



Site Monitoring Report of

Tooele County
Valley Behavioral Health

Local Authority Contracts #122399 and #130350

Review Dates: March 8th, 22nd, 23rd & April 5th 2016

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Tooele County – Valley Behavioral Health (also referred to in this report as Tooele - VBH or the Center) on March 8th, 22nd & 23rd 2016. 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; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

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

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance	None	
	Significant Non-Compliance	2	7 - 10
	Minor Non-Compliance	3	10 - 11
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	3	15 - 16
<i>Adult Mental Health</i>	Major Non-Compliance	None	
	Significant Non-Compliance	2	19 - 20
	Minor Non-Compliance	1	20
<i>Substance Abuse Prevention</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
<i>Substance Abuse Treatment</i>	Major Non-Compliance	None	
	Significant Non-Compliance	2	26 - 27
	Minor Non-Compliance	2	27 - 28

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review at Tooele County – Valley Behavioral Health (Tooele-VBH). The Governance and Fiscal Oversight section of the review was conducted on March 8th, 2016 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 had been gained. Detailed service and operating expenditures were examined for proper approval and supporting documentation.

The CPA firm Ulrich & Associates, PC completed an independent audit of Tooele County for the year ending December 2014. The auditors issued an unqualified opinion in the Independent Auditor’s Report dated June 25th, 2015. However, one significant deficiency was identified that is related to proper oversight, this was a repeat finding from the previous year:

Finding 2014-1 – Subrecipient Monitoring: *Tooele County, Utah’s monitoring system related to the A & D Substance Abuse SAPT Block Grant, in which they have a long standing contract with a local not-for-profit, is not adequate. Internal controls related to subrecipient monitoring should be in place that provide reasonable assurance that the subrecipient is complying with laws, regulations, grants and contracts.*

Tooele County’s response: The County has implemented procedures to inform sub-recipients and others of the monitoring and documentation requirements. In 2014, the County Commission has met with top management at the sub-recipient. Together they have set expected deliverables for each month with timelines for each expectation. Additionally, the County Commission has assigned a specific County Health Director with the responsibility to follow-up on the agreed upon deliverables.

This issue is addressed in the report below; please see Significant Non-compliance Issue #1.

The CPA firm Tanner LLC completed an independent audit of Valley Behavioral Health for the year ending December 2014. The auditors issued an unqualified opinion in the Independent Auditor’s Report dated June 3, 2015. Two findings were issued in the report.

Finding 2014-1 – Inaccurate SEFA: *Policies and procedures should be in place to ensure that the Schedule of Expenditures of Federal Awards (SEFA) is complete and accurate.*

Valley Behavioral Health’s response: “Management agrees with the recommendation. During 2015 a new department was created to focus on and ensure the proper accounting, reporting, and compliance related to all federal awards. Management believes that the emphasis of this department will address this issue.”

Finding 2014-2 – Program Billings: *Grant for Progressive Adulthood: Skills, Support, Advocacy, Growth and Empowerment (PASSAGE) passed through the State Department of Human Services and Tooele County (CFDA 93.243). Policies and procedures should be in place to ensure that billings can be substantiated by actual expenses incurred for the operation of the program.*

Valley Behavioral Health’s response: “Management agrees with the recommendation. During 2015 a new department was created to focus on and ensure the proper accounting, reporting and compliance related to all federal awards. Management believes that the emphasis of this department will address this issue.”

These issues are addressed in the report below; please see Minor Non-compliance Issue #1.

Follow-up from Fiscal Year 2015 Audit:

FY15 Minor Non-compliance Issues:

- 1) Findings were issued in the financial statement audits of both Tooele County and Valley Behavioral Health (VBH) that indicate there has been a lack of involvement, oversight and communication from Tooele County over the services provided by VBH.

This issue has not been resolved and will be continued in FY16; see Significant Non-compliance Issue #1.

FY15 Deficiencies:

- 1) One employee file was found to be missing records of sexual harassment training during the file review.

All sampled employee files that were reviewed in the FY16 site visit included the necessary documentation and training records.

This deficiency has been resolved.

Findings for Fiscal Year 2016 Audit:

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

- 1) A repeat finding was issued in Tooele County’s financial statement for the second year regarding the County’s involvement in VBH’s provision of mental health and substance use disorder services. Although VBH is contracted by Tooele County to provide mental health and substance abuse services, Tooele County is the Local Authority contracted by DSAMH and is ultimately accountable to the State for the use of state and federal funds and for the level of services provided. VBH provided agendas for “Yardstick” meetings they are now

having with the County to keep both parties informed and involved, however there were no minutes taken in the meetings to review. This is a finding specifically for Tooele County, please provide a more detailed action plan that includes specific deliverables that are expected, any plans for routine site visits and names of the people responsible within the County.

Center’s Response and Corrective Action Plan:

As Commissioners of Tooele County, we do understand our role in overseeing behavioral health services as the Local Authority for Mental Health and Substance Abuse services. The Tooele County Commission will hold monthly meetings with Valley Behavioral Health previously noted as “Yardstick” meetings to assure oversight of mental health and substance use services and use of state and federal funding. The agendas of these meetings will be sent by Valley Behavioral Health to The County Commission’s Administrative Assistant at least 24 hours in advance of the meeting to assure all agenda items are present for both parties. These agendas, along with minutes taken during the meeting will be kept on file in the Commissioner’s office for record and for availability for the Utah State Division of Substance Abuse and Mental Health Oversight and Governance review. Agenda items will include the following: Organizational Charts and Changes, Hospitalization rates, Financial variances on a monthly basis for each program, and other updates such as JRI, Food Bank and Resource Center updates, and Clubhouse updates among others. We ask that Valley set quarterly tours (either in conjunction with Yardstick meetings or separately) of facilities to assure the County Commission has an opportunity to visit each site Valley Behavioral Health provides services in a minimum of yearly.



May 18, 2016

RE: FY16 Non-compliance Issues

Dear Chad,

As Commissioners of Tooele County, we do understand our role in overseeing behavioral health services as the Local Authority for Mental Health and Substance Abuse services. The Tooele County Commission will continue to hold monthly meetings with Valley Behavioral Health previously noted as "Yardstick" meetings to assure oversight of mental health and substance use services and use of state and federal funding. The agendas of these meetings will be sent by Valley Behavioral Health to The County Commission's Administrative Assistant at least 24 hours in advance of the meeting to assure all agenda items are present for both parties. These agendas, along with minutes taken during the meeting will be kept on file in the Commissioner's office for record and for availability for the Utah State Division of Substance Abuse and Mental Health Oversight and Governance review. Agenda items will include the following: Organizational Charts and Changes, Hospitalization rates, Financial variances on a monthly basis for each program, and other updates such as JRI Food Bank and Resource Center updates, and Clubhouse updates among others. We ask that Valley set quarterly tours (either in conjunction with Yardstick meetings or separately) of facilities to assure the County Commission has an opportunity to visit each site Valley Behavioral Health provides services in a minimum of yearly.

Sincerely,

A handwritten signature in black ink, appearing to read "Myron Bateman".

Myron Bateman
Commissioner

Wade Bitner
Chairman

Myron E. Bateman

Shawn Milne

TOOELE COUNTY COMMISSION

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

Center’s Response and Corrective Action Plan:

To strengthen our financial controls, we have initiated a process whereby Accounting meets regularly with Operations to discuss and reconcile the services provided with the billings for those services. With this additional communication, we can make sure that only costs for services which have been provided will be billed. If a planned service line is not started, or is stopped before the contract year ends, all concerned parties will be made aware. We are confident that this process will keep this type of occurrence from happening in the future.

FY16 Minor Non-compliance Issues:

- 1) Valley Behavioral Health was issued a finding in their financial statement audit regarding their billings for the PASSAGE grant passed through DSAMH and Tooele County. The audit stated that VBH needs to put policies and procedures in place to ensure that federal grant billings are substantiated by actual expenses. The PASSAGE grant ended in FY15 and is monitored separately from the Division’s site visit. VBH’s response to this finding stated that a new department was created to focus on and ensure the proper accounting, reporting and compliance related to all federal awards. Please provide more detail on the new department, what steps have been taken and the individuals who will be responsible.

Center’s Response and Corrective Action Plan:

Valley Behavioral Health created the Contracting Department in order to track all grants and contracts. The Contracts Department established a new software that tracks all grant expenditures and justification of expenditures. A report is pulled monthly and discussed at the grants & contracts meeting. If there is any discrepancy it is addressed and taken care of at the meeting. This allows for accurate and timely tracking of all grants and contracts.

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

Center's Response and Corrective Action Plan:

Upon review of the VBH "Expense Reimbursements" policy it was identified that no current policy was in place to include proper backup and approval signatures for travel. The policy will be updated and submitted to our policy and procedures committee for final review. The updated policy will include language ensuring that no personal gain or restricted purchases are made and that all transactions are clear and appropriate. The policy will also include language that all travel reimbursements will require an approval signature and they are documented.

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

Center's Response and Corrective Action Plan:

Our IT department in conjunction with our EHR vendor completed a review of the reports system concerning both SUD and MH. The review focused on ensuring the report was pulling accurate data. Upon review some issues were identified and corrected. In conjunction with the IT review additional training was provided to end users to ensure information was entered into the system correctly. Some errors were identified and corrected. We continue to provide ongoing training and monitoring to ensure the numbers being submitted are accurate and meet expectations. Monitoring includes steps to track the number of admissions and validate that they are being pulled into the report that is uploaded into SAMHIS.

FY16 Deficiencies:

- 1) *Year-end Data:* A comparison of year-end data that was submitted to the Division and data reported in SAMHIS showed some significant differences. Tooele-VBH should ensure that the finance team is communicating with their data team to reconcile client counts. A data meeting is held each year with the site visits between each Local Authority and DSAMH. The data meetings are a good opportunity for Tooele-VBH to get technical assistance and to discuss ways to improve data reporting.

FY16 Recommendations:

None

FY16 Division Comments:

None

Mental Health Mandated Services

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

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

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

Consultation and Education Services

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

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

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

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

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, and Families team conducted its annual monitoring review at Tooele County – Valley Behavioral Health on March 22nd & 23rd, 2016. The monitoring team consisted of Dinah Weldon, Program Administrator; Eric Tadehara, Program Manager; and Tracy Johnson, Utah Family Coalition (New Frontiers for Families). The review included the following areas: record reviews, discussions with management, case staff, program visits, and feedback from families through questionnaires and a discussion group. During the visit, the monitoring team reviewed Fiscal Year 2014 audit findings and center responses; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); Wraparound to fidelity; Multi-Agency Coordinating Committee; Mental Health Early Intervention funding; 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 2015 Audit

FY15 Significant Non-compliance Findings:

- 1) *Access to Care:* Access to care has been disrupted due to significant staff turnover and policy changes; quality of care has also been impacted by the loss of clinical supervisors for children and youth.

Staffing on the Children's Team stabilized in FY15 and the first part of FY16. Access to appointments, both in a timely manner and overall, has improved, and family feedback, and chart reviews verify increased access.

This finding has been resolved.

FY15 Minor Non-compliance Findings:

- 1) *Youth Outcome Questionnaire:* The Youth Outcome Questionnaire (YOQ) is not being administered at the required frequency.

This finding has not been resolved and is continued in FY16; see Minor Non-compliance Finding #1.

- 2) *Psychosocial Rehabilitation Services:* Tooele-VBH provided psychosocial rehabilitation services at a rate of 3.7% of the children and youth in FY14.

This finding has not been resolved. Due to improvements it is reduced to a recommendation in FY16; see Recommendation #1.

- 3) *Juvenile Civil Commitment:* Tooele-VBH needs to strengthen their Juvenile Civil commitment tracking process to ensure that statutory requirements are met.

This finding has not been resolved and is continued in FY16; see Minor Non-compliance Finding #2.

FY15 Deficiencies:

- 1) Data reported to the Division of Substance Abuse and Mental Health regarding emergency services is incomplete. Although emergency services are being provided, they are only being reported minimally on the Substance Abuse and Mental Health Information System (SAMHIS), with three total children and youth served for crisis in FY14. Evidence of the provision of emergency services was found in chart reviews. This deficiency is continued from the previous year.

This deficiency has not been resolved and is continued in FY16; see Deficiency #1.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

None

FY16 Minor Non-compliance Issues:

- 1) *Youth Outcome Questionnaire*: The Youth Outcome Questionnaire (YOQ) is not being administered at the required frequency. Division Directives require that the YOQ be administered at a frequency of “every thirty days or every visit (whichever is less frequent)” for each child and youth. Charts reviewed had an average of three administrations within the last twelve months.

Center’s Response and Corrective Action Plan:

Internal electronic health record flags will be set to inform receptionist staff and therapist of frequency of needed YOQ’s. Additionally, supervision will include training on importance and utility of YOQ results and review of charts.

- 2) *Juvenile Civil Commitment*: Tooele-VBH needs to strengthen their Juvenile Civil commitment administrative tracking process to ensure that all requirements are completed within the time frames required by statute. Tooele-VBH also needs to ensure that copies of the Juvenile Civil Commitment forms are maintained administratively until it has verified that the forms are attached to the client’s electronic medical record.

Center's Response and Corrective Action Plan:

- 1) Summit VBH and Tooele VBH met for training purposes on March 16, 18th and April 5th with the state, to understand these findings and create a PIP to correct future non-compliance issues. Utilization Management/Utilization Review (UM/UR) process now includes close monitoring and tracking of Youth Civil Commitments by assigned RN in Tooele. This includes collection of: the date of admission, date of commitment, facility, examiner and discharge date. All civil commitments from the State Hospital are also being collected and placed in client charts. The petitions are being completed by the Summit therapist or CM that works closely with the client and collected by UM/UR department to go with the civil commitment form. All patients under age 18 are expected to have a civil commitment completed if they are expected to be inpatient longer than 72 business hours and a blue sheet collected as well by UMUR dept. UMUR dept. is now working closely with all emergency room departments to collect clients' blue sheets completed on all youth.
- 2) These processes will be monitored for compliance by our UM/UR Team and Regulatory Oversight Team to assure tracking accuracy.

- 3) *Objectives:* Recovery plan objectives were not achievable or meaningful in five of the seven charts reviewed. Objectives seen in the charts include: client "will learn 2 new skills" for their varying situations; "client will participate in individual group and family treatment with goal of emotional regulation, distress tolerance, and mindfulness;" and the client "will participate in EMDR." The examples are difficult to achieve and lack meaning for the child, youth, and/or their family. Division Directives state that "short term goals/objectives are measurable, achievable and within a timeframe."

Center's Response and Corrective Action Plan:

All Children's LMHT's will be formally trained by Regulatory Oversight Staff and Tooele Management on how to develop meaningful goals and objectives that are specific measurable, achievable and realistic. Training will include identification to how assessment, goals, and treatment are connected to objectives that are realistic and connected to measurable targeted behaviors that will increase the function of the child. Sign in sheet will record attendance in this training, and this will be reviewed in supervision and in chart reviews.

FY16 Deficiencies:

- 1) *Emergency Data:* Data reported to the Division of Substance Abuse and Mental Health regarding emergency services is incomplete. Although emergency services are being provided, they are only being reported minimally on the Substance Abuse and Mental Health Information System (SAMHIS), with 27 total children and youth served for crisis in FY15. Evidence of the provision of emergency services was found in chart reviews. This deficiency is continued from the previous year.

FY16 Recommendations:

- 1) *Psychosocial Rehabilitation Services:* Tooele-VBH provided psychosocial rehabilitation services to 26 children and youth (a rate of 4.1%) in FY15. For the first half of FY16, Tooele-VBH has provided psychosocial rehabilitation services to 37 children and youth, an increase of 11 children and youth from FY15. It is recommended that Tooele-VBH continue providing psychosocial rehabilitation services to more children and youth.
- 2) *Peer Support Services:* Although Tooele-VBH provided Family Peer Support services to 332 children and youth and families, only 25 of them were open clients in the Electronic Health Record (EHR). While not all of these 332 children and youth are Medicaid eligible and open clients, it is recommended that Tooele-VBH offer peer support services as needed to each child and youth who is an open client.

FY16 Division Comments:

- 1) *Family Feedback:* Family feedback was obtained from 11 families who completed the Utah Family Coalition (UFC) questionnaire. Families reported that the staff are caring, helpful and friendly. Families are grateful for the various programs offered by Tooele-VBH, including respite services and the Hero group. One parent stated that “the staff at the children’s unit treat us with respect and genuine concern. They are so helpful in educating on things to try and explain what to expect and how to handle all sorts of behaviors that we encounter. I have 4 grandchildren in therapy. These children have made great progress in 6 months and they love the staff.”
- 2) *Wraparound and FRF:* Tooele-VBH provides wraparound to fidelity as defined by the UFC. The services provided are valued by families and the community partners involved with the children and youth. A family interviewed for the Wraparound Fidelity Index (WFI) 4.0 stated “we love the Family Resource Facilitator (FRF) and wraparound. They are the biggest blessing in our life. Our home feels safer and we all feel happier. Our team has empowered us as parents and we felt listened too, heard, and respected.” It is recommended that Tooele-VBH provide opportunities for the FRF to share the Strengths, Needs, and Cultural Discovery tool with clinical staff to give insight on how it can be utilized in therapy.

Adult Mental Health

The Division of Substance Abuse and Mental Health Adult Mental Health team conducted its annual monitoring review at Tooele County - Valley Behavioral Health on March 22nd and April 5th, 2016. The monitoring team consisted of Pam Bennett, Adult Program Administrator, LeAnne Huff, Adult Program Manager and Cami Roundy, Peer Support Program Manager. The review included record reviews and discussions with clinical supervisors and management teams. During this monitoring visit, site visits were conducted at New Reflection House, Tooele Resource Center and Food Bank; and the Tooele-VBH Administrative Office. During the discussions, the team reviewed the FY15 audit findings and center responses, 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 2015 Audit

FY15 Significant Non-Compliance Issues:

- 1) Emergency and Jail services data are not being reported to the Division of Substance Abuse and Mental Health.

This finding has not been resolved and is continued in FY16; see Significant Non-compliance issue #1.

FY15 Minor Non-Compliance Issues:

- 1) *Documentation:* Care/Treatment plans and goals for charts reviewed were strengths-based. However, Division Directives also require that short term goals/objectives are measurable, achievable and within a timeframe.

This finding has not been resolved and is continued in FY16; see Significant Non-compliance issue #2.

FY15 Deficiencies:

- 1) *Access to Care:* Excessive staff turnover and low staff numbers have resulted in clients struggling with long periods of time between appointments and changing therapists repeatedly. A new intake methodology has decreased time to initial intake. However, excessive staff turnover and low staff numbers continue to affect clients.

This deficiency has been partially resolved and is continued in FY16; see Deficiencies #1.

- 2) *Consumer Satisfaction Surveys:* DSAMH reporting requirements include a minimum consumer satisfaction survey rate of 10% of the number of annual unduplicated clients served for the prior year. Tooele-VBH returned an insufficient number of surveys for FY15. DSAMH requires that Tooele-VBH increase the percentage of surveys returned to meet or exceed the sample rate of 10%.

This finding has not been resolved and is continued in FY16; see Minor Non-compliance issue #1.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

- 1) *Data Submission Regarding Incarcerated Individuals:* According to the FY15 Mental Health Score Card, Tooele-VBH provided emergency jail services to zero (0) individuals. Year-to-date FY16 also report emergency jail service to zero (0) individuals. Services provided are not accurately reflected by the data submitted to the DSAMH as mandated by the Division Directives. Data submission of jail services on the Mental Health Score Card have been under-reported since prior to FY11. Corrective action plans provided in response to this finding in previous years have not resolved this issue. The ongoing inability to correct this issue, in conjunction with documentation issues (see FY16 Significant Non-Compliance Issues #2), raises questions about Tooele-VBH's ability to respond to and partner with DSAMH.

Center's Response and Corrective Action Plan:

Our IT department in conjunction with our EHR vendor completed a review of the reports system concerning both SUD and MH. The review focused on ensuring the report was pulling accurate data. Upon review some issues were identified and corrected. In conjunction of the IT review additional training was provided to end users to ensure information was entered into the system correctly. Some errors were identified and corrected. We continue to provide ongoing training and monitoring to ensure the numbers being submitted are accurate and meet expectations. Monitoring includes steps to track the number of admissions and validate that they are being pulled into the report that is uploaded into SAMHIS.

- 2) *Documentation/Objectives:* Division Directives require that short term goals/objectives are measurable, achievable and within a timeframe. Five of eight adult mental health charts reviewed during the FY16 site visit did not have objectives that were measurable and did not identify frequency and duration of prescribed interventions. One of these charts did not contain any objective. One possible option for developing measurable goals is encouraging staff to utilize **SMART** goals; **S**pecific, **M**easurable, **A**ttainable, **R**elevant, and **T**ime-based. The corrective action plan provided in response to this finding in FY15 has not resolved this issue.

A review of documentation also revealed serious deficiencies which could impact the quality of care that clients receive. Two of eight charts had individual therapy progress notes that

were not individualized, and appeared to be cut and pasted. Two of eight charts had progress notes which were brief and not descriptive. Two charts included “empty” progress notes without documentation. One chart did not include any objectives. One chart included a substance use disorder diagnosis that was not substantiated by the assessment. The assessment for one individual had several empty sections, primarily due to check boxes that had not been marked.

Center’s Response and Corrective Action Plan:

A 3-part approach will be undertaken to correct charting deficiencies.

- 1) First, additional training in effective software use will be available and encouraged for all therapists on a minimum of a quarterly basis. This training will address a specific topic and answer general questions.
- 2) Second, individual focus on specific charts will be provided during supervision at least twice monthly to explore and adjust example notes of the therapist so that they include SMART goals.
- 3) Third, quarterly training will be provided during staff meeting which addresses topics pointed out during the audits. These trainings will be documented by having staff sign-in sheets, agendas and brief review questions.

FY16 Minor Non-compliance Issues:

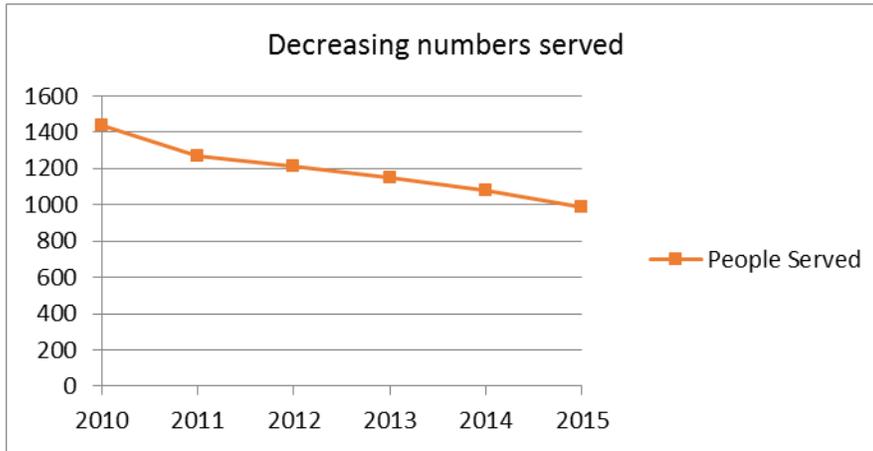
- 1) *Consumer Satisfaction Surveys*: DSAMH reporting requirements include a minimum consumer satisfaction survey rate of 10% of the number of annual unduplicated clients served for the prior year. Tooele-VBH returned an insufficient number of surveys for FY15 (7.8%) and FY16 (0.9%). DSAMH requires that Tooele-VBH increase the percentage of surveys returned to meet or exceed the sample rate of 10%. This is a shared finding with the DSAMH Substance Use Disorder team.

Center’s Response and Corrective Action Plan:

VBH – Tooele is committed to meeting the requirement for consumer satisfaction surveys. This is a valuable tool for our programs in terms of feedback that will guide and lead our future goals and directions as well as address more immediate concerns. We have committed to this process this current FY and have been able to significantly improve the responses across adult mental health, adult substance abuse and parents and children’s responses. Some noticeable changes will be in the coming year to make sure that we are exceeding the 10%. These changes include a more robust tracing system and an ability to track the surveys at the unit level and at the administrative level. This will increase communication between the units and administration. We have already begun planning for next year ensure that we get these surveys completed with a minimum of 10% or higher.

FY16 Deficiencies:

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



- 2) *OQ as an Intervention:* DSAMH recognizes the increased administration of the OQ at Tooele-VBH. However, Division Directives require that data from the OQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart. The use of the OQ as an intervention was only evident in one of eight charts reviewed. In addition, the FY15 scorecard indicates that Tooele-VBH had the highest rural measure for % of treatment episodes “deteriorated” and the highest state measure for % of discharged episodes “not recovered”. Appropriate use of the OQ as an intervention has been demonstrated to improve treatment outcomes.

FY16 Recommendations:

- 1) *Recovery Plus:* Recovery Plus is an initiative to promote health and wellness in people with mental illness and/or substance use disorders. Smoking cessation classes are not a provided service at Tooele-VBH, and charts reviewed identified nicotine use without evidence of referral or offering resources or cessation services. Division Directives indicate that tobacco use will be identified in the assessment with resources offered as indicated.
- 2) *Data Submission for Peer Support:* Tooele-VBH had not hired a Certified Peer Support Specialist (CPSS) until March 2016. However, Adult Mental Health data from the FY15 scorecard reports that four adults received CPSS services, and FY16 year-to-date data indicates that 66 adults have received CPSS services. Tooele-VBH is encouraged to review data and ensure that services are being billed correctly.

FY16 Division Comments:

- 1) *Peer Support:* DSAMH commends Tooele-VBH for the recent hire of a CPSS. The new CPSS expressed his excitement and passion for Peer work. CPSS notes, documentation and the use of lived experience were discussed.

- 2) *Participant Feedback:* Individuals at New Reflection were interviewed. It was the general consensus that the staff is “remarkable” and “would do anything for anyone”. It was mentioned that they all feel like they are an integral part of decisions such as hiring new staff. Members were complimentary of the program. One member said that “I was in a really dark place when I first came to Clubhouse. These people actually cared about me. They noticed when I wasn’t there and checked on me to see if I was OK. I feel like a person here, not like a patient.” Another commented that “coming to Clubhouse helps me with socializing and gets me out of the house so that I don’t isolate.” An additional comment was “It is sustainable. Most of us can’t afford treatment. This is viable, effective and it works.”
- 3) *Tooele Food Bank and Resource Center:* DSAMH commends Tooele-VBH for recent changes to the Tooele Food Bank and Resource Center. The space has been well-thought-out, is open and bright, and continues to efficiently provide critical support services to citizens of Tooele County.

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review of Tooele County – Valley Behavioral Health on March 22nd, 2016. The reviews focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the reviews evaluated the services described in the annual prevention area plan and evaluated the data used to establish prevention priorities.

Follow-up from Fiscal Year 2015 Audit

FY15 Deficiencies:

- 1) There were no EASY checks reported during FY14.

Tooele reported an increase of Eliminating Alcohol Sales to Youth from zero in FY2014 to 30 for FY2015. The compliance rate was 90% (27 did not sell, 3 establishments did sell alcohol to youth).

This deficiency has been resolved.

Findings for Fiscal Year 2016 Audit

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

None

FY16 Minor Non-compliance Issues:

None

FY16 Deficiencies:

None

FY16 Recommendations:

- 1) It is recommended that Tooele-VBH incorporates efforts from Tooele Communities that Care, Tooele Interagency Prevention Professionals (TIPP), and Wendover Coalition into Tooele's full Strategic Plan by December 2016.
- 2) It is recommended that Tooele-VBH complete a full assessment in collaboration with coalitions prior to Fall 2016.
- 3) It is recommended that Tooele-VBH looks to enhance the number of evidence based strategies offered. Currently, 72% of the programming is considered Evidence Based.

- 4) It is recommended that Tooele-VBH incorporates observation as a fidelity monitoring technique of current evidence based strategies.
- 5) It is recommended that Tooele-VBH increases the capacity building opportunities for staff and coalition members.

FY16 Division Comments:

- 1) Tooele-VBH continues to do a census of the Student Health and Risk Prevention (SHARP) survey. This is the gold standard.
- 2) Tooele-VBH has submitted an annual report on the different programs and strategies they have implemented.
- 3) Tooele-VBH has begun working with the Wendover community. The collaboration is innovative and unique as it is a community that impacts two states.
- 4) Tooele-VBH assisted with a Clergy training, they partnered with Tooele CTC and the faith based community. The training pulled in members and leaders from different faiths to discuss the needs of the community.

Substance Abuse Treatment

Shanel Long, Program Administrator, and Heather Lewis, Program Manager, conducted the review of Tooele County - Valley Behavioral Health Substance Use Disorders Treatment Program on March 22rd, 2016. The review focused on Substance Abuse Treatment (SAPT) Block Grant Compliance, Drug Court and DORA Program compliance; clinical practice and compliance with contract requirements. Drug Court was evaluated through staff discussion, clinical records and attendance at the Adult Felony Drug Court staffing and court session. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to SAPT Block Grant requirements, contract requirements and DORA Program requirements were evaluated by a review of policies and procedures, interviews with clients, a discussion with Tooele - VBH staff and a review of program schedules and other documentation. Tooele-VBH performance was evaluated using Utah Substance Abuse Treatment Outcomes Measures Scorecard and Consumer Satisfaction Survey Data. Client satisfaction was measured by reviewing records, Consumer Satisfaction Survey data and results from client interviews.

Follow-up from Fiscal Year 2015 Audit

FY15 Significant Non-Compliance Issues:

- 1) Tooele-VBH continues to allow Drug Court Phases to determine level of care. All clients are required to start with a specified number of groups per week and the phases of drug court determine the level of treatment.

This issue has not been resolved and will be addressed in the Significant Non-Compliance Issue #1 below.

FY15 Minor Non-Compliance Issues:

- 1) The FY14 Utah Substance Abuse Treatment Outcomes Measures Scorecard reflects that Tooele – VBH increased the use of tobacco as measured from admission to discharge

This issue has not been resolved and will be addressed in the Minor Non-Compliance Issue #1 below.

- 2) The FY14 Utah Substance Abuse Treatment Outcomes Measures Scorecard reflects that Tooele–VBH failed to meet the Division Directive’s goal of increasing the number of individuals utilizing Social Support Recovery as measured from admission to discharge.

From the FY14 to FY15, the use of Social Support Recovery increased from -7.6% to 36.4% respectively, which now meets Division Guidelines.

This issue has been resolved.

- 3) *Documentation:* Tooele-VBH has not made significant progress in meeting requirements in the Division Directives requiring that documentation be focused on engagement, person centered planning; and the requirement that assessments, ASAMs and treatment plans be current rather than based on time frames for updates. All charts reviewed found significant problems with the following:
- a. objectives were not measurable,
 - b. recovery plans and assessments weren't current,
 - c. objectives didn't change over long periods of time.

This issue has not been resolved and will addressed in the Significant Non-Compliance Issue #2 below.

- 4) Currently Tooele-VBH reports that they do not have individuals enrolled in their Juvenile Drug Court.

In FY15, Tooele-VBH enrolled at least 15 individuals in this court, which now meets Division Guidelines.

This issue has been resolved.

- 5) It is reported that the Tooele County Drug Court does not allow addiction Medications to be used by clients in the Drug Court.

In FY15, the Toole Drug Court started allowing the use of medication assisted treatment while in the program.

This issue has been resolved.

Findings for Fiscal Year 2016 Audit:

FY16 Major Non-compliance issues:

None

FY16 Significant Non-compliance issues:

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

Center's Response and Corrective Action Plan:

Training in use of assessment including RANT, Daily Living Assessment (DLA), and psycho social assessment, ASAM, and information from probation, drug testing and courts will be used to customize treatment plans. Staff will use treatment plans to guide placement in specific interventions, groups, and evidences based treatments. Client information including updated ASAM reviews will be reviewed in staff meeting and in supervision to guide treatment recommendations and phase changes throughout treatment. This will also be addressed in chart reviews.

- 2) *Documentation:* Tooele-VBH has several factors demonstrating failure to meet Division Directives regarding proper documentation in their electronic health record. Documentation should be current, person centered, updated regularly, and have measurable goals and objectives showing client involvement. In charts reviewed (*chart #'s 2104862, 941680, 2109724, 2108820, 2110753, 1224520*), most are lacking valid releases of information, and no consent-to-treat or Privacy statement notice forms. The American Society of Addiction Medicine (ASAM) is a check-box form, which does not list the dimensions or objectives; and the ASAM is not uniquely identifiable in any of the assessments. The recovery plans do not show client participation in the creation of these plans. Group notes do not tie back to client goals and objectives. Tobacco, Medication Assisted Treatment (MAT) and other health factors (high priority risk factors such as HIV/Hep B&C/ TB) are not screened for nor documented in the charts. Family involvement is not documented correctly under appropriate family services.

Center's Response and Corrective Action Plan:

Quarterly training will be provided during staff meeting which addresses topics pointed out during the audits. These trainings will be documented by having staff sign-in sheets, agendas and brief review questions. A few of the topics addressed will be individualized treatment goals, client language in goal statements, and screening for health factors. ROIs and Privacy Statement notice forms will be completed during each client's assessment. A checklist will be provided for each assessment along with blank forms as a reminder for the clinician.

FY16 Minor Non-compliance issues:

- 1) The FY15 Substance Abuse Treatment Outcomes Measures Scorecard showed an increase in the use of tobacco from admission to discharge at Tooele –VBH from -0.7% to -1.4% from FY14 to FY15 respectively. Division Directives state that Local Authorities should demonstrate a 5% decrease in tobacco use from admission to discharge.

Center's Response and Corrective Action Plan:

Center will provide and encourage smoking cessation groups throughout the year. Clients will be offered nicotine replacement patches and encouraged to use them. The offer of the groups and patches and the client response will be documented in their file. Prescribers will ask about nicotine use and document responses in their note. Prescribers and therapist will encourage client to address tobacco use, and document in chart. This will be addressed in supervision and chart reviews.

- 2) The FY15 Consumer Satisfaction Survey showed that:
- 3.1% of Adult Satisfaction Surveys were collected
 - 0% of Youth Satisfaction Surveys were collected
 - 0% Youth (Family) Satisfaction Surveys were collected

Division Directives state that a minimum sample rate of 10% needs to be collected to obtain accurate data results. This is a shared finding with Adult Mental Health.

Center's Response and Corrective Action Plan:

Tooele-VBH adult admin staff have increased distribution of satisfaction surveys. Going forward the surveys will be distributed for at least 3 days each month and the number of surveys completed will be tallied cumulatively to insure minimum of 10%.

FY16 Deficiencies:

- 1) *Drug Court:* Tooele-VBH does not keep record of the Risk and Needs Triage Assessment (RANT) in client files, which need to be addressed and corrected. Division Directives state: *"Felony Drug Courts shall serve participants identified as High Risk/High Need by the Risk and Needs Triage Assessment... A copy of the completed RANT shall be in the participant's clinical record."*

FY16 Recommendations:

- 1) *Staff Turnover:* It is clear that staff are aware of the impact the high turnover rate has had on all aspects of the services and methods of delivery at Tooele-VBH. It is recommended that the Program Directors continue to strive to become fully staffed and offer regularly scheduled trainings to keep all clinicians up to speed regarding agency and division requirements.
- 2) *Staff Training:* There appears to be a need for staff training on the use of the Electronic Health Records. Staff members are not clear which files they have access to or where to find certain documentation, such as the release of information. This is an issue as staff members need to be reviewing current releases of information in the process of working with clients on therapeutic issues, coordinating of care and working on treatment and recovery plans. Staff training could rectify this issue.

FY16 Division Comments:

- 1) *Recovery Support:* Tooele-VBH showed an increase in Social Support Recovery Activities from -7.6% in FY14 to 36.4% in FY15. These types of activities are integral in sustaining long term recovery. Staff should be commended for their efforts in improving recovery supports in their program.

- 2) *Schedules and Availability:* It was clear that the staff care for their client's wellbeing. Clients report that they feel they can reach out to staff for support and help. They also reported that they are able to attend a variety of classes that meet their recovery needs.

Section Two: Report Information

Background

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

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

Non-Compliance Issues, Action Plans and Timelines

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

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

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

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

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

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to require a formal action plan. However, the monitoring team may request action to fix the problem by a given date.

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

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

Signature Page

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

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

The Division of Substance Abuse and Mental Health

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