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Deputy Director
NATE WINTERS
Deputy Director

Date: December 11, 2023

Commissioner Bruce Adams
San Juan County Commission
333 S. Main, #2
Blanding, UT 84511
Dear Commissioner Adams:

In accordance with Utah Code Annotated 62A-15-103, the Office of Substance Use 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 Office 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,

Brent Kelsey
Office Director

Enclosure
cc: Commissioner Silvia Stubbs, San Juan County Commission
Commissioner Jamie Harvey, San Juan County Commission
Tammy Squires, Director of San Juan Counseling Center

Utah Department of
Health & Human Services
Integrated Healthcare

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 17, 2023

Draft Report

Table of Contents

Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 26B-5-102, the Office of Substance Use and Mental Health (also referred to in this report as OSUMH or the Office) conducted a review of San Juan Counseling Center (also referred to in this report as SJCC or the Center) on October 17, 2023. 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; Office 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)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Combined Mental Health Programs	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	10
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	2	15-17
Substance Use Disorders Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Substance Use Disorders Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	20-21

Governance and Fiscal Oversight

The Office of Substance Use and Mental Health (OSUMH) conducted its annual monitoring review of San Juan Counseling Center (SJCC). The Governance and Fiscal Oversight section of the review was conducted on October 17, 2023 by Kelly Ovard, Administrative Services Auditor IV.

Overall cost per client data was analyzed and compared to the statewide Local Authority average. State licensing 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, 2022. 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 opinion in the Independent Auditor's Report dated June 10, 2023 stating; 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.

Follow-up from Fiscal Year 2023 Audit:

There were no findings in FY23

Findings for Fiscal Year 2024 Audit:

FY24 Major Non-compliance Issues:

None

FY24 Significant Non-compliance Issues:

None

FY24 Minor Non-compliance Issues:

None

FY24 Deficiencies:

None

FY24 Recommendations:

1) **Emergency Plan:** The Disaster Plan audit team appreciates your consistent participation in the 800 MHz radio checks, despite technical difficulties with radios that we continue to work towards resolving on our end.
    a) We highly recommend development of a procedure to protect their healthcare information system and networks (i.e., ransomware attack) or include where this procedure is located if it has already been developed as this item was not addressed this year.
    b) We also would encourage you to participate with your regional healthcare coordination council.

FY24 Office Comments:

1) Thank you to Tammy, Aaron, Alyn and the staff at SJCC for the timely upload of documents for the audit.

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 Office 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 Office of Substance Use 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 Office 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.

Mental Health Programs

The Office of Substance Use and Mental Health monitoring team conducted its annual monitoring review in person with San Juan Counseling Center (SJCC) on October 17, 2023. The monitoring team consisted of Leah Colburn, Program Administrator; Cody Northup, Program Administrator; Pam Bennett, Assistant Director; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: record reviews, internal agency chart review, discussions with clinical supervisors, management teams, peer support, and case staffings. During the discussions, the site visit team reviewed the FY23 Monitoring Report; statistics, including the mental health scorecard; area plans; adult and youth outcome questionnaires (OQs/YOQs); Office Directives, and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Combined Mental Health Programs

Follow-up for Fiscal Year 2023 Audit:

FY23 Minor Non-compliance Issues:

1) **Outcome Questionnaire (OQ)/Youth Outcome Questionnaire (YOQ) Use as Intervention:** The FY22 monitoring chart review demonstrates that SJCC administers the OQ/YOQ. The chart review found evidence of OQ/YOQ administration in 9 of 10 youth charts and 4 of 5 adult charts. However, there was no documentation that the tool was used as part of a clinical intervention in 6 of 9 youth charts and 2 of 4 adult charts with an OQ/YOQ administered. The internal peer reviewed monitoring reports provided by SJCC also indicated that the administration and use as an intervention was missing in all 3 charts reviewed. OSUMH Office 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". The SJCC internal peer reviewer and OSUMH recommend that continued training on the administration and use of OQ/YOQ as a clinical tool would be beneficial. OSUMH is available for technical assistance.

   This finding has been reduced, SJCC is actively training therapists to address this issue. See Combined Deficiency #1.

FY23 Deficiencies:

1) **Columbia Suicide Severity Rating Scale (CSSRS):** Both the OSUMH chart review (only 2 of 5 charts reviewed included the CSSRS) and the SJCC internal chart review indicates that there has not been regular administration of the CSSRS. The Office Directives state: "Records must contain a suicide screener, suicide risk assessment, and a suicide/crisis safety plan, when indicated, that includes indication of lethal

means counseling when clinically indicated". OSUMH recommends that SJCC review with their clinical teams to ensure that the CSSRS is administered and documented.

The SJCC peer chart review demonstrated that 67% of charts did contain a C-SSRS that had been administered within one year. This finding will be moved to a recommendation for ongoing training. See Combined Recommendation #1.

Findings for Fiscal Year 2024 Audit:

FY24 Major Non-compliance Issues:
None

FY24 Significant Non-compliance Issues:
None

FY24 Minor Non-compliance Issues:
None

FY24 Deficiencies:

1) **Outcome Questionnaire (OQ)/Youth Outcome Questionnaire (YOQ):** SJCC has been working on internal processes to ensure compliance and clinical quality with the OQ/YOQ. At this time, the internal chart review continues to demonstrate low utilization as an intervention; 60% of charts did not demonstrate use of the OQ as a clinical tool. An agency approach is being developed to increase use. This approach includes working with front office staff and clinical staff to ensure completion, and training at the provider level to increase understanding of the OQ/YOQ purpose and role in treatment, in order to change culture related to clinical outcomes.

County's Response and Corrective Action Plan:

Action Plan:
SJCC clinical team will have trainings (initial and follow up) on OQ/YOQ and its importance, how to navigate the OQ/YOQ system to get greater insight on the data, as well as how to access and use subsequent tools related to OQ/YOQ (e.g., ASC) in the analyst system. We will then train on treatment planning with specificity on the incorporation of the OQ/YOQ as an intervention.

Timeline for compliance: Initial training completed by 12/27/2023, follow up by 03/27/2024.

Person responsible for action plan: Clinical Director- Aaron Duke

Tracked at OSUMH by: Cody Northup

FY24 Recommendations:

1) **Columbia Suicide Severity Rating Scale (C-SSRS):** Effective suicide prevention requires the identification of clients at risk. The C-SSRS provides a brief framework for rapid screening. The SJCC internal chart review demonstrates that the regular administration of the C-SSRS has improved. Use of the C-SSRS as a component of follow-up after inpatient hospitalization is included in the current SJCC QAPI plan. It is recommended that SJCC continue to reinforce the importance of the screening for suicidal ideation across their client population.

2) **Crisis Services:** The FY23 SJCC Adult and Youth Mental Health scorecards both indicate drop in MCOT services. However this does not mirror reports by the agency in the service provision. (FY22: Youth 19/Adult 57 services; FY23: Youth 0/Adult 35 services). It is recommended that SJCC prioritize communicating and meeting regularly with the SUMH crisis team to assess provision of services and brainstorm issues related outreach and data reporting.

FY24 Comments:

1) **Cross-Cultural Responsivity:** SJCC is continually developing multicultural responsiveness by ensuring staff have training regarding marginalized populations. All providers have received training specific to the Native American cultures, with Native speakers on staff. SJCC has also collaborated with the SUMH Transition-Aged Youth (TAY) team to provide LGBTQ+ and TAY training for staff. SJCC has worked to stabilize their workforce needs by valuing their clinical teams' needs. Caring Connections trained staff on secondary trauma and grief support for sudden/unexpected death. See Substance Use Treatment Comment #2 for additional information on SJCC efforts.

2) **Quality Assurance and Performance Improvement (QAPI):** SJCC has focused their QAPI plan this year on clinical engagement following discharge from acute inpatient settings. The agency will develop and engage targeted interventions to increase documented outreach, individualized safety plans, and administration of Columbia Suicide Severity Risk Screenings. They will be establishing a clear pathway for follow up with the goal to increase quality of care and reduce risk of suicide.

3) **Staff Recognition:** SUMH would like to highlight Aaron Duke, clinical director. He has worked to bring in new programming, developed community partnerships, and worked to ensure staff have access to training they feel would benefit their professional development. SUMH looks forward to continued collaboration with Aaron and the SJCC team.

Child, Youth and Family Mental Health

Follow-up from Fiscal Year 2023 Audit

FY23 Deficiencies:

1) **Family Peer Support Services (FPSS):** The FY22 scorecard indicates no FPSS services were provided. This is the second year in which this service has experienced a decrease at the agency. Office Directives require Local Authorities to “establish, maintain and/or expand access to Adult, Youth, and Family Peer Support Services'', as FPSS is a vital service. SJCC is receiving technical assistance from the OSUMH. OSUMH recommends that SJCC continue to meet with the OSUMH Children's team to identify barriers to this service and develop a strategy to increase FPSS.

   This finding will be decreased to a recommendation, See Recommendation #1. SJCC has hired a FPSS and is providing this service in the community. See CYF Recommendation #1.

2) **Respite:** SJCC has continued to provide respite services at a lower rate than the rural average per the FY22 scorecard (SJCC: 0.5%/ Rural 4.3%). OSUMH continues to recognize that staffing patterns impact the ability to increase this service. As a mandated service required by Utah Code 17-43-301, SJCC should explore options to ensure provision of this service. OSUMH is available for technical assistance upon request.

   This finding is resolved. The FY23 Youth mental health scorecard demonstrates that SJCC has improved access to this service and is no longer providing this service below the rural average.

3) **Psychosocial Rehabilitation Services (PRS):** SJCC should increase the provision of PRS. The FY22 scorecard identifies a slight increase in the provision of PRS from FY21 in which they provided no PRS (FY22: SJCC:1%/ Rural: 6.6%). SJCC reports an adjustment in staff roles that may have impacted provision of this service. SJCC should review options to provide PRS, as this service will support access for youth. SUMH is available for technical assistance upon request.

   This finding will be decreased to a Recommendation due multi-year progress in access to this service. See CYF Recommendation #2.

Findings for Fiscal Year 2024 Audit

FY24 Major Non-compliance Issues:
None

FY24 Significant Non-compliance Issues:
None

FY24 Minor Non-compliance Issues:
None

FY24 Deficiencies:
See Combined Mental Health Deficiency #1.

FY24 Recommendations:

1) **Family Peer Support Services (FPSS):** SJCC due to recently hiring a FPSS was able to provide this service to the community. The FY23 scorecard indicates 2 individuals were able to access this service. SUMH recommends SJCC to continue to work to expand access to this vital service in their community. SUMH is available to support SJCC as requested to support their investment in this service.

   Heather Rydalch, Peer Support Program Manager, met with the Family Peer Support Specialist (FPSS). She is providing FPSS services part time and she is currently the only FPSS within the agency. She is receiving coaching from a SUMH contracted community agency and says that "*having coaching is really helping, being the only FPSS here is difficult*". It was indicated that *"there are barriers with FPSS. Trying to find the families to serve. Families might be scared or unsure of what FPSS services are"*. The therapists at SJCC are advocating for FPSS services and making more FPSS referrals.

2) **Psychosocial Rehabilitation Services (PRS):** SJCC has been working to increase access to this service. Over the past three years, SJCC has demonstrated steady increase in the provision of this service. FY21: 0 services; FY22: 1 service/1.5%; FY23: 3 services/2.2%. It is recommended that as SJCC engages in strengthening access to child services they explore and engage pathways to ensure that PRS services are expanded in their community.

FY24 Comments:

1) **Community Partnership:** SJCC has been recognized as a key partner in a local school based mental health project with San Juan School District and University of Utah's Technology in Training Education and Consultation Lab (U-TTEC) to support collaborative community driven approach to addressing layering mental health support and access. The U-TECC Director is highly appreciative of the partnership with SJCC to help support education and access to the broad continuum of mental health services they provide in the community, specifically crisis, medication management, intensive therapeutic, and recovery supports.

2) **Children and Youth Programming:** SJCC recognizes they have had a decrease in children and youth served in their community (FY22:195/FY23:137). The agency is working to strengthen community partnerships and reestablish school based mental health services. SJCC is also working to increase training opportunities for their clinical teams to develop evidence-based practice clinical skills to support youth treatment needs.

Adult Mental Health

Follow-up from Fiscal Year 2023 Audit

FY23 Minor Non-compliance Issues:
See Combined Mental Health Minor Non-compliance Issue #1.

FY23 Deficiencies:
See Combined Mental Health Deficiency Issue #1.

Findings for Fiscal Year 2024 Audit

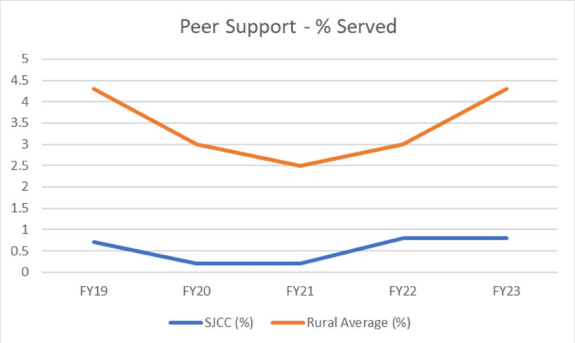
FY24 Major Non-compliance Issues:
None

FY24 Significant Non-compliance Issues:
None

FY24 Minor Non-compliance Issues:
None

FY24 Deficiencies:
See Combined Mental Health Deficiency #1.

1) **Peer Support Services (PSS):** SJCC does not have an adult mental health peer support specialist, although adult services have been provided by the Family Peer Support Specialist on staff. The FY23 Adult Mental Health Scorecard indicates that only 3 adults received mental health PSS from SJCC in FY22 and in FY23. As demonstrated by the rural average in the graph below, PSS dropped statewide during the pandemic. However, these services are not increasing with the end of the public health emergency. It is recommended that SJCC prioritize hiring an adult peer support specialist to provide critical recovery support services to mental health clients.



County's Response and Corrective Action Plan:

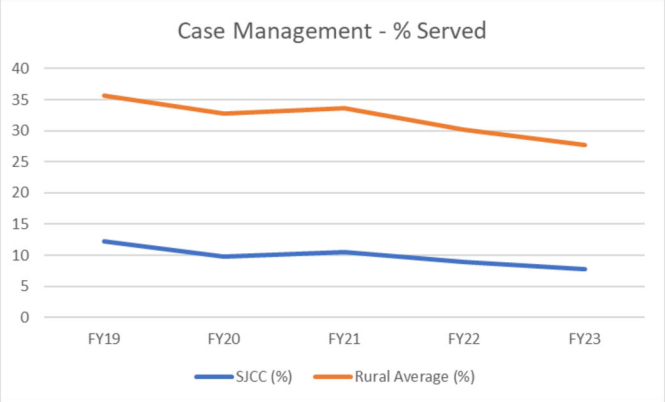
Action Plan: (PSS) SJCC will advertise (local media) and actively identify at least two individuals (within agency/community) that may be interested and would qualify for the adult PSS position. SJCC will also look at the P&P's concerning PSS and the clinical director will take one training to bolster knowledge, supervisory skills, etc., related to having a PSS on staff.

Timeline for compliance: 06/30/2024

Person responsible for action plan: Clinical Director- Aaron Duke (PSS), Case Manager Director- Jamie Meyer (CM)

Tracked at OSUMH by: Cody Northup

2) **Case Management Services (CM):** The FY23 Adult Mental Health Scorecard demonstrates that SJCC has reported a decreasing number of case management services to adult clients each year for the past 5 years. The percentage of clients receiving CM is also much lower than the rural average (FY23: SJCC-7.8%; Rural average-27.7%). A component of the decrease in CM services offered across the rural LAs is the increased use of case management in mobile crisis outreach teams (MCOT), and documentation of those services as MCOT. However, SJCC is reporting decreases in MCOT services. CM is a mandated service as per Utah Code 17-43-301, and addressing the low level of CM has been a recommendation from SUMH in three of the four previous monitoring reports. SUMH requires that SJCC address this ongoing requirement.



County's Response and Corrective Action Plan:

Action Plan: CM) CM director will visit a LMHA to tour, collect information, and be a part of training on CM services to get insight and identify areas that SJCC can bolster this area. The CM Director will conduct in-house training with her team. SJCC will also reach out and educate community partners on services we offer and advertise within the community. A system will be set up with MCOT to promote and educate individuals and families within the community on CM services offered through SJCC.

Timeline for compliance: 06/30/2024

Person responsible for action plan: Clinical Director- Aaron Duke (PSS), Case Manager Director- Jamie Meyer (CM)

Tracked at OSUMH by: Cody Northup

FY24 Recommendations:

1) **Services to Incarcerated Individuals and Documentation:** The FY23 Adult Mental Health Scorecard indicates that services to adults who are incarcerated continues to be very low (FY22-4; FY23-2). This is not reflective of the reported ongoing and regular services that SJCC is providing to the San Juan County Jail. SUMH recommends that SJCC review service provision, charting, and data collection to ensure that the Scorecard and the data submission to SUMH is accurate.

FY24 Office Comments:

1) **Ag Stress Assistance Program:** SJCC has partnered with Utah State University Extension's AgWellness program to accept Ag Stress vouchers for behavioral healthcare for agricultural producers and their families. This program increases access for farming and ranching families, a population with an increased rate of mental health distress and death by suicide. SJCC provides services to many unique and important communities within their catchment and SUMH appreciates their support of the farming community.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of San Juan Counseling Center (SJCC) on October 10, 2023. The review focused on the requirements found in State and Federal law, Office 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 2023 Audit

There were no findings in FY23

Findings for Fiscal Year 2024 Audit

FY24 Major Non-compliance Issues:

None

FY24 Significant Non-compliance Issues:

None

FY24 Minor Non-compliance Issues:

None

FY24 Deficiencies:

None

FY24 Recommendations:

1) **Coalition Efforts:** SJCC is working with Montezuma Creek, Monument Valley, and Monticello to build coalitions in their communities. SJCC has positive relationships with these communities which they are planning to strengthen and to continue to build new partnerships in these areas. It is recommended that SJCC continue working with White Mesa, Bluff and Navajo Mountain on coalition efforts. OSUMH can provide technical assistance and support as needed.

FY24 Office Comments:

1) **Recovery Day Event:** SJCC held their first Recovery Day Event in Blanding in September 2023, which was a great success. They worked with the Utah Support Advocates for Recovery Awareness (USARA) coalition partners from Moab and Drug Court partners from San Juan County to host this event. SJCC understands that prevention is an important part of recovery, and has made a concerted effort to build a partnership with USARA. There were over 100 people that attended the Recovery Day event. SJCC shared that this event was a great step in continuing to build partnerships to promote prevention and recovery efforts in their community.

2) **Prevention Efforts / Building Capacity:** SJCC was awarded the Drug Free Communities (DFC) Grant and received another year with the Community Prevention (CPP) Grant. SJCC used the CPP Grant funds to implement targeted messaging that resonates with their San Juan communities. Examples include: SJCC installed panels with prevention messaging in the gym at Whitehorse High School; Basketball backboards were installed at Monument Valley High School and at the Blanding Centennial park; Murals were created at White Mesa Education Center and at Monticello High School; and messaging on windows were included at the Blanding Wellness Center swimming pool. SJCC had three events involving coalition members and key leaders to highlight these efforts. They used a videographer to film spots at these events, which they are planning to share during sporting events that are streamed online for viewers at home. SJCC is also planning to put spots on their San Juan County Prevention Action Coalition (SJCPAC) website and show them before movies at the San Juan Theater. These messages are tied back to San Juan's initial theme of "Stoodis / Let's Do This," which is how SJCC tailored the Parents Empowered campaign in a way that resonates with San Juan County families. SJCC has been able to engage new key leaders and community partners through these projects to continue efforts in this area. SJCC hired more Prevention Specialists over the past year with grant funds, which has increased their team from three to five prevention specialists who are located in different communities.

3) **Community Readiness Assessment:** SJCC is working with the SJCPAC Coalition Data Work Group to conduct official community readiness assessments for their community, according to the Tri-Ethnic model. This also included a county Parent Survey in November. SJCC took their coalitions "on the road" to do community engagement/assessments in the following communities: Monument Valley in January 2023, Montezuma Creek in February 2023, and Monticello in March 2023. SJCC received helpful data from these outreach activities, including increased responses from youth on the 2023 Student Health and Risk Prevention (SHARP) survey. SJCC shared that they are looking forward to learning more about their community's needs through this data.

Substance Use Disorders Treatment

Becky King, Program Administrator for Substance Use Disorder Services conducted the monitoring review with San Juan Counseling Center (SJCC) on October 17, 2023. The review focused on compliance with State and Federal laws, Office Directives, Federal Substance Abuse Treatment (SAPT) block grant requirements, Justice Reinvestment Initiatives (JRI), scorecard performance, and consumer satisfaction. The review included a document review, internal clinical chart review, and an interview with the clinical director and other staff members. Consumer satisfaction and performance were also evaluated using the Office Outcomes Scorecard, and the Consumer Satisfaction Scorecard.

Follow-up from Fiscal Year 2023 Audit

FY23 Deficiencies:

1) **The Treatment Episode Data Set (TEDS) Shows**:
   a) 8.9% of SJCC's **charts have not been closed**, which does not meet Office Directives. There needs to be less than 4% of charts open at any given time.

      This issue has been resolved. SJCC has reduced their Old Open Admissions to 3%, which meets Office Directives.

   b) 17.9% of **criminogenic risk data was not collected** and 3.6% was unknown for individuals involved in the criminal justice system in FY22, which does not meet Directives. There needs to be less than 10% of data that is not collected or unknown.

      This issue has not been resolved. See Deficiency #1 below.

Findings for Fiscal Year 2024 Audit:

FY24 Major Non-compliance Issues:
None

FY24 Significant Non-compliance Issues:
None

FY24 Minor Non-compliance Issues:
None

FY24 Deficiencies:

1) **The Treatment Episode Data Set (TEDS) Shows:**

a) **50% Criminogenic Risk Data was not collected in the FY23,** which does not meet Office Directives. There needs to be less than 10% of data that is not collected or unknown at any given time.
b) The number of clients using **Social Recovery Support Services** decreased at SJCC from 26% in FY22 to 24% in FY23, which does not meet Office Directives.
c) SJCC's **rate of suicide deaths** (25/100,000) has been increasing and is now higher than the state overall (22/100,000).
d) The use of **Medication Assisted Treatment (MAT)** is low at SJCC (4% for admissions and 7% for all served).
e) There were **no decreases in nicotine use** from admission to discharge in FY23.

County's Response and Corrective Action Plan:

Action Plan:

A) SJCC will train clinical staff on the use of the RANT system and get the appropriate individuals set up in the system.

B) SJCC will train clinical team and CM team on what SRSS are available and systemize a way to relay this to individual clients as well as on a community level to promote SRSS.

C) SJCC will bring this information to be placed on the agenda for discussion in the Zero Suicide Coalition and create (with the coalition) a plan for reduction in numbers. SJCC will also train for the CRSS and the importance of administration as a tool for prevention.

D) SJCC will advertise to clients, community, and train community partners on what MAT is and that we can provide. SJCC will train the clinical/CM on the importance of continuity of care in the sense of using in-house providers for MAT.

E) SJCC will train and ensure that all evaluations are addressing nicotine use as well as promoting the Tobacco Cessation group "Dimensions" that is offered through SJCC. We will make a concerted effort to ensure flyers for this group and other materials related to decreasing nicotine use are available and visible in public areas. SJCC will disseminate information to community partners including Coalitions, public health, the clinic, SJSD, UNHS to ensure that they are also educating and promoting that these services are offered and available.

Timeline for compliance: 06/31/2024

Person responsible for action plan: Clinical Director- Aaron Duke

Tracked at OSUMH by: Rebecca King

FY24 Recommendations:

1) **Transportation Barriers:** The largest hurdle for individuals in Mexican Hat and Montezuma Creek is transportation. SJCC has been working on hiring a driver for these areas to help clients get to treatment. However, the reservations in these areas don't have addresses, which makes it difficult to locate houses. Google Maps has been working on setting up addresses in the Mexican Hat and Montezuma Creek to help resolve this issue. It is recommended that SJCC continue with their clients with transportation needs. OSUMH can provide support as needed.

FY24 Office Comments:

1) **The Treatment Episode Data Set (TEDS Shows:**
   a) SJCC has a **lower rate of drug overdose deaths** (12/100,000) than the state overall (20/100,000).
   b) **Youth need for Alcohol and Drug Treatment** at SJCC is lower than the state and has been decreasing.
   c) The percentage of clients at SJCC who had **successfully completed SUD Treatment** at discharge increased from FY2022 to FY2023 and is higher than the state or rural average.
   d) SJCC has a **high rate of abstinence from alcohol and drugs** at discharge.

2) **Expansion of Staff / Services:** SJCC expanded their clinical staff over the past year and now have seven full time therapists. With more staff, SJCC has been able to expand services in their community, including providing more services in schools. Two of the therapists are Native American, which has helped reduce cultural barriers with their Native American clients. SJCC also hired a therapist to work specifically with children, and they are one of the busiest therapists in the agency. SJCC has continued to use telehealth and provide services in person. Their telehealth services have helped reduce barriers for individuals with transportation or child care issues. Telehealth services have also helped clients have more anonymity while they are attending treatment, which can be difficult living in a small community.

3) **Medication Assisted Treatment (MAT):** When the SJCC Medical Director retired last year, he left to work for Indian Health Services where several clients left with him. As a result, the number of clients receiving MAT at SJCC decreased at that time. After the Medical Director left, SJCC hired two Advanced Practice Registered Nurses (APRNs). These APRNs are providing telehealth services in the SJCC Office since they are located in the Salt Lake area. Since SJCC has incorporated telehealth services, this has helped reach a broad range of individuals, which has also helped increase the number of clients receiving MAT services. SJCC will be asking the APRNs to start coming into the SJCC Office once a month to coordinate with staff on MAT services and meet with clients in person as needed. SJCC shared that they feel like hiring in house medical providers has helped provide a better continuity of care for their program.

Section Two: Report Information

Background

Utah Code Section 26B-5-102 outlines duties of the Office of Substance Use and Mental Health. Paragraph (2)(c) states that the Office 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 Office 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 Office of Substance Use and Mental Health may be relied upon for technical assistance and training and the Local Authority is encouraged to utilize Office resources. Each corrective action plan must be approved by Office 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 Office as evidenced by their signature and date; follow-up and verification actions by the Office 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 Office of Substance Use and Mental Health. Upon receipt, the Center will have five business days to examine the report for inaccuracies. During this time frame, the Office 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 Office 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 Office of Substance Use 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 Office 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 Office of Substance Use and Mental Health

Prepared by:

Kelly Ovard Kelly J. Ovard Date 12/11/2023
Administrative Services Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 12/11/2023
Administrative Services Director

Pam Bennett Date 12/11/2023
Assistant Office Director

Eric Tadehara Eric Tadehara (Dec 12, 2023 11:39 MST) Date 12/12/2023
Assistant Office Director

Brent Kelsey Brent Kelsey (Dec 11, 2023 14:33 MST) Date 12/11/2023
Office Director

Attachment A

UTAH OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY24

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

Date: **10/25/2023**

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

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.

Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Confirmation of the plan's official status (i.e., signature page, date approved)	X			Plan has a signature page but is unsigned
Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)	X			
Method of distribution to appropriate parties (i.e. employees, members of the board, etc.)	X			
Table of contents	X			
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			
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			
Identify continuity of leadership and orders of succession	X			
Identify leadership for incident response	X			

List alternative facilities (including the address of and directions/mileage to each)	X			
Communication procedures with staff, clients' families, state and community stakeholders and administration	X			
Describe participation in and coordination with county and regional disaster preparedness efforts, which could include participation in Regional Healthcare Coordination Councils (HCC) . Participated in a minimum of three of the four yearly DHHS radio checks		X		Attempted to participate in all quarterly radio calls. Has had radio difficulty getting an "out of range" notification which is being checked by the DHHS Emergency Services office. It is strongly recommended SJCC participate in their Regional Healthcare Coalition.
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
Procedure for protection of healthcare information systems and networks			X	It is highly recommended that SJCC develop a procedure for protection of healthcare information systems and networks or document where this procedure is available if this has already been developed.
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			
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			

SUMH is happy to provide technical assistance.

OSUMH San Juan FY24 Final Report - Google Docs

Final Audit Report 2023-12-12

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