State of Utah

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Lieutenant Governor

Department of Human Services

TRACY S. GRUBER
Executive Director

Division of Substance Abuse and Mental Health
DOUG THOMAS
Director

June 10, 2021

James A Welch
Tooele County Manager
47 South Main
Tooele, UT 84074

Dear Mr. Welch:

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

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

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

Sincerely,

Doug Thomas (Jun 10, 2021 14:11 MDT)

Doug Thomas
Division Director

Enclosure
cc: Rebecca Brown, Interim Director, Valley Behavioral Health
Tracy Louma, Executive Director, Optum
Gina Attallah, Director of Compliance and Quality Improvement, Optum
Mark Schull, Program Manager, Optum
Teresa Winn,Valley Behavioral Health Operations Director
Gary Dalton, Tooele County Behavioral Health Administrator

utah department of
human services
SUBSTANCE ABUSE AND MENTAL HEALTH

Annual Site Monitoring Report of
Tooele County / Valley Behavioral Health

Local Authority Contracts #160235 and #160236

Review Date: April 13, 2021

Final Report

Table of Contents

Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Tooele County – Valley Behavioral Health (also referred to in this report as Tooele-VBH or the Center) on April 13, 2021. The review was conducted remotely due to the Covid 19 pandemic. 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)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	1	10-11
	Minor Non-Compliance	1	11-12
	Deficiency	2	12-13
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	2	16-17
	Deficiency	2	17-19
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	21-22
	Deficiency	2	22-23
Substance Abuse Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Substance Abuse Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	3	30-31
	Deficiency	None	

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of Tooele County – Valley Behavioral Health (Tooele-VBH). The Governance and Fiscal Oversight section of the review was conducted on April 13, 2021 by Kelly Ovard, Administrative Services Auditor IV. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Client fees were reviewed for consistency and adherence to approved fee schedules. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Meeting minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided by the governing board and County.

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

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

As required by the Local Authority, Tooele County received a single audit for the year ending December 31, 2019 and submitted it to the Federal Audit Clearinghouse. The firm Larson and Company, PC completed the audit and issued a report dated June 26, 2020. The auditor issued an unmodified opinion. In accordance with Government Auditing Standards and the OMB Compliance Supplement, the auditors also issued reports on Internal Control Over Financial Reporting and Compliance for Each Major Federal Program. As required by the State Compliance Audit Guide they also issued a report on Compliance and Internal Control Over Compliance. Two material weakness issues were reported as State Compliance Findings and one weakness was only partially resolved from the prior year's audit. See Minor Non-compliance Issue #1 for more details.

The CPA firm Tanner LLC completed a single audit of Valley Behavioral Health for the year ending December 31, 2019. The auditors issued an unmodified opinion on the financial statements in the Independent Auditor's Report dated May 29th, 2020. Block Grant for Prevention and Treatment of Substance Abuse was tested as a major program. No findings or deficiencies were reported in the audit.

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

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

   One material weakness was reported as a State compliance finding:
   - *2018-C: Material Weakness in Budgetary Compliance* - Expenditures exceeded the appropriated budget for multiple funds.

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

County's Response and Corrective Action Plan:

Action Plan: On June 26, 2020 Larson and Company, PC, issued an independent audit report regarding the financial status of Tooele County for FY2019. Larson's report to the Tooele County Commission stated an "unqualified opinion". Tooele County through its Auditor's Office will continue to strengthen its controls and budgeting processes to mitigate or ensure that the preparation, accuracy, review and approval of account approvals and reconciliations continue in place. Three areas of material weakness to be monitored will be:

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

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

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

Timeline for compliance: FY21; the County will review and comply throughout the fiscal year.
Person responsible for action plan: County Auditor, Alison McCoy

Partially resolved with new issues. See Significant Non-Compliance issues below.

FY20 Minor Non-compliance Issues:

1) *Local Authority Compliance/ Oversight of Contracted Services:* As the Local Authority and recipient of State and Federal funds, Tooele County is responsible to be in compliance with Federal requirements and to appropriately monitor services provided by their contracted service provider. The following issues were found in the site visit, please provide an action plan detailing how Tooele County will be brought into compliance with each issue:
   - Tooele County has created and filled a full time position that will be responsible for oversight over their contracted service providers, which is an improvement and a positive step towards better oversight. Last year it was discussed with Tooele County that they are required by contract to monitor their service provider and to provide a written report to DSAMH as part of annual monitoring. Although Tooele County has taken steps to provide better oversight, a written report was not completed for this year as discussed.
   - It was found that Tooele County does not have a current contract in place with their service provider.
   - Tooele County has not created a written Federal Awards policy as discussed in the previous year and required by 2 CFR 200.

County's Response and Corrective Action Plan:

Action Plan: (1) Tooele County is pleased with the selection of a Behavioral Health Administrator who can and will oversee the annual plan, the DSAMH contract, and the selection of a PMHP/MCO by November, 2020. The County is aware of its responsibility to monitor their service provider and subcontractors. Since September, 2019, the BHA has been engaged in meetings, reviews, discussions, and decision-making with the provider and allied resources. A 2019 written report was completed and discussed with Chad Carter. (2) One of the weaknesses in the past relationship of the County with VBH was the lack of a formal contract or MOU detailing respective duties and responsibilities. This lack of contract was allowed to 'fester' for over 20 yrs. Tooele County owns their lack of attention to this matter but hoped that the DSAMH would have cleared this hurdle in any one of their many audits of the provider in question. A transition MOU has been put into place until such time as a new MCO will be contracted with. (3) Tooele County has a written Federal Awards policy that will be approved and put into place July 21, 2020 and thanks to Mr. Carter for his resourcefulness in providing Tooele County with the 'boilerplate' for such a policy.

Timeline for compliance: August 1, 2020
Person responsible for action plan: Gary K. Dalton Behavioral Health Administrator

Partially Resolved see Minor Non-Compliance 2 below. Federal Awards Policy Provided.

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

This issue has been resolved.

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

This issue has been resolved.

FY20 Deficiencies:

None

FY20 Recommendations:

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

FY20 Division Comments:

None

<u>Findings for Fiscal Year 2021 Audit:</u>

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

1) In the single audit conducted for Tooele County, the auditors reported one material weakness issue; two issues were reported as financial statement findings, one was a carryover from the prior audit. (See Audit pages 143-144)

    a) *SC 2018-1: Material Weakness in Budgetary Compliance* - Expenditures exceeded the appropriated budget for multiple funds. This is an ongoing finding that has not been resolved to the auditors satisfaction. Although there are no

material budget overages, there were still some departments/funds in excess of budgeted appropriations. **This has continued to be an issue in the 2017, 2018 and now the 2019 audits.**

b) *SC 2019-1: General Unrestricted Fund Balance*: Tooele County's unrestricted general fund balance exceeded both an amount equal to 50% of the total revenues of the general fund and an amount equal to the estimated total revenues from property taxes for the current fiscal period.

c) *SC 2019-2: Budgetary Compliance:* Total expenditures exceeded the amounts appropriated in the final adopted budget for the following funds and department: Fund 21 (Human Service), and Fund 32 (MBA), as well as the Fund 10 Economic Development department. Expenditures were approved and posted which exceeded budgeted amounts.

County's Response and Corrective Action Plan:

Action Plan: (The response to this item was previously submitted on April 23, 2021, as requested.) The noted budget overages are a result of a prior accounting process wherein revenues and expenditures are netted to ensure that all funding is spent. The accounts in question were then reconciled and entered as a journal entry at the end of the year to properly reflect the revenues and expenditures. In the case of the two impacted funds, the revenues and expenditure overages were purely the result of an accounting function as the funding reported on the statements never actually flowed through to Tooele County; however the County does indirectly benefit. Management has now taken steps to desegregate these accounts during the initial recording of the transaction rather than at year end. This new policy will allow management to properly show actual revenues and expenditures and budget more appropriately in the future.

Timeline for compliance: December, 2021
Person responsible for action plan: Alison McCoy, County Auditor
DSAMH tracking by: Kelly Ovard

FY21 Minor Non-compliance Issues:

1) *Subcontractor Monitoring by County:* Tooele County did not provide a monitoring report for Valley Behavioral Health that was conducted between 7/1/19 and 6/30/20 or shortly after the end of the audit year. There should be a monitoring audit each year with its contracted provider. Since the audit year FY22 covering 7/1/20 to 6/30/21 will have 2 contracted providers (Valley 7/1/20 - 12/31/20 and OptumHealth (Optum) (1/1/21 -6/30/21), Tooele County will need to make sure they complete the monitoring process for both entities for FY21 which will be conducted in the FY22 audit.

County's Response and Corrective Action Plan:

Action Plan: Addendum 6/6/21: Tooele County has read the Division's concerns about an ongoing monitoring presence for both VBH and Optum because of the fiscal year overlap with each provider serving six months. Tooele County concurs that for FY22 it will monitor both entities for fiscal as well as programmatic fidelity.
Tooele County also accepts the following statement identifying the role of Optum in ensuring the managed services are effective going forward. Optum has already begun to manage the plan, and as such will monitor VBH moving forward. Optum and Tooele County will be responsible for formulating any CAPs to address the management of behavioral health services in Tooele County. VBH will not directly address DSAMH regarding any findings moving forward.
During the audit, Optum requested the opportunity to meet with Tooele County and DSAMH in FY22 to discuss a plan for monitoring Optum with a network of providers, unlike the other LMHAs.

Timeline for compliance: Monitoring of VBH by December, 2021; Monitoring of Optum by March, 2022 or First Quarter of FY22
Person responsible for action plan: Gary Dalton, Tracy Luoma, Gina Attallah and Jason Norwood
DSAMH tracking by: Kelly Ovard

FY21 Deficiencies:

1) *Turnover Issues:* There were 44 employees terminated between 7/1/19 and 6/30/20. The total number of current employees submitted was 87. That equates to roughly a 51% turnover rate. Some of this could be attributed to the changes with prevention, the food pantry and homeless units being transferred to the county. Nevertheless, Valley Behavioral Health continues to have turnover issues. This will need to be addressed by the County, Valley and OptumHealth before the next audit.

County's Response and Corrective Action Plan:

Action Plan: VBH reports they are currently exploring the staff turnover. Optum will meet with VBH Leadership to assess their ability to staff their current contracted services and efforts to retain employees and/or maintain needed staff.

Timeline for compliance: before August 1, 2021 (initial meeting)
Person responsible for action plan: Randy Dow
DSAMH tracking by: Kelly Ovard

2) *Subcontractor audits and SubContractor conflict of interest forms:* While there were annual audits of Valley's subcontractors, there were no summary narrative reports giving an accounting of the overall quality of charts, where the deficiencies lie and what improvements were recommended to the subcontractors. There was also no conflict of interest forms for any of Valley's Subcontractors. Tooele County, as the Local Authority, should put a plan in place going forward, to have its primary contract holder (OptumHealth) monitor all of it's Tooele County Subcontractors which includes annual conflict of interest forms, similar to what it does in other counties.

County's Response and Corrective Action Plan:

Action Plan: During the audit, Optum requested the opportunity to meet with Tooele County and DSAMH in FY22 to discuss a plan for monitoring Optum's network of providers. DSAMH agreed to a future discussion regarding an audit plan.

Regarding the Conflict of Interest Forms for Subcontractors, Optum will distribute the Forms to the in-network providers for completion, no later than July 1, 2021.

Timeline for compliance: First Quarter FY22
Person responsible for action plan: Gary Dalton, Tracy Luoma, Gina Attallah and Jason Norwood
DSAMH tracking by: Kelly Ovard

FY21 Recommendations:

1) The Tooele-VBH emergency plan was reviewed by Robert Snarr, Program Administrator and Geri Jardine, Program Support Specialist, as part of monitoring. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. **It is recommended that Tooele-VBH review these suggestions and update their emergency plan accordingly regarding any partial or non-compliance issues.**

FY21 Division Comments:

None

Mental Health Mandated Services
According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:
Inpatient Care
Residential Care
Outpatient Care
24-hour Emergency Services
Psychotropic Medication Management
Psychosocial Rehabilitation (including vocational training and skills development)
Case Management
Community Supports (including in-home services, housing, family support services, and respite services)
Consultation and Education Services
Services to persons incarcerated in a county jail or other county correctional facility

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

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

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

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review Tooele County – Valley Behavioral Health on April 13 and 14, 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 (Family 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.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:
None

FY20 Significant Non-compliance Issues:
None

FY20 Minor Non-compliance Issues:

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

   This finding will be reduced to a deficiency. Chart reviews indicate improvement in YOQ administration and use as intervention; see Deficiency #1

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

   This finding was not resolved and will continue in FY21 report; see Minor Non-Compliance #1.

FY20 Deficiencies:

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

This finding was not resolved and increased to a Minor Non-compliance Issue; see Minor non compliance #2.

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

This finding was not resolved and will remain a Deficiency. See Deficiency #2.

<u>Findings for Fiscal Year 2021 Audit</u>

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

1) *Substance Abuse Mental Health Information System (SAMHIS) OQ Match:* The percentage of clients that match SAMHIS is required to be at least 90%. The FY21 Youth Mental Health scorecard indicates that Tooele-VBH had a match rate of 82.5%, FY20 rate was 80.8%. DSAMH requires that Tooele-VBH resolve data entry issues and ensure the match rate improves to at least 90%.

County's Response and Corrective Action Plan:

Action Plan: All Optum providers will be required to use the OQ Analyst. This will be monitored through provider audits. In addition, the Optum Reporting and Analytics Team will pull down the DSAMH unmatched report and evaluate it against the data in the Optum

system on a quarterly basis. Missing/incorrect information will be identified, then Optum will work with the provider to make updates as needed.
*Tooele County Providers (other than VBH) did not gain access to the OQ Analyst until April 2021. Therefore, matching rates for the following year will likely be impacted.
Timeline for compliance: FY22
Person responsible for action plan: Gary Dalton, Cynde Davis, and Gina Attallah
DSAMH tracking by: Leah Colburn

2) *Strength Based Assessments:* Three of the ten charts reviewed had no indication of an assessment being completed. In FY20, two of nine charts did not have an assessment. An assessment is required in order to structure appropriate treatment planning, goals, and objectives. Per division directives, "Each client shall have a strength-based assessment (please note that when the client is a minor, the word client also refers to the parent/guardian/family). At a minimum, assessments, planning and treatment shall comply with the Medicaid Provider Manual and current Administrative Rule as described in R523."

County's Response and Corrective Action Plan:

Action Plan: Optum requires all Network providers to complete an assessment or to review a recently completed assessment by another behavioral health provider. If the latter is chosen, the provider must meet with the member in-person/via telehealth, and review to determine if they agree or disagree with the diagnoses and prescribed treatment. The provider's decision is to be documented and any clinical justification or any discrepancy is to be noted. Assessments from Optum providers will be included in the records requested for FY21 monitoring by DSAMH. This topic will be included in the mandatory provider training conducted in June 2021.

Timeline for compliance: FY22
Person responsible for action plan: Gary Dalton, Randy Dow, and Gina Attallah
DSAMH tracking by: Leah Colburn

FY21 Deficiencies:

1) *Youth Outcome Questionnaire (YOQ) Administration and Use as an Intervention:* Of the ten charts reviewed four charts had no evidence of the YOQ being administered or being used as an intervention in treatment. This is a noted improvement from FY20 during which all charts reviewed did not demonstrate evidence of administration of the YOQ or use in treatment. The Division Directives state "the Youth Outcome Questionnaire (OQ/YOQ) be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent)" and "Data from the OQ or YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart." While it is recognized that COVID-19 and the move to telehealth may have impacted

administration of the YOQ, DSAMH encourages Tooele-VBH to review processes to ensure that the YOQ is administered and utilized as a tool in treatment.

County's Response and Corrective Action Plan:

Action Plan: Optum requires all mental health providers (not inpatient) to follow the DSAMH mandate related to OQ and Y-OQ administration and inclusion in treatment planning. Training for beginners and advanced levels were offered to Optum Tooele providers in Fall 2020. These trainings will be made available to providers in FY22. Providers will be monitored for compliance during audits.
*Tooele County Providers (other than VBH) did not gain access to the OQ Analyst until April 2021. Although Gary Dalton and Optum had requested assistance creating a new account for Tooele County, intervention from DSAMH was required to obtain a response from OQ Measures. Therefore administration of the questionnaires and access to Clinician Reports will not be evident in treatment initiated and/or services rendered prior to this time.

Timeline for compliance: FY22
Person responsible for action plan: Gary Dalton and Gina Attallah
DSAMH tracking by: Leah Colburn

2) *Family Peer Support Services:* Toole-VBH remained steady in provision of family peer support services from FY19 (55 services) to FY20 (54 services), however Family Resource Facilitation (FRF) dropped significantly FY19 (139 services) to FY20 (20 services) due to changes in the employment structure of their FRF. While it is recognized that COVID-19 public health guidelines may have impacted service provision, it is recommended that Tooele-VBH review referral pathways, access, and sustainability of this service in their continuum. It is to be noted that Tooele-VBH reports that they have had case managers providing family peer support services. It is critical that persons providing these services are certified family peer support specialists. It is recommended that Tooele review how they utilize staffing patterns to ensure that family peer supports are able to fulfill their roles and responsibilities to provide family peer support and better engage with youth and their families in the community. The DSAMH Children's team is available for technical assistance related to family peer support specialist service provision.

County's Response and Corrective Action Plan:

Action Plan: To address the need for more family peer support specialists in Tooele County, Optum is in the process of contracting with Allies with Families to provide these services. The Multicultural Counseling Center has been added to the Network and they offer family peer support. Optum recognizes the difference between peer support and case management services, as well as the supervision requirements related to these roles. Before August 1, 2021, Optum will collaborate with VBH to create a plan to ensure these services are being

correctly identified, documented, billed and required supervision is offered to the rendering providers.

Timeline for compliance: Allies with Families (TBD) and VBH follow-u by 8/1/21
Person responsible for action plan: Gary Dalton, Randy Dow, Robyn Emery, and Gina Attallah
DSAMH tracking by: Leah Colburn

FY21 Recommendations:

1) *Holistic Approach to Health*: It is recommended that Tooele-VBH review their assessment template to encourage conversation about healthcare access and appropriate linkages to physical health care providers, including dental and vision, for children. During the review of their assessments there is no documentation of identifying a client's primary care physician. Ensuring that youth have an identified provider and access to physical healthcare is a key metric in ensuring a child's overall health and wellbeing. This is a shared Recommendation with the Child, Youth and Family report.

2) *Case Managemen*t: Tooele-VBH has a higher rate of case management utilization than both rural and urban services provision averages. Case Management was provided at a rate of 68% in FY21 and 50.7% in FY20. Tooele-VBH reports they were providing case management services with incorrect information pertaining to who should be receiving services. It is recommended that Tooele-VBH reviews referral processes and desired outcomes to ensure that children and families who need case management services are appropriately referred for impactful case management. DSAMH is available for technical assistance if desired.

3) Y*OQ Measures and Outcomes:* The FY20 Mental Health Scorecard indicates that Tooele-VBH has the highest percentage of individuals discharged as "deteriorated" (16.67%) and the second highest percentage of individuals in treatment with a clinically significant increase in symptoms from intake across the rural counties (15.61%). DSAMH recommends that Tooele-VBH work with OptumHealth as the new managed care organization for Tooele County, to understand the implications of YOQ results, ensure provision of evidence-based practices, and address training gaps if needed.

FY21 Division Comments:

1) *Network Change*: Tooele County will be changing the management of their PMHP in FY21 to Optum. With this change, Optum will be utilizing a contracting network to expand the number of providers in Tooele County. Optum reports that they are actively trying to bring providers into their network that have community ties or that seek to expand their presence in the community. DSAMH encourages Tooele Co and Optum to seek technical assistance to support this transition to ensure that the community needs and division directives are met.

Adult Mental Health

The DSAMH Adult Mental Health team conducted its annual monitoring review Tooele County – Valley Behavioral Health on April 13 and 14, 2021. Due to COVID-19, the annual monitoring review was held virtually. The monitoring team consisted of Pam Bennett, Program Administrator; Mindy Leonard, Program Manager; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, review of clinical staffing, and virtual meetings with Bears Ears Therapy and Aspen Ridge Counseling. During the discussions, the team reviewed the FY20 audit; statistics, including the Mental Health Scorecard; area plans; Outcome Questionnaires and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:
None

FY20 Significant Non-compliance Issues:
None

FY20 Minor Non-compliance Issues:

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

   This finding is resolved. Tooele County has contracted with a new provider, OptumHealth.

2) *Substance Abuse Mental Health Information System (SAMHIS) OQ Match:* The percentage of clients that match SAMHIS is required to be at least 90%. The FY19 Adult Mental Health scorecard indicates that Tooele-VBH had a match rate of 76%, a

lower rate than FY18 (rate-81.9%). DSAMH requires that Tooele-VBH resolve data entry issues and ensure the match rate improves to at least 90%.

The finding will continue in FY21 as a Deficiency (see Deficiency #1). The SAMHIS OQ match rate in FY20 was 88.1%. This is an improvement from FY19, but does not meet the required 90%. The finding is ongoing as Tooele-VBH continues to be the major provider in Tooele County.

FY20 Deficiencies:

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

   This finding will continue in FY21 as a Minor Non-compliance Issue (see Minor Non-compliance Issue #1). Three of ten charts reviewed did not include an assessment.

<u>Findings for Fiscal Year 2021 Audit</u>

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

1) *Strengths-Based Assessments:* Three of the 10 charts in FY21 (30%) reviewed did not include an assessment. Division Directives, Administrative Rule (R523) and the Medicaid Provider Manual all require that each client have a strengths-based assessment. During the FY20 monitoring visit, Tooele-VBH reported that contracted providers had not been submitting their assessments and indicated that this would be addressed. However, the rate in FY21 is a decrease from FY20 when one of seven charts (14.3%) did not have an assessment. Two of the three charts without an assessment in FY21 were from community providers.

County's Response and Corrective Action Plan:

Action Plan: Optum requires all Network providers to complete an assessment or to review a recently completed assessment by another behavioral health provider. If the latter is chosen, the provider must meet with the member in-person/via telehealth and review to determine if they agree or disagree with the diagnoses and prescribed treatment. The provider's decision is to be documented and any clinical justification for any discrepancy is to be noted. Assessments from Optum providers will be included in records requested for FY21 monitoring by DSAMH. This topic will be included in the mandatory provider training conducted in July 2021. Further training related to identifying member strengths through assessment and incorporating them into treatment planning will be included in clinical training for providers during FY22.

Timeline for compliance: FY22
Person responsible for action plan: Gary Dalton, Randy Dow and Gina Attallah
DSAMH tracking by: Pamela Bennett

FY21 Deficiencies:

1) *Substance Abuse Mental Health Information System (SAMHIS) OQ Match:* The percentage of clients that match SAMHIS is required to be at least 90%. The FY20 Adult Mental Health scorecard indicates that Tooele-VBH had a match rate of 88.1%, the third consecutive year that the match rate has fallen below the required level (FY19-76%, FY20-81.9%). DSAMH requires these data entry issues be resolved, as Tooele-VBH continues to be a major provider in Tooele County.

County's Response and Corrective Action Plan:

Action Plan: All Optum providers will be required to use the OQ Analyst. This will be monitored through provider audits. In addition, the Optum Reporting and Analytics Team will pull down the DSAMH unmatched report and evaluate it against the data in the Optum system on a quarterly basis. Missing/Incorrect information will be identified, then Optum will work with the provider to make updates as needed.
*Tooele County Providers (other than VBH) did not gain access to the OQ Analyst until April 2021. Therefore, matching rates for the following year will likely be impacted.

Timeline for compliance: FY22
Person responsible for action plan: Gary Dalton, Cynde Davis and Gina Attallah
DSAMH tracking by: Pamela Bennett

2) *Outcome Questionnaire (OQ) Use as an Intervention:* Six of the 10 charts reviewed did not include evidence of the OQ being used as an intervention in treatment. The Division Directives state that "Data from the OQ or YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart." While Covid-19 and

the move to telehealth could have impacted administration of the instrument, the OQ had been administered in eight of ten charts reviewed by DSAMH but not used as an intervention. DSAMH has reviewed OQ training strategies with the new managed care organization, OptumHealth, and recommends that Tooele-VBH focus on improved understanding of the purpose and use of the OQ as a clinical tool.

County's Response and Corrective Action Plan:

Action Plan: Optum requires all mental health providers (not inpatient) to follow the DSAMH mandate related to OQ and Y-)Q administration and inclusion in treatment planning. Training for beginners and advanced levels were offered to Optum Tooele providers in Fall 2020. These trainings will again be made available to providers in FY22. Providers will be monitored for compliance during audits.
*Tooele County Providers (other than VBH) did not gain access to the OQ Analyst until April 2021. Although Gary Dalton and Optum had requested assistance creating a new account for Tooele County, intervention from DSAMH was required to obtain a response from OQ Measures. Therefore administration of the questionnaires and access to Clinician Reports will not be evident in treatment initiated and/or services rendered prior to this time.VBH will provide training to treatment providers to ensure OQ's are implemented into treatment.

Timeline for compliance: FY221
Person responsible for action plan: Gary Dalton and Gina Attallah
DSAMH tracking by: Pamela Bennett

FY21 Recommendations:

1) *Holistic Approach to Care*: During the chart review, ten of ten charts did not include identification of a primary care physician. In addition, three of the ten charts did not document whether nicotine use was assessed or did not indicate cessation options were offered when nicotine use was identified. Division Directives require the Local Authorities use a holistic approach to wellness. DSAMH recommends that clinicians review and document primary care needs. This is a shared Recommendation with the Child, Youth and Family report.

2) *OQ Measures and Outcomes:* The FY20 Mental Health Scorecard indicates that Tooele-VBH has the highest percentage of individuals discharged as "not recovered" (18.31%) and the second highest percentage of individuals in treatment with a clinically significant increase in symptoms from intake (14.89%). DSAMH recommends that Tooele-VBH work with OptumHealth as the new managed care organization for Tooele County to understand the implications of OQ results, ensure provision of evidence-based practices, and address training gaps if needed.

3) *Peer Support Services (PSS)/Case Management (CM):* Tooele-VBH continues to report a high percentage of clients receiving PSS (FY20-9.8%, rural-3%). A Peer Support Specialist reported that being able to be open with her past helps clients see that recovery

is possible and it helps the program. However, an attempt to review PSS charts was unsuccessful and Tooele-VBH staff indicated that PSS charts are listed under CM. It is recommended that Tooele-VBH review how PSS and CM are provided and documented, to ensure that clients are receiving needed support services from individuals that are trained appropriately.

4) *Cultural and Linguistic Responsivity:* Tooele-VBH has created a Cultural Competency Committee and has started to train staff, but has not yet created an overall plan to address cultural responsiveness. Cultural understanding and humility are critical to working effectively with clients. Tooele-VBH is encouraged to create a Cultural and Linguistic Responsivity agency plan.

FY21 Division Comments:

1) *Network Change*: Tooele County will be changing the management of their PMHP in FY21 to OptumHealth. With this change, OptumHealth will be utilizing a contracting network to expand the number of providers in Tooele County. OptumHealth reports that they are actively trying to bring providers into their network that have community ties or that seek to expand their presence in the community. DSAMH encourages Tooele Co and OptumHealth to seek technical assistance to support this transition to ensure that the community needs and Division Directives are met.

2) *Expansion of Community Recovery Supports:* Tooele County has made significant efforts to increase the range of recovery supports available within the county. This has included a partnership with Friends of Switchpoint and the proposed development of shelter and supportive housing options, in addition to the Tooele Community Resource Center.

3) *Integrated Care:* Tooele-VBH and community health agencies appear to partner at Level 2 of the six levels of Collaboration and Integration (Substance Abuse and Mental Health Services Administration). Behavioral and physical health providers are in separate facilities and have separate systems. Communication is driven by specific patient issues. Medical staff will note physical health concerns and refer clients for follow up with primary care. Physical health is also reviewed during the case management needs assessment.

4) *Participant Feedback:* Heather Rydalch, Peer Support Program Manager, met with 4 members at New Reflection House. All members said their treatment is going well, and they feel that the staff always cares about how they are doing. Coming to the Clubhouse helps them avoid isolating. They are all working on different goals that they helped create. One member is learning to use the computer more efficiently and work on effective communication. Another member said that she was able to get a TE job and learn how to clean the facilities. On Wellness Tuesday, they were able to bring in others to teach them various wellness topics (before the pandemic), including a dentist to teach them oral health. Member comments included, “They really have a grasp on what they

are doing", "Clubhouse is my extended family", and "Clubhouse has brought me back to life".

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Tooele Valley Behavioral Health (Tooele-VBH) on April 13, 2021. The Tooele Prevention Team transitioned to the Tooele Health Department in July 2020, so the Tooele HD was present at the Site Visit this year. 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 Major Non-compliance Issues:
None

FY20 Significant Non-compliance Issues:
None

FY20 Minor Non-compliance Issues:
None

FY20 Deficiencies:
None

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) *Readiness Assessment:* Tooele has not completed a Readiness Assessment for the communities identified in the area plan. DSAMH recommends Tooele complete Readiness Assessments within the next year. DSAMH staff and the Regional Prevention Director are available if needed to provide technical assistance.

FY21 Comments:

1) *Assessment:* When the Tooele Prevention Unit was housed under Valley Behavioral Health, their local prevention needs were assessed based on the epidemiological data presented in the Student Health and Risk Prevention (SHARP) survey, issued biennially in their region. This same data was broken into community profiles and used by each individual coalition within their county, namely Grantsville City Communities that Care, Wendover Prevention Group, Tooele City Communities that Care (CTC), and Stansbury Prevention Group (name pending). The assessments that were conducted were part of the Communities that Care model, in which a process that is prescribed to analyze various data from legitimate sources then compile them into a report to be shared both with coalition members and relevant parties (i.e. local government, school districts, policymakers, etc.) While SHARP is the primary source of the data that drives their strategies as a Local Substance Abuse Authority (LSAA), they also have reviewed Utah's Public Health Indicator Based Information System along with informal survey tools where no formal tool existed.

2) *Community Partnerships:* Almost all strategies implemented in Tooele's area require some level of collaboration with those outside of their organization. During FY20, the prevention team and Tooele City CTC strengthened partnerships with the School District through a project to promote the Parents Empowered Campaign attaching messaging to school buses. Tooele also had 6 different sectors represented at the 2019 Substance Abuse Fall Conference to learn more about prevention science which also involved socializing after conference sessions for relationship building and collaboration. Typically, spring and summer is when the prevention team has the most opportunities to partner with other organizations. However, the COVID-19 pandemic stifled multiple projects that were in place.

3) *Transition to the Tooele Health Department:* Much of January-June 2020 was spent advocating for the prevention team in preparation for the transition to the Health Department. These efforts lead to more administrative support, logistical resources, access to other similar divisions like Health Promotion and Education, Aging Services, and School and Family Nursing, and access to the community center in Wendover City. Tooele Prevention was able to keep all three of their full time employees and open up a part time position. They also received a discretionary TANF grant to addresses sexual violence prevention, which allowed them to add another part time staff member. Prevention staff have also been better compensated with the Tooele Health Department than they were at Valley Behavioral Health, which will help with staff retention.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Tooele County - Valley Behavioral Health Substance Use Disorders (SUD) Treatment Program on April 14, 2021. The Tooele SUD Treatment Team transitioned to OPTUM in July 2020, so OPTUM was present at the Site Visit this year. The Site Visit focused on Substance Abuse Treatment (SAPT) Block Grant Compliance; Drug Court; clinical practice, compliance with contract requirements and DORA program compliance. Drug Court was evaluated through staff discussion, clinical records, and the Drug Court Scorecard. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to SAPT Block Grant requirements and contract requirements were evaluated by a review of policies and procedures in interviews with Tooele County staff. Treatment schedules, policies, and other documentation were reviewed. The Utah Substance Abuse Treatment Outcomes Measures Scorecard results were reviewed with Tooele County staff. Client satisfaction was measured by reviewing records and consumer satisfaction survey data. Finally, opiate use data and the year-end reports were reviewed and discussed.

Follow-up from Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:
None

FY20 Significant Non-compliance Issues:
None

FY20 Minor Non-compliance Issues:

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

The clinical charts now have a SUD Screening tool and ASAM goals were included in the Recovery plan and Reviews this year, which meets Division Directives.

This issue has been resolved.

2) The Treatment Outcomes Scorecard Shows:

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

The percent of individuals that were employed from admission to discharge moved from 0.0% to -2.8% from FY19 to FY20 respectively, which does not meet Division Directives.

This issue has not been resolved, which will be addressed in the Minor Non-Compliance Finding #1 below.

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

The percent of individuals that were involved in the Criminal Justice System moved from 11.3% to 0.0% from FY19 to FY20 respectively, which does not meet Division Directives.

This issue has not been resolved, which will be addressed in Minor Non-Compliance Finding #2 below.

3) Treatment Episode Data (TEDS) Data Shows:

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

Tooele-VBH submitted TEDS data on Medication Assisted Treatment last year, which meets Division Directives.

This issue has been resolved.

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

Old open admissions (old charts that need to be closed) in the FY20 was 22%, which is above the allowable amount of 4%. This does not meet Division Directives.

This issue has not been resolved, which will be addressed in the Minor Non-Compliance Finding #3 below.

FY20 Deficiencies:

None

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:
None

FY21 Significant Non-compliance Issues:
None

FY21 Minor Non-compliance Issues:

1) *The Treatment Outcomes Scorecard shows:*

a) The percent of individuals that were employed from admission to discharge moved from 0.0% to -2.8% from FY19 to FY20 respectively, which does not meet Division Directives.

b) The percent of individuals that were involved in the Criminal Justice System from admission to discharge moved from 11.3% to 0.0% from FY19 to FY20 respectively, which did not meet Division Directives.

c) The percentage of individuals using recovery supports from admission to discharge decreased from 46.5% to 5.1% from FY19 to FY20 respectively, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan: After Optum and Tooele County reviewed these findings and the possible drivers for the numbers, the impact of COVID-19 is notable with regard to the employment and use of recovery supports. Closures related to the pandemic drove an increase in unemployment throughout the community. Social recovery supports also decreased as in-person services went remote and other service providers or members needed to quarantine. The data indicating the percentage of individuals who decreased criminal justice involvement does reflect the known success of those involved with the courts during FY20. Additional technical support is requested to better understand the timeline of the progression of the data through the year. This may help us to better identify the potential impacts to these numbers, so we may formulate a more specific plan to address these deficiencies.

Timeline for compliance: First quarter of FY22
Person responsible for action plan: Gary Dalton and Gina Attallah
DSAMH tracking by: Becky King

2) *The Consumer Satisfaction Survey shows:*

a) The percent of clients sampled in the Youth Consumer Satisfaction Survey was 8.4%, which is below the allowable amount of 10%, which does not meet Division Directives.

b) The percent of parents sampled in the Youth Family Consumer Satisfaction Survey was 9.3%, which is below the allowable amount of 10%, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan: At this time, the draft report for the MHSIP numbers for 2021 indicates the 10% threshold may not have been met for all categories. Optum will orient Network providers to the MHSIP questionnaires and process during June 2021 mandatory training. Providers will be required to designate an MHSIP agency contact. Optum's Compliance Manager will conduct live training with the agency contacts in December 2021, to outline the expectations associated with MHSIP distribution and collections. Since all contracted providers now have access to the OQ Analyst, questionnaires may be submitted through the system or keyed into Qualtrics.

Timeline for compliance: December 31, 2021
Person responsible for action plan: Gary Dalton, Randy Dow and Lori Maxfield
DSAMH tracking by: Becky King

3) *The Treatment Episode Data Set (TEDS) shows* that the old open admissions (charts that need to be closed) in FY20 was 22%, which is above the allowable amount of 4%. This does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan: Before July 1, 2021, Optum will meet with VBH Leadership to outline a plan to ensure TEDS data for members receiving services from VBH and other SUD providers is submitted timely.

Timeline for compliance: July 1, 2021
Person responsible for action plan: Tracy Luoma, Randy Dow and Cynde Davis
DSAMH tracking by: Becky King

FY21 Deficiencies:

None

FY21 Recommendations:

1) *Medication Assisted Treatment / Methadone Treatment* **-** It was reported that there is a group in Tooele that is interested in setting up an Opioid Treatment Program (OTP) that provides Methadone services in Tooele County. Tooele-VBH shared that if there was an OTP in their community, they would utilize methadone treatment as needed. It is recommended that Tooele-VBH follow through in looking into options for setting up an OTP in their community.

FY21 Comments:

1) *Work Stress and Secondary Trauma:* Tooele-VBH has focused on work stress and secondary trauma with staff, clients and the community, especially with what happened in the Grantsville shooting. They have developed a few support groups for staff (Wellness Support Group), which were held weekly during the COVID Pandemic and are currently being held monthly. They also have Project Rainbow, which is a support group for LGBTQ+ individuals, which runs once a month. Tooele-VBH has an internal Employee Assistance Program (EAP), which provides five free therapy sessions and ongoing therapy for staff at a discounted rate. Tooele-VBH also has a Trauma-Informed Care Committee that provides training on trauma and Trauma-Informed Care for their staff. They also ensure that Trauma-Informed Services are being provided throughout their agency. When there is a crisis, staff debrief one another and provide assistance to the community as needed.

2) *Opioid Use / Naloxone* - Tooele-VBH has a grant for $6,000.00 for Naloxone, which they have been purchasing from the Macy's Drug Store in Tooele. They always have Naloxone on hand and have provided them to families, law enforcement and other community members as needed. Clients' lives have been saved through the use of Naloxone. For example, one client was saved by their family member when they had overdosed on opioids and has now been in recovery for two years. A Nurse also saved another client's life in a parking lot. All staff, families and community members are trained on the use of Naloxone.

3) *Suicide Prevention / Intervention:* Tooele-VBH offers suicide prevention training to their staff and outside agencies through their prevention programs. All therapists have completed the Valley Academy which has a two hour course in suicide prevention. They use the Columbia Suicide Severeity Rating Scale (C-SSRS) to screen for suicide ideation. It is administered at intake and when any risk is identified. If the client answers "yes" to questions #1 or 2 on the C-SSRS, a Safety Plan is completed, reviewed and updated with the client as needed.

Section Two: Report Information

Background

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

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

Non-Compliance Issues, Action Plans and Timelines

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

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

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

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

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

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.
A **recommendation** occurs when the contractor is in compliance. The Division is simply making best practice or technical suggestions. The contractor is encouraged to implement the suggestion but not required.

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

Signature Page

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

If there are any questions regarding this report please contact Kelly Ovard at 385-310-5118.

The Division of Substance Abuse and Mental Health

Prepared by:

Kelly Ovard _____ Date 06/10/2021
Administrative Services Auditor IV

Approved by:

Kyle Larson _____ Date 06/10/2021
Administrative Services Director

Eric Tadehara _____ Date 06/14/2021
Assistant Director Children's Behavioral Health

Kimberly Myers Kim Myers (Jun 10, 2021 14:30 MDT) Date 06/10/2021
Assistant Director Mental Health

Brent Kelsey Brent Kelsey (Jun 11, 2021 12:38 MDT) Date 06/11/2021
Assistant Director Substance Abuse

Doug Thomas Doug Thomas (Jun 10, 2021 14:11 MDT) Date 06/10/2021
Division Director

Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY21

Name of Local Authority: **Valley Behavioral Health-Tooele**

Date: **April 27, 2021**

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

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 int 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		Plan indicates a draft plan which needs to be finalized
Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)			X	Need signature page, approval of plan and confirmation of i official status
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)			X	Need to identify scheduled reviews for plan
Record of changes (indicating when changes have been made and to which components of the plan)		X		Plan indicates updates quarterly; however, the last revised d on plan is 9/2020
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		Need to identify communicating changes to staff, and traini staff on the plan updates
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	Need order of succession (i.e., an organizational chart)
Identify leadership for incident response	X			
List alternative facilities (including the address of and directions/mileage to each)			X	Need to identify alternative facilities to be used, if needed.
Communication procedures with staff, clients' families, the State and community			X	Need to address procedure for communication with staff, clients' families and other stakeholders
Procedures that ensure the timely discharge of financial obligations, including payroll.			X	Need to document plan for timely discharge of financial obligations
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: ● 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	Please identify how residential/housing services will be supported in the event of a disaster.

DSAMH is happy to provide technical assistance.

FY21 Final Report Tooele County

Final Audit Report 2021-06-14

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