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 Kelly Ovard at 385-310-5118.

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

Sincerely,

Brent Kelsey
Division Director

Enclosure

cc: Caroline Moreno, SUD Prevention Manager, Community Health, SLCo Health Department
    D. Angela Dunn, 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 Contract # A03082

Review Date: February 22, 2022

Final Report
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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 22, 2022. Due to current DSAMH policy, the audit was conducted remotely. 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

<table>
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<tr>
<th>Programs Reviewed</th>
<th>Level of Non-Compliance Issues</th>
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<td>Major Non-Compliance, Significant Non-Compliance, Minor Non-Compliance, Deficiency</td>
<td>None</td>
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<tr>
<td><strong>Substance Use Disorders Treatment</strong></td>
<td>Major Non-Compliance, Significant Non-Compliance, Minor Non-Compliance, Deficiency</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
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 22, 2022 by Kelly Ovard, Administrative Services Auditor IV. The audit was conducted remotely due to current DSAMH policy. 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 for MH services and an SUD cost report for DSAMH funding. 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 the Local 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 31, 2020 and submitted it to the Federal Audit Clearinghouse. The firm Squire and Company, PC completed the audit and issued a report dated June 25, 2021. The auditors’ opinion was unqualified stating that the financial statements present fairly, in all material aspects, the financial position of Salt Lake County and stated it was an unmodified or “clean” audit. 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 Coronavirus Relief Fund (21.019) was identified as a major program and was selected for additional testing. No findings or deficiencies were reported in the audit.
Follow-up from Fiscal Year 2021 Audit:

FY21 Deficiencies:
1) **Timely Billings** - SLCo Division of Behavioral Health Services (DBHS) has had an issue with submitting billings timely as required by contract. Local Authorities are required to submit each billing within 30 days, DBHS has submitted them at an average of 31 days throughout the FY21 audit period. The billing process should be reviewed to identify areas of improvement to be brought into compliance.

This issue has been resolved.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None

FY22 Recommendations:
1) The **SLCo emergency plan** was reviewed by Nichole Cunha, Program Administrator II 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.

FY22 Division Comments:
1) **Thank you** to the Salt Lake County Division of Behavioral Health Services for their help in uploading the audit data and documents in a timely manner. Your help was greatly appreciated.
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.
Combined Mental Health Programs

The Division of Substance Abuse and Mental Health, Mental Health Team conducted its annual monitoring review at Salt Lake County on February 22, 2022. Due to current DSAMH policy, the annual monitoring review was held virtually. Duplicate findings for Child, Youth and Family and Adult Mental Health have been combined below to provide clarity and avoid redundancy.

Combined Adult and Child, Youth and Family Mental Health

Follow-up from Fiscal Year 2021 Audit:

FY21 Deficiencies
1) Substance Abuse Mental Health Information System (SAMHIS) Match: The SLCo Adult and Youth OQ/YOQ match rate to submitted clients in SAMHIS is below the required standard of 90%, as stated on the FY20 Mental Health treatment scorecards for Adults (85.7%) and Youth (85.1%). It is to be noted that in FY21, SLCo, OptumHealth, OQ Measures, and DSAMH have worked to correct the match requirement so that the OQ medical record number matches the provider-submitted client identifier in SAMHIS. SLCo has worked with Optum to correct this misalignment. DSAMH is working to provide SLCo with a quarterly report to see when/if this misalignment occurs again.

This is resolved. The OQ match rate for Adult Mental Health SMI clients is 98.6%. The match rate for SED clients is 99.6%.

2) OQ/YOQ Administration and Use: DSAMH Division Directives require that the OQ, an evidence-based practice, be administered at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation. The data from the OQ/YOQ shall also be shared with the client and incorporated into the clinical process, as evidenced in the chart. The DSAMH FY20 site visit report indicated ongoing issues with administration and use of the OQ. This is supported by the SLCo Monitoring Report of Optum/Mental Health Services FY20. The report indicates that “77% (24 of 31) of the records reviewed did not document monthly OQ/YOQ administration and how it was used to inform treatment decisions.” It is recommended that OptumHealth review their training process and approach to address this ongoing finding.

This is not resolved. This continues to be a finding in the current year. See Combined Mental Health Deficiency #1.

3) SLCo/OptumHealth’s Provider Charting (Goals/Objectives): This is a continued finding from FY20. The SLCo Monitoring Report of Optum/Mental Health Services FY20 indicates noncompliance in goal and objective writing in the charts that were reviewed. “18 of 31 of the records reviewed contained objectives that were not behaviorally measurable, nor did they describe the desired outcome for the client” and “20 of 31 of the records reviewed did
not contain methods that were measurable, nor did they contain action verbs or identifiable outcomes.” The monitoring report indicates that this is an improvement from FY19 in which 87% of the charts had goals that were not measurable with identifiable outcomes. In accordance with the Preferred Practice Guidelines and ongoing planning principles, “short term goals/objectives are to be measurable, achievable and within a timeframe.” It is encouraged to review processes for training providers in the preferred practice of utilizing SMART goals: Specific, Measurable, Attainable, Relevant, and Time-based in treatment planning.

This finding is partially resolved. Review of the FY21 SLCo Monitoring Report of Optum/Mental Health Services determined there were no findings on measurable objectives. There was an improved finding on SMART goals (13 of 31 charts). This finding will move to Combined Recommendation #2, due to Optum’s commitment to focus on “back to basics” training for documentation standards in their network.

Findings for Fiscal Year 2022 Audit:

FY22 Deficiencies:
1) Outcome Questionnaire (OQ)/Youth Outcome Questionnaire (YOQ) Administration:
The FY21 review of both Optum and SLCo internal audits revealed the administration and use as a clinical intervention among network providers remains of concern at a system level.

a) The FY21 SLCo Monitoring Report of Optum/Mental Health Services found that 52% (16 of 31) of the records reviewed did not contain evidence that the OQ or YOQ were given at intake.
b) The FY21 SLCo Monitoring Report of Optum/Mental Health Services found that 77% (24 of 31) of the records reviewed did not contain evidence that the OQ/YOQ was administered monthly (at minimum).
c) The FY21 SLCo Monitoring Report of Optum/Mental Health Services found that 81% (25 of 31) of the records reviewed did not contain evidence that the OQ/YOQ was incorporated into the clinical process to inform treatment decisions.
d) The SLCo FY21 Reviews of providers for unfunded services found that 67% (6 of 9) agencies expected to complete the OQ/YOQ were not administering the tool at intake, and 100% (9 of 9) had reporting that the OQ/YOQ was not being consistently administered at regular intervals

While DSAMH recognizes the challenges of ensuring a large network of providers are in compliance with this requirement, the OQ/YOQ is an important tool in determining if clients are experiencing symptom reduction and recovery. DSAMH recognizes the efforts of Optum in regards to training on this tool, however notes that something is lost between training and clinical use across the system. DSAMH encourages Optum/SLCo to work with providers to identify and close this gap in learning to practice change. Of note, DSAMH appreciates efforts that Optum has made to work with OQ Analyst and request training-on-demand videos.
County’s Response and Corrective Action Plan:

*Note: The time period reviewed during this audit took place during the COVID pandemic. While providers quickly moved to offering services via telehealth, switching to remote OQ® and Y-OQ® administration with members then submitting the completed questionnaire remotely was an additional transition. The value of the questionnaires to monitor clients’ distress was encouraged and links were made to the OQ® Measures’ Team to support providers in this effort. Additional provider trainings were added in an attempt to train those who were new to OQ®.

**Action Plan:** Optum SLCo has developed reports for providers which identify client profiles with incorrect client identification numbers within the OQ® Analyst. Providers are instructed to update the Identification Numbers to improve the match rate. We are also developing another report to be sent to providers which identifies which individuals have received services but have no questionnaire in the OQ® Analyst. These reports will help Optum to identify providers who are not compliant with administering the questionnaires. Reports will be issued quarterly, though this will be evaluated throughout the process to determine if a different frequency is needed. Providers who are audited and found to not administer questionnaires and/or use the information from the Clinician Report in treatment planning will be required to attend an upcoming OQ® Training. In addition, these providers are also required to administer the questionnaires to current clients within 60 days or submit documentation indicating the justification when they are not using the tools.

**Timeline for compliance:** FY22

**Person responsible for action plan:** Cory Westergard (DBHS), Cynde Davis (Optum SLCo), Randy Dow (Optum SLCo) and Gina Attallah (Optum SLCo)

**Tracked at DSAMH by:** Mindy Leonard

**FY22 Recommendations:**

1) **SLCo Monitoring Report Process:** As recommended in FY21, the monitoring process should include tracking the age of the client during the internal chart review (e.g. 0-5, 5-17, 18+). This identification could support targeted training on best practices that may be lacking for specific age groups to ensure quality care (e.g. YOQ/OQ, assessment, safety planning, treatment and discharge planning, etc.). DSAMH commends the change in SLCo/OptumHealth monitoring process to separate OQ/YOQ administration from utilization as a clinical intervention as these are separate measures of compliance.

2) **Annual Monitoring:** DSAMH commends SLCo and Optum for the focused intentionality of their annual monitoring process with targeted training that includes all components of clinical work to ensure that clients are receiving quality services. There have been repeated issues with documentation across the providers that are reviewed each year. DSAMH encourages Optum to review their monitoring and training teams to assess whether the size of
the team can meet the extensive network needs. Ongoing training and monitoring are imperative to making improvements to repeated findings, such as those with clinical documentation standards.

**FY22 Division Comments:**

1) **Valley Behavioral Health (VBH) and Cultural Responsiveness:** DSAMH commends SLCo, and specifically VBH, for efforts to address diversity and equity. During the DSAMH needs assessment, VBH leadership provided answers that were in line with the vision of the assessment group, and the agency staff demonstrated an awareness of bias. VBH had designated space for youth of all ages, had HIPAA and privacy information that was easily accessible, and had items demonstrating diversity and cultural responsiveness in their public spaces.
Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Salt Lake County on February 22, 2021. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Leah Colburn, Program Administrator; Mindy Leonard, Program Manager; Tracy Johnson, Wraparound and Family Peer Support Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, program visits, and allied agency visits. During the discussion the team reviewed the FY21 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Peer Support, school based behavioral health and 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 2021 Audit

FY21 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 FY20. In FY17, 6,684 children and youth were served while only 4,819 children and youth were served in FY20, representing a 29% decrease in the number of youth who received services. To note its a 9.71% decrease from FY19 to FY20 in youth services.

DSAMH remains concerned about the continual trend of a reduction in clients served. 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 private mental health agencies, (3) a large number of youth with access to Employer-Sponsored Insurances, and (4) the impact of COVID-19 on services. 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.

It is recognized that the addition of Stabilization Mobile Response (SMR), Valley Behavioral Health’s recommitment to community mental health and the addition of other children's providers into the network, should have a positive impact on increased access for children's services. DSAMH encourages targeted engagement with the “provider network” to explore different approaches to engage with community and non-traditional partners to explore avenues to increase referral pathways for children's services. The DSAMH Children's Team is available for technical assistance, if desired.

There is continued concern for the decrease in youth served in SLCo. However, this trend appears to be slowing. Access to care in the county will be continued to be monitored. This finding will be decreased to a deficiency for FY22.
FY21 Deficiencies:
See Combined Mental Health section above

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
1) **Access to Care:** The number of youth served in SLCO from FY20 to FY21 showed a decrease of 5.3%. This decrease is not unexpected in FY21 due to the impacts of COVID-19, limited workforce capacity, and additional stakeholders engaging in youth behavioral health services. The percent decrease of clients served in SLCO is lower than the 9.71% decrease in the prior year. Due to this stabilization this finding has been decreased to a deficiency. DSAMH notes that OPTUM/SLCO has been working with their provider network to explore pathways to increase access for youth and families in the county. DSAMH will continue to monitor closely the trends in SLCO regarding youth accessing services, and will follow up mid year on this data to ensure that this youth in treatment data remains steady or increases.

County’s Response and Corrective Action Plan:

**Action Plan:** DBHS and Optum SLCo have collaborated on a flier to be distributed throughout Salt Lake County with information and resources for families to access services in their communities and prior to presentation in an emergency room. The flier is available in English and Spanish. Printed and electronic versions of the flier will be distributed before April 30, 2022.

The Optum SLCo Youth Care Coordinator continues to work directly with youth and their families to improve the transition from inpatient care to community-based treatment. The contacts with families are tracked and supports are offered to facilitate initial and continued engagement in treatment. Monthly reporting is provided to DBHS for this project and data related to follow-up after hospitalization is reviewed quarterly by the Optum Utilization Management Committee. Brian Currie is a member and participates in discussions regarding trends and outliers. Most recently, this committee is reviewing the outpatient providers offering follow-up care and the time between inpatient discharge and the initiation of outpatient medication management services. The data generated from the youth care coordinator will be
further evaluated in FY22 and used to drive efforts to support youth engagement in treatment services.

**Timeline for compliance:** April 30, 2022 and ongoing

**Person responsible for action plan:** Brian Currie (DBHS) and Gina Attallah (Optum SLCo)

**Tracked at DSAMH by:** Mindy Leonard

**FY22 Recommendations:**
See Combined Mental Health Recommendations above.

**FY22 Division Comments:**
1) **Youth Care Coordinator:** To better support the high acuity needs of youth in the community, Optum with support from SL Co hired a youth care coordinator. The primary role of this position is to engage in care coordination with Optum Medicaid non-DCFS youth under 18 years and/or their families with serious suicide attempts, multiple hospitalizations, and complex clinical situations to ensure adequate linkage to the most appropriate resources available to members in support of their mental health recovery and engagement in treatment. The coordinator also maintains relationships with hospitals, other providers, community resources, and families to ensure adequate linkage takes place for all families who have had a youth discharge from an acute inpatient hospital setting. This role has been instrumental in linking and supporting a warm hand off for families as they transition high need services. Optum reports they are collecting data regarding the impact of this role on the impact on recidivism and follow through with accessing community services post discharge. DSAMH would like to share that community partners statewide have reported they found value in this role and its impact on ease of coordination for youth in the SLCO area.

2) **Family Peer Support Services (FPSS):** SLCO leadership has an understanding of the value and role of FPSS to support youth and families in finding success. FY21 Scorecard indicates that the provision of FPSS maintained steady from the prior year (FY20/105 clients, FY21/104 clients). Recognizing that the closure of Allies with Families created a gap with FPSS coaching and ongoing training, DSAMH is available for technical assistance. DSAMH encourages SLCO to seek support to ensure that best practices in the provision of the service continues. DSAMH would like to recommend that SLCO explore opportunities to expand FPSS, and promote the services they provide through continued training for providers and community partners on FPSS and the impact this service has on youth and families.
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 22, 2022. The team consisted of Pam Bennett, Program Administrator, Heather Rydalch, Peer Support Program Manager and Mindy Leonard, Program Manager. The review included: internal audit reviews and discussions with management teams including Salt Lake County Division of Behavioral Health (SLCo) and OptumHealth, and interviews with representatives from multiple agencies. A site visit was also conducted virtually with Adult Mental Health Court. During the site visit, the team discussed and reviewed the FY21 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 2021 Audit

FY21 Deficiencies:
See Combined Mental Health section above

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies
See Combined Mental Health Deficiencies above.

FY22 Recommendations:
See Combined Mental Health Recommendations above.

FY22 Division Comments:

1) **Continuum of Care Expansion:** SLCo is notable for multiple efforts to expand the continuum of care for individuals with serious mental illness. Assertive Community Treatment (ACT) services increased by two additional teams in FY21, and now available from three providers. In addition, SLCo and Huntsman Mental Health Institute will be opening a no-refusal receiving center for individuals struggling with mental health and substance use issues, providing a critical diversion point for individuals who may otherwise be treated at an emergency room. SLCo also continues to expand housing, and programs that include housing, for individuals with serious mental illness. Odyssey House, Volunteers of America, and House of Hope are all actively developing and opening residential and housing
programs for high need individuals. This is remarkable growth, particularly in consideration of the two-year pandemic.

2) **Adult Mental Health (MH) Court**: Pam Bennett, Program Administrator, Heather Rydalch, Peer Support Program Manager, and Mindy Leonard, Program Manager, met with representatives from SLCo and Optum to review the Adult MH Court program. An OptumHealth care coordination specialist attends meetings to assist with appropriate program referrals, assist with access to treatment, and to work with the client as they transition across levels of care. An OptumHealth Certified Peer Support Specialist (CPSS) meets participants at court and coordinates follow up support. This arrangement is a significant improvement as referrals are more appropriate and participants receive immediate access to CPSS services.

3) **Peer Support Services (PSS)**: Heather Rydalch, Peer Support Program Manager, and Tracy Johnson, Wraparound and Family Peer Support Program Administrator met virtually with several Certified Peer Support Specialist (CPSS) and Family Peer Support Specialist (FPSS) supervisors working with CPSS and FPSS in the Salt Lake City area. Some agencies represented were Odyssey House, First Step House, Latino Behavioral Health Services, Volunteers of America (VOA), Clinical Consultants, and Multicultural Counseling Center. Everyone agreed that PSS are very beneficial to their agencies and to those in treatment receiving services. Peer Support Specialists “are able to engage with the clients”. Supervisors from First Step House mentioned that “PSS are impactful for those coming into treatment at reducing the numbers of those clients going AWOL, and keeping individuals engaged in treatment.” They also mentioned that they “would love to find a way to be able to bill for PSS because PSS helps individuals in long term recovery and staying engaged after treatment.” An individual from VOA commented that they are “grateful for our 6 CPSS, we need more. They play such a crucial role in building the community and healing.” One FPSS supervisor stated “having PSS makes us more rounded as an agency and makes a huge difference in the lives of families”.

4) **Participant Feedback**: Heather Rydalch, Peer Support Program Manager, met with three individuals at Alliance House who have a range of attendance from two to ten years. Participants emphasized that they enjoy learning skills such as food prep, as well as making new friends - “I have made three very close friends here that I can talk to anytime and go hang out with”. One member stated, “I have been to other Clubhouses and they are not the same as this one”. Another member stated, “It’s great to have somewhere to go and learn, and it gets me out of the house”.

Utah Department of Human Services, Division of Substance Abuse and Mental Health
Salt Lake County Division of Behavioral Health Services
FY2022 Monitoring Report
Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Salt Lake County Health Department (SLCHD) Prevention on February 22, 2021. 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 2021 Audit

There were no findings in the FY21 Audit.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None

FY22 Recommendations:

1) The **Eliminating Alcohol Sales to Youth (EASY) checks** decreased from 299 to 109 checks from FY20 to FY21 respectively, which does not meet Division Directives. The number of EASY Compliance Checks should increase by a minimum of at least one check each year.

FY22 Division Comments:

1) **Coalitions:** SLCHD is proud that all three of their evidence-based coalitions remained robust and engaged during FY21. While the county did not actively work with the coalitions on training, all of the coalitions stepped up during the COVID pandemic to ensure community needs were being met. Both Magna United Communities that Care (CTC) and Spy Hop CTC were able to progress through the CTC phases virtually, which is a significant accomplishment. Evidence2Success Kearns took an active role in their...
community and brought new projects and grants to the coalition as well as created new relationships with members of the community they have been working on for years.

2) **Coalition and Community Support:** SLCHD formed an internal Coalitions Team in FY21, uniting the evidence-based framework of the substance use disorder (SUD) coalitions with the Health Communities coalitions. Due to staff being reassigned to COVID duties, the goals of this team were put on hold for FY21. The purpose of this group is to build capacity for all coalitions within Salt Lake County. Some of the goals for this coalition include holding a quarterly meeting for all coalitions within the county, provide training and resources for all coalitions, introduce evidence-based frameworks and practices, and provide a place where coalitions throughout the county can network and discuss common challenges and successes. This team has reformed and is working on these goals in FY22.

3) **EASY Compliance Checks:** SLCHD hired Amber Lietz to provide technical assistance to local police departments in Salt Lake County. She also compiled a list of Cadets for police agencies to utilize so they didn’t have to recruit them on their own. She was redeployed to COVID duties for the majority of FY21 and was unable to provide as much assistance and time to the EASY compliance checks. However, since she was taken off COVID duties, she has put a lot of effort into getting EASY compliance checks back on track and has a plan to increase numbers in FY22. SLCHD has made a concerted effort to build partnerships and statewide relationships, which has helped improve efforts with EASY Compliance Checks in their community.
Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the annual review of Salt Lake County Behavioral Health Services (DBHS) on February 23, 2021. The visit focused on Substance Abuse Prevention and Treatment (SAPT) block grant compliance, compliance with Division Directives and Contracts, DBHS’ 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 DBHS’ audit reports. Compliance with Division Directives was evaluated by reviewing DBHS’ audit instruments and procedures, reviewing provider contracts, comparing program outcome measures against DSAMH standards and visits with DBHS’ agencies’ staff members. Monitoring of clinical practices was evaluated by reviewing DBHS’ audit reports, audit instruments, procedures and discussions with staff responsible for the audits of contracted providers.

Follow-up from Fiscal Year 2021 Audit

FY21 Deficiencies:

1) The Treatment Data Episode (TEDS) shows that 16.9% of criminogenic risk data for justice involved clients was not collected, which does not meet Division Directives.

The Treatment Data Episode (TEDS) in FY21 shows that 4.1% of criminogenic risk data for justice involved clients was not collected, which meets Division Directives.

This issue has been resolved.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues
None

FY22 Deficiencies:
None

FY22 Recommendations:
1) Workforce Recruitment / Retention: Workforce capacity continues to be an issue in Salt Lake County and across the state, which impacts services. DBHS has worked
tirelessly on educating and advocating for a multipronged approach to recruiting and retaining staff. The 2022 general session will bring opportunities for increasing slots in universities, loan repayment programs for those willing to work three years in the public system, scholarships and additional bills targeted to ease this shortage. It is recommended that DBHS continue to work on methods of staff recruitment and retention.

**FY22 Division Comments:**

1) **New Residential / Housing Programs:** DBHS has supported the House of Hope in starting a housing program, recently purchased through American Rescue Plan Act (ARPA) dollars. The project is anticipated to house up to 13 women, including women with children. The property has been purchased, renovations have begun, and the licensing and contracting process is currently underway. Placements are anticipated to begin in February or March. The DBHS program manager has been integral to this project, and will continue to oversee and support this effort. DBHS has continued to support Volunteers of America (VOA) as they start the Theodora Housing project. This project, when it opens, will provide up to 14 housing units for female Salt Lake County residents who are clients of the VOA Assertive Community Treatment (ACT) team. The women are usually transitioning out of the State Hospital or other inpatient setting, or on some occasions are at-risk of inpatient hospitalization. Rental assistance and Medicaid supportive living rates are provided. DBHS also continues to support Odyssey House in their efforts to open another 16-bed men’s mental health residential program.

2) **COVID Pandemic:** The COVID pandemic has impacted services in Salt Lake County in various ways. Though most of the kinks have been worked out, there are various issues that continue to come up which DBHS handles. DBHS has done everything to help the providers serve clients and remain open, which they will continue doing. Their role to the providers has consisted mostly of ensuring that they have the necessary personal protective equipment (PPE) and rapid test kits to serve clients in their facility, especially in residential facilities. They have also been connecting them with resources through the county Health Department and reporting weekly to county leadership on provider challenges and needs. DBHS is committed to continuing to support their providers through the pandemic to ensure that they are able to provide services in their community.

3) **Community Partnerships:** DBHS is planning to expand their Top Ten Program, staffing frequently booked individuals with behavioral health conditions, to soon include Salt Lake City PD’s Top 20 list. This effort has many challenges, one being that some of these individuals are in need of Division of Services for People with Disabilities (DSPD) services, with a dim outlook on receiving these services due to the long wait list at the state level. DBHS continues to work with the Huntsman Mental Health Institute (HMHI) and private donors in the building of a new state of the art non-refusal Receiving Center that will allow individuals in crisis to receive mental health and/or substance use disorder services and allow law enforcement and other emergency responders to bring individuals directly to these services, rather than jails or hospitals.
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 Kelly Ovard at 385-310-5118.

The Division of Substance Abuse and Mental Health

Prepared by:

Kelly Ovard  ___________________________  Date 04/12/2022
Administrative Services Auditor IV

Approved by:

Kyle Larson  ___________________________  Date 04/12/2022
Administrative Services Director

Eric Tadehara  ___________________________  Date 04/13/2022
Assistant Director

Brent Kelsey  ___________________________  Date 04/12/2022
Director
### Compliance Ratings

Y = Yes, the Contractor is in compliance with the requirements.

P = Partial, the Contractor is in partial compliance with requirements; comments provided as a suggestion to bring into compliance.

N = No, the Contractor is not in compliance with the requirements.

<table>
<thead>
<tr>
<th>Monitoring Activity</th>
<th>Compliance</th>
<th>Comments</th>
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<tbody>
<tr>
<td></td>
<td>Y</td>
<td>P</td>
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<tr>
<td><strong>Preface</strong></td>
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<tr>
<td>Cover page (title, date, and facility covered by the plan)</td>
<td>X</td>
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<tr>
<td>Confirmation of the plan’s official status (i.e., signature page, date approved)</td>
<td>X</td>
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<tr>
<td>Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)</td>
<td>X</td>
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<tr>
<td>Method of distribution to appropriate parties (i.e. employees, members of the board, etc.)</td>
<td>X</td>
<td>Need a distribution record (how and to whom)</td>
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<tr>
<td>Table of contents</td>
<td>X</td>
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<tr>
<td><strong>Basic Plan</strong></td>
<td></td>
<td></td>
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<tr>
<td>Statement of purpose and objectives</td>
<td>X</td>
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<tr>
<td>Summary information</td>
<td>X</td>
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<tr>
<td>Planning assumptions</td>
<td>X</td>
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<tr>
<td>Conditions under which the plan will be activated</td>
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<tr>
<td>Procedures for activating the plan</td>
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<td>Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan</td>
<td>X</td>
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<tr>
<td><strong>Functional Annex: The Continuity of Operations (COOP) Plan</strong> to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.</td>
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<td>List of essential functions and essential staff positions</td>
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<td>Identify continuity of leadership and orders of succession</td>
<td>X</td>
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<td>Identify leadership for incident response</td>
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<td>List alternative facilities (including the address of and directions/mileage to each)</td>
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<td>Communication procedures with staff, clients’ families, the State and community</td>
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<tr>
<td>Planning Step</td>
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<td>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.)</td>
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<tr>
<td>The planning team has identified requirements for disaster planning for Residential/Housing services including:</td>
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<td>● Engineering maintenance</td>
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<td>● Housekeeping services</td>
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<td>● Food services</td>
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<td>● Pharmacy services</td>
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<td>● Transportation services</td>
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<td>● Medical records (recovery and maintenance)</td>
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<td>● Evacuation procedures</td>
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<td>● Isolation/Quarantine procedures</td>
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<td>● Maintenance of required staffing ratios</td>
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<td>● Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic</td>
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Provide a statement that contracted providers will ensure these needs are being met for Residential/Housing services.

DSAMH is happy to provide technical assistance.