



State of Utah

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Governor

Deidre Henderson
Lieutenant Governor

Department of Human Services

Tracy S. Gruber
Executive Director

Division of Substance Abuse and Mental Health
DOUG THOMAS
Director

January 12, 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 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 (Jan 12, 2021 16:03 MST)

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 Contracts #152314 and #152315

Review Date: October 20th, 2020

Final Report

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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 20th, 2020. 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

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	7
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 2	11-12
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	15
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	19
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 1	21-22 23

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 20th, 2020 by Chad Carter, Auditor IV and finalized by Kelly Ovard, Auditor IV on December 18, 2020.

Due to potential risks from COVID-19, 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, 2019. 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, 2020; 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 two findings reported in the audit:

2019-1 Stale Checks in Regular and Protective Payee Accounts: Several outstanding checks were found in the Regular and Protective Payee account that were a few years old. They were small and immaterial amounts, but need to be investigated and determined if they are valid.

2019-2 Submission of Expenditure Reimbursement Within 30 Days: It was found that San Juan is not submitting monthly reimbursement requests to the Utah Department of Health on a timely basis. Reports should be submitted within 30 after the month ends. This is reported as a Significant Deficiency. This has also been an issue with billings to DSAMH and will be addressed as a finding. See Minor Non-compliance Issue #1 below.

Follow-up from Fiscal Year 2020 Audit:

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

This issue has not been resolved and will be continued for FY21; see Minor Non-compliance Issue #1.

Findings for Fiscal Year 2021 Audit:

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

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.

Center’s Response and Corrective Action Plan:

Action Plan: This is a carry-over from last year. During our 2020 monitoring visit it was noted that for the first couple months of FY2020 we were going to be late on the billings and that this would be a finding again in 2021. Since the monitoring visit in 2020 all of San Juan’s billings have been submitted within the timeframe (the only exceptions are Prevention billing in 2021 when OEM changes were being made and SOC billing because it was late on the Allocation letter). San Juan Counseling will continue to be diligent to submit the billings timely.

Timeline for compliance: Currently in compliance. Will continue to monitor monthly to stay in compliance.

Person responsible for action plan: Tammy Squires

FY21 Deficiencies:

None

FY21 Recommendations:

- 1) The SJCC emergency plan was reviewed by Robert Snarr, Program Administrator 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. **Please note there are a number of issues with the emergency plan. Please review with your staff these issues and make the necessary corrections.**

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 Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at San Juan Counseling Center on October 20th and 21st, 2020. Due to COVID-19, 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, program visits, and allied agency visits. During the discussion the team reviewed the FY20 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Resource Facilitation (Peer Support), High Fidelity Wraparound, 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 2020 Audit

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.

This issue has improved and will be reduced to a deficiency in FY21; see Deficiency #1

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.

This issue has been partially resolved, and will remain as a deficiency in FY21; see Deficiency #2

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

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 FY20. 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.

Center’s Response and Corrective Action Plan:

Action Plan: SJCC will provide respite services to five clients by June 30, 2021 by taking the following steps:

- 1. The children’s team will meet twice a month and, among other tasks, identify children and SED youth in need of respite services.
- 2. A part-time BSW practitioner will set aside at least 2 hours / week to provide respite services for referred youth from January - May 2021.
- 3. Respite services will be scheduled due to limited staff availability.

Timeline for compliance:

- 1. Respite provider will begin scheduling out time weekly for respite services, starting January 4, 2021.
- 2. At least five clients will receive at least one respite service by June 30, 2021.

Person responsible for action plan: Ryan Heck, Clinical Director

- 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.

Center’s Response and Corrective Action Plan:

Action Plan:

1. The clinical team will receive a 2 hour Y/OQ training by February 28, 2021 to highlight the use of the Y/OQ in treatment plans and as an intervention tool.
2. Starting immediately, SJCC office staff track when clients are due for a monthly Y/OQ and make note of this on the client's appointment time in the EHR. This will cue the front desk and the clinician of the need to administer the Y/OQ prior to or during the appointment.
3. The clinical director will include a review of Y/OQ administrations in a monthly review of therapist charting, starting January 2021.

Timeline for compliance: See above.

Person responsible for action plan: Shurrell Meyer will note when Y/OQs are due. Ryan Heck will review therapist charting and provide the Y/OQ training.

FY21 Recommendations:

- 1) *Case Management:* SJCC had a decrease in case management services provided from FY19 (18 clients/ 6.9%) to FY20 (11 clients/ 3.6%). While it is recognized that access to these services for youth were likely impacted due to COVID-19, it is recommended that SJCC review case management service provision and explore ways to increase this service for youth and families.
- 2) *Holistic Approach to Health:* It is recommended that SJCC review their assessment template to encourage conversation about healthcare access and appropriate linkages to physical health care providers, including dental and vision, for children. During the review of their assessments there is no documentation of identifying a client's primary care physician. Ensuring that youth have an identified provider and access to physical healthcare is a key metric in ensuring a child's overall health and wellbeing.
- 3) *Family Resource Facilitation and Family Peer Support (FPS):* SJCC had a decrease in families served with family peer support services (FY19 - 31 families, FY20 - 19 families). It is recommended that SJCC review Peer Support Services to identify and rectify any barriers, improve referral pathways, and explore different methods to fund FPS. It is also recommended to review ways to hire and maintain FPS staff at the center. Please utilize DSAMH and Allies with Families staff to help in the improvement process.

FY21 Division Comments:

- 1) *Agency Resilience:* DSAMH would like to recognize SJCC for the center's resilience over this past year. SJCC has experienced great loss with the passing of two of their team members, workforce shortages related personnel leaving the area, and the extended impact of COVID-19 on their team and the community. SJCC has continued to prevail in providing quality mental healthcare to their community, fostering relationships with community partners and expanding programming to meet community needs.
- 2) *Community Partnerships:* SJCC was recognized by multiple community agencies as being a collaborative partner in providing services for youth and families. Partners from the

Division of Child and Family Services (DCFS) and the Division of Juvenile Justice Services (DJJS) both reported that they have a positive, collaborative relationship with SJCC when serving clients children and families. Both highlighted the willingness for SJCC to respond to their clients' needs. DCFS reported that SJCC has been great at problem solving to develop creative solutions for their clients' and families. DJJS reported that they utilize SJCC to respond to mental health crises and provide linkages to community support, as they do not have a therapist on site with their program, which has been extremely helpful for the individuals they serve.

- 3) *School Based Services:* SJCC has a well established partnership with the San Juan School District (SJSD) to provide a continuum of services within their schools. SJSD reported local school teams are very supportive of the services that SJCC provides and is able to observe positive outcomes of these services in their schools. SJSD has partnered with SJCC with monies received from GS2019 HB373 to expand access to school based mental health services for their students. SJCC and SJSD are working collaboratively to find creative ways to ensure that students who are attending school remotely have access to services, recognizing the barriers to providing mental health access to those students who do not have access to technology on the reservations or in other rural parts of the county.

Adult 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 20th and

21st, 2020. Due to COVID-19, 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, program visits, and allied agency visits. During the discussion the team reviewed the FY20 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 2020 Audit

FY20 Deficiencies:

- 1) *Outcome Questionnaire*: The frequency that 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.

This issue has been partially resolved and will remain as a deficiency in FY21; see Deficiency #1.

- 2) *Peer Support Services (PSS)*: 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.

This issue has not been resolved despite extensive efforts by SJCC and will be continued in FY21; see Recommendation #1.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

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.

Center’s Response and Corrective Action Plan:

Action Plan:

1. The clinical team will receive a 2 hour OQ training by February 28, 2021 to highlight the use of the OQ in treatment plans and as an intervention tool.
2. Starting immediately, SJCC office staff track when clients are due for a monthly OQ and make note of this on the client’s appointment time in the EHR. This will cue the front desk and the clinician of the need to administer the OQ prior to or during the appointment.
3. The clinical director will include a review of OQ administrations in a monthly review of therapist charting, starting January 2021.
4. Every therapist will administer the ASC to at least two clients with a red alert status by June 30, 2021.

Timeline for compliance: See above.

Person responsible for action plan: Shurrell Meyer will note when OQs are due. Ryan Heck will review therapist charting and provide the OQ training.

FY21 Recommendations:

- 1) *Provision of Peer Support Services (PSS):* A review of the FY20 Adult Mental Health Scorecard demonstrates only 0.2% received Certified Peer Support Services (compared to a rural average of 3.0%). SJCC has partnered with DSAMH in efforts to expand PSS for their clients, as required in the Division Directives. An exceptional PSS was hired full-time but passed away before being able to impact the PSS program at SJCC. Two other candidates for the position have been identified. In addition, a Family Resource Facilitator has been providing PSS for adults on the Navajo Nation, but has been unable to document those efforts in the electronic health record (EHR) due to issues related to internet access. DSAMH appreciates the significant efforts that SJCC has made to increase this program for their clients and recommends that SJCC continue efforts to work towards robust PSS service provision.

- 2) *Case Management (CM)*: The FY20 Adult Mental Health Scorecard reports a decrease in the number of clients receiving case management services from FY19 (12.3%) to FY20 (9.8%). Although SJCC has continued to provide case management to fewer clients than other Local Authorities (FY20 state average-39.5%), those clients receive significantly more case management services per person (FY20 average-35.18 hours) in comparison to other Local Authorities (FY20 average-8.8 hours). It is recommended that SJCC review CM service provision and ensure that this service is available for all clients that may benefit from case management.
- 3) *Suicide Prevention*: SJCC has several efforts related to suicide prevention. For example, the agency is launching a mobile crisis outreach team (MCOT) which will monitor clients at increased suicide risk and initiate caring outreach efforts. All documentation reviewed by DSAMH included the Columbia-Suicide Severity Rating Scale (C-SSRS) with a safety plan when indicated. However, the SJCC internal chart reviews included several charts that did not have a suicide assessment. DSAMH recommends that SJCC provide training on the administration and documentation of the C-SSRS for all clients in treatment, in addition to other suicide prevention efforts.
- 4) *Physical Health Documentation*: A review of SJCC charts indicated that documentation did not include whether an individual is using nicotine (seven of ten charts) or identify the primary care physician (nine of ten charts reviewed). DSAMH recommends that the SJCC EHR be updated to prompt the documentation of this type of information during the assessment, and that information collected on paper documents be scanned or entered into the electronic database.

FY21 Division Comments:

- 1) *Resilience*: DSAMH would like to recognize SJCC for the center's resilience over this past year. SJCC has experienced great loss with the passing of two of their team members, workforce shortages related to personnel leaving the area, and the extended impact of COVID-19 on their team and the community. SJCC has continued to provide consistent quality mental healthcare to their community, fostering relationships with community partners, and expanding programming to meet community needs.
- 2) *Supported Employment*: SJCC has trained a staff member to provide evidence-based Individual Placement and Support employment services. In addition, five individuals with serious mental illness have been hired by a community recycling program that was developed in a collaboration between SJCC and the San Juan Foundation, and three additional clients work at the SJCC main office.
- 3) *Integration*: SJCC and community health agencies appear to partner between Level 2 and Level 3 of the six levels of Collaboration and Integration (Substance Abuse and Mental Health Services Administration). SJCC, the San Juan Medical Clinic and the Health Department are located in the same building, with communication driven by specific patient issues. Behavioral and physical health providers have separate electronic health systems. Medical staff will note physical health concerns of serious mentally ill (SMI) clients, who receive a warm handoff to primary care. Follow up for clients without SMI receiving a referral to primary care is less coordinated. The APRN and primary care clinics share use of

the PHQ-9 screening tool, and SJCC and the hospital emergency room share use of the C-SSRS screening tool.

- 4) *Participant Feedback:* Heather Rydalch, DSAMH Peer Support Program Manager, met with three clients individually. They all reported that SJCC is helping them and they like it there. All individuals have wellness goals to stay healthy by exercising every day and they do this by walking, sit ups and crunches. One individual said that he has been with SJCC for about four years and they are helping him with the voices in his head and his depression. He expressed gratitude that the agency provides transportation so that he can attend every Tuesday and Thursday.
- 5) *Cultural and Linguistic Responsivity:* SJCC has adopted a Cultural Competency Plan addressing policy guidelines and nondiscrimination across administration and clinical treatment. The plan has not been fully implemented and was last updated in 2009. The agency has a Native American staff member on a Health Disparities steering committee and collaborates regularly with the Utah Navajo Health System. DSAMH encourages tracking of plan implementation and progress.
- 6) *Support for Survivors of Suicide Loss:* SJCC is partnering with community members to provide outreach to individuals affected by suicide. The agency provides a suicide survivors support group when needed, and works with the Zero Suicide Coalition to provide care packages that are delivered to persons impacted by suicide loss.
- 7) *Nicotine Cessation:* SJCC has been receiving nicotine cessation-related technical assistance from DSAMH and the Department of Health for several months. The agency has three staff members who have taken the DIMENSIONS train-the-trainer course recently offered, and SJCC is starting to offer free nicotine cessation courses for all community members. SJCC is also developing a nicotine cessation workgroup involving community physical health care partners.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of San Juan Counseling on October 20th, 2020. 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 2020 Audit

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.

In FY20, there were no EASY Compliance completed, which does not meet Division Directives.

This issue has not been resolved and will be continued in FY21, see Deficiency #1.

- 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/>.

This issue has been resolved. SJCC completed a community survey in August 2020 and are waiting for the Student Health and Risk Prevention (SHARP) Survey for their southern schools to complete their full community assessment and Area Plan. Because SJCC has completed the initial steps for this assessment, they are now in compliance with Division Directives.

Findings for Fiscal Year 2021 Audit

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

FY21 Minor Non-compliance Issues:

None

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.

Center’s Response and Corrective Action Plan:

Action Plan: Local law enforcement no longer conducts these checks, so we will continue to try and contact and collaborate with the state agency responsible for the checks, to offer any needed support. COVID19 eliminated any response from the state agency this year.

Timeline for compliance: As designated by the state agency responsible for checks. Hopefully by Spring 2021.

Person responsible for action plan: State agency responsible for checks, with support and encouragement from San Juan Prevention team.

FY21 Recommendations:

- 1) *Local Authority Assessment:* SJCC completed a community survey in August 2020, which has provided them with helpful information. They are still waiting on the Student Health and Risk Prevention (SHARP) survey results for their southern school to complete their assessment and Area Plan. SJCC has also utilized their relationship with the Navajo Nation to include data for this assessment as well. This is the first time that SJCC has been able to receive surveys that are beneficial for their local area assessment and planning. It is recommended that SJCC continue their efforts in gathering the data necessary for their Local Authority Assessment and Area Plan.
- 2) *COVID-19 Pandemic:* It has been difficult for SJCC to implement prevention strategies due to the COVID-19 Pandemic. Historically, community events and prevention classes have been held in person, which changed due to the COVID Pandemic. SJCC has offered a hybrid of on-site and off site classes, which has worked for most individuals. However, most families on the Navajo Reservation don’t have access to the internet or live too far away from SJCC to attend classes. It is recommended that SJCC continue to work on finding ways to provide prevention services to their community through on-line and on site methods.

FY21 Division Comments:

- 1) *Community Partnerships:* SJCC has done a good job in fostering partnerships with community agencies. They have been working with the University of Utah to procure funding for Opioid, Methamphetamine and other Substance Use Intervention Identification / Adaption for women of childbearing ages in San Juan County. As a result of this partnership, they have received helpful information regarding substance use and the needs of women of childbearing age in their community. They have also hired a Project Director to work with the San Juan County Prevention Action Collaboration (SJCPAC) Coalition to further prevention efforts for women of child bearing age in San Juan County.
- 2) *Coalition Efforts:* The SJCPAC Coalition received the Coalition Partnership Award in 2019. SJCC has done a good job of building relationships with their community over the past several years, which has led to implementation of prevention strategies in various areas in their community. SJCC is working on building coalitions in other communities, including youth coalitions.
- 3) *Text Messaging Campaign:* SJCC will be implementing the Upward Reach Campaign, which is a text messaging campaign that shares prevention messages to the community. This campaign uses the same prevention science as Guiding Good Choices. The Developers of this model are also interested in following the Community that Cares (CTC) and Parents Empowered Model for their campaign. DSAMH is working with SJCC to ensure that the curriculum for this campaign is science based. It is predicted that this campaign might be able to be adapted to other substance use disorder (SUD) programs in the future.

Substance Use Disorders Treatment

Becky King, Program Administrator for Substance Use Disorder Services conducted the monitoring review on October 20th, 2020. 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 2020 Audit

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.

This issue has been resolved. SJCC collected 14.4% Youth (Family) Satisfaction Surveys in the FY20, which meets Division Directives.

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.

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

This issue has not been resolved and will be continued in FY21; see Deficiency #1.

Findings for Fiscal Year 2021 Audit:

FY21 Major Non-compliance Issues:

None

FY21 Significant Non-compliance Issues:

None

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.

Center's Response and Corrective Action Plan:

Action Plan: Given that all drug court participants are required to obtain and maintain employment, this is very likely a data entry issue. That said, SJCC will continue to make efforts to encourage and bolster employment opportunities for clients receiving substance abuse services. These include:

1. The clinical director will meet with office staff with the responsibility of submitting TEDS data and all SUD therapists to identify why client employment was reported as 0% last year. This will be completed by 1/31/21.
2. Determine a process whereby accurate employment data is reported. This will be completed by 1/31/21.
3. Provide clinical staff with training on how to accurately report employment data at intake and discharge. This will be completed by 2/15/21.
4. SJCC administration will determine the feasibility of having a case manager trained in the Individual Placement and Support (IPS) employment model and provide employment support for SUD clients. This will be determined by 3/1/21.

Timeline for compliance: See above timelines.

Person responsible for action plan: Clinical Director

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

Center's Response and Corrective Action Plan:

Action Plan: SJCC administration will:

1. Formulate and implement a plan to identify SUD charts that need to be closed.
 - a. Run a monthly report of SUC clients not seen in 60 days and provide this to the therapists monthly in an SUD team meeting.
 - b. Review process currently in place for identifying open SUD charts that have no services entered in the past 60 days.
2. If possible, utilize peer support specialists to outreach to SUD clients who have had no recent contact with the center. Collect updated TEDS data on clients who indicate no plan to return for treatment.
3. Coordinate with the assigned therapist on SUD clients who have not received a service for 60 days or more and make a determination whether to close the chart.
4. Regularly follow-up with therapists to ensure these SUD charts have been closed in a timely fashion.

Timeline for compliance: 2/1/21

Person responsible for action plan: Clinical Director

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 the FY20, which does not meet Directives.

Center’s Response and Corrective Action Plan:

Action Plan: This is largely a training issue with our clinicians who provide SUD services. The following steps will be taken:

1. Research the circumstances where a SUD client is reported as compelled to treatment and the risk factors are not collected.
2. Provide training to SUD therapists on the need to administer the RANT for all SUD clients, most specifically those who have been court ordered to treatment.
3. Run a monthly report to determine whether any compelled SUD clients have not had a risk/need assessment and coordinate with the therapist to have this completed.

Timeline for compliance: 2/1/21

Person responsible for action plan: Clinical Director

FY21 Recommendations:

- 1) *Adolescent Services:* SJCC receives few youth referrals for substance use disorder (SUD) treatment, so they don’t have a robust program for them. SJCC usually provides individual therapy for youth. It is recommended that SJCC continue to find ways of increasing youth referrals to their SUD Treatment Program and consider using telehealth services for groups and partnering with prevention on the Upward Reach Text Messaging Campaign to reach more youth in their community.

FY21 Division Comments:

- 1) *Sober Living:* SJCC is planning to renovate a ten bedroom residence to build a Sober Living Program. SJCC has owned this home for a long time, which was previously used for a girls group home. This home is fairly large and is located in a residential area which can be used for commercial purposes. SJCC has been reviewing State regulations to see what is practical for a sober living in San Juan County. They received \$350,000.00 from COVID relief funds to begin renovations on this property. This home has five bedrooms on two levels, which should be able to house seven residents. SJCC is looking into having staff stay overnight in the home to provide more structure. This Sober Living Program should be ready by December 31, 2020.
- 2) *COVID-19 Pandemic:* The COVID-19 Pandemic was interesting and challenging for SJCC. They did a soft close in their office at the beginning of the pandemic. SJCC worked with DSAMH to try the telehealth system, which they struggled with. They ended up using Skype for Business for groups and classes instead. In June 2020, SJCC moved to having groups in person, which is where they are now. SJCC is also providing video and telephone services for therapy. They are requiring clients and staff to wear a mask at all times and to report any symptoms of COVID. The reservation was impacted severely by COVID, so SJCC has been meeting with adults and children on the reservation and schools to provide

them with help and support. SJCC has also provided phones to clients to help them stay in touch with them during the pandemic.

- 3) *Staff:* SJCC lost two employees in a car accident in July 2020, which was hard for their clients and staff. They lost their Drug Court Therapist and Peer Support Specialist. After this accident, SJCC's small team pulled together to continue to provide services for clients and their families. They also provided them with support for grief and loss issues. Despite this loss, SJCC has persevered and moved forward serving their community with their current resources. SJCC has a dedicated team that cares for their staff and clients, which has helped them through difficult times.
- 4) *Tobacco Cessation:* SJCC has been working with DSAMH on building a tobacco cessation program that will include outcome measures using questions from the Fagerstrom Test for Nicotine Dependence. SJCC will be holding their first group next week, where there will be one group in person and one on-line. This six week course covers reasons why people smoke, reasons to quit, triggers and coping skills. SJCC is advertising for this group by posting on social media and distributing flyers in the community. Therapists are also encouraged to assess for and diagnose Nicotine Dependence and provide resources for tobacco cessation like the WaytoQuit program.

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.

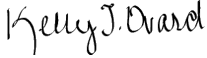
Signature Page

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 Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health


Prepared by:


Kelly Ovard  Date 01/12/2021
Auditor IV

Approved by:

Kyle Larson  Date 01/12/2021
Administrative Services Director

Eric Tadehara  Date 01/12/2021
Eric Tadehara (Jan 12, 2021 20:48 MST)
Assistant Director Children's Behavioral Health

Kimberly Myers  Date 01/13/2021
Kim Myers (Jan 13, 2021 15:34 MST)
Assistant Director Mental Health

Brent Kelsey  Date 01/14/2021
Assistant Director Substance Abuse

Doug Thomas  Date 01/12/2021
Doug Thomas (Jan 12, 2021 16:03 MST)
Division Director

Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY21

Name of Local Authority: San Juan Counseling Center

Date: 10/29/2020

Reviewed by: Robert H. Snarr, MPA, LCMHC
Geri Jardine

<i>Compliance Ratings</i>				
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.				
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 signature on the 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 a schedule for updating the plan.
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			X	Need to identify who is on the planning team and representing which department(s)

services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)				
The planning team has identified requirements for disaster planning for Residential/Housing services including: <ul style="list-style-type: none"> • 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
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		X		Please attach staff positions (i.e., org chart)
Identify continuity of leadership and orders of succession			X	Identify continuity or leadership (i.e., org chart)
Identify 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) such as an org chart
List alternative facilities (including the address of and directions/mileage to each)			X	Need to identify alternative facilities to be used, if needed
Address recovery and maintenance of client records				Need to address recovery/maintenance of client records
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: <ul style="list-style-type: none"> • Engineering maintenance 			X	Need to specify how these functions will be provided

<ul style="list-style-type: none"> ● 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 				
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DSAMH is happy to provide technical assistance.












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Final Audit Report

2021-01-14

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