



State of Utah

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Department of Human Services

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Division of Substance Abuse and Mental Health

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July 8, 2019

Bobby Richardson, Board Chairman
Uintah Basin Try-County Mental Health and Substance Abuse Local Authority Board
1140 West 500 South
Vernal, UT 84078

Dear Mr. Richardson:

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, Northeastern Counseling Services; the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental health services, substance abuse treatment and prevention services, and general operations.

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

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

Sincerely,

DocuSigned by:

Doug Thomas

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Doug Thomas
Division Director

Enclosure

cc: Randy Asay, Daggett County Commission

Greg Todd, Duchesne County Commission
Brad Horrocks, Uintah County Commission
Kyle Snow, Director, Northeastern Counseling Center



Site Monitoring Report of

Northeastern Counseling Center

Local Authority Contracts #152250 and #152251

Review Dates: April 23rd, 2019

Table of Contents

| | |
|--|----|
| Section One: Site Monitoring Report | 3 |
| Executive Summary | 4 |
| Summary of Findings | 5 |
| Governance and Fiscal Oversight | 6 |
| Mental Health Mandated Services | 9 |
| Child, Youth and Family Mental Health | 10 |
| Adult Mental Health | 13 |
| Substance Abuse Prevention | 16 |
| Substance Abuse Treatment | 19 |
| Section Two: Report Information | 24 |
| Background | 25 |
| Signature Page | 28 |

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 Northeastern Counseling Center (also referred to in this report as NCC or the Center) on April 23rd, 2019. 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 2 None | 7 |
| <i>Child, Youth & Family Mental Health</i> | Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency | None None None 2 | 10-12 |
| <i>Adult Mental Health</i> | Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency | None None None 2 | 13-15 |
| <i>Substance Abuse Prevention</i> | Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency | None None None 1 | 16-17 |
| <i>Substance Abuse Treatment</i> | Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency | None None 2 1 | 21-22 22 |

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of the Local Authority, Northeastern Counseling Center (NCC). The Governance and Fiscal Oversight section of the review was conducted on April 23rd, 2019 by Chad Carter, Auditor IV.

The site visit was conducted at NCC as the Local Mental Health Authority for Daggett, Duchesne and Uintah Counties. 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. 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.

As part of the site visit, NCC 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. NCC met its obligation of matching a required percentage of State funding.

As the Local Authority, NCC received a single audit as required. The CPA firm Aycock, Miles & Associates, CPAs, P.C. completed the audit for the year ending June 30th, 2018. The auditors issued an unmodified opinion in their report dated October 9th, 2018. The SAPT Block Grant was selected for specific testing as a major program. There were no findings or deficiencies reported.

Follow-up from Fiscal Year 2018 Audit:

No findings were issued in FY18

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) NCC had a difficult time showing that they had enough services to pregnant women and women with dependent children to justify the amounts they had billed in this category for FY18. They were able to substantiate their amounts during the review, but it took some additional steps. In their electronic health record, they have a flag that clearly identifies clients that fit this category. But in looking through samples, it was found that several women had dependent children, as evidenced by the notes, but the indicator flag was not marked. NCC should ensure that staff are trained to ask if clients meet the requirements for this category and to mark it appropriately in the client file. It is essential that the Local Authorities are able to clearly identify clients that are eligible for specific funding.

Center’s Response and Corrective Action Plan:

Action Plan: NCC will continue to evaluate better ways of tracking specific grants and pots of money. We will have more of the work done before the audit, in the future.

Timeline for compliance: NCC will continue to evaluate better ways of tracking specific grants and pots of money.

Person responsible for action plan: Brandon Aldridge, Kyle Snow

- 2) NCC received a single audit, but it was not submitted and available on the Federal Audit Clearinghouse website at the time of the site visit. According to Uniform Guidance 2 CFR 200.512(a), recipients of single audits are required to submit a copy 30 days after receipt of the auditor’s reports, or nine months after the end of the fiscal year - whichever comes first.

Center’s Response and Corrective Action Plan:

Action Plan: Report was submitted within 5 minutes of becoming aware of the problem.

Timeline for compliance: Completed

Person responsible for action plan: Kyle Snow

FY19 Deficiencies:

None

FY19 Recommendations:

None

FY19 Division Comments:

- 1) As a subrecipient of Federal funds, NCC is required to be in compliance with Federal regulations. It was discussed that starting next year, DSAMH will be checking to ensure the Local Authority’s written procurement and federal awards policies meet Federal guidelines.

DSAMH also discussed additional requirements for subcontractor monitoring. NCC was very responsive and willing to be in compliance. We appreciate the relationship we have with NCC and their willingness to work with the Division.

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 Northeastern Counseling Center on April 23rd, 2019. The monitoring team consisted of Mindy Leonard, Program Manager and Kim Bartley, Family Coach with the Utah Family Coalition (Allies with Families). The review included the following areas: record reviews, discussions with clinical supervisors and management, program visits, and feedback from families through questionnaires. During the visit, the monitoring team reviewed FY18 audit findings and County responses; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention funding; juvenile 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 2018 Audit

FY18 Minor Non-compliance Issues:

- 1) *Juvenile Civil Commitment*: NCC are not completing the necessary Civil Commitment paperwork for youth. Specifically, NCC is not utilizing the Notice of Discharge From Commitment to the Local Mental Health Authority of a Child when a child and youth is being released from the Civil Commitment process. Civil Commitment paperwork for juveniles needs to be completed consistent with State of Utah statute 62A-15-703; through use of the proper forms located on the DSAMH website at: <https://dsamh.utah.gov/provider-information/civil-commitment/>.

This issue has been resolved. The charts reviewed in FY19 had the appropriate documentation for juvenile civil commitment.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

- 1) *Youth Outcome Questionnaire (YOQ)*: Of the seven charts reviewed, there were no notes indicating that the YOQ data was used in the treatment process. Division Directives require

that data from the YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart. The YOQ is listed in the National Registry of Evidence Based Programs and Practices in the United States and has been adopted by the State of Utah Local Mental Health Authorities (LMHAs) and by DSAMH. NCC is encouraged to continue training efforts on appropriate clinical use of the YOQ in the treatment process.

Center’s Response and Corrective Action Plan:

Action Plan: Northeastern Counseling has experienced significant turnover in clinicians over the past two years. This area will require more training specific to the YOQ for therapists including practicum students. Training will emphasize that data from the YOQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart.

Timeline for compliance: Training will be completed and this specific item emphasized by August 31, 2019. Another area that contributes is the distribution of the YOQ at the time the consumer arrives. This is being addressed in the adult section.

Person responsible for action plan: Robert Hall

- 2) *Objectives:* The recovery plan objectives were not measurable or achievable within the charts. Objectives in four of the seven chart reviewed were vague and difficult to achieve (e.g. the “client will learn social skills” and the client “will reduce anxiety”). Division Directives state, “The current version of the approved Utah Preferred Practice Guidelines shall be the preferred standard for assessments, planning and treatment.” The current Utah Preferred Practice Guidelines state, “objectives are measurable, achievable and within a timeframe.”

Center’s Response and Corrective Action Plan:

Action Plan: Improving objectives will always be an area of required training and monitoring. The Center is actively striving through its available resources to improve objectives through the quality improvement program. This involves monitoring each individual provider’s records and training to correct those lacking in specific measurable objectives and or their misunderstanding of Recovery Plan nomenclature and definitions. The Center requests technical assistance from the Division, in the form of a brief list that contains a few examples of approved Objectives for the most common clinical presentations. For example, very limited objective examples for a Mood, Anxiety, Trauma and Psychotic Disorders. The intent of this request is not to have an exhaustive list or library from the Division but to have a few examples approved by the Division that can be used in training for years to come. This may also benefit other Center’s in training. The Center does have its own lists that have been developed internally. However, as discussed across the State’s public system in previous years, having a consistent standard to train to would be helpful to reduce some of the inconsistencies regarding objectives. The Center does recognize that some providers will benefit from additional training and monitoring regarding Plans. Training provided to the Center would also include personalizing objectives to each client as their situation dictates.

Timeline for compliance: The Center will continue its internal training program and quality improvement program that includes reviewing and training to individual providers based on chart review findings. The Center will train all providers in a formal training-in addition to individual provider quality improvement training- that is documented by August 31, 2019.

Person responsible for action plan: Robert Hall

FY19 Recommendations:

None

FY19 Division Comments:

- 1) *Family Feedback:* Family feedback was collected by the Utah Family Coalition (UFC) via a survey and a family feedback group, which was held on 4/22/2019. The UFC collected five written surveys, while one family participated in the feedback group. Families reported an overall positive experience working with your center, and stated that staff was helpful and knowledgeable about resources in the community. One family stated that they wish there were more school based services, they felt it would be helpful for the treatment of their child. None of the families indicated that they knew about YOQ measures and the purpose of the tool. NCC should continue to involve families in the YOQ process and help them understand the importance of the results.
- 2) *Family Resource Facilitation:* The Family Resource Facilitator (FRF) is an integral part of the service delivery system in NCC. The FRF provides High Fidelity Wraparound services to support families in need of substance use issues, transitioning youth to and from residential and hospital settings, and youth involved with other children's systems.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Northeastern Counseling Center on April 23rd, 2019. The team included Mindy Leonard, Program Manager. The review included the following areas: Discussions with clinical supervisors, management teams and staff, record reviews, interviews with individuals in treatment, and a site visit to the administrative office. During the discussions, the team reviewed the FY18 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 2018 Audit

FY18 Deficiencies:

- 1) *Documentation of Outpatient Services:* During the chart review, two of fifteen charts indicated the client had suicidal ideation and no follow-up was provided when they missed their next appointment. A third chart indicated a client had suicidal ideation, but there was no evidence of a C-SSRS being completed and no safety plan in their chart. Two other charts had no documentation on follow up after they did not show up for their appointment. Research shows that providing follow up to clients who have expressed suicidal ideation can reduce suicide attempts, and following up on clients who do not show for an appointment can promote recovery and prevent clients from dropping out of treatment.

This issue has not been resolved and will be continued in FY19; see Deficiency #1.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

- 1) *Administration and Clinical Use of the Outcome Questionnaire (OQ):* The FY18 scorecard indicates that 100% of the adult mental health clients have received the OQ. However, the OQ is being administered at a lower frequency than that described in the Division Directives ("every thirty days or every visit, whichever is less frequent"). A review of documentation demonstrated that the OQ was not administered in three of seven charts at the required frequency and five charts lacked evidence that the OQ was being used clinically. 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 encourages NCC to have an updated training on the use of the OQ in the treatment process.

Center’s Response and Corrective Action Plan:

Action Plan: Northeastern Counseling has experienced significant turnover in clinicians over the past two years. This area will require more training specific to the OQ for therapists including practicum students. Training will emphasize that data from the OQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart. Another area that contributes to results is the distribution of the OQ at the time the consumer arrives. The Center has a respectable rate of administration for adults as indicated in the annual scorecard. Efforts to capture all consumers at the desired rate will continue and barriers are assessed by administration. The Center will run a report to indicate the number of OQ Outcomes administered by location and develop a plan for administration rate improvement. The second part of improvement is the ongoing training of clinicians on utilizing the OQ as part of therapy. As clinicians embrace the State’s and Center’s requirement and the benefit of using the measure in treatment, they will also be part of encouraging clients and support staff to complete the OQ.

Timeline for compliance: Training will be completed and this specific item emphasized by August 31, 2019.

Person responsible for action plan: Robert Hall

- 2) *Measurable Objectives:* In accordance with Preferred Practice Guidelines and ongoing planning principles, short term goals/objectives are to be measurable, achievable and within a time frame. Five of seven charts that were reviewed demonstrated objectives that were not measurable (ie. “less depression”, “more stability”, “improve skills”). One possible option for developing measurable goals is encouraging staff to utilize SMART goals - Specific, Measurable, Attainable, Relevant, and Time-based.

Center’s Response and Corrective Action Plan:

Action Plan: Improving objectives will always be an area of required training and monitoring. The Center is actively striving through its available resources to improve objectives through the quality improvement program. This involves monitoring each individual provider’s records and training to correct those lacking in specific measurable objectives and or their misunderstanding of Recovery Plan nomenclature and definitions. The Center requests technical assistance from the Division, in the form of a brief list that contains examples of approved Objectives for the most common clinical presentations. For example, very limited objective examples for Mood, Anxiety, Trauma and Psychotic Disorders. The intent of this request is not to have an exhaustive list or library from the Division but to have a few examples approved by the Division that can be used in training for years to come. This may also benefit other Center’s in training. The Center does have its own lists that have been developed internally. However, as discussed across the State’s public system in previous years having a consistent standard to train to, would be helpful and reduce some of the inconsistencies regarding objectives. Training provided to the Center would also include personalizing those objectives to each client as their situation dictates.

Timeline for compliance: The Center will continue its internal training program and quality improvement program that includes reviewing and training to individual providers based on chart review findings. The Center will train all providers in a formal training-in addition to individual provider quality improvement training- that is documented by August 31, 2019.

Person responsible for action plan: Robert Hall

FY19 Recommendations:

- 1) *Staffing:* NCC continues to struggle to attract and maintain adequate staffing, the economy has a large impact on the retention of staff. They recently lost two therapists due to relocation. NCC has also had to compete with other government and private entities for the small amount of therapists that are available in the area. DSAMH recommends that NCC continue to work with other rural Local Mental Health Authorities to look for methods to incentivize and retain staff, including the use of telehealth.

FY19 Division Comments:

- 1) *Homeless Resources:* NCC utilizes the shelter in Vernal as a resource for their homeless population, and provides a food bank with resources for those seeking services. NCC has eight affordable apartments in the Roosevelt area. Challenges in maintaining these resources include ongoing costs to repair client damage to transitional housing.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Northeastern Counseling Center on April 23rd, 2019. 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 evaluated the data used to establish prevention priorities.

Follow-up from Fiscal Year 2018 Audit

FY18 Minor Non-compliance Issues:

- 1) The Tri-County Synar Tobacco Compliance rate is 83.33%. This is below the Division Directives standard of 90%.

This issue has been resolved. The Tri-County Synar Tobacco Compliance rate for the FY18 was 100%, which now meets Division Directives.

FY18 Deficiencies:

- 1) The Tri-County area saw a decrease in Eliminating Alcohol Sales to Youth (EASY) compliance checks from 584 to 95. The Uintah County Sheriff's department is the only law enforcement agency that reported any EASY Compliance checks.

This issue has not been resolved and will be continued in FY19; see Deficiency #1.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

- 1) The Tri-County area saw a decrease in Eliminating Alcohol Sales to Youth (EASY) compliance checks from 95 to 64, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

Action Plan: Northeastern Counseling Center actively addresses EASY Compliance checks with the local law enforcement. Northeastern Counseling Center’s Prevention Coordinator has met with the newly appointed Duchesne County Sheriff, Travis Tucker. Sheriff Tucker has assigned Officer Derrick Kearney to the EASY Compliance checks. On 04/01/19, the Prevention Coordinator connected Officer Derrick Kearney with Jill Sorenson, the State EASY Program Coordinator, to obtain the necessary training to complete EASY checks in Duchesne County. On 05/30/19, Prevention Coordinator sent a follow up email to both Officer Kearney and Jill Sorenson to inquire on the status of the EASY training/compliance checks.

Timeline for compliance: Compliance was being addressed before audit took place. Full compliance is ultimately in the hands of local law enforcement.

Person responsible for action plan: Robin Hatch

FY19 Recommendations:

- 1) *Community Needs and Collaboration:* In a recent county wide assessment, NCC discovered that several individuals reported that they did not know where to access prevention services in their community. In addition, they discovered that various programs have been setting up duplicate services and not communicating with one another. NCC is planning to conduct focus groups in May and June and talk with the therapists to determine what the prevention needs are for their community. In addition, they are working on methods of consolidating efforts with NCC and programs in the community through regular meetings and funnelling initiatives through the NCC Prevention Advisory Council (PAC). It is recommended that NCC continue to work with programs to consolidate efforts and develop a plan to inform the community where they can access prevention services.
- 2) *Eliminating Alcohol Sales to Youth (EASY) Compliance Checks:* NCC has had difficulty with the completion of the EASY Compliance Checks for various reasons; however, they have been encouraging Law Enforcement and working with the Sheriff and Key Players to complete these checks. It is recommended that NCC continue to work with Law Enforcement and local leaders to complete these checks and follow up on their progress as needed.

FY19 Division Comments:

- 1) *Student Health and Risk Prevention (SHARP) Survey:* In the past, NCC had issues with the schools conducting the SHARP Survey due to staffing shortages. However, NCC recently decided to take over the administration of the SHARP Survey in the schools to resolve this issue, which has worked out well. They were able to obtain a large sample from the SHARP data this year, which has helped them identify gaps in the system, prioritize risk and protective factors and develop services to meet the needs of their community.
- 2) *Prime for Life (PRI) Classes:* NCC staff have been providing the PRI Teen and PRI Under 21 classes every month. They have also been looking into providing an eight hour Prime for Life Driving Under the Influence (DUI) Class at no cost for the community. This class would be for individuals that don’t meet the requirements for treatment, but could benefit from an eight hour PRI class. NCC has found through their community assessment that the

perception of harm to marijuana has decreased and for this reason are planning to focus on marijuana use in this eight hour PRI class. This class would help meet the needs for individuals in the community that are in need of a brief intervention for their substance use issues.

- 3) *Accomplishment of Long Term Prevention Goals:* NCC has been focusing on the following prevention goals over the past several years: (1) Reduce Underage Drinking (2) Reduce Alcohol Motor Vehicle Crashes (3) Reduce E-Cigarette Use (4) Reduce Tobacco Use (5) Reduce Binge Rates for Adults. NCC reported that the long term outcomes for the 30-day use rates for underage drinking were reduced by 57% over the past 10 years, which is a significant improvement over time. NCC has focused on the risk and protective factors and evidence-based programs, which have contributed to successful community outcomes.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Northeastern Counseling Center on April 23rd, 2019, which focused on Substance Use Disorders Treatment, Drug Court, clinical practice and compliance with contract requirements, DORA, and JRI. 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 JRI and DORA requirements and contract requirements were evaluated through a review of policies and procedures by interviews with Northeastern Counseling staff. Treatment schedules, policies, and other documentation were reviewed. The Utah Substance Abuse Treatment Outcomes Measures Scorecard results were reviewed with staff. Client satisfaction was measured by reviewing records, Consumer Satisfaction Survey data and results from client interviews. Finally, additional data was reviewed for Opiate Use in Duchesne, Uintah, and Daggett Counties.

Follow-up from Fiscal Year 2018 Audit

FY18 Minor Non-compliance Issues:

1) The Utah Substance Abuse Treatment Outcomes Measures Scorecard showed:

- The percent of individuals that completed a treatment episode successfully decreased from 65.8% to 52.5%, from FY15 to FY16 respectively, then decreased again to 36.6% in FY17 which does not meet Division Directives.

Local Substance Abuse Authorities will meet or exceed their FY2018 Successful Treatment Episode Completion rates in FY2019 and will work towards achieving a goal of 60%. Local Substance Abuse Authorities whose FY2018 completion rate was over 60% are required to meet or exceed a 60% completion rate in FY2019. Successful Treatment Episode Completion is defined as a successful completion of an episode of treatment without a readmission within 30 days. An episode of treatment is defined in the Treatment Episode Data Set.

This issue has been resolved. The percent of individuals that completed a treatment episode successfully went from 36.6% to 26.3% from FY17 to FY18, which meets Division Directives.

- The percent of individuals that engaged in Social Support Recovery Services decreased from 12.1% in FY16 to -35.7% in FY17, which does not meet Division Directives.

Local Substance Abuse Authorities' Scorecard will show that the percent of clients participating in social support recovery activities increased from admission to discharge by at least 10%. Participation is measured as those participating in social support recovery activities during the 30 days prior to discharge minus percent of clients participating in social support of recovery activities in 30 days prior to admission

The percent of individuals that engaged in Social Support Recovery decreased from -35.7% to -54.8%, which does not meet Division Directives.

This issue has not been resolved and will be continued in FY19; see Minor Non-Compliance Finding #1.

- Percentage of decrease in individuals reporting the use of tobacco products from admission to discharge went from 6.2% in FY16 down to -0.6% in FY17. This does not meet Division Directives.

Local Substance Abuse Authorities' scorecard will show that the percent of clients who use tobacco will decrease from admission to discharge by 5%.

This issue has been resolved. The percent of individuals that reported the use of tobacco from admission to discharge increased from -0.6% to 1.8% from FY17 to FY18 respectively, which meets Division Directives.

FY18 Deficiencies:

- 1) There was no evidence of urine drug screens being conducted with clients. The Division Directives state that "Drug use during treatment should be carefully monitored through drug testing and other means." If this drug testing is conducted outside NCC, there should be documentation that drug testing is being conducted off site and that there is ongoing collaboration between NCC and this outside provider.

This issue has been resolved. There was evidence of urine drug screens in the client's charts during the chart reviews this year, which meets Division Directives (*Chart #'s 23593, 235, 94771, 463, 38666, 40519, 94769, 9934, 64718*).

- 2) There were no Recovery Plans found in the client's charts. The Division Directives require recovery planning, which is an important part of the individual's engagement in treatment and long term sobriety (Charts reviewed: *73811, 95214, 93107, 32269, 53170, 95914, 95800, 94460, 95336 and 23977*). Below is a summary of these requirements:

Recovery Planning Principles: The client is involved in ongoing and responsive recovery planning.

- *Plans incorporate strategies based on the client's motivations.*
- *Where possible, the plan represents a negotiated agreement.*
- *The plan is kept current and up to date.*
- *Short term goals/objectives are measurable, achievable and have a timeframe.*
- *Planning anticipates developing and maintaining independence.*

This issue has been resolved. Recovery Plans were found in the client's charts during the chart review this year, which meets Division Directives (*Chart #'s 23593, 235, 94771, 463, 38666, 40519, 94769, 9934, 64718*).

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) The percent of individuals that engaged in Social Support Recovery decreased from -35.7% to -54.8%, which does not meet Division Directives.

Center’s Response and Corrective Action Plan:

Action Plan: This area is a challenging area to make improvements for several reasons. Only a few of those reasons are mentioned here with a plan to improve. Social Support is often reported higher at the beginning of assessment than in later stages. For example, individuals that have been incarcerated and released often attend social support groups in the last 30 while incarcerated but discontinue once released and do not take advantage of community social support options. This leads to the number of activities attended as being lower than at admission. Transportation for those in rural areas to social support can also be an issue including the availability of social support resources that the individual is willing to engage.

The Center will train staff on motivating those in treatment to access available social support options in their community.

Another factor is the collection and definitions used by clinicians to capture the data. Staff will be trained on the definition of social support so that more accurate data is collected from those in treatment and at discharge.

Timeline for compliance: August 31, 2019

Person responsible for action plan: Robert Hall

- 2) The Treatment Episode Data Set (TEDS) showed that 19.9% of criminogenic risk data was not collected for individuals compelled to treatment in the criminal justice system, which does not meet Division Directives.

Center’s Response and Corrective Action Plan:

Action Plan: The Center believes it has identified a potential reason for the discrepancy. Some individuals that are compelled have not been having the risk assessment completed while other did have it completed but the Assessor did not access the information. Training will be completed by August 31, 2019. This will include resolving the process issue that at times

involves the information from the risk tool not being recorded in the Assessment for compelled treatment.

Timeline for compliance: August 31, 2019

Person responsible for action plan: Robert Hall

FY19 Deficiencies:

- 1) There were 25% of old open admissions (charts), which is above the standard of 4%. This does not meet Division Directives.

Center's Response and Corrective Action Plan:

Action Plan: The Center has recently closed a large number of these admissions and will close the remainder by August 31, 2019.

Timeline for compliance: August 31, 2019

Person responsible for action plan: Mike Safford

FY19 Recommendations:

- 1) *Staff Retention:* NCC has had been experiencing difficulty retaining staff over the past years. They have tried to do things to recruit and retain staff including: (1) providing staff with a signing bonus upon hire (2) paying off school loans through the National Health Service Corps (3) Internal bonuses and raised salaries for staff and (4) offering to hire social work students after their practicum has ended. This year, NCC has seven Social Work students through the Utah State University Graduate School of Social Work. NCC also donated \$50,000.00 to the Utah State University Masters of Social Work Program, which has helped this program significantly. It is recommended that NCC continue to seek ways to recruit and retain staff.
- 2) *Prevalence of Suicide Attempts in Uintah County:* There is a high prevalence of suicide in Uintah County. In chart reviews, there were several clients who reported suicide attempts or had a family member with a history of suicide (*Chart #'s 23593, 235, 94771, 463, 38666, 40519, 94769, 9934, 64718*). NCC has implemented several initiatives to help prevent suicide in their community, which have been helpful. It is recommended that NCC continue with suicide prevention and intervention efforts.

FY19 Division Comments:

- 1) *Suicide Prevention and Mental Health First Aid:* Every year, NCC hosts the Enchanted Forest event, where they highlight suicide prevention in their community. This event provided \$12,000.00 last year, which was used to train 1,000 adult and 100 youth in Mental Health First Aid. In addition, the proceeds from this event were able to set up two Mental Health First Aid Classes for youth in the Ute Tribe for individual age 16+. In addition, NCC has conducted suicide screenings with the Columbia Suicide Severity Rating Screening (CSSRS) tool and are using the Stanley Brown Safety Plan as needed. NCC held a Suicide Prevention Summit where 1,400 individuals attended. At this event, they provided over 700

gun locks to participants. All of these efforts are making a positive difference in their community.

- 2) *Medication Assisted Treatment (MAT)*: NCC has expanded access to MAT in their community over the past year. They have four clinics in their community and two Waivered Physicians that are providing Suboxone. They are assessing individuals with opioid use disorders for MAT and providing it as needed. NCC is looking into providing individuals with their first dose of Vivitrol in the Jail prior to their release and the Nursing Team is assisting individuals with opioid use disorders in completing Vivitrol applications. NCC is planning to use Medicaid Expansion to fund the Vivitrol project in the jail.
- 3) *Data and Performance Evaluation*: NCC has been using the Daily Living Assessment (DLA-20) for clients with mental health issues and are planning to use this tool with their clients with substance use disorders in the coming year. The DLA-20 is a research based outcomes measurement tool that measures the daily living areas impacted by mental illness or disability, which has now been validated for substance use disorders. It provides a quick way to identify where outcomes are needed so that clinicians can address functional deficits on individualized service plans. This tool ensures valid scores and consistent utilization for healthcare report cards ([National Council for Behavioral Health: DLA-20 Mental Health Outcomes Measurement](#)).

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 Northeastern Counseling Center and for the professional manner in which they participated in this review.

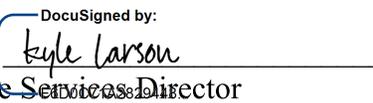
If there are any questions regarding this report please contact Chad Carter at (801)538-4072.

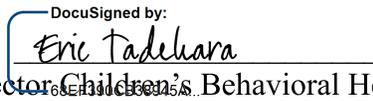
The Division of Substance Abuse and Mental Health

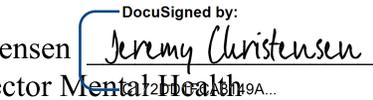
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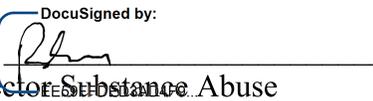
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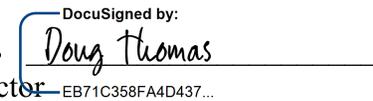
Approved by:

Kyle Larson  Date July 9, 2019
 Administrative Services Director DocuSigned by: 66E73163E9256...

Eric Tadehara  Date July 8, 2019
 Assistant Director, Children's Behavioral Health DocuSigned by: 66E73163E9256...

Jeremy Christensen  Date July 8, 2019
 Assistant Director Mental Health DocuSigned by: 2100CAAB19A...

Brent Kelsey  Date July 9, 2019
 Assistant Director Substance Abuse DocuSigned by: E53E7F36...

Doug Thomas  Date July 9, 2019
 Division Director DocuSigned by: EB71C358FA4D437...

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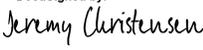
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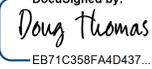
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