State of Utah

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Deputy Director

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Deputy Director

Date: March 25, 2025
Mr. Robert Hunter, Board Chair
Weber Human Services/ Weber County Commission
2380 Washington Blvd., #360
Ogden, UT 84401

Dear Mr. Hunter:

In accordance with Section 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. SUMH 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 there are 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 (Mar 26, 2025 18:15 MDT)
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: December 3, 2024

Final Report

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Section One: Site Monitoring Report

Executive Summary

In accordance with Section 26B-5-102, the Office of Substance Use and Mental Health (also referred to in this report as SUMH) conducted a review of Weber Human Services (also referred to in this report as WHS) on December 3, 2024. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance use prevention and treatment services and general operations.

The nature of this examination was to evaluate the local authority's compliance with: State policies and procedures incorporated through the contracting process; SUMH 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 WHS'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 Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	7
Mental Health Programs	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
Substance Use Disorders Prevention	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 2	13-14
Substance Use Disorders Treatment	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	

Governance and Fiscal Oversight

The Office of Substance Use and Mental Health (SUMH) 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 December 3, 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 SUMH to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the local authority 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 February 13, 2024. The SAPT Block Grant was selected for specific testing as a major program. Their opinion was unmodified with no findings or deficiencies reported.

Follow-up from Fiscal Year 2024 Audit:

There were no findings for the FY24 audit.

Findings for Fiscal Year 2025 Audit:

FY25 Major Non-compliance Issues:
None

FY25 Significant Non-compliance Issues:
None

FY25 Minor Non-compliance Issues:
None

FY25 Deficiencies:

1) WHS Emergency Plan: WHS participated in one quarterly radio check. **The Office Directives require participation in a minimum of three quarterly radio checks per year (75%) and for the past two years WBH has participated in one (25%).** If additional support or technical assistance is needed, please contact Jennifer Hebdon-Seljestad and Geri Jardine at the office and they can schedule training sessions.

County's Response and Corrective Action Plan:

Action Plan:
WHS security will participate in the Statewide radio checks to ensure that emergency contact is established and monitored. WHS has not had a problem with this requirement in the past. There are a couple of reasons why this occurred during FY 2025. At least one if not two of these checks were during our General staff meeting where everyone is required to attend and our building is shut down. It was an over-sight that we will monitor better in the future and make sure that our security staff are participating. The other reason is that this responsibility lapsed when our security officer/ supervisor retired. Dane Mortensen is now over-seeing this.

Timeline for compliance: Immediately

Person responsible for action plan: Dane Mortensen/ Kevin Eastman

Tracked at OSUMH by: Kelly Ovard

FY25 Recommendations:

1) **Review Unspent Funding**: SUMH recommends the local authority discuss unspent funding with WHS to determine how best to use the resources provided.

Program	Service Code	Awarded Amount	Spent Amount	Unspent Amount
MH	EBI - Evidence Base Psychosis (State)	$16,085	$14,432	$1,653
	EBI (Federal)	$78,750	$26,816	$51,934
	RCS - Receiving Center Services (State)	$410,683	$225,288	$185,395
	SS1 - Self Directed Services	$12,000	$2,022	$9,978
	Total MH	**$517,518**	**$268,558**	**$248,960**
SUD	CMF - Covid Mitigation Funds	$47,946	$25,892	$22,054
	LIT - Opioid Litigation Funded Projects	$200,000	$0	$200,000
	PTR - ATR Corrections	$140,708	$137,043	$3,665
	RSS - Recovery Support Services	$33,356	$29,907	$3,449
	SLF - Sober Living (Federal)	$178,546	$77,365	$101,181
	SOR2 - State Targeted Response	$98,000	$83,634	$14,366
	YTS - Youth Treatment Services	$83,712	$82,950	$762
	Total SUD	**$782,268**	**$436,791**	**$345,477**
Prevention	Total Prevention	$0	$0	$0
	Total Unspent	**$1,299,786**	**$705,349**	**$594,437**
	Grand Total	**$13,226,344**	**$12,631,907**	**$594,437**
Total Spent/Unspent %			**95.5%**	**4.49%**

FY25 Comments:

1) Thank you to Kevin, Matt and staff for the timely uploading of documents for the audit this year.

Mental Health Mandated Services

According to Section 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 SUMH 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 SUMH 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 SUMH is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Mental Health Programs

Cody Northup, Program Administrator, and Heather Rydalch, Peer Support Program Manager, conducted the annual monitoring review for mental health programs at Weber Human Services (WHS) on December 3rd, 2024. 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 FY24 Monitoring Report; statistics, including the mental health scorecard; area plans; adult and youth outcome questionnaires (OQs/YOQs); Office Directives, and the Center's provision of the ten mandated services as required by Section 17-43-301.

Findings for Fiscal Year 2024 Audit:

FY24 Deficiencies:

Children, Youth, and Families

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 SUMH 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 SUMH acknowledges the re-focus on this area, it is a deficiency for the FY24 report.

   This will no longer be a deficiency for the FY25 monitoring report as WHS has increased FPSS numbers and continues to emphasize the service to clients. See FY25 Recommendations, Combined Mental Health #1.

Findings for Fiscal Year 2025 Audit:

FY25 Major Non-compliance Issues:

None

FY25 Significant Non-compliance Issues:

None

FY25 Minor Non-compliance Issues:

None

FY25 Deficiencies:

None

FY25 Recommendations:

Combined Mental Health

1) **Peer Support Services (PSS) & Family Peer Support Services (FPSS):** During the on-site visit, WHS and the monitoring team had discussions about their internal referral process and focus for both PSS and FPSS. SUMH would like to commend WHS on the ongoing focus and significant growth specifically related to FPSS being offered to clients according to the FY24 youth mental health scorecard (FY23:14; FY24:40; +185%). A review of the FY24 adult mental health scorecard shows a slight decrease of PSS being offered (FY23:66 - FY24:64; -3%). Despite the increase with FPSS and only slight decrease with PSS, comparatively WHS is providing both services at a lower percentage than other urban areas in both youth and adult populations. With this comparison, SUMH would like to recommend a continued focus on both services, and for WHS to consider how these services may be bolstered to match client needs.

Children, Youth, and Families

1) **Unfunded Clients:** The FY24 youth mental health scorecard shows a significant decrease in unfunded clients being served (FY23:228 - FY24:31; -86%). WHS reported during the review that they believe this decrease is due to a smaller presence in the schools in comparison to previous years, in addition to funding movement to pediatric clinics whose clients have Medicaid or private insurance. WHS noted that they have sought various other community connections to ensure unfunded clients are still being served including working with various community partners, local hospitals, religious leaders, and the Saeger Clinic. However, they acknowledged that unfunded referrals have been lower than expected. SUMH recommends that WHS continue to place an emphasis in this area, and explore other target areas that may serve unfunded youth clients to ensure the youth still have access to services.

FY25 Comments:

Combined Mental Health

1) **Seager Clinic:** WHS has partnered with the Seager Clinic which offers medical care for uninsured and underinsured individuals in the catchment area. The reviewer met with the Seager Clinic as part of the review, and the agency reported that they are currently open 3 days per week and see between 12-20 patients during that time. Additionally, they have a pharmacy on-site and are able to provide all medications to clients free of charge. All employees are volunteers. Part of WHS partnership includes offering mental health services on-site. At the time of the on-site review, WHS reports that they are serving 13 youth who have been referred from the Seager Clinic. The contract is currently focused on providing services for youth with mental health needs. However, both partners report that they hope to extend the services to adults in the future.

2) **Professional Quality of Life for Clinicians:** During the on-site review, WHS mentioned a recent focus on reducing burnout and improving the quality of work life for their clinicians. During the summer of 2024, they implemented a 5 week course that focuses on self care and job sustainability practices for all clinicians. In addition to this course, each clinician is required to take 1 designated self-care hour, 2 times per week, during which they are not allowed to do any work-related activities. Thus far, WHS reports positive feedback and is committed to ensuring the wellbeing of their staff.

Children, Youth, and Families

1) **Partnership with Ogden School District:** As part of the FY25 monitoring process, the reviewer met with a member of the Ogden School District who is overseeing the student services program. It was reported that WHS and the Ogden School District have formed a partnership to serve at-risk youth and their families. The partnership includes funding for a day treatment program, regular meetings to discuss resources and support available for students with Medicaid, coordination with families' needs, and an ongoing referral network for youth who need extra support. It was also noted that there is a clinician from WHS who is able to provide support in Spanish to a local elementary school, and there is an ongoing discussion about how to provide skills training in the schools as well. SUMH recognizes and appreciates the collaboration between WHS and the Ogden School District focused on meeting the needs of these youth and their families.

Adult Mental Health

1) **Evidence Based Practices (EBP):** During both the opening meeting and the mental health managers meeting of the on-site review, WHS emphasized their focus on EBPs, and how they have been implemented throughout the agency. WHS reviewed implementation of transdiagnostic treatment for adults with multiple mental health diagnosis. WHS noted that the model is known as Common Elements of Treatment Approach (CETA) and they began implementing the model in 2020, which has allowed for outcome data to be gathered. At the time of the review WHS reports that they have seen positive outcomes with 73% of their clients that have engaged in the treatment. WHS has addressed the challenge of keeping clients engaged in enough sessions to produce positive outcomes with a focus on motivational interviewing (MI) with new clientele. Further, WHS has adapted their training model to get licensed therapists trained in MI upon being hired to ensure the most effective clinical services possible. SUMH acknowledges the WHS focus and commitment to providing evidence based practices and research backed supports to their clients.

Substance Use Disorder Prevention

David Watkins, Program Administrator, conducted the annual prevention review of Weber Human Services on December 3, 2024. The review focused on the requirements found in State and Federal law, SUMH 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 2024 Audit

FY24 Findings:

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

   This has been resolved. The LA achieved 91.8% compliance in FY24. For FY25 LAs were required to provide a plan for how they will impact the Synar rates. Moving forward it will be important for the LA to demonstrate that they have met the goals outlined in that plan. While falling below the 90% standard will not automatically lead to a finding, doing so may be an indicator that current efforts are not working and will need to be adjusted.

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 SUMH Directives. There needs to be at least one more compliance check completed than the year before.

   This has been resolved. This deficiency has been corrected as the LA achieved at least 1 more compliance in FY24. For FY25 LAs were required to provide a plan for how they will impact the number of EASY checks. Moving forward it will be important for the LA to demonstrate that they have met the goals outlined in that plan. While failing to do 1 more check will not automatically lead to a finding, doing so may be an indicator that current efforts are not working and will need to be adjusted.

Findings for Fiscal Year 2025 Audit:

FY25 Deficiencies:

1) **DUGS data entry:** WHS failed to properly record data within the DUGS data system during FY24. Many of the services, whether provided by WHS itself, coalitions, or other contractors, were not reported at all. The area plan listed a total of 17 strategies to be implemented throughout the year, well it can be expected that some of these strategies did not happen, only 3 unique strategies were reported into DUGS. Of the entries that were entered into DUGS only 30% met the 45 day requirement. The Office Directives state "the LA must enter prevention data into the SUMH approved system within 45 calendar days of the delivery of service." It is

recommended that WHS work to enter data into the DUGS system within the 45 day requirement.

County's Response and Corrective Action Plan:

Action Plan:
Set up training and coaching calls with each data entry user. Prevention Coordinator will send reminder emails once a month for data entry as well as review current data collected every 60 days.

Timeline for compliance: June 30, 2025

Person responsible for action plan: Susannah Burt

Tracked at OSUMH by: David Watkins

2) **Communities that Care (CTC) seed funding match:** The CTC funding report that was submitted to the SUMH reported that two of the coalitions that received the CTC seed funding in FY24 used a funding source for the required match that does not meet the match criteria. This was found to be an error and WHS corrected the report after the completion of the site visit. SUMH encourages the LA to ensure all funds are being used appropriately and that all requirements are being met in future years.

County's Response and Corrective Action Plan:

Action Plan:
WHS has corrected the report. Prevention will ensure that the report is submitted correctly and timely for FY25.

Timeline for compliance: June 30, 2025

Person responsible for action plan: Susannah Burt

Tracked at OSUMH by: David Watkins

FY25 Recommendations:

1) **Readiness assessments:** Office directives state that areas that receive opioid settlement funding need to increase the number of opioid readiness assessments completed within the first 3 years of receiving the funding. WHS has not completed an opioid readiness assessment to meet the requirement an assessment will need to be completed in FY25. At the site visit, WHS did state they are in the process of doing a readiness assessment.

FY25 Comments:

1) **Coalition support:** WHS has been committed to increasing locally driven prevention through the development of community coalitions. WHS is the fiscal agent for many of the coalitions within the LA area, and they provide staff support through key leader and community board membership. In recognition of coaching support needed for these coalitions, WHS not only houses one of the Regional Prevention Directors, but they worked with SUMH and the BRHD in an unique partnership to hire a full time coalition coach/support person that works across both the BRHD and WHS.

2) **National Guard partnership:** In another unique partnership the Utah National Guard and WHS have teamed up on prevention support. The National Guard Counter Drug Team provides a staff person that has the ability to help coalitions work through the strategic prevention framework and to implement prevention activities. These efforts are coordinated with WHS. WHS offers a space where the National Guard staff can come and work with the WHS prevention team.

3) **Evidence-based programs and strategies:** During FY24 WHS worked to replace many of the non-evidence based strategies they had been implementing or supporting. Understanding that local coalition planning efforts will dictate what evidence based strategies are implemented in the future, WHS has begun training staff on a few evidence based programs to ensure they are ready to support coalitions with trained instructors. This will eliminate some of the burden from coalitions and the time it takes to move from planning to implementing.

Substance Use Disorder Treatment

Becky King, Program Administrator, conducted the review of Weber Human Services on December 3, 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 2024 Audit

FY24 Deficiencies:

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

   a) WHS has more clients who use tobacco/nicotine at admission and discharge (80%). This is similar to last year.

      This issue has not been resolved, which will be addressed in Recommendation #1 below.

   b) Only 23% of clients are using social recovery support at discharge.

      This issue has not been resolved, which will be addressed in Recommendation #2 below.

Findings for Fiscal Year 2025 Audit:

FY25 Major Non-compliance Issues:
None

FY25 Significant Non-compliance Issues:
None

FY25 Minor Non-compliance Issues:
None

FY25 Deficiencies:
None

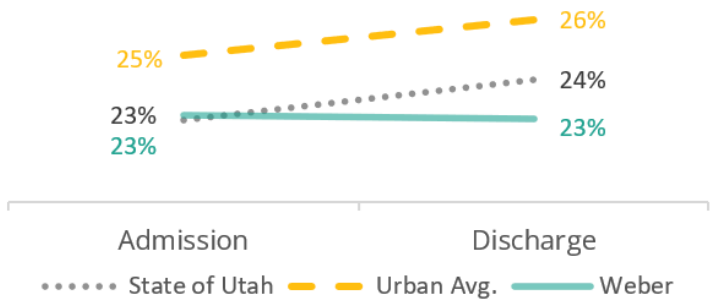
FY25 Recommendations:

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

a) The percentage of clients who attended social recovery support in FY24 did not increase from admission (23%) to discharge (23%). SUMH recommends that WHS check their data for accuracy and look into ways of connecting clients to social recovery support services through offering it in their program or referring to community groups.

Figure 10. % Attending Social Recovery Support

Source: TEDS data, SUD Scorecard

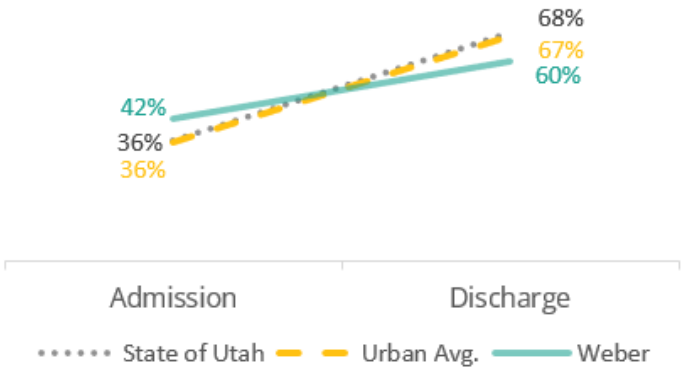


b) Drug abstinence at discharge (60%) was lower than state (68%) and urban averages (67%). WHS uses evidence-based methods and individualized treatment to ensure that their clients are successful in treatment, so they are planning to look into this data point to determine if there are issues with data entry.

SUMH reccomends WHS review their data for accuracy or look for ways to reduce drug abstinence through treatment and recovery support options.

Figure 6. % Abstinent from Drugs

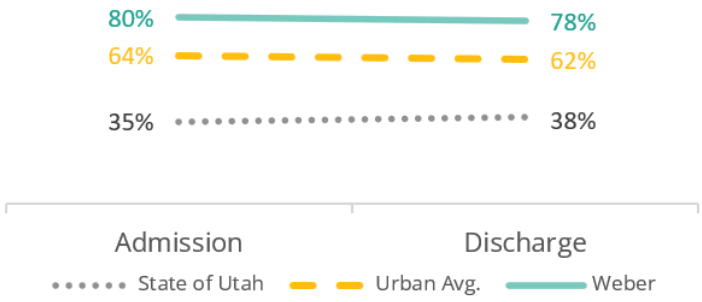
Source: TEDS data, SUD Scorecard



c) WHS had a higher percentage of SUD clients using tobacco/nicotine in FY24 at admission (80%) and discharge (78%) than the state (admission - 35%, discharge - 38%) and urban averages (admission - 64%, discharge - 62%). WHS shared that they do various things to reduce tobacco / nicotine use and are planning to look into this issue to see if they are experiencing data entry issues. Some of their efforts include screening for tobacco/nicotine use in the assessment that include questions related to use of tobacco/nicotine, the type of use, amount used, how often, and whether they are vaping. WHS provides resources that include smoking cessation groups, the Quit Line, Weber/Morgan Health Department and referral to a medical provider for possible prescriptions for smoking cessation medications if they are available. Objectives are added in the treatment plan to help the client with tobacco/nicotine cessation efforts.

Figure 11. % Using tobacco

Source: TEDS data, SUD Scorecard



d) SUMH recommends that WHS check their data for accuracy. It is also recommended that WHS continue working on their Area Plan Goals to reduce Tobacco / Nicotine Use through the following measures: (1) Maintaining a nicotine free environment in their agency and ensuring their contract providers are doing this as well (2) Ensuring ongoing engagement through

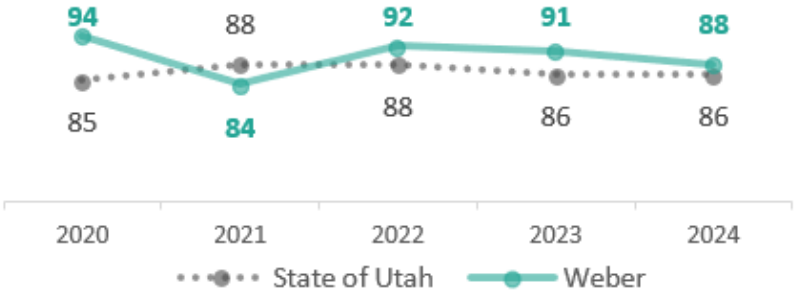
the use of a evidence-based nicotine dependence tool such as a Fagerstrom scale. The SUD Target is to reduce nicotine use to 4.8 in 2021 in TEDS.

e) Consumer satisfaction at WHS is higher (88%) than the State average (86%) in FY24; however, it should be noted that these rates have been decreasing in their agency since 2022 (FY22 - 92%, FY23 - 91%, FY24 - 88%). WHS shared that they use evidenced-based treatment and an individualized approach to treatment, so they are planning to look into this data to determine why consumer satisfaction has been decreasing over the past three years.

SUMH recommends WHS review their data for accuracy and determine why consumer satisfaction has been decreasing since 2022.

Figure 12. Adult satisfaction with SUD treatment (%)

Source: MHSIP Consumer Satisfaction Survey

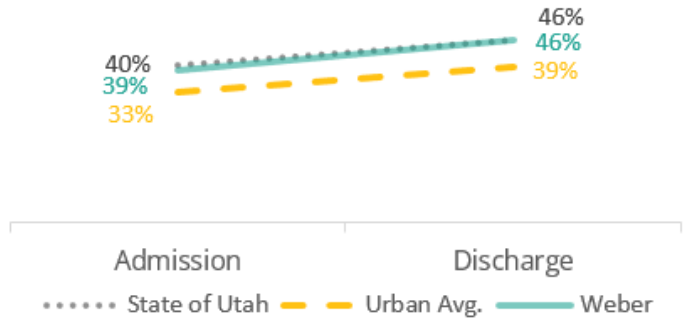


FY25 Comments:

1) **Employed or In School:** The percentage of SUD clients employed or in school at discharge was 46%. WHS is dedicated to helping their clients prepare for employment and school while they are in treatment. This has helped clients have viable employment and school options upon discharge.

Figure 8. % Employed or in School

Source: TEDS data, SUD Scorecard



2) **Program Expansion/Community Partnerships:** WHS partners with the following programs which have expanded their services: (1) BAART Programs in Ogden, (2) Discovery House, (3) Clinical Consultants, (4) Odyssey House of Utah, and (5) Weber Recovery Center. WHS does a great job of contracting with community providers and offering a variety of services for their clients.

3) **Staff Recruitment and Retention:** WHS continues to focus on various methods of recruiting and retaining staff. WHS is using the Professional Quality of Life Measure to evaluate the quality of life of staff in the agency. One of the areas that WHS focuses on is to increase the stress resiliency of therapists to help them sustain a career in the helping profession by finding meaning and purpose in their work. They also implemented a Self Care Hour twice a week during which clinicians are able to socialize with one another and engage in self-care activities. This Self Care Hour has been helpful to staff. WHS also provides supervision and support to staff as needed. WHS is dedicated to providing a work environment that is supportive to their staff, which has assisted with increasing and retaining staff at WHS.

Section Two: Report Information

Background

Section 26B-5-102 outlines duties of the SUMH. Paragraph (2)(c) states that SUMH 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 SUMH 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 SUMH 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. SUMH 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 SUMH 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 03/25/2025
Administrative Services Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 03/25/2025
Administrative Services Director

Pam Bennett Date 03/26/2025
Assistant Director

Eric Tadehara Eric Tadehara (Apr 1, 2025 21:58 MDT) Date 04/01/2025
Assistant Director

Brent Kelsey Brent Kelsey (Mar 26, 2025 18:15 MDT) Date 03/26/2025
Director

Attachment A

UTAH OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY25

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

Date: **11/27/2024**

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. Per SUMH Directives, 75% participation is required which has not been met. WHS participates regularly in their Regional Healthcare Coordination Council and this 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.