

**2007/2008 Western UP Substance Abuse Services CA  
Prevention Provider Site Monitoring Protocol**

PROVIDER \_\_\_\_\_ Date: \_\_\_\_\_

CA Participants: Jim O'Brien  
\_\_\_\_\_

Provider Participants: \_\_\_\_\_  
\_\_\_\_\_

License #'s/Sites to be visited (if located in more than one community):

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For the Provider

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

For the Coordinating Agency

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**PREVENTION Site Visit Questionnaire**

**FY 2007-08**

**Contractual Obligations**

**ADMINISTRATIVE:**

**Follow-up on Previous Site Review and any Outstanding Areas/Issues**

Applicable only if there are unresolved findings or if on-site discussion and review is needed.

Were there any previous contract violations? YES NO

If yes, are there minimally policies and procedures with which to address those violations?

**(Contract Section IV. Section 6, on page 19.)**

Is a corrective active plan implemented for previous site visit areas/issues? YES NO

Additional comments or monitoring issues:

**Audit Items (Contract Section IV. Section 7, on page 19.)**

Did the provider receive more than \$500,000 in Federal funds during FY 2007-08?

**YES NO**

Has the provider undergone an "Outside" audit(s) for FY 2007-08?

**YES NO**

Has the audit been forwarded to the CA?

**YES NO**

Were there any findings and recommendations?

**YES NO**

If yes, have they been resolved?

**YES NO**

Documentation Submitted:

Discussion/Comments:

Findings and Recommendations:

**DRUG FREE WORKPLACE**

Does the provider meet the requirements of the Drug Free Workplace Act of 1988 34 CFR Part 85, Subpart F? (**Contract Section VIII Section 3, page28**) YES NO

**Licensure, Accreditation, Staff Qualifications, Representation**

Requirement: (**Contract Section IV, General 2 on page 4.**)

Does the Provider establish and maintain credentials file on all salaried or contractual staff providing clinical services?

**YES NO**

Does the Provider conduct a criminal background check on all potential employees?

**YES NO**

Does the Provider provide professional development of counselors and all health care workers relative to HIV/AIDS prevention and the prevention of other serious communicable diseases?

**YES NO**

Requirement: (**Contract Section IV, General, 3 on page 4.**)

**Staff Qualification Requirements**

Do all prevention staff have all licenses and/or certifications required by local, state or federal regulations to provide the services needed to meet program objectives?

**YES NO**

What minimum education requirements does the program have for prevention personnel?

**Staff Development/Training Plans and Ongoing Education**

Does the program have professional staff development plans and policies?

**YES NO**

If, yes please provide a copy.

Do prevention personnel participate in an identified or minimum number of staff development hours yearly? If yes, please explain the process.

Is there a mechanism within your program to assure that substance abuse provider staff meet the minimum Knowledge Standard requirement regarding HIV/AIDS?

**YES NO**

If yes, attach documentation or explain the assurance process.

Does the Vendor's Plan include cultural competency?

**YES NO**

Have staff been trained to deliver services as described in the respective evidence-based program guidelines? Provider assures that all direct services staff hired have passed the CPC or CPS examination, or have a 6-month waiver or are exempt.

**YES NO**

Provider assures that all personnel who provide client services as a provider, are licensed, certified, or otherwise qualified to carry out their responsibilities.

**YES NO**

***Provider assures that measures have been implemented to meet the ODCP professional qualification standards beginning October 1, 2008. YES NO***

***Describe:***

Does the Provider display current license status by MDCIS?

**YES NO**

Describe location of the license(s):

Is the Provider accredited by a nationally recognized designated body?

**YES NO**

If yes, please list the designated body(s):

Describe how the "Training Log\*" is maintained (Contract Section IV, Paragraph 14)?  
**(\*current list of 'in service' training completed)**

Who is the designated representative to the Coordinating Agency?  
Has an "alternate" been designated?

Where are your board meeting minutes maintained?  
Are they available for review?

**YES NO**

Discussion/Comments: (including improvement to the requirement)

Findings and Recommendations:

**FIDELITY BONDING**

Requirement: The Provider shall submit to the Agency a program specific Fidelity Bonding confirmation and proof of professional liability insurance for the fiscal year with the executed agreement (***Contract Section IV, Section 8 subsection f on page 7***).

Does the Provider maintain fidelity bonding documentation?

**YES NO**

Is the bonding documentation available for review?

**YES NO**

Does the Provider maintain Professional Liability Insurance?

**YES NO**

Is a copy of insurance available for review?

**YES NO**

Discussion/Comment:

Findings and recommendations:

**Service Delivery**

Have units of service been provided according to contract?

**RESEARCHED BASED PROGRAM**

**Units Contracted**

**Units Delivered**

**NON- RESEARCHED BASED PROGRAM**

**Units Contracted**

**Units Delivered**

Is service provision on schedule to meet full utilization of funding for the current fiscal year?

**YES NO**

**School/Community Programming**

Does the program maintain a 35/65% School based versus Community based mix?

**YES NO**

If not please explain, and identify a plan to meet this requirement.

**Planning Requirements**

Has the program submitted an Annual Action Plan and amendments as necessary for prevention services to the Coordinating Agency for approval?

**YES NO**

If not please explain, and identify steps to meet this requirement.

Has the provider conducted a formal needs assessment or plan to during FY 2007-08?

**YES NO**

If yes, provide a copy and describe how the information will be used. If no, will the program conduct a needs assessment in the next 18 months?

How is the program assessing prevention needs for High Risk (HR) service

populations? Please provide documentation.

What particular HR populations are served, how are they chosen for programming and how are they serviced? Please provide documentation. (Referrals from other agencies are not sufficient to establish need.)

Is the program experiencing any challenges with providing services to HR populations?

**YES NO**

If yes, what are they?

**Evidence-Based Programming**

Does the provider employ CSAP-approved Model Program(s) or other evidence-based models in the delivery of its prevention services?

**YES NO**

If yes, please list the program models utilized and the populations they serve.

If not used, what is the program's plan to achieve the provision of evidence-based prevention services?

Are participants using the full curriculum and materials specified by the program's developers?

**YES NO**

If not, what is the rationale for altering the delivery of the program?

Are model program evaluation instruments being used?

**YES NO**

If yes, please provide copies of aggregate results of evaluations.

If not, what is the provider rationale and what are the alternative evaluation methods being used? Please provide copies of aggregate results of evaluations.

Are pre and post assessment tools used to evaluate the effectiveness of prevention activities?

**YES NO**

If, yes please provide a sample.

Is information about participant satisfaction collected regarding funded prevention activities?

**YES NO**

If yes, please provide documentation.

Are outcomes and information obtained from evaluations used to modify activities as needed?

**YES NO**

Please explain.

If no to any of the above (A - J) please provide a corrective action plan.

**Reporting**

Does the program comply with CA contractual requirements for monthly submission of prevention data on the SUDPDS system?

**YES NO**

If not please explain, and identify a plan to meet this requirement.

Are SUDPDS records used to verify monthly FSR billings to the CA for prevention services? (In FY 2008-09, billings will only be reimbursed for the number of hours recorded on the SUDPDS system).

**YES NO**

Please be prepared to discuss specific prevention session data entry records upon request.

## **Key Collaborations and Coordination**

What procedures are being used to promote collaboration and coordination with other providers:

Collaboration with other Substance Abuse providers?

Collaboration with other Human Services?

Please provide documentation. If none, what are your plans to collaborate and document that collaboration?

## **Discussion of Provider Accomplishments, Concerns, Future Directions**