



State of Utah

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Department of Human Services

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Division of Substance Abuse and Mental Health
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Director

May 11, 2021

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

Dear Mayor Wilson:

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

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Kelly Ovard at 385-310-5118.

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

Sincerely,

A handwritten signature in blue ink that reads "DPAS".

Doug Thomas (May 11, 2021 17:00 MDT)

Doug Thomas
Division Director

Enclosure

cc: Caroline Moreno, SUD Prevention Bureau Manager, Community Health, Salt Lake County Health Department
Gary Edwards, Director, Salt Lake County Health Department
Tim Whalen, Director, Salt Lake County Division of Behavioral Health Services
Karen Crompton, Department Director, Salt Lake County Human Services



Site Monitoring Report of

Salt Lake County
Division of Behavioral Health Services and
Health Department

Local Authority Contracts #160237 and #160424

Review Date: February 23, 2021

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 23, 2021. Due to Covid-19 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

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	9
<i>Combined Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 3	12-14
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	17-18
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	26

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 23, 2021 by Kelly Ovard, Administrative Services Auditor IV. The audit was conducted remotely due to the Covid-19 pandemic. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Client fees were reviewed for consistency and adherence to approved fee schedules. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained.

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

Mental health and substance use disorder services are contracted to outside providers. SLCo must ensure that subcontractors comply with all provisions listed in the DHS Contract with 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 31st, 2019 and submitted it to the Federal Audit Clearinghouse. The firm Squire and Company, PC completed the audit and issued a report dated June 24, 2020. The auditors' opinion was unqualified stating that the financial statements present fairly, in all material aspects, the financial position of Salt Lake County. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on internal control over financial reporting and compliance for each major Federal program. The SAPT Block Grant and the Opioid STR Grant were both identified as major programs and were selected for additional testing. No findings or deficiencies were reported in the audit.

Follow-up from Fiscal Year 2020 Audit:

FY20 Minor Non-compliance Issues:

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

This issue has been resolved.

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

This issue has been resolved.

FY20 Deficiencies:

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

This issue has been resolved.

Findings for Fiscal Year 2021 Audit:

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

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.

Center's Response and Corrective Action Plan:

Action Plan: Because calendar year-end billing always involves some additional delay as we close our books for the year, to ensure average billing is 30 days or less, DBHS will target submitting billing within 27 days or sooner all other months.

Timeline for compliance: Immediately

Person responsible for action plan: Zac Case

DSAMH Tracking by: Kelly Ovard

FY21 Recommendations:

- 1) There were several audits from Odyssey House and their Residential, Outpatient and Parents with Children programs, where the audit was completed but there were no responses entered from the subcontractor. The audits in question were conducted from November 2020 - January 2021 which are not in the period being audited. **In light of the Covid Pandemic and the extensive audits that DBHS completes on an annual basis, it is recommended that the correct timeframe audits are submitted or if newer audits, that the audit and findings are included.** The audits as is, are thorough, extensive and adequate for the audit.
- 2) The SLCo emergency plan was reviewed by Robert Snarr, Program Administrator and Geri Jardine, Program Support Specialist, as part of monitoring. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that SLCo review these suggestions and update their emergency plan accordingly. **There is one item that is not compliant and 2 items that are partially compliant.**

FY20 Division Comments:

- 1) **The payment files** were a great help to the audit. They were organized and easy to reference. The financial staff was great to work with and the process was quick. Thanks Ray, Zac and Marjeen for your help.

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 23 and 24, 2021. Due to COVID-19, 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

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.

Center's Response and Corrective Action Plan:

Action Plan: As indicated above, SLCo and Optum have developed a plan to monitor the member information in the encounter and the corresponding OQ Analyst data. Since providers can change the demographic information, this needs to be consistently updated. Providers are notified when the member profiles within the OQ Analyst do not align with the eligibility criteria, they are asked to reevaluate and update the information to match the member's Medicaid card. SLCo has requested a quarterly report from DSAMH mirroring the scorecard matching process which will be used to implement a process to address the mismatching.

Optum providers appreciate the benefits of the OQ Measures questionnaires, and some have chosen to purchase their own accounts. Subsequently, they can use the questionnaires for all served, including those only with commercial insurance plans. When they purchase their own account, more tools are available beyond those as part of the DSAMH account. Therefore, this member OQ data is not in the DSAMH OQ account for SLCo, thus it cannot be matched to the encounter data. DBHS and Optum would gladly engage in further discussion with DSAMH about how these situations can be managed or considered in scorecard calculations.

Timeline for compliance: Scorecard for FY21

Person responsible for action plan: Cory Westergard (DBHS) and Cynde Davis (Optum)

DSAMH Tracking by: Leah Colburn, Pam Bennett

- 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.

Center’s Response and Corrective Action Plan:

Action Plan: Due to the volume of providers in the Optum SLCo Network and the volume of clinical staff within those agencies, Optum has contacted OQ Measures to inquire about additional train-the-trainer sessions. More trainers offering more trainings throughout the year and within the larger agencies could improve the number of clinicians who understand how to administer questionnaires and how to implement the results in treatment planning. In the meantime, Optum will offer multiple sessions of both, Beginner and Advanced OQ Measures Trainings, two times each year vs. annually.

Timeline for compliance: FY22

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

DSAMH Tracking by: Pam Bennett

- 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.

Center’s Response and Corrective Action Plan:

Action Plan: A mandatory provider training was offered in April 2021 which covered utilizing the member’s voice in goal development and documenting objectives that are measurable and outcome driven. Those providers without SMART goals submitted a corrective action plan to address the deficiency, and monitoring will continue for those providers who have historically

had these issues. Optum and DBHS consistently monitor for measurable objectives during audits of providers. Training is offered onsite when treatment records are reviewed at the provider's location vs. a desk audit which has been the monitoring method during COVID.

A similar training will be offered in the fall of FY22.

Timeline for compliance: FY22

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

DSAMH Tracking by: Leah Colburn

FY21 Recommendations

- 1) *SLCo Monitoring Report Process:* It is recommended that the age of the client is indicated 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.). In review of the internal monitoring process, it is also recommended that SLCo/OptumHealth separate OQ/YOQ administration from utilization as a clinical intervention as these are separate measures of compliance.
- 2) *Discharge Planning:* It is recommended to review and revisit the importance of re-engagement, outreach, and discharge planning for clients within the provider network. In review of the SLCo Monitoring Report of Optum/Mental Health Services FY20, “71% (10 of 14) of the records did not adequately explain gaps in treatment or show evidence of outreach efforts to re-engage clients.” It was indicated that this was also an internal finding the year prior. Additionally, “80% (20 of 25) of the records reviewed did not document that discharge and continuing care planning was ongoing.” It is clinical best practice to complete and document outreach related to gaps in treatment, no-show appointments, and discharge planning in client care. With the additional challenges related to clients moving on and off different forms of Medicaid, discharge planning and outreach become a critical effort to ensure that seriously mentally ill (SMI) clients are not dropping off Medicaid or discontinuing services due to an exacerbation of symptoms.
- 3) *Diagnosis:* In review of the SLCo Monitoring Report of Optum/Mental Health Services FY20, “42% (13 of 31) of the records reviewed did not adequately substantiate the diagnosis in the record.” DSAMH appreciates the depth of chart review done during by the SLCo monitoring team, and the challenges of education across a large pool of providers. With this finding increasing in non-compliance from the previous year, it is recommended that there is a concerted effort to work with providers and review the importance of quality documentation related to diagnosis, as it is a key component of the clinical care process and “Golden Thread approach to documentation.”

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 23 and 24, 2021. Due to COVID-19, 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 FY20 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Resource Facilitation (Peer Support), High Fidelity Wraparound, 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 2020 Audit

FY20 Minor Non-compliance Issues:

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

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

* Published Children’s Mental Health Scorecard
 +Mental Health Early Intervention Reporting

DSAMH continues to recognize the systemic issues that may have contributed to the decreases in children and youth receiving services, including: (1) HB239 and the Juvenile

Justice Reforms, (2) increased school based providers including the Local Education Agencies, and (3) a large number of youth with access to Employer-Sponsored Insurances. Although these challenges exist, the continued decrease in the number of children and youth served is a trend that should be investigated as the number of youth in need grows each year.

This finding is continued as there is a continued significant drop in youth who receive services in SLCO. Due to COVID-19 and public health guidelines having possible impacts to ability to increase access to services over FY20, this will remain a minor non-compliance.

FY20 Deficiencies:

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

An internal review process of SLCO charts was completed for this annual monitoring. The internal review process indicated that 18 of 31 charts did not use measurable or outcome based objectives. This issue has not been resolved and will be continued for FY21; see Mental Health Program Deficiencies #3 above.

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

An internal review process of SLCO charts was completed for this annual monitoring. The internal review process indicated that 24 of 31 charts did document use of YOQ/OQ and its incorporation into treatment. This issue has not been resolved and will be continued for FY21; see Mental Health Program Deficiencies #2 above.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

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.

Center's Response and Corrective Action Plan:

Action Plan: During an Optum Provider Advisory Committee meeting in FY22, DSAMH CYF Team will be invited to present information regarding DSAMH concerns about the ongoing decrease in service access and to share methods to engage those in the community who may be unaware of the agency. It would be helpful if DSAMH could share data which related to the decrease in service access over time, relative to Medicaid eligibility and Unfunded status, as well as based on latency age and older youth. This information would help providers to target untapped groups/partners in their community who could benefit from behavioral health services.

Optum will collaborate with DBHS to create a marketing tool for providers to physically or electronically post and/or distribute to their community partners which guides youth and families to phone numbers and web pages where they can learn more about available services.

Timeline for compliance: FY22

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

DSAMH Tracking by: Leah Colburn

FY21 Deficiencies:

See Combined Mental Health section above

FY21 Recommendations:

See Combined Mental Health section above

FY21 Division Comments:

- 1) *COVID-19 response:* SLCO was able to prepare and transition their provider network (117 providers) to telehealth/telephonic services at the start of the COVID-19 pandemic to allow for continuity of care among clients. Providers were provided with training through Optum on billing and compliance to support service provision. Optum also worked to help keep providers “whole” fiscally if an agency was unable to provide clinical services/programming with the same manner due to public health guidelines. Providers within the Optum network, specifically those providing services for in-home, school-based, day treatment and congregate care settings, were able to creatively work to maintain access to treatment both in person and through virtual platforms.
- 2) *School based services:* It is recognized there are changes in school based services utilization across the county. SLCO met with the five local education agencies (LEA) throughout FY20 to work towards smoother coordination of services between the LEAs and community mental health providers. This has resulted in greater communication and understanding between the LEAs and SLCO DBHS related to funding and access. Three agencies, Odyssey House, Hopeful Beginnings, and Project Connection have increased access to behavioral health services for youth and families in schools across the SLCO through expanding partnerships in the LEAs they work with.
- 3) *Care Coordination:* Optum has recently added a youth care coordination position to support high level transitions of care for its youth members and their families. This position is a liaison for the families and service providers to support ensuring that youth receive the appropriate follow up care following discharge. DSAMH is hopeful that this role will help support high acuity youth across the county to ensure they get the proper follow through of care as they transition from high acuity placements to community based programming.
- 4) *Family Resource Facilitation/Family Peer Support Specialists:* Salt Lake County had a decrease in families served with family peer support services (FY19 329 families, FY20 291 families). While it was identified that due to the public health guidelines stemming from the COVID-19 pandemic that the role and responsibilities of the FPSS was shifted to meet other needs in the community and at their agencies, it is encouraged that efforts are focused on

returning FPSS to their roles in providing family peer support. It is recommended to review this service to identify and rectify barriers, including referral pathways to providing Family Peer Support. We encourage a review of the agencies that FPSS are assigned to, to ensure that access to these services is achievable for mental health providers within the county, as peer support is an important part of the continuum of services. Additionally, with a long time peer support supervisor retiring it is encouraged to seek technical assistance from both Allies with Families and DSAMH in supporting training the replacement.

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 23rd and 24th, 2021. The team consisted of Pam Bennett, Program Administrator, LeAnne Huff, Program Administrator, Heather Rydalch, Program Manager and Mindy Leonard, Program Manager. The review included: record reviews, and discussions with clinical supervisors and management teams, including Salt Lake County Division of Behavioral Health (SLCo), OptumHealth, and multiple providers and community partnerships throughout the County. Site visits were conducted virtually with Odyssey House Women's Residential Program, Fourth Street Clinic, Recovery International FACT team, Multicultural Counseling Center and Valley Behavioral Health. During the site visit, the team discussed and reviewed the FY20 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 2020 Audit

FY20 Deficiencies:

- 1) *Use of the OQ as an Intervention:* The SLCo DBHS Monitoring Reports of OptumHealth Services FY17, FY18 and FY19 indicate that the OQ is not being used as a clinical intervention in treatment. A review of charts by DSAMH demonstrated that 6 of 10 charts did not include the OQ as an intervention. Division Directives require that data from the OQ shall also be shared with the client and incorporated into the clinical process, as evidenced in the chart. The OQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. Salt Lake County and OptumHealth noted a higher rate of noncompliance (83%) in the SLCo Monitoring Report of Optum/Mental Health Services FY19, and they are encouraged to continue the training as described in that report.

This issue has not been resolved and will be continued for FY21; see Combined Mental Health Program Deficiencies #2 above.

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

This issue has not been resolved and will be continued for FY21; see Combined Mental Health Program Deficiencies #3 above.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

FY21 Deficiencies:

See Combined Mental Health section above

FY21 Recommendations:

See Combined Mental Health section above

FY21 Division Comments:

- 1) *Recovery International Forensic Assertive Community Treatment (Forensic ACT) Team:* DSAMH commends SLCo for the development of a Forensic ACT team, an essential partner in the continuum of care for SMI individuals with criminal justice involvement. The team provides wrap-around services for those who are high-need, including those who are returning to the community from incarceration or the Utah State Hospital. The Forensic ACT team is often a critical component in the ability of the individual to maintain stability and avoid a return to a higher level of care.
- 2) *Integrated Services:* Salt Lake County (SLCo) faces unique challenges to integration due to the size and nature of service provision in the county. As a result, SLCo falls at a Level 2 on the Standard Framework for Levels of Integrated Healthcare. On the scale, Level 2 is categorized as basic collaboration at a distance. This is supported by the provided examples of Odyssey House integrated services not being co-located, Optum arranging meetings to create an overall care plan for complex behavioral and physical healthcare needs, and a lack of standard screening and procedures to identify and provide integrated services, among others. There are opportunities for strong integrated services at the provider level, demonstrated by Odyssey House and Fourth Street Clinic. Using the service structure and outcomes from Odyssey House and Fourth Street Clinic to guide other agencies toward the successful implementation of integrated care services is recommended.
- 3) *Cultural and Linguistic Responsiveness:* The Cultural Responsiveness Committee (CRC) in SLCo meets quarterly and is focused on training needs. The CRC has offered training

to establish a foundation, and are now encouraging providers to conduct an internal cultural responsiveness assessment. SLCo and OptumHealth are commended for including community stakeholders on the CRC, and for attempts to systematically address change across their system.

- 4) *Multicultural Counseling Center (MCC)*: MCC provides bilingual mental health services in SLCo including peer support services (PSS). The agency has focused on hiring diverse Peers, and providing more targeted PSS which allows for different types of healing. They report - “it is empowering to share your story, to tell them that you made it and they can too, to share resources that you have found that will help others. Mental health is so isolating and it helps clients to know that they are not alone.”
- 5) *Fourth Street Clinic*: The Federally Qualified Health Center (FQHC) functions as the health home to 5,000 people per year, providing medical, dental, case management services, mental health/substance use disorder, and transportation services in one location. Among the array of care provided, Fourth Street Clinic has a mobile health clinic and will be adding behavioral health treatment to primary care services offered by the mobile team. The street medicine team works with community partners to assist individuals outside the clinic, including those placed in hotels. The FQHC office adapted and was able to continue a majority of services during the pandemic by moving into tents outdoors. DSAMH commends the Fourth Street Clinic for adjusting over the past year and offering comprehensive services to some of the most vulnerable and disenfranchised individuals in Salt Lake County.
- 6) *Participant Feedback*: Individuals in treatment that receive Peer Support services (PSS) have expressed gratitude for the unique support provided by PSS. A few examples: “Over the last several months my experience with the peer support and [Recovery International] staff has changed my outlook in life, and with the positive reinforcement coupled with medication management. The peer support team has a way of accepting and encouraging us, no matter where we start: homeless, incarcerated or struggling with self-medication” and “You have no idea how [PSS] help me when they tell me their story. It helps me to know in my heart that I can change my life for a better and healthy life. I always look forward to their visits.”

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Salt Lake County Health Department (SLCHD) Prevention on February 23rd, 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 2020 Audit

FY20 Deficiencies:

- 1) The Eliminating Alcohol Sales to Youth (EASY) checks decreased from 424 to 286 checks from FY18 to FY19 respectively, which does not meet Division Directives. The number of EASY Compliance Checks should increase by a minimum of at least one check each year.

The number of EASY Compliance checks increased from 286 to 299 from the FY19 to FY20 respectively, which meets Division Directives.

This issue has been resolved.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

FY21 Deficiencies:

None

FY21 Recommendations:

- 1) SLCHD did not complete a community readiness assessment for their local area last year. It is recommended that they SLCHD work with their Prevention Regional Director to complete a community readiness assessment this year.

FY21 Division Comments:

- 1) **Increased Capacity:** SLCHD has been able to offer prevention of marijuana, tobacco, and other drug grants to partners in the community. One of their Communities that Care (CTC) Coalitions, Kearns E2S, was also a grant recipient. SLCHD also received State Opioid Response (SOR) dollars this year in order to maintain their current subcontracted amounts after the SAPT Block Grant dollars had a minor budget cut. SLCHD meets monthly with their Provider Service Network to ensure all providers are working together on prevention efforts. SLCHD also provides training during meeting times. The Provider Service Network consists of their subcontractors and coalitions, where attendance is required. SLCHD coalitions have also been able to engage stakeholders and provide the community board orientation.
- 2) **Community and Cares Coalitions (CTC):** The Magna CTC and Salt Lake City CTC were both trained in the CTC model in November 2019. The Magna CTC coordinator also attended the Community Anti-Drug Coalitions of America (CADCA) Leadership Forum in 2020. SLCHD has been working with the Murray School district partners for prevention coalition to move it toward a CTC model, but due to staff changes at Murray school district and COVID these efforts have been paused. SLCHD also has been working internally at the Health Department to create a team to focus on coalitions across all disciplines. This has also been paused due to COVID responsibilities.
- 3) **Fidelity Checks -** SLCHD just started doing their own fidelity checks in the Fiscal Year 2021. Before that, their subcontractors were responsible for conducting their own fidelity checks. SLCHD has also been participating in the provider's Site Visits to assist with this process as well. SLCHD feels that it is best practice to take the lead on providing fidelity checks for their subcontractors, which has also been helpful to providers. SLCHD developed a general fidelity checklist, which they are using for their fidelity checks. The checklist will also help with contract compliance.
- 4) **Scorecard:** The 2020 Prevention Scorecard identifies that none of the 24 communities identified in the SLCHD geographic catchment area have completed a community readiness assessment. DSAMH recommends that SLCHD work with local communities to complete this process. DSAMH is available to provide technical assistance if needed.

Substance Use Disorder Treatment

Becky King, Program Administrator, conducted the annual review of Salt Lake County Behavioral Health Services (DBHS) on February 24th, 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 2020 Audit

FY20 Deficiencies:

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

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.

This issue has not been resolved, which will be addressed in Deficiency #1 below.

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

DBHS had 3.1% of old open admissions, which meets Division Directives.

This issue has been resolved.

Findings for Fiscal Year 2021 Audit:

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

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.

Center’s Response and Corrective Action Plan:

Action Plan: With DSAMH’s clarification that consented or verified scores from outside partners being valid and acceptable, our criminogenic risk assessment “not collected” percentage has improved by 12% from the prior year. To further improve and comply with the DSAMH requirement we are sending monthly data reports per agency for SUD enrolled adult justice involved clients when this element is “not collected”. We are also utilizing internal reports per agency for our Quality Assurance and Utilization management team to be reviewed and investigated for compliance throughout the year.

Though efforts will never stop being made, with a contracted network of providers utilizing multiple funding sources (some outside of the purview of DSAMH and DBHS, e.g., private insurance, TAM, ACO Medicaid, etc.), achieving DSAMH’s outcome target will continue to be difficult.

Timeline for compliance: FY22

Person responsible for action plan: Brian L. Currie and Cory Westergard

DSAMH Tracking by: Becky King

FY21 Recommendations:

- 1) **Access to Services:** A broad goal for DBHS is to work out their kinks in accessing services through the somewhat complicated Medicaid landscape. They are working on ensuring that their network providers are able to get contracted and paneled with the Accountable Care Organizations (ACOs). They are also assisting in the exchange of information between contracted providers, ACOs and Utah Medicaid to ensure that residents are able to access treatment and do not experience unnecessary treatment disruptions. DBHS is working on continuing to ensure that contracted providers are utilizing Medicaid to the fullest potential, and helping individuals determine how to enter treatment. It is recommended that DBHS continue to work with community partners to provide funding sources and access to quality services for residents in their community.

FY21 Division Comments:

- 1) **Continuum of Services:** One of DBHS’ strengths is their network of contracted providers who are able to provide the full spectrum of American Society of Addiction Medicine (ASAM) level of care services to their Medicaid and unfunded residents. A full continuum of

ASAM services are available for citizens of Salt Lake County. Salt Lake County DBHS and Optum SLCo share a network of providers which accommodates member insurance/payor changes between Legacy Medicaid to Unfunded with no disruption to treatment. Members are able to move through the ASAM levels of care based on need to support recovery.

- 2) **Problem Solving:** DBHS focuses on problem-solving. From a macro level of solving systemic-level gaps to the individual-level of assisting residents struggling to get their needs met, their staff values open dialogue about their network of services and striving to be the best public network of behavioral health care in their community.
- 3) **Tobacco / Nicotine Cessation:** Through our Provider Services Coordinating Council, DBHS provides education to providers about accessing Salt Lake County Health Department's Tobacco Prevention and Cessation Programs, including Quit Line support, resources, and free Nicotine Replacement Therapy medications. At the beginning of March 2021, Lauren Sackett-Syphus, LCSW (SLCo DBHS) and Lisa Hancock, BCJ, CPSS (Optum SLCo) will conduct Dimensions training for smoking cessation for SUD providers. Invitees are expected to provide the Dimensions curriculum to members at their agencies before June 30, 2021.
- 4) **COVID-19 Pandemic:** Providers have been impacted by the COVID-19 pandemic. They have been impacted by the reduction in court operations, a primary referral source for treatment; a decline in jail substance use disorder (SUD) programming as the census decreased to accommodate quarantine and isolation protocols; and a diminished capacity in behavioral health congregate settings such as SUD residential programs and social detoxification programs as they struggled to address COVID infection safety protocols. Immense efforts were undertaken in congregate settings to separate residents, acquiring additional space when able, referring to the county's quarantine and isolation facility as needed, deploying rapid testing kits provided by the county, all as they faced the additional struggle of maintaining workforce as staff became ill, too high risk to remain in certain positions or redeployed to work on ordering and disseminating personal protective equipment and rapid test kits. Despite the challenges of the COVID-19 pandemic, DBHS has continued providing quality services for their community.

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 05/11/2021
Administrative Services Auditor IV

Approved by:

Kyle Larson  Date 05/11/2021
Administrative Services Director

Eric Tadehara  Date 05/12/2021
Assistant Director Children's Behavioral Health

Kimberly Myers 
Kim Myers (May 12, 2021 10:12 MDT) Date 05/12/2021
Assistant Director Mental Health

Brent Kelsey 
Brent Kelsey (May 12, 2021 11:56 MDT) Date 05/12/2021
Assistant Director Substance Abuse

Doug Thomas 
Doug Thomas (May 11, 2021 17:00 MDT) Date 05/11/2021
Division Director

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY21

Name of Local Authority: Salt Lake County

Date: 3/2/2021

Reviewed by: Robert H. Snarr, MPA, LCMHC
Geri Jardine

<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 a 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			
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 name and signature on signatory page
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)	X			
Record of changes (indicating when changes have been made and to which components of the plan)	X			
Record of distribution (individual internal and external recipients identified by organization and title)			X	Need distribution record
Table of contents	X			
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan	X			
Functional Annex: The Continuity of Operations (COOP) Plan to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.				
List of essential functions and essential staff positions	X			
Identify continuity of leadership and orders of succession	X			
Identify leadership for incident response	X			
List alternative facilities (including the address of and directions/mileage to each)	X			

Communication procedures with staff, clients' families, the State and community	X			
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
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 (recovery and maintenance) ● Evacuation procedures ● Isolation/Quarantine procedures ● Maintenance of required staffing ratios ● Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic 		X		Provide a statement that contracted providers will ensure these needs are being met for Residential/Housing services.

DSAMH is happy to provide technical assistance.

DSAMH SLCO FY21 Final Report

Final Audit Report

2021-05-12

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