



State of Utah

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SUBSTANCE ABUSE AND MENTAL HEALTH

February 1, 2017

Commissioner Phil Lyman
San Juan County Commission
333 S. Main, #2
Blanding, UT 84511

Dear Commissioner Lyman:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of San Juan Counseling Center and the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental services, substance abuse treatment and prevention services, and general operations.

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

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

Sincerely,

Doug Thomas
Division Director

Enclosure

cc: Tammy Squires, Director, San Juan Counseling



Site Monitoring Report of

San Juan Counseling Center

Local Authority Contracts #152314 and #152315

Review Date: October 24th, 2016

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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 San Juan Counseling Center (also referred to in this report as SJCC or the Center) on October 24th, 2016. 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 1 None	7
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	10 - 11
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 1	14 14 - 15
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 4	17 - 18 18 - 19
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 5 2	21 - 22 22 - 23

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review at San Juan Counseling Center (SJCC). The Governance and Fiscal Oversight section of the review was conducted on October 24th, 2016 by Chad Carter, Auditor IV and Kyle Larson, Administrative Services Director. 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. Board 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/or the contracted County.

As part of the site visit, the cost allocation methodology used by San Juan Counseling was examined. It was verified that administrative costs are equitably distributed across all cost centers and that the billing costs for services are consistently used throughout the system. DSAMH continues to refine monitoring methodologies to more closely appropriate the Medicaid Cost Study and will continue to work with San Juan Counseling to establish methodologies that will work within its unique situation, as it is incorporated into Northeastern's Medicaid Cost Study.

The CPA firm Smuin, Rich & Marsing completed an independent audit of San Juan Mental Health/Substance Abuse Special Service District for the year ending December 31st, 2015. The auditors issued an unqualified opinion in the Independent Auditor's Report dated June 21st, 2016. There were two deficiencies discussed in the auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters:

2015-1 – State Compliance – Government Records Access Management Act: According to Utah Code 63G-2-108, each records officer of a government entity or political subdivision shall, on an annual basis, successfully complete online training and obtain certification from state archives.

This issue has been resolved, all required training has been completed. During the site visit, the training certificates for each officer was reviewed.

2015-2 – State Compliance – Government Records Access Management Act: According to Utah Code 63A-12-103, each entity should adopt a uniform fee schedule and that fee schedule should be formally approved by the entity's governing board. We reviewed with the District's Director the requirements of this act. It was determined upon inquiry, that the District does not currently have a uniform fee schedule in place.

SJCC has created a new fee schedule and it has been approved by the board, but the law also requires that a public hearing/town meeting is conducted to include public input before it is officially adopted. The Center is currently working on this process.

Follow-up from Fiscal Year 2016 Audit:

No findings were issued in FY16.

Findings for Fiscal Year 2017 Audit:

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

- 1) SJCC's FY16 Substance Abuse Treatment cost per client has increased to a level that is outside of Division Directive standards. DSAMH Division Directives state, "*The Local Authority shall meet an overall client cost within fifty (50) percent of the statewide Local Authority overall average cost per client and **with-in twenty-five (25) percent of their previous year actual cost per client.***" SJCC's FY15 cost per client was \$3,103; this has increased by 41.5% in FY16 with a cost per client of \$4,390, which is outside of the 25% maximum standard. Please explain this increase.

Center's Response and Corrective Action Plan:

San Juan Counseling is a small center and with this comes great differentials from year to year. A few changes can dramatically change cost of service or cost per client every year. In 2016 one such example is the extra \$20,000 that was given to San Juan Counseling from DSAMH for MAT. By taking out the extra \$24,000 additional allocation it brings the client cost to \$4,082, which is a 31.6% increase. Other factors that have contributed to an increase in cost per client is an increase in staff costs, an increase in additional UA's (we now test on the weekends), and an increase in staff time associated with additional UA's. San Juan Counseling will continue to monitor the cost per client and will look at ways to be more efficient.

FY17 Deficiencies:

None

FY17 Recommendations:

None

FY17 Division Comments:

- 1) FY17 Division Directives require that each Local Authority conduct a walk-through testing of their adherence to access standards. SJCC completed their access testing after the scheduled site visit. The results of the walk-through were positive and showed that all minimum access standards were being met. The caller felt like the receptionist provided good information and was very compassionate. The test showed some areas that could be

improved on including the large amount of paperwork clients are required to complete, parking availability and the size of the waiting area. Some of these areas will be improved when the new building is completed.

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

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

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

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

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Four Corners Community Behavioral Health on October 24th, 2016. The monitoring team consisted of Eric Tadehara, Program Administrator; Tiesha Cohen, Program Manager; and Tracy Johnson, Utah Family Coalition (Allies With Families). The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, program visits, allied agency visits, and feedback from families through questionnaires. During the visit, the monitoring team reviewed the Fiscal Year 2016 audit; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); Wraparound to fidelity; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention Funding; civil commitment; 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 2016 Audit

FY16 Minor Non-compliance Issues:

- 1) *Youth Outcome Questionnaire (YOQ)*: The frequency the YOQ is being administered at is below the required guidelines of “every thirty days or every visit (whichever is less frequent)” as described in the Division Directives. In the chart review, the frequency was approximately four administrations during the past calendar year, even with more frequent services being provided. The Division Directives require “a 50% utilization rate” for clients served; it should be noted that SJCC has improved the utilization rate the YOQ is being administered to 50.7%, above the required rate. There is also continued evidence that the YOQ is not being addressed in the clinical process when a red flag is presented.

This issue has not been resolved and will be continued in FY17; see Minor Non-compliance Issue #1.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

- 1) *Youth Outcome Questionnaire (YOQ)*: The frequency the YOQ is being administered at is below the required guidelines of “every thirty days or every visit (whichever is less frequent)” as described in the Division Directives. In the chart review, YOQs were being administered approximately four times in the last calendar year. The Division Directives require “a 50% utilization rate” for clients served; the FY16 utilization rate for SJCC YOQ administration is at 44.2%, below the required rate and a decrease from the FY15 rate of 50.7%. There is also continued evidence that the YOQ is not being addressed in the clinical process.

Center's Response and Corrective Action Plan:

We are making the following efforts to increase our YOQ administration rates:

1. All therapists have the off-line version of the YOQ instrument on their lap top computers and have been trained in its use.
2. The date of the last YOQ administration now appears on every progress note, acting as a prompt for the therapist in real time.
3. Increasing the YOQ administration and review rates is an overt goal for the agency that will be talked about monthly in clinical staff meetings.
4. Therapists will be given regular feedback on their client YOQ administration and review rates.
5. Our front desk staff will continue to assist in administering the YOQ SR and PR to clients who receive services at the center.

As we have increased our school based mental health and substance abuse services over the past year, we have faced the challenge of having our therapist not having support staff on sight to assist in administering the YOQ. In addition, for youth 9 and younger being seen at school, we often do not have many opportunities to interact with their parents who often have poor cell phone service, particularly if they live on the reservation. We are confident we can overcome these barriers to reach the goal of the 50% administration rate.

FY17 Deficiencies:

None

FY17 Recommendations:

- 1) *Psychosocial Rehabilitation*: SJCC has slightly decreased the rate of Psychosocial Rehabilitation provided from 3.9% in FY15 to 3.4% in FY16. Psychosocial Rehabilitation is being provided at a lower rate than the rural average of 15.7%. SJCC is continuing to look for ways to provide more Psychosocial Rehabilitation services. SJCC is encouraged to increase the rate Psychosocial Rehabilitation services are being provided.
- 2) *Respite Services*: SJCC provided Respite services at a lower rate than the rural and State averages. In FY16, Respite services were provided at a rate of 1.4%, which was a decrease of 0.3% from FY15. SJCC is continuing to make efforts to improve the rate Respite is provided and reported that the center is starting to utilize the local college for respite services during parenting classes. It is recommended that SJCC continue to increase access to this mandated service for children and youth.
- 3) *Juvenile Civil Commitment*: SJCC needs to include the Notice of Discharge From Commitment to the Local Mental Health Authority of a Child form when the Juvenile Civil Commitment process is completed. SJCC is using the appropriate Civil Commitment forms when necessary. Civil Commitment Paperwork for juveniles needs to be completed consistent with State statute 62A-15-703; the forms are located at <http://dsamh.utah.gov/provider-information/civil-commitment/>.

FY17 Division Comments:

- 1) *Family Feedback*: Family feedback was collected by the Utah Family Coalition (UFC) from eight completed questionnaires and six individual interviews. The survey is used to improve services for the clients served. Every family involved reported that they felt that their input had influenced their child's treatment and that they were included in the treatment plan process. Every family also reported that the Family Resource Facilitators (FRF) went "above and beyond" to make sure their family received the help they needed.
- 2) *Wraparound and Family Resource Facilitator*: SJCC is providing High Fidelity Wraparound as defined by the UFC. The FRFs are an integral part of the service delivery system, and the services they provide help to establish new clients and community partnerships. It was recommended from the Utah Family Coalition that SJCC look for ways to increase peer support billing and sustain the FRF program. Additionally, it was recommended that SJCC look at how they are utilizing the YOQ's so that families know why they are completing the surveys and how they are being used.
- 3) *School-Based Behavioral Health (Partnership)*: SJCC is providing school-based behavioral health services. Program visit feedback reported that SJCC is providing "great" services. One provider was noted as saying, "When we have a crisis, they always respond." The behavioral health resources provided by SJCC are supportive and integral to the school populations being served.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of San Juan Counseling Center on October 24th, 2016. The team included LeAnne Huff, Adult Mental Health Program Manager and Cami Roundy, Recovery and Resiliency Peer Program Manager. The review included the following areas: discussions with clinical supervisors and management teams, record reviews, site visits to administrative offices, outpatient clinic, and Utah Navaho Indian Health Services in Montezuma Creek. During the discussions, the team reviewed the FY16 audit; statistics, including the Mental Health Scorecard; area plans; Outcome Questionnaires and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2016 Audit

FY16 Significant Non-compliance Issues:

- 1) *Targeted Case Management (TCM)*: The Mental Health Scorecard for SJCC in FY15 indicates a lower than state average services in TCM provided. The state average for rural areas in TCM is 23.2% and the SJCC rate of TCM services went from 14.5% in FY14 to 12.6% in FY15. DSAMH recognizes and appreciates the increase in TCM services provided from 8.9 % in FY13 to 12.6% in FY15. DSAMH encourages SJCC to continue efforts to increase TCM services.

This issue has been resolved. DSAMH appreciates SJCC efforts to address this issue by hiring a full time supervisor for the day treatment programs, as well educating community partners with a goal of improving referrals. Review of the program has demonstrated that TCM is available, is offered when appropriate, and that levels below the state average have not resulted in clients' requiring a higher level of care.

FY16 Minor Non-compliance Issues:

- 1) *Division Directives on Outcome Questionnaire (OQ) Administration*: DSAMH Division Directives require at least 50% OQ administration rates to clients served. According to the Mental Health SJCC Scorecard, OQ rates have increased from 29.1% in FY14 to 43.1 % in FY15 in a six month period. It was evident during the chart reviews that SJCC is using OQ scores to work with their clients and address progress. DSAMH recognizes and appreciates these improvements and encourages SJCC to continue their efforts in meeting the OQ Administration required rate.

This issue has not been resolved and will be continued in FY17; see Minor Non-compliance Issue #1.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

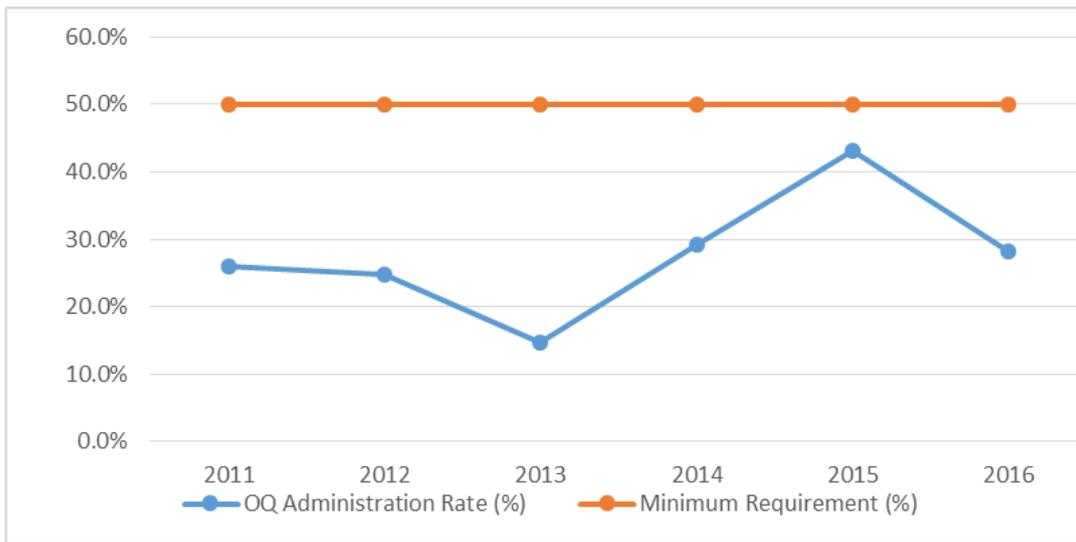
None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

- 1) *Division Directives on Outcome Questionnaire (OQ) Administration:* According to the Mental Health SJCC Scorecard, OQ rates have remained below the 50% administration rate required by Division Directives since 2011. This finding remains as a Minor Non-compliance Issue in recognition of the time required to increase OQ administration and have that increase reflected in the data. DSAMH encourages SJCC to continue their efforts in meeting the OQ administration required rate.



Center’s Response and Corrective Action Plan:

We are making the following efforts to increase our OQ45 administration rate in FY 2017:

1. All therapists have the off-line version of the OQ instrument on their lap top computers and have been trained in its use.
2. The date of the last OQ administration now appears on every progress note, acting as a prompt for the therapist in real time.
3. Increasing the OQ administration and review rates is an overt goal for the agency that will be talked about monthly in clinical staff meetings.
4. Therapists will be given regular feedback on their client OQ administration and review rates.
5. Our front desk staff will continue to assist in administering the OQ45 to clients who receive services at the center.
6. Support staff and the clinical director will regularly enter the most recent date of the OQ administration so the date appearing on the progress note remains current.

FY17 Deficiencies:

- 1) *Use of OQ as an intervention:* During chart reviews, there was no indication that OQ scores were being used as an intervention in the progress notes. Division Directives require that the

data from the OQ be shared with the client and incorporated into the clinical process, as evidenced in the chart. DSAMH recommends that SJCC train staff to utilize the OQ tool in session as an intervention.

Center's Response and Corrective Action Plan:

We implemented the following in FY 2017 to increase the use of the OQ45 as a clinical intervention tool:

1. Therapist will be given monthly feedback on the OQ45 administration rates for their current clients. This will include the percentage of the time their progress notes include the OQ45 score on the day of service. We believe this will promote increased conversation about the OQ45 score within the session as well as increase documentation to the fact.
2. Clinical staff will be provided three, 1 hour long trainings on the OQ Analyst instruments, including the SOQ, TSM and ASC, during the 2017 calendar year. The first training took place on 1/11/2017 with a focus on using the ASC and TSM with clients who indicate a red alert status.

FY17 Recommendations:

- 1) *Continuity of Care (CoC)*: DSAMH recognizes and appreciates SJCC work in transitioning clients out of the Utah State Hospital (USH) and back into the community. It is recommended that SJCC attend CoC monthly meetings at the USH, in person or by conference call, to facilitate ongoing continuity and coordination of care between SJCC and USH.
- 2) *Adult Peer Support*: DSAMH commends SJCC for using Family Resource Facilitators to provide Peer Support services to adults when appropriate. It is recommended that this service be expanded to a wider range of adult clients through the employment of a Certified Peer Support Specialist.

FY17 Division Comments:

- 1) *Community Collaboration*: DSAMH recognizes and appreciates SJCC support of their community partners, including the Sheriff's office, Emergency Department, and with Utah Navajo Health System (UNHS). SJCC is participating and working closely with UNHS on the zero-suicide initiative and currently provides 24/7 crisis response to the county jail, hospital and UNHS. Chart documentation indicates excellent treatment collaboration between agency and intra-agency partners.
- 2) *Housing*: DSAMH commends SJCC for their efforts to address housing issues in San Juan by purchasing a mobile home and providing supportive housing to individuals experiencing homelessness.
- 3) *Recovery Plus*: DSAMH applauds efforts made by SJCC to provide tobacco cessation support to their clients. A review of the charts and responses to the Focus Group Peer Questionnaire indicated that tobacco cessation had been offered to clients, and some individuals reported that they have been able to stop smoking.

- 4) *Consumer Feedback:* DSAMH Peer Support, Recovery and Resiliency Program Manager Cami Roundy attended a group in the Blanding Day Treatment Program. Individuals in the program were asked questions from the Focus Group Peer Questionnaire. All clients reported that they felt they were making progress in treatment and several expressed appreciation for assistance with housing and transportation.

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review of San Juan Counseling on October 24th, 2016. 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 2016 Audit

FY16 Deficiencies:

- 1) San Juan Counseling Center does not have an active Area Plan entered into the data collection system, WITS. This prohibits any data collection in the system. A plan for FY16 and data needs to be entered into the system by November 30, 2015.

This finding has not been resolved and will be continued in FY17; see Minor-non Compliance Issue # 1.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

- 1) San Juan Counseling Center did not enter in an Area Plan into the Data Collection System, WITS. SJCC has entered in an active Area Plan for this Fiscal Year. No prevention data was collected in FY16. Division Directives require data entry within 60 days of service, including coalition activities.

Center's Response and Corrective Action Plan:

For FY 2017 San Juan Counseling has entered a plan is collecting data.

- 2) SJCC did not submit an Annual Prevention Report. The Division Directives require each local authority to submit an annual prevention report *“within 60 days of the end of the state fiscal year that summarizes performance of prevention programs policies and strategies based on the short and long term outcomes identified in the logic models.”*

Center's Response and Corrective Action Plan:

Report was submitted in November (due is September) with support from Regional Director.

San Juan Counseling will complete FY17 report within 60 days ending 2017.

FY17 Deficiencies:

- 1) No Eliminating Alcohol Sales to Youth (EASY) compliance checks occurred in FY16. This is a decrease from five checks in FY15.

Center's Response and Corrective Action Plan:

San Juan Counseling collaborated with law enforcement on the EASY checks – and were told that there are planned compliance checks to be conducted in February 2017. San Juan Counseling will follow-up with law enforcement after February to insure the checks have taken place.

- 2) Currently San Juan County's Synar compliance rate is 72%. Division Directives measure for a compliance rate of 90%.

Center's Response and Corrective Action Plan:

Tobacco checks were conducted by the health department and law enforcement in December 2016. Of the 23 businesses checked, 7 sold to minors. A recheck was implemented within 30 days (January 2017). All of the 7 businesses who had sold were in compliance. At the time of the first check law enforcement issued 4 citations. The other locations in non-compliance were on tribal lands, thus out of county law enforcement jurisdiction. These locations were given warnings. All locations that were originally in non-compliance were cited civilly through the health department.

- 3) SJCC programming is only 50% evidence based. The Division Directives require a goal of 80%.

Center's Response and Corrective Action Plan:

The following are the logic models for FY 2017:

- *Parents Empowered – Evidence Based
- *SJCPAC Coalition – Evidence Based
- *EASY Checks – Evidence Based
- *Hope Squads – Evidence Based
- *Youth Coalitions – Probably Evidence Based
- *Community Events – Not Evidence Based

- 4) SJCC did not complete a full community assessment. No community readiness assessment was completed. *The Division Directives require each local authority to assess local prevention needs based on epidemiological data. This assessment shall include the most current Student Health and Risk Prevention Survey (SHARP) data and additional local data.*
 1. Assessments shall be done at minimum every three years.
 2. Resources that shall be used to perform the assessment include, but are not limited to:

(a) <http://bach-harrison.com/utsocialindicators.html>

(b) <http://ibis.health.utah.gov>

(c) *Communities that Care, Community Assessment Training (CAT)*

<http://www.communitiesthatcare.net/getting-started/ctc-training/>.

Center's Response and Corrective Action Plan:

The SJC-PAC is currently working toward implementation of a community assessment.

FY17 Recommendations:

- 1) It is recommended that San Juan complete a full community assessment, including a Community Readiness and data review, with the San Juan Prevention Action Collaboration coalition by February 2017 with a report as evidence of the completed assessment.
- 2) It is recommended that San Juan have a full Strategic Plan, with community involvement, completed by June 2017.
- 3) It is recommended that San Juan increase the number of programs that are considered evidence based. Currently 50% of all prevention programming is evidence based. The goal for FY17 is 90%. Increase the number of evidence based strategies through the Strategic Prevention Framework process with participation from the community coalition.
- 4) It is recommended that San Juan expand the number of coalitions in the county, including Montezuma Creek.

FY15 Division Comments:

- 1) San Juan Counseling has sent their Director, Clinical Director and Prevention Coordinator to CADCA Mid Year. SJCC also sent coalition members to statewide coalition training. SJCC has enlisted the support of their Regional Director to provide coalition training on Risk and Protective Factors, Prevention Science, and the Social Development Strategy.
- 2) The San Juan Prevention Action Collaboration coalition did use more than one data source to begin an assessment. One member of the coalition reviewed the Student Health and Risk Prevention survey data, as well as the Navajo Risk Survey. The addition of data that relates to over 50% of the population is a great sign of collaboration for the coalition.

Substance Abuse Treatment

Brent Kelsey, Assistant Director conducted the substance use disorder treatment review of San Juan Counseling Center on October 24th, 2016. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to SAPT Block Grant requirements, contract requirements and Drug Court requirements were evaluated by a review of policies and procedures, interviews with clients, a discussion with SJCC staff and a review of program schedules and other documentation. SJCC performance was evaluated using Utah Substance Abuse Treatment Outcomes Measures Scorecard and Consumer Satisfaction Survey Data. Client satisfaction was measured by reviewing records, Consumer Satisfaction Survey data and results from client interviews.

Follow-up from Fiscal Year 2016 Audit

FY16 Minor Non-compliance Issues:

- 1) Treatment plan objectives need to be specific, time limited, measureable and achievable. The discharge summary only contains the required state data information and is missing the summary of the client's progress in treatment and recommendations for ongoing services. SJCC needs to continue working on improving the objectives in the treatment plan and the discharge summary (*Chart #'s 80373, 82652, 82952, 80622, 81856, 80443, 81585*).

This issue has been partially resolved but will be continued in FY17; see Minor Non-Compliance Issue #1.

- 2) The percent of old open admissions increased from 5.8% in FY14 to 9% in FY15, which continues not to meet Division Directives. *The old open admissions should account for less than 4% of clients served for a given fiscal year for non-methadone outpatient and/or IOP, residential and/or detox*

This issue has not been resolved and will be continued in FY17; see Minor Non-Compliance Issue #5.

- 3) The Utah Substance Abuse Treatment Outcomes Measures Scorecard shows that the percent of clients that decreased their involvement in the Criminal Justice System moved from 50.0% in FY14 to -66.7% in FY15, which does not meet Division Directives.

This issue has not been resolved and is continued in FY17; see Minor Non-compliance Issue #2.

Findings for Fiscal Year 2017 Audit:

FY16 Major Non-compliance Issues:

None

FY16 Significant Non-compliance Issues:

None

FY16 Minor Non-compliance Issues:

- 1) DSAMH Division Directives require that treatment plan objectives be “specific, time limited, measureable and achievable.” SJCC has provided training to clinicians and has been providing feedback to clinicians quarterly. However, a number of reviewed treatment plans did not contain objectives that were “specific, time limited, measurable and achievable” (Chart #s 83312, 83306,54036,83371,44895). This is a repeat finding from FY16.

Center’s Response and Corrective Action Plan:

1. The clinical director will meet at least monthly with the agency’s primary substance therapist to review the treatment plans of current clients and identify ways to objectify treatment objectives. Emphasis will be placed on the setting of short term, measurable objectives.
2. During 1Q 2017, the entire clinical team will be provided training on treatment planning with emphasis on appropriate treatment plan objectives. The primary reference for this training will be “Treatment Planning in Psychotherapy” by Woody, Detweiler-Bedell, Teachman and O’Hearn.
3. The substance abuse team will identify at least 3 objective instruments (in addition to the OQ45) that are likely to have wide application to our SA clients and experiment with their use in 2017.

- 2) The FY16 Utah Substance Abuse Treatment Outcomes Measures Scorecard shows that 0% of SJCC clients decreased their involvement in the Criminal Justice System. This is a repeat finding from FY15. SJCC data shows improvement from FY15 (-66%), however the results do not meet with DSAMH Directive requirements.

Local Substance Abuse Authorities’ Outcome Scorecard will show that they decreased the percentage of their clients who were involved in criminal activity from admission to discharge at a rate greater to or equal to 75% of the national average. Criminal activity is defined as being arrested within the past 30 days.

Center’s Response and Corrective Action Plan:

We believe this is largely due to data entry errors and the fact that many of our court ordered clients delay appearing for an intake evaluation which means many have not been arrested within the last 30 days even though legal charges are what bring them treatment. Our steps will be as followed:

1. We would like to expand the definition of criminal activity to include any recent arrests that led to the client being referred for the current treatment.
2. Our clinical staff will be trained in conducting quarterly reviews of all state reporting data so any subsequent arrests, or lack thereof, can be accurately accounted for.
3. The clinical director will meet with our support staff who report state data to ensure the data being entered in the EHR by the clinician is being accurately reflected in reported data and what steps can be taken to ensure it is so.

- 3) According to the FY16 Utah Substance Abuse Treatment Outcomes Measures Scorecard, the percent of clients completing a treatment episode successfully decreased from 48.6% in FY 15 to 36.4%. This does not meet with Division Directive requirements.

Local Substance Abuse Authorities will meet or exceed their FY2015 Successful Treatment Episode Completion rates in FY2016 and will work towards achieving a goal of 60%.

Center's Response and Corrective Action Plan:

1. The clinical director will provide training regarding the definition of successful treatment (e.g. 74% or more of the treatment objectives were reached.) We believe an accurate appraisal of this fact will be aided by the efforts outlined in item #1 regarding measureable treatment objectives.
2. The agency will initiate discussion with our municipal and district court judges to explore ways to encourage court ordered clients to complete treatment.

- 4) The FY16 Utah Substance Abuse Treatment Outcomes Measures Scorecard shows the percent of clients that increased employment from admission to discharge was 0%. This does not meet the Division Directive requirement.

Local substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of their clients who were employed full/part time or enrolled as student from admit to discharge at a rate greater to or equal to 75% of the National Average (13.7).

Center's Response and Corrective Action Plan:

We believe this is largely a data reporting issue that can be corrected through regular updates to the client's TEDS data. Training will be provided to our therapists to encourage regular referencing of the quarterly review due date that already appears in every progress note.

- 5) The percent of old open admissions increased from 9.0% in FY15 to 11.5% in FY16, which continues not to meet Division Directives. *The old open admissions should account for less than 4% of clients served for a given fiscal year for non-methadone outpatient and/or IOP, residential and/or detox.*

Center's Response and Corrective Action Plan:

After looking further into this issue many of the old open admissions have been closed in our EHR but this has not translated into closed in SAMHIS. San Juan Counseling will work with the Division Data people to get appropriate old open admissions closed. We will have these data lines cleaned up by March 1, 2017.

FY16 Deficiencies:

- 1) Treatment Episode Data Set (TEDS) submissions for the first two months of FY17 do not indicate whether clients have been "compelled to treatment" by the criminal justice system. All 16 admissions submitted to DSAMH in FY17 lack this information. A maximum of

10% of clients can be unknown for this field according to the 2017 data specifications. This information is necessary to track outcomes related to Utah's Justice Reinvestment Initiative.

Center's Response and Corrective Action Plan:

We are now collecting this data within our EHR as part of the initial assessment and expect this will correct this issue.

- 2) Treatment Episode Data Set (TEDS) submissions for the first two months of FY17 does not identify clients criminogenic risk level. All 16 admissions in FY17 lack this information. This field is optional for 2017 but is critical to evaluating Utah's Justice Reinvestment Initiative.

Center's Response and Corrective Action Plan:

We are now collecting this data within our EHR as part of the initial assessment and expect this will correct this issue. The RANT and LS/RNR will be used as a risk and needs assessment for SA clients. A domestic violence assessment tool will be used to determine the same with clients referred for DV treatment.

FY17 Recommendations:

- 1) Federal law and regulations restrict communications about identifiable individuals by "programs" that provide substance use diagnosis, treatment, or referral for treatment (42 U.S.C. §290dd-2, 42 C.F.R. Part 2). Information may be released if the client has signed a consent form. DSAMH requires that consent forms be kept in the client record. SJCC keeps all releases at the front desk and summarizes their content in the electronic health record (EHR). DSAMH recommends scanning a copy of the signed release and including as an attachment in the EHR. This will reduce likelihood of inappropriate releases of information or errors in summarizing signed consent forms.
- 2) DSAMH recommends additional training for staff on language that furthers public understanding of addictive disorders as a medical issue to reduce stigma and stereotyping. Use of terms like "clean" and "dirty" were often found in clinical charts. One excellent resource that could be distributed to staff can be found at: https://www.naabt.org/documents/NAABT_Language.pdf. Another excellent resource can be found online at: <https://www.whitehouse.gov/ondcp/changing-the-language-draft>. DSAMH is also available to provide technical assistance if desired.

FY16 Division Comments:

- 1) *Suicide Prevention, Intervention and Postvention*: SJCC has taken the lead to prevent suicide in their community. The Suicide Prevention Coalition meets monthly, all new clients are screened with the Columbia Suicide Severity Rating Scale and SJCC recently received a grant from the National Alliance for Mental Illness (NAMI) to further their efforts.

- 2) *Medication Assisted Treatment (MAT) and Naloxone*: SJCC has been using Vivitrol successfully with Drug Court clients. In addition, SJCC has a contract with the University of Utah to broaden access to MAT and to begin distributing Naloxone.
- 3) *Direct Access*: The support staff evaluates the risk level for all new clients when they arrive for an intake. Individuals in need of immediate services receive an intake within a day. Low risk individuals are admitted to services within 14 days. SJCC makes an effort to provide immediate services to the 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 San Juan Counseling Center and for the professional manner in which they participated in this review.

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

The Division of Substance Abuse and Mental Health

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