal entry should be accompanied by sufficient documentation to allow others to determine accuracy and appropriateness of the entry.

Management response: Beginning in 2019, management now required standardized documentation for all journal entries. This documentation, at a minimum, is acknowledged by the department head requesting the entry and the Auditor. Entries over \$5,000 appear on the Commission consent agenda and require acknowledgment and approval from the Commission

2018-C: Material weakness in budgetary compliance

Criteria: Utah Code 17-36-20 states that “no officer or employee of a county shall make any expenditure or encumbrance in excess of the total appropriation for any department. Any obligation that is contracted by any officer or employee in excess of the total departmental appropriation is the personal obligation of the officer or employee and is unenforceable against the county.

Condition: Expenditures materially exceeded the appropriated budget for multiple funds.

Cause: Multiple transactions were not entered on a timely basis, contracts entered into, and lack

of review procedures allowed material excess expenditures over budgeted appropriations.

Effect: The County is not in compliance with budgetary compliance requirements required by the State Compliance Audit Guide and are also not compliance with Utah State Code.

Recommendation: We recommend that the County Officials and management work together to implement appropriate internal controls over budgetary compliance. Periodic reviews (recommended monthly) of budget to actual reports should be performed. This will allow for timely and accurate information to be available to County Officials and management as decisions are made, and authorizations of expenditures are approved. We also recommend that County Officials and management update and follow a procurement policy which should dictate the level of authority authorizing transactions, and to allow the County to make appropriate decisions regarding the best value of goods or services received.

Management response: Beginning in 2019, management provides all departments individual access to reporting information that allows them to see their budget status in real time. Management also notifies departments on a quarterly basis of accounts that are in danger of exceeding budgeted appropriations. Departments, management, and governance will work together throughout the year to identify, correct, and prevent any expenditures in excess of budgeted appropriations.

Prior Year Findings

2017-E: Material weakness in budgetary compliance

Condition: Expenditures exceeded the appropriated budget for multiple funds

Status of finding: see current year state compliance findings.

Sincerely,

Alison H. McCoy Tooele County Auditor

Tom Tripp

Tooele County Commission Chair

FY19 Minor Non-compliance Issues:

- 1) *Oversight of Contracted Services:* As the Local Authority and recipient of State and Federal funds, Tooele County is responsible for the quality of services provided by their contracted service provider. DSAMH provides annual monitoring that includes a direct review of services, but the County is also contractually required to provide monitoring and oversight of services provided under the DHS Local Authority Contract. Section E. 1. c.(1) of the contract states, “*LMHA/LSAA Responsibilities Regarding Subcontracts. When the LMHA/LSAA subcontracts, the LMHA/LSAA shall at a minimum: (1) Conduct at least one annual monitoring review. The LMHA/LSAA shall specify in its Area Plan how it will monitor their subcontracts.*”

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

Tooele County recognizes the importance of providing adequate services to those in our community with mental health and substance abuse issues. In an effort to address the issues found within the 2019 audit conducted by the Utah Department of Human Services Substance Abuse and Mental Health of both Tooele County and Valley Behavioral Health, Tooele County Commissioners have authorized the hiring of a Behavioral Health Administrator who will reside within the Tooele County Auditor's office and oversee the relationship between Tooele County and our contract service provider. It is the intent of both the Auditor's office and the Commission that this position will insure compliance with all State and Federal guidelines and will monitor the services provided by our contract service provider. It is anticipated that the person filling this position will begin work on or near September 1, 2019.

Tooele County commends the Utah Department of Human Services Substance Abuse and Mental Health for their efforts in providing us this opportunity to review our policies and practices. We are committed to adequately and lawfully providing the much-needed services to those underserved populations within our County.

Sincerely,

Alison H. McCoy Tooele County Auditor

Tom Tripp
Tooele County Commission Chair

FY19 Deficiencies:

- 1) *Staff Turnover:* During 2018, Tooele-VBH has had an average count of 76 employees. During this period, they have had 32 employee separations and 29 new hires. Tooele-VBH experienced a 42% turnover rate for 2018. The United States Department of Labor - Bureau of Labor Statistics shows the average separations rate in the United States for Health Care and Social Assistance in 2017 was 33.2%.² Turnover for Tooele-VBH is higher than the national average, it is recommended that Tooele County and Tooele-VBH make the issue of turnover a high priority and look into the different factors that may be contributing to Tooele-VBH's high turnover rate.

Center's Response and Corrective Action Plan:

² United States Department of Labor - Bureau of Labor Statistics
<https://www.bls.gov/news.release/jolts.t16.htm>

Action Plan: Valley Behavioral Health takes retention and turnover very seriously. To address the concerns related to turnover Valley Behavioral Health has implemented the following.

Valley Behavioral Health has implemented Pay for Performance to Tooele-VBH staff to increase compensation for staff. Peakon data will be used to identify areas that Tooele-VBH staff are unsatisfied with their job and/or Valley and develop strategies with the Tooele-VBH leadership team to resolve the issues and make improvements.

We are actively trying to fill all open positions. Due to the occasional difficulty involved in hiring therapists to work in Tooele County, we have recently started reaching out offering telehealth positions. Sign-on bonus are being offered for key Tooele-VBH positions.

Valley Employee Retention Initiatives

- Built a new Retention Dashboard for in-depth analysis and reporting
- Developed and launched two Leadership Development courses. One for seasoned leaders and one for new leaders.
- Restructured the New Employee Orientation, hired a new Onboarding Coordinator, and deployed an Onboarding Roadmap with a focus on in-unit orientation. Developed goals to reduce 90-day and 1-year turnover.
- Deployed Peakon, a comprehensive employee engagement solution. Train managers on data analysis and impact planning. Will start sharing engagement data with employees in Skip-Level meetings.
- Leverage the predictive analytics features of the HRIS system to target and engage high flight-risk employees
- HR conducts Stay Interviews and reports trends to leadership.
- Developing a comprehensive Talent Management strategy to engage high-potential, high-performing employees in career development.

Timeline for compliance: On going

Person responsible for action plan: Tooele's Operational and Clinical Director

FY18 Recommendations:

- 1) *Meal Reimbursement Policy:* Currently, VBH does not have an official policy limiting dollar amounts for meal reimbursements while traveling. Some meal reimbursements appear to be excessive, for example; \$154.19 in meal reimbursements for one executive-level employee in one day, with an expense of \$128.95 accounting for one meal. As a recipient of State and Federal funding, it is recommended that VBH creates a policy that puts reasonable restrictions on meal reimbursements. Please consult U.S. General Services Administration (<https://www.gsa.gov/travel/plan-book/per-diem-rates>) and/or the Utah State Travel office (<https://fleet.utah.gov/state-travel-a/>) as a benchmark.

FY19 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 adults, youth, and children of Utah.

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Tooele County – Valley Behavioral Health on March 27th, 2019. The monitoring team consisted of Mindy Leonard, Program Manager; and Kim Bartley, Family Coach 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 2018 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 2018 Audit

FY18 Minor Non-compliance Issues:

- 1) 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.

This issue has not been resolved and will be continued in FY19; see Significant Non-Compliance Issue #1.

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.

This issue has not been resolved and will be continued in FY19; see Minor Non-Compliance Issue #1.

Findings for Fiscal Year 2019 Audit**FY19 Major Non-compliance Issues:**

None

FY19 Significant Non-compliance Issues:

- 1) *Youth Outcome Questionnaire (OQ) Administration and Use as an Intervention*: A review of the charts indicated that eight of the ten charts reviewed did not have the mandated 30 day administration of the YOQ. The frequency the YOQ is being administered is below the required guidelines of “every thirty days or every visit (whichever is less frequent)” as described in the Division Directives.

All ten of the charts reviewed also lacked any reference to the YOQ being utilized in the treatment process. Division Directives require that data from the YOQ shall also be shared with the client and incorporated into the clinical process, as evidenced in the chart. The YOQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. Appropriate use of the OQ as an intervention has been demonstrated to improve treatment outcomes.

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

Tooele’s Attending Clinician and/or Clinical Director will conduct a training for OQ/YOQ administration by October 1, 2019. The training will include the frequency of distribution and how to document that an OQ/YOQ was administered and discussed with the client in the client’s chart.

Timeline for compliance: October 1, 2019

Person responsible for action plan: Tooele’s Attending Clinician and Clinical Director

FY19 Minor Non-compliance Issues:

- 1) *Community Engagement and Outreach*: DSAMH met with DCFS regarding community involvement. Community partners, including the Local Education Agency and private mental health agencies, have also communicated with DSAMH staff during the year to express concerns related to engagement and partnerships. 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 community mental health center. Tooele-VBH has also experienced high turnover which has contributed to a lack of employees able to participate in community activities. 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. The continued community reports and staffing issues will result in a minor non-compliance issue.

Center’s Response and Corrective Action Plan:

Action Plan:

VBH will support community events throughout the year with booths to educate residents to our programs. Tooele – VBH will support our rural community partners by engaging in local Holiday parades. Tooele – VBH will support community stakeholders by allowing staff to attend Q & As and panel discussions without any penalties to direct service hours. Tooele – VBH will continue to aid stakeholders with crisis support and outreach. All services will be provided without any penalties to staff. Tooele-VBH has meets with Tooele school district and DCFS monthly

Valley Behavioral Health takes retention and turnover very seriously. To address the concerns related to turnover Valley Behavioral Health has implemented the following.

Valley Behavioral Health has implemented Pay for Performance to Tooele-VBH staff to increase compensation for staff. Peakon data will be used to identify areas that Tooele-VBH staff are unsatisfied with their job and/or Valley and develop strategies with the Tooele-VBH leadership team to resolve the issues and make improvements.

We are actively trying to fill all open positions. Due to the occasional difficulty involved in hiring therapists to work in Tooele County, we have recently started reaching out offering telehealth positions. Sign-on bonus are being offered for key Tooele-VBH positions.

Valley Employee Retention Initiatives

- Built a new Retention Dashboard for in-depth analysis and reporting
- Developed and launched two Leadership Development courses. One for seasoned leaders and one for new leaders.
- Restructured the New Employee Orientation, hired a new Onboarding Coordinator, and deployed an Onboarding Roadmap with a focus on in-unit orientation. Developed goals to reduce 90-day and 1-year turnover.
- Deployed Peakon, a comprehensive employee engagement solution. Train managers on data analysis and impact planning. Will start sharing engagement data with employees in Skip-Level meetings.
- Leverage the predictive analytics features of the HRIS system to target and engage high flight-risk employees
- HR conducts Stay Interviews and reports trends to leadership.
- Developing a comprehensive Talent Management strategy to engage high-potential, high-performing employees in career development.

Timeline for compliance: starting 7/17/19---on going

Person responsible for action plan: Tooele’s Operational and Clinical Directors

- 2) *Continuity of Care:* Tooele-VBH has continued to experience staff turnover and high caseload sizes for the therapists. High turnover continues to contribute to long wait times between appointments, repeated therapist changes for children and families, and inconsistent care for clients. One of the community partners stated, “I don’t think the new therapists know what they are doing. They are new graduates and have no experience.” Tooele-VBH should ensure staff have adequate training and a supportive environment to aid with the continuity of care of children, youth, and their families.

Center’s Response and Corrective Action Plan:

Action Plan:

All Tooele therapist will participate in Valley Academy Training which is an intense 44 hour clinical training provided by Valley's Valley Academy Trainers starting 8/1/19. All new therapist will participate in Valley Academy Training as part of their onboarding process. The training consists of weekly 2-hour training sessions for 6 months.

Timeline for compliance: April 2019

Person responsible for action plan: Tooele’s Clinical Director

- 3) *Juvenile Civil Commitment:* Tooele is not using and/or maintaining Juvenile Civil Commitment forms. Of the five charts reviewed with recent history of inpatient and/or residential treatment, there was only one chart with evidence of Juvenile Civil Commitment forms being used and the records being kept on file. Juvenile Civil Commitment paperwork needs to be completed consistent with UCA 62A-15-703, through the use of the proper forms located on the DSAMH webpage:
<https://dsamh.utah.gov/provider-information/civil-commitment/>.

Center’s Response and Corrective Action Plan:

Action Plan:

Tooele-VBH staff will be trained on how to documents Civil Commitment, including, the use of the Juvenile Civil Commitment forms and how to document in encounter note by Tooele's attending Clinician and/or Attending Clinician. Clinical teams will complete chart audits on a minimum of 5% (in accordance with DSAMH State standards) of charts at Tooele to ensure appropriate services and documentation. This will be completed by October 1, 2019

Timeline for compliance: October 1, 2019

Person responsible for action plan: Tooele’s Attending Clinician and Clinical Director

FY19 Deficiencies:

- 1) *High Fidelity Wraparound*: Kim Bartley, Family Coach, from Allies with Families reported, “I did not review any Wraparound charts because there were none available. One Family Resource Facilitators (FRF) is too new in her position to have any Wraparound families to complete documentation on, and the other two FRF’s on site have not had any families opt in to the Wraparound Process. Additional coaching on engaging potential Wraparound families and orienting them to the process has already been discussed in regards to this issue and the FRF’s are working on getting families involved in the Wraparound Process.” The Division Directives state “Local Authorities shall utilize Wraparound Facilitation” which is conducted by the FRF. It is recommended that Tooele-VBH work with the Coach and Allies with Families to ensure High Fidelity Wraparound is being completed by FRFs to provide intensive, collaborative services for children, youth, and families.

Center’s Response and Corrective Action Plan:

Action Plan:

Tooele-VBH children's clinical and operations team met with the DSAMHA and Kim Bartley, Family Coach, from Allies with Families on 7/2/19 to discuss FRF and High Fidelity Wraparound in Tooele. A plan was created to increase FRF services and get families involved in High Fidelity Wraparound.

Timeline for compliance: 7/2/19

Person responsible for action plan: Tooele’s Clinical and Operations Director

FY19 Recommendations:

None

FY19 Division Comments:

- 1) *Family Resource Facilitation and Family Feedback*: The Utah Family Coalition (UFC) collected family feedback survey and conducted a family feedback group. Overall, parents reported being able to access appropriate mental health services in a location that is convenient for them. The majority of families have a crisis/safety plan for their child. The survey also revealed the following concerns and challenges: difficulty with appointment days and times that work with the family’s schedule, continued changes with their child’s therapist which was difficult for the youth receiving services, and having more access to male therapists.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Tooele County – Valley Behavioral Health on March 27th, 2019. The team included Mindy Leonard, Program Manager. The review included the following areas: Discussions with clinical supervisors and management teams, record reviews, site visits to administrative offices, and on-site visits with the Tooele County Jail and Adult Probation and Parole. During the discussions, the team reviewed the FY18 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 2018 Audit

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.

This issue has not been resolved and will be continued in FY19; see Significant Non-compliance #1.

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 the use of the Audit Tool, to ensure that those who are doing reviews understand that measurability should reflect a method to identify treatment progress.

This issue has been resolved. Ten of ten charts reviewed had objectives that were measurable and tied to the goals.

- 2) *Outcome Questionnaire (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 one 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.

This issue has not been resolved and will be continued in FY19; see Significant Non-compliance Issue #2.

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.

This has not been resolved and will be continued in FY19; see Minor Non-compliance Issue #1. Private mental health providers and other community agencies are not indicating that community engagement has improved.

- 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.

This issue has not been resolved and will be continued in 2019; see Minor Non-compliance Issue #2.

- 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.

This issue has been resolved. Tooele-VBH has hired a Certified Peer Support Specialist and is providing Peer Support services to individuals in treatment.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

- 1) *Safety Planning:* During the chart reviews, safety plans were present in six of the ten charts reviewed (60%). One chart indicated a need for a safety plan that was not available in the chart. Safety plan documentation continues to be inadequate. 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. Added training on safety plan intervention was a recommendation in both the FY17 and FY18 Monitoring Reports.

The FY18 Monitoring Report Follow-Up from Tooele-VBH indicated that VBH would develop Safety Plan training for staff. DSAMH recommends that VBH provide additional training to staff; In addition, DSAMH is available to offer Safety Plan training.

Center’s Response and Corrective Action Plan:

Action Plan:

Valley's Senior Clinical Treatment Team created a step by step training for completion of Medicaid approved Safety Planning. Therapist will be trained on Safety Planning by Tooele’s Attending Clinician and/or Clinical Director. Clinical teams will complete chart audits on a minimum of 5% (in accordance with DSAMH State standards) of charts at Tooele to ensure appropriate services and documentation. This will be completed by October 1, 2019

Timeline for compliance: October 1, 2019

Person responsible for action plan: Tooele’s attending Clinician and Clinical Director

- 2) *Outcome Questionnaire (OQ) Administration and Use as an Intervention:* A review of the charts indicated that four of ten charts did not have an OQ administered or had only had one OQ in several months. DSAMH Division Directives require that the OQ be given to individuals in treatment at intake, every thirty days or every visit (whichever is less frequent), and at discharge. Division Directives also state that data from the OQ be shared with the client and incorporated into the clinical process, as evidenced in the chart. Appropriate use of the OQ as an intervention has been demonstrated to improve treatment outcomes. The use of the OQ as an intervention was only evident in two of the ten charts reviewed.

During the FY18 Follow-Up Report, Tooele-VBH indicated that OQ administration and scores would be added to the Key Performance Indicator Report. However, administration and clinical use of the OQ appears to be decreasing. Tooele-VBH is encouraged to train clinicians on appropriate administration and use of the OQ, and to track use of the OQ in supervision and when completing peer chart reviews, to assess clinician understanding and compliance.

Center's Response and Corrective Action Plan:

Action Plan:

Tooele's Attending Clinician and/or Clinical Director, will conduct a training for OQ/YOQ administration by October 1, 2019. The training will include the frequency of distribution and how to document that a OQ/YOQ was administered and discussed in client's charts

Timeline for compliance: October 1, 2019

Person responsible for action plan: Tooele's Attending Clinician and Clinical Director

FY19 Minor Non-compliance Issues:

- 1) *Community Engagement and Outreach:* Community partners continue to express frustration with Tooele-VBH engagement and outreach. Community partners stressed the vital role Tooele-VBH plays in the community as the County Mental Health Center, and the importance of having Tooele-VBH provide a strong presence in the community. In order to have 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 with partners, including state and county agencies, those engaged in recovery services such as housing and employment, and service providers.

Center's Response and Corrective Action Plan:

Action Plan:

VBH will support community events throughout the year with booths to educate residents to our programs. Tooele – VBH will support our rural community partners by engaging in local parades including parade in Tooele. Tooele – VBH will support community stakeholders by allowing staff to attend Q & As and panel discussions without any penalties to direct service hours. Tooele

– VBH will continue to aid stakeholders with crisis support and outreach. All services will be provided without any penalties to staff.

Timeline for compliance: starting 7/17/19 and on going

Person responsible for action plan: Tooele’s Operational and Clinical Director

2) *Continuity of Care:* DSAMH is concerned about the excessive staff turnover and high caseload size per therapist at Tooele-VBH, as noted in the Adult Mental Health section of the FY18 Tooele-VBH monitoring report and in the Governance and Fiscal Oversight section of the FY19 Tooele-VBH monitoring report. This leads to long wait times between appointments, repeated therapist changes and inconsistent care for clients. Tooele-VBH should review policies and other factors related to turnover in order to stabilize staff. This may include receiving direction from other rural Local Authorities, in order to stabilize staff.

Center’s Response and Corrective Action Plan:

Action Plan:

Valley Behavioral Health takes retention and turnover very seriously. To address the concerns related to turnover Valley Behavioral Health has implemented the following.

Valley Behavioral Health has implemented Pay for Performance to Tooele-VBH staff to increase compensation for staff. Peakon data will be used to identify areas that Tooele-VBH staff are unsatisfied with their job and/or Valley and develop strategies with the Tooele-VBH leadership team to resolve the issues and make improvements.

We are actively trying to fill all open positions. Due to the occasional difficulty involved in hiring therapists to work in Tooele County, we have recently started reaching out offering telehealth positions. Sign-on bonus are being offered for key Tooele-VBH positions.

Valley Employee Retention Initiatives

- Built a new Retention Dashboard for in-depth analysis and reporting
- Developed and launched two Leadership Development courses. One for seasoned leaders and one for new leaders.
- Restructured the New Employee Orientation, hired a new Onboarding Coordinator, and deployed an Onboarding Roadmap with a focus on in-unit orientation. Developed goals to reduce 90-day and 1-year turnover.
- Deployed Peakon, a comprehensive employee engagement solution. Train managers on data analysis and impact planning. Will start sharing engagement data with employees in Skip-Level meetings.
- Leverage the predictive analytics features of the HRIS system to target and engage high flight-risk employees

- HR conducts Stay Interviews and reports trends to leadership.
- Developing a comprehensive Talent Management strategy to engage high-potential, high-performing employees in career development.

Timeline for compliance: starting 7/17/19 and on going

Person responsible for action plan: Tooele's Attending Clinician and Clinical Director

FY19 Deficiencies:

- 1) *Substance Abuse Mental Health Information System (SAMHIS) OQ Match:* The percentage of clients that match SAMHIS is required to be at least 90%. The FY18 Adult Mental Health scorecard indicates that Tooele-VBH had a match rate of 81.9%. DSAMH requires that Tooele-VBH resolve data entry issues and ensure the match rate improves to the required level.

Center's Response and Corrective Action Plan:

Action Plan: VBH will train staff on how to properly input SAMHIS data to ensures the match rate improve to the required level. The training will be completed by 10/1/19

Timeline for compliance: October 1, 2019

Person responsible for action plan: Tooele's Operational Director and Clinical Director

- 2) *Holistic Approach to Wellness:* Division Directives indicate that Local Authorities will promote integrated programs that address an individual's substance use disorder, mental health, intellectual/developmental disabilities, physical health, and criminal risk factors as described in UCA 62A-15-103(2)(vi). Ten of ten charts were missing information that is important to providing a holistic approach including the following: Ten charts did not include the primary care provider information, six charts did not document whether the individual used nicotine, and eight charts did not address physical health or how to improve it. DSAMH recommends that Tooele-VBH work with staff to develop a holistic approach to client care.

Center's Response and Corrective Action Plan:

Action Plan:

Valley's Senior Clinical Treatment Team created a step by step training for completion of Medicaid approved Care Plan (treatment planning) and assessment training. The training will address how to use a holistic approach for treatment. Tooele Therapist will be trained on Care Plans and assessments by Tooele's Attending Clinician and/or Clinical Director. Clinical teams will complete chart audits on a minimum of 5% (in accordance with DSAMH State standards) of charts at Tooele to ensure appropriate services and documentation. This will be completed by October 1, 2019

Timeline for compliance: October 1, 2019

Person responsible for action plan: Tooele’s Operational Director and Clinical Director

FY19 Recommendations:

None

FY19 Division Comments:

- 1) *Penetration:* The FY18 Adult Mental Health Scorecard indicates that Tooele-VBH has the highest level of penetration for services to the seriously mentally ill in the State at 35.7% (Rural, 20.1%; Statewide, 18.3%).
- 2) *Increase in Services Provision:* The FY18 Adult Mental Health Scorecard reports that Tooele-VBH has increased the number of unfunded individuals serves from FY17 (257) to FY18 (635). In addition, the number of incarcerated individuals served has doubled from FY17 (182) to FY18 (366), which may be a function of the strengthened relationship between Tooele-VBH and forensic providers.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Tooele Valley Behavioral Health on April 2nd, 2019. 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 2018 Audit

FY18 Deficiencies:

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

This issue has not been resolved and will be continued in FY19, see Deficiency #1.

- 2) Tooele-VBH has not submitted any indicated prevention data during FY17.

This issue has been resolved. Tooele-VBH submitted indicated prevention data in the FY18, which now meets Division Directives.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

- 1) No EASY Checks were conducted in FY18, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

<p>Action Plan: Tooele Prevention Unit will meet with Tooele City Police department to develop a timeline for completing an EASY compliance check for retailers within Tooele City limits. Youth recruitment, Youth training, Operations plan approval, Site EASY check and documentation in GEARS system will be completed by August 2, 2019. The site check is scheduled for July 19,</p>
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2019. Due to delays in gaining access to GEARS system we are asking for an additional 2 weeks to coordinate with the Department of Public Safety for technical support.

Summary: EASY compliance checks will occur on the night of 7/19/19 at Tooele City retail locations - All documentation will be completed by 8/2/2019

Timeline for compliance:

Meeting with TCPD: 7/9/19 - Complete

Youth CUB recruitment: 7/9/19 - Complete

Youth CUB training: 7/16/19

Ops plan approval: 7/18/19

Site checks: 7/19/19

Documentation: 8/2/19

Person responsible for action plan: Peter Clegg - Prevention Coordinator

FY19 Recommendations:

- 1) *Participation from Administration in Prevention Efforts:* Tooele-VBH Administration provides oversight for prevention services; however, they are not aware of overarching prevention goals or prioritized risk and protective factors for their local area. It is recommended that Tooele-VBH Administration meet with the Prevention Coordinator on a regular basis to remain informed on prevention efforts, prioritized risk and protective factors and goals to ensure that evidence-based services are provided in their community.
- 2) *Prevention Annual Report:* Tooele-VBH completed their Annual Report in 2017, but did not complete one for 2018. They are waiting for the results of the 2019 Student Health and Risk Needs Assessment (SHARP) Survey to complete their Annual Report. It is recommended that Tooele-VBH complete their Annual Report as soon as the SHARP Survey results are available.

FY19 Division Comments:

- 1) *Capacity Building:* Tooele-VBH focused on building capacity over the past year by hiring two new prevention specialists (full and part time), which has expanded prevention efforts in their area. They have also applied for grants, which have expanded coalition efforts, increased services and training opportunities. These grants include: (1) Parents Empowered Grant (2) National Alliance on Mental Illness (NAMI) Prevention by Design Grant
- 2) *Opioid Prevention:* Tooele-VBH has engaged in a number of opioid prevention efforts over the past year, including: (1) Increased Community Engagement: All local law enforcement, ambulance, fire department, and physicians were trained in prevention of misuse and abuse of opioids in May and June 2018. Topics discussed in this training focused on the role they play in helping in preventing the problem from spreading. Tooele's local judge has also been working motivating the casinos for a special training for their security staff. (2) Prevention Messaging / Marketing: 50,000 prescription bags with Tooele County prescription drop off

locations were printed and distributed to over six pharmacies countywide. In addition, free-standing message boards with brochures were placed throughout Wendover and Tooele. Ice packs, journals and magnets-clips with Use Only as Directed prevention messaging on them were ordered and have been hand out at trainings and events. Due to opioid related prevention and treatment efforts, Tooele-VBH has been able to help reduce the number of opioid overdose deaths in their community:

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Tooele County - Valley Behavioral Health Substance Use Disorders Treatment Program on April 2nd, 2019, 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 in interviews with Tooele County staff. Treatment schedules, policies, and other documentation were reviewed. 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 and Year-end reports.

Follow-up from Fiscal Year 2018 Audit

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.

Tooele-VBH made progress in their clinical charts over the past year by including current and updated documentation for the ASAM, including screening and documenting for tobacco, MAT and other high risk factors such as HIV/Hep B&C/TB; however, the group notes still are not individualized and do not show progress or lack of progress in treatment. The recovery plan objectives are not specific, time limited, measureable or achievable.

This issue has not been resolved and will be continued in FY19; see Minor Non-Compliance Finding #1.

- 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.

The percent of individuals that were employed from admission to discharge decreased from -1.7% in the FY17 to -4.4% in the FY18, respectively, which does not meet Division Directives.

This issue has not been resolved and will be continued in FY19, see Minor Non-Compliance Finding #2.

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.

This issue has been resolved. Tooele-VBH is now including the RANT in their EHR, which was evidenced by the chart review this year.

- 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.

Individual therapy notes showed the client's progress or lack of progress with therapeutic interventions in the chart review this year; however, the group notes were not individualized and did not show progress or lack of progress in treatment.

This issue has not been resolved and will be continued in FY19; see Minor Non-Compliance Finding #1.

- 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.

This issue has been resolved. Tooele-VBH reported no concerns with time requirements for staff or their workload this year. They stated that this issue was brought up last year by one staff member who left Tooele-VBH. Staff have been able to collaborate with community partners and continue to nurture partnerships.

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) *Clinical Charts:* Group notes are not individualized, are not showing progress or lack of progress in treatment or the therapist's clinical observations of the client's progress on recovery goals. Group notes have a general overview of the group topic and client's interactions in group. Recovery plan objectives are not specific, time limited, measurable or achievable. Group notes should be individualized, show the client's progress or lack of progress in treatment and therapist's clinical observation of the client's progress on their recovery plan goals. Recovery plan objectives should be specific to the recovery goal, be measurable, time limited and achievable (*Chart #'s: 2124671, 2130109, 2118397, 2135233, 2134366*).

Center's Response and Corrective Action Plan:

Action Plan:

Valley's Senior Clinical Treatment Team created a step by step training for completion of Medicaid approved psychotherapy (individual and group). Therapist will be trained on psychotherapy notes by Tooele's Attending Clinician and/or Clinical Director. Clinical teams will complete chart audits on a minimum of 5% (in accordance with DSAMH State standards) of charts at Tooele to ensure appropriate services and documentation. This will be completed by October 1, 2019

Timeline for compliance: 10/1/19

- 2) The FY18 Substance Abuse Outcomes Measures Scorecard shows:
 - a) The percent of individuals that were employed from admission to discharge decreased from -1.7% in FY17 to -4.4% in FY18 respectively, which does not meet Division Directives.
 - b) Involvement in Social Recovery Supports decreased from 0.0% in FY17 to -12.2% in FY18 respectively, which does not meet Division Directives.
 - c) Criminal Justice Involvement decreased from admission to discharge, decreased from 57.3% in FY17 to - 9.8% in FY18 respectively, which does not meet Division Directives.

Center’s Response and Corrective Action Plan:

Action Plan:

- a) VBH Tooele will create plan of action on how to retain and gain employment for SUD clients while in treatment.
- b) VBH Tooele will look into the social recovery services and identify the reasons for decrease in involvement. An action plan will be created to bring services meet Division Directives.
- c) VBH Tooele will look into criminal justice involvement and identify the reasons for decrease in involvement. An action plan will be created to bring services meet Division Directives.

Timeline for compliance: October 1, 2019
Person responsible for action plan: Tooele’s Operational and Clinical Director

- 3) The FY18 Consumer Satisfaction Survey shows:
 - a) Youth (Family) Satisfaction Survey - Positive Service Outcomes decreased from 68% in the FY17 to 39% in the FY18 respectively, which does not meet Division Directives.

Center’s Response and Corrective Action Plan:

Action Plan:

VBH-Tooele will review the FY18 Youth (Family) Satisfaction Survey and create and implement an action plan by October 1, 2019 on how to increase positive services outcomes in Tooele.

Timeline for compliance: October 1, 2019
Person responsible for action plan: Tooele’s Operational and Clinical Director

- 4) The FY18 Treatment Episode Data Set (TEDS) shows:

- a) Tooele-VBH is not collecting or submitting TEDS data on Medication Assisted Treatment services as required by Division Directives.

Center's Response and Corrective Action Plan:

Action Plan:

VBH-Tooele will re-train staff on how to properly input TEDS data

Timeline for compliance: October 1, 2019

Person responsible for action plan: Tooele's Operational and Clinical Director

FY19 Deficiencies:

- 1) *Old Open Admissions:* Old open admissions in FY18 was 7.1%, which is above the allowable amount of 4%, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

Action Plan:

Valley's Senior Clinical Treatment Team created a step by step training for completion of Medicaid approved discharges. Tooele Therapist will be trained on discharges by Tooele's Attending Clinician and/or Clinical Director. Clinical teams will complete chart audits on a minimum of 5% (in accordance with DSAMH State standards) of charts at Tooele to ensure appropriate services and documentation. This will be completed by October 1, 2019

Timeline for compliance: October 1, 2019

Person responsible for action plan: Tooele's Operational and Clinical Director

FY19 Recommendations:

- 1) *Data Training:* Tooele-VBH had several data findings in FY18 due to various factors. It is recommended that Tooele-VBH seek technical assistance from DSAMH on data collection methods and definitions for the Substance Abuse Treatment Outcomes Measures Scorecard, Consumer Satisfaction Survey and the Treatment Episode Data Set (TEDS). Once Tooele-VBH is clear on data set definitions and collection methods, it is recommended that they provide ongoing training to their staff in this area.
- 2) *Clinical Chart Training:* Tooele-VBH has made progress on their clinical charts this year, but still need to work on improving group progress notes and recovery plan objectives. It is recommended that Tooele-VBH provide ongoing training to their staff on their clinical charts to ensure that they are meeting the needs of their clients and including the necessary documentation. Technical assistance can be provided by DSAMH upon request.

FY19 Division Comments:

- 1) *Community Collaboration:* Tooele-VBH has built strong relationships with their community partners. Community Partners speak highly of Tooele-VBH and the community members are

appreciative of Tooele-VBH's responsiveness and their commitment to community engagement. Through ongoing collaboration with community partners over the years, Tooele-VBH has been able to expand the number of quality services in their community. difference.

- 2) *Telehealth*: Tooele-VBH has been working on expanding treatment services in Tooele and Wendover through telehealth. They recently hired their first telehealth therapist and are in the process of setting up the program for these services. Through these efforts, Tooele will be able to provide needed services for individuals with transportation issues or other barriers. Tooele is invested in expanding services through innovative methods, which is making a positive difference in their community.
- 3) *Justice Reinvestment Initiative - CIT Utah*: Tooele-VBH has been working with local law enforcement with the Crisis Intervention Team (CIT) - Utah to implement this approach in their community, which they have been working for the past eighteen years. CIT Utah is a program in the State of Utah, which develops and sustains partnerships between criminal justice services, behavioral healthcare services, and community members. These partnerships provide three basic services: the training of law enforcement officers and other first responders in proper methods of crisis response and resolution; developing effective crisis response systems; and advocating for accessible behavioral health services and programming. Tooele's first CIT class starts on April 19, 2019 for Law Enforcement and Mental Health Staff.
- 4) *Suicide Prevention*: Tooele-VBH has focused on suicide prevention efforts in their community over the past year, including the following: (1) The Question, Persuade and Refer (QPR) training, which was provided in 2018 for fifteen new instructors in the Tooele County area. These trainers have been hosting QPR trainings for schools, churches, and community-based organizations. In October, Tooele-VBH sent nine community partners to a Suicide Prevention conference at Utah Valley University. (2) Professional development training was provided to partners from Tooele Community That Cares (CTC), Utah State Extension, and Life's Worth Living Foundation. (3) Tooele also provided the Mental Health First Aid training to community partners from the Boy's and Girls club, Tooele County School District, Life's Worth Living Foundation, Tooele City Police, Tooele County Health Department, Utah State Extension, Division of Workforce Services and private businesses. On March 12-14th, 2019 Tooele-VBH sent three community partners to become instructors of Mental Health First Aid. All of these efforts have helped reduce the number of suicides in their community.

Section Three: 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 the 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 suggestions. 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.

Corrective Action Requirements: It is the responsibility of the Local Authority to develop a corrective action plan sufficient to resolve each of the noncompliance issues identified. These corrective action plans are due within 15 working days of the receipt of this report. The Division of Substance Abuse and Mental Health may be relied upon for technical assistance and training and the Local Authority is encouraged to utilize Division resources. Each corrective action plan must be approved by Division staff and should include a date by which the Local Authority will return to compliance. This completion date and the steps by which the corrective action plan will return the Local Authority to contract compliance must be specific and measurable.

Please submit the corrective action plan in the spaces provided.

Steps of a Formal Corrective Action Plan: These steps include a formal Action Plan to be developed, signed and dated by the contractor; acceptance of the Action Plan by the Division as evidenced by their signature and date; follow-up and verification actions by the Division and formal written notification of the compliance or non-compliance to the contractor.

Timeline for the Submission of the Action Plan: This report will be issued in DRAFT form by the Division of Substance Abuse and Mental Health. Upon receipt, the Center will have five business days to examine the report for inaccuracies. During this time frame, the Division requests that Center management review the report and respond to Chad Carter if any statement or finding included in the report has been inaccurately represented. Upon receipt of any challenges to the accuracy of the report, the Division will evaluate the finding and issue a revision if warranted.

At the conclusion of this five day time frame, the Center will have 10 additional business days to formulate and submit its corrective action plan(s). These two time deadlines will run consecutively (meaning that within 15 working days of the receipt of this draft report, a corrective action plan is due to the Division of Substance Abuse and Mental Health).

The Center's corrective action plan will be incorporated into the body of the report when issued.

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.

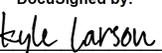
If there are any questions regarding this report please contact Chad Carter at (801)538-4072.

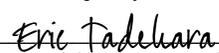
The Division of Substance Abuse and Mental Health

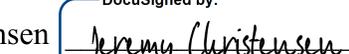
Prepared by:

Chad Carter Auditor IV	DocuSigned by:  8EC5063970BB41F...	Date <u>August 15, 2019</u>
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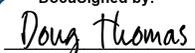
Approved by:

Kyle Larson Administrative Services Director	DocuSigned by:  68E416389254...	Date <u>August 15, 2019</u>
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Eric Tadehara Assistant Director Children's Behavioral Health	DocuSigned by:  68E416389254...	Date <u>August 15, 2019</u>
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Jeremy Christensen Assistant Director Mental Health	DocuSigned by:  68E416389254...	Date <u>August 15, 2019</u>
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Brent Kelsey Assistant Director Substance Abuse	DocuSigned by:  68E416389254...	Date <u>August 18, 2019</u>
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Doug Thomas Division Director	DocuSigned by:  EB71C358FA4D437...	Date <u>August 19, 2019</u>
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 erictadehara@utah.gov
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 Jeremy@Utah.gov
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