utah department of
human services
SUBSTANCE ABUSE AND MENTAL HEALTH

Site Monitoring Report of

San Juan Counseling Center

Local Authority Contracts #152314 and #152315

Review Date: November 14th, 2017

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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 November 14th, 2017. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	9 - 10
	Deficiency	2	10 - 11
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Substance Abuse Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	14 - 15
	Deficiency	3	15 - 16
Substance Abuse Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	2	19 - 20
	Deficiency	2	20

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of San Juan Counseling Center (SJCC). The Governance and Fiscal Oversight section of the review was conducted on November 14th, 2017 by Chad Carter, Auditor IV. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Client fees were reviewed for consistency and adherence to approved fee schedules. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. 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.

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, 2016. The auditors issued an unqualified opinion in the Independent Auditor's Report dated June 30th, 2017. There were two deficiencies discussed in the auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters:

2016-1 – Stale checks in the Protective Payee account: During the review, some outstanding checks were found in the Protective Payee account that were a few years old. The amounts were immaterial for the audit, but they need to be investigated and a determination needs to be made as to their validity.

2016-2 – Proper handling of voided/stale checks: Some of the stale checks had been improperly voided in subsequent years. These determinations and actions should be taken in the current year.

SJCC will implement a review process and make timely correction with their stale checks. These issues do not directly affect the delivery of mental health or substance abuse services, or the funding for these services. The Division is satisfied with the Center's response.

Follow-up from Fiscal Year 2017 Audit:

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.

This issue has been resolved. SJCC's FY17 cost per client in substance abuse services was $4,060. This is a $7.5% decrease from the previous year and is 10.9% of the State average cost per client.

Findings for Fiscal Year 2018 Audit:

FY18 Major Non-compliance Issues:
None

FY18 Significant Non-compliance Issues:
None

FY18 Minor Non-compliance Issues:
None

FY18 Deficiencies:
None

FY18 Recommendations:

1) *Executive Travel:* All executive travel is reported to and approved by the board. A list of travel locations is given to the board each time they meet. A separate expenditure report is also given to the board for each meeting and both of these are approved. It would take further investigation and discussion to find out which expenditure amounts went with each travel incident. It is recommended that a copy of each travel approval sheet is provided to the board for approval. These were used during the Division's review of executive travel, they include detailed travel information (hotel names, locations, etc…) and also include a breakdown of all costs and not just a total sum amount. No issues were found in the Division's review of travel, but the board should have more detail available in order to provide sufficient oversight.

FY18 Division Comments:
None

Mental Health Mandated Services

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

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

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

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to 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 San Juan Counseling Center on November 14th, 2017. The monitoring team consisted of Eric Tadehara, Program Administrator; Mindy Leonard and Codie Thurgood, Program Managers; 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 2017 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 2017 Audit

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%, which is below the required rate. There is also continued evidence that the YOQ is not being addressed in the clinical process.

   This finding has not been resolved and is continued in FY18; see Minor Non-compliance issue #1.

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 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. There is also continued evidence that the YOQ is not being addressed in the clinical process. Within the chart review, the YOQ was not utilized throughout the treatment process, either in the treatment

plan or when a red flag is identified, with only one chart referencing the YOQ clinically. SJCC has made good progress in the rate of at least two YOQ administrations throughout FY17, with the rate being increased from 44.2% in FY16 to 62.7% in FY17.

Center's Response and Corrective Action Plan:

Nearly half of the clinical services we provide children and youth now occur in the school setting. For youth 11 years and younger, this has created challenges in terms of gathering YOQ-PR data since the parents are not present when the services are provided. To help address this, we had our BSW interns make outreach phone calls to these parents beginning September 2017. Although this is a temporary solution (our interns will complete their schooling in April 2018), we will continue to look for ways to obtain this data. Even with targeted effort however, we do not anticipate being able to achieve a monthly administration rate for our youth 11 years and younger receiving services in the school setting.

For youth who are brought to the counseling center by a parent or guardian, our front desk staff is now in the practice of noting which clients have not had a YOQ-SR or YOQ-PR within the past 30 days and inviting the youth or parents to complete the instrument. We believe this has contributed greatly to 18.5% increase in YOQ administrations rates. We will continue this effort.

As for utilizing the YOQ instrument in the clinical session and within the treatment plan, San Juan Counseling administration will take the following steps:

1. Provide feedback to clinicians no less than semi-annually on their utilization of the YOQ based on internal chart reviews. Specific focus will be placed on whether the suicide red flag is addressed within the progress note.
2. Clinicians will be provided training in FY18 on ways to use the YOQ in creating treatment plan objectives for youth and children.

FY18 Deficiencies:

1) *Psychosocial Rehabilitation:* SJCC has decreased the rate of Psychosocial Rehabilitation provided from 3.4% in FY16 to .4% in FY17 with a total of one youth being served. Psychosocial Rehabilitation is one of the ten mandated services as required by Utah Code 17-43-301.

Center's Response and Corrective Action Plan:

Beginning February 2018, SJCC will begin offering a skills development group for SED students at ARL Middle School using the Zones of Regulation curriculum. The group will meet weekly for 10 weeks and will be facilitated by a child case manager. Our plan is to continue offering the group at San Juan County schools. As needed, this curriculum will be adapted for individual skills development for youth with an SED designation.

2) *Respite Services:* SJCC provided Respite services at a lower rate than the rural and State averages. In FY17, Respite services were provided at a rate of 0.9 %, which was a decrease

of 2.5% from FY16. SJCC provided Respite services to two youth during FY17. Respite is one of the ten mandated services as required by Utah Code 17-43-301.

Center's Response and Corrective Action Plan:

SJCC will continue to provide scheduled respite services for SED youth through our adult case managers. In addition, we will: 1. Conduct a quarterly case review of SED youth who might benefit from respite services and arrange for respite services as recommended by the treatment team. 2. Explore the feasibility of having our Family Resource Facilitator provide respite services during after school hours.

FY18 Recommendations:

1) *Case Management:* SJCC provided Case Management services at a lower rate than the rural and State averages. Case management in FY17 was provided at a rate of 1.6% to four children and youth, a decrease from the FY16 rate of 12% and 25 children and youth. SJCC is encouraged to find ways to utilize case management more effectively within the array of children and youth services.

FY18 Division Comments:

1) *Family Feedback:* Family feedback was collected by the Utah Family Coalition (UFC) from five completed questionnaires and four families who attended focus group. The survey is used to improve services for the clients served. Every family involved reported that their input had influenced their child's treatment and that they were included in the treatment plan process. Families and caregivers believe the center cares about them and their children.

2) *Wraparound and Family Resource Facilitator:* SJCC is providing High Fidelity Wraparound as defined by the UFC. The Family Resource Facilitators (FRF) are an integral part of the service delivery system, and the services they provide help to establish relationships and rapport with new clients and foster community partnerships. One family stated "Wraparound helped our family in crisis, our team works together for our son."

   It is recommended that SJCC examine how the YOQ is being utilized to help families understand why they are required to complete the YOQ, and how it is being used. It is also recommended that SJCC look for ways to sustain the FRF program and increase billing for family peer support.

3) *Community Partnerships:* SJCC collaborates with the various community partners within the catchment area. These partnerships include local schools and the Division of Juvenile Justice Services (DJJS). SJCC has been in communication with DJJS to ensure services provided in the community are collaborative and not duplicative.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of San Juan Counseling Center on November 16th, 2018. The team included Pam Bennett, Adult Mental Health Program Administrator. The review included the following areas: discussion with the clinical director, record reviews, and a site visit to the Utah Navajo Indian Health System in Montezuma Creek. During the discussion, the team reviewed the FY17 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 2017 Audit

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 issue has been resolved. In 2017, SJCC OQ administration rates reached 61.7%, exceeding the 50% administration rate.

FY17 Deficiency Issues:

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.

   This issue has been resolved. There was evidence of use of the OQ as an intervention in all charts with an OQ administered. In two of nine charts, the individuals receiving services refused to take the OQ and this was documented.

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

None

FY18 Deficiencies:

None

FY18 Recommendations:

1) *Peer Support Services (PSS):* The FY17 Scorecard continues to report services below the rural average (SJCC-1.5%; rural average-4.8%). Peer Support Services have been recognized as an Evidence-Based Practice by the Centers for Medicare and Medicaid Services (CMS) since 2007. DSAMH commends SJCC for using Family Resource Facilitators to provide Peer Support services to adults when appropriate. It is recommended that SJCC continue efforts to employ a Certified Peer Support Specialist in order to expand this service to a wider range of adult clients.

2) *Case Management (CM):* Case management is one of ten mandated services listed in Utah Code 17-43-301. SJCC continues to report a level of CM services that are lower than the State rural average (SJCC-8.1%; rural average-26.4%). A review of charts indicates that case management has been available for individuals needing this service. SJCC is encouraged to ensure that the decreasing levels of CM do not result in unanswered client needs.

FY18 Division Comments:

1) *Personal Services/Psychosocial Rehabilitation Services (PSR*): SJCC is commended for provision of client-centered and culturally competent services for individuals with serious mental illness. In particular, documentation detailed the provision of personalized living skills and payee services, often in Navajo.

2) *Employment Services/Supported Education:* DSAMH recognizes and appreciates efforts SJCC is making to develop employment opportunities for individuals with serious mental illness. In addition, collaborative efforts between the Utah Department of Human Services and the Utah Navajo Health System have resulted in employment and education supports for transition-age Navajo youth.

3) *Housing*: DSAMH commends SJCC for their continued efforts to address housing issues in San Juan. The FY17 Mental Health scorecard reports an increase from two individuals receiving supportive housing to ten, and SJCC reports this service has been a critical aspect of maintaining those individuals in the community.

4) *Inpatient Hospitalization:* DSAMH appreciates the efforts that SJCC has made to use effective crisis services and diversion to continue to decrease the number of clients receiving inpatient services. This demonstrates best practice by providing care in the least restrictive environment.

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review of San Juan Counseling on November 14th, 2017. 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 2017 Audit

FY17 Minor Non-compliance Issues:

1) SJCC 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 the FY17 and data needs to be entered into the system by November 30, 2016.

   This finding has been resolved, SJCC entered in a plan for FY17.

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.*"

   This finding has been resolved, SJCC submitted an Annual Report for FY16 and FY17.

Findings for Fiscal Year 2018 Audit

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

1) 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:

SJCC is currently working to complete a full community assessment, through SJCPAC and Youth Coalition efforts. SJCPAC is hoping to raise better community awareness and education as to the importance of the SHARP Survey, as the numbers for this survey have declined in 2017 – from the year 2015. This makes any SHARP data, not as effective as we need it to be. We are also working on trying to implement trust within the southern schools and the logistics needed to encourage them to take the survey as well. To date, only schools in Blanding and Monticello have participated**.** We are working on finding different forms of data that we can use, as well as the SHARPS. We are also taking steps to implement a Community Readiness Assessment, as we continue efforts to complete a full Strategic Plan in the coming months.

FY18 Deficiencies:

1) No Eliminating Alcohol Sales to Youth (EASY) compliance checks occurred in FY17.

Center's Response and Corrective Action Plan:

We have reached out to law enforcement twice in the last couple of weeks to talk about compliance checks. The Drug Task Force Commander stated that it is someone from another agency that conducts those checks. He is working on getting me the contact information for that individual. I am still waiting to hear back from him, but will continue to follow-up. We will continue to strengthen collaborative relationships with law enforcement in city, county, and tribal jurisdictions.

2) Currently SJCC's Synar compliance rate is 77%. Division Directives measure for a compliance rate of 90%.

Center's Response and Corrective Action Plan:

In talking with the Public Health Department this week regarding the Synar compliance rate; we received the following response:

"In June of 2017, 2 out of 22 tobacco retail outlets sold a tobacco product to a minor. In December of 2017, 2 out of 22 outlets sold to a minor. So 91% of retail outlets complied with the law.

Every retail outlet that complies with the law gets a letter of congratulations and a reminder of how important it is to keep tobacco away from underage people. Those who sell to our buyer get cited immediately by law enforcement, and they get a letter from us informing them of their civil penalty of $300. We agree to lower that penalty to $150 in exchange for proof that they have properly trained (retrained) their employees, and we offer to help them with the training if they need it. It seems to be working."

The Health department has a strong presence on our Substance Abuse Prevention Coalition (SJCPAC) and we will continue working with them to ensure continued and better compliance

through collaborative coalition efforts.

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

Center's Response and Corrective Action Plan:

Hope Squads, EASY Checks, and Parents Empowered are evidence based programs.

The other two programs that are close to being evidence based (as far as I understand it) are the **SJCPAC and Youth Coalitions**. The **SJCPAC** has been trained in the SPF model from the beginning and is trying to follow it as they grow and develop. We are also incorporating CTC principles. Our Youth Coalition is very new, but has also been trained in the SPF model. It is our goal to continue in the direction of implementation of evidence based strategies and programs that support that model. We continue to try building capacity and community awareness as we need to build partnerships to help support and sustain those efforts, especially since it has been a challenge to obtain direct funding to support new evidence based models.

Our recent start-up of our **county youth coalition** yielded student representatives from Whitehorse HS in Montezuma Creek, Monument Valley HS in Monument Valley, San Juan HS (with students representing Blanding & White Mesa communities), and Monticello HS in Monticello. There are also student representatives from Navajo Mountain HS in Navajo Mountain and Bluff (a part of San Juan HS) that were unable to attend the meeting. These student leaders will form a cohesive county youth coalition and report to the SJCPAC. They have also committed to start prevention groups/clubs and work within their own schools and communities to identify specific needs regarding substance abuse prevention within their geographic areas; while still feeling the strength and support of relationship building with each other as we work to build a stronger county family. They are excited about this collaborative spirit. They are all currently on assignment to develop a coalition name and logo, as well as community assessment work. We will be assigning youth coalition leadership assignments within the next month.

This leaves the last logic model, which is community events. This of course is NOT evidence based. **However with 5 out of 6 logic models being evidence based, or close to it, our 50% programming has been raised.**

FY18 Recommendations:

1) It is recommended that SJCC complete a full community assessment, including a Community Readiness and data review, with the San Juan Prevention Action Collaboration coalition by February 2018 with a report as evidence of the completed assessment.

2) It is recommended that SJCC have a full Strategic Plan, with community involvement, completed by June 2018.

3) It is recommended that SJCC expand the number of coalitions in the county, including Montezuma Creek.

FY18 Division Comments:

1) SJCC has sent their Director, Clinical Director and Prevention Coordinator to Community Anti-Drug Coalitions of America (CADCA). 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) SJCC has increased the involvement and services to the southern part of the County.

3) SJCC has increased representation on the San Juan Prevention Advisory Coalition (SJPAC). Previously, there was a lack of invitation to native populations.

Substance Abuse Treatment

Christine Simonette, Adult Program Manager for Substance Use Disorder Services conducted the monitoring review on November 14th, 2017. The review focused on: compliance with State and Federal laws, Division Directives, Federal Substance Abuse Treatment (SAPT) block grant requirements, JRI, scorecard performance, and consumer satisfaction. The review included a document review, clinical chart review, and an interview with the clinical director and other staff members. Consumer satisfaction and performance were also evaluated using the Division Outcomes Scorecard, and the Consumer Satisfaction Scorecard.

Follow-up from Fiscal Year 2017 Audit

FY17 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 FY15.

   This issue has been resolved. Charts reviewed were more specific in goals that clients participated in. All charts reviewed, however, did show a lack of specificity in group notes that showed client progress in those particular groups.

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.

   This issue has been resolved. FY18 reflected 94.2% of clients decreasing criminal involvement from admission to discharge which meets Division Directives.

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 FY15 to 36.4%. This does not meet with Division Directive requirements.

   This issue has been resolved. FY18 reflected that 53.3% of clients completed their treatment episode successfully, which is an increase from 36.4% and meets Division Directives.

4) The FY17 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.

   This issue has been resolved. FY18 reflects an increase of clients employed at discharge of 68.9% which meets Division Directives.

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.*

   This issue has been resolved. In FY18 San Juan decreased open charts to 2.5%, which meets Division Directives.

FY17 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.

   This issue has not been resolved and will be continued in FY18; see Minor Non-compliance Issue #2.

<u>Findings for Fiscal Year 2018 Audit:</u>

FY18 Major Non-compliance Issues:

None

FY18 Significant Non-compliance Issues:

None

FY18 Minor Non-compliance Issues:

1) Data from the FY17 Utah Substance Abuse Treatment Outcomes Scorecard shows the percent of non-homeless clients from admission to discharge is 0%. The State average in FY17 was 2.5%.

Center's Response and Corrective Action Plan:

SJC Administration will review the data submitted to ensure that the homeless rate is correct. SJC Administration will also review the definition of homeless to confirm that the corrent population is be represented.

2) Treatment Episode Data Set (TEDS) submissions do not reflect if 31.9% of incoming clients have been "compelled to treatment" by the criminal justice system. 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:

In the FY18 Treatment Episode Data Set (Admits) it is showing that there are no "unknowns" in the compelled to treatment category. SJC Administration will continue to monitor this to certify that the data is being reported correctly.

FY18 Deficiencies:

1) Client charts lacked information that would indicate whether a client was offered, or using Medication Assisted Treatment (MAT) to assist with their recovery. It is recommended to include if MAT is offered, and client progress if they're receiving MAT, including a urinalysis to confirm.

Center's Response and Corrective Action Plan:

SJCC's Medical Director, Stephen Hiatt, APRN is licensed to provide MAT services. SJCC will take the following steps to address MAT reporting and monitoring:
1. Add a question to our intake evaluation about whether or not the client is receiving MAT.
2. Conduct reviews no less than quarterly of clients with alcohol or opiate use to see if any could potentially benefit by MAT. Any clients identified will then be approached by their therapist with this option.
3. Substance abuse therapists will be trained in the use of the ASAM as a tool for tracking MAT history, current use and progress.

2) Client charts did not indicate if tobacco cessation was offered to clients who reported tobacco use. Upon talking with the center, there is no specific groups to offer, they will, however, look into online support groups.

Center's Response and Corrective Action Plan:

SJCC will coordinate with San Juan Public Health about tobacco cessation programs, such as Way to Quit and provide instruction to our SPMI clients on methods and supports available to them. SJCC will provide or arrange for group skills instruction on tobacco cessation at our day treatment programs on a semi-annual basis.

SJCC will continue to promote all our locations as tobacco free campuses through signage and written documents signed by the client at intake.

FY18 Recommendations:

1) It was noted that charts of clients in drug court did not contain urinalysis results. At this time, it is requested that the center scan and attach drug testing results to document effective treatment.

2) Clinician notes for progress in groups was not specific to client's participation. It is recommended that these notes reflect participation and progress in groups.

3) In charts reviewed, required documents were not electronically attached to client's Credible chart. It is recommended to scan and attach the following documents for off-site review:
   a. Signed fee agreement that identifies individual financial responsibility for services;

b. Drug testing agreement that identifies the purpose of testing, potential consequences for testing positive, and right to confirmation test;
c. Consent form (only required if information is released);
d. Intake documents that include a Privacy statement that is signed and witnessed (It was noted that none of the charts reviewed had witness signatures, which is a requirement).

FY18 Division Comments:

None

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

Prepared by:

Chad Carter
Auditor IV

Date February 12, 2018

Approved by:

Kyle Larson
Administrative Services Director

Date February 12, 2018

Ruth Wilson
Assistant Director Children's Behavioral Health

Date February 12, 2018

Jeremy Christensen
Assistant Director Mental Health

Date February 12, 2018

Brent Kelsey
Assistant Director Substance Abuse

Date February 12, 2018

Doug Thomas
Division Director

Date February 12, 2018