State of Utah
GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Department of Human Services
ANN SILVERBERG WILLIAMSON
Executive Director

Division of Substance Abuse and Mental Health
DOUG THOMAS
Director

January 29, 2020

Commissioner Kenneth Maryboy
San Juan County Commission
333 S. Main, #2
Blanding, UT 84511

Dear Commissioner Maryboy:

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

Douglas P. Thomas
Douglas P. Thomas (Feb 11, 2020)

Doug Thomas
Division Director

Enclosure
cc: Commissioner Willie Grayeyes, San Juan County Commission
Commissioner Bruce Adams, San Juan County Commission
Tammy Squires, Director of San Juan Counseling Center

utah department of
human services
SUBSTANCE ABUSE AND MENTAL HEALTH

Site Monitoring Report of

San Juan Mental Health/ Substance Abuse Special Service District
DBA San Juan Counseling Center

Local Authority Contracts #152314 and #152315

Review Date: October 29th, 2019

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of San Juan Counseling Center (also referred to in this report as SJCC or the Center) on October 29th, 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)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	7
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	10
	Deficiency	1	10-11
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	2	13-14
Substance Abuse Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	2	16-17
Substance Abuse Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	20
	Deficiency	1	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 October 29th, 2019 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. 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. SJCC provided copies of their written procurement and Federal awards policies.

As part of the site visit, SJCC sent several files and explained their process to demonstrate their allocation plan and to justify their billed amounts. The allocation plan is clearly defined and shows how administrative and operational 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 31, 2018. A single audit was not done as SJCC did not receive enough Federal funding to meet the $750,000 threshold to require a single audit for this year. The auditors issued an unqualified opinion in the Independent Auditor's Report dated June 30, 2019; stating that in their opinion, the financial statements present fairly, in all material respects, the respective financial position of the business-type activities of San Juan Mental Health/Substance Abuse Special Service District. There were no findings or deficiencies reported.

Follow-up from Fiscal Year 2019 Audit:

No findings issued in FY19.

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:
None

FY20 Significant Non-compliance Issues:
None

FY20 Minor Non-compliance Issues:
None

FY20 Deficiencies:

1) *Timely Billings* - SJCC has had a minor issue with submitting billings timely as required by contract. Local Authorities are required to submit each billing within 30 days, SJCC has submitted them at an average of 35 days throughout FY19. The billing process should be reviewed to identify areas of improvement to be brought into compliance.

Center's Response and Corrective Action Plan:

Action Plan: SJC staff has reviewed the processes and is looking into areas of improvement. Staff will monitor the areas that are slowing down the process and address them monthly. Starting in December 2019 billings will be submitted by the end of the following month.

Timeline for compliance: Monthly compliance starting December 2019

Person responsible for action plan: Tammy Squires

FY20 Recommendations:

1) Cost per client data was analyzed and compared to State-wide averages. SJCC's cost per client in substance abuse increased by 32.9% from the previous year and is at 66.8% over the State average. This issue was discussed with the Director, because of their size and the number of clients served, it only takes a small change in client numbers to cause large swings in cost per client data. It is recommended that SJCC analyzes their costs to see if there are any other factors that could be causing this increase.

2) The SJCC emergency plan was reviewed by Robert Snarr, Program Administrator as part of the site visit. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that SJCC review these suggestions and update their emergency plan accordingly. DSAMH is available for technical assistance.

FY20 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 Children, Youth, & Families team conducted its annual monitoring review at San Juan Counseling Center on October 29th, 2019. The monitoring team consisted of Mindy Leonard, Program Manager; Leah Colburn, Program Administrator, Tracy Johnson, Wraparound and Family Peer Support Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, program visits, allied agency visits, review of the Fiscal Year 2019 audit, statistics, including the Mental Health Scorecard, Area Plans, Family Resource Facilitation (Peer Support), High Fidelity Wraparound, Multi-Agency Coordinating Committee, school-based behavioral health, 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 2019 Audit

FY19 Minor Non-compliance

1) Youth Outcome Questionnaire: SJCC does not administer the Youth Outcome Questionnaire (YOQ) at least once every 30 days. The Division Directives state "DSAMH will require that the Youth Outcome Questionnaire be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt)." Through records reviews, eight of the ten charts reviewed had YOQs that were not administered at the required frequency of at least once every 30 days.

   There has been improvement made, this issue will be reduced to a Deficiency for FY20; see Deficiency #1.

2) Respite Services: SJCC continues to provide Respite services at a low rate. In FY18, only one youth received Respite services, which decreased from the two children who received Respite services in FY17. Respite is one of the ten mandated services as required by Utah Code 17-43-301.

   SJCC provided Respite Services to an increased number of children, however it will continue as a finding for FY20; see Minor Non-compliance Issue #1.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

1) *Respite Services*: SJCC continues to provide Respite services at a low rate. In FY19, only two youth received Respite services, which increased from the one child who received Respite services in FY18. Respite is one of the ten mandated services as required by Utah Code 17-43-301. This is an improvement over last year. SJCC should continue to find ways to provide Respite services to more children and youth as appropriate.

Center's Response and Corrective Action Plan:

Action Plan: SJCC will provide respite services to 5 youth in FY20. To meet this goal, the following steps will be taken:
1. The clinical director will meet with the adult day treatment program manager to identify how to adjust the schedules of our adult case managers to make them available for scheduled respite services during after-school hours. This initial meeting will take place on 1/6/20.
2. The clinical director will meet with all agency therapists working with children and youth to identify SED youth and families who could benefit by scheduled respite services. A list of eligible youth will be generated by 1/31/20.
3. This site visit report and corrective action plan will be shared with the day treatment program manager and all adult case managers to provide a context for discussion and to solicit their input in ways SJCC can reach the goal of 5 youth served in FY20. This discussion will occur with all agency case managers by 1/31/20.
4. The clinical director will meet with the two Family Resource Facilitators employed by SJCC to explore the possibility of them providing respite services. These meetings will occur by 2/1/2020.
5. The clinical director will monitor the number of respite services provided in the previous month and report this to the agency director starting 2/1/20.

Timeline for compliance: See dates listed in the above action steps**.**

Person responsible for action plan: Ryan Heck

FY20 Deficiencies:

1) *Youth Outcome Questionnaire:* SJCC does not administer the Youth Outcome Questionnaire (YOQ) at the required frequency of once every 30 days. SJCC does not utilize the YOQ in the treatment process. The Division Directives state "the Youth Outcome Questionnaire (OQ/YOQ) be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt)." Through records reviews, seven of the ten charts had YOQs that were not administered at the required rate of at least once every 30 days. Five of the ten charts reviewed also did not utilize the YOQ in the treatment process.

Center's Response and Corrective Action Plan:

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

1. All therapists have the off-line version of the YOQ instrument on their lap top computers and have been trained in its use.
2. An office staff member currently reviews every client appointment scheduled for the week and writes a reminder on the EHR calendar that an YOQ is due for a given client. This is to prompt both the front desk and the clinician to have the client complete the instrument in that session.
3. Increasing the YOQ administration and review rates is an overt goal for the agency that will be talked about monthly in clinical staff meetings.
4. Therapists will be given regular feedback on their client YOQ administration and review rates.
5. Our front desk staff will continue to assist in administering the YOQ SR and PR to clients who receive services at the center.
6. This site visit report and corrective action plan will be shared with the SJCC clinical team on 1/8/20 with discussion and feedback sought from them. The goal of this is to provide context and buy-in for the clinicians in increasing YOQ administration rates and use of the instrument in the treatment process.

As we have increased our school based mental health and substance abuse services over the past 3 years, we have faced the challenge of having our therapist not having support staff on sight to assist in administering the YOQ. In addition, for youth 9 and younger being seen at school, we often do not have many opportunities to interact with their parents who often have poor cell phone service, particularly if they live on the reservation. We will continue to work toward the goal of monthly administration for all youth seen at the SJCC office and for all youth 10+ years of age who are seen in the school setting.

Timeline for compliance: The above steps will begin immediately or on the dates listed.

Person responsible for action plan: Ryan Heck

FY20 Recommendations:

1) *Peer Support Services and Family Resource Facilitation:* The number of youth and families who received Peer Support Services decreased from 31 in FY18 to 19 in FY19. It is recommended that SJCC develop methods for referring youth and families to the Family Resource Facilitator (FRF), look at methods for utilizing FRFs in group settings, and train staff on the appropriate uses of FRF and Peer Support Services. Each of these will allow for SJCC to increase the number of youth and families receiving Peer Support Services.

FY20 Division Comments:

1) *School Based Services:* SJCC has a strong partnership with the school district in their catchment area. SJCC had been able to provide mental health treatment with referrals from the school. SJCC is also providing prevention groups in two grade schools, Montezuma Creek and Monument Valley, both located on the Reservation. Bachelor of Social Work students are providing ten groups each week in the two schools. SJCC indicates high numbers of school based clients are not on Medicaid, they have requested support in identifying ways to increase youth enrollment on Medicaid.

2) *Prevention*: SJCC has implemented the "Making a Difference" monthly community award for students in response to SHARP data which indicated low reinforcement for prosocial behaviors. SJCC has reported great community response to this award.

3) *Cultural Competency:* SJCC is committed to having culturally competent staff in their treatment facility while identifying the need to continue their efforts through training. SJCC identified that approximately 51% of the population in San Juan county are Navajo. SJCC has a bi-lingual staff member who speaks the Navajo language, works to incorporate culturally competent approaches in their treatment programs, and are providing space in their facility for a peer led support group for the LGBTQ population. SJCC should continue to strive to provide treatment for identified populations in the area.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of San Juan Counseling Center on October 29th, 2019. The team included Mindy Leonard, Program Manager, Tracy Johnson, Wraparound and Family Peer Support Administrator and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussion with the clinical director, record reviews, and a site visit to the Montezuma Creek Day Treatment Facility. During the discussion, the team reviewed the FY19 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 2019 Audit

No findings were issued in FY19.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:
None

FY20 Significant Non-compliance Issues:
None

FY20 Minor Non-compliance Issues:
None

FY20 Deficiencies:

1) *Outcome Questionnaire:* The frequency the Outcome Questionnaire (OQ) was administered did not meet requirements set in the Division Directives. The Division Directives state, "DSAMH will require that the Outcome Questionnaire (OQ/YOQ) be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt)." Through records reviews, five of the ten charts reviewed had OQs that were not administered at the required rate of at least once every 30 days. In addition, four of the ten charts did not provide information to indicate that the OQ was used in treatment.

Center's Response and Corrective Action Plan:

Action Plan: We are making the following efforts to increase our OQ45 administration rate in FY20:
1. All therapists have the off-line version of the OQ instrument on their lap top computers and have been trained in its use.

2. Increasing the OQ administration and review rates is an overt goal for the agency that will be talked about monthly in clinical staff meetings.
3. Therapists will be given regular feedback on their client OQ administration and review rates.
4. Our front desk staff will continue to assist in administering the OQ45 to clients who receive services at the center.
5. This site visit report and corrective action plan will be shared with the SJCC clinical team on 1/8/20 with discussion and feedback sought from them. The goal of this is to provide context and buy-in for the clinicians in increasing OQ45 administration rates and use of the instrument in the treatment process.
6. Clinical staff will be provided three, 1 hour long trainings on the OQ Analyst instruments, including the SOQ, TSM and ASC, during the 2020 calendar year. All three trainings will be completed by 7/1/20.

Timeline for compliance: These actions steps will begin immediately or on the dates listed.

Person responsible for action plan: Ryan Heck

2) *Peer Support Services*: DSAMH Division Directives require Local Authorities to continue to establish and/or expand Adult, Youth, and Family Peer Support Services, and to effectively utilize peer and family voice. A review of the FY19 Adult Mental Health Scorecard demonstrates only 0.7% received Certified Peer Support Services (compared to a rural average of 4.3%). This is the lowest level of adult mental health Peer Support Services since FY16. SJCC received recommendations to increase Peer Support to the adult mental health population in FY17, FY18 and FY19.

Center's Response and Corrective Action Plan:

Action Plan: SJCC hired a full time Peer Support Specialist in Fall 2019 and are in the process of hiring an additional part-time PSS with an emphasis on supporting clients receiving substance abuse services. With this personnel in place, SJCC will take the following steps to increase PSS:

1. SJCC administration will provide ongoing training to our Family Resources Facilitators and Recovery Support Coordinator on the definition of Peer Support Services. Chart reviews will be conducted regularly to ensure services are billed to the appropriate service category. (We have noticed some peer support services have been billed at TCM or skills development in the past.)
2. Continued training and follow-up with our FRF/PSS's to ensure all services provided are entered in the EHR.

Timeline for compliance: March 2020

Person responsible for action plan: Ryan Heck

FY20 Recommendations:

1) *Opportunities to Expand/Improve Treatment Programs:* It is recommended that SJCC follow through with the requested technical assistance to use fidelity tools to monitor quality and

direct improvement of evidence based practices. Other opportunities include addressing integration of services with the co-located San Juan Health Department, and the provision of mental health services to local nursing homes (in addition to medication management).

FY20 Division Comments:

1) *Supported Employment:* SJCC has a very dedicated employee who is providing supported employment, and receiving ongoing training and support in the Individual Placement and Support (IPS) evidence-based employment model. SJCC has been diligent in identifying businesses in the community that are a good fit for employment and has contacted 40 different local companies about supporting the program. To date, Utah State University has provided the most support for the program.

2) *Addressing the Workforce Shortage:* SJCC has been working with several Master's level students who are accessing online education. By developing a workforce of individuals who are already residents of the frontier catchment area, it is likely that SJCC can address the chronic workforce shortage with a cadre of local behavioral health professionals.

3) *Participant Feedback*: Heather Rydalch, Peer Support Program Manager, and Tracy Johnson, Wraparound and Family Peer Support Administrator went to the SJCC Day Treatment program and were able to meet with four members. One individual said going to the day program and playing ball "helps with the voices", and that he has a part time job he has been able to go back to. Another participant said that going to the SJCC program makes her feel good. Those interviewed indicated that they are happy with their housing and transportation, and that time is available to be physically active. Tobacco cessation has been offered, but one client said he is not ready to quit smoking. Participants reported that SJCC is "doing awesome" and "doing everything great".

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of San Juan Counseling on October 29th, 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 the data used to establish prevention priorities.

Follow-up from Fiscal Year 2019 Audit

FY19 Deficiencies:

1) No Eliminating Alcohol Sales to Youth (EASY) compliance checks occurred in FY18.

   This issue has not been resolved and will be continued for FY20; see Deficiency #1.

2) Currently SJCC's Synar compliance rate is 70%. Division Directives require a compliance rate of 90%.

   This issue has been resolved. In FY19, SJCC's Synar compliance rate was 100%, which now meets Division Directives.

3) SJCC did not complete a full community assessment. The Division Directives require each local authority to assess local prevention needs based on epidemiological data.

   This issue has not been resolved and will be continued for FY20; see Deficiency #2.

Findings for Fiscal Year 2020 Audit

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

None

FY20 Deficiencies:

1) *EASY Checks:* In FY19, nine restaurants were visited for the EASY compliance checks (ON PREMISE Sales) where three sales to minors was discovered. However, this does not meet Division Directives which requires that EASY compliance checks are conducted for OFF PREMISE sales (i.e. retail stores) rather than restaurants.

Center's Response and Corrective Action Plan:

Action Plan: SJC will continue to work with Lt. Holley who now does the EASY checks in San Juan County. They have stated that they will conduct off-premise checks on their next visit in early 2020.

Timeline for compliance: March 2020

Person responsible for action plan: Alyn Mitchell

2) *Full Community Assessment*: In FY19, SJCC did not complete a full community assessment; however, they reported that they are planning to conduct a full assessment this Spring now that they have the Student Health and Risk Prevention Survey (SHARPS) Data Survey and other resources.

   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:

Action Plan: SJC will be conducting a Key Leader "Readiness Assessment" in January 2020 – with town hall meetings and a community survey to conclude by the end of June 2020. SJC will also be receiving SHARPs baseline data from tribal land high schools in our county within the next month or so.

Timeline for compliance: June 2020

Person responsible for action plan: Alyn Mitchell

FY20 Recommendations:

1) *Guiding Good Choices Fidelity Checklist:* It is recommended that SJCC use the Guiding Good Choices Fidelity Checklist to monitor the fidelity of this program. This can be done by the SJCC Prevention Team or Coalition Members.

FY20 Division Comments:

1) *SHARPS Survey:* SJCC reported that they have worked diligently to gather support from the area Chapter Houses and the Navajo Nation to begin the administration of the SHARP Survey in their schools and tribal land. As of October 29th, 2019, SJCC received conditional

permission to administer the SHARP survey in their schools. SJCC reported that they are hopeful that by showing Tribal leadership the benefit of this survey for youth, they will receive permission for testing in the coming years. SJCC also reported that they met all of their goals on the SHARP survey except for one goal, which is a significant achievement.

2) *Capacity Building:* SJCC has increased capacity in their community through building partnerships and relationships with key stakeholders and community members. They have used grant funding to hire new staff and increase the Prevention Coordinator to full time. SJCC has provided ongoing training for staff and coalition members on evidence-based programs, which has helped increase the skills of their team. The San Juan County Prevention Action Coalition (SJCPAC) has been meeting for three years and consists of a variety of representatives and the San Juan County Youth Coalition (SJCYC) is meeting on a regular basis as well.

3) *Risk and Protective Factors:* SJCC focuses on risk and protective factors to determine the needs of their community. They have used the Parents Empowered campaigns, community events, ball games, school events, Guiding Good Choices and Coalition work to reduce risk factors and increase protective factors associated with underage drinking and other drug use in their community. This year, they are planning to include Native American messaging in the Parents Empowered campaigns, which they are excited about.

Substance Use Disorders Treatment

Becky King, Program Administrator for Substance Use Disorder Services conducted the monitoring review on October 29th, 2019. 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 2019 Audit

FY19 Minor Non-compliance Issues:

1) Data from the FY17 Utah Substance Abuse Treatment Outcomes Scorecard and TEDS shows:

   a) The percent change, admission to discharge, in clients using social recovery supports decreased from 39.7% to -14.2% from FY17 to FY18 respectively, which does not meet Division Directives.

      This issue has been resolved. The percent change, admission to discharge, in clients using social recovery supports increased from -14.2% to 294.7%, which now meets Division Directives.

   b) The percent change, admission to discharge, of tobacco use for clients moved from 14.7% to -13.3% from FY17 to FY18 respectively, which does not meet Division Directives.

      This issue has been resolved. The percent change, admission to discharge, of tobacco use for clients moved from -13.3% to 0.0% , which now meets Division Directives.

   c) Out of 33 admissions that were compelled to treatment, criminogenic risk factors were not collected for 21 admissions, which is 63.6%. Only 10% of compelled admissions can be unknown for criminogenic risk. This does not meet Division Directives.

      This issue has improved, but will be continued for FY20; see Deficiency #1.

Findings for Fiscal Year 2020 Audit:

FY20 Major Non-compliance Issues:

None

FY20 Significant Non-compliance Issues:

None

FY20 Minor Non-compliance Issues:

1) The DSAMH review found that 6.9% surveys were collected for the Youth (Family) Satisfaction Surveys, which does not meet the required collection rate of 10% in Division Directives.

Center's Response and Corrective Action Plan:

Action Plan: 1.SJCC administration will meet with front desk staff to identify steps that can be taken to increase survey participants. This meeting will take place by 2/1/2020.
2. MSW and BSW interns will make outbound calls to at least 25 families with an invitation to complete the survey by phone.

Timeline for compliance: March 2020

Person responsible for action plan: Ryan Heck

FY20 Deficiencies:

1) The DSAMH review found that 38.2% of criminogenic risk data was not collected for individuals involved in the criminal justice system.

Center's Response and Corrective Action Plan:

Action Plan: The following steps will be taken:
1. Clinical staff serving clients in the substance program will be trained on the importance of completing the RANT when the Recovery Support Coordinator has not already done so.
2. Clinical will be trained on the definition of a "compelled" client to clear up data entry errors.

Timeline for compliance: March 2020

Person responsible for action plan: Ryan Heck

FY20 Recommendations:

1) *Substance Use Disorders Treatment Program:* SJCC provides a comprehensive program for Drug Court clients, but has limited services available for their adult and youth substance use disorders (SUD) treatment program. They currently provide individual therapy, one open ended SUD group and one Recovery Support class. It is recommended that SJCC meet with Four Corners Behavioral Health to receive ideas on building their SUD Treatment Program and receive guidance from DSAMH as needed.

2) *Addiction Society of Addiction Medicine (ASAM):* Most charts showed that the Addiction Society of Addiction Medicine (ASAM) Goals were not included in the Recovery Plan and Reviews. ASAM and Recovery Plans should have specific goals to change behavior along with the client's goals. It is recommended that SJCC include the ASAM goals in Recovery

Plans and Reviews. *(Chart #'s 83368, 87119, 86923, 86998, 83206, 87047, 87101, 88188, 73223)*

3) *Client Retention:* SJCC has struggled with client retention. Most clients in their program are court referred and very few are self referred. SJCC reported that most clients drop out of treatment after their Assessment. It is recommended that SJCC meet with Four Corners Behavioral Health to learn more about methods of improving client retention and receive guidance from DSAMH as needed.

FY20 Division Comments:

1) *Team Collaboration:* The SJCC SUD Treatment Team meets with the Mental Health Team on a regular basis to coordinate care for their clients. They also collaborate with other team members and community partners to expand access to care for their clients. They have a small team, but are dedicated to providing quality care.

2) *Medication Assisted Treatment (MAT):* SJCC provides MAT for their clients and has an Advanced Practice Registered Nurse (APRN) that prescribes Suboxone for their community. They also offer Naloxone for clients, their families and officers in the community. Through their ongoing support of MAT, they have helped many clients with their recovery efforts.

3) *Drug Court:* The Drug Court in San Juan County has been very successful. Their Drug Court Team works well together and is committed to the long term success of their clients. SJCC reports that Drug Court is the backbone of their program, which has made a positive difference in the lives of many individuals.

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:

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Auditor IV

Approved by:

Kyle Larson Kyle Larson (Feb 6, 2020) Date 02/06/2020
Administrative Services Director

Eric Tadehara Eric Tadehara (Feb 11, 2020) Date 02/11/2020
Assistant Director Children's Behavioral Health

Kimberly Myers Kim Myers (Feb 11, 2020) Date 02/11/2020
Assistant Director Mental Health

Brent Kelsey Brent Kelsey (Feb 11, 2020) Date 02/11/2020
Assistant Director Substance Abuse

Doug Thomas Douglas P. Thomas (Feb 11, 2020) Date 02/11/2020
Division Director

Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool

Name of Agency: **San Juan Counseling Center**

Date: **October 29, 2019**

Compliance Ratings

Y = Yes, the Contractor is in compliance with the requirements.
P = Partial, the Contractor is in partial compliance with requirements; comments provided as suggestion to bring into compliance.
N = No, the Contractor is not in compliance with the requirements.

Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Signature page (with placeholders to record management and, if applicable, board of directors' approval of the plan and confirmation of its official status)		X		Need signatures on plan
Title page (with placeholders to record the dates that reviews/revisions are scheduled/have been made)		X		No date for when review/revision is scheduled
Record of changes (indicating when changes have been made and to which components of the plan)			X	Need place to identify changes to the plan, made by whom, and date of change
Record of distribution (individual internal and external recipients identified by organization and title)			X	Need distribution record
Table of contents			X	Need table of contents
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan		X		Need to identify schedule for updating plan.
Functional Annex: The Continuity of Operations (COOP) Plan				
Essential functions and essential staff positions	X			
Continuity of leadership and orders of succession	X			

Leadership for incident response		X		Identify staff on the "Incident Team" and define "First Responder" (i.e., First Responder is the first staff member on the scene…)
Alternative facilities (including the address of and directions/mileage to each)			X	Need to identify alternative facilities to be used, if needed
Planning Step				
Disaster planning team has been selected, to include all departments (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)			X	Need to identify who is on the planning team and representing which department(s)
The planning team has identified requirements for disaster planning for Residential/Housing services including: ● Engineering maintenance ● Housekeeping services ● Food services ● Pharmacy services ● Transportation services ● Medical records			X	Need to specify how these functions will be provided
The team has coordinated with others in the State and community.			X	Need to specify coordination with State and community partners