State of Utah

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Department of Health & Human Services

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Date: February 26, 2024
Mr. Robert Hunter, Board Chair
Weber Human Services/ Weber County Commission
2380 Washington Blvd., #360
Ogden, UT 84401

Dear Mr. Hunter:

In accordance with Utah Code Annotated 26B-5-102, the Office of Substance Use and Mental Health has completed its annual review of the contracted Local Authority, Weber Human Services; 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. OSUMH 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 (Feb 26, 2024 13:22 MST)
Brent Kelsey
Director

Enclosure
cc: Sharon Bolos, Weber County Commissioner
Matt Wilson, Morgan County Council
Kevin Eastman, Director, Weber Human Services

Utah Department of
Health & Human Services
Integrated Healthcare

Site Monitoring Report of

Weber Human Services

Local Authority Contract #A03084

Review Date: January 23, 2024

Final Report

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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 Weber Human Services (also referred to in this report as WHS or the Center) on January 23, 2024. 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; OSUMH 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.

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	None	
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	12-13
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Substance Use Disorders Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	2	18-19
Substance Use Disorders Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	22-23

Governance and Fiscal Oversight

The Office of Substance Use and Mental Health (OSUMH) conducted its annual monitoring review of the Local Authority, Weber Human Services (WHS). The Governance and Fiscal Oversight section of the review was conducted on January 23, 2024 by Kelly Ovard, Financial Services Auditor IV.

The audit was conducted with WHS as the Local Mental Health Authority for Weber and Morgan Counties. 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.

As part of the site visit, WHS provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows OSUMH to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter. Random samples were taken from the backup provided to verify that the listed services qualified for each different service category.

As the Local Authority, WHS received a single audit as required. The CPA firm Christensen, Palmer & Ambrose completed the audit for the year ending June 30, 2023 The auditors issued an unmodified opinion in their report dated December 29, 2023. The SAPT Block Grant was selected for specific testing as a major program. There were no findings or deficiencies reported.

Follow-up from Fiscal Year 2023 Audit:

FY23 Deficiencies:

1) The timeline for providing documentation for the audits is as follows;
   Requested Documents **-**
   Please provide all requested **documents two weeks** prior to the scheduled site visit. **Charts and system access** will be requested **three weeks** prior to the audit to provide adequate time to review. An updated schedule will be sent with due dates for documentation and chart access to be provided. The due dates for the documentation and chart access will be monitored.

   The financial audit, service code spreadsheets and subcontractor i**nformation were not provided prior to the audit date**.

   This item improved over last year and is resolved.

2) The final report for the 2021-2022 annual audit was not sent or **uploaded to the State Auditor prior to the audit**. It is required in the Weber Human Services contract that the audit be uploaded within 180 days of year end. It was due on 01/01/23 and is still in process of review by the outside auditors as of 02/27/23.

   The audit was in the finalization at the time of the audit. The year ended July 30, 2023. The audit is currently being uploaded to the Federal Audit Clearinghouse. There have been statewide issues with audits this year due to Medicaid issues with PRISM. This item is resolved.

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) Section 3.02(A) of the interlocal agreement states that the **WHS Board shall consist of 2 Morgan County Commissioners** now (council members). Currently there is only one county council member assigned to the board and that council member only attended 5/9 meetings during FY23. Morgan county should fulfill its interlocal agreement and have two commissioners (council members) on the board. It is reasonable to expect that at least one council member will attend each board meeting. Last year, in FY22 for the FY23 audit, the Morgan County Council member attended less than half of the board meetings.

Section 3.02 **Board Membership.**

A. The Board shall consist of eight (8) directors. Five (5) of the eight (8) shall be members of the boards of county commissioners; three (3) from Weber County and two (2) from Morgan County. The other three (3) directors shall be citizens appointed by the board of commissioners of Weber County with the concurrence of the board of commissioners of Morgan County, one (1) each representing the service areas of aging, mental health and substance abuse. No citizen director shall serve more than two consecutive terms.

2) **Emergency Plan:**
   a) Weber Human Services **participated** in only **one quarterly check**. Please remember that this is a requirement. If additional support is needed in this regard, please let us know.
   b) The audit team appreciates your participation in your Regional Healthcare Coalition. Also, thank you for the provisions of the procedures to protect their healthcare information system and networks.
   c) Please review the **audit** of the **Emergency Plan on page 28**. Please refer any questions regarding this report to Nichole Cunha or Geri Jardine.

3) **Service ID Report:** It is recommended that the annual report on payment codes be **sorted by service ID**. It is the best practice to ensure that services are not reported multiple times in multiple service ID's. This report improved from last year and reporting is being implemented for next year's audit.

FY24 Office Comments:

1) Thanks to the staff of Weber Human Services for working with the OSUMH in uploading documents and preparation 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 (6)(a)(ii) each local authority is required to "annually prepare and submit to the OSUMH 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 OSUMH 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 OSUMH 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 (OSUMH) conducted its annual monitoring review at Weber Human Services (WHS) on January 23rd, 2024. The monitoring team consisted of Leah Colburn, Program Administrator; Cody Northup, Program Administrator; Heather Rydalch, Peer Support Program Manager, and Amy Campbell, Program Administrator. 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); OSUMH Directives, and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Combined Mental Health Programs

Findings for Fiscal Year 2023 Audit:

There were no findings for the FY23 audit.

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:

None

FY24 Office Comments:

1) **Outcome Questionnaire/Youth Outcome Questionnaire (OQ/YOQ):** During the on-site review, it was reported that WHS is utilizing the OQ/YOQ as an educational tool to train clinicians, help with caseload management, and also with clients during sessions to develop awareness regarding their treatment progress and discharge timeline. With respect to adults, it was noted that WHS has been able to help some long term clients recognize their desired improvements and reduce intensity of treatment or discharge altogether. Regarding youth clients, it was reported that having clinicians compare caregiver and youth scores has been useful to guide discussions regarding the differences, helping treatment progress. Additionally, it was reported that WHS has been utilizing electronic delivery of the YOQ, which has made it easier and more convenient for school-based clients. OSUMH commends WHS for the dedication to utilizing the assessment tool, and for improvements to make the tool more convenient for clients.

2) **Intellectual/Developmental Disability (I/DD) Webinars:** OSUMH would like to thank WHS for participation and engagement in the I/DD webinars offered by OSUMH. It has been reported that the WHS liaison regularly attends the webinars and offers feedback on a frequent basis. If WHS feels that the I/DD webinars would be helpful for other staff, including case managers, OSUMH would like to invite them to attend as well.

3) **Integrated Care:** WHS has placed an emphasis on integrated care and built a relationship with Intermountain Health (IH) and two separate clinics over the last two years. During the on-site review, WHS reported that Medicaid clients are referred back and forth between agencies, which has been a positive experience for both agencies. Additionally, WHS has a primary clinic and pharmacy on the first floor of their building, ensuring ongoing coordination with mental health and physical health care, and making it convenient for clients to engage in both services. OSUMH would like to commend WHS on the focus with integrated care and providing this opportunity for clients.

4) **Employee Retention:** OSUMH would like to recognize the attention that WHS has placed on employee retention and job satisfaction. During the on-site visit it was reported that WHS has implemented a number of strategies to maintain employees and ensure their ongoing well-being. These strategies include: reallocating funds for sign-on bonuses and more competitive pay structure, implementing burnout and compassion fatigue surveys and following up with classes and education to address concerns, focusing on building team support through various activities, and de-siloing focus areas to build a more cohesive agency.

Child, Youth and Family Mental Health

Follow-up from Fiscal Year 2023 Audit

There were no findings issued for the FY23 audit.

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) **Family Peer Support Services (FPSS):** FPSS was an area of recommendation in the FY23 report with a suggestion to continue engaging in technical assistance to help identify needs. The FY24 OSUMH Directives (Section E. iii) state that local authorities shall continue to establish, maintain, and expand access to Adult, Youth, and Family Peer Support Services. During the on-site review it was discussed that WHS had a decrease in FPSS over the last fiscal year (FY22: 48 - FY23: 14; -70.8%) and that this is an area of focus for the agency going forward. Additional to that focus, it was reported that WHS staff have identified this as a gap for the agency and recently hired an additional individual to provide this service to clients. While OSUMH acknowledges the re-focus on this area, it is a deficiency for the FY24 report.

   FPSS (continued): The OSUMH peer support team met with several Family Peer Support Specialists (FPSS)/Certified Peer Support Specialist (CPSS) and their supervisors. It was mentioned that "*one of the benefits of providing FPSS is being able to connect with families and being able to have that empathy is super beneficial".* Families expressed gratitude that someone is not just telling them what to do. Barriers in working with families include negative experiences from other agencies; it takes time to rebuild that trust, although WHS is able to do that. The team also met with a grandmother that is receiving FPSS and she said "*Our granddaughter was very traumatized when she came to us. After being referred to WHS from Grandfamilies and now working with a FPSS, she is now doing fabulous. Her social skills are coming along and our granddaughter trusts our FPSS, and she considers her to be her best little friend. Everyone in the office is so supportive."*

County's Response and Corrective Action Plan:

Action Plan:
There is an additional staff this year and training on codes will be addressed further as well as the referral process from clinicians to FPSS.

Timeline for compliance: +
March 2024 training for FPSS and codes, April 2024 youth clinician training on FPSS, June 2024 start focused tracking and review January 2025.

Person responsible for action plan: Anna Lopez LCSW

Tracked at OSUMH by: Cody Northup

FY24 Recommendations:

1) **Case Management (CM):** CM services show a slight increase over the last fiscal year according to a review of the FY23 youth scorecard (FY22: 83; 4.3% - FY23: 90; 4.7%). However, the percentage of clients utilizing the service remains low. During the on-site review, WHS reported that this has been a focus, including educating clinicians on the service, acknowledging a cultural change, and recognizing that the focus has room to grow. OSUMH would like to highlight the increase given last year's recommendation, and would also like to recommend that WHS continue their efforts and emphasis on helping this service grow over the next fiscal year.

2) **Respite:** A review of the FY23 youth scorecard shows a decrease in respite services (FY22: 16; 0.8% - FY23: 12; 0.6%) over the previous fiscal year. Respite services was an area of recommendation for the FY23 report. During the on-site review, it was noted that WHS has been working to further educate clinicians and clients on the service, as well as remove barriers that may be in place. OSUMH would like to recommend that WHS continue to place a focus and effort on utilizing respite services for clients.

FY24 OSUMH Comments:

1) **Midtown Community Health Center:** During the on-site visit, the OSUMH team had the opportunity to visit with the clinical director of the Midtown Community Health Center, a pediatric clinic in the area. It was reported that the relationship between OSUMH and the Midtown Clinic has been beneficial for both agencies, and aligns with the integrated care recognition in the combined mental health section. During the conversation, it was noted that a WHS clinician is housed at the Midtown clinic 3 days per week; they are working on adding a 4th day due to the success and ongoing collaboration between the agencies. OSUMH commends the WHS for the focus and effort regarding the integration of care for clients, and for the relationship that they have built with the Midtown clinic.

Adult Mental Health

Follow-up from Fiscal Year 2023 audit:

FY23 Deficiencies:

1) **Case Management Services:** The FY22 OSUMH Adult Mental Health scorecard indicates that case management services continue to decrease (FY19-25.6%; FY20-24.4%; FY21-20.7%; FY22-18.7%). This continues to be a significantly lower rate than the urban average (WHS-18.7%; urban average-43.6%), and has continued despite easing of pandemic restrictions. While OSUMH commends WHS for creating a refresher training for staff to prompt appropriate referrals for supportive services, this finding is a deficiency as it has been a recommendation in FY20 and FY22.

   This finding has been reduced to a Recommendation, see FY24 Recommendation #1 due to the continued focus on case management services and an increase in percentage of services offered in the FY23 scorecard.

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) **Case Management (CM) Services:** CM services was a deficiency on the FY23 report and had a goal to increase the percentage of CM services from 18.7% to 25% by April 2024. Per a review of the FY23 Scorecard (ending in June 2023), WHS has increased CM services (FY22: 737 - FY23: 898; 21.8%) through continued education with the clinicians and utilizing case managers to engage with clients who have not attended services for some time. Additionally, WHS reported that they are focusing on a holistic approach with clients that includes utilizing CM services. OSUMH commends WHS efforts regarding CM services and recommends the continuation of focus to achieve the goal of 25% set in the FY23 report.

FY24 Office Comments:

1) **The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP):** During the on-site review, WHS reported that they hadn't had an evidence based practice (EBP) for specific adult clientele prior to September 2022. The agency began integrating UP and now reports they have 8 UP certified therapists and 4 others who are in the process of certification. WHS is serving 169 clients with UP and 48% have seen improvement in their outcome questionnaire (OQ) scores. One success story involved a therapist who has been using UP with a client and has seen the client OQ score go from 140 down to 78. OSUMH commends WHS for successfully addressing evidence-based service needs with specific populations.

2) **Jail Services:** A review of the FY23 adult scorecard shows WHS has increased jail services to clients over the last fiscal year (FY22: 965-1166; 20.8%). During the on-site visit, WHS reported that the agency has had one case manager housed in the local jail and the agency has been able to become more integrated. WHS reported that the case manager works with the clients prior to and post release to ensure referrals are made and that the client engages with ongoing services. OSUMH recognizes the efforts being made to work with the local jail and the increase in services being offered to clients.

3) **Receiving Centers (RC):** Thank you for continuing to meet with the OSUMH administrative crisis team to provide system updates; we appreciate the ongoing collaboration. We want to call attention and offer gratitude for WHS' assistance gathering routine data from the program being offered in the WHS area. We look forward to continued discussions and work with both WHS and Intermountain Health in the delivery of RC services.

4) **Mobile Crisis Outreach Teams (MCOT):** MCOT teams provide an important function to the overall crisis system in Utah, providing timely face to face support and intervention to those experiencing a crisis wherever they are in the community. OSUMH commends WHS for their dedication in providing this service to their community,and for working diligently with other important components of the crisis system including 988 crisis line, dispatch, and local law enforcement. WHS has built strong relationships with all of these partners resulting in efficient and effective community MCOT response averaging 80 outreaches a month.

5) **Peer Support Services (PSS):** The FY23 adult scorecard showed a client increase for peer support services (FY22: 39 - FY23: 66; 69.2%). One of the recent success stories is a former WHS client who successfully completed treatment as a Peer Support Specialist and was hired by the agency. WHS currently has strong interest with clients interested in PSS and WHS typically is able to have services set up by a client's second visit. The peer support team met with three Peer Support Specialists and their supervisors. Some of the feedback that was shared was: *"Peer Support provides inspiration and lets individuals know that they are not alone, they give hope!"; "I have such an amazing supervisor"; and "I have been receiving PSS services for around 3 years and my recovery is better than it has been. I am more confident in my sobriety".*

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Weber Human Services on January 23, 2024. The review focused on the requirements found in State and Federal law, OSUMH 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

FY23 Deficiencies:

1) **Evidence-Based Policies, Programs and Practices (EBP's)**: 40% of WHS programs, policies and practices are evidence-based, which does not meet OSUMH Directives. The current standard for the Local Authorities is to have 90% of their programs, policies and practices that are evidence-based.

   This finding has been resolved. 90% of WHS programs, policies and practices are now evidence-based.

2) **SYNAR Compliance Checks:** The percentage of SYNAR checks decreased from 93.2% to 89.5% from FY21 to FY22 respectively, which does not meet OSUMH Directives. The standard is to have a compliance rate of 90% for SYNAR Checks.

   This issue has not been resolved, which will be addressed in Deficiency #1 below. The percentage of SYNAR checks decreased from 89.5% to 86.0% from FY22 to FY23 respectively, which does not meet OSUMH Directives. The standard is to have a compliance rate of 90% for SYNAR Checks.

3) **DUGS Data Entry:** DUGS Data Entry decreased from 92% to 8% from the FY21 to FY22 respectively, which does not meet OSUMH Directives. It is recommended that WHS increase their DUG Data Entry over the next year.

   OSUMH can provide technical assistance and support as needed.

   This issue has been partially resolved which will be addressed in Recommendation #1 below. DUGS Data Entry increased from 8% to 50% from the FY22 to FY23 respectively, which meets OSUMH Directives.

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) **SYNAR Checks:** The percentage of SYNAR checks decreased from 89.5% to 86.0% from FY22 to FY23 respectively, which does not meet OSUMH Directives. The standard is to have a compliance rate of 90% for SYNAR Checks.

County's Response and Corrective Action Plan:

Action Plan:
Work with the Weber-Morgan Health Department, local coalitions, and retail establishments on educating regarding compliance laws.

Timeline for compliance:
Collaboration with youth coalitions and WMHD has begun. We will begin education courses and information by June 1, 2024.

Person responsible for action plan: Susannah Burt/Bryce Sherwood

Tracked at OSUMH by: Becky King

2) **Eliminating Alcohol Sales to Youth (EASY) Compliance Checks:** The number of EASY Compliance Checks decreased from 135 to 110 from the FY22 to FY23 respectively, which does not meet OSUMH Directives. There needs to be at least one more compliance check completed than the year before.

County's Response and Corrective Action Plan:

Action Plan: We will work with local Law Enforcement partners and local coalitions to educate officers AND our retail establishments. The coalitions will coordinate their youth with local officers to conduct compliance checks. Weber Human Services and coalitions will work with retail establishments (by coalition area) to ensure all establishments that sell off premise are SMART trained.

Timeline for compliance: Already started. Will be completed by June 30, 2024.

Person responsible for action plan: Susannah Burt/Jason Skinner

Tracked at OSUMH by: Becky King

FY24 Recommendations:

1) **DUGS Data Entry:** WHS has made progress with their DUGS Data Entry, which increased from 8% to 50% from the FY22 to FY23 respectively. It is recommended that WHS continue to work on entering their DUGS data consistently.

2) **LSAA Assessment:** WHS has made good progress on their LSAA Assessment and are planning to do a comprehensive assessment update. They completed a Readiness Assessment last year and have been working on their Resource Assessment. It is recommended that WHS continue working on their LSAA Assessment. OSUMH can provide technical assistance and support as needed.

FY24 Office Comments:

1) **Community Impact:** WHS made significant changes over the past year which has made a positive impact on their community. This included increasing evidence-based programs and strategies in their program. They also focused on elevating and preparing communities through the following measures:
    - Joining efforts across multiple communities
    - Sharing plans and collaborating efforts
    - Developing new partnerships
    - Strengthening current partnerships

    WHS is partnering with several organizations, including: United Way of Northern Utah, Weber Morgan Health Department, Ogden and Weber School Districts and Partnership for Success.

2) **Community Centered Evidence Based Prevention (CCEBP):** WHS focuses on CCEBP to ensure that the needs of their communities are met. They increased coalition efforts with the addition of two full time and one part time staff positions to coordinate in Weber and Morgan Counties. They were awarded the Opioid Settlement Funding for the next several years, which will help sustain prevention efforts long term. Their coalitions are also transitioning their priority to implementing evidence-based programs.

3) **Fiscal Year 2024 Objectives:** WHS established the following objectives for the FY24: (1) Strengthening youth coalitions; (2) Training coalition coordinators; (3) Increasing proficiency in evidence-based programming; (4) Establishing sustainable funding; and (5) Increasing community participation in CCEBP. WHS has been able to provide more coaching and training with the new staff they hired. They have also developed a plan with the Prevention Coordinator, Regional Director, and new coordinators to address the needs of the coalitions and to support coalition progress. WHS is also getting back to the basics by focusing on implementing the Strategic Prevention Framework (SPF) and using the data to drive their services.

Substance Use Disorder Treatment

Becky King, Program Administrator, conducted the review of Weber Human Services on January 23, 2024. The review focused on Substance Abuse Treatment (SAPT) Block Grant Compliance, Drug Court compliance, clinical practice and compliance with contract requirements. Clinical practices and documentation were evaluated by reviewing WHS' Internal chart reviews and discussing current practices. Adherence to SAPT Block Grant requirements and contract requirements were evaluated by a review of policies and procedures, discussion with WHS staff and a review of program schedules and other documentation. WHS performance was evaluated using Utah Substance Abuse Treatment Data Dashboard and Consumer Satisfaction Survey data. Client satisfaction was measured by reviewing records and the Consumer Satisfaction Survey data.

Follow-up from Fiscal Year 2023 Audit

FY23 Deficiencies:

1) **The Treatment Episode Data Set (TEDS) shows:**
   a) **Tobacco / Nicotine Use:** The percentage of clients with nicotine use at admission that successfully stop using nicotine during treatment is low compared to other urban areas (i.e., 4% of Weber clients compared to 14% of other urban clients stop using nicotine).

      This issue has not been resolved, which will be addressed in Deficiency #1 below. Weber has more clients who use tobacco at both admission and discharge (80%). This is similar to last year.

   b) **Social Recovery Support:** WHS clients are slightly less likely than other clients in the state to be connected to social recovery support by the end of treatment (20% at Weber vs. 27% across other agencies). The percentage of youth and young adults is particularly low with just 11% of clients under 27 years of age connected to social recovery support.

      This issue has not been resolved, which will be addressed in Deficiency #1 below. Only 23% of clients are using social recovery support at discharge. This is similar to both the state and urban averages.

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) WHS has more clients who use tobacco at admission and discharge (80%). This is similar to last year.
   b) Only 23% of clients are using social recovery support at discharge.

County's Response and Corrective Action Plan:

Action Plan:

A. Smoking Reduction Plan:
Clients in our residential programs will be provided smoking cessation groups. We will look to partner or gain awareness through the Weber County Health Department services provided for clients in our outpatient services. We have added a question for all clinicians to ask clients as part of the intake. Training will be provided to train clinicians and case managers about if clients are desiring to make a change that they can be provided resources. Our Medical Clinic has been asking their own set of questions about the desires to quit smoking as part of their assessment.

B. Increase Recovery Support:
Currently each therapist is assigned a Case Manager/Peer Support Specialist. The plan will remain that clinicians will directly refer clients to their assigned CM/Peer for wrap around services and peer coaching.
We have and will continue to further develop a partnership with USARA in helping to train clinicians and case managers on the services that USARA has to offer. We will continue to work to help link clients to USARA for post treatment services and for USARA to help link clients to the greater Ogden Recovery Community. One area that we are considering is to help link USARA to begin more of an Alumni Association for our specialty court programs. They have been attending specialty courts and are to share information to the clients and gain awareness of activities.

They are also able to start to bridge and connect with their peers for support while in drug court and that can remain after completion of the program.
Training will continue to be emphasized and help clinicians who have clients not associated with specialty courts these resources. That they will be trained in regards to how to further answer the questions in TEDS data.

Timeline for compliance: A. Smoking Reduction Timeline: Staff will be trained in April's team meeting.
In January 2025 we will determine whether our intervention strategies have resulted in improvement.

B. Peer Recovery Support Timeline: Staff will be trained in the April's team meeting on the TEDS data and be provided resources to help link clients to the PEERS in house and through USARA. They will also gain ideas from other organizations that PEER Recovery Support could be answered.

In January 2025 we will determine whether our intervention plan is moving the needle to increase our peer support data to be similar to other urban centers in the state.

Person responsible for action plan: Craig Anderson

Tracked at OSUMH by: Becky King

FY24 Recommendations:

1) **TEDS Shows:**

   a) WHS has a higher rate of drug overdose deaths (24/100,000) than the state overall (20/100,000), but a similar pattern.
   b) WHS rate of suicide deaths (26/100,000) is also higher than the state overall (22/100,000). The suicide rate has been increasing.
   c) Youth need for AOD treatment at WHS is higher than the state, but has shown a similar decreasing pattern since 2019.
   d) Weber shows slightly lower rates of alcohol and drug abstinence at discharge than both the state and urban averages, despite having higher rates of abstinence at admission.

   It is recommended that WHS check their data for accuracy or work on ways of reducing overdose death, decreasing suicide rates, increasing alcohol and drug abstinence rates and looking for methods of referring more youth to treatment services.

FY24 OSUMH Comments:

1) **TEDS Shows:**

   a) The use of Medication Assisted Treatment (MAT) has been increasing at WHS.
   b) The WHS percentage of clients who are in treatment for at least 90 days is higher than both the state and urban averages. For clients who successfully complete treatment, the median number of days in Weber is 229 days, which is an increase from last year (191).

2) **Outcome Improvement Plan through Evidence-Based Implementation:** WHS has an Outcome Improvement Plan to improve services through the use of evidence-based implementation (EBP), which includes the following steps: (1) **Identifying the right client** through screening, diagnosis inclusion and exclusion criteria; (2) **Selecting sustainable EBP's** and asking whether they should or can implement these EBP's; (3) **Monitoring Dosage** through systems and a data process for educating clinicians and clients; and (4) Focusing on **Purpose and Outcomes Improvement** to improve outcomes for consumers.

3) **Medication Assisted Treatment (MAT):** The use of MAT has increased at WHS over the past year. One reason for this is that WHS has incorporated a new practice at WHS where clients are allowed to come to the clinic on a same day basis. When clients arrive for treatment, a WHS staff member takes them to the Medical Clinic to meet with a medical provider. They are also scheduled with a clinical evaluation for treatment at that time. WHS has been focusing on overdose prevention and believe it is important to provide clients access to the medications as soon as possible. WHS has discovered that some clients would prefer just to receive MAT and not attend treatment, so they hired someone to follow up with these clients to help engage them in treatment.

Section Two: Report Information

Background

Utah Code Section 26B-5-102 outlines duties of the OSUMH. Paragraph (2)(c) states that OSUMH 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 OSUMH 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 OSUMH 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. OSUMH 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.

Signature Page

We appreciate the cooperation afforded OSUMH monitoring teams by the management, staff and other affiliated personnel of Weber Human Services and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Kelly Ovard at 385-310-5118.

The Office of Substance Use and Mental Health

Prepared by:

Kelly Ovard Kelly J. Ovard Date 02/26/2024
Administrative Services Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 02/26/2024
Administrative Services Director

Pam Bennett Date 02/26/2024
Assistant Director

Eric Tadehara Eric Tadehara (Feb 26, 2024 12:39 MST) Date 02/26/2024
Assistant Director

Brent Kelsey Brent Kelsey (Feb 26, 2024 13:22 MST) Date 02/26/2024
Director

Attachment A

OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY24

Name of Local Authority: **Weber Human Services**

Date: **January 31, 2024**

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			
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		WHS has participated in only one radio check the past year. It is strongly encouraged that participation in all quarterly tests to ensure radio is working and staff know how to use it. WHS participates regularly in their Regional Healthcare Coordination Council and is greatly appreciated.
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
Procedure for protection of healthcare information systems and networks	X			
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.

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OSUMH Weber Human Services FY24 Final Report - Google Docs

Final Audit Report 2024-02-26

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