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 Kelly Ovard at 385-310-5118.

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

Sincerely,

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
Site Monitoring Report of

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

Local Authority Contract #A03089

Review Date: October 19, 2021

Final Report
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Utah Department of Human Services, Division of Substance Abuse and Mental Health
San Juan Counseling Center
FY2022 Monitoring Report
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 19, 2021. 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.

The Center is required to respond in writing within 15 business days of this draft report with a plan of action addressing each non-compliance issue and the Center employee responsible to ensure its completion.
### Summary of Findings

<table>
<thead>
<tr>
<th>Programs Reviewed</th>
<th>Level of Non-Compliance Issues</th>
<th>Number of Findings</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance and Oversight</strong></td>
<td>Major Non-Compliance, Significant Non-Compliance, Minor Non-Compliance, Deficiency</td>
<td>None</td>
<td></td>
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<tr>
<td><strong>Combined Mental Health Programs</strong></td>
<td>Major Non-Compliance, Significant Non-Compliance, Minor Non-Compliance, Deficiency</td>
<td>None, None, 1</td>
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</tr>
<tr>
<td><strong>Child, Youth &amp; Family Mental Health</strong></td>
<td>Major Non-Compliance, Significant Non-Compliance, Minor Non-Compliance, Deficiency</td>
<td>None, None, None, 2</td>
<td>13-14</td>
</tr>
<tr>
<td><strong>Adult Mental Health</strong></td>
<td>Major Non-Compliance, Significant Non-Compliance, Minor Non-Compliance, Deficiency</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse Prevention</strong></td>
<td>Major Non-Compliance, Significant Non-Compliance, Minor Non-Compliance, Deficiency</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse Treatment</strong></td>
<td>Major Non-Compliance, Significant Non-Compliance, Minor Non-Compliance, Deficiency</td>
<td>None, None, None, 2</td>
<td>22-23</td>
</tr>
</tbody>
</table>
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 19, 2021 by Kelly Ovard, Administrative Services Auditor IV.

Due to current DSAMH policy, the site visit was conducted remotely. 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. SJCC was able to demonstrate how they calculate and justify costs for each funding source.

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, 2020. 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 24, 2021; 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. One finding from the FY19 audit was resolved. It appears all FY19 audit findings have now been resolved.

2019-1 FINDING 2019 - 2 SUBMISSION OF EXPENDITURE REIMBURSEMENT – WITHIN 30 DAYS (Significant Deficiency) Recommendation:

We would recommend the District file reimbursement reports within the 30 days with all their contracts. We would further recommend the District use actual expenditures in the time period involved for reporting. These expenditures should have sufficient supporting documentation and should correspond with the reports. The District should make sure that internal controls are in place and that they are being followed so reports will be timely submitted. District's Response The District will review reimbursement requests and submit them on a timely basis. (Resolved)
Upon review with the District, the District implemented proper controls and the corrective action was taken.

Follow-up from Fiscal Year 2021 Audit:

FY21 Minor Non-compliance Issues:
1) *Timely Billings* - SJCC has had an 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 33 days throughout FY20. This issue was also addressed as a finding in the most recent independent financial statement audit. There was a personal tragedy that occurred to an employee at SJCC that was involved with submitting billings for reimbursement. SJCC has done well dealing with this difficult situation, but will need to address this issue so they can be in compliance with billing deadlines.

This item has been resolved.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None

FY22 Recommendations:

1) The SJCC emergency plan was reviewed by Nichole Cunha, Program Administrator II and Geri Jardine, Program Support Specialist, as part of monitoring. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that SJCC review these suggestions and update their emergency plan accordingly. In review of last year's tool, the areas remarked as non-compliant resulted in recommendations not addressed. In discussion with Kim Myers, Nichole Cunha and Geri Jardine, you will have a 90-day window to resolve non-compliant areas. Should the non-compliance not be resolved, at that time, a finding would be issued. We would like to emphasize that Technical Assistance is available to the San Juan team during this time. We are here to support and develop a plan with their team. Please resolve by 02/28/2022.
2) There was one I9 that was signed by the LA in mid June 2020 after the employee start date was in early May. It is recommended that the LA follow the current federal guidelines and sign the I9’s within 3 working days.

3) While the financial audits over the past 5 years have stated the same opinion on the audits, the term unmodified or unqualified is not found in the audit. It is recommended that the auditors clarify their reasoning for this in future audits.

FY22 Division Comments:

1) The Division is appreciative of Tammy Squires and her staff, for the timely upload of documentation for the audit. Please let the Division know if we can be of any assistance to your program. We understand the difficult times in San Juan County with Covid and staff shortages. We are here to help you with any issues that might arise year round.
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.
Combined Mental Health Programs

The Division of Substance Abuse and Mental Health (DSAMH) Mental Health Team conducted its annual monitoring review at San Juan Counseling Center (SJCC) on October 19, 2021. Due to the current DSAMH policy, the annual monitoring review was held virtually. Duplicate findings for Child, Youth and Family and Adult Mental Health have been combined below to provide clarity and avoid redundancy.

Findings for Fiscal Year 2022 Audit:

FY22 Minor Noncompliance:

1) Outcome Questionnaire (OQ)/Youth Outcome Questionnaire (YOQ): The DSAMH FY21 chart review revealed that the OQ/YOQ is being administered, but is not being used as an intervention. Findings around administration and use of the OQ/YOQ have been documented for at least three years. Evidence of clinical use of the OQ was only present in one of ten adult and three of ten youth mental health charts reviewed. This is particularly concerning when treatment goals are focused on improvement in the OQ/YOQ score. DSAMH Division Directives require that data from the OQ/YOQ shall also be shared with the client and incorporated into the clinical process, as evidenced in the chart.

County’s Response and Corrective Action Plan:

<table>
<thead>
<tr>
<th>Action Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The clinical team will be provided with two clinical training sessions on the YOQ/OQ by <strong>January 28th, 2022</strong>. These trainings will cover the validity and evidence basis of each instrument, subcategories of the instruments, how to incorporate in treatment planning, and how to use as an intervention.</td>
</tr>
<tr>
<td>2. The clinical staff have already been informed that they are the point of accountability in ensuring the OQ/YOQ is taken monthly. The clinical director will follow up monthly in supervision to create additional accountability and action plans as needed.</td>
</tr>
<tr>
<td>3. The clinical director will do a quarterly internal audit specific to the YOQ/OQ in the EHR to identify and provide accountability and direction.</td>
</tr>
</tbody>
</table>

**Timeline for compliance:** See above.

**Person responsible for action plan:** Clinical Director

**Tracked at DSAMH by:** Mindy Leonard
FY22 Recommendations:

1) *Consistency in Documentation:* The DSAMH FY21 chart review demonstrated that Child and Youth (CYF) charts had a range of quality in the assessments, with some evaluations having excellent detail and other charts having sparse information. When evaluations are not complete, diagnostic formulation and treatment planning may be impacted. Both adult and CYF charts had inconsistencies within treatment goals, ranging from strong SMART objectives to those lacking specificity, measurability and timeliness. Adult objectives, in particular, were dated and often vague. In accordance with the Preferred Practice Guidelines and ongoing planning principles, “short term goals/objectives are to be measurable, achievable and within a timeframe.” It is recommended to review processes for training providers in the preferred practice of utilizing SMART goals: Specific, Measurable, Attainable, Relevant, and Time-based in treatment planning.

FY22 Comments:

1) *Mental Health Crisis Services and Community Outreach:* SJCC has implemented the Mobile Crisis Outreach Team (MCOT) program over this past year. Within the first quarter of FY22, 35 MCOT responses were made in the community with only 14% including law enforcement on scene with the team. Law enforcement made 17% of the MCOT referrals during this period. The SJCC MCOT are also following up with individuals who have made crisis calls and those who are missing appointments. The program is looking at expansion to include Stabilization and Mobile Response (SMR).

2) *Cultural Responsiveness:* SJCC is notable for ongoing efforts to integrate the Native American culture into service provision. In addition to hiring a Native-speaking therapist, a review of charts documented respect for and coordination with traditional healing preferences. During the recent DSAMH needs assessment, the SJCC leadership demonstrated the ability to ensure that services for youth-in-transition were age appropriate, and public-facing documents were notably inclusive of LGBTQ+ clients. SJCC is in the process of creating eight meaningful goals in response to the health disparity needs assessment, and DSAMH looks forward to continuing to work towards equity.

3) *Technical Assistance and Support:* SJCC has had a number of leadership and staffing changes over the past year. DSAMH wants to remind the agency that we are available to provide technical assistance related to all services for adult and youth mental health services.
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 October 19, 2021. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Leah Colburn, Program Administrator; Pam Bennett, Program Administrator; Tracy Johnson, Wraparound and Family Peer Support Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, and program visits. During the discussion the team reviewed the FY21 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Peer Support, school based behavioral health and compliance with Division Directives and the center’s provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2021 Audit

FY21 Deficiencies:
1) **Respite Services:** SJCC continues to provide respite services at a lower rate than the rural average (SJCC 1%, Rural 2.8%). DSAMH acknowledges that SJCC increased respite services provided by one client, and that continued efforts to increase services were impacted by COVID-19 which resulted in SJCC not being able to attain their self imposed target goal of five respite clients during FY21. It is recommended that SJCC continue to explore ways to increase respite service delivery for families and youth when appropriate, especially as their region continues to be heavily impacted by the pandemic.

   **This finding has not been resolved and will remain as a deficiency for the upcoming year. See Deficiency #1.**

2) **YOQ as an intervention:** Of the ten charts reviewed, eight charts had no evidence of YOQ being used as an intervention. One chart reviewed did not use the YOQ as an intervention, however they only had an assessment and no ongoing services. There was noted improvement in the overall use of the YOQ from FY19 to FY20; only three charts showcased administration every 30 days in FY19, while nine charts reviewed had the YOQ administered every 30 days. It is recommended that SJCC review with its clinical teams the use of the YOQ as an intervention in treatment and its documentation in clinical notes.

   **This has been moved to a combined Mental Health finding above. See Combined Minor Non-compliance Issue #1.**
Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
1) Respite: SJCC has continued to provide respite services at a lower rate than the rural average (SJCC 1.3%; Rural 2.5%). The number of youth served was the same as the prior year. DSAMH recognizes that staffing patterns may impact the ability to increase this service, however it is recommended that SJCC continue to explore pathways to support and increase this service as respite provides access to support beyond traditional psychotherapy for youth and families.

County’s Response and Corrective Action Plan:

<table>
<thead>
<tr>
<th>Action Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. San Juan is in the process of working with both the University of Utah and Utah State University to potentially increase staffing through the use of MSW/BSW interns/practitioners that can be trained and potentially provide these services.</td>
</tr>
<tr>
<td>2. We are in the process of offering employment to an individual (PT) who will graduate and has expressed interest in working with this population and will explore this avenue further.</td>
</tr>
<tr>
<td>3. The children's team will continue to meet twice a month with this being a continued item for brainstorming/discussion/exploration that will remain on the agenda.</td>
</tr>
</tbody>
</table>

Timeline for compliance: ASAP based on the ability to increase staffing.

Person responsible for action plan: Clinical Director

Tracked at DSAMH by: Mindy Leonard (Follow-up by 02/28/2022)

2) Psychosocial Rehabilitation Services (PRS): SJCC provided zero PRS as indicated by the scorecard, in the prior year 53 youth were served. It was unclear if this decline was caused by the change in programming due to the impacts of COVID-19 and public health guidelines or staffing changes. DSAMH recognizes that staffing shortages or programming changes have impacted the ability to provide this, however SJCC needs to
review the provision of this service as it is one of the ten mandated services as required by Utah Code 17-43-301.

County’s Response and Corrective Action Plan:

<table>
<thead>
<tr>
<th>Action Plan:</th>
<th>In looking into this, the decline is due to the public health guidelines, coupled with our current staffing shortage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>As public health guidelines change and as we start to increase staffing through the use of BSW/MSW students, we anticipate being able to get back into the schools we have not been in since COVID.</td>
</tr>
<tr>
<td>2.</td>
<td>Training will be done on documentation pertaining to the individual and group skills. This will be completed with the children/youth team in our bi-weekly meetings.</td>
</tr>
<tr>
<td>3.</td>
<td>We are implementing the DLA-20 and focus on competing with more youth. The hope is that this will get more youth and families interested in both TCM and skills.</td>
</tr>
</tbody>
</table>

Timeline for compliance: ASAP after public health clearance is given and staffing is increased

Person responsible for action plan: Clinical Director

Tracked at DSAMH by: Mindy Leonard (Follow-up by 02/28/2022)

FY22 Recommendations:

1) Serious Emotional Disturbance (SED): It is recommended that SJCC review SED determination criteria for all youth clients. All ten charts reviewed indicated the clients did not meet criteria for SED, however there was clinical information in multiple evaluations which would lead to a SED determination. Scorecard data indicates that zero SED youth were served which is a drop from 56 clients the prior year. Per the 1915(b)3 waiver for the PHMPs, clients who receive services designated under this waiver are required to have SMI/SED designation. Collection of this information is required as a component of the State plan under Federal Title 42, 300x-1. Information on SED determination can be found on the DSAMH website. Technical assistance can be provided as requested.
FY22 Division Comments:

1) *Family Peer Support Services (FPSS)*: SJCC leadership has a strong understanding of the value and role of FPSS to support youth and families in finding success. Currently SJCC does not employ any FPSS which is indicated in a drop in services (FY21, 2 clients; FY22, 1 client). SJCC is actively recruiting for this role, but has not found success in hiring. DSAMH encourages SJCC to explore additional options to hire and expand this service such as possible recruiting from past youth and families who had success in treatment. Technical assistance can be provided as requested.
Adult Mental Health

The Division of Substance Abuse and Mental Health, Adult Mental Health monitoring team conducted its annual monitoring review at San Juan Counseling Center on October 19, 2021. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Pam Bennett, Program Administrator; Leah Colburn, Program Administrator; Sharon Cook, Program Administrator; Heather Rydalch, Peer Support Program Manager; and Tracy Johnson, Wraparound and Family Peer Support Program Administrator. The review included the following areas: discussions with clinical supervisors, management, and staff, record reviews, and program participant interviews. During the discussion the team reviewed the FY21 audit statistics, including the Mental Health Scorecard, Area Plans, Outcome Questionnaires and 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 2021 Audit

FY21 Deficiencies:

1) *OQ used as an intervention:* Of the ten charts that were reviewed, nine indicated that the OQ was administered to the client. However, eight of ten charts did not include documentation that the OQ was used as a clinical intervention in the treatment process. This deficiency was also noted in the SJCC internal chart reviews. It is recommended that SJCC continue to train staff on the use of the OQ as an intervention in treatment and documentation of the OQ in clinical notes.

This finding has not been resolved and will be continued for FY22; see Combined Mental Health Program Deficiencies #1 above.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
See Combined Mental Health Minor Non-compliance Issue.

FY22 Deficiencies:
None

FY22 Recommendations:

1) *Case Management (CM):* The FY21 Adult Mental Health Scorecard reports a slight increase in the number of clients receiving case management services from FY20 (9.8%)
to FY21 (10.5%). Although SJCC has continued to provide case management to fewer clients than other Local Authorities (FY21 rural average-33.7%), those clients continue to receive significantly more case management services per person (FY21 average-39.27 units) in comparison to other Local Authorities (FY21 average-9.34 units). This remains as a recommendation as SJCC continues to have one of the lowest rates of inpatient hospitalizations (FY21-0.9% vs FY21 rural average-4.1%). In addition, a review of the charts demonstrates that CM services are comprehensive and extensive for individuals receiving those supports. It is recommended that SJCC continue to review CM provision and ensure that this service is available for all clients that may benefit from case management.

2) *Suicide Prevention:* The DSAMH FY21 chart review demonstrated that only 2 of 10 charts included a Columbia-Suicide Severity Rating Scale (C-SSRS) that had been administered in the last year. Regular screening, rather than screening only at intake, has been a recommendation in previous years. DSAMH is available to provide technical assistance to SJCC and to assist in training on the administration and documentation of the C-SSRS for all clients in treatment, in addition to other suicide prevention efforts.

**FY22 Division Comments:**

1) *Peer Support Services (PSS):* Heather Rydalch, Peer Support Program Manager, met with the Certified Peer Support Specialist (CPSS) and supervisor. San Juan currently has one fulltime CPSS, a Drug Court graduate who provides individual support, and facilitates groups to individuals in Day Treatment, Drug Court, and in the jail. He indicated that he is enjoying providing PSS and helping to build a recovery community. He said “I see a difference in the clients that are receiving PSS, and they seem to open up more and are more willing to ask for more help.”

2) *Participant Feedback:* Sharon Cook, Program Administrator, and Heather Rydalch, Peer Support Program Manager, met with 3 individuals in treatment who said that they enjoy SJCC. Clients indicate that they create their own person-centered goals - One client expressed interest in playing the guitar, and is saving money to buy new music/guitar equipment. Another client said his goals are to exercise and eat healthy. Participants expressed gratitude for efforts made by SJCC during the pandemic including providing home visits, bringing meals, and dropping off packets - “[Day Treatment staff] always made sure we were doing ok”. Individuals have been able to attend Day Treatment for the last 6 months. “I like coming in and being with others” and “I feel safe here”.

3) *Recovery Supports:* Individuals participating in services that include Day Treatment reported that they had received assistance with finding competitive and integrated employment. Two of three clients interviewed are currently working part-time in the community. SJCC has also assisted them with their housing and they are all living in apartments.
Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of San Juan Counseling on October 19, 2021. 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 2021 Audit

FY21 Deficiencies:

1) *EASY Checks:* There were no Eliminating Alcohol Sales to Youth (EASY) Compliance Checks in FY20, which does not meet Division Directives. Local Authorities are required to complete one more EASY Compliance Check from the year prior.

There were no Eliminating Alcohol Sales to Youth (EASY) Compliance Checks in FY21, which does not meet Division Directives. Local Authorities are required to complete one more EASY Compliance Check from the year prior.

*This deficiency is resolved, however the issue is not resolved and will be addressed in Recommendation #1 below.*

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:

None

FY22 Significant Non-compliance Issues:

None

FY22 Minor Non-compliance Issues:

None

FY22 Deficiencies:

None

FY22 Recommendations:

1) *EASY Checks:* There were no Eliminating Alcohol Sales to Youth (EASY) Compliance Checks in FY21, which does not meet Division Directives. Local Authorities are required to complete one more EASY Compliance Check from the year prior. SJCC is also planning to work with local law enforcement on training at the end of this month and planning on attending the statewide training in March. It is recommended that SJCC
continue to work on training law enforcement and methods of reducing alcohol use in their community.

2) *Prevention and Response to DUI:* According to the 2020 18th Annual Driving Under the Influence (DUI) Report to the Utah Legislature Utah completed by the Commission on Criminal and Juvenile Justice (CCJJ), there were 100 DUI arrests in San Juan County, which is a rate of 653.25% per 100,000 people in their community, which is higher than the state average of 311.76%. It is recommended that SJCC continue working with law enforcement to support their work in enforcing DUI as well as ongoing work with the local coalitions to reduce the number of people driving while under the influence of drugs including alcohol.

3) *Community Readiness Assessment:* SJCC is in the process of completing community readiness assessments in the upcoming months. They have been doing some readiness assessment training and discussion in their San Juan County Prevention Action Collaboration (SJCPAC) coalition meetings. It is recommended that they continue working with SJCPAC and other community partners as needed to complete their readiness assessment.

**FY22 Division Comments:**

1) *Increased Capacity:* Monticello High School (MHS) has been identified as a lead agency with school advocates as a possible champion in their area to help with youth coalition and San Juan County Prevention Action Collaboration (SJCPAC) coalition efforts. They have planned various youth campaigns for the coming year that tied directly to identified risk factors through community and the Student Health and Risk Prevention (SHARP) Statewide Survey assessments. SJCC has made an effort to engage in building relationships with the community over the years, which has resulted in various accomplishments in prevention efforts.

2) *Moving the Community Status:* SJCC raised more awareness in communities through prevention events. They have been working to strengthen youth coalition involvement in each high school. The youth from Abajo Mt. Schools were involved in two youth prevention trainings, in June and July. Students from River Region (reservation schools) were still in lockdown due to the COVID Pandemic, but had some good success with “drive through” community events in those areas with prevention messaging and family bonding components.

3) *Evidence-Based Services:* The Guiding Good Choices parenting classes were delivered by trained instructors to parents and youth (ages 9-14) throughout San Juan County virtually and in-person. In these classes, parents learn to set clear family guidelines on drugs, as well as learn and practice skills to strengthen family bonds, help children develop healthy behaviors and increase children’s involvement in the family. Research shows that when children are bonded to their parents, school and non-drug-using peers, they are less likely to get involved in drug use or other behavior problems. The
Strengthening Families 10-14 parenting classes were delivered by trained instructors to parents and youth throughout San Juan County virtually and in-person. These classes focused on positive relationship building between parents and youth to help lower rates of alcohol, tobacco and marijuana use. Communication, family bonding and problem-solving skills were addressed as well.
Substance Use Disorders Treatment

Becky King, Program Administrator for Substance Use Disorder Services conducted the monitoring review on October 20, 2021. 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 2021 Audit

FY21 Minor Non-compliance Issues:
1) The percent of clients employed from admission to discharge decreased from 17.6% in F19 to 0.0% in FY20 respectively, which does not meet Division Directives.

   The percent of clients employed from admission to discharge increased from 0.0% in the FY20 to 36.4% in the FY21 respectively, which meets Division Directives.

   This issue has been resolved.

   1) The DSAMH review found that 16.6% of SJCC’s charts have not been closed, which does not meet Division Directives.

   The DSAMH review found that 16.4% of SJCC’s charts have not been closed, which does not meet Division Directives.

   This issue has not been resolved and will be addressed in Deficiency #1 below.

FY21 Deficiencies:

1) The DSAMH review found that 14.9% of criminogenic risk data was not collected for individuals involved in the criminal justice system in FY20, which does not meet Directives.
The DSAMH review found that 13.0% of criminogenic risk data was not collected for individuals involved in the criminal justice system in FY20, which does not meet Directives.

   This issue has not been resolved and will be addressed in Deficiency #2 below.
Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:

1) The DSAMH review found that 16.4% of SJCC’s charts have not been closed, which does not meet Division Directives.

County’s Response and Corrective Action Plan:

**Action Plan:** Identify the carts in question and ensure they are properly closed.
1. Follow up quarterly and train the SUD therapists on procedures to run a report specific to their caseloads and identify clients that have not been seen in 60 days.
2. Utilize Therapists/case managers/MCOT to reach out to these identified individuals.
3. Review with therapists how to properly close these charts, as appropriate.

**Timeline for compliance:** 3/31/22

**Person responsible for action plan:** Clinical Director

**Tracked at DSAMH by:** Becky King

2) The DSAMH review found that 13.0% of criminogenic risk data was not collected for individuals involved in the criminal justice system in FY20, which does not meet Directives.

County’s Response and Corrective Action Plan:

**Action Plan:** Identify where the issue is on appropriate collection of this data.
1. Identify all clients compelled to treatment through involvement in the criminal justice system and update that monthly.
2. Provide training on the administration of the RANT.
3. Run a report monthly and follow up with SUD therapists on individuals identified on the aforementioned list that need risk/needs assessment completed/collected.

**Timeline for compliance:** 3/31/22
FY22 Recommendations:

1) **Recovery Supports:** The percent increase in those using social recovery supports remained at 0.0% from the FY20 to FY21 respectively, which does not meet Division Directives. SJCC reports that they have been providing recovery support services, but have not been entering their Recovery Support Data into the Substance Abuse and Mental Health Services Information System (SAMHIS). It is recommended that SJCC start entering their data in the SAMHIS system. DSAMH can provide technical assistance upon request.

FY22 Division Comments:

1) **Tobacco / Nicotine Cessation:** SJCC did a great job of implementing their Nicotine Replacement Therapy (NRT) site. They have been using the Fagerstrom Tolerance Scale to identify levels of NRT treatment, which has been effective in decreasing nicotine use. For example, the percent decrease in the number of clients reporting tobacco/nicotine use from admission to discharge decreased from 9.0% to 0.00% from FY20 to FY21 respectively.

2) **Workforce and Service Delivery:** SJCC is 50% down in staff. Two of SJCC’s staff recently passed away - one last year and one this year, which was really difficult for the SJCC Team and their clients. They currently have three full time therapists, two interns and one Peer Support Specialist. SJCC also has a Mobile Crisis Outreach Team (MCOT) with two full time staff. SJCC is losing one of their best Peer Support Specialists and are hoping to retain them part time. One of the MCOT Team members is moving to another program, but she will try to be available on-call. SJCC is working on incentivizing positions and getting people invested in the area to work at SJCC. Despite the challenges that SJCC has experienced with workforce issues, they have continued to provide quality services to individuals and families in their community. The FY21 Consumer Satisfaction Survey reflects a general satisfaction rate of 100% in substance use disorder treatment services for adults, a 79% satisfaction rate for youth and 88% satisfaction rate for parents of children and youth (age 6 - 17) receiving services at SJCC.

3) **Drug Court:** Things have improved for the Drug Court Program. This past year, three clients graduated from Drug Court. Last year, there was a period of time where there was a bottleneck of the number of clients referred to Drug Court due to issues with the Sheriff’s Office. SJCC hired an Administrative Assistant to take on the reporting of Drug Court on the biweekly report, which she sends to the team prior to the hearing. San Juan Drug Court has a limit of working with 10 people due to limited resources, which works well for their area. With a small program, there is close coordination between team members and good cohesion in Drug Court groups.
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.

**Corrective Action Requirements:** It is the responsibility of the Local Authority to develop a corrective action plan sufficient to resolve each of the noncompliance issues identified. These corrective action plans are due within 15 working days of the receipt of this report. The Division of Substance Abuse and Mental Health may be relied upon for technical assistance and training and the Local Authority is encouraged to utilize Division resources. Each corrective action plan must be approved by Division staff and should include a date by which the Local Authority will return to compliance. This completion date and the steps by which the corrective action plan will return the Local Authority to contract compliance must be specific and measurable.

Submit the corrective action plan inside of the provided box after each finding or deficiency. **Please do not make any edits outside of these boxes.**

**Steps of a Formal Corrective Action Plan:** These steps include a formal Action Plan to be developed, signed and dated by the contractor; acceptance of the Action Plan by the Division as evidenced by their signature and date; follow-up and verification actions by the Division and formal written notification of the compliance or non-compliance to the contractor.

**Timeline for the Submission of the Action Plan:** This report will be issued in DRAFT form by the Division of Substance Abuse and Mental Health. Upon receipt, the Center will have five business days to examine the report for inaccuracies. During this time frame, the Division requests that Center management review the report and respond to Chad Carter if any statement or finding included in the report has been inaccurately represented. Upon receipt of any challenges to the accuracy of the report, the Division will evaluate the finding and issue a revision if warranted.

At the conclusion of this five day time frame, the Center will have 10 additional business days to formulate and submit its corrective action plan(s). These two time deadlines will run consecutively (meaning that within 15 working days of the receipt of this draft report, a corrective action plan is due to the Division of Substance Abuse and Mental Health).

The Center’s corrective action plan will be incorporated into the body of the report when issued.
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 Kelly Ovard, Administrative Services Auditor IV @ 385-310-5118.

The Division of Substance Abuse and Mental Health

Prepared by:

Kelly Ovard ________________________ Date 11/29/2021
Administrative Services Auditor IV

Approved by:

Kyle Larson ________________________ Date 11/29/2021
Administrative Services Director

Eric Tadehara ________________________ Date 11/29/2021
Assistant Director Children’s Behavioral Health

Kimberly Myers ________________________ Date 11/29/2021
Assistant Director Mental Health

Brent Kelsey ________________________ Date 11/29/2021
Assistant Director Substance Abuse

Doug Thomas ________________________ Date 11/29/2021
Division Director
**Attachment A**

**UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH**

**Emergency Plan Monitoring Tool FY22**

**Name of Local Authority:** San Juan Counseling Center

**Date:** October 19, 2021

**Reviewed by:** Nichole Cunha, LCSW
Geri Jardine

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### Compliance Ratings

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

<table>
<thead>
<tr>
<th>Monitoring Activity</th>
<th>Compliance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>X</td>
<td>Need confirmation of official status (i.e., signature or date approved)</td>
</tr>
<tr>
<td>Confirmation of the plan’s official status (i.e., signature page, date approved)</td>
<td>X</td>
<td>Need to identify changes to the plan, made by whom, and date of change.</td>
</tr>
<tr>
<td>Record of changes (indicating dates that reviews/revisions are scheduled/have been</td>
<td>X</td>
<td>Need record of who receives a copy of the plan</td>
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<td>made and to which components of the plan)</td>
<td></td>
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<tr>
<td>Method of distribution to appropriate parties (i.e. employees, members of the</td>
<td>X</td>
<td></td>
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<tr>
<td>board, etc.)</td>
<td></td>
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<tr>
<td>Table of contents</td>
<td>X</td>
<td>Need table of contents</td>
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**Basic Plan**

- Statement of purpose and objectives
- Summary information
- Planning assumptions
- Conditions under which the plan will be activated
- Procedures for activating the plan
- Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan

**Functional Annex: The Continuity of Operations (COOP) Plan**

to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.

- List of essential functions and essential staff positions
- Identify continuity of leadership and orders of succession
- Identify leadership for incident response

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Utah Department of Human Services, Division of Substance Abuse and Mental Health
San Juan Counseling Center
FY2022 Monitoring Report
List alternative facilities (including the address of and directions/mileage to each) | X | Need to identify alternative facilities to be used, if needed
Communication procedures with staff, clients’ families, the State and community | X | Need to specify coordination with State and community partners
Procedures that ensure the timely discharge of financial obligations, including payroll. | X | Need to identify procedure addressing continuation of financial obligations

**Planning Step**

| Disaster planning team has been selected, to include all areas (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.) | X | 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 (recovery and maintenance)
- Evacuation procedures
- Isolation/Quarantine procedures
- Maintenance of required staffing ratios
- Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic

| X | Need to specify how these functions will be provided

DSAMH is happy to provide technical assistance.

DSAMH is happy to provide technical assistance.
Agreement completed.

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