



State of Utah

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Governor

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Lieutenant Governor

Department of Human Services

ANN SILVERBERG WILLIAMSON
Executive Director

Division of Substance Abuse and Mental Health

DOUG THOMAS
Director

July 15, 2020

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

Dear Commissioner Thomas:

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

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

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

Sincerely,


Doug Thomas (Jul 27, 2020 19:06 MDT)

Doug Thomas
Division Director

Enclosure

cc: Gary Larcenaire, Director, Valley Behavioral Health

Marilyn K. Gillette, Tooele County Clerk
Teresa Winn, Valley Behavioral Health
Jeff Coombs, MPH Executive Director, Tooele County Health Department
Gary Dalton, Tooele County Behavioral Health Administrator



Annual Site Monitoring Report of
Tooele County / Valley Behavioral Health

Local Authority Contracts #160235 and #160236

Review Date: March 10th, 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 Tooele County – Valley Behavioral Health (also referred to in this report as Tooele-VBH or the Center) on March 10th, 2020. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

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

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

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance	None	
	Significant Non-Compliance	1	8-9
	Minor Non-Compliance	3	9-11
	Deficiency	None	
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	2	15-16
	Deficiency	2	16
<i>Adult Mental Health</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	2	20
	Deficiency	1	21
<i>Substance Abuse Prevention</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
<i>Substance Abuse Treatment</i>	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	3	27-28
	Deficiency	None	

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of Tooele County – Valley Behavioral Health (Tooele-VBH). The Governance and Fiscal Oversight section of the review was conducted on March 10th, 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. Meeting minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided by the governing board and County.

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

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

As required by the Local Authority, Tooele County received a single audit for the year ending December 31st, 2018 and submitted it to the Federal Audit Clearinghouse. The firm Larson and Company, PC completed the audit and issued a report dated June 18th, 2019. The auditor issued an unmodified opinion. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on Internal Control Over Financial Reporting and Compliance for Each Major Federal Program. As required by the State Compliance Audit Guide they also issued a report on Compliance and Internal Control Over Compliance. Two material weakness issues were reported as financial statement findings and one material weakness was reported as a State compliance finding. See Minor Non-compliance Issue #1 for more details.

The CPA firm Tanner LLC completed a single audit of Valley Behavioral Health for the year ending December 2018. The auditors issued an unmodified opinion on the financial statements in the Independent Auditor's Report dated May 29th, 2019. The SAPT Block Grant was selected as a major program for specific testing. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2019 Audit:

FY19 Significant Non-compliance Issues:

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

This issue has not been resolved, but has been improved and will be continued for FY20; see Significant Non-compliance Issue #1.

FY19 Minor Non-compliance Issues:

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

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

FY19 Deficiencies:

- 1) *Staff Turnover:* During 2018, Tooele-VBH has had an average count of 76 employees. During this period, they have had 32 employee separations and 29 new hires. Tooele-VBH experienced a 42% turnover rate for 2018. The United States Department of Labor - Bureau of Labor Statistics shows the average separations rate in the United States for Health Care and Social Assistance in 2017 was 33.2%. Turnover for

Tooele-VBH is higher than the national average, it is recommended that Tooele County and Tooele-VBH make the issue of turnover a high priority and look into the different factors that may be contributing to Tooele-VBH's high turnover rate.

This issue has not been resolved, but will not be continued in the FY20 report. The issue of turnover was analyzed only as part of the Special Audit conducted for Tooele-VBH in the previous year, it is not part of the standard monitoring process and will not continue to be addressed as a finding. Tooele County and Tooele-VBH is strongly urged to continue looking at the issue of turnover because of its negative impact on service quality.

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

- 1) In the single audit conducted for Tooele County, the auditors reported three material weakness issues; two were reported as financial statement findings:
 - *2018-A: Material Weakness in Reconciliation Process* - Tooele County does not have a formal process to ensure the preparation or accuracy of general ledger account reconciliation. Some sub-ledger accounts were not reconciled to the general ledger at year end. Reconciliations were not reviewed or approved by management.
 - *2018-B: Material Weakness in Journal Entry Process* - Tooele County did not retain documentation supporting certain journal entries by Tooele County personnel. Journal entries were not reviewed or approved by management.One material weakness was reported as a State compliance finding:
 - *2018-C: Material Weakness in Budgetary Compliance* - Expenditures exceeded the appropriated budget for multiple funds.

In the previous year, the single audit listed five material weakness issues. The most recent single audit dated June of 2019 reports two of these issues as being resolved; improvements have been made, but the material weakness issues still being reported are significant. Please provide a detailed action plan explaining what steps have been taken to resolve these issues and what steps Tooele County will be taking to be brought back into compliance with these findings.

County's Response and Corrective Action Plan:

Action Plan: On June 26, 2020 Larson and Company, PC, issued an independent audit report regarding the financial status of Tooele County for FY2019. Larson's report to the Tooele County Commission stated an "unqualified opinion". Tooele County through its Auditor's Office will continue to strengthen its controls and budgeting processes to mitigate or ensure that

the preparation, accuracy, review and approval of account approvals and reconciliations continue in place. Three areas of material weakness to be monitored will be:

*Material weakness in Reconciliation Process: Reconciliations will be reviewed and approved by management.

*Material weakness in Journal Entry Process: Journal entries will be reviewed and approved by management.

*Material weakness in Budgetary Compliance: Expenditures will be reviewed and approved by management so as to not exceed budgeted amounts.

Timeline for compliance: FY21; the County will review and comply throughout the fiscal year.

Person responsible for action plan: County Auditor, Alison McCoy

FY20 Minor Non-compliance Issues:

1) *Local Authority Compliance/ Oversight of Contracted Services:* As the Local Authority and recipient of State and Federal funds, Tooele County is responsible to be in compliance with Federal requirements and to appropriately monitor services provided by their contracted service provider. The following issues were found in the site visit, please provide an action plan detailing how Tooele County will be brought into compliance with each issue:

- Tooele County has created and filled a full time position that will be responsible for oversight over their contracted service providers, which is an improvement and a positive step towards better oversight. Last year it was discussed with Tooele County that they are required by contract to monitor their service provider and to provide a written report to DSAMH as part of annual monitoring. Although Tooele County has taken steps to provide better oversight, a written report was not completed for this year as discussed.
- It was found that Tooele County does not have a current contract in place with their service provider.
- Tooele County has not created a written Federal Awards policy as discussed in the previous year and required by 2 CFR 200.

County's Response and Corrective Action Plan:

Action Plan: (1) Tooele County is pleased with the selection of a Behavioral Health Administrator who can and will oversee the annual plan, the DSAMH contract, and the selection of a PMHP/MCO by November, 2020. The County is aware of its responsibility to monitor their service provider and subcontractors. Since September, 2019, the BHA has been engaged in meetings, reviews, discussions, and decision-making with the provider and allied resources. A 2019 written report was completed and discussed with Chad Carter. (2) One of the weaknesses in the past relationship of the County with VBH was the lack of a formal contract or MOU detailing respective duties and responsibilities. This lack of contract was allowed to 'fester' for over 20 yrs. Tooele County owns their lack of attention to this matter but hoped that the DSAMH would have cleared this hurdle in any one of their many audits of the provider in question. A transition MOU has been put into place until such time as a new MCO will be

contracted with by the County. (3) Tooele County has a written Federal Awards policy that will be approved and put into place July 21, 2020 and thanks Mr. Carter for his resourcefulness in providing Tooele County with the 'boilerplate' for such a policy.

Timeline for compliance: August 1, 2020

Person responsible for action plan: Gary K. Dalton Behavioral Health Administrator

2) *Background Checks:* During the review of personnel documentation, it was found that two of the selected files contained outdated and expired BCI background checks. Valley Behavioral Health has started a new process for completing these checks and ensuring they get approved, it appears that some may have fallen through the cracks with the new process.

County's Response and Corrective Action Plan:

VBH Response:

Action Plan:

VBH-TC uses Ultipro to track BCI compliance. Ultipro notifies HR and staff's direct Supervisor when BCI is in noncompliance. Currently all Tooele BCIs are in compliance

Timeline for compliance: Current

Action Plan: The expectation of Background Checks is acceptable to Tooele County. VBH will resolve this issue within FY21 with continuous monitoring and employment processing. The County BHA will review this issue on a quarterly basis with the provider.

Timeline for compliance: July---September, 2020

Person responsible for action plan: Teresa Winn, Lead and Gary K. Dalton

3) *Executive Travel:* Some issues were found during the review of executive travel packets: (one receipt used for a reimbursement was not itemized, one packet was missing an approval signature and one packet included expenses for two employees, but only included an approval sheet for one). Similar issues have been found in previous years during executive travel reviews. Valley Behavioral Health is considering switching to a per diem system, which the Division strongly recommends. This would simplify the process, set expected limits and help to avoid administrative errors like these.

County's Response and Corrective Action Plan:

VBH Response:

Action Plan: VBH-TC has adopted a written policy regarding this and has been provided to the Division.

Timeline for compliance: Completed

Action Plan: The expectation of Executive Travel being authorized and accounted for is important for Tooele County. VBH will resolve this issue within FY21 with continuous monitoring and by adopting the recommended per diem system. The County BHA will review this issue on a quarterly basis with the provider.

Timeline for compliance: July---September, 2020

Person responsible for action plan: Teresa Winn, Lead and Gary K. Dalton

FY20 Deficiencies:

None

FY20 Recommendations:

- 1) The Tooele-VBH 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 Tooele-VBH 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 adults, youth, and children of Utah.

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Tooele County – Valley Behavioral Health on March 10th, 2020. The monitoring team consisted of Mindy Leonard, Program Manager; and Heather Rydalch, Program Manager. 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 Fiscal Year 2019 audit findings and County responses; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention funding; 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 Significant Non-compliance Issues:

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

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

This issue has not been fully resolved and will continue as a minor finding in FY20; There was improvement in the frequency of the administration, however all reviewed charts lacked evidence of using the OQ in treatment. See Minor Non-compliance Issue #1.

FY19 Minor Non-compliance Issues:

- 1) *Community Engagement and Outreach:* DSAMH met with DCFS regarding community involvement. Community partners, including the Local Education Agency and private mental health agencies, have also communicated with DSAMH staff during the year to express concerns related to engagement and partnerships. Community partners voiced concerns regarding Tooele-VBH's ability to continue to nurture the partnerships because of recent policy changes within Tooele-VBH. Community partners stressed the

importance of Tooele-VBH having a strong presence in the community, as well as the vital role Tooele-VBH plays in the community as the community mental health center. Tooele-VBH has also experienced high turnover which has contributed to a lack of employees able to participate in community activities. In order to provide the level of oversight and coordination as required by Utah Code 62A-15-608 and DSAMH Division Directives, it is critical that Tooele-VBH continue to cultivate their community engagement and outreach.

This issue has been resolved for children and youth services. Community partners have reported better working partnerships with Tooele-VBH, with the recent example of Tooele-VBH's work in providing ongoing support for the Local Education Agency and others to help with a community wide event.

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

This issue has been resolved. Tooele-VBH has worked very hard to retain staff who provide children's services. The clinic has been fully staffed since November. Tooele-VBH has changed their pay structure to address staff turnover.

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

This issue has been resolved. Tooele-VBH utilized the correct forms for the juvenile civil commitment process as seen in the chart review process.

FY19 Deficiencies:

- 1) *High Fidelity Wraparound:* Kim Bartley, Family Coach, from Allies with Families reported, "I did not review any Wraparound charts because there were none available. One Family Resource Facilitators (FRF) is too new in her position to have any Wraparound families to complete documentation on, and the other two FRF's on site have not had any families opt in to the Wraparound Process. Additional coaching on engaging potential Wraparound families and orienting them to the process has already been discussed in regards to this issue and the FRF's are working on getting families involved in the Wraparound Process." The Division Directives state "Local Authorities

shall utilize Wraparound Facilitation” which is conducted by the FRF. It is recommended that Tooele-VBH work with the Coach and Allies with Families to ensure High Fidelity Wraparound is being completed by FRFs to provide intensive, collaborative services for children, youth, and families.

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) *Youth Outcome Questionnaire (YOQ) Administration and Use as an Intervention:* A review of the charts indicated that seven of the seven charts did not have evidence that the YOQ was utilized in the treatment process. Division Directives state that the YOQ be “shared with the client and incorporated into the clinical process.” The YOQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. Appropriate use of the OQ as an intervention has been demonstrated to improve treatment outcomes.

County’s Response and Corrective Action Plan:

Action Plan:

VBH-TC's Attending Clinician and/or Clinical Director, will conduct a training for OQ/YOQ administration by August 1, 2020. The training will include the frequency of distribution, how to document that a OQ/YOQ was administered in the charts, discussing the OQ/YOQ with client, and how to use the OQ/YOQ in treatment planning.

Timeline for compliance: August 1, 2020

Person responsible for action plan: Stephen Palmer, Julie Winn

- 2) *Substance Abuse Mental Health Information System (SAMHIS) OQ Match:* The percentage of clients that match SAMHIS is required to be at least 90%. The FY19 Youth Mental Health scorecard indicates that Tooele-VBH had a match rate of 80.8%, a lower rate than FY18 (rate-97.8%). DSAMH requires that Tooele-VBH resolve data entry issues and ensure the match rate improves to at least 90%.

County’s Response and Corrective Action Plan:

Action Plan:

VBH-TC's leadership team will working with the data analytics team to identify data entry issues realted to OQ/YOQ and resolve the issues. VBH-TC leadership will reach out to DSAMH for assistance if needed. The team will meet prior to August 1, 2020 to identify issues

Timeline for compliance: August 1, 2020

Person responsible for action plan: Julie Winn, Teresa Winn

FY20 Deficiencies:

- 1) *Strength Based Assessments:* Two of the seven charts reviewed had no indication of an assessment being completed. Per division directives, “Each client shall have a strength-based assessment (please note that when the client is a minor, the word client also refers to the parent/guardian/family). At a minimum, assessments, planning and treatment shall comply with the Medicaid Provider Manual and current Administrative Rule as described in R523.” An assessment is required in order to structure appropriate treatment planning, goals, and objectives.

County’s Response and Corrective Action Plan:

Action Plan:

VBH-TC Attending Clinician and/or Clinical Director will retrain staff on the requiement of having an assessment completed for all client and that they need to be update yearly. The Attending Clinician and/or Clinical Director will be pulling a weekly tableau report to make sure charts are in compliance. Training will occur prior to August 1, 2020 and tracking is ongoing.

Timeline for compliance: August 1, 2020

Person responsible for action plan: Stephen Palmer, Julie Winn

- 2) *High Fidelity Wraparound and Family Resource Facilitation:* Tooele-VBH is not utilizing their Family Resource Facilitators (FRFs) in the High Fidelity Wraparound process. There was a large drop in families served with High Fidelity Wraparound from FY18 (82 families) to FY19 (46 families). The Division Directives state “Local Authorities shall utilize Wraparound Facilitation” which is conducted by the FRF. It is recommended that Tooele-VBH continue to work with the FRF Coach and Allies with Families to ensure High Fidelity Wraparound is being completed by FRFs to provide intensive, collaborative services for children, youth, and families.

County’s Response and Corrective Action Plan:

Action Plan:

VBH-TC children's clinical and operations team met with Allies with Families to discuss FRF and High Fidelity Wraparound in Tooele. A plan will be created to increase FRF services and get families involved in High Fidelity Wraparound.

Timeline for compliance: FRF is currently furloughed. Will complete within 1 month of return.

Person responsible for action plan: Teresa Winn

FY20 Recommendations:

- 1) *Respite Services:* It is recommended that Tooele-VBH work with DSAMH to provide more appropriate respite services for families and youth. Tooele-VBH requested technical assistance regarding appropriate use cases of respite services.

FY20 Division Comments:

- 1) *Children's Services:* Tooele-VBH is moving all of their children's services into the same facility as the adult services. Tooele-VBH is being proactive and mindful in ensuring the children's services are separated from the adult services, including creating a separate children's entrance. Tooele-VBH reports services will continue with no lapse for children or families.
- 2) *Crisis Response:* Tooele County recently experienced a crisis that impacted the entire community. Tooele-VBH utilized their crisis team to actively engage with those in need throughout the county. They quickly responded and provided resources for those impacted, while working with local and state partners, including DSAMH, local law enforcement, and Tooele County School District.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Tooele County – Valley Behavioral Health on March 10th, 2020. The team included Mindy Leonard, Program Manager and Heather Rydalch, Program Manager. The review included the following areas: Discussions with clinical supervisors and management teams, record reviews, site visits to administrative offices, and on-site visits with the Tooele County Jail and Adult Probation and Parole. During the discussions, the team reviewed the FY19 audit; statistics, including the Mental Health Scorecard; area plans; Outcome Questionnaires and the center’s provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2019 Audit

FY19 Significant Non-compliance Issues:

- 1) *Safety Planning*: During the chart reviews, safety plans were present in six of the ten charts reviewed (60%). One chart indicated a need for a safety plan that was not available in the chart. Safety plan documentation continues to be inadequate. DSAMH Division Directives require that records contain a safety/crisis plan when clinically indicated. At a minimum, safety plans should include warning signs, coping strategies, specific identified support people, and methods to keep the environment safe. Added training on safety plan intervention was a recommendation in both the FY17 and FY18 Monitoring Reports.

This issue has been resolved and will no longer be treated as a finding. There was one chart of the seven reviewed that required and did not have a safety plan. A recommendation related to the safety plan training has been made; see Recommendation #1.

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

This issue has been resolved and will no longer be treated as a finding. Only one of the charts lacked consistent OQs as mandated by the Division Directives. A recommendation related to the OQ training has been made; see Recommendation #1.

FY19 Minor Non-compliance Issues:

- 1) *Community Engagement and Outreach:* Community partners continue to express frustration with Tooele-VBH engagement and outreach. Community partners stressed the vital role Tooele-VBH plays in the community as the County Mental Health Center, and the importance of having Tooele-VBH provide a strong presence in the community. In order to have the level of oversight and coordination as required by Utah Code 17-43-301 and DSAMH Division Directives, it is critical that Tooele-VBH cultivate their community engagement and outreach with partners, including state and county agencies, those engaged in recovery services such as housing and employment, and service providers.

This issue has not been resolved and will continue in FY20; see Minor Non-compliance Issue #1.

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

This issue has been resolved. The Tooele staff has been continuous for the last six months, the clinical director is dedicated to retention and continuity. Valley has implemented a pay structure to assist with keeping quality employees. There is a recommendation related to this topic; see Recommendation #2.

FY19 Deficiencies:

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

This issue has not been resolved and will be continued in FY20; see Minor Non-compliance Issue #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) *Community Engagement and Outreach:* DSAMH placed a call to Tooele-VBH to speak to agency Leadership due to a community situation. After being placed on hold several times, DSAMH staff were informed that there wasn't anyone available and no one knew when they would return. Voice messages were left but not returned. A second set of phone calls were attempted and again there was no agency Leadership available. DSAMH staff were finally routed to a second support staff, and the call went to voicemail. In addition to this example, community partners continue to express frustration with Tooele-VBH engagement and outreach. Community partners stressed the vital role Tooele-VBH plays in the community as the County Mental Health Center, and the importance of having Tooele-VBH provide a strong presence in the community. In order to have the level of oversight and coordination as required by Utah Code 17-43-301 and DSAMH Division Directives, it is critical that Tooele-VBH cultivate their community engagement and outreach with partners, including state and county agencies, those engaged in recovery services such as housing and employment, and service providers.

County's Response and Corrective Action Plan:

Action Plan:
 VBH-TC leadership will be creating a "contact tree" and train all clinical, operations, and support staff on the "contact tree" to make sure that community partner can speak to agency leadership. Training will be conducted by August 1, 2020
Timeline for compliance: August 1, 2020
Person responsible for action plan: Steve Barrett Teresa Winn

- 2) *Substance Abuse Mental Health Information System (SAMHIS) OQ Match:* The percentage of clients that match SAMHIS is required to be at least 90%. The FY19 Adult Mental Health scorecard indicates that Tooele-VBH had a match rate of 76%, a lower rate than FY18 (rate-81.9%). DSAMH requires that Tooele-VBH resolve data entry issues and ensure the match rate improves to at least 90%.

County's Response and Corrective Action Plan:

Action Plan:
 VBH-TC leadership team will working with the data analytics team to identify data entry issues realted to OQ/YOQ and resolve the issues. Valley-TC leadership will reach out to DSAMH for assistance if needed. The team will meet prior to August 1, 2020 to identify issues
Timeline for compliance: August 1, 2020
Person responsible for action plan: Julie Winn, Teresa Winn, Steve Barrett

FY20 Deficiencies:

- 1) *Strength Based Assessments:* One of the seven charts reviewed had no indication of an assessment being completed. Per Division Directives, each client shall have a strength-based assessment. At a minimum, assessments, planning and treatment shall comply with the Medicaid Provider Manual and current Administrative Rule as described in R523. Treatment options cannot be addressed if there is no evidence of an assessment being completed. Tooele-VBH also indicated that contracted providers have not been handing in their assessments.

County's Response and Corrective Action Plan:

Action Plan:

VBH-TC Attending Clinician and/or Clinical Director will retrain staff on the requirement of having an assessment completed for all client and that they need to be update yearly. The Attending Clinician and/or Clinical Director will be pulling a weekly tableau report to make sure charts are in compliance. Training will occur prior to August 1, 2020 and tracking is ongoing.

Timeline for compliance: August 1, 2020

Person responsible for action plan: Stephen Palmer, Julie Winn

FY20 Recommendations:

- 1) *Provision of Training:* Tooele-VBH provided training through the Valley University to address issues with safety planning, OQ administration and clinical use. While these measures improved, the training for OQs and YOQs were 15 minutes each. The safety plan training was 30 minutes long (adult unit) and 20 minutes long (children's unit). It's not likely the necessary content could be covered in such a short period of time. For example, the shorter state-recommended training for safety plans is 3 hours. It is recommended that the trainings be expanded to include all the required information, with evaluation to measure increase in knowledge, and follow-up during supervision to ensure staff develop a complete understanding of the topics being addressed.
- 2) *Continuity of Care:* It was stated during the audit that Tooele-VBH is fully staffed. However, staff was decreased dramatically when the pandemic started. It is recommended that Tooele-VBH re-engage staff as soon as possible, as the pandemic is having a dramatic, negative impact on clients. Tooele-VBH should review policies and other factors related to turnover in order to stabilize staff. This may include receiving direction from other rural Local Authorities.
- 3) *Holistic Approach to Wellness:* Division Directives indicate that Local Authorities will promote integrated programs that address an individual's substance use disorder, mental health, intellectual/developmental disabilities, physical health, and criminal risk factors as described in UCA 62A-15-103(2)(vi). Ten of ten charts were missing information that is important to providing a holistic approach including the following: ten charts did not include the primary care provider information, six charts did not document whether the individual used nicotine, and eight charts did not address physical health or how to improve it. DSAMH recommends that Tooele-VBH work with staff to develop a holistic approach to client care.

- 4) *Fidelity Measures:* Tooele-VBH has not implemented a system to ensure that therapy is being provided to fidelity. It is suggested that the clinical team utilize on-line resources for fidelity tools to help with monitoring evidence-based practices to fidelity. In addition, scheduled observation with feedback focused on technique and outcomes should be implemented, to ensure therapists are improving skills for treatment modalities.

FY20 Division Comments:

- 1) *Feedback from Individuals in Treatment:* DSAMH Peer Support Program Manager, Heather Rydalch, attended lunch at New Reflections House and then met with three clients. One client said her treatment is going very well. She used to be shy and now she is able to do public speaking. She is more social now, not isolating, and has made new friends. Another client said that one of his goals is just coming to New Reflections House and he enjoys it. Clients take a walk before noon or exercise in the exercise room to stay healthy. They have been offered Tobacco Cessation classes and report that the classes have helped to cut down on tobacco use.
- 2) *Certified Peer Support Specialists (CPSS):* DSAMH Peer Support Program Manager, Heather Rydalch, met with one CPSS and one Family Resource Facilitator (FRF). Tooele currently has one FRF, one CPSS at the Food Bank, and one CPSS that primarily works in the Tooele County Detention Center. They are hiring one more full-time CPSS, but have had some struggles to find a qualified applicant. The CPSS said she sees the hope that she gives to the individuals that are incarcerated. She stated, “It has changed my life and it keeps me sober”. Some of the Peer-led groups in the jail are: Relapse Prevention, Relationships, Men’s Group and Women’s Group. Peer Support also attends court with clients; they think it is beneficial and the judges like it.
- 3) *Transitions:* Due to some changes in services that are taking place, many of the services are transitioning to other providers. During this transition, Tooele-VBH is working to ensure that clients do not lose recovery services during transitions, including services provided by the Tooele Food Bank and the domestic violence shelter.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Tooele Valley Behavioral Health on March 10th, 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

FY19 Deficiencies:

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

This issue has been resolved. In FY19, three Eliminating Alcohol to Youth (EASY) Checks were completed, which meets Division Directives.

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:

None

FY20 Recommendations:

- 1) *Community Assessment:* Tooele-VBH has not done a new assessment for their community yet, but are planning to do one this year. Their Data Workgroup will be meeting on March 19, 2020 to start working on this assessment. It is recommended the Tooele County work with their Prevention Regional Director for guidance and assistance with this assessment as needed.
- 2) *Organization Transition:* The Tooele-VBH Prevention Team will be moving to the Tooele County Health Department April 1, 2020. DSAMH is available to provide technical assistance if needed.

FY20 Division Comments:

- 1) *Capacity Building:* Tooele-VBH hired two full time prevention staff and one volunteer over the past year, which has allowed them to apply for grants to fund more projects and be more involved with community efforts. For example, they applied for the National Alliance for Mental Illness (NAMI) Prevention by Design Grant to focus on Depressive symptoms, which is one of the risk factors in their community. In addition, they were able to focus more on suicide prevention efforts as well. Tooele-VBH also received funding from the State Opioid Response (SOR) Grant to help fund various programs, such as the RAD Pack Youth Coalition and Wendover Prevention Group. These dollars were also used to fund community events and marketing efforts to recruit youth to coalitions. The Youth Coalition did a Legislative dinner last year where they presented on specific substances of concern in their community, which made a positive impact on the Legislators and public officials that attended this event.
- 2) *Coalitions:* Tooele County started two new coalitions in their community, one in Stansbury Park and the other in Grantsville. They now have five coalitions including Tooele City Communities that Care, Tooele Interagency Prevention Professionals (TIPP) and the Wendover Prevention Coalition. Tooele City, Grantsville and the Stansbury Park Coalitions operate on the Communities that Care (CTC) Model. The Wendover Prevention Coalition operates on the Strategic Prevention Framework (SPF) model and the TIPP Coalition is based loosely on the SPF model. Tooele-VBH is working with the TIPP Coalition to help them move more closely to a SPF model.
- 3) *Prime for Life:* Tooele-VBH is one of the few Local Authorities in Utah that are still providing Prime for Life Classes in-house. All four prevention team members are certified to teach Prime for Life and are providing classes every other month for youth and adults. They receive referrals from the court on a regular basis and have an average between nine to twelve students in their classes. They are teaching Prime for Life Classes that focus on alcohol and drug use, including a specialized class for Marijuana use. Tooele-VBH reports that they enjoy teaching the Prime for Life Class and seeing the positive results from this program.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Tooele County - Valley Behavioral Health Substance Use Disorders Treatment Program on March 10th, 2020, which focused on Substance Abuse Treatment (SAPT) Block Grant Compliance; Drug Court; clinical practice, compliance with contract requirements and DORA program compliance. Drug Court was evaluated through staff discussion, clinical records, and the Drug Court Scorecard. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to SAPT Block Grant requirements and contract requirements were evaluated by a review of policies and procedures in interviews with Tooele County staff. Treatment schedules, policies, and other documentation were reviewed. The Utah Substance Abuse Treatment Outcomes Measures Scorecard results were reviewed with Tooele County staff. Client satisfaction was measured by reviewing records and consumer satisfaction survey data. Finally, opiate use data and the year-end reports were reviewed and discussed .

Follow-up from Fiscal Year 2019 Audit

FY19 Minor Non-compliance Issues:

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

This issue has not been resolved and will be continued in FY20; see Minor Non-Compliance Issue #1.

- 2) The FY18 Substance Abuse Outcomes Measures Scorecard shows:
 - a) The percent of individuals that were employed from admission to discharge decreased from -1.7% in FY17 to -4.4% in FY18 respectively, which does not meet Division Directives.

This issue has not been resolved and will be continued in FY20; see Minor Non-Compliance Issue #2(a).

- b) Involvement in Social Recovery Supports decreased from 0.0% in FY17 to -12.2% in FY18 respectively, which does not meet Division Directives.

This issue has been resolved. Involvement in Social Recovery Support increased from -12.2% to 46.5% from the FY18 to FY19 respectively, which meets Division Directives.

- c) Criminal Justice Involvement decreased from admission to discharge, decreased from 57.3% in FY17 to - 9.8% in FY18 respectively, which does not meet Division Directives.

This issue has not been resolved and will be continued in FY20; see Minor Non-Compliance Issue #2(b).

- 3) The FY18 Consumer Satisfaction Survey shows:

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

This issue has been resolved. Youth (Family) Satisfaction Surveys - Positive Service Outcomes increased from 55% to 74% from the FY18 to FY19 respectively, which meets Division Directives.

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

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

This issue has not been resolved and will be continued in FY20; see Minor Non-Compliance Issue #3(a).

FY19 Deficiencies:

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

This issue has not been resolved and will be continued in FY20 as a finding; see Minor Non-Compliance Issue #3(b).

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

- 1) *Clinical Charts*: This is a continued finding from the previous year. There were improvements with group notes and recovery plan objectives, however, the charts were missing a Substance Use Disorder (SUD) Screening tool and ASAM Goals were not included in the Recovery Plan and Reviews. LSAA's should screen for substance use with a standardized SUD screening instrument to determine the severity of use and best course of treatment. ASAM Goals should be included in the Recovery Plan and Reviews. This should include: (1) identifying the ASAM Dimension that is the issue, (2) identifying the condition or issue that creates a high use/relapse potential, (3) and writing the objectives that move the individual towards resolving these issues or conditions. (*Chart #'s 1396710, 1690290, 1555690*).

County's Response and Corrective Action Plan:

Action Plan:

VBH-TC Attending Clinician and/or Clinical Director will identify a SUD screening tool and train staff on using the screening which will be used to screen for SUD. Staff will be retrain son the requiriement of having an ASAM completed for all client with an SUD disorder and how to use the ASAM dimensions in the treatment planning and goal creation process. The training will be completed by August 1, 2020

Timeline for compliance: August 1, 2020

Person responsible for action plan: Stephen Palmer, Julie Winn

- 2) The Treatment Outcomes Scorecard Shows:

- a) The percent of individuals that were employed from admission to discharge decreased from 4.4% to 0.0% from the FY18 to FY19 respectively, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan:

VBH-TC leadership team will identify where the employment information is being pulled to identify if this is a data entry issues, if so, the leadership team will retrain staff on how to input data at admission/discharge this will be completed by August 1, 2020. Valley-TC will also training staff to address employment issues in thearpy and look at create a social skills group related to seeking and keeping employment.

Timeline for compliance: August 1, 2020

Person responsible for action plan: Julie Winn, Teresa Winn, Steve Barrett

- b) Decreased Criminal Justice Involvement from admission to discharge moved from 9.8% to 11.3% respectively, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan:

VBH-TC leadership team will identify where the criminal justice involvement information is being pulled to identify if this is a data entry issues, if so, the leadership team will retrain staff on how to input data at admission/discharge this will be completed by August 1, 2020. VBH-TC will also training staff to address criminal justice involvement issues in therapy. The training will be completed by August 1, 2020. The leadership team will work with Data Analytics to create a report to pull the needed data to check for compliance.

Timeline for compliance: August 1, 2020

Person responsible for action plan: Julie Winn, Teresa Winn, Steve Barrett

3) Treatment Episode Data (TEDS) Data Shows:

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

County's Response and Corrective Action Plan:

Action Plan:

VBH-TC leadership team will work with Data Analytics on collecting and submitting TEDS data on MAT treatment.

Timeline for compliance: August 1, 2020

Person responsible for action plan: Julie Winn, Teresa Winn, Steve Barret

- b) Old open admissions in the FY19 was 4.7%, which is above the allowable amount of 4%, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan:

VBH-TC leadership team will continue to work with the treatment team on closing old open admissions. The team will be retrained on how to close the old admissions. The clinical director will pull a monthly tableau report to identify admissions that need to be closed.

Timeline for compliance: August 1, 2020

Person responsible for action plan: Julie Winn

FY20 Deficiencies:

None

FY20 Recommendations:

- 1) *Organization Transition:* Tooele County will be operating under the umbrella of an Accountable Care Organization (ACO) in the coming year. They reported that their goal is to ensure that this transition goes as smoothly as possible and that they continue to provide good client care during the process. It is recommended that Tooele County develops a plan for this transition to ensure that client services continue without interruption and crisis services are available as needed.

FY20 Division Comments:

- 1) *Continuum of Services:* Tooele-VBH offers a continuum of services for a wide array of individuals, including court ordered clients. They also have their own Drug Test Laboratory and provide a rapid turnaround for drug test results. Tooele-VBH is fully staffed, which has allowed them to increase services in their program. They revamped the groups and classes and how the Justice Reinvestment Investments (JRI) and Adult Probation and Parole (AP&P) programs run. They have twenty-nine new groups and are running six classes in the evening. They have gender responsive services, combined groups for men and women and have added a Moral Reconciliation Therapy Group as well. Tooele-VBH also has access to residential services for women and children through the Valley Phoenix Program.
- 2) *Drug Court:* Tooele-VBH increased their capacity in Drug Court from 55 to 75 clients. Tooele-VBH reports that their Drug Court Program has been going well, which consists of a supportive team that is invested in the well being of their clients. For example, AP&P has allowed clients to use an ankle monitor as a sanction rather than go to jail to avoid disrupting their treatment and employment. Tooele-VBH recently had a new Judge assigned to their Drug Court Program, which is receptive to feedback and supportive of their program. Tooele-VBH has five phases for their Drug Court Program. In phase five, clients teach classes, continue to take drug tests and stay involved in services, which provides them with support needed to successfully graduate from Drug Court. Tooele-VBH also has a Recovery Warriors Group that provides ongoing support for their clients.
- 3) *Crisis Intervention Team (CIT):* Tooele-VBH recently started a CIT Program in Tooele, which has partnered with the Sheriff's Office in Tooele City. Their CIT Team consists of three Regional Coordinators, two Sergeants and a staff member from Tooele-VBH. So far, they have trained and certified around 60 people from Summit County to Vernal. They were also able to certify the Tooele Crisis Team over the past year. Tooele-VBH reports that Ron Bruno, a CIT Leader in Salt Lake, was so impressed with the CIT accomplishments with Tooele-VBH that he has recommended that they take the lead in helping other rural communities set up CIT 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 the services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

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

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

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

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

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

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

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

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

Signature Page

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

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

The Division of Substance Abuse and Mental Health

Prepared by:


Chad Carter  Date 07/15/2020
Chad Carter (Jul 15, 2020 14:31 MDT)
Auditor IV

Approved by:

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Kyle Larson (Jul 15, 2020 16:59 MDT)
Administrative Services Director

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Eric Tadehara (Jul 16, 2020 09:41 MDT)
Assistant Director Children's Behavioral Health

Kimberly Myers  Date 07/16/2020
Kim Myers (Jul 16, 2020 09:52 MDT)
Assistant Director Mental Health

Brent Kelsey  Date 07/27/2020
Brent Kelsey (Jul 27, 2020 16:36 MDT)
Assistant Director Substance Abuse

Doug Thomas  Date 07/28/2020
Doug Thomas (Jul 27, 2020 19:06 MDT)
Division Director

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool

Name of Agency: Tooele Behavioral Health

Date: April 28, 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		BCP is in compliance; EAP indicates a draft plan which needs to be finalized
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 page, approval of plan and confirmation of its official status (on both EAP & BCP)
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)		X		Need to identify scheduled reviews for plan (on both EAP & BCP)
Record of changes (indicating when changes have been made and to which components of the plan)			X	Need place to identify changes to the plan, made by whom, and date of change (on both EAP & BCP)
Record of distribution (individual internal and external recipients identified by organization and title)			X	Need distribution record (on both EAP & BCP)
Table of contents	X			
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		1) Need to identify the methods for communicating changes and how staff are trained on BCP 2) Need to identify methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan on EAP
Functional Annex: The Continuity of Operations (COOP) Plan				
Essential functions and essential staff positions	X			
Continuity of leadership and orders of succession			X	Need order of succession (i.e., an organizational chart)
Leadership for incident response	X			

Alternative facilities (including the address of and directions/mileage to each)			X	Need to identify alternative facilities to be used, if needed.
Planning Step				
Disaster planning team has been selected, to include all areas (i.e., safe/security, clinical 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.)	X			
The planning team has identified requirements for disaster planning for Residential/Housing services including: <ul style="list-style-type: none"> ● Engineering maintenance ● Housekeeping services ● Food services ● Pharmacy services ● Transportation services ● Medical records 	X			
The team has coordinated with others in the State and community.	X			

DSAMH is happy to provide technical assistance.











DSAMH FY20 Monitoring Report - Tooele County


Final Audit Report

2020-07-28


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