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NORTHWEST INDIAN
TREATMENT CENTER

Residential Program
Annual Report Addendum
January, 2015

Northwest Indian Treatment Center

P.O. Box 477

Elma, WA 98541

(360) 482-2674

Stephanie Tompkins, Director

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Northwest Indian Treatment Center provides residential chemical dependency treatment for adults, provides some mental health services, and medication management of psychotropic medicines. The program is located in Elma, about twenty miles from the Squaxin Island Tribe. It is organized as a single department of the Squaxin Island Tribe.

The population served is composed primarily of American Indians. It was developed to serve Indian patients from Washington State. There are tribes from other states that also refer with some purchasing bed days for their tribal members. Some non-Indian adults are also accepted for admission.

In 2014, three grants continue to add resources to the residential program. Each of the grants bring DBT (Dialectical Behavior Therapy) into the treatment environment. Each has provided intensive follow up after patient discharge to support use of skills, resolve crises and ensure linkages. The overall goal of the grants was to take the treatment outside the walls, to follow the patient home and it proved to be successful. The team, providing these transition and alumni activities, is called the Recovery Support Team. Two of the grants added a Recovery Coach program or also called Peer Services. We have grant-funded Recovery Coach Academies and have trained over 200 people to offer support to fellow peers on a volunteer basis. The grants have also funded community specific trainings and have trained the Makah and Suquamish communities to date.

Residential and recovery support services are provided in coordination with tribal services, mental health providers, parole and probation services, attorneys, vocational rehabilitation services, and transition and recovery houses.

Referrals into the residential program are accepted from other chemical dependency programs, mental health programs, child protective service providers, employers, employee assistance programs, human resource departments, medical practitioners, law enforcement organizations, courts, schools, families, social services or by self-referral.

Referrals are made by calling the intake coordinator. The information is collected sufficient to screen the prospective patient for appropriateness. If the initial information indicates probable appropriateness, the contact person is given information regarding making a formal referral which includes a medical history and physical. A tentative admission date may be given.

After receiving the complete **referral packet,** the information is again screened by the intake coordinator and the nurse. If the patient is not emotionally and mentally stable, if there have been serious or immediate medical needs or conditions that cannot be safely managed at the residential program, or if the referred person does not meet other admission criteria, a referral to another program or resource is made. The reason for exclusion can include current infectious state, recent suicide attempts and child sexual abuse offenses. When exclusion occurs, the information is communicated to the referral source and/or prospective patient. A recommended referral is made and documented.

There is usually a **waiting list** for admission into the residential program. During the waiting period, the intake coordinator maintains contact with the referring person to stay abreast of the status of the individual and to offer support, if appropriate. If an opening occurs unexpectedly, the person next on the list who has submitted all the necessary pre-admission documents is contacted to determine if an earlier admission is feasible. Occasionally the list does not follow in strict order of who is next.

Needs Assessment

NWITC engages in on-going activities to assess the unmet needs of the population served. 7.01 Plans developed under the Centennial Accord between tribes and DSHS are part of the larger needs assessment process and are described elsewhere in this document. 7.01 Plans are developed between DSHS programs and the tribes every two years and reviewed on the alternate year. The 7.01 Plan format was reviewed and updated at IPAC.

Public meetings of the Squaxin Island Tribe are an important source of input. Notes are taken based on the content of these meetings regarding unmet needs and **satisfaction** with services. Attending these meetings are people who have been patients and **families** of patients. NWITC goals and objectives and the annual report are **distributed** at the meetings.

The Northwest Indian Treatment Center Director meets several times each year with the **Tribal Council** to report program progress, discuss issues, request direction, and for planning. Tribal Council formally meets with each director to review progress towards goals and objectives at mid-year and provides input into the next year's goals and objectives. **Administration** approves annual goals and objectives of each program, reviews the annual reports, and meets with directors approximately twice each month at directors' meetings. The Finance Department reviews expenditures, revenue and provides financial statements. They are responsible for reviewing financial grant compliance.

The **technology needs** of the programs are evaluated by the IS Department annually including hardware, software and virus protection. Input from staff members helps evaluate and identify areas for improvement. The director plans implementation strategies in terms of resources and based on IS evaluation.

Cell phone changes, like changes in the phone and internet systems, are made by the IS Department. IS also replaces cell phones and changes phone plans to ensure safe equipment and cost effective plans. Technology is used to improve efficiency and productivity, assisting counselors to complete patient record requirements, office assistants to track budget expenditures and personnel status. The residential clinical staff has shared drives that increase efficiency and help manage copy control.

In the **residential program,** computer needs are met. There is battery backup for the phone system (thirty minutes) and a cell phone for emergency use as well as use during patient transports. A generator supports the phone system and lighting in the administration building.

Clinical staff, office assistants and intake personnel in the **residential program** have internet access. The residential program intake coordinator has built an extensive e-mail database to alert referral sources about upcoming admission openings. This position is also responsible for administering the food stamp program using internet access. Another employee uses internet

access to submit billing for services. The latter works closely with external referral sources, with the intake coordinator and the billing person to make sure each billing is successful and accurate.

All computers have personal access codes to protect the confidentiality of information.
NWITC synchronizes with the primary domain controller at the Tribal Center Site, as well as the backup domain controller and domain controller Disaster Recovery Site every 15 minutes. A disk backup is created Monday through Friday night at 6:00PM, and the newest 14 days of backups are kept on disk. In addition to disk backups, a tape backup is created every Saturday with a 2 week retention period, and a yearly backup is created on the first Saturday of January each year.

Backup tapes are stored off-site in a safe at the TGA offices and are rotated weekly.
In the event of a disaster that compromises the original data location, employees will have access to login and access replicas of all data above just as they would at the live site. There are **no other unmet needs** currently in this area.

Assistive technology includes tape recorders. Patients with vision problems are evaluated by optometrists and recommendations followed. Large print books are available through local resources. Most often, patient needs for assistance is met by pairing them with another patient who can help and increased individual counseling. Resources are also available through DBHR.

Tribal alcohol and drug treatment organizations or other agencies who make referrals to NWITC **residential program,** identify unmet needs on **questionnaires**. A phone contact is made and a NWITC staff member completes the questionnaire. Identified unmet needs of referral sources usually cluster around **access.** In the past, the access problems have been related to the tedious process of finding patients ABP (state treatment funds for the indigent) eligible. The ABP eligibility of a patient allows NWITC to bill against a DBHR contract. DBHR/ABP funds are the primary sources of revenue for the **residential program**. ABP eligibility provides a medical card for the patient and as of 2014 it also provides Mental Health Services. For all these reasons – revenue for NWITC and services and resources for patients - ABP eligibility for patients is important.

Each year, the unmet needs identified **by patients** are similar. They identify **unmet needs** to include more opportunities for phone calls, sweat lodge ceremonies and external events. As a result more ceremonies happen and patients attend 12 step meetings in the community twice monthly.

One of the primary reasons patients give for choosing residential treatment at NWITC is the need for treatment with strong **cultural orientation**. Patients identify activities that support this goal as sweat lodge, Shaker services, the Quinault church and Smokehouse activities regularly included in the treatment schedule. Patients make drums every other week. There is a traditional foods and medicine class weekly. A lot of the food and plants for the medicine come from the garden the patients care for with the help of the native plants specialist. Cultural leaders come twice each month. Beading kits are issued to each patient and classes occur to teach patients how to bead. In 2014 the patients were taken to Sundance. Participation in these activities affirms their worth and identity as Indian people.

At the 2014 **annual general body meeting** no unmet needs were identified.

*Outcomes

Outcomes are measured in the areas of **efficiency, effectiveness, satisfaction and access**. Outcomes are gathered from patients that reflect their status at intake/admission, at mid-treatment, discharge and post discharge. Questionnaires are also sent to referral sources and/or collateral providers. Outcome results are compiled, assessed and dispersed quarterly. A cover letter identifies who to contact if there are questions or a need for more information. The results for 2014 are below.

Reliability of data is ensured by making sure the process is the same with each collection. Validity and reliability are assessed by soliciting data from both the patient and another source and by monitoring changes in trends. When there are significant changes in outcomes the process is evaluated carefully to see if inadvertent contamination has occurred. Completeness is ensured by having a large enough sample of input.

Residential quarterly reports including outcomes are **dispersed** to a mailing list that includes tribal leaders, alcohol and drug treatment program directors, funding sources, referral sources, aftercare providers, I.H.S., and employees of the Squaxin Island Tribe and NWITC. The annual report has the same distribution but includes the community. The reports are also linked to NWITC website and put in the front office lobby to be sure the person's served have access to them.

Patient discharge planning begins early in treatment. Resources are sought that allow the patient to live in the **community of their choice**. The grants help make this more possible. Sometimes, if the place they prefer to live is not rich in appropriate resources or is too close to friends and family who are still using the patient is encouraged to live in a transition setting before returning to the community of choice.

Effectiveness

One measure of effectiveness is provided by referring organizations and aftercare providers regarding alumni sobriety at the end of each quarter. The goal is 55% of alumni drug and alcohol free or with a pattern of significantly diminished use as identified by the referral contact. The result for 2014 is 75%, it has been in this range for the past several years. 88% of referring/aftercare providers were contacted regarding outcomes. The goal is 40%. The variation between years is small in most areas of outcomes.

Alumni are contacted for post discharge outcomes by phone soon after leaving. **78% of alumni were contacted compared to 2013 which was the same.** The questionnaire includes questions about satisfaction with services received, whether they have made an aftercare contact, if they are clean and sober, and if they need assistance of any kind. Most alumni at this point of contact identify themselves as clean and sober. Problems and concerns identified by organizations and by patients and alumni are reviewed by the director and other staff members. This means of measurement has served the organization's purpose.

Satisfaction

The **satisfaction** of referral sources, patients, alumni and the community is high. Complaints from referents usually relate to the length of time waiting for admission, the necessity of a medical history and physical before admission, and more treatment beds. The strengths

identified by referral sources dwell, in particular, on the intake coordinator, the intensity of services related to unresolved trauma and the aftercare support from the Recovery Support Team.

Patients are usually strongly positive about the program and their counselors. By various written statements on questionnaires, they identify that staff support, learning about themselves, learning skills, and cultural aspects of the program as positive. **Complaints** tend to be around wanting more phone calls, more cultural foods and activities, more exercise opportunities and more external activities. These have been increased over the years but patients are hungry for more.

Alumni usually report satisfaction with their program, report sobriety and that they have made contact with their aftercare provider.

Access

The length of time a person **awaiting admission** is on the waiting list has been consistently low. The average number of days was 13 in 2014, three more than in 2013. Often after all the referring documents are submitted to the intake coordinator, admission can occur within a couple of days or sometimes immediately. The waiting period is sometimes longer than necessary because of delays requested by the patient or the referring agency. Work in this area has brought a consistent result in that the waiting period for **access** is about the same each quarter. This area is stable and satisfactory.

No referrals were denied admission this year. .

Efficiency

Each quarter, the payer mix and number of patient bed days is monitored by the intake coordinator and the billing person. There were 1 I.H.S. "only" beds in 2014. There was a decrease in purchase order paid beds, only 19 were purchased. The percentage was 12%, four percentage points less than 2013.

The payer mix continues to decrease. With most patients eligible for APB (Obama Care) we get less purchase order paid beds.

Quality

Billings for the residential program are strong. The data entry person, the intake coordinator and the billing person cross check records to ensure billings are correct. Dates of service are cross-checked with the office assistant.

A **review of open and closed patient records** presents a solid pattern of compliance. The clinical aspects of treatment always assess well. In 2014, weekly staffing in the **residential program** continued to be a formal process and the result is a sustained improvement in timely documentation.

Clinical supervision from a number of supports make counselors more confident in accepting difficult or complex patients. A psychologist on contract provides monthly clinical supervision; the psychiatric nurse practitioner meets with staff to gather input about patients she sees and

makes suggestions about treatment planning; the director interacts with counselors when they want to discuss a patient's progress and at regular staffing makes suggestions about treatment interventions. A primary counselor has been trained to provide daily supervision to staff.

The ARNP's assessments and treatment are examined for the appropriateness of the assessment and diagnosis, documentation, and appropriateness of medication prescribed. The review is conducted by a contract psychiatrist and it assesses the state-of-the-art use of medications, utilization patterns and effectiveness and the resulting satisfaction of the patient. She assesses that laboratory tests are completed and the co-existing conditions and medications that might be important are considered in the diagnosis and treatment choices. This review occurs semi annually. They are consistently positive.

The **medical quality assurance** is conducted by the nurse twice each year. She reports in the review any outstanding problems. In some instances, she asks for additional tests and medical referrals. These are usually deferred to the medical discharge plan. There were no significant patterns of problems this year but there is an increased focus on documentation of acute medical problems that result in necessity of emergency care.

Treatment attendants are well trained to monitor patients during times when other staff are not present. When problems arise, they call the nurse and/or the director. When the problem is acute, they may have already left for the emergency room or called for an ambulance. This is an area that appears to be going well.

There have been several patient complaints and **grievances** filed. Most are filed in anger and are related to consequences related to behavior that staff members are trying to correct. Sometimes they are an objection to the rules for patient behavior and treatment structure. Occasionally patients identify voice tones of treatment attendants that are offensive. These informal complaints are evaluated and if indicated, staff is coached for modulation of tones.

Records are kept by the three grant funded staff but these are not primary clinical records. The information included is related to grant objectives.

Safety

The **residential program's** measures of safety include information from incident reports, quarterly safety self-checks of the buildings and grounds, at least annual **external inspections**, reports of drills related to the emergency plans, vehicle safety checks, vehicle maintenance records and checks of the two generators.

For internal **self-inspections and disaster plan drills** there are forms and checklists. Safety checks occur quarterly conducted by the NWITC maintenance person. Drills occur each quarter staged so that each area of the disaster plan is addressed on each shift annually. Fire drills occur on each shift, quarterly. Deficiencies are identified and corrected. A **quarterly report** summarizes all self-checks, disaster plan reviews, and drills except that the report does not include medical emergency drills. Drills are de-briefed with patients each month. Those are reviewed by director.

NWITC programs are included in the overall **disaster plan** of the Squaxin Island Tribe. If necessary, patients can be taken by staff to the Squaxin Island Tribal Center where there are emergency cots, toilets, food, a kitchen and a generator (i.e. all essential services.) Medical care is nearby. From there, the residential building can be evaluated for return or calls can be made to transfer patients to other facilities or return them to their referring programs. Counselors will provide support of patients during the transfer to shelter and decision making about outcomes. Any court or law enforcement officials that need to be kept informed of decisions regarding patients will be contacted regarding disposition.

All employees are oriented to every aspect of the **disaster plan** initially after employment begins and annually in all staff training. Treatment attendants are trained more intensively than other employees. They are trained to monitor the generator during power outages and to recognize the codes on the monitor. Staff is trained in the use of fire suppression equipment in the orientation and annual training.

When evacuation occurs, the treatment attendants take a patient list and check each name to ensure all are out of the building. Patient information is kept in a rolling cart that can easily be taken from the facility. **Essential services** are counseling support, emergency contacts, transition plans and meeting medical and medication needs of patients. All of these can be met from Tribal buildings and resources through the Tribe's emergency plan on the reservation if buildings in Elma are uninhabitable. A list of **emergency contact people** for employees is kept in the medication room and Treatment Attendant station.

The **fire extinguishers** are checked annually in addition to quarterly inclusion in safety self checks. Fire extinguishers used for autos are one-time use and replaced afterwards so annual inspections do not apply. Disaster plans are posted near the treatment attendant station. MSDS sheets are available for products used for cleaning. Cleaning supplies are kept in the housekeeping room or in the supply room in the basement.

Reports are provided each quarter by the head cook regarding **safety in food related areas**. Problems are identified and the corrections described. The **annual inspection** of the stove hood is recorded. Hot and cold food and refrigerator and freezer temperatures are recorded. Rags are kept in a bleach solution. There is a separate container for rags to be washed. Food placed in the refrigerators are dated and thrown out on the third day from the date. There is a refrigerator area specifically for defrosting.

All employees of NWITC are trained regarding infection control, universal precautions, prevention of workplace violence, preventing and recording adverse events and in responding to medical emergencies. They are trained regarding safety practices, emergency procedures including evacuation, reducing physical risk and medication management. Initial and on-going training includes the rights of patients, person centered treatment, confidentiality, cultural competency and professional conduct. All employees are trained in CPR and First Aid. Staff who visit alumni outside the office are coached for safety including staff related to the grants who visit alumni in their home communities.

The **first aid kit location** is marked and directions adjacent. Gloves and masks are located near or in each first aid kit. Body fluid clean up bags are located in three places. Sharps are disposed of in an appropriate receptacle. When it is full, it is sent to the Squaxin Island Health Clinic, together with any **other biohazard material**, for appropriate disposal.

The Department of Health makes **annual (approximately) inspections** unless they are behind schedule. They assess medication use and documentation, kitchen and food handling, water temperatures, cleanliness, personal records, etc. (For the checklist, see "external inspections" in the safety manual). The **Department of Health** inspector commended staff for meeting standards, made minor recommendations and those were corrected. The **fire marshal inspection** of the residential site found no major deficiencies.

Related to safety is the **accessibility plan**. It is reviewed annually. The buildings and grounds are evaluated in relationship to disabilities or problems related to balance and mobility such as what might be expected of someone coming straight from detox. There are crutches and a wheel chair available. Ramps are in place for both buildings. There is a handicap accessible bathroom on the first floor. There is a room with a handicap accessible bathroom that men can use on the main floor if they are unable to climb the stairs to the men's wing. Other areas of accessibility are described in the Accessibility Plan and in the Annual Accessibility Evaluation.

NWITC has a psychiatric nurse practitioner who makes the program more **accessible** to people with emotional and mental disorders that previously would have been prevented from admission. She comes each week for initial and on-going evaluations for medication. Her services made treatment accessible to a broader range of personalities and diagnoses. This specialty was added a number of years ago as more and more patients exhibited symptoms consistent with significant mental health problems. In 2015 there may be budget cuts effecting this population which could diminish access.

Incident reports are primarily related to minor patient and staff accidents such as falls or twisted ankles. Patient accidents seem related to early recovery – patients are feeling better but do not have the muscle tone or stamina to do what they are trying. Areas in the patient building that might cause trips have been smoothed. Some other trends relate to patient illness or infections that are related to their addiction. Staff is well trained to identify symptoms that indicate a trip to the emergency room. The nurse and intake coordinator work hard to monitor incoming patients for problem health issues and alert the treatment attendants. Another area routinely monitored by the nurse and by incident reporting is medication errors. When treatment attendants reach a too high medication error rate, they are re-trained by the nurse. Treatment attendant meetings occur when several staff appear to need re-training. All these patterns are part of re-training at annual training as well. The necessary action has been taken to improve this area. There are few unusual spikes in trends as a result of the careful monitoring and consistent training and re-training. In 2014 there were no incidents that involved mandatory reporting to external authorities. Internal reporting involved issues reported to Human Resources and/or the Legal Department.

The **residential program** has sight and sound fire alarms. There are fire extinguishers which are annually checked and clearly marked. Exits are posted with lighted signs with battery backup. Routes to the exits are mapped and posted.

Transportation

The program has two GSA **vehicles** assigned to it. All vehicles have regular **maintenance** at intervals appropriate to the manufacturer's guideline. GSA notifies the program and the vehicle is transported to the appropriate resource. **Transportation** includes picking up patients arriving at airports at either SeaTac or Portland or bus lines in Olympia. Each vehicle has seat belts.

Vans have emergency plans, first aid kits, insurance information, flares, fire extinguisher and first aid supplies including mask and gloves. Employees transporting patients also have **cell phones in the vehicle**. When staff must transport in their own vehicles there are kits for them to take with all the supplies that are in the program vehicles. Copies of **current driver's license and proof of personal vehicle insurance** is kept in employee personnel records. The Tribe's insurance agent checks the driving record of each employee regularly and for cause. All staff is trained during orientation and annual training as to procedures and requirements of driving for the organization.

A requirement was added to all job descriptions that the employee must be insured by the Tribe's auto insurance company. This protects patients and the Tribe from liability concerns.

Training Needs

Training includes CPR and First Aid for all employees, to have someone present at all times who is trained. Staff is trained about the NWITC Mission Statement, the budget process, accessibility and outcomes. On-going training includes training about the rights of patients, the grievance process, patient and family centered service, confidentiality, cultural competency, the prevention of infections, universal precautions, heath and safety, unsafe environmental factors, reducing physical risks, transportation requirements, professional conduct and the identification and reporting of critical incidents, the safety and disaster plan, prevention of violence, and medications. Training regarding medications includes how medications work, the benefits, rationale, risks including pregnancy, side effects, contraindications, interaction potential with foods, drugs and other medicine, alternatives and relapse including non-adherence. Training includes the importance of taking medication as prescribed, the need for laboratory monitoring, potential interaction with alcohol, tobacco, caffeine, illicit drugs, self-administration, wellness/recovery management and the availability of resources associated with costs.

Personnel

It is important to attract, hire and retain staff who are reliable, who are able to support patients through emotional crises, are consistent in interventions, and who have excellent boundaries. Counselors must be able to facilitate treatment that moves into trauma and grief areas, facilitate expression of grief and trauma and at the same time move patients into stability. This requires experience and confidence, empathy and the ability to communicate clear direction.

The **Human Resource** Department reviews job descriptions, reclassification requests, new position requests and personnel action forms to make sure they are current and accurate, and alerts directors about overdue annual performance evaluations. They are responsible for personnel policy changes and provide support to directors. Personnel policies are reviewed annually by the Human Resource Director. A copy of the personnel policies of the Tribe is provided to each employee and a copy is on the NWITC premises. NWITC has a **personnel policy addendum handbook** approved by Tribal Council. It is given to each NWITC employee and contains documents particular to NWITC programs. When significant changes are made, the revised copy is distributed. A copy is provided to each staff member at the annual training. Quarterly all-staff meetings at the tribal level are planned by Human Resources to keep employees informed about changes in policies and benefits. In addition, if there is information that is critical for employees to have, an enclosure is in the paycheck envelope.

Job openings are posted on the Squaxin Island Tribe website and at the Tribe's administrative offices.

Reasonable accommodation requests are presented to the Director, are reviewed in conjunction with the Director of Human Resources, a decision is made and documented by the HR Department. Any supporting medical documents are placed in the employee's medical file. Most NWITC reasonable accommodation requests are granted. Historically they have been in relationship to chairs, keyboards, stools. This year there was not a request for **reasonable accommodation** from staff.

Financial Plan

The financial strategy is to diversify revenue, protect resources and reduce expenses without losing the treatment niche for which NWITC is known. **Revenue** is from I.H.S., ABP, insurance, purchase orders and Medicaid. I.H.S. provides a base funding each year. ABP bed/days are contracted with the State of WA. Medicaid outpatient mental health services are billed at the encounter rate for eligible patients.

The Director is in frequent contact with DBHR to protect ABP contracts. Several of the Tribe's directors and managers participate in state/tribe meetings to preserve access to resources for tribal programs and tribal people. They also participate in conference calls with CMS and I.H.S. to achieve the same.

There is frequent communication between the office assistant who participates in billing activities, the intake coordinator, the nurse and the billing person, sufficient to make sure each potential billing occurs and that billing is accurate. Insurance is also billed when patients have coverage. ABP is billed for eligible patients.

Beginning in 2005, NWITC entered the food stamp program for eligible patients. While this is a labor intensive effort, it continues to bring about $2700 into the food budget each month.

Monthly revenue tracking is provided by regular interaction with the organization that does billing for NWITC. Grants have substantially enriched services without increasing program expenses. The **Finance Department** has helped to evaluate the budgets for strategies for reducing expenses.

NWITC programs are vulnerable to small changes in the environment. If expenses are elevated to meet some emergent need or revenue is decreased, treatment will have to change. Services like medication management and intensive staffing will all need to be reduced or eliminated.

Risk Management

Risk management is monitored and used in several ways. (See Risk Management Plan). Revenue is monitored so that the financial projections and needs of the program are met: payer mix and maximization of potential resources in relationship to all services and patients, diversification of revenue. Insurance denials in the residential program are all appealed.

Personnel records are reviewed to make sure that all auto insurance and drivers' licenses are current. Contract providers are evaluated against the contents of the contract, and are

monitored to assure that liability insurance and professional licenses are current. Safety and disaster planning are priorities and include careful frequent training of treatment attendants. All professional licenses and liability insurance of contractors are complete and current.

Summary and Plan

The program is clinically strong and functioning well. The program is well known for excellence and the caring, sustained support provided to patients and alumni. The work with unresolved grief and trauma in a population of chronic relapse continues, now enhanced with providing patients skills to manage their emotions, interpersonal skills, crises self management and self validation. This may increase the numbers who successfully complete the program and/or reduce relapse.

The three grants obtained in 2012 continue to be fully operational. All of the objectives were met. The richness brought to alumni helps them stabilize in early recovery. The relationships built with tribal referents help the program understand the patient's home context, its pressures and strengths. The Recovery Coach Program continues to grow.

Problem gambling lectures and groups were brought into the program menu in 2010 and continues to have positive feedback in 2014.. The focus is to address the interplay between problem gambling and addiction.

Input and outcomes are used to monitor the programs and evaluate their success, the satisfaction of the community, patients and alumni, funding sources, and develop new programs and develop programs as needs are identified and to improve services. Input and outcomes collected all affirm that NWITC programs are strong in many areas and appear to be responding to identified community needs. It will be important to monitor trends in payers as 2015 develops as the organization may need to adjust to reduced revenue.

External input and internal assessment finds the NWITC programs are in compliance with and meet the requirements of licensing, certifying and accrediting bodies including those that license professionals, those that assess safety and those that issue permits. In 2013, NWITC had a three-year review of its services by CARF. The result was an outcome with three recommendations. A correction plan was developed and corrections have been completed. The next CARF survey will be in 2016.

The organization's performance in 2014 was consistent with its mission and core values as are the planned improvements.