



Site Monitoring Report of

Salt Lake County
Division of Behavioral Health Services and
Health Department

Local Authority Contracts #160237 and #160424

Review Date: February 27th, 2018

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Salt Lake County Division of Behavioral Health Services (also referred to in this report as SLCo or the County) on February 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 Significant Non-Compliance Minor Non-Compliance Deficiency	None None 3 None	7-9
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	11-12
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None 2 2 2	15-16 16-17 18-19
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	20
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 1	23-24 24

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of Salt Lake County Division of Behavioral Health Services (SLCo) and Salt Lake County Health Department (SLCHD) for prevention. The Governance and Fiscal Oversight section of the review was conducted on February 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.

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

Mental health and substance use disorder services are contracted to outside providers. SLCo must ensure that subcontractors comply with all provisions identified in the DHS Contract with Local Mental Health Authority. The Governance and Oversight section of the review was extended to include some contracted providers to test for compliance. Site visits were done on First Step House and Fourth Street Clinic. The visits included a review of insurance, code of conduct, conflict of interest and licensing.

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

As required by the Local Authority, Salt Lake County received a single audit for the year ending December 31st, 2016 and submitted it to the Federal Audit Clearinghouse. The firm Squire completed the audit and issued a report dated June 29th, 2017. The auditors' opinion was unqualified stating that the financial statements present fairly, in all material aspects, the financial position of Salt Lake County. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on internal control over financial reporting and compliance for each major Federal program. Substance Abuse and Mental Health were both identified as major programs and were selected for additional testing. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2017 Audit:

No findings were issued in FY17.

Findings for Fiscal Year 2018 Audit:

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

1) *Subcontractor Monitoring:* The following issues were found:

- SLCo contracts with Optum as a Managed Care Organization (MCO). The DHS Contract sets up a monitoring structure where DSAMH is responsible for monitoring SLCo, as a subrecipient of State and Federal funds. SLCo is then responsible to monitor Optum to ensure that Federal, DHS contract, Utah Code and Division Directive requirements are followed. The Division relies on SLCo's audit and reviews it each year as part of annual monitoring. This year, SLCo had not yet finalized their FY16 financial review of Optum and their FY17 review was still in progress. Provider monitoring should be completed at the time of the Division's scheduled site visit. It is essential that these reviews are completed timely so that any issues that have been identified can be addressed within a reasonable time frame. SLCo contracts for all services, so monitoring is now one of its primary functions and should be given a high priority. DSAMH will work with SLCo to schedule the annual site visit later in the year if needed.
- During the review of SLCo subcontractor files, the DSAMH Substance Abuse Disorder team found two subcontractors (Project Reality and First Step House) that were not monitored in the previous year by SLCo as required by the DHS Contract and SAPT Block Grant.
- Subcontractor files were reviewed at the Salt Lake County Health Department. All contracts were monitored, but one file was found to have an expired insurance certificate that was not addressed in the monitoring review.

Center's Response and Corrective Action Plan:

- Regarding the first bullet, Salt Lake County Division of Behavioral Health Services (DBHS) recognizes that to not have the FY16 monitoring completely finalized by the FY18 DSAMH monitoring visit is unacceptable. Internal re-structuring has occurred and additional employees hired in order to assure that this does not reoccur.

Regarding the issue of the FY17 monitoring still being in progress, this is not completely accurate. The monitoring was completed by June 30, 2017 but the report had not yet been finalized due to various personnel issues. We realize taking so long to complete the report is not acceptable, and is certainly not the standard to which we hold ourselves. Due to the issues which caused such a lengthy completion of the report, the entire process was

re-examined. The Quality Assurance team was re-structured and the report has been re-formatted to ensure this does not occur again. However, it is not possible to have the entire monitoring visit with the accompanying report for the present fiscal year completed before DSAMH performs their monitoring visit. DSAMH needs to recognize the scope and magnitude of this audit. It would be akin to DSAMH completing all of their monitoring visits for all the LMHAs, and completing the reports, within four months, with less than half the staff DSAMH currently uses to complete these visits. All this while continuing to perform all the other many job responsibilities the QA team has. To begin earlier is not practical due to changes within the DSAMH and Medicaid contracts. Time is needed for the providers to put into practice the changes the contracts may necessitate. Additionally, the administrative part of the monitoring visit which requires significant preparation by Optum is most easily completed simultaneously when Utah Medicaid's externally quality review organization completes their monitoring visit, which is usually in the July after the fiscal year has closed. Therefore, if DSAMH would like to re-schedule DBHS' monitoring visit for the second half of June, we would have all of the clinical monitoring completed. However, we could only provide verbal feedback as the written report will not be completed until September 15 of any given year (this is the new standard).

- Regarding the second bullet of the two subcontractors not being monitored, measures have already been taken to assure that this will not occur again. All subcontractors either have been monitored with the reports issued or are scheduled to be monitored for FY18.
- Salt Lake County Health Department will contact this provider to obtain an updated insurance certificate, and add it to their contract file no later than July 16, 2018.

2) *Code of Conduct:* The DHS contract requires that the Local Authority and its contracted providers develop, maintain and enforce a Code of Conduct for the provision of services to its clients which includes the elements, and is at least as stringent as the DHS Provider Code of Conduct. Salt Lake County Health Department only has their employees sign the Salt Lake County Code of Conduct, but it is missing many elements from the DHS Provider Code of Conduct, only addressing employee conduct at work and not conduct between employees and their clients. SLCo has all of their employees sign both of these codes, SLCHD should ensure that any employees providing services under this contract do this also.

Center's Response and Corrective Action Plan:

Salt Lake County Health Department employees providing services under this contract will sign both the Salt Lake County Health Department Code of Conduct and the Division of Human Services Code of Conduct, and those documents will be added to the employees' files no later than July 16, 2018.

3) *Contractor Compliance:* SLCo is required to ensure that all contracted service providers are complying with the provisions in the DHS contract. Some contracted providers are selected for sampling to test for contract compliance. During the review of Fourth Street Clinic, it was found that one employee did not have a current conflict of interest form completed. The

previous form was completed in 2016 and stated that a potential conflict did exist. The DHS contract requires that all potential conflicts of interest are declared in writing and reviewed annually.

Center’s Response and Corrective Action Plan:

As part of our annual contract renewal process, we ask agencies to fill out and submit conflict of interest forms. We then remind them of this contract requirement throughout the fiscal year during provider meetings and at the time of the annual site visit. For FY18, we were negotiating a contract modification for Fourth Street Clinic and it was not noticed that the form did not get submitted. The contract was modified from providing assessment services to providing case management services. At the time of the contract signing Fourth Street Clinic was in the process of hiring someone to fill the case manager role. For FY17, the form that we have on file indicates that no conflict existed. This is available for review upon request. We have a new form that was filled out in May of 2018 for FY19 that indicates that no conflicts exist.

FY18 Deficiencies:

None

FY18 Recommendations:

None

FY18 Division Comments:

- 1) Each year, SLCo provides a match amount that is well over the required minimum. DSAMH appreciates SLCo’s commitment to the health of its population through funding mental health and substance use services.

Mental Health Mandated Services

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

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

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

Consultation and Education Services

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

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

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

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

Child, Youth and Family Mental Health

Child, Youth, & Families team conducted its annual monitoring review at Salt Lake County on February 27th and 28th of 2018. The monitoring team consisted of Eric Tadehara, Program Administrator; Codie Thurgood, Program Manager; Mindy Leonard, Program Manager; and Wendy Mair, Family Mentor with the Utah Family Coalition (NAMI Utah). The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, program visits, and feedback from families through questionnaires and a focus group. During the visit, the monitoring team reviewed Fiscal Year 2017 audit; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention funding; juvenile civil commitment; compliance with Division Directives; and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2017 Audit

No findings were issued in FY17.

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

None

FY18 Deficiencies:

- 1) *Youth Outcome Questionnaire (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. In seventeen charts reviewed, only six charts showed evidence of the YOQ being administered within the required guidelines. It is recommended SLCo continue to hold trainings for their providers on the administration and clinical use of the YOQ to increase the administration rate to fall within the required guideline of "every thirty days or every visit (whichever is less frequent)."

Center's Response and Corrective Action Plan:

In July 2018, all Optum SLCo providers will receive step-by-step instructions to create client profiles in the OQ Analyst. Subsequent use of the OQ Analyst will be monitored and providers not using the system will be required to attend and in-person training in the Fall of 2018. Optum

SLCo will continue to provide, at a minimum, annual OQ/YOQ Measures Trainings for providers. In addition, the training for FY19 will focus more on how to interpret the Clinician Report for inclusion in treatment planning, per provider feedback. OQ and YOQ administration with incorporation into treatment planning continues to be monitored through provider audits. Any training regarding the YOQ will emphasize the need and importance of completing the YOQ “every thirty days or every visit (whichever is less frequent)”.

FY18 Recommendations:

- 1) *Emergency data:* SLCo has made improvements in the way it captures emergency data, with FY17 emergency data reported as 150 children and youth receiving these services. DSAMH recognizes that data for emergency services through the Mobile Crisis Outreach Team is not accessible at this time and efforts are being made to be able to capture the data. It is recommended that SLCo continue to work with their other providers who provide emergency services to continue to effectively capture this data.
- 2) *School-based Behavioral Health:* SLCo continues to provide school-based behavioral health (SBBH) services through Valley Behavioral Health. Over the past six months, community partners have reported concerns regarding providers not being available in the capacity they have been in the past. It is noted that there are state wide problems in maintaining a full therapeutic workforce and that Valley Behavioral Health is working on filling the open positions. It is recommended that SLCo and Valley Behavioral Health continue to monitor and fill these positions to ensure children and youth are able to maintain access to SBBH services throughout the schools in Salt Lake County. It is also recommended that SLCo work with Valley Behavioral Health if there are other needs regarding SBBH and the partnerships with the local schools throughout the county.

FY18 Division Comments:

- 1) *Community Partnerships:* SLCo partners with the Carmen B. Pingree Autism Center of Learning and with New Beginnings Behavioral Treatment Agency. Carmen B. Pingree Autism Center of Learning has continued to evolve and adapt their services to provide a learning environment that can be tailored to fit the needs of each child attending. Additionally, New Beginnings Behavioral Treatment is able to tailor interventions for each youth and is willing to think outside the box to meet the needs of their clients. These community partners reported positive feedback in their relationship with SLCo and the collaboration to provide quality services for the clients.
- 2) *Family Feedback:* The Utah Family Coalition (UFC) collected feedback from four families via survey and two families who participated in a focus group. Feedback included a young transition aged adult who reported positive experiences in regards to their mental health treatment and supportive services.

It is recommended that SLCo and Optum continue to collaborate with the Utah Family Coalition (UFC) to strengthen the family feedback process.

- 3) *Wraparound and Family Resource Facilitators:* SLCo is using High Fidelity Wraparound principles with many of their families. Some of the charts reviewed demonstrated to all

fidelity measures and are considered High Fidelity Wraparound as defined by the UFC. SLCo Family Resource Facilitators (FRF) are an integral part of the service delivery system. FRFs play a key role in helping families engage with the services offered through SLCo. Families report that they appreciate the ability the FRFs have to “just listen” and be a support for them.

Adult Mental Health

The Division of Substance Abuse and Mental Health Adult Monitoring Team conducted its annual monitoring review at Salt Lake County on February 27th and 28th, 2018. The team consisted of Pam Bennett, Program Administrator, Robert H. Snarr, Program Administrator, LeAnne Huff, Program Manager and Cami Roundy, Peer Support and Resiliency Program Manager. The review included: record reviews, and discussions with clinical supervisors and management teams, including Salt Lake County Division of Behavioral Health (SLCo), OptumHealth, and multiple providers and community partnerships throughout the County. Site visits were conducted at Volunteers of America Assertive Community Treatment (VOA/ACT) team, University Neuropsychiatric Institute (UNI) receiving center and UNI weekly discharge planning meeting. During the site visit, the team discussed and reviewed the FY17 audit findings; the mental health scorecard; area plan; Outcome Questionnaires; and SLCo's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2017 Audit

FY17 Minor Non-compliance Issues:

- 1) *Documentation of Mandated Outpatient Services:* This finding is continued from FY13 as documentation issues continue to be found in the assessment, treatment plans and progress notes, which could result in inadequate treatment. Thorough documentation in all these areas helps clinicians evaluate treatment progress and work with clients to create new goals and objectives as life adjustments occur. Issues were found related to ongoing assessments, inconsistencies within the progress notes, and missing objectives.

This Finding has not been resolved and will continue in FY18; see Significant Non-compliance Issue # 1

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

This Finding has not been resolved and will continue in FY18; see Significant Non-compliance Issue # 2

FY17 Deficiencies:

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

OQ administration to reach the Division Directives requirement of 50%. This reflects the finding in the SLCo FY15 Monitoring Report of OptumHealth.

FY18 scorecard shows OQ administration for SLCo at 59.7% which exceeds the 50% required administration rate; this deficiency has been resolved

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

During the chart review, eleven of sixteen charts did not have the OQ used as an intervention. This finding has not been resolved and will be continued in FY18; see Minor Non-compliance Issue #1

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

- 1) *Safety-Related Documentation:* Sixteen charts were reviewed and four charts did not have a Columbia Suicide Severity Rating Scale (CSSR-S) when needed, reflective of the Salt Lake County Division of Behavioral Health Services (DBHS) Monitoring Report of Optum/Mental Health Services FY16 and FY17 findings. Three of those four charts did not contain safety plans. One chart that did include a CSSR-S (indicated due to a previous suicide attempt), but did not include an adequate safety plan. For example, the safety plan was: 1) “I feel overwhelmed when I am in a crisis”; and 2) “I need time to myself”.

Center’s Response and Corrective Action Plan:

In July 2018, information related to the C-SSRS mandate will again be distributed to all Optum SLCo providers. This will include step-by step instructions of how to submit the data. Reference to the screening tools, as well as the Stanley Brown Safety Plan will be offered. Provider use of the tool will be monitored by their data submissions, which will indicate if a safety plan was warranted as well. Providers not complying with the mandate will be required to attend an in-person training in the Fall of 2018.

We request the name for the providers who did not administer the C-SSRS and created an inadequate safety plan so we may follow-up and provided targeted support.

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

Center’s Response and Corrective Action Plan:

As is known by DSAMH, the SLCounty Jail provides mental health (MH) services to incarcerated individuals without any State or Federal funds and without oversight by DBHS. It was our intent to have the data extracted from the Jail’s electronic medical record (EMR) for these services and provide it via a data sharing agreement. It was determined this year, FY18, that the data extraction from the SLCo Jail EMR was not possible. We have been working with the Jail staff to format and extract data from the Jail data system (OMS) that would be representative of the individuals served in a Jail specific area as Residential MH. It is a cumbersome process and may not be accurate of all individuals or all service days. We have requested a Provider ID for the Jail under which to submit, but we have not yet received that from DSAMH. Once the ID is provided we will be submitting the data extracted for the last quarter of FY18 and submitting it as a pilot process. From there we will work with Jail staff to extract and report on a regular basis in FY19.

FY18 Minor Non-compliance Issues:

- 1) *Use of OQ as an Intervention:* Division Directives require that data from the OQ shall also be shared with the client and incorporated into the clinical process, as evidenced in the chart. The OQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. During chart reviews, eleven of sixteen, or 69% of the charts had no evidence of integration of OQ as a tool in treatment. The SLCo DBHS Monitoring Report of Optum/Mental Health Services FY16 and FY17 indicates that OptumHealth has provided training around treatment plan reviews and the OQ. This issue has been noted in DSAMH monitoring reports since FY14

Center’s Response and Corrective Action Plan:

While the use of OQ Measures has continued to be noted in the DSAMH Audit since FY14, the use of OQ has increased since Optum SLCo has been offering additional trainings. In July 2018, all Optum SLCo providers will receive step-by-step instructions to create client profiles in the OQ Analyst. Subsequent use of the OQ Analyst will be monitored and providers not using the system will be required to attend an in-person training in the Fall of 2018. Optum SLCo will continue to provide, at a minimum, annual OQ Measures Trainings for providers. In addition, the training for FY19 will focus more on how to interpret the Clinician Report for inclusion in treatment planning, per provider feedback. OQ and YOQ administration with incorporation into treatment planning continues to be monitored through provider audits.

- 2) *SLCo/OptumHealth's Provider Charting (Goals/Objectives) and Outpatient Documentation:* This finding has been addressed in previous years, as charts continue to have insufficient documentation, including issues with assessments, absence of goals and objectives, and inadequate treatment plans. Ten of sixteen charts (62%) reviewed did not have measurable goals. In accordance with Preferred Practice Guidelines and ongoing planning principles, short term goals/objectives are to be measureable, achievable and within a timeframe. One possible option for developing measurable goals is encouraging staff to utilize SMART goals; Specific, Measurable, Attainable, Relevant, and Time-based. One of the sixteen charts reviewed (Volunteers of America) had no presenting problem, no clinical information in the assessment, symptoms did not support diagnosis, goals were not measurable, and there was no evidence of coordination. Nine of sixteen charts reviewed were from Valley Behavioral Health (VBH). Six of nine VBH charts did not have measurable goals (see comment above). Only three of the nine charts included adequate documentation. One chart reviewed had a hand written assessment, minimal clinical information, no symptoms to support diagnosis and no progress notes. Three other charts also did not have symptoms to support the diagnosis. Three charts had no assessment updates, and one of these charts did not have an assessment in the electronic medical record. Three of the charts did not provide follow up when indicated by client not showing up for treatment or dropping out of treatment. A review of the VBH Internal Audit Report indicates that only 10 of 30 SLCo VBH units had completed the required percentage of peer chart reviews over the previous 12 months. This is concerning, as the number of issues within each chart could have an impact on client care. DBHS/Optum has a network of 174 providers and 56% of the files reviewed came from just one provider, so this finding is not necessarily representative of the DBHS/Optum network of providers. This was brought to the attention of the DSAMH monitoring team prior to the monitoring visit, and they concurred that this was the data available for this monitoring visit through random data pull and acknowledge the limitations of the representative sample. Similar findings were reflected in the audit report SLCo provided DSAMH that they had performed on Optum.

Center's Response and Corrective Action Plan:

Optum SLCo meets with Valley Behavioral Health leadership on a bi-weekly basis. During the month of July, Optum will address the findings with VBH and request plan of action to address the items listed above. In addition, Optum will audit these issues within the next 6 months.

Regarding the larger network, Optum SLCo will offer a provider training focused on the Golden Thread concept in treatment planning, delivery and documentation. We will emphasize having client centered goals and measureable objectives. Interventions/methods will also be addressed which describe the specific activity, service or treatment, the provider or other responsible person (including the individual or family), and the intended purpose or impact as it relates to the Objective. The intensity, frequency and duration must be specified. We will revisit key requirements from previous trainings related to assessments and treatment plans, including medical necessity, support for diagnoses and SMART objectives to better monitor treatment progress.

FY18 Deficiencies:

- 1) *Readiness, Evaluation and Discharge Implementation (REDI) Program:* The REDI program is a list of patients referred for discharge, and not yet discharged, from the Utah State Hospital (USH). At the time of the site visit, there were 14 patients from SLCo on the REDI list. SLCo is working to ensure patients ready for discharge are discharged from the USH within 30 days. In the past State fiscal year, the average annual number of days the patient has been on the REDI list is 102 days. 48% on the REDI list in the past State Fiscal Year exceeded 30 days on the list. Two of these clients were on the list for an extended period of time due to multiple complicated issues. If these outliers are removed, the average length of time on the REDI list for SLCo patients would be 43 days. DSAMH recognizes the barriers to discharge and the work being done by SLCo and OptumHealth on creative solutions, along with the development of additional affordable housing resources. DSAMH recommends SLCo continue to work with DSAMH and the USH to refine the discharge process, addressing barriers from intake and engaging high level processes to find sustainable solutions to difficult barriers.

Center’s Response and Corrective Action Plan:

The Optum SLCo Utah State Hospital Committee will continue to collaborate with USH and DSAMH personnel to discharge Salt Lake County consumers with complex circumstances, including those who were moved from Forensics to the Civil side. Some consumers’ histories include violent crimes which pose unique challenges to coordinate housing and services in a community based setting. Optum SLCo is committed to creating discharge plans to maximize each consumer’s potential for success while being mindful of the community’s safety. We will support further discussion regarding the purpose of the REDI list and criteria for consumers to be added. In FY18, two consumers (one included in the data cited) remained on the REDI list after comprehensive discharge plans were created, but rejected by the USH physicians. As the LMHA, Salt Lake County accepts responsibility and liability for consumers leaving the USH. We believe the Optum SLCo Team is most knowledgeable to create consumer specific plans based on the resources available in our community.

- 2) *Coordinated Transitions:* It was noted in the University Neuropsychiatric Institute FCA meeting that staff turnover in Valley Behavioral Health’s Assisted Outpatient Team had impacted the transition from inpatient to outpatient care. In addition, there are barriers to tracking unfunded individuals that are released on civil commitment. These issues impact the ability of the individuals to remain stable in the community.

Center’s Response and Corrective Action Plan:

Valley Behavioral Health hired a dedicated staff to collaborate with inpatient providers and to coordinate discharge from inpatient care. In July 2018, VBH will hire a clinician to offer supervision and back-up support to the inpatient discharge coordinator. Optum SLCo continues to meet with Utilization Reviewers (UR) at UNI on a weekly basis and reviews cases as appropriate with URs at Jordan West Valley and St. Mark’s Hospital. Optum SLCo also has providers other than Valley Behavioral Health who are able to accommodate consumers discharging from inpatient care with more complex needs. Optum Care Advocates, Recovery & Resiliency Staff and Case Management Coordinator are able to assist with coordination of care

with these providers as well.

FY18 Recommendations:

- 1) *Continuity of Care:* SLCo serves over 25% of the adult mental health clients in Utah (FY17 Mental Health Scorecard for Adults). With the closure of the Wellness Receiving Center, SLCo will lose 16 of 48 mental health residential beds, leaving only 32 beds (CORE and CORE II) and limiting the continuum of care available. DSAMH appreciates efforts to alleviate this gap by developing a partnership to provide subacute beds at Highland Ridge Hospital. DSAMH encourages SLCo to continue to address limitations in the residential services provided.
- 2) *Salt Lake County DBHS Monitoring Report:* DSAMH recognizes and appreciates the comprehensive monitoring the Salt Lake County provides over a complex mental health system. It was noted that review and assessment of safety plans are not included in the current report, and it is recommended that SLCo add this to the monitoring list.

FY18 Division Comments:

- 1) *Intensive Case Management Teams (OptumHealth):* OptumHealth is commended for the development of Intensive Case Management teams at four agencies. These community-based model of care has been demonstrated to improve functioning in individuals with severe mental illness.
- 2) *Peer Support Services and Volunteers of America (VOA):* DSAMH Peer Support Program Manager Cami Roundy visited with a Certified Peer Support Specialist who is part of the team at VOA. He is an asset and is treated as an integral part of the team. His documentation includes how he has been able to use his story and experience to help others. The VOA Peer Support supervision model is also outstanding.
- 3) *Utah Support Advocates for Recovery Awareness (USARA):* DSAMH Peer Support Program Manager Cami Roundy met with a Seeking Safety Group that is held at USARA. This group is facilitated by Peer Support Specialists. There were seven peers who attended the group. All in attendance reported that the group is helpful and that USARA is an excellent resource. All group members also indicated that they have created their own treatment goals, that USARA helps them to make progress toward those goals, and that Peer Support is critical to their recovery. Quotes from the group include: “Peer Support helps more than anything, I don’t know what I would do without it.” “I am completely self- sufficient now and own my own vehicle. I am doing a great job.”

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review of Salt Lake County Health Department Prevention on February 27th, 2018. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from Fiscal Year 2017 Audit

FY17 Deficiency:

- 1) SLCo saw a decrease in the number of Eliminating Alcohol Sales to Youth compliance checks that occurred in FY16.

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

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

None

FY18 Deficiencies:

- 1) SLCO saw a decrease in the number of Eliminating Alcohol Sales to Youth (EASY) compliance checks for a fourth year. In FY16, SLCo had 378 compliance checks completed compared to 310 in FY17.

Center's Response and Corrective Action Plan:

There was a 21.9 percent decrease in the number of Eliminating Alcohol Sales to Youth (EASY) compliance checks during the fiscal year 2017. The total number of agencies performing compliance checks decreased from seven agencies to five agencies. The overall compliance rate increased from 90 percent to 92.58 percent. Salt Lake County has developed the following action plan to help resolve the discrepancy for the fiscal year 2018.

- 1) Contact all precinct offices to determine who are performing EASY compliance checks
- 2) Provide an EASY training with the Utah Highway Safety Office for all precincts in the county
- 3) Recruit precincts currently not involved in EASY compliance checks

FY18 Recommendations:

- 1) It is recommended that SLCo develop a data entry plan in collaboration with Salt Lake Behavioral Health. This is specific to the indicated services provided and required to be entered into the SAMHIS system.
- 2) It is recommended that SLCo share the information identified regarding the strategies funded and how those line up with prevention principles with existing coalitions. Identifying the strategies currently implemented within the coalition boundaries would be best for communities to see how they are addressing prevention principles.
- 3) It is recommended that SLCo work with the Health Community Coalitions (HCC) to draft up priority issues for each HCC.

FY18 Division Comments:

- 1) SLCo has a Data Dashboard, this assessment tool highlights the needs of the County. The data identified priority issues including substance use prevention and mental health needs.
- 2) SLCo is working with eight coalitions at this time. They are looking to build additional coalitions and capacity within the northwest area of Salt Lake County and West Valley City.
- 3) The community of Murray had a higher participation rate on the 2017 Student Health and Risk Prevention survey. This will allow the community to have data specific to them for prevention planning.
- 4) SLCo Synar compliance rate is 93.7%, this is an increase from the previous fiscal year. Synar compliance checks monitor tobacco sales to youth from establishments within the County.
- 5) More than 90% of the strategies contracted or implemented through Salt Lake County Health Department (SLCHD) are evidence based.
- 6) With other grant funding, SLCHD has distributed over 300 Naloxone kits throughout the County this fiscal year.
- 7) The Director of SLCHD attended the Community Anti-Drug Coalitions of America (CADCA) Forum. Director Edwards supports utilizing the Strategic Prevention Framework and Community Centered Evidence Based Prevention.

Substance Abuse Treatment

Becky King and VaRonica Little, Program Administrators, conducted the annual review of Salt Lake County Behavioral Health Services on February 27th, 2018. The visit focused on Substance Abuse Prevention and Treatment (SAPT) block grant compliance, compliance with Division Directives and Contracts, SLCo's monitoring of contracted programs and their providers compliance with contract and clinical requirements. Block grant compliance was evaluated through a review of provider contracts, discussions with staff members and a review of SLCo's audit reports. Compliance with Division Directives was evaluated by reviewing SLCo's audit instruments and procedures, reviewing provider contracts, comparing program outcome measures against DSAMH standards and visits with SLCo's agencies' staff members. Monitoring of clinical practices was evaluated by reviewing SLCo's audit reports, audit instruments, procedures and discussions with staff responsible for the audits of contracted providers.

Follow-up from Fiscal Year 2017 Audit

FY17 Major Non-compliance issues:

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

This issue is resolved. It should be noted in the FY18 audit that SLCo completed on Criminal Justice Services files, identified no documentation of sliding scale fee. There was no documentation in the SLCo files on this audit about the follow up and changes made by Criminal Justice Services, however SLCo staff stated that Criminal Justice Services has corrected this issue and they will include documentation of the correction in their records.

FY17 Minor Non-compliance Issues:

- 1) The FY16 Utah Substance Abuse Treatment Outcomes Measures showed:
 - a) From FY15 to FY16, the percent of abstinence from alcohol use decreased from 20.6% to 13.6% respectively, which does not meet Division Directives.

- b) From FY15 to FY16, the percent of clients completing a treatment episode successfully decreased from 42.5% to 40.0% respectively, which does not meet Division Directives.
- c) From FY15 to FY16, the percent of clients retained in treatment 60 days or more decreased from 73.0% to 65.4% respectively, which does not meet Division Directives.
- d) From FY15 to FY16, the percent of clients employed from admission to discharge decreased from 21.2% to 5.9% respectively, which does not meet Division Directives.

Issues b, c, and d were all resolved and will no longer be findings for the next fiscal year. The percent of clients completing a treatment episode (b) increased from 40% to 41.3% from FY16 to FY17. The percent of clients retained in treatment 60 days or more (c) remained at 65.4% from FY16 to FY17 which meets the standard in the Division Directives. Percent of clients employed from admission to discharge (d) increased from 5.9% to 21.9% from FY16 to FY17. Issue A has not been resolved and will be a continued finding in FY18; see Minor Non-compliance Issue #1.

Findings for Fiscal Year 2018 Audit:

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

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

- a) From FY15 to FY16, the percent of abstinence from alcohol use decreased from 20.6% to 13.6% respectively, which does not meet Division Directives. In FY17 the percentage went to 17.7%, so this will continue to be a minor non-compliance finding.

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

Center's Response and Corrective Action Plan:

DBHS would first like to note that improvement was seen in this area going from 13.6% to 17.7%. Additionally, we foresee this pattern continuing in the reporting of alcohol abstinence when only first admission data is compared to last reported discharge data of a client's episode. If the State were to take into consideration the incremental and concurrent data submitted during the client episode it would see more improvement as client's full data picture is collected across our network of providers. We would also estimate that more than half of clients' reported episode

end at a different provider than the provider under which they admitted. This is only an estimate as the State does not include this information in the SAOutcomes report.

FY18 Deficiencies:

- 1) *Treatment Data Episode Set (TEDS)*: DSAMH requires local authorities to report whether clients have been “compelled” to treatment by the justice system. This has been required since January 1, 2016. DSAMH recognizes the effort SLCo has made to train and educate providers on this requirement. However, 31.1% of all SLCo’s TEDS submissions for the first six months of FY17 did not include this information, which is required to track outcomes related to Utah’s Justice Reinvestment Initiative. Please continue to reinforce with contracted providers the importance of tracking this information.

Center’s Response and Corrective Action Plan:

DBHS requests that DSAMH share their methodology for calculating the figure of 31.1%. DBHS calculated the data and found of the admissions submitted that fall between 7/1/2016 and 12/31/2016, in the current data we see that 61% are compelled = YES, 19% are compelled = NO, and 21% are ‘not collected’ or ‘Unknown’. The majority of these last 21% are for Detox client admissions, 60%, where the client was no longer available to obtain updated information. Therefore, will continue to have a certain amount of “not collected” or “unknowns” because some clients will immediately leave the social detox program once sober and not be willing to engage in any further conversations. Keeping that in mind, DBHS has and will continue to emphasize to providers the importance of tracking this information during our monthly provider meetings. However, it needs to be noted that without the effort DBHS made, DSAMH would have had very little, if any, information to provide to their stakeholders. Additionally, during the first six months it had not been made clear by DSAMH exactly what comprised “compelled”. When we had further discussions with DSAMH leadership about this and obtained a clearer understanding, DBHS (including the providers) devoted a lot of time and effort to not only correctly identifying those who were compelled going forward, but also going in and correcting records that had previously been misidentified. We believe this finding does not accurately represent all the effort made to be able to identify all those who were correctly identified as compelled to treatment.

FY18 Recommendations:

- 1) *Treatment Data Episode Set (TEDS)*: Please continue to review the TEDS submissions to ensure that medication assisted treatment (MAT) is accurately reflected in this data set. This is important to show the use of this evidence based practice (EBP) and ensure accurate Federal grants reporting.
- 2) *Monitoring*: There were some contracts that were not monitored in the past fiscal year. There was concern that there was not enough staff to complete these audits. If there are concerns or if there is support that is needed to be in compliance with doing the annual audits please seek support from DSAMH to ensure that they are completed.

FY18 Division Comments:

- 1) *Monitoring*: SLCo has started to complete the audits of CJS and this will help with continued compliance and ensure that all data and programming is consistent with the other contracted entities.
- 2) *Medication Assisted Treatment*: SLCo continues to encourage the use of MAT, which has improved client and program outcomes. All Drug Court and justice related programs are also required to allow the use of MAT, which has resulted in long term recovery and reduced recidivism rates. This was evident in some of the audit reports, but should be reviewed annually to ensure that there is no limitations to accessing treatment.
- 3) *Vivitrol Project*: SLCo Behavioral Health continues to experience positive outcomes with the Vivitrol Project. By providing the Vivitrol injection in jail and up to six months of injections for individuals in Salt Lake County Treatment Programs, there has been increased rates of sobriety. This project has made a positive difference in the community.
- 4) *Peer Support Specialists*: OPTUM has been working on increasing the reimbursement rates for the Peer Support Specialists, which will result in increased recruitment and retention efforts. SLCo considers Peer Support Specialists to be an asset to their community and are dedicated to increasing incentives for programs to employ Peer Support Specialists in their programs.

Section Two: Report Information

Background

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

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

Non-Compliance Issues, Action Plans and Timelines

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

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

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

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

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

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

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

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

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Salt Lake County 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:

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Auditor IV



Date July 10, 2018

Approved by:

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Date July 10, 2018

Ruth Wilson
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Date July 10, 2018

Jeremy Christensen
Assistant Director Mental Health



Date July 10, 2018

Brent Kelsey
Assistant Director Substance Abuse



Date July 10, 2018

Doug Thomas
Division Director



Date July 10, 2018