



State of Utah

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Department of Human Services

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Division of Substance Abuse and Mental Health

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Director

May 15, 2019

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 62A-15-103, the Division of Substance Abuse 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. The Division 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 Chad Carter (801)538-4072

We appreciate the cooperation and assistance of the staff and look forward to a continued professional relationship.

Sincerely,

Doug Thomas

Doug Thomas
Division Director

Enclosure

cc: Gage Froerer, Weber County Commissioner

Daryl Ballantyne, Morgan County Council
Sarah Swan, Morgan County Council
Kevin Eastman, Director, Weber Human Services



Site Monitoring Report of

Weber Human Services

Local Authority Contracts #160383 and #160384

Review Date: January 29th, 2019

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Weber Human Services (also referred to in this report as WHS or the Center) on January 29th, 2019. 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; Division 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)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	9-10
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 1	11-12
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 2	13-14
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 3 None	17-18

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) 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 29th, 2019 by Chad Carter, Auditor IV.

The site visit was conducted at 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. Personnel 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 is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. 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 the Division 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, 2018. The auditors issued an unmodified opinion in their report dated December 21, 2018. 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 2018 Audit:

FY18 Deficiencies:

- 1) During the review of subcontractor files, it was found that one file had an insurance certificate that was expired. The other files that were reviewed had current documentation.

This issue has been resolved. The FY19 review of subcontractor files showed that all required documentation was included and current.

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

None

FY19 Recommendations:

None

FY18 Division Comments:

- 1) As a subrecipient of Federal funds, WHS is required to be in compliance with Federal regulations. It was discussed that starting next year, DSAMH would check to ensure the Local Authority's had written procurement and federal awards policies in place and that they meet Federal guidelines. WHS had these policies and were able to provide them at the site visit. DSAMH also discussed some additional requirements for subcontractor monitoring. WHS was very responsive and willing to be in compliance. We appreciate the relationship we have with WHS and their willingness to work with the Division.

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to “annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract.” This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Weber Human Services on January 29th, 2019. The monitoring team consisted of Mindy Leonard, Program Manager and Brenda Chabot, Utah Family Coalition (Allies With Families). The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, program visits, allied agency visits, and feedback from families through questionnaires. During the visit, the monitoring team reviewed the FY18 audit; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention Funding; youth civil commitment; compliance with Division Directives; and the Center’s provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2018 Audit

No findings were issued.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

- 1) *Youth Outcome Questionnaires (YOQ)*: During the chart review process for WHS, four of the ten charts did not show evidence of the YOQ being provided at the mandated frequency of every 30 days. Division Directives state, “the Youth Outcome Questionnaire (OQ/YOQ) be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt).” It is recommended that WHS monitor the administration of YOQs to ensure they are provided at the required frequency.

Center’s Response and Corrective Action Plan:

Action Plan: Clients are required to check in for every appointment in the main building. Customer Care is asking clients to complete the OQ at each appointment. Clinicians have been

asked to complete the OQ, in the office, if the client as refused at check-in. Off-site programs are preparing to complete the OQ, with clients, on tablets or on paper. Clinicians are being sent their monthly report of OQ completion which is addressed with a supervisor. All clinical staff have been, or will be trained, by April 8th of this year. A training video has been created which shows how a clinician is able to administer the OQ in the office setting,

Timeline for compliance: Plan has been implemented.

Person responsible for action plan: Jed Burton

FY19 Recommendations:

None

FY19 Division Comments:

- 1) *Family Feedback:* Thirteen families completed the family feedback survey. In addition to the surveys, a family feedback forum was scheduled concurrently with the “123 Magic” parenting class. Parents mentioned how helpful the FRFs were in their treatment programs. One parent reported that her child’s overall demeanor had improved including reduced meltdowns, better self-control, better communication skills, and an overall improved mood. One parent stated that “[She] found very few barriers with regard to treatment, I feel they have been able to accomodate my needs.”

- 2) *First Episode Psychosis:* The Prevention and Recovery from Early Psychosis (PREP) team has started a referral service with outreach from Weber State University and Ogden School District. Once referred for services, the initial interview is done via telephone to screen for appropriate clients to receive treatment. The PREP team has been providing services for the past four years and continues to participate in discussions and outreach with other PREP teams in the state.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Weber Human Services on January 29th, 2019. The team included Mindy Leonard, Mental Health Program Manager. The review included the following areas: Discussions with clinical supervisors and management teams, record reviews, site visits to administrative offices, and on campus services. During the discussions, the team reviewed the FY18 audit; statistics, including the Mental Health Scorecard; area plans; Outcome Questionnaires and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2018 Audit

No findings were issued.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

- 1) *Outcome Questionnaire (OQ)*: DSAMH recommends the OQ/YOQ should be included in and adopted as part of the standard intake and ongoing clinical protocol. DSAMH requires policy to be in place that prescribes the appropriate clinical response, follow-through, and patient, family, or guardian involvement for the empirical results of the OQ/YOQ. Seven of the ten charts that were reviewed did not show clear signs that the OQ was being used as part of the intervention. Five of the seven charts reviewed did have the OQ administered but not at the rate of every 30 days. DSAMH recommends that WHS work with staff to find opportunities to integrate OQ into the treatment program.

Center's Response and Corrective Action Plan:

Action Plan: Clients are required to check in for every appointment in the main building. Customer Care is asking clients to complete the OQ at each appointment. Clinicians have been asked to complete the OQ, in the office, if the client as refused at check-in. Off-site programs are preparing to complete the OQ, with clients, on tablets or on paper. Clinicians are being sent their monthly report of OQ completion which is addressed with a supervisor. All clinical staff

have been, or will be trained, by April 8th of this year. A training video has been created which shows how a clinician is able to administer the OQ in the office setting,

Timeline for compliance: Plan has been implemented.

Person responsible for action plan: Jed Burton

FY19 Recommendations:

None

FY19 Division Comments:

- 1) *Community Collaboration:* WHS has been meeting with Davis monthly to review the Mobile Crisis Outreach Team (MCOT) program. They are building better communication between the two Local Authority teams. WHS has developed stronger working relationships with Law Enforcement and Weber County Fire District; they continue to work effectively with the local hospitals to provide mental health services. In addition, WHS has reached out to the Weber-Morgan Health Department to improve their working relationship.
- 2) *Homeless Services:* Since the inception of Operation Rio Grande in Salt Lake County, WHS has seen a large increase in the number of individuals experiencing homelessness who have migrated to Ogden. WHS has been working with Lantern House to find more support for this population.
- 3) *Assisted Outpatient Treatment (AOT):* The two year evaluation of the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded AOT program indicated that individuals with inpatient hospitalizations decreased from 37% during the two years pre-enrollment in AOT to 27% after enrollment (average days per inpatient stay dropped from 22 days to 10 days). In addition, the percentage of individuals with criminal cases dropped from 54% before AOT enrollment to 22% after enrollment in the program. WHS is commended for expanding the WHS AOT program to include additional case managers, providing treatment and recovery services to individuals who struggle to remain compliant with treatment recommendations.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Weber Human Services on January 29th, 2019. The review focused on the requirements found in State and Federal law, Division 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 2018 Audit

FY18 Deficiencies:

- 1) There was a decrease in the number of Eliminating Alcohol Sales to Youth compliance checks in Weber County. In FY17 there were 150 compliance checks down from 215 in FY16.

The Eliminating Alcohol Sales to Youth compliance checks for Weber County decreased from 150 in FY17 to 78 in FY18. The FY18 standard for EASY compliance checks is to increase the amount from the previous year.

This issue has not been resolved and will be continued in FY18; see Deficiency #1.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

- 1) The Eliminating Alcohol Sales to Youth compliance checks for Weber County decreased from 150 in the FY17 to 78 in the FY18, which does not meet the 90% standard in Division Directives.

Center's Response and Corrective Action Plan:

Action Plan:

Goal 1: Increase number of EASY compliance checks in Weber County.

Objective 1: Educate County Commissioners and City Mayors about the effectiveness of EASY to reduce underage drinking.

Objective 2: Educate local police chiefs and sheriffs about the effectiveness of EASY to reduce underage drinking

Objective 3: Ask City Mayors to require their local police departments complete EASY compliance checks 3 times a year.

Objective 4: Ask City Mayors to require their city's licensing division to give citations/fines as outlined in the law for businesses that fail the compliance checks.

Objective 5: Assist in coordinating the training of officers on conducting compliance checks.

Objective 6: Ask Police Chiefs and Sheriff's to ensure that their officers enter the data into the state EASY system.

Timeline for compliance: June 30, 2020

Person responsible for action plan: Prevention Coordinator

- 2) SYNAR checks for Weber / Morgan County had a compliance rate of 88%, which is below the standard of 90% in the Division Directives.

Center's Response and Corrective Action Plan:

Reason for the lower rate of compliance: Compliance rates dropped because the health department did an assessment exercise at the CADCA training and noticed that there was a gap. The gap was they weren't conducting compliance checks through the drive thru windows only inside the store. They then started doing the checks through the drive thru and found that stores were selling to youth via the drive thru windows. We anticipate that the compliance rates will increase now that the stores are aware that compliance checks are inside the store and via the drive thru windows.

Action Plan:

Goal: Increase compliance of Synar checks to 90%.

Objective 1: Support the Weber Morgan Health Department in completing the Synar checks quarterly inside the stores and via the drive thru windows.

Objective 2: Support the Weber Morgan Health Department in providing retailer education to those establishments selling tobacco products.

Timeline for compliance: June 30, 2020

Person responsible for action plan: Prevention Coordinator

FY19 Recommendations:

- 1) *Coalition Recruitment:* WHS has done a great job of building coalitions in their local area over the past several years, but are interested in receiving more training and technical assistance on coalition recruitment. It is recommended that WHS follow up with DSAMH for technical assistance on coalition retention.
- 2) *Strategies for Early Initiation of Drug Use:* WHS would like more information on strategies for early initiation of use, but stated that there are not many evidence-based practices in this area. They are interested in receiving more information. It is recommended that WHS follow up with DSAMH for guidance on strategies for early initiation of drug use.

FY19 Division Comments:

- 1) *Community that Cares Coalitions (CTC's):* All of WHS' coalitions are based on the CTC model, which take a significant amount of time and dedication to build. Their current coalitions include Bonneville CTC, which has existed for seven years and is in phase five of the CTC process. Roy CTC and Weber CTC are in phase four and the Fremont Coalition is in phase three of the CTC process. WHS is actively involved in all their coalitions and have spent a significant amount of time providing support, training and coaching to sustain coalition efforts. In addition, they meet with key stakeholders in the community on a regular basis to advocate for prevention services, which has resulted in ongoing support for prevention efforts in the community. All of these efforts have resulted in improved outcomes for Weber and Morgan Counties. The plan for WHS is to enhance the existing CTCs in their area by helping communities move through the CTC process, and increasing the number of CTC coalitions throughout Weber and Morgan Counties.
- 2) *Evidence-Based Programming:* Through the assessment and planning process, WHS implemented Mental Health First Aid and Mindfulness training in the schools, based on the results of the assessment. The Mental Health First Aid has become so popular that there is now a waiting list for this training. Due to the high demand for Mental Health First Aid, WHS is now holding this class once a month and training all of their prevention coordinators to teach this class. Interest in Mindfulness training is gradually taking momentum and there are plans to teach this at Bonneville High, Two Rivers and in Morgan County in the Junior and High Schools. Through Mindfulness training, health and yoga teachers are learning breathing techniques which has produced positive outcomes.
- 3) *Risk and Protective Factors:* One of WHS' primary goals is to develop a profile of risk and protective factors, including problem behaviors in their community; and to develop a plan for addressing the risk factors that are more elevated while enhancing protective factors. Over the past year, WHS collected data on risk factors, protective factors and problem behaviors in Weber and Morgan Counties, conducted a resource assessment and identified gaps in their community to develop an effective plan for their local area. The results of this work lead to the development of services that are meeting the needs of their community.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the review of Weber Human Services on January 29th, 2019. The review focused on Substance Abuse Treatment (SAPT) Block Grant Compliance, Drug Court and DORA Program compliance, clinical practice and compliance with contract requirements. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to SAPT Block Grant requirements, contract requirements and DORA Program 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 Outcomes Measures Scorecard and Consumer Satisfaction Survey data. Client satisfaction was measured by reviewing records and the Consumer Satisfaction Survey data.

Follow-up from Fiscal Year 2018 Audit

FY18 Significant Non-compliance Issues:

- 1) The percent of clients completing a treatment episode successfully decreased from 49.9% in FY16 to 45.8% in FY17.

The percent of clients completing a treatment episode successfully decreased from 45.8% in FY17 to 41.2% in FY18 respectively, which does not meet Division Directives.

This issue has not been resolved and will be continued in FY18; see Minor Non-Compliance Finding #1.

- 2) The percent of clients that used social recovery support services decreased from -9.4% in FY16 to -11.2% in FY17.

This issue has been resolved. The percent of clients that used social recovery support services increased from -11.2% in FY17 to 5.5% in FY18, which now meets Division Directives.

FY18 Minor Non-compliance Issues:

- 1) *Access to care:* WHS reports they have implemented new screening procedures that include screening every individual with a Risk/Needs tool. WHS then uses the results of the screening for individual placement into High Risk, Moderate Risk and Low Risk treatment services and groups. Based on the screening outcomes, individuals that screen Low Risk and that do not meet priority population criteria, or have preferred funding sources but may be deemed as part of the unfunded population, are referred to other community providers.

Access to care has been disrupted for individuals that screen at Low Risk. WHS reports that those individuals are referred to outside agencies, preferably that use a sliding scale fee schedule. Although WHS reports that the other agencies sliding fee scales are not comparable to theirs.

Individuals seeking treatment services of all risk levels should have access to State and Federally funded treatment service programs and should not be limited access due to risk level screening.

This issue has been resolved. WHS continues to use the screening process to identify high and low risk clients to determine the most appropriate level of services for them. This has also helped WHS separate high and low risk clients, which is best practice outlined by national guidelines and Division Directives. Over the past year, WHS has seen good outcomes with this screening process, identifying high and low risk clients and placing them in the appropriate level of services. While WHS has chosen to serve high risk clients and refer low risk clients to the community, they are looking into methods to ensure that low clients receive the services that they need by helping to fund their treatment or by partnering with free or low cost programs. Ensuring that all individuals in their community are receiving services through their program or community partners, meets the county requirement of providing access to State and Federally funded programs in their local area.

- 2) The percent of clients that decreased use of tobacco from admission to discharge decreased from 0.2% in FY16 to -1.1% in FY17.

The percent of clients that decreased tobacco use from admission to discharge decreased from -1.1% in the FY17 to -0.3% in the FY18, which does not meet Division Directives.

This issue has not been resolved and will be continued in FY18; see Minor Non-Compliance Issue #2.

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) The percent of clients completing a treatment episode successfully decreased from 45.8% in FY17 to 41.2% in FY18 respectively, which does not meet Division Directives.

Center's Response and Corrective Action Plan:

<p>Action Plan: During this past year, WHS has focused upon same day access for an evaluation and entering services, focusing upon the motivation interviewing model as an engagement strategy. As completion rates continued to decrease, WHS drilled down into the data and found drug court completion rates at 75%, DORA completion rates at 55%, and other programs</p>

including self-referred or other court ordered at 30% respectively. Focus will be on additional engagement and outreach efforts for this population including a team approach consisting of a clinician, case manager, and peer support specialist for each client. Outreach efforts will also include assisting client to access resources that may support recovery goals. Training with clinicians will include defining Treatment Completion according to client goals.

Timeline for compliance: WHS will be reviewing data on a monthly basis. Treatment teams will be formed by July 1, 2019. An increase in completion rates is expected by July 1, 2020.

Person responsible for action plan: Wendi Davis-Cox

- 2) The percent of clients that decreased tobacco use from admission to discharge is -0.3% in FY18, which does not meet Division Directives.

Center’s Response and Corrective Action Plan:

Action Plan:

For tobacco use, as well as other drugs and alcohol, WHS is focusing on a harm or risk reduction model vs. an abstinence based model. Staff recently attended a SCRIPT training and will be implementing SCRIPT for tobacco cessation along with continuing current resources for smoking cessation including the QUIT Line, coordination with Health Dept, and peer led smoking cessation groups. Education will be offered to clients and staff regarding benefits of smoking cessation while in treatment services.

Timeline for compliance: WHS will be reviewing data on a monthly basis. A reduction in use is expected by July 1, 2020.

Person responsible for action plan: Wendi Davis-Cox

- 3) 43.4% of the data was reported as unknown/not collected for criminogenic risk for adults compelled by the criminal justice system. The Division data collection rate standard is 10% or less unknown/not collected.

Center’s Response and Corrective Action Plan:

Action Plan: WHS clinicians will coordinate with AP&P and private probation to collect criminogenic risk information. Training along with ongoing follow up review will be provided to clinicians regarding assessing criminogenic risk for adults compelled by the criminal justice system.

Timeline for compliance: Data will be reviewed monthly. WHS will meet the 10% or below standard by July 1, 2020.

Person responsible for action plan: Wendi Davis-Cox

FY19 Deficiencies:

None

FY19 Recommendations:

- 1) *Community Services for Low Risk Clients:* It is recommended that WHS continue to seek methods of ensuring that low risk clients referred to the community receive services by assisting them in funding their treatment with State and Federal dollars, partnering with free or low cost providers, and placing them in early intervention / indicated prevention services. WHS is currently working with Utah Support Advocates for Recovery Awareness (USARA) to refer clients to the free Community Reinforcement and Family Treatment (CRAFT) groups and start a group at WHS as well. Placing low and high risk clients in the appropriate level of service will produce better outcomes long term.

FY19 Division Comments:

- 1) *Medication Assisted Treatment (MAT):* Over the past year, WHS and their physician met with the Drug Court Team and Judges to educate them on Medication Assisted Treatment, which has helped change their attitude toward the use of MAT in Drug Court. WHS has also increased the use of MAT through Suboxone services provided by their physician. In addition to this, WHS assigned a Peer Support Specialist to Drug Court, who has been helpful in promoting the use of MAT and connecting clients to services. Through these efforts, the Drug Court Team has started updating the Drug Court Manual to eliminate old language and replace it with best practice for MAT. WHS is also working on creating a document for clients on best methods of sustaining MAT long term.
- 2) *Evidence-based Practice:* WHS continues to take the lead in Utah for providing evidence-based services to fidelity. They are able to do this through ongoing clinical supervision, training on current practices and fidelity checks. By carefully selecting the most appropriate evidence-based method of their clients, WHS has produced better outcomes for their clients.
- 3) *Data Driven Treatment:* WHS has used data over the past several years to evaluate programs and make changes to improve outcomes and service delivery. In the past year, WHS partnered with DSAMH to develop data in real time and measure the following outcomes: (1) improvement or lack of improvement in treatment (2) review survey scores (3) help therapists improve outcomes (4) compare the difference between evidence-based and non evidence-based outcomes. WHS also conducted a recidivism study, which provided helpful information on reducing recidivism rates.
- 4) *Expansion of Services:* WHS is working on re-opening their Men's Residential Program and including detoxification services, which closed several years ago due to funding issues. The men will receive outpatient services from WHS while living at the Men's Residential Facility. The addition of a men's residential program will increase access to gender responsive residential services in their local area, which will help improve outcomes long term.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 10 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 15 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division 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 the Division 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 Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health

Prepared by:

Chad Carter Chad Carter Date May 15, 2019
Auditor IV

Approved by:

Kyle Larson Kyle Larson Date May 15, 2019
Administrative Services Director

Eric Tadehara Eric Tadehara Date May 16, 2019
Assistant Director Children's Behavioral Health

Jeremy Christensen Jeremy Christensen Date May 15, 2019
Assistant Director Mental Health

Brent Kelsey Brent Kelsey Date May 15, 2019
Assistant Director Substance Abuse

Doug Thomas Doug Thomas Date May 16, 2019
Division Director

Certificate Of Completion

Envelope Id: 4F33C47C9B3A4B22AD9DAF005E9EDCDO	Status: Completed
Subject: Please DocuSign: Cover Letter (Weber) - Google Docs.pdf, DSAMH Weber FY19 Report Final - Google...	
Source Envelope:	
Document Pages: 26	Signatures: 7
Certificate Pages: 5	Initials: 0
AutoNav: Enabled	Envelope Originator:
Enveloped Stamping: Enabled	Kyle Larson
Time Zone: (UTC-07:00) Mountain Time (US & Canada)	195 N 1950 W
	Salt Lake City, UT 84116
	kblarson@utah.gov
	IP Address: 45.56.61.0

Record Tracking

Status: Original	Holder: Kyle Larson	Location: DocuSign
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Electronic Record and Signature Disclosure:
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Brent Kelsey bkelsey@utah.gov Security Level: Email, Account Authentication (None)		Sent: 5/15/2019 12:35:04 PM Viewed: 5/15/2019 2:26:54 PM Signed: 5/15/2019 2:27:07 PM
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Electronic Record and Signature Disclosure:
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ID: 1ff10e40-5c97-4e4f-bb42-d89daa497f8d

Eric Tadehara erictadehara@utah.gov Security Level: Email, Account Authentication (None)		Sent: 5/15/2019 12:35:03 PM Viewed: 5/16/2019 8:49:37 AM Signed: 5/16/2019 8:50:28 AM
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Jeremy Christensen Jeremy@Utah.gov Security Level: Email, Account Authentication (None)		Sent: 5/15/2019 12:35:03 PM Viewed: 5/15/2019 1:57:29 PM Signed: 5/15/2019 1:57:39 PM
	Signature Adoption: Pre-selected Style Using IP Address: 174.52.61.16	

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ID: 3705ed22-aaf5-45be-9e63-098a690d2972

Signer Events	Signature	Timestamp
Kyle Larson kblarson@utah.gov Administrative Services Director DSAMH Security Level: Email, Account Authentication (None)	 Signature Adoption: Pre-selected Style Using IP Address: 45.56.61.0	Sent: 5/15/2019 12:35:03 PM Viewed: 5/15/2019 2:09:01 PM Signed: 5/15/2019 2:09:09 PM

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Doug Thomas dothomas@utah.gov Director Security Level: Email, Account Authentication (None)	 Signature Adoption: Pre-selected Style Using IP Address: 166.70.188.1	Sent: 5/16/2019 8:50:29 AM Viewed: 5/16/2019 9:09:24 AM Signed: 5/16/2019 9:09:36 AM
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Electronic Record and Signature Disclosure:
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In Person Signer Events	Signature	Timestamp
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Kevin Eastman kevine@weberhs.org Executive Director Security Level: Email, Account Authentication (None)	COPIED	Sent: 5/16/2019 9:09:41 AM
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Witness Events	Signature	Timestamp
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Notary Events	Signature	Timestamp
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Envelope Summary Events	Status	Timestamps
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