



State of Utah

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Lieutenant Governor

Department of Human Services

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Division of Substance Abuse and Mental Health

DOUG THOMAS
Director

July 8, 2020

The Honorable Jenny Wilson
Mayor, Salt Lake County
2001 South State St., #N2100
Salt Lake City, UT 84190

Dear Mayor Wilson:

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

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

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

Sincerely,


Doug Thomas (Jul 13, 2020 16:50 MDT)

Doug Thomas
Division Director

Enclosure

cc: Caroline Moreno, SUD Prevention Bureau Manager, Community Health, Salt Lake County Health Department

Gary Edwards, Director, Salt Lake County Health Department
Tim Whalen, Director, Salt Lake County Division of Behavioral Health Services
Karen Crompton, Department Director, Salt Lake County Human Services



Site Monitoring Report of

Salt Lake County
Division of Behavioral Health Services and
Health Department

Local Authority Contracts #160237 and #160424

Review Date: February 25th, 2020

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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) and Salt Lake County Health Department for prevention services (also referred to in this report as SLCHD) on February 25th, 2019. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

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

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 1	7-8 8-9
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 2	13-14 14-15
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 2	18-19
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	22-23
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 2	24-25

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 25th, 2020 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, SLCo provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter. Random samples were taken from the backup provided to verify that the listed services qualified for each different service category.

Mental health and substance use disorder services are contracted to outside providers. SLCo must ensure that subcontractors comply with all provisions listed 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 Clinical Consultants and Interim Group Services. Only partial monitoring was done with Interim Group Services by telephone due to closings related to COVID-19. 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, 2018 and submitted it to the Federal Audit Clearinghouse. The firm Squire and Company, PC completed the audit and issued a report dated June 20th, 2019. 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. The SAPT Block Grant and the Opioid STR Grant 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 2019 Audit:

FY19 Minor Non-compliance Issues:

- 1) SLCo had completed their FY18 clinical audit of Optum, but had not yet finalized their FY17 financial report at the time of the site visit. They were able to provide a draft copy, but had not yet started their review of FY18.

This issue has been improved. SLCo has improved their timeliness in completing these reports. This issue will only be addressed as a recommendation for FY20, see Recommendation #1.

FY19 Deficiencies:

- 1) During the review of personnel files, it was found that two contained copies of expired licenses. Both licenses were found to be active, but documentation in the file had not been updated.

This issue has been resolved. All licenses examined in the personnel file review were active and the files contained updated documentation.

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

- 1) *Code of Conduct:* The DHS Contract states “*The Local Authority shall develop, maintain and enforce a Code of Conduct for the provision of services to its clients which at least includes the elements of the DHS Provider Code of Conduct and is at least as stringent as the DHS Provider Code of Conduct*”. During the review, it was found that the administrative employees of Salt Lake County Health Department and the employees of SLCo’s subcontractor Interim Group Services, were not signing a Certificate of Understanding for the DHS or an equivalent code of conduct each year. The question came up if these individuals needed to do this as they did not have direct contact with DHS clients. The DHS Provider Code of Conduct states the following: “*The Provider shall distribute a copy of this Code of Conduct to each employee and volunteer, regardless of whether the employees or volunteers provide direct care to clients, indirect care, administrative services or support services. The Provider shall require each employee and volunteer to read the Code of Conduct and sign a copy of the attached "Certificate of Understanding" before having any contact with DHS clients. The Provider shall file a copy of the signed Certificate of Understanding in each employee and volunteer's personnel file.*” Salt Lake County should

ensure that all employees and subcontractors providing services under this contract are in compliance with this standard.

County’s Response and Corrective Action Plan:

Action Plan: We will immediately have all County administrative staff read the DHS Code of Conduct and sign the Certificate of Understanding form that is attached. These certificates will be filed in each employee’s personnel file. This process will be done every year going forward. We will also inform Interim Group Services that they are to do the same and we will audit to ensure compliance going forward.

Timeline for compliance: By June 30, 2020

Person responsible for action plan: Caroline Moreno/Marjeen Nation

- 2) Subcontractor Monitoring: As part of the site visit, several subcontractor files were reviewed for completeness and proper oversight. SLCo did not monitor one of the subcontractors selected for review in the last year. Monitoring responsibilities had changed between staff and it appears that this was inadvertently left out in the process. All other subcontractors were reviewed as part of the annual monitoring required by contract.

County’s Response and Corrective Action Plan:

Action Plan: Beginning in fiscal year 2021, the DBHS fiscal team has created and will utilize a comprehensive audit tracking form to track the progress of all the audits that are performed each year to ensure that no subcontractor is missed. It will be reviewed every two weeks throughout the year.

Timeline for compliance: July 1, 2021 going forward

Person responsible for action plan: Zac Case

FY20 Deficiencies:

- 1) Optum’s monitoring of service providers was reviewed as part of SLCo’s audit of Optum. It was found that Optum was performing audits of providers according to contract, but some instances were found where Optum had issued a finding and did not provide any details on how the issue was addressed. Please provide an action plan detailing how this will be addressed.

County’s Response and Corrective Action Plan:

Action Plan: All provider audits completed by Optum to meet the requirement for all in-network providers to be audited, are submitted to the Salt Lake County DBHS Associate Director of Treatment Services. Some changes have been made to the documentation of the claims validation process within the audit report sent to the provider, since the audits were reviewed by the DBHS Finance Auditing Team for FY18. Currently, all activity related to the

claims validation process, known at the time of the report, is documented in the provider report. Therefore, when all records and claims match, this is documented as “no findings” related to the claims validation component. When adjustments need to be made, the specific service information is included in the report. When the provider is referred to the Optum Program Network Integrity Team (PNI) for further investigation, this is indicated in the record. This was the case with one provider In Tune, as cited in the example above. PNI may request additional records to determine if billing issues exist, if recoupment is appropriate and if there is potential FWA. A process is in place for Optum SLCo to be notified of the outcome of the investigations.

Timeline for compliance: This action item was implemented at the beginning of FY20.

Person responsible for action plan: Gina Attallah, (Optum) and Jason Norwood, CPA (Optum)

FY20 Recommendations:

- 1) SLCo has received findings in the past regarding the timeliness of their clinical and financial audits of Optum. SLCo includes the results of their annual Medicaid audit in their review of Optum, which affects the timing of their final report. It is requested that SLCo provide their expected completion time for their clinical and financial audits of Optum in their FY21 Area Plan on the Governance and Oversight Narrative under Subcontractor Monitoring, this will help to provide a measurement for future monitoring.

- 2) The SLCo emergency plan was reviewed by Robert Snarr, Program Administrator and Geri Jardine, Program Support Specialist, as part of monitoring. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that SLCo review these suggestions and update their emergency plan accordingly.

FY20 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 Children, Youth, & Families team conducted its annual monitoring review of Salt Lake County Division of Behavioral Health Services on February 25th, 26th, and March 4th, 2020. The monitoring team consisted of Eric Tadehara, Assistant Director; Codie Thurgood, Program Manager; Mindy Leonard, Program Manager; and Tracy Johnson, Program Administrator. The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, and program visits. During the visit, the monitoring team reviewed the Fiscal Year 2019 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; 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 2019 Audit

FY19 Minor Non-compliance Issues:

- 1) *Access to care:* The number of youth who received services in SLCo showed a significant decrease from FY17 to FY18. In FY17, 6,684 children and youth were served while only 5,832 children and youth in FY18, representing a 12.75% decrease in the number of youth who received services. Areas of concern include the number of youth in need of services, ages 5-17 receiving treatment, unfunded youth served, and youth served in schools. The table below illustrates each decrease in youth served from FY17 to FY18.

Reduced Access: Overall and by Type of Service				
	FY17	FY18	Number Decrease	Percentage Decrease
Total Children and Youth*	6,684	5,832	852	-12.75%
5-17 Year Olds*	6,177	5,427	750	-12.14%
Unfunded Youth*	347	263	84	-24.21%
School-Based Services*	1,402	1,020	382	-27.25%
School-Based Services+	757	461	296	-39.10%

* *Published Children’s Mental Health Scorecard*

+*Mental Health Early Intervention Reporting*

DSAMH recognizes some of the systemic issues that may have contributed to the decreases in children and youth receiving services, including HB239 and the Juvenile Justice Reforms

which have been occurring over the past two years. Although these challenges exist, the decrease in the number of children and youth served was significant year over year.

This issue has not been resolved and will be continued for FY20; see Minor Non-compliance Issue 1.

- 2) *Treatment Plans and Objectives:* During the chart review process, five of the fourteen charts had inadequate updates or were completely missing the treatment plans. One treatment plan from the Trauma Awareness Treatment Center was completely missing from the chart. Two of the charts had a history of treatment but no treatment plan until February 2019. The other two charts had outdated treatment plans without any current notes about treatment or diagnosis. The Division Directives state, “The current version of the approved Utah Preferred Practice Guidelines shall be the preferred standard for assessments, planning and treatment. At a minimum assessments, planning and treatment shall comply with the Medicaid Provider Manual and current Administrative Rule as described in R523.” The Medicaid Provider Manual requires that the treatment plan “is current and accurately reflects the patient’s rehabilitative goals and needed behavioral health services.”

In six of the fourteen charts reviewed, measurable achievable objectives were lacking. Samples of the objectives written include, client will “maintain and deepen relationship with grandmother, increase client’s sense of safety and well being.” In accordance with the Preferred Practice Guidelines and ongoing planning principles, “short term goals/objectives are to be measurable, achievable and within a timeframe.” One possible option for developing measurable goals is to train staff on utilizing SMART goals: Specific, Measurable, Attainable, Relevant, and Time-based.

This issue has been improved and will be continued for FY20 as a deficiency; see Deficiency #1.

FY19 Deficiencies:

- 1) *Youth Outcome Questionnaire (YOQ):* The frequency the YOQ is being administered at is below the required guideline of “every thirty days or every visit (whichever is less frequent)” as described in the Division Directives. In six of the fourteen charts that were reviewed, there was no included YOQ data or evidence of use. In four of the charts, the YOQ was given, but not at regular 30 day intervals. 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. Salt Lake County and OptumHealth are encouraged to continue training efforts on appropriate clinical use of the OQ, particularly with the smaller provider agencies.

This issue has not been resolved and will be continued for FY20; see Deficiency #2.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

- 1) *Access to care:* The number of youth who received services in SLCo showed a significant, continued decrease from FY17 to FY19. In FY17, 6,684 children and youth were served while only 5,337 children and youth were served in FY19, representing a 20.15% decrease in the number of youth who received services. A particular area of concern is the number of youth served with school based services. The table below illustrates each decrease in youth served from FY17 to FY19. DSAMH is very concerned about the continual trend of a reduction in clients served.

Reduced Access FY17-FY19: Overall and by Type of Service					
	FY17	FY18	FY19	Number Decrease	Percentage Decrease
Total Children and Youth*	6,684	5,832	5,337	1,347	-20.15%
School-Based Services*	1,402	1,020	453	949	-67.69%
School-Based Services+	757	461	146	611	-80.71%

* *Published Children’s Mental Health Scorecard*

+*Mental Health Early Intervention Reporting*

DSAMH continues to recognize the systemic issues that may have contributed to the decreases in children and youth receiving services, including: (1) HB239 and the Juvenile Justice Reforms, (2) increased school based providers including the Local Education Agencies, and (3) a large number of youth with access to Employer-Sponsored Insurances. Although these challenges exist, the continued decrease in the number of children and youth served is a trend that should be investigated as the number of youth in need grows each year.

County’s Response and Corrective Action Plan:

Action Plan: As mentioned in the response to this same item in the FY19 Audit, further analysis of the data demonstrates a reduction in Medicaid enrollment which can contribute to the decrease in services rendered. Since FY16, there has been a 24% decrease in youth ages 0-5 who are eligible for Optum Medicaid, with a 7.6% decrease in this category from FY19 to FY20. In

addition, there has been a 19% decrease in eligibility for those ages 6-18 and 19-20 years old who are in independent living since FY16. This category showed a 6% decrease in enrollment from FY19 to FY20. Therefore, the volume of services rendered decreases due to eligibility. However, we will continue to make all the efforts which were delineated in the FY21 Area Plan to provide services to those under the age of 18. In addition, in this past year, Utah schools saw the benefit of legislative changes increasing the number of mental health professionals within the school districts. Optum Medicaid providers continue to expand the list of schools and services where behavioral health services are covered. Hopeful Beginnings offers services to Unfunded youth and their families on a sliding fee schedule, however because they do not receive reimbursement through Medicaid or DSAMH grant dollars, these services are not counted. Ultimately, the numbers included in this finding do not reflect the reduction in Medicaid eligible youth and all of the services rendered to youth in Salt Lake County.

Timeline for compliance: Ongoing. Additionally, DBHS/Optum providers continue to offer school-based services in every school district within Salt Lake County and some charter schools. In light of the circumstances related to COVID-19, providers are rendering services via telehealth and phone therapy to support youth who are unable to receive their therapeutic and support services in the school setting.

Person responsible for action plan: Brian Currie, LCSW (DBHS) and Gina M. Attallah, LCSW (Optum)

FY20 Deficiencies:

- 1) *Objectives:* During the chart review process, 3 of the 15 charts had vague or difficult to measure objectives. Some examples of goals include, “improve relations with sisters, work on controlling emotions, and find something in common with sisters.” In accordance with the Preferred Practice Guidelines and ongoing planning principles, “short term goals/objectives are to be measurable, achievable and within a timeframe.” One possible option for developing measurable goals is to train staff on utilizing SMART goals: Specific, Measurable, Attainable, Relevant, and Time-based.

County’s Response and Corrective Action Plan:

Action Plan: Optum trainings will continue to emphasize the requirements for measurable and attainable objectives utilizing SMART goals within treatment plans which guide treatment. Optum offered a mandatory provider training for clinical supervisors/directors to ensure these documentation standards are taught and reinforced in practice. The mandatory training was held in January 2020. Free CEUs were available and trainings were in person.

Timeline for compliance: Provider training was completed in January 2020. Future documentation trainings will continue to emphasize the SMART goal planning strategy.

Person responsible for action plan: Brian Currie, LCSW (DBHS), Randy Dow, LCSW (Optum) and Gina M. Attallah, LCSW (Optum)

- 2) *Youth Outcome Questionnaire (YOQ)*: The frequency the YOQ is being administered at is below the required guideline of “every thirty days or every visit (whichever is less frequent)” as described in the Division Directives. In 6 of the 14 charts that were reviewed, there was no included YOQ data or evidence of use. In four of the charts, the YOQ was given, but not at regular 30 day intervals. 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 YOQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. SLCO is encouraged to continue training efforts on appropriate clinical use of the YOQ, particularly with the smaller provider agencies.

County’s Response and Corrective Action Plan:

Action Plan: Further research into the numbers indicate that of the 19 charts mentioned in the finding, 11 were associated with VBH and 8 were from other providers. Within these 19 charts it was found that due to the members being inpatient or younger than the age required to administer the YOQ®, 5 charts did not require YOQ®. Therefore, there were 14 charts which required a YOQ®, not 19. Of these 14 charts, there were 8 charts that had YOQ®s and of these 8, 4 which only had the initial YOQ® without the 30-day intervals. For VBH and the other provider whose record did not include the YOQ®, Optum SLCO will send a written request for the agencies’ policy and procedure related to YOQ®. We will also request the provider review the records included in the audit and to indicate the reason for the omission of the YOQ or proof of administration in their response.

Optum is committed to providing annual YOQ® training to in-network providers, and will do so again in FY21.

Timeline for compliance: Optum will send the written requests described above to providers by May 22, 2020 with a response due in 30 days.

Person responsible for action plan: Gina M. Attallah, LCSW (Optum)

FY20 Recommendations:

- 1) *Family Peer Support Services:* SLCO does great work in supporting families to help youth and families to access the support they need to be successful in treatment and their community. SLCO offers family peer support services (FPS) provided by Family Resource Facilitators (FRF) through local referrals. FPS are additionally offered for community referrals and for families who are unfunded.

It is recommended that SLCO explore avenues to increase FPS as there has been a decrease in provided services. It is also recommended that SLCO review family peer support charting

internally to improve training on content and consistency of notes. DSAMH additionally encourages SLCo to provide ongoing training to clinical teams on family peer support services and the opportunities it has to support clinical progress.

FY20 Division Comments:

- 1) *Continuum of Care:* SLCo offers a vast continuum of services to support children and families. SLCo contracts with providers to offer services including: mobile crisis; inpatient, residential and day treatment; in home, outpatient, and school based psychotherapy and prevention programs; community respite and emergency respite through Youth Services; and family peer support services to support youth and family needs. SLCo continues to actively seek additional agencies to contract with to enhance service delivery and access points for clients. SLCo seeks agencies to support cultural considerations in underserved populations, including LGBTQ and Latino groups.
- 2) *School Based Collaboration:* SLCo has continued to provide school based behavioral health services for youth and families throughout the County. Over the course of the past calendar year, SLCo has worked to improve their relationships with each of the five districts located in the County. SLCo meets regularly with representatives from each district and is actively working to increase access to behavioral health services through these partnerships.
- 3) *Early Childhood Services:* SLCo supports services for families with children ages 0-5 supporting 384 children within this age group. SLCo utilizes The Children's Center to provide a majority of the early childhood services. The Children's Center continues to improve their efforts to provide quality services and technical assistance for the State of Utah. SLCo is supporting their efforts to work with the Kem Gardner Institute to develop and implement an early childhood behavioral health study for the State of Utah.
- 4) *Children's Mental Health Court:* SLCo supports the Third District's Children's Care Court (C3 Court) run by Judge Knight. C3 Court is a strengths based, collaborative process for youth in Salt Lake County who have mental health treatment needs. C3 Court meets regularly to staff each of the youth involved with multiple other agencies and service providers, including Valley Behavioral Health, DCFS, SOC, and JJS. Family Resource Facilitators are used to engage both the families and youth involved in the process, which is often seen as one of the bigger challenges for each youth.

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 25th and 26th, 2020. The team consisted of Pam Bennett, Program Administrator, Pete Caldwell, Program Administrator, Sharon Cook, Program Administrator, Heather Rydalch, Program Manager and Mindy Leonard, 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 Alliance House, Denver Street, Odyssey House, and North Valley Fresh Start. During the site visit, the team discussed and reviewed the FY19 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 2019 Audit

FY19 Minor Non-compliance Issues:

- 1) *Coordinated Transitions*: Barriers to tracking unfunded individuals that are released on civil commitment were noted in the FY18 Monitoring Report as a Deficiency. Individuals with Medicaid funding are tracked by OptumHealth. Individuals released on civil commitment who are covered by private insurance (with or without combined Medicaid funding) have not been tracked consistently after discharge into the community. These issues impact the ability of individuals to remain stable in the community. After initial discussions with DSAMH, SLCo has determined that these individuals will be tracked at the County level. The primary ongoing issues include methodology for identifying these individuals and their outpatient provider.

This issue has been resolved. SLCHD has identified a dedicated team member who is tracking all individuals under civil commitment and assisted outpatient treatment court orders.

FY19 Deficiencies:

- 1) *Use of OQ as an Intervention*: The SLCo DBHS Monitoring Reports of OptumHealth Services FY16, FY17 and FY18 indicate that the OQ is not being used as a clinical intervention in treatment. A review of charts by DSAMH demonstrated that 45% (five of eleven) charts did not include the OQ as an intervention, which is a marked improvement from 69% (DSAMH findings in FY18) and 91% (SLCo findings in FY18).

This issue has not been resolved and will be continued for FY20; see Deficiency #1.

- 2) *SLCo/OptumHealth's Provider Charting (Goals/Objectives)*: This finding has been addressed in previous years, and charts continue to have insufficient documentation including issues with assessments, absence of goals and objectives, and inadequate treatment plans. Seven of fourteen charts (50%) reviewed did not have measurable goals. This is an

improvement from DSAMH monitoring findings in FY18 (62%) and SLCo monitoring findings in FY18 (77%).

This issue has not been resolved and will be continued for FY20; see Deficiency #2.

- 3) *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). The average number of days on the discharge list has improved from 102 (FY17) to 79.3 (FY18). Two individuals with extended time on the list due to complex histories were discharged in FY18. When outliers are removed, the average length of time is 43 days on the list (FY17 and FY18).

This issue has been improved and will be continued in FY20 as a recommendation; see Recommendation #1.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

None

FY20 Deficiencies:

- 1) *Use of the OQ as an Intervention:* The SLCo DBHS Monitoring Reports of OptumHealth Services FY17, FY18 and FY19 indicate that the OQ is not being used as a clinical intervention in treatment. A review of charts by DSAMH demonstrated that 6 of 10 charts did not include the 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. Salt Lake County and OptumHealth noted a higher rate of noncompliance (83%) in the SLCo Monitoring Report of Optum/Mental Health Services FY19, and they are encouraged to continue the training as described in that report.

County's Response and Corrective Action Plan:

Action Plan: Of the 14 charts selected for the adult mental health audit, only 8 charts met the criteria for OQ administration. In one case, it was determined the questionnaires were deemed not clinically appropriate for the member and documented as such. Administration and implementation of the OQ questionnaires continues to increase and substantial improvement has

been noted over the past three years. Therefore, Optum SLCo will continue to offer annual provider trainings related to implementation of OQ® Measure questionnaires as mandated by DSAMH.

Timeline for compliance: Provider trainings were conducted in FY20 and will continue to be offered annually.

Person responsible for action plan: Brian Currie, LCSW (DBHS); Randy Dow, LCSW and Gina M. Attallah, LCSW (Optum)

2) *SLCo/OptumHealth's Provider Charting (Goals/Objectives)*: This finding has been addressed in previous years. Charts continue to have insufficient documentation, including issues with assessments, absence of goals and objectives, and inadequate treatment plans. Seven of fourteen charts (50%) reviewed did not have measurable goals, predominantly charts from smaller providers. Valley Behavioral Health demonstrated an improvement in documentation including measurable objectives. In accordance with Preferred Practice Guidelines and ongoing planning principles, short term goals/objectives are to be measurable, achievable and within a timeframe. Salt Lake County and OptumHealth are encouraged to review trainings related to measurable goals/objectives, and to continue efforts to ensure providers work with clients to create objectives that focus on discrete behavioral changes.

County's Response and Corrective Action Plan:

Action Plan: Optum trainings will continue to emphasize the requirements for measurable and attainable goals and objectives within treatment plans which guide treatment.

Optum offered a mandatory provider training for clinical supervisors/directors to stress the importance of measurable treatment objectives. The goal was to have these leaders help teach and monitor clinicians and to reinforce in practice. The mandatory training was held in January 2020 with free CEUs available and the trainings were in person. Future trainings related to treatment planning will continue to emphasize the SMART goal planning strategy.

Timeline for compliance: Completed January 2020. Future documentation trainings will continue to emphasize SMART goal planning strategy.

Person responsible for action plan: Brian Currie, LCSW (DBHS), Randy Dow, LCSW and Gina Attallah, LCSW (Optum)

FY20 Recommendations:

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). The average number of days on the discharge list through FY19 increased from 79 days (FY18) to 109 days (FY19). This includes 14 individuals with over

90 days on the discharge list due to complex histories, legal barriers and/or funding issues related to the need for disability-related services. Of note, 11 of those 14 individuals have been discharged within FY20. SLCo and Optum have participated at least monthly, and in some cases weekly, with the Utah State Hospital, DSAMH and the Salt Lake District Attorney, in efforts to address barriers and to facilitate discharge. It is recommended that Salt Lake County and Optum continue collaborative efforts so that patients ready for discharge are discharged from the USH within 30 days.

FY20 Division Comments:

- 1) *IPS Employment:* The Individual Placement and Support (IPS) evidence-based Supported Employment model has been implemented at Alliance House, First Step House and Volunteers of America (VOA) Cornerstone Counseling. All three IPS sites have received a baseline fidelity review (Alliance House- Fair, First Step House- High Good, and VOA Cornerstone Counseling- Exemplary). VOA Cornerstone is the first IPS site to achieve an Exemplary fidelity score at baseline. The three IPS sites continue to improve their employment services and have established employer and community partner relationships.
- 2) *Supportive Housing/Services:* The County has partnered with providers to increase housing and high intensity services for those living with mental illnesses in Salt Lake County. This includes Denver Street Apartments, First Step Housing, additional beds at local boarding homes and development of a Forensic Assertive Community Treatment (FACT) team.
- 3) *North Valley Behavioral Health (VBH) Fresh Start:* Fresh Start is a Valley Behavioral Health day treatment program run by Certified Peer Support Specialists (CPSS). Heather Rydalch, Peer Support Program Manager, and Sharon Cook, Program Administrator, met with three CPSS at Fresh Start. There are nine CPSS total working at Fresh Start, West Valley office and Valley Woods. The CPSSs run several groups, including a resume class and a fitness class that is held in Murray Park. At the beginning of each group everyone checks in and if there is a client struggling, they are able to receive crisis services right away. The program refers individuals to case managers and community vocational partners, including Vocational Rehabilitation and Department of Workforce Services. Fresh Start has an average of about 40 clients per day.
- 4) *Optum Peer Retraining Program:* Optum has developed an impressive and beneficial refresher course for CPSSs, and piloted the course with Odyssey House. This program fills a notable gap in the Peer Support program within the state, and results in better peer services to the individuals in treatment. The training includes a section on de-escalation that several of the CPSSs said has been very helpful. DSAMH would like to partner with Optum to provide this training statewide for all Peers who have certified for one year or longer.
- 5) *Odyssey House Integrated Services:* Odyssey House offers integrated care services to Odyssey House clients, referrals from community partners, and to people from the community. While the services don't line up specifically with any model of integrated care, the services offered are comprehensive and reflect the values of integrated care. The high level of support from the physicians is particularly commendable. The facility and close

proximity of behavioral health and physical health services also stands out as notable strengths of the integrated services.

- 6) *Alliance House*: Alliance House provides Supported Employment, Independent Employment and Transitional Employment services, and has achieved a "Fair" score on their baseline Individual Placement and Support (IPS) fidelity review. Alliance House worked to maintain engagement and connection with individuals in treatment during the pandemic, including virtual outreach and providing meals. This is particularly critical for those individuals who rely on the Clubhouse model for daily in-person support.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Salt Lake County Health Department (SLCHD) Prevention on February 25th, 2020. 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 2019 Audit

No findings were issued in FY19.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

None

FY20 Deficiencies:

- 1) The Eliminating Alcohol Sales to Youth (EASY) checks decreased from 424 to 286 checks from FY18 to FY19 respectively, which does not meet Division Directives. Local Authorities are required to increase EASY checks by at least one check each year.

County's Response and Corrective Action Plan:

Action Plan: With increased staffing, the Prevention team is able to allocate additional time to increasing EASY checks. Although the Prevention team does not have the authority to conduct EASY checks, we will work closely with police departments to support their EASY efforts. In FY20, SUD Prevention staff member Amber Lietz began reaching out to police departments in Salt Lake County to provide education and resources for EASY checks. She also attended two EASY trainings administered by the State. Support activities include building relationships with police departments to ensure they have the information and support needed to conduct EASY checks, assisting with CUBS so police departments do not have to conduct recruitment themselves, and connecting departments with training and resources. Amber will continue working with police departments to support their efforts with EASY checks.

Timeline for compliance: June 30, 2020

Person responsible for action plan: Austin Strebel for program oversight and Amber Lietz for implementation.

FY20 Recommendations:

- 1) *Staff Turnover:* There has been significant staff turnover over the past year on the prevention team, so SLCHD has been working on building capacity by hiring new staff and joining efforts with the Mental Health Team at the Department of Health. SLCHD was able to expand their team from two to four people and acquire two new Coalition Coordinators through working with the mental health coalition, Healthy Communities. It is recommended that SLCHD continue to work on building capacity on their team and seek guidance from their Regional Director as needed.

FY20 Division Comments:

- 1) *Collaboration:* There are several coalitions in the Salt Lake County Department of Health that have focused on substance use disorder (SUD) and mental health (MH) issues separately, so this past year, SLCHD and the MH Team (Healthy Communities) decided to work together on joint initiatives. They are planning to use risk and protective factors to develop strategies for their community. This partnership has helped increase capacity in their program and expanded several positive prevention efforts for their community.
- 2) *Comprehensive Prevention Services:* Salt Lake County currently provides a comprehensive array of prevention services ranging from early pregnancy programs to increased education for the elderly. They use tested, effective, best practice, evidence based programs as well as encourage other community-based organizations in their county to align with evidence-based community programs and processes such as Communities that Care (CTC) and Community Anti-Drug Coalitions of America (CADCA) models. Salt Lake County reports that these proven community centered prevention models are critical pieces toward the goal of reducing substance use and improving the quality of life for the citizens of Salt Lake County. They build community readiness and community capacity by leading their communities in learning about and supporting science based prevention.
- 3) *Building Capacity:* Coalitions are continually training individuals in prevention science, increasing stakeholder awareness, strengthening collaboration efforts, and how to prepare the prevention workforce. SLCHD also looks for opportunities to educate and network with the community. Each year their prevention staff provides several presentations as a way of raising readiness by discussing prevention. SLCHD reports that the ultimate aim of capacity building is to prevent the misuse of drugs by educating all members of the community to the science of prevention. One other change to Salt Lake's prevention services was a Drug Free Communities grant which was awarded to Kearns Evidence2Success Community Coalition. This four year grant has allowed this coalition to hire a full time Coalition Coordinator. In addition to this grant, two new coalitions were funded over the past year (Magna and Central 9th) which have helped expand prevention efforts in their communities.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the annual review of Salt Lake County Behavioral Health Services on February 25th, 2020. 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 2019 Audit

FY19 Deficiencies:

- 1) The Treatment Data Episode Set (TEDS) shows that 37.4% of the criminogenic risk data was not collected for adults compelled to treatment in a non-detox setting in the criminal justice system, which does not meet Division Directives. There can be only 10% or less of data not collected for adults compelled to treatment in the criminal justice system.

This issue has not been resolved and will be continued for FY20; see Deficiency #1.

- 2) *Old Open Admissions:* SLCo had a 6.4% old open admission rate, which does not meet the Division Directives. There can only be 4% or less of old open admissions.

This issue has not been resolved and will be continued for FY20; see Deficiency #2.

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

None

FY20 Deficiencies:

- 1) The Treatment Data Episode (TEDS) shows that 28.1% of criminogenic risk data for justice involved clients was not collected, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan: We were appreciative of DSAMH's guidance in the preceding year, that as long as a screen was captured at any point in an episode, it was valid and acceptable. This prevents repetitive criminogenic screenings as clients transition to other providers, or other levels of care. Unfortunately, this also provides an anomaly in data as this information is pulled. An additional concern is that this population is composed of both court-ordered individuals, and those without court orders, as providers aggressively work in concert with alternatives-to-incarceration efforts, engaging offenders in treatment prior to a court order being initiated (or in cases where the court order did not require treatment). It appears from the FY 19 Division Directives and JRI Certification guidelines (R523-4), that criminogenic risk screens are required only of those participating in mandatory treatment programs. We look to you for guidance on how to resolve this discrepancy in data, as these results are not being pulled from that population.

Timeline for compliance: TBD based on DSAMH's guidance

Person responsible for action plan: TBD based on DSAMH's guidance

- 2) SLCo had 4.5% of old open admissions, which does not meet Division Directives. There can only be 4% or less of old open admissions.

County's Response and Corrective Action Plan:

Action Plan: DBHS would like it noted that the number of open admissions for FY18 was 6.4%, so 4.5% represents a noted improvement in a system with multiple providers and the largest number of clients served within all the LMHAs. We will continue to produce and distribute Open client reports to providers and request that they close old open cases. As we run the reports, if a provider has demonstrated a higher than 4% rate of old open admissions, this will be included as a finding during the provider's annual audit. Additionally, VBH has had the highest volume of old open enrollments and they are working on getting these closed in FY20.

Timeline for compliance: Ongoing during FY21

Person responsible for action plan: Cory Westergard for the creation and distribution of the reports. Brian L. Currie for ensuring it is included within the audit reports.

FY20 Recommendations:

- 1) *Unfunded Resources:* SLCo reports that an area for improvement is to ensure that they are reaching everyone in need of services in their community. SLCo reports that there are residents in need of unfunded resources, but may not be aware of their treatment options. As the Salt Lake County population changes, there will also be a need for expanding services for diverse communities. It is recommended that SLCo continue to increase access to services for all individuals in their community.

FY20 Division Comments:

- 1) *Quality Assurance:* A strength of SLCo is in the utilization review process where they have the ability to provide agency and clinician specific training in real time to address concerns with documentation and client care issues. They also have the ability to understand the deficits of agencies and in some cases to hold funding until deficiencies are corrected. Optum also works closely with SLCo on the utilization review process by sharing their Audit results with them and joining SLCo at their Site Visits as needed. By doing this, they are able to provide a unified approach to the utilization process.
- 2) *Network of Services:* A major strength of SLCo is their network of contracted providers who are able to provide a wide-range of mental health and substance use disorder services to Medicaid and unfunded residents. Through their network model, they are able to capitalize on the expertise that is already present in their community, such as Impact Mental Health, a non-profit psychiatry clinic that partners with the University of Utah schools of psychiatry and nursing. Another strength of SLCo is their focus on problem-solving. From a macro level of solving systemic-level gaps to the individual-level of assisting residents struggling to get their needs met, their staff values open dialogue regarding their network of services and being the best public network of behavioral health care in their community.
- 3) *Medication Assisted Treatment (MAT):* SLCo offers MAT to their community through contracted providers such as Project Reality, Clinical Consultants and Odyssey House of Utah. They have also opened two new clinics in Murray and West Jordan and refer individuals for MAT services to other community providers as needed. SLCo has a Vivitrol Program where individuals receive a Vivitrol injection prior to their release from jail, which has been a successful project. SLCo recently opened a “Jail MAT Program,” which provides Methadone and other forms of MAT for incarcerated individuals, which have produced positive outcomes.

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:

Chad Carter  Date 07/08/2020
Chad Carter (Jul 8, 2020 11:11 MDT)
Auditor IV

Approved by:

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Kyle Larson (Jul 8, 2020 11:22 MDT)
Administrative Services Director

Eric Tadehara  Date 07/08/2020
Eric Tadehara (Jul 8, 2020 11:35 MDT)
Assistant Director Children's Behavioral Health

Kimberly Myers  Date 07/08/2020
Kim Myers (Jul 8, 2020 13:31 MDT)
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Brent Kelsey  Date 07/13/2020
Brent Kelsey (Jul 13, 2020 08:55 MDT)
Assistant Director Substance Abuse

Doug Thomas  Date 07/13/2020
Doug Thomas (Jul 13, 2020 16:50 MDT)
Division Director

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool

Name of Agency: Salt Lake County

Date: March 2, 2020

<i>Compliance Ratings</i>				
Y = Yes, the Contractor is in compliance with the requirements.				
P = Partial, the Contractor is in partial compliance with requirements; comments provided as suggestion to bring into compliance.				
N = No, the Contractor is not in compliance with the requirements.				
Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)			X	Need cover page
Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)			X	Need signature on plan
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)		X		Need title page
Record of changes (indicating when changes have been made and to which components of the plan)	X			
Record of distribution (individual internal and external recipients identified by organization and title)			X	Need distribution record
Table of contents			X	Need a table of contents
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan	X			
Functional Annex: The Continuity of Operations (COOP) Plan				
Essential functions and essential staff positions	X			
Continuity of leadership and orders of succession	X			
Leadership for incident response	X			
Alternative facilities (including the address of and directions/mileage to each)	X			
Planning Step				
Disaster planning team has been selected, to include all departments (i.e., safe/security, clinical			X	Need to identify individuals on the planning committee

services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)				
<p>The planning team has identified requirements for disaster planning for Residential/Housing services including:</p> <ul style="list-style-type: none"> ● Engineering maintenance ● Housekeeping services ● Food services ● Pharmacy services ● Transportation services ● Medical records 			X	Identify statement that contracted providers will ensure these needs are being met
The team has coordinated with others in the State and community.	X			

DSAMH is available for technical assistance if needed.