FORM A - MENTAL HEALTH BUDGET NARRATIVE

Local Authority: Weber

Instructions:

In the cells below, please provide an answer/description for each question. **PLEASE CHANGE THE COLOR TO BLUE, OF SUBSTANTIVE NEW LANGUAGE INCLUDED IN YOUR PLAN THIS YEAR!**

1) Adult Inpatient		*Program Manager*	*Pam Bennett*
Form A1 - FY23 Amount Budgeted:	$1,422,467	**Form A1 - FY23 Projected clients Served:**	140
Form A1 - Amount budgeted in FY22 Area Plan	$1,870,575	**Form A1 - Projected Clients Served in FY22 Area Plan**	188
Form A1 - Actual FY21 Expenditures Reported by Locals	$1,075,258		175

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

WHS provides inpatient psychiatric care for Medicaid and involuntary clients through contracts with McKay Dee Hospital which has 33 beds and Ogden Regional which has 12 beds. WHS has a full-time inpatient coordinator who provides consultation and support to McKay Dee providers who provide treatment. The Inpatient coordinator focuses on collaboration, financial responsibility, and clinical expertise. The inpatient coordinator meets daily with McKay-Dee care managers, social workers and psychiatrists, and weekly with WHS to staff high risk clients. The Inpatient coordinator contacts other hospitals by phone and in person, where our clients may be placed, to identify discharge plans. Nineteen designated examiners are utilized for completion of blue sheets and involuntary treatment hearings for forced medications. Follow-up from hospitalizations includes an appointment with the assigned clinician and consideration for varying levels of case management including CTI, and AOT. Daily and weekly summary emails are sent to WHS interdisciplinary providers to further correlate care. Inpatient Hospital doctors will staff with Weber Prescribers by phone as needed.   WHS continues to focus on prevention to minimize inpatient treatment and provide efficient, coordinated, client-centered care. WHS utilizes McKay-Dee's Access 23 hour Access Center as a short-term hospital diversion option. WHS has also contracted with the Lantern House homeless shelter for access to two diversion beds which can be utilized to support clients in crisis for up to 72 hours.

Describe your efforts to support the transition from this level of care back to the community.

The Critical Time Intervention TCM program has continued following high utilizers of the hospital by providing intensive case management. MCOT workers respond to area hospitals to help with possible diversions and reductions of inpatient stays. WHS has contracted with the local homeless facility (Lantern House) for two behavioral health beds, for our clients. Clients who are being discharged from the inpatient unit, who do not have a current residence, may be discharged to the Lantern House. A WHS clinician is able to monitor daily and assist with

> **behavioral health needs. WHS holds a high acuity staffing meeting weekly with prescribers, supervisors, the inpatient coordinator, case management supervisor and other treatment team members to discuss how best to support clients transitioning between various levels of care.**

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

There is no significant increase or decrease expected in funding or individuals served.

Describe any significant programmatic changes from the previous year.

We have invested in MCOT, residential, and other services and anticipate a lower amount spent on inpatient care in the next year.

2) Children/Youth Inpatient   *Leah Colburn*

Form A1 - FY23 Amount Budgeted:	$749,835	Form A1 - FY23 Projected clients Served:	116
Form A1 - Amount budgeted in FY22 Area Plan	$749,835	Form A1 - Projected Clients Served in FY22 Area Plan	112
Form A1 - Actual FY21 Expenditures Reported by Locals	$639,534	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	111

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

Weber Human Services contracts with Intermountain Healthcare (IHC) to provide inpatient treatment to children and youth between the ages of 6 and 18 suffering from acute psychiatric disorders. This level of care is designed to provide acute psychiatric stabilization and/or assessment. The referral must meet admission criteria including but not limited to imminent danger to self and/or others. Should inpatient care be necessary, three major treatment components are emphasized: a) an in-depth diagnosis and treatment plan, b) intensive treatment for stabilization, and c) aftercare. WHS has maintained an inpatient liaison and has included a case manager to assist the patient and family in a smooth transition to ongoing treatment, community resources and/or home. Parents/families are required to take an active role with their child in the treatment process. Children requiring this level of treatment beyond a 72 hour window will be evaluated by a neutral and detached fact finder (NDFF).

Describe your efforts to support the transition from this level of care back to the community.

WHS youth inpatient numbers have continued to increase in number and cost. IHC has increased their bed capacity to eighteen (18) in an effort to better meet the demand. We hope this will reduce the number of patient/s diverted to community inpatient providers outside of our catchment.
WHS has a case manager who follows up on each individual transitioning from the inpatient unit to outpatient care. Phone contacts are made by the case manager to caregivers to ensure attendance at follow-up appointments. WHS also has an inpatient coordinator who works to ensure that all clients have a follow-up appointment scheduled upon discharge. Upon discharge, WHS will update the level of care needed for the client.

Justify any expected increase or decrease in funding and/or any expected increase or decrease

in the number of individuals served (15% or greater change).
There is no significant increase or decrease expected in funding or individuals served.
Describe any significant programmatic changes from the previous year.
No significant programmatic changes from the previous year.

3) Adult Residential Care
Pam Bennett

Form A1 - FY23 Amount Budgeted:	$1,253,251	**Form A1 - FY23 Projected clients Served:**	120
Form A1 - Amount budgeted in FY22 Area Plan	$1,255,658	**Form A1 - Projected Clients Served in FY22 Area Plan**	130
Form A1 - Actual FY21 Expenditures Reported by Locals	$1,327,605	**Form A1 - Actual FY21 Clients Serviced as Reported by Locals**	116

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.
WHS operates a Men's and Women's combined Residential facility (CTU) for sixteen Seriously and Persistently Mentally Ill SMI clients (generally 8 male and 7 female) with one (1) of those being a crisis bed available for a client in transitional or hospital diversion/crisis situations. The Residential facility is staffed 24 hours per day and clients are offered comprehensive services including case management, individual and group therapy, individual skills development, psychosocial rehabilitation, and medication management. Clients are often placed at the CTU as a diversion from hospital admissions as well as a step-down for hospital discharges. The CTU offers a comprehensive range of clinical services seven days/week including a psychiatrist, nursing support, individual and family therapists, aides, and case management. WHS has initiated a 23 hour bed program for clients in crisis who need short-term support to refocus and stabilize. CTU staffing has increased to maintain clinical coverage seven days per week. Clients meet with their primary clinician three times per week. They meet with the prescriber at least weekly.
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or great change.)
There is no significant increase or decrease expected in funding or individuals served.
Describe any significant programmatic changes from the previous year.
COVID restrictions are now being lifted slowly. Clients at the CTU are now allowed to attend STEPS, attend appointments outside of WHS, and have visitors.

4) Children/Youth Residential Care   *Leah Colburn*

Form A1 - FY23 Amount Budgeted:	$0	**Form A1 - FY23 Projected clients Served:**	0
Form A1 - Amount budgeted in FY22 Area Plan	$0	**Form A1 - Projected Clients Served in FY22 Area Plan**	0
Form A1 - Actual FY21 Expenditures Reported by Locals	$0	**Form A1 - Actual FY21 Clients Serviced as Reported by Locals**	0

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. *Please identify any significant service gaps related to residential services for youth you may be experiencing.*

Weber Human Services has access to residential treatment for severely emotionally disturbed youth between the ages of 6 and 18 through area service providers. The residential program/s offer a treatment alternative designed to provide more intensive supervision and/or treatment for an extended length of time (average length of stay is 6 to 9 months). We can access services to treat male or female youth with a history of emotional and/or behavioral problems which have not responded to less intensive treatment options. We can also access services to treat male or female youth with a history of emotional and/or behavioral problems who are transitioning from a more restrictive setting (i.e. inpatient/Utah State Hospital). Weber Human Services contracts with Licensed Child Placement Providers for access to Therapeutic Foster Home(s). Such homes provide twenty-four hour family-based care and supervision in a family home setting for up to three children/youth who have behavioral or adjustment problems. Weber Human Services contracts with Licensed Child Placement Providers for access to Community-based Residential Treatment Settings (i.e. Utah Youth Village, Chrysalis, and Rise). Such placements provide twenty-four hour supervision and treatment in a setting that permits exercise of critical skills yet the support required to be more successful in the community. WHS also partners with the Archway Youth Receiving Center. Archway is a 5 bed program that serves as a Respite and/or inpatient diversion opportunity for youth needing a safe, supportive environment for a brief time.

WHS accesses such placements via single case agreements.

How is access to this level of care determined? Please describe your efforts to support the transition from this level of care back to the community.

Youth considered for residential treatment are typically staffed at the local MACC meeting. Lesser restricted options are considered at that time, with residential/out of home placement for treatment being the last resort.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No expected change in this area.

Describe any significant programmatic changes from the previous year.

No significant programmatic changes from the previous year.

5) Adult Outpatient Care *Pam Bennett*

Form A1 - FY23 Amount Budgeted:	$4,845,474	Form A1 - FY23 Projected clients Served:	3,726
Form A1 - Amount budgeted in FY22 Area Plan	$4,522,329	Form A1 - Projected Clients Served in FY22 Area Plan	4,355
Form A1 - Actual FY21 Expenditures Reported by Locals	$5,406,245	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	4,337

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

Weber Human Services provides mental health services to Medicaid, Medicare, civilly committed clients and a limited number of unfunded residents of Weber and Morgan Counties. Weber Human Services offers a full continuum of adult mental health outpatient services. These include, but are not limited to: Mental health evaluation; Individual mental health therapy; Group mental health therapy; Substance abuse services for the dually diagnosed; and Targeted Case Management. The above services are designed and integrated to ameliorate the effects of mental illness and improve the quality of life for mental health consumers of Weber and Morgan Counties. The Adult Outpatient Team currently provides eight evidence based practices—Motivational Interviewing, Psychoeducational Multifamily Group Therapy, Critical Time Interventions, Illness Management and Recovery, CBT-SA , Prolonged Exposure, and Dialectical Behavioral Therapy. The Adult Mental Health team has continued to provide a 24 Hour Access intake for our clients in order to provide services to the client at the time of the expressed need. WHS provides outpatient care to the 2nd District Mental Health Court participants. A therapist, case manager, and prescriber have been assigned to address the needs of this population.

SNF: WHS has therapists that go to several of the skilled nursing facilities in Ogden. There are **3** therapists and 3 case managers who help with the mental health needs in 8 different facilities. We also have a prescriber assigned to help with the medication needs of the clients in the SNF.

AOT : WHS provides enhanced services to the civilly committed clients under our care. a team of a supervisor, clinician, 3 case managers and peer support specialist provide intensive services to clients under civil commitment who are at risk of re-hospitalization or incarceration

PATH: PATH provides one-time rental and deposit assistance to assist those in imminent risk of homelessness in Weber County and case management to provide ongoing permanent housing support services to formerly homeless individuals. PATH funds have paid for and supported one full-time Case Manager who provides direct services to formerly homeless individuals. PATH dollars also fund one part-time shelter outreach worker who coordinates PATH services through the local homeless shelter (Lantern House). WHS staff serve on various committees within the community to address the needs of homeless individuals and families and those who are at imminent risk of becoming homeless. Those committees include the Weber County Homeless Coordinating Committee and the local Coordinated Entry Committee. McKay Dee Hospital has contracted with the local homeless shelter for 4 beds for those homeless individuals being discharged.
WHS provides individual and group therapy, along with case management services to individuals experiencing homelessness. Our case management services include applying for benefits and

maintaining them, exploring housing options, medication management, transportation, food assistance, and shopping. The Weber Housing Authority provided 5 set-aside vouchers for clients on the AOT program that need housing. They also had 30 vouchers for the chronic homeless population that our clients could apply for.

The Weber Human Services Adult Mental Health Team offers both traditional services and the specialty clinic. The Specialty Clinic provides the majority of evidence-based practices and serves clients with more severe mental health diagnosis. Traditional Services provides treatment to clients who do not qualify for the evidence-based practices in the specialty clinic.

Describe the approach to serving individuals with complex behavioral health presentations or who need multiple supports to remain in the community, including the programmatic approach to serving individuals in the least restrictive level of care. Identify your proposed fidelity monitoring and outcome measures.

Weber Human Services uses a collaborative approach to manage clients with a variety of different resources. Clients can receive medication management, therapy services (individual and group), primary care services, case management, individual skills development, peer support work, supportive employment, day treatment services and housing resources. We have a regular meeting with the treatment teams including medical providers, where we can address problematic behaviors and brainstorm various solutions.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

We anticipate budgeting more in this area while serving a smaller amount.

Describe any significant programmatic changes from the previous year.

Several clinicians are in the process of being trained in Prolonged Exposure.

Weber Human Services' adult mental health team now offers traditional services and the speciality clinic. The specialty clinic is for any new clients (and existing clients that opted in) that have a qualifying diagnosis for IMR, PEMFG and DBT. The primary goal of the specialty clinic is to connect clients to the effective treatment and to front-line it, meaning that each of these clients will receive 80-100 encounters (IT and GT) within the first year of treatment. After completing their intakes, clients will be allotted 4 IT sessions. By this time the goal is to have them engaged in an EBP (IMR, PEMFG or DBT). If the client opts out of this treatment, they will be placed on the low-value care protocol and will be asked to attend the open-hour. Clients will still be able to receive medication management and case management services while in low-value care. Clients in both traditional services and the speciality clinic will have access to PET and CBT-SA. Supervisors are currently exploring having a new EBP targeted specifically at depression and anxiety and hope to have a plan by the end of the year to have it started.

Describe the programmatic approach for serving individuals in the least restrictive level of care who are civilly committed or court-ordered to Assisted Outpatient Treatment. Include the process to track the individuals, including progress in treatment.

The AOT and Critical Time Interventions programs are frequently utilized to transition consumers from an inpatient level of care to outpatient services and to help civilly committed consumers who are at high risk for hospitalization maintain in the community. Individuals are tracked through a clinical reporting tracking bit which includes separate tracking for AOT, inpatient discharges, and civilly committed clients. OQ alerts are also a part of the reporting services. Civilly committed consumers are tracked in

terms of contacts by clinicians and prescribers. A High Utilizer meeting is held weekly to staff clients and their level of care. Progress is documented in the clinical record.

6) Children/Youth Outpatient Care Leah Colburn

Form A1 - FY23 Amount Budgeted:	$3,567,711	Form A1 - FY23 Projected clients Served:	1,787
Form A1 - Amount budgeted in FY22 Area Plan	$3,658,602	Form A1 - Projected Clients Served in FY22 Area Plan	1,713
Form A1 - Actual FY21 Expenditures Reported by Locals	$3,533,112	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	1,631

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. *Please highlight approaches to engage family systems*.

Outpatient services are offered to children between the ages of 0 and 18* and their families. The outpatient mental health team is divided into two teams and three areas of expertise; the Children's Mental Health Team with those members skilled in treating an infant population (0-5) and children (6-11); and, the Adolescent Mental Health Team with those members skilled in treating youth (12-18*). This allows for a more specialized and skilled level of care while building team support and enhanced collaboration. *Under some circumstances, the youth team will continue to provide services to a youth beyond age 18. The Principles of the Hope and Recovery model have been adopted and implemented (i.e. assessment process, direct service delivery, documentation, training and monitoring of services). We practice person-centered planning, produce strength-based assessments, and have implemented wellness initiatives (i.e. smoking cessation, metabolic wellness, etc.) The Youth Outpatient Mental Health Team prides itself on adopting and practicing evidence-based practices such as Motivational Interviewing (MI), Aggression Replacement Therapy (ART), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and 1,2,3 Magic (a parenting approach).

In the past year, WHS has trained and implemented the use of the MATCH (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems) across the youth team. Five clinicians have also been trained on the Family Check Up Model, which is specific to the 2-5 population. Implementation will begin this year. All youth team clinicians encourage parent/guardian involvement in the treatment process. For the latency age group, parent/guardian involvement occurs in almost every session.

Ongoing research in the fields of mental health and substance abuse intervention has resulted in identification of models of services that have been shown to significantly improve symptom reduction and functional improvement outcomes for those receiving the service. A committee representing the various teams in the agency is meeting regularly to increase the number of evidence-based practices being delivered to our clients at WHS. Motivational Interviewing education has been provided to all clinicians on the youth team and skills are practiced and monitored in twice monthly group supervision and with individual supervisors. We have also added group supervision for the ART and TF-CBT models. Audio recordings and "direct line of sight" supervision are used to ensure adherence to the model/s.

MATCH and Family Checkup Model also adheres to the WHS supervision model.

Describe the approach to serving individuals with complex behavioral health presentations or who need multiple supports to remain in the community, including the programmatic approach to serving individuals in the least restrictive level of care. Identify your proposed fidelity monitoring and outcome measures.

The youth team has a weekly medication management meeting where clinicians, supervisors, psychologists, Family Peer Support Specialists and CM are present to staff high acuity clients. This team provides treatment recommendations and explores other resources the family may need to maintain stability in the home. This may include therapists and/or FPSS going to the client's home or school to provide additional services to the client and parent/guardian.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No changes are expected beyond the 15%.

Describe any significant programmatic changes from the previous year.

No significant programmatic changes from the previous year. WHS will continue to explore appropriate Evidence-based Practices. WHS has trained staff and offers telehealth services to our outpatient population.

7) Adult 24-Hour Crisis Care   LeAnne Huff

Form A1 - FY23 Amount Budgeted:	$1,088,175	Form A1 - FY23 Projected clients Served:	1594
Form A1 - Amount budgeted in FY22 Area Plan	$784,659	Form A1 - Projected Clients Served in FY22 Area Plan	616
Form A1 - Actual FY21 Expenditures Reported by Locals	$1,009,398	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	1,648

Describe access to crisis services during daytime work hours, afterhours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and the criminal justice system. Identify what crisis services are provided and where services are provided and what gaps need to still be addressed to offer a full continuum of care to include access to a crisis line, mobile crisis outreach teams, and facility-based stabilization/receiving centers. Identify plans for meeting any statutory or administrative rule governing crisis services. For each service, identify whether you will provide services directly or through a contracted provider. Describe how you coordinate with state and local partners for services to include the Utah Crisis Line, JJS and other DHS systems of care, for the provision of crisis services.

Emergency services are provided by the Utah Crisis Line 7 days a week, and are available to anyone in Weber and Morgan counties needing mental health crisis services. Daytime walk-in crisis services are available on weekdays between 8:00 AM - 5:00 PM.   WHS provides crisis counseling and mental

health information and referrals. All crisis workers are trained on a risk assessment evaluation instrument. Crisis workers consider the most appropriate settings for individuals in crisis. Medical emergencies or Mental Health emergencies with substantial risk are immediately referred to hospital emergency departments. The WHS CTU is also considered for crisis placements. Crisis workers continue to provide weekend coverage at the CTU to prevent hospitalizations while providing the coaching and support the client needs to continue towards recovery. Crisis workers can continue to respond to the community 24/7 with MCOT. MCOT's 24/7 coverage includes a therapist and either a case manager or peer counselor that can respond to community crises. MCOT is accessed via 911/Dispatch calls or deployment from the Statewide crisis line. WHS MCOT services also include a follow-up stabilization service to help clients and families get linked to needed resources and further stabilize from the initial crisis situation. Crisis workers also have an On-Call psychiatrist available for consultation when necessary. Crisis workers have home access to client's clinical records and can view the current treatment plan, diagnosis, progress notes, and medications. WHS has a built-in notification system in the electronic chart designed to alert all assigned staff for a particular client having a current crisis. Crisis workers use the CSSRS and Stanley-Brown safety plans as tools to manage risk. If needed, after hours workers are able to respond to local hospitals to help determine appropriate levels of care. WHS continues to coordinate community crisis services with area first responders, Lantern House, and area hospitals to help provide an effective service and mitigate risk. WHS has a designated inpatient coordinator that responds to local hospital authorization requests during regular working hours M-F 8am-5pm. Outside of these hours, MCOT responds to local hospitals when needed to help determine an appropriate level of care and will make authorization decisions if medical necessity is met. MCOT works expeditiously to make these decisions and to utilize community supports when needed. MCOT has not experienced a significant denial of MCOT community requests as a result of this service. The MCOT collaboration with EDs has assisted hospital personnel to better understand what MCOT can do and to advocate to consumers to utilize MCOT services in the future. MCOT has reduced response to local hospitals due to COVID, but is able to respond if needed.

How is access to this level of care determined? How is the effectiveness and accessibility of residential care evaluated?

CTU bed availability is determined by a priority system. Priorities are for Medicaid clients, USH discharges, and civilly committed clients. Ten beds are allotted for traditional Medicaid clients. One bed is allotted for emergent, short-term needs. MCOT workers utilize the CSSRS, LOCUS and CALOCUS to help determine the level of care of crisis clients.

Clients are provided this level of care through different portals:
1.   Clients in the CTU are required to complete an OQ on a weekly basis to monitor progress in treatment. The CSSRS is completed 3-7 times/week depending on the client's risk and needs.
2.   A high CSSRS may indicate a need for CTU level of care, specifically if the client is not able or willing to engage in a safety plan to manage their risks.
3.   Clients can also be placed in the CTU as a less restrictive placement to an acute hospitalization. This may be indicated for medication changes, management of increasing symptoms.
4.   Clients are also placed in the CTU as a transition back into the community from the state hospital, from acute hospitalizations, or from incarceration.
5.   CSSRS may indicate a need for this level of care, specifically if the client is not able or willing to engage in a safety plan to manage their risks.

Describe your evaluation procedures for crisis intervention services that objectively measure access and measurable outcomes for persons with both mental health and substance use disorders using data. Technical assistance with data specifications is available if needed, please describe any areas for help that are required.

When a client is civilly committed the WHS inpatient coordinator works with assigning the client prior to them leaving the hospital to a therapist and prescriber on the Adult Mental Health team. A client is assigned to either a regular outpatient therapist with CM services, or they are assigned to the AOT/unfunded civilly committed team with CM services. If a client only has private insurance or Medicare then they start on the AOT/unfunded civilly committed team and when ready and with approval from the Medical Director, Clinical Director and Agency Director they are transferred to a provider with their insurance. WHS then follows the progress of the client with the private provider until the client's commitment is terminated. WHS has a clinical report that is run regularly to ensure that clients are participating with the requirements of the commitment. If a client is civilly committed, the client's chart has a tracking bit on it. There is one weekly staff meeting that therapists and treatment team members can attend to get clinical assistance with civilly committed clients. If a client is homeless, outreaches occur at the Lantern House to attempt to locate the client and engage them in services. Every day a designated examiner is available to help with return to restrictive care forms when needed. When a committed individual is transferred to us from another catchment the client is then assigned to a therapist and outreaches are done to engage the client in treatment. WHS has formed a cooperative venture to enhance crisis services. We received MCOT funding and have developed a program to provide 24/7 emergency response.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

With the addition of the receiving center funding in Weber County, we anticipate serving more individuals and spending more in this area.

Describe any significant programmatic changes from the previous year.

No significant programmatic changes.

8) Children/Youth 24-Hour Crisis Care   Nichole Cunha

Form A1 - FY23 Amount Budgeted:	$500,000	Form A1 - FY23 Projected clients Served:	450
Form A1 - Amount budgeted in FY22 Area Plan	$393,000	Form A1 - Projected Clients Served in FY22 Area Plan	256
Form A1 - Actual FY21 Expenditures Reported by Locals	$385,066	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	263

Describe access to crisis services during daytime work hours, afterhours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and the criminal justice system. Identify what crisis services are

provided, where services are provided, and what gaps need to still be addressed to offer a full continuum of care (including access to a Crisis Line, Mobile Outreach, Receiving Center and In-Home Stabilization Services). Include if you provide SMR services, if you are not an SMR provider, how do you plan to coordinate with SMR providers in your region? For each service, identify whether you will provide services directly or through a contracted provider. Describe how you coordinate with state and local partners, to include JJS and other DHS systems of care, for the provision of services to at risk youth, children, and their families.

Emergency services are available 24 hours a day through the Utah Crisis Line, MCOT, SMR. Daytime (between 8:00 a.m. and 5:00 p.m. Monday through Friday) walk-in emergencies are dealt with face to face by the WHS crisis therapist assigned. After business hours (between 5:00 p.m. and 8:00 a.m. Monday through Friday and on weekends and holidays) requests for emergency services will be screened by phone by the Utah Crisis Line, subsequent face to face services will be provided as necessary. Daytime and after hours crisis services are managed as one program (MCOT/SMR). MCOT/SMR services respond to youth and children as well as adults. MCOT/SMR may be called out by dispatch or statewide crisis line to address youth and families in crisis situations. Whenever an MCOT/SMR response involves children, youth, and their families, MCOT refers to (SMR)- Stabilization and Mobile Response to follow-up with them. SMR is a team of therapists and Case managers that works primarily with children, youth, and their families. Currently at WHS, the staff includes 2 therapists and 2 case managers. MCOT also responds to Safe-Fam hotline calls when SMR primary services are not available, such as late in the evening and on Holidays and Weekends. When such occurs, coordination occurs with full time SMR staff and MCOT to assure children, youth , and families' needs are addressed. Crisis therapists are trained on a risk assessment evaluation instrument, and follow WHS established levels of care standards for emergency, urgent, and nonurgent care. Medical emergencies are immediately referred to hospital emergency departments. The hospital is one of our receiving centers along with Archway for youth. Our youth team supervisor continues to participate in the weekly MAS meeting with JJS and other providers. If a youth scores high on the Massey screening instrument, the Archway facility will contact MCOT for further assessment. Placements are made by MCOT at the Archway facility as needed..

Describe your evaluation procedures for children and youth crisis intervention services that objectively measure access and measurable outcomes for persons with both mental health and substance use disorders using data. Technical assistance with data specifications is available if needed, please describe any areas for help that are required.

Youth MCOT and stabilization is available for children and families in Weber County. When a family calls the state crisis line or the Saf-Fam hotline they can receive an in-person crisis and risk assessment if required. If the family requires more than 1 or 2 follow up sessions, a UFACET screener tool can be used to measure client functioning and determine if an 8-week intensive stabilization program is appropriate.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

We have received Youth MCOT funding and anticipate spending more in this area while serving more clients. .

Describe any significant programmatic changes from the previous year.

WHS continues to consult with Davis Behavioral Health and Bear River MH in delivering Youth MCOT and stabilization services. This effort is designed to address emergency services in our region and to enhance services currently available.

9) Adfult Psychotropic Medication Management *Pam Bennett*

Form A1 - FY23 Amount Budgeted:	$1,669,092	**Form A1 - FY23 Projected clients Served:**	1,884
Form A1 - Amount budgeted in FY22 Area Plan	$1,479,724	**Form A1 - Projected Clients Served in FY22 Area Plan**	1,388
Form A1 - Actual FY21 Expenditures Reported by Locals	$1,758,176	**Form A1 - Actual FY21 Clients Serviced as Reported by Locals**	1,587

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. *Please list any specific procedures related to continuity of medication management during transitions between from or between providers/agencies/level of care settings*

Weber Human Services continues to provide medication management services in-house. Evaluations and ongoing medication management are provided by a team of prescribers (APRNs), Medical Doctors, and nursing staff. An evaluation and current list of medications is kept in each client's electronic chart. Prescribers and nursing staff communicate and coordinate with the providers to ensure that both behavioral and physical health needs are considered. Nursing staff provide an evaluation prior to each appointment and notify the prescribers of any concerns. This evaluation may include areas such as blood pressure, waist circumference, and weight. Lab values are also provided to prescribers to monitor the impact of medication on the client's overall health. Prescribers and nursing staff also provide information to the clients regarding the purpose of medications, expected results, and possible side effects. Weber Human Services also provides service to clients at our in-house pharmacy and integrated wellness/primary care to help clients gain access to medication and medical care. We have two Medical Doctors that work in our integrated clinic along with several medical assistants and support staff. When clients are transitioning between agencies and/or levels of care, nursing staff/inpatient coordinators work to obtain records and arrange a "Doc to Doc" phone call when needed. WHS also has a provider who completes rounds in the Crisis Transition Unit/residential to ensure continuity of care.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Based on actuals from previous years, we anticipate serving more clients in this area while increasing the budget.

Describe any significant programmatic changes from the previous year.

No significant changes from last year. We are working diligently to financially support our primary care clinic. We continue to provide telehealth options to our clients.

10) Children/Youth Psychotropic Medication Management *Leah Colburn*

Form A1 - FY23 Amount Budgeted:	$341,060	**Form A1 - FY23 Projected clients Served:**	407
Form A1 - Amount	$281,852	**Form A1 - Projected Clients**	355

budgeted in FY22 Area Plan		Served in FY22 Area Plan	
Form A1 - Actual FY21 Expenditures Reported by Locals	$383,320	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	346

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. *Please list any specific procedures related to continuity of medication management during transitions between providers/agencies/level of care settings.*

Medication evaluations and medication management services are provided by a prescriber specializing in children and/or youth and a registered nurse (RN). Medications are prescribed and followed with routine review. Prescriber and nursing staff are available to see clients on a weekly basis or as necessary. When medication regimens are stable, clients are seen every 1 to 3 months. A current list of all medications prescribed is kept in each client's clinical chart. The prescriber and registered nurse initiate contact with other prescribers as necessary to coordinate services and prevent negative medication interactions. Prescriber, registered nurse, and primary therapists meet regularly to plan and coordinate care. Primary therapists are encouraged to attend psychiatric appointments with their clients when needed. When clients are transitioning between agencies and/or levels of care, nursing staff/inpatient coordinators work to obtain records and arrange a "Doc to Doc" phone call when needed.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Based on actuals from previous years, we anticipate serving more clients in this area while increasing the budget.

Describe any significant programmatic changes from the previous year.

No significant programmatic changes from the previous year. We continue to provide telehealth options to our clients.

11) Adult Psychoeducation Services & Psychosocial Rehabilitation   *Pam Bennett*

Form A1 - FY23 Amount Budgeted:	$781,464	Form A1 - FY23 Projected clients Served:	277
Form A1 - Amount budgeted in FY22 Area Plan	$778,210	Form A1 - Projected Clients Served in FY22 Area Plan	268
Form A1 - Actual FY21 Expenditures Reported by Locals	$792,769	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	266

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

Psychosocial rehabilitation services are provided Monday through Friday through the STEPS program. We offer a group each morning that runs from 8:30 AM to 12:00 PM, with a focus on Recovery Model

principles. The groups focus on returning clients' to their maximum functioning through improving skills to assist with wellness concerns, personal development, independent living, communication, anger management, problem solving, and basic daily living activities. We also provide individual skills development to clients in their place of residence or in the community. STEPS also provides a drop-in center which is a venue for clients to engage in leisure, social activities, and a place to practice their skills and develop new ones. Clients are also provided lunch Monday through Friday in the drop-in center. The STEPS team also works with PAAG to help clients access affordable housing. The 3 full time ISD/PSS workers are able to work one on one in real time with clients on the social skills they are learning in the drop-in center. Some STEPS clients who have increased their daily functioning have been trained to assume responsibilities in the day-to-day operations of the drop-in center. In addition to the group and the work we are doing in the drop-in center, we provide ISD services in the client's apartments to further assist them to develop and implement the maintenance skills taught in the group. We have a full time PSS worker who works afternoons 1:00 PM to 9:00 PM Wednesday through Sunday which has allowed us to provide services to clients at the group homes and in their residences at night and on the weekends.

Describe how clients are identified for Psychoeducation and/or Psychosocial Rehabilitation services. How is the effectiveness of the services measured?

Potential clients are identified by their therapist and referred for services. The clients are assessed using the DLA to determine eligibility and specific services offered. Progress is measured by the OQ and DLA's are reviewed regularly. There are specific objectives that are connected with the program that are reviewed with the client on a regular basis.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes on budget or projected clients were served.

Describe any significant programmatic changes from the previous year.

Due to the Covid 19 pandemic, services were no longer available at the center. Services were taken into the homes following CDC guidelines. Meals were also delivered to clients at their respective residences. Groups were provided in group homes, on a daily (including weekend) basis.Psychosocial rehab services have been re-opened for the past several months. Clients participate in groups, socialization, and lunch onsite. Masks have been required at times due to concern of COVID transmission.

12) Children/Youth Psychoeducation Services & Psychosocial Rehabilitation *Leah Colburn*

Form A1 - FY23 Amount Budgeted:	$696,300	Form A1 - FY23 Projected clients Served:	95
Form A1 - Amount budgeted in FY22 Area Plan	$663,155	Form A1 - Projected Clients Served in FY22 Area Plan	95
Form A1 - Actual FY21 Expenditures Reported by Locals	$580,926	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	58

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.
Psycho-education Services and Psycho-social Rehabilitation Services are offered in early intervention programs as well as traditional outpatient mental health programming. We currently partner with three area school districts; Ogden City Schools, Weber County School District and Morgan School District. We have clinical and supportive staff in area schools offering both psycho-educational services and psycho-social rehabilitation services. We partner with Weber State University and provide eligible students the opportunity to work directly with our client/s in the school and/or community setting.
Describe how clients are identified for Psychoeducation and/or Psychosocial Rehabilitation services. How is the effectiveness of the services measured?
Clients are identified as needing these services when their DLA demonstrates a score of 4 or less in any functional assessment area. Effectiveness of service is measured by a reduction of the YOQ score as well as parent/caregiver, client and teacher reports. For example, effectiveness can be measured by a client's improved social skills and/or a reduction in problematic behavior. WHS will continue to offer a year round weekly skills development group.
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).
No expected changes to budget or numbers served.
Describe any significant programmatic changes from the previous year.
No significant programmatic changes from the previous year.

13) Adult Case Management   *Pete Caldwell*

Form A1 - FY23 Amount Budgeted:	$2,116,748	Form A1 - FY23 Projected clients Served:	825
Form A1 - Amount budgeted in FY22 Area Plan	$2,138,483	Form A1 - Projected Clients Served in FY22 Area Plan	845
Form A1 - Actual FY21 Expenditures Reported by Locals	$2,366,983	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	793

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please include how you ensure each case management provider is certified to provide these services.
Weber Human Services recognizes that case management is an extremely important service which promotes service delivery efficiency and treatment effectiveness. It continues to be an area of focus and a priority for allocation of available resources. Case managers coordinate and connect with patient and family/formal supports, assess and develop service plans, link patient/s to available services, monitor service provision and advocate for patient rights. They also assess life domains to gather

information about the entire life. Weber Human Services offers Targeted Case Management (TCM) and Case Management (CM) services to adult mental health clients. These services are designed to build independent living skills and to assist clients in gaining access to needed medical, social, educational and other services to promote independence and a healthier lifestyle in the most appropriate and least restrictive environment. WHS has also adopted and implemented an evidence-based practice in the case management field. Critical Time Intervention (CTI) is a limited time case management model proven to help adults diagnosed with severe persistent mental illnesses (SPMI) during times of transition in their lives by strengthening their network of support within the community.

The certification process for our case manager/s is meeting and completing certification requirements (i.e. years of experience and Pass Grade of written exam), review and authorization from the Division. Additional training opportunities are offered based on population needs. Certification is monitored and updated as required by our Managed Care Supervisor

Please describe how eligibility is determined for case management services. How is the effectiveness of the services measured?

Eligibility is initially determined by the assigned therapist upon admission utilizing the Daily Living Activities (DLA) tool. Once it has been determined that case management services are needed, a referral form is sent to our CM supervisor who assigns the case to a CM. The assigned CM completes a needs assessment and provides services based on need.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Describe any significant programmatic changes from the previous year.

No significant changes are expected with case management services this year. WHS continues to struggle in finding, hiring, and retaining CM staff. We are currently down 5 CM positions and are looking at creative ways of recruiting qualified staff.

14) **Children/Youth Case Management**   *Pete Caldwell*

Form A1 - FY23 Amount Budgeted:	$247,113	Form A1 - FY23 Projected clients Served:	52
Form A1 - Amount budgeted in FY22 Area Plan	$237,609	Form A1 - Projected Clients Served in FY22 Area Plan	45
Form A1 - Actual FY21 Expenditures Reported by Locals	$8,314	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	71

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please include how you ensure each case management provider is certified to provide these services.

Weber Human Services recognizes that youth case management is an extremely important service which promotes service delivery efficiency and treatment effectiveness. It continues to be an area of focus and a priority for allocation of available resources. Case managers coordinate and connect with the child and family, assess and develop service plans, link children and family members to available services, monitor service provision and advocate for child and family rights. They also assess life domains to gather information about the entire life. WHS also has a designated Case Manager that works hand in hand with our inpatient therapist/liaison in an effort to reduce inpatient admissions, facilitate more timely discharges, and coordinate treatment and care.

The certification process for our case manager/s is meeting and completing certification requirements (i.e. years of experience and Pass Grade of written exam), review and authorization from the Division. Additional training opportunities are offered based on population needs. Certification is monitored and updated as required by our HR department.

Case Managers and Family Peer Supports attend a weekly supervision meeting to review client needs, staff needs, and processes when providing these services.

Please describe how eligibility is determined for case management services. How is the effectiveness of the service measured?

Clients are identified as needing these services when their DLA demonstrates a score of 4 or less in any functional assessment area. Effectiveness of services is measured by an increase of a client's DLA score, a reduction of the client's YOQ score, and/or parent/caregiver, client and teacher report. For example, effectiveness can be measured by clients/families' connection to community resources and link to additional services as needed (i.e. application to ABA services, completed IEP).

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes in this area.

Describe any significant programmatic changes from the previous year.

No significant programmatic changes from the previous year

15) Adult Community Supports (housing services)   *Pete Caldwell*

Form A1 - FY23 Amount Budgeted:	$66,119	Form A1 - FY23 Projected clients Served:	49
Form A1 - Amount budgeted in FY22 Area Plan	$75,121	Form A1 - Projected Clients Served in FY22 Area Plan	60

Form A1 - Actual FY21 Expenditures Reported by Locals	$86,202	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	59

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

WHS has staff working closely with clients and landlords in housing placements in various privately held rental units, such as Weber Housing Authority, Ogden Housing Authority, St. Benedicts Manor, Kier Properties, and McGregor apartments.   A WHS liaison works exclusively with PAAG which has over 100 beds in the community that WHS has been able to access. We also lease 20+ beds directly from PAAG for our clients. WHS provides services including instruction, monitoring, medication management, and leisure activities. WHS has a Transitional Living Community model utilizing Residential, Group Home and independent living in a continuum and providing services for clients to move on that continuum. The group homes each have a therapist and a case manager who monitor clients several times per week and hold twice weekly groups. WHS provides in-home Case Management. Skill development services, when delivered in the client's home, are designed to help facilitate the learning of daily living skills and maintain independent living.   WHS provides on-site support at the men's group home. A part-time position was converted to two live-in aides at the men's and women's group homes.

Indicate what assessment tools are used to determine criteria, level of care and outcomes for placement in treatment-based and/or supportive housing? Technical assistance is available through Pete Caldwell: pgcaldwell@utah.gov

Clients in treatment-based and/or supportive housing are staffed in either the High Utilizer weekly meeting or, if involved in PAAG housing, are staffed in a separate meeting with WHS and PAAG staff. This meeting is also held weekly to determine progress and readiness to move to a different level of care. Clients take the OQ and complete the CSSRS on a regular basis to indicate progress and outcomes. DLA scores indicate areas of need and are reviewed regularly to determine continued need.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes in this area.

Describe any significant programmatic changes from the previous year.

No significant changes are expected. WHS has gradually lifted some of the COVID restrictions for client interaction over the past 6 months and will continue to monitor community rates and restrictions.

16) Children/Youth Community Supports (respite services)   *Leah Colburn*

Form A1 - FY23 Amount Budgeted:	$10,000	Form A1 - FY23 Projected clients Served:	14
Form A1 - Amount budgeted in FY22 Area Plan	$10,000	Form A1 - Projected Clients Served in FY22 Area Plan	20
Form A1 - Actual FY21	$700	Form A1 - Actual FY21	9

Expenditures Reported by Locals		Clients Serviced as Reported by Locals	

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please identify how this fits within your continuum of care.

Family Support/Respite Services: Weber Human Services respite care and family support gives families of children with at-risk behaviors a break from their demands. Respite gives families a chance to re-energize while knowing that their children are safe. Short term in-home as well as out-of-home services are available. Family Peer Supports and Weber State BSW Students provide a weekly respite group and individual respite services. Out-of-home services by a respite worker provide social, recreational , and educational activities for the child. Archway Youth Service Center: Weber Human Services is a collaborative partner with the Archway Youth Service Center in providing a safe, therapeutic environment for our youth that don't meet criteria for inpatient or detention, yet require immediate intervention and support. They continue to provide needed Respite for our youth and families in need.

Please describe how you determine eligibility for respite services. How is the effectiveness of the service measured?

Eligibility for respite services is based on clinician referral after they have completed an informal parent needs assessment. Referral can occur at any point in the treatment process as the need arises. Effectiveness is based on parent/guardian reports that they have been able to utilize and benefit from respite services by involving themselves in self-care, by giving them the option to spend time with other family members in the home. The end result is that the child is able to remain in the home and the parent/guardian is able to have their needs met while caring for a high needs child and they have developed their own natural respite resources.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No significant changes in the budgeted amount. We hope to serve more individuals than in the previous fiscal year.

Describe any significant programmatic changes from the previous year.

No significant programmatic changes from the previous year

17) Adult Peer Support Services   *Heather Rydalch*

Form A1 - FY23 Amount Budgeted:	$153,293	Form A1 - FY23 Projected clients Served:	40
Form A1 - Amount budgeted in FY22 Area Plan	$147,397	Form A1 - Projected Clients Served in FY22 Area Plan	145
Form A1 - Actual FY21 Expenditures Reported by Locals	$106,645	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	85

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

WHS adult mental health has 1 peer support that works in the AOT program and two that work out of the STEPS program. The peer support that is working in the AOT program primarily works with committed clients that are difficult to engage in traditional services. The two peer support specialists that work in the STEPS program are primarily working with clients in the community during the afternoon. They provide both individual and group services.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served and number of services provided (15% or greater change).

Based on actuals from previous years, we anticipate serving fewer clients on the adult team with a similar amount budgeted.

Describe any significant programmatic changes from the previous year.

All Peer Support Specialists are now supervised by the program supervisor in which they are working and by the Managed Care supervisor for documentation and certification.

18) Family Peer Support Services   Tracy Johnson

Form A1 - FY23 Amount Budgeted:	$124,984	**Form A1 - FY23 Projected clients Served:**	46
Form A1 - Amount budgeted in FY22 Area Plan	$125,561	**Form A1 - Projected Clients Served in FY22 Area Plan**	124
Form A1 - Actual FY21 Expenditures Reported by Locals	$40,472	**Form A1 - Actual FY21 Clients Serviced as Reported by Locals**	64

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. *Describe how Family Peer Support Specialists will partner with other Department of Health & Human Services child serving agencies, including DCFS, DJJS, DSPD, and HFW.*

The Youth Team currently employs 2 Full Time Family Peer Support Specialists (FPSS's). The FPSS's have acquired and demonstrated Family Facilitation Knowledge and Skills according to national fidelity guidelines and have been certified in the delivery of Family Peer Support Services. They have developed a working partnership with designated children's mental health clinician(s); attend clinical staff meetings, local interagency meetings and other policy meetings as directed by the local mental health center champion. These individuals represent the family voice in the service delivery and administration process. One of the most significant vehicles for such a practice is the Multi-Agency Coordination Council (MACC). Weber continues to serve as an example of such a practice and has been successful in bringing area stakeholders such as, but not limited to, The Division of Child and Family Services (DCFS), The Division of Juvenile Justice Services (DJJS), Juvenile Court, schools, families, and Family Peer Support Specialists (FPSS) to the table and engaging in a discussion that identifies client needs/available resources/ and, an appropriate treatment plan and level of care. We

are also invested in the statewide System of Care (SOC) process and currently have agency/family voices at the MACC level and the Regional Advisory Council level.

WHS FPSS's are encouraged to participate in monthly FPSS meetings through the OSUAMH. They also will participate in ongoing training and conference opportunities as they come available.

Describe how clients are identified for Family Peer Support Specialist services. How is the effectiveness of the services measured?

Eligibility for FPSS services is based on clinician informal needs assessment, DLA score, and parent/teacher report or request for connection to resources and most importantly, it is determined that these clients benefit from working with an individual with lived experience.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served and number of services provided (15% or greater change).

Based on 2022 data, we overestimated the amount of clients that would be served within the budget. Current budget and amount served are based on data from previous years. .

Describe any significant programmatic changes from the previous year.

WHS youth team FPSS's have partnered with Tranquility Home to work with parents with children in the facility to specifically focus on parenting skills and supporting positive relationships with their children.

19) Adult Consultation & Education Services   *Pam Bennett*

Form A1 - FY23 Amount Budgeted:		Form A1 - FY23 Projected clients Served:	
Form A1 - Amount budgeted in FY22 Area Plan	$0	Form A1 - Projected Clients Served in FY22 Area Plan	
Form A1 - Actual FY21 Expenditures Reported by Locals	$0	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

WHS begins to educate consumers and their families at the time of the initial assessment, giving the consumer information about the nature of their illness and types of interventions available that may include: Individual and/or group therapy, medication management, etc. Education in terms of mental illness and substance use is provided to clients in the Illness Management and Recovery program; the Psycho-educational workshop in the first three joining sessions, and ongoing group therapy provided in the Psycho-educational Mutli-family group (education is provided to both client and family); Prolonged Exposure also focuses on education in the first 2 sessions .
Clients are encouraged to sign a disclosure so that treatment information can be coordinated with family members. The Adult Team encourages family involvement and coordination with consumer consent. Family members are invited to individual sessions, medication clinic appointments, and interdisciplinary staffing when appropriate.   Weber Human Services contributes clinical support in the community by advocating for consumers with mental illness in other community projects and programs,

such as the Homeless Programs and Crisis Intervention Team Training. Weber Human Services staff has provided training on mental illness to the Department of Workforce Services, the Deaf and Blind school, Weber State University, the Weber County Case Manager's meeting, and various local churches. Outreach efforts have also been made with the police and fire departments to provide outreach to 911 calls that seem appropriate for behavioral health follow-up. WHS also provides space and literature in a computer center located in the WHS lobby for consumers to research illness-related information.The Adult Mental Health Team provides clinicians to speak at, or provide information booths at various community events. Clinicians have been availabl at several community events where difficult circumstances (primarily suicides) are being processed.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

We do not expect an increase or decrease in funding or number of individuals served.

Describe any significant programmatic changes from the previous year.

Weber Human Services recently partnered with Latino Behavioral Health to provide office space in the building. They are hoping to connect Latinx clients with Weber Human Services for treatment and provide other resources for this population.

20) Children/Youth Consultation & Education Services   *Leah Colburn*

Form A1 - FY23 Amount Budgeted:		**Form A1 - FY23 Projected clients Served:**	
Form A1 - Amount budgeted in FY22 Area Plan	$0	**Form A1 - Projected Clients Served in FY22 Area Plan**	
Form A1 - Actual FY21 Expenditures Reported by Locals	$0	**Form A1 - Actual FY21 Clients Serviced as Reported by Locals**	

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

The Weber Human Services' Youth Team has created and made available a written outline of services available to our families. We have and will continue to support available sensitivity training for our staff (i.e. family to family offered by NAMI). The Youth Team trains and promotes education with our families with each contact whether it is in an individual, family, group, and/or medication appointment. Staff members have access to resources and are encouraged to research and share information with the client and their family. We have adopted evidenced-based family approaches in our practice. The Family Peer Support Specialists are also available on-site and provide valuable information and/or access to community resources.

An education center has been constructed in the lobby of WHS and is open to anyone from the community seeking education about mental illness.

WHS also provides consultation and education services in our school-based program/s. We currently

partner with two area school districts; Ogden City Schools and Morgan School District. We have clinical and supportive staff in area schools offering both consultation and education services. Our partnerships extend into the System of Care (SOC) and efforts to serve our families better through enhanced coordination and care. WHS has a representative at the Regional Advisory Council level of this effort and one or more representatives at the Multi-Agency Coordinating Council (MACC) level.

Youth Case Managers and Family Peer Support Specialists provide education to community members. Examples of this include an information booth at a local school for kindergarten roundup and upcoming participation in a community health fair at Youth Impact.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

We do not expect an increase or decrease in funding or number of individuals served.

Describe any significant programmatic changes from the previous year.

WHS is working to educate families and the community on WHS Prevention Programming. And when Prevention services are more appropriate than outpatient mental health services.

21) Services to Incarcerated Persons   *Pam Bennett*

Form A1 - FY23 Amount Budgeted:	$0	**Form A1 - FY23 Projected clients Served:**	1,392
Form A1 - Amount budgeted in FY22 Area Plan	$0	**Form A1 - Projected Clients Served in FY22 Area Plan**	
Form A1 - Actual FY21 Expenditures Reported by Locals	$0	**Form A1 - Actual FY21 Clients Serviced as Reported by Locals**	1,074

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider, and how you will coordinate with the jail to ensure service delivery is adequate.

Mental Health services are available for all county inmates at the Weber County Jail, contracted from Weber County (not Weber Human Services) to Alpha counseling. Current mental health clients, and Medicaid recipients with behavioral health needs are referred to WHS for ongoing services when discharged from the county jail. Those appropriate for the Mental Health Court are assessed and those qualified may be placed in the WHS residential facility and offered supportive services upon release.

Inmates also are screened by WHS for the possibility of meeting the criteria for civil commitment. There is coordination with the WCCF on occasion for medications that are not provided by the jail. They are provided by WHS if acceptable to the jail for administration by the jail medical staff.

Describe how clients are identified for services while incarcerated. How is the effectiveness of the services measured?

Inmates are able to request mental health services while incarcerated. They are assessed for their needs in the booking process. The jail staff may also refer an inmate to be seen and assessed for mental health needs to Alpha Counseling in the jail. Where WHS is not involved in the mental health

services in the jail, it is not known how the effectiveness of services are measured.

Describe the process used to engage clients who are transitioning out of incarceration.

Alpha Counseling identifies inmates who need more long term mental health treatment and they let the jail know and the jail will relay the information to WHS so we can try to engage the client upon their release. If the need is urgent, upon release, WHS will arrange for a TCM to pick the client up and bring them to WHS for initiation of services.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

The number served is based on data from the contracted provider in the jail (Alpha Counseling).

Describe any significant programmatic changes from the previous year.

WHS has a Case Manager housed at the jail as part of reentry services and assists with coordination of services when an individual is leaving jail and in need of ongoing care through WHS. This position is budgeted through state funds. The position is described further in the Substance Narrative.

22) Adult Outplacement   *Pam Bennett*

Form A1 - FY23 Amount Budgeted:	$119,548	Form A1 - FY23 Projected clients Served:	30
Form A1 - Amount budgeted in FY22 Area Plan	$119,548	Form A1 - Projected Clients Served in FY22 Area Plan	30
Form A1 - Actual FY21 Expenditures Reported by Locals	$0	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	0

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

WHS provides ongoing financial support and community assistance to expedite discharges from the Utah State Hospital. Routinely, in anticipation of consumers receiving medical and financial benefits, clients are discharged from the USH into a WHS Co-ed residential facility while awaiting reinstatement of benefits. This can take anywhere from several weeks to many months. Some discharges are ineligible for benefits, and WHS must absorb the costs of medication, housing, meals, and treatment.WHS is willing to make ongoing financial commitments to maintain former USH discharges in the community.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No expected increase or decrease in funding. Adult outplacement dollars are included in our other service categories. There is no line item in our budget for this category.

Due to the fact that outplacement dollars are not listed as a line item in the budget, we do not identify them differently when utilized for outpatient services.

The outplacement dollars are identified and utilized for clients leaving the state hospital when additional specialized services are needed or required to maintain the client in the community.

Describe any significant programmatic changes from the previous year.

No changes

23) Children/Youth Outplacement   Codie Thurgood

Form A1 - FY23 Amount Budgeted:	$0	Form A1 - FY23 Projected clients Served:	0
Form A1 - Amount budgeted in FY22 Area Plan	$0	Form A1 - Projected Clients Served in FY22 Area Plan	0
Form A1 - Actual FY21 Expenditures Reported by Locals	$0	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	0

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

Children's Outplacement dollars continue to play a significant role in funding community placement options and/or wrap-around services for children/youth not otherwise eligible for such services. Weber Human Services has chosen to partner with area stakeholders and typically cost-share higher cost placements for children/youth coming out of the State Hospital and transitioning to a community placement, some with and others without support. Our clients have experienced better outcomes when they transition more slowly rather than a move from the most restrictive clinical setting to home and school. Currently, we have one youth using COP dollars for community placement and/or treatment post discharge from the hospital (day tx at McKay Dee Summit) and three (3) using COP dollars to off-set cost of transportation to and from the hospital.

Describe any significant programmatic changes from the previous year.

No significant programmatic changes from the previous year. Budget is dependent on clients released from USH who have outplacement needs.

24) Unfunded Adult Clients   Pam Bennett

Form A1 - FY23 Amount Budgeted:	$62,397	Form A1 - FY23 Projected clients Served:	100
Form A1 - Amount budgeted in FY22 Area	$62,397	Form A1 - Projected Clients Served in FY22 Area Plan	100

Plan			
Form A1 - Actual FY21 Expenditures Reported by Locals	$84,723	**Form A1 - Actual FY21 Clients Serviced as Reported by Locals**	0

Describe the activities you propose to undertake and identify specific populations where services are and are not provided. For each service, identify whether you will provide services directly or through a contracted provider.

Weber Human Services provides direct services to the unfunded/underfunded of our community with the primary focus of unfunded/underfunded services being with those on a civil commitment, those with Medicare only, and those who have recently lost Medicaid. These clients continue to be provided with individual and group therapy and medication management services as needed. WHS provides all community individuals, on a walk-in basis, with a clinical crisis evaluation and screening to determine appropriate internal or external referrals for treatment. WHS will also respond to requests by police or fire department personnel for follow-up calls to provide referrals for individuals regardless of insurance status. In most cases, referrals are made to external resources for treatment due to a lack of funding to treat this population in-house. Internal referrals are made for unfunded clients when deemed clinically necessary and services are authorized based on need. Our after-hours crisis service is also available to any individual on a 24-hour basis from any catchment area. We have seen a decrease in funding for unfunded clients and therefore show a corresponding decrease in clients served based on available funding. This is caused by both a decrease in funding and an increase in the number of clients projected to be on Medicaid. WHS has formed a relationship with Family Counseling Services to pay for 6-8 sessions of therapy for those who do not have Medicaid. WHS has begun providing screens for all those in the community who are unfunded/underfunded. After an initial screening, clients are provided with community resources and, if needed, WHS Foundation provides vouchers for limited treatment through community providers.

Describe agency efforts to help unfunded adults become funded and address barriers to maintaining funding coverage.

Unfunded clients initiating an admission through a civil commitment are assigned a TCM to help in the qualification for the Medicaid process. General AMH clients who lose Medicaid are referred to the DWS worker who has an office in the WHS building.

We have not measured the number of clients that we have assisted in securing coverage. Helping clients qualify for Medicaid is a major responsibility of case managers, particularly those on the AOT Team. Most of the clients on this team are unfunded. We provide this service regularly.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No expected changes

Describe any significant programmatic changes from the previous year.

No significant changes

25) Unfunded Children/Youth Clients   *Leah Colburn*

Form A1 - FY23 Amount	$22,280	**Form A1 - FY23 Projected**	40

Budgeted:		clients Served:	
Form A1 - Amount budgeted in FY22 Area Plan	$22,280	Form A1 - Projected Clients Served in FY22 Area Plan	40
Form A1 - Actual FY21 Expenditures Reported by Locals	$0	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	0

Describe the activities you propose to undertake and identify specific populations where services are and are not provided. For each service, identify whether you will provide services directly or through a contracted provider.

Weber Human Services provides direct services to the unfunded/underfunded of our community. These clients continue to be provided with individual, family and group therapy and medication management services as needed. WHS provides all community individuals, on a walk-in basis, with a clinical crisis evaluation and screening to determine appropriate internal or external referrals for treatment. In most cases, referrals are made to external resources for treatment due to a lack of funding to treat this population in-house. Internal referrals are made for unfunded clients when deemed clinically necessary and services are authorized based on need. Our after-hours crisis service is also available to any individual on a 24 hour basis from any catchment area. Due to our partnerships with local school districts we have been able to serve their unfunded population with the Early Intervention Funding.

Describe agency efforts to help unfunded youth and families become funded and address barriers to maintaining funding coverage.

Review eligibility in-house/out of house. Partner with Workforce Services.

We have not measured the number of clients that we have helped secure coverage. We typically utilize early intervention dollars for those who are not covered. CMs, FPSSs will assess coverage needs and help connect as needed.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

None expected

Describe any significant programmatic changes from the previous year.

None

26) Other non-mandated Services

Form A1 - FY23 Amount Budgeted:	$78,600	Form A1 - FY23 Projected clients Served:	29
Form A1 - Amount budgeted in FY22 Area Plan	$50,000	Form A1 - Projected Clients Served in FY22 Area Plan	0

Form A1 - Actual FY21 Expenditures Reported by Locals	$13,972	Form A1 - Actual FY21 Clients Serviced as Reported by Locals	0

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.			

No other services are provided.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).			

the $50,000 budgeted from last year was one time funding.

Describe any significant programmatic changes from the previous year.			

We will offer mental health recovery support services.

27) First Episode Psychosis Services   *Jessica Makin*

Form A1 - FY23 Amount Budgeted:	$206,165	Form A1 - FY23 Projected clients Served:	30
Form A1 - Amount budgeted in FY22 Area Plan	$206,165	Form A1 - Projected Clients Served in FY22 Area Plan	30
Form A1 - Actual FY21 Expenditures Reported by Locals		Form A1 - Actual FY21 Clients Serviced as Reported by Locals	

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.			

Clients referred to Early Psychosis receive an initial evaluation, additional testing (SIPS, SCID and/or psychological testing), a referral for medication management services, case management, and supported employment services. Group and individual therapy is also provided by a clinician. The Psycho-Educational and Multi-Family Group is the primary modality. The team outreaches to the county school districts, hospitals, and community resource centers to coordinate services. These services are provided by in-house providers.

Describe how clients are identified for FEP services. How is the effectiveness of the services measured?			

Community outreach and education is done quarterly to local school districts, DCFS, DJJS, & Juvenile Court. Hospitals, schools, and local community resource centers refer age-appropriate clients to WHS for screening. Multiple screening tools are used to identify prodromal symptoms and make appropriate referrals. YOQs and OQs are administered at regular treatment intervals.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).			

This is not broken out on the budget sheet. We do receive $206,165 for evidence-based first psychosis treatment.

Describe any significant programmatic changes from the previous year.

No programmatic changes from the previous year

28) Client Employment   *Sharon Cook*

Increasing evidence exists to support the claim that competitive, integrated and meaningful employment is an essential part of the recovery process and is a key factor in supporting mental wellness.
In the following spaces, please describe your efforts to increase client employment in accordance with Employment First 62A-15-105.2

Competitive, integrated and meaningful employment in the community (including both adults and transition-aged youth).

The Weber Human Services Supported Employment Team offers clients assistance with preparing for and obtaining jobs in the competitive market and not in sheltered settings. Our program is different from standard employment services because our specialists go out and build relationships with local businesses in a field the client is interested in. This model has proven to be successful in helping individuals, with mental illness and/or substance use, to find jobs leading to long-term employment. Assistance is given with resume writing, interviewing skills, transportation, obtaining interview clothing and many other services in preparing the clients for work. A study initiated by Johnson & Johnson in conjunction with Dartmouth Community Mental Health Program, found that 60% of clients obtained jobs by following this method as compared to 24% using other services. In addition, integrated MH/SUD meetings occur weekly with employment specialists, clinicians, prescribers and case managers.
The grant for supported employment ended in Sept/2019 but we have been able to maintain four employees in the program to work across clinical teams.

The referral process for employment services and how clients who are referred to receive employment services are identified.

The therapist fills out the SEP referral form and sends it to the SEP email. In order to qualify, a client must have Medicaid and must be meeting with a therapist regularly. The client must have a mental health or substance use diagnosis.

Collaborative employment efforts involving other community partners.

WHS has worked to collaborate with community partners--Deseret Industries, Vocational Rehabilitation, Your Community Connection, Cottages of Hope, Episcopal Church of Good Shepherd, DWS, UWIPS, and Focus Telemarketing. WHS also works closely with PAAG to provide clients with job-training opportunities.

Employment of people with lived experience as staff through the Local Authority or subcontractors.

WHS has one full-time worker employed on the SEP team with lived experience.

Evidence-Based Supported Employment.

The Supported Employment program works from the Individual Placement Services (IPS) model which

is an evidence-based practice. All of the current Employment Specialists have received training in this model and the upcoming Employment Specialists will receive this training as well. WHS' IPS employment specialists have become ACRE certified through Utah State University. This certification allowed for WHS to become an approved Community Rehabilitation Provider (CRP) vendor for Vocational Rehabilitation. Becoming a CRP has allowed IPS employment specialists to partner with Vocational Rehabilitation and receive milestone payments for job development, job placement and job coaching services.

29) Quality & Access Improvements
   Identify process improvement activities:

Evidence Based Practices: In this section please describe the process you use to ensure fidelity to EBPs. Attach a list of EBPs in the attachment section.

We begin by hiring coachable staff who will respond to fidelity coaching. All clinicians must participate in the full training of any EBP prior to delivering the EBP. Individual and group sessions are regularly recorded and submitted for review. Trained supervisors use fidelity tools for each EBP and evaluate the sessions for fidelity. A fidelity feedback summary is then sent to the clinician with strengths and areas for improvement. The supervisor meets with the clinician to practice specific items from the feedback summary. All fidelity data is stored in a single document so that individual, EBP specific, and organizational fidelity can be evaluated.

Outcome Based Practices: Identify the metrics used by your agency to evaluate client outcomes and quality of care.

WHS primarily relies on the OQ/YOQ to evaluate outcomes.

Quality of care is measured in several ways including, an automated dashboard that contains individual and aggregated outcome data, clinician PEER reviews that consider clinician's efforts to submit their work for review, and attitude towards coaching/improvement.

Service Capacity: Systemic approaches to increase access in programs for clients, workforce recruitment and retention, Medicaid and Non-Medicaid funded individuals, client flow through programming

WHS has made significant changes to the system, including establishing a specialty clinic in which adults with serious mental illness are moved quickly into evidence-based treatments that reduce symptoms. WHS is working closely with WSU to both train and recruit master's level clinicians. Client success and competitive wages are retention strategies.

Efforts to respond to community input/need. Describe your participation with key community partners (e.g.: Multi-Agency Coordinating Committees, Regional Advisory Councils, High Fidelity Wraparound teams, Local Interagency Councils, Local Recovery Community, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts, Regional Healthcare Coalitions, Local Homeless Councils, and other partnership groups relevant in individual communities).

WHS is involved with a number of community partners:
   1.   Behavioral Health Network which coordinates services with other behavioral and physical

health partners in the community.
2. Community Action Network to plan and execute activities to improve the lives of inner-city Ogden residents.
3. Housing authorities-we currently provide an office for Weber Housing Authority in the WHS building
4. DWS-an office is provided for a DWS worker who is able to provide information and help to those applying for benefits
5. Weber County Attorney to coordinate release services
6. MCOT coordinates crisis responses with police officers in the community.
7. McKay Dee Hospital is provided by a WHS liaison to monitor and coordinate treatment.
8. Latino Behavioral Health is available on site to connect those from the Latinx population to services within the community and at WHS.
9. Vocational Rehabilitation, PAAG, AP&P, Alpha Counseling, prosecuting attorneys, and defense attorneys attend the Mental Health Court in order to provide wrap-around services for all clients who are involved in the MHC program.
10. Member of the Weber LHC

Describe how mental health needs for people in Nursing Facilities are being met in your area

WHS has assigned a clinician to each of the primary nursing facilities in the Weber County area. Clinicians meet regularly with clients in nursing facilities (depending on need). They also coordinate case management services and medication management services. An APRN is provided for medication management consultations. In addition, outreach and coordination with the nursing homes is provided when an inpatient psychiatric need is identified. Mental health training is also provided for nursing home staff. Over the last year clinicians and case managers were not allowed face to face access with our clients. Creative ways were found to provide telehealth or "window therapy" in order to meet the needs of the clients. Close contact was maintained with SNF staff to ensure that clients' needs were met.

Telehealth: How do you measure the quality of services provided by telehealth? Describe what programming telehealth is used in.

WHS has provided training and equipment to all of our clinicians and prescribers to enable clients to access services through telehealth. WHS continues to utilize telehealth services even after clients and staff have returned to the buildings. Currently, all clinicians are working from the office. Most of their services are provided in person. Telehealth remains available at client request. Some groups have remained available via telehealth. All clinicians are given the opportunity to work one day a week from their home office using telehealth. We anticipate that telehealth will be a great option for clients and staff who have mild symptoms that prevent them from in-person services. We also anticipate utilizing telehealth to reduce travel during inclimate weather.

Describe how you are addressing maternal mental health in your community. Describe how you are addressing early childhood (0-5 years) mental health needs within your community. Describe how you are coordinating between maternal and early childhood mental health services. Technical assistance is available through Codie Thurgood: cthurgood@utah.gov

WHS provides residential treatment for women and their children. Services including but not limited to case management are provided for the family residing at Tranquility Home. The WHS Youth Team provides treatment for children (0-5) and families in an outpatient setting. The Youth Team maintains a team specializing in children 0-5 and their mental health needs. The Youth Team 0-5 specialist is working more closely with WHS Tranquility Home. Rachel Hopkins is the MMH specialist.

Other Quality and Access Improvement Projects (not included above)

WHS continues to maintain Reconnect (a group and support) for youth-in-transition and related issues. WHS has adopted the Modular Approach to Treating Children in the last year, and will be adopting the Unified Protocol for adult clients in the coming year. Each is an EBP that provides relief from symptoms of depression and anxiety.

30) Integrated Care   *Pete Caldwell*

Describe your partnerships with local Health Departments, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers.

WHS continues to have an in-house integrated health clinic to serve the physical health needs of all WHS clients. We currently offer a full-service laboratory, pharmacy and physical/mental health treatment in our main facility at WHS. Two full time Medical Doctors, several medical assistants, and customer care staff work in the integrated clinic.

Describe your efforts to integrate care and ensure that children, youth and adults have both their physical and behavioral health needs met, including screening and treatment and recovery support. Identify what you see as the primary barriers to implementing integrated care at your agency and your efforts to overcome those barriers. Please also describe how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).

Each new client at WHS goes through an assessment process which includes an assessment of their physical, mental health, and substance use treatment needs. Each existing client has an annual review of these needs. If physical health needs are identified, in addition to the behavioral health concerns, the primary service coordinator can refer to our care coordination team and/or our integrated Wellness Clinic.

We have an integrated primary care clinic at WHS. We believe that integration is vital to the wellbeing of our clients but there are several barriers.   One of the main barriers is documentation/efficiency for our medical providers. We do not have an EHR that was built with primary care in mind. We have looked at other options that are either too expensive or would decrease communication between behavioral health and medical providers. Our IT department has made several changes to the system to increase efficiency with notes, looking up medications, and writing prescriptions. Even with these changes, our EHR is not nearly as efficient as an EHR that is made for primary care.
The billable rate for medical services is also a barrier. Private primary care organizations often put a cap on the number of Caid/Care recipients that are allowed but we do not. We helped sponsor legislation this year that may impact the reimbursement rate in the future. Most entities are supportive of integration, but very few provide the means to truly integrate.

Describe your efforts to incorporate wellness and wellness education into treatment plans for children, youth and adults. Please consider social determinants of health in your response.

Clients coming into WHS have physical health concerns addressed at the time of intake with

appropriate referrals to our integrated WEllness Clinic or Health Connections (for those individuals with greater physical health needs). case managers are assigned to ensure that clients are able to access wellness programs and medical support.

Quality Improvement: **What education does your staff receive regarding health and wellness for client care including children, youth and adults?**

A supervisor has been identified to become educated in the behavioral health needs of perinatal and postnatal mothers
Rachel Hopkins (supervisor) has recently attended a training specific to these areas. She will continue to utilize her knowledge to educate staff internally.

Describe your plan to reduce tobacco and nicotine use in SFY 2023, and how you will maintain a *nicotine free environment* as a direct service or subcontracting agency. For ongoing engagement, it is recommended to use an evidence-based nicotine dependence tool such as the Fagerstrom scale. SUD Target= reduce tobacco and nicotine use by 4.8%.

Clients are screened and assessed at the beginning and throughout treatment regarding treatment and referrals for smoking cessation options. WHS will explore use of the Fagerstrom scale for screening and recommendations for NRT.   Nicotine replacement strategies such as patches, gum, and medication are available with the medical team as well as referrals within the community including use of the QUITline.   WHS will also explore implementing an education group specifically designed for women who are pregnant and seeking to reduce nicotine use. WHS will also reimplement use of smoking cessation groups led by peer support specialists.. WHS will coordinate with the Weber County Health Dept. and WHS Prevention programs to provide education for both staff and clients in treatment.

Describe your efforts to provide mental health services for individuals with co-occurring mental health and autism and other intellectual/developmental disorders. Please identify an agency liaison for OSUMH to contact for IDD/MH program work.

Our MH Assessment identifies areas of functioning and related delays/deficits. We also have access to additional screening instruments that assist in identifying client's specific needs on all levels. Programming has been modified to better meet the needs of those with intellectual/developmental disorders. Those clients identified with Autism will be linked with an ABA provider in our community.   If there is a co-occurring MH disorder with the Autism diagnosis, additional services will be authorized as appropriate. Weber Human Services continues to provide the NUAP program.

31) Children/Youth Mental Health Early Intervention   *Leah Colburn/Tracy Johnson*

Describe the Family Peer Support activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. For those not using MHEI funding for this service, please indicate "N/A" in the box below.

Weber Human Services' Early Intervention/school-based mental health therapist/s provide assessments, individual, family and group therapy, crisis intervention, and consultation services. Additional services include, but are not limited to, psychological assessments, psychiatric evaluation, medication, and/or medication management. These services are provided to clients referred from the school districts and through our partnership through IHC Northern Pediatric Clinic.

Weber Human Services partners with our Prevention Team. WHS recognizes the importance of bridging the gap between Prevention and Treatment Services. The Family Peer Support Specialist (FPSS) is also available to assist client and family in identifying their own needs, determining which

needs are priorities, deciding what they want the outcome to look like, to decide who they want to ask to be involved, and, to identify how the needs might be met. The FPSS's also are trained/certified and available to assist with resource coordination, individual family advocacy, PEER and other related duties. We also have an eligibility worker available for families wishing to explore eligibility for Medicaid, CHIP, or SSI as we recognize the importance of qualifying client/families for long term treatment and care. As far as funding allows, we are accessible and available to serve any child in need regardless of their ability to pay, including those without insurance. We not only partner with our area schools but also with DCFS, DJJS, and DSPD in an effort to screen children sooner vs. later, promote access to community resources, and formulate plans that generate positive outcomes for the child and family.

The school-based services related to our Early Intervention Grant are provided directly by WHS.

Include expected increases or decreases from the previous year and explain any variance over 15%.

None expected.

Describe any significant programmatic changes from the previous year.

WHS is working on building a partnership with Midtown Clinic to have a therapist co-located in their facility. This is to provide mental health services and participants will have access to all other Early Intervention Services similar to school participants.

Do you agree to abide by the Mental Health Early Intervention Family Peer Support Agreement? YES/NO

Yes

32) Children/Youth Mental Health Early Intervention   *Leah Colburn/Nichole Cunha*

Describe the *Mobile Crisis Team* activities you propose to undertake and identify where services are provided. *Please note the hours of operation.* For each service, identify whether you will provide services directly or through a contracted provider. <u>For those not using MHEI funding for this service, please indicate "N/A" in the box below.</u>

Crisis services for Children will continue. A model of either Youth MCOT or SMR-Stabilization and Mobile Response Services or a Hybrid model will be provided in Weber and Morgan counties to children and youth experiencing escalating emotional symptoms, behaviors or traumatic circumstances that compromise their ability to function within their family, living situation, school and/or community environments. Youth MCOT and SMR models of service at the State level are still being formulated and decided at the writing of this response. Initially, the SMR services were triaged through DBH and the SMRT team will work flexible hours M-F with possible after-hours work. Therapist's and case manager/s will respond to calls based on needs after a triage call through the DBH/SafeFam phone line. Crisis services for SMR clients have been provided by the Weber Human Services MCOT team on evenings, overnights, weekends, and holidays. WHS 'intention is to continue a 24 hour crisis service for children going forward as stated.
Stabilization services may be offered based on family need and willingness to participate and a timeframe to be determined by need.
Services may include but are not limited to crisis intervention and/or assessment, instruction on de-escalation and coping skills, in-home therapy (both individual and family), case management services including linking and monitoring services not provided by local mental health providers.

Include expected increases or decreases from the previous year and explain any variance over 15%.
None expected.
Describe any significant programmatic changes from the previous year.
Crisis services for children will continue and we do anticipate some changes related to SMR/Youth MCOT and stabilization as we receive direction from OSUMH.
Describe outcomes that you will gather and report on. Include expected increases or decreases from the previous year and explain any variance over 15%.
Refer to SMR/MCOT Data Outcomes.

33) Children/Youth Mental Health Early Intervention   *Leah Colburn/Scott Eyre*

Describe the School-Based Behavioral Health activities you propose to undertake. Please describe how you intend to support family involvement in treatment. For each service, identify whether you will provide services directly or through a contracted provider. Please include: any partnerships related to 2019 HB373 funding and any telehealth related services provided in school settings. For those not using MHEI funding for this service, please indicate "N/A" in the box below.
We started this program with an award of $45,000.00 from the Division of Substance Abuse and Mental Health. We have since been awarded additional funds, state and federal, and currently provide this program to the Ogden School District. We serve clients within their district at a variety of their schools. Our FPSS also attend a few of their school meetings. We also have partnerships with two of the local Charter Schools. We continue to serve Medicaid, unfunded, and underfunded clients. WHS continues to partner with Morgan County and expand our service population to include adults and children with mental health needs.

Weber Human Services provides direct services to the unfunded/underfunded of our community with the primary focus on unfunded or those who have recently lost Medicaid. These clients continue to be provided with individual, family and group therapy and medication management services as needed. WHS provides all community individuals, on a walk-in basis, with a clinical crisis evaluation and screening to determine appropriate internal or external referrals for treatment. In most cases, referrals are made to external resources for treatment due to a lack of funding to treat this population in-house. Internal referrals are made for unfunded clients when deemed clinically necessary and services are authorized based on need. Our after-hours crisis service is also available to any individual on a 24 hour basis from any catchment area. |
| **Include expected increases or decreases from the previous year and explain any variance over 15%.** |
| WHS may serve fewer individuals in the schools due to districts hiring their own therapists. |
| **Describe any significant programmatic changes from the previous year and include a list of the schools where you plan to provide services for the upcoming school year. (Please email Leah** |

Colburn lacolburn@utah.gov a list of your FY23 school locations.)

We have trained and included telehealth services for our school-based population. WHS has also started a partnership with IHC Northern Pediatric Clinic to have 2 therapists located in their clinic and hope to expand this in the future to other Pediatric Clinics including Midtown Clinic.

Please describe how you plan to collect data including MHEI required data points and YOQ outcomes in your school programs. Please identify who the MHEI Quarterly Reporting should be sent to, including their email.

We have a designated case manager that assists with intake paperwork and data collection from the schools. MHEI quarterly reporting should be sent to Anna Lopez annah@weberhs.org and Christina Zamora christinaz@weberhs.or

34) Suicide Prevention, Intervention & Postvention   Carol Ruddell

Identify, define and describe all current strategies, programs and activities in place in suicide prevention, intervention and postvention. Strategies and programs should be evidence-based and alight with the Utah State Suicide Prevention Plan. For intervention/treatment, describe your policies and procedures for suicide screening, risk assessment, and safety planning as well as suicide specific treatment and follow up/care transition services. Describe how clients are identified for suicide specific services. How is the effectiveness of the services measured? Include the evaluation of the activities and their effectiveness on a program and community level. If available, please attach the localized agency suicide prevention plan or link to plan.

WHS continues the partnership with the State Suicide Coalition coordinator in the Zero Suicide Initiative. WHS has begun utilizing the 7 elements of Zero suicide in our agency and to direct our suicide prevention policies. WHS clinical supervisors provide supervision to therapists as well as trainings to other organizations to promote suicide prevention awareness and skills. WHS has started providing suicide prevention to all new employees. Through the use of partnerships we continue to provide prevention services to the community through NUHOPE and partnering with the Weber Morgan county health department. WHS has a designee that works with NUHOPE. When needed, WHS responds to community organizations who are in need of training or postvention involvement to help move forward. WHS has educated many partners in community of suicide prevention resources including local hospitals,Juvenile Justice Services, Law enforcement agencies, Fire Departments, Courts, local city workers, Shelter staff, local school district administration and local school personnel, and Aging Services. Currently, when a call comes, from a community provider, asking for service, the MCOT team is deployed. The MCOT team will meet with community providers and those that they serve in both a group and individual format to assess for risk and provide resources for those that have been affected. We continue to provide a brief suicide prevention training to new employees on a monthly basis. We have continued taking steps with clinical documentation and policy for safety plans to be completed in a timely manner and the Stanley Brown Safety plan is now part of our EMR. We have crisis worker availability 24/7 and this service is regularly promoted to community partners. We have developed a version of an ACT Team to work with our highest risk population to provide regular intervention and support. We continue to maintain a therapist at the McKay Dee Inpatient Unit to develop relationships with clients in the hospital and facilitate discharge planning. We have discontinued the PIP related to the C-SSRS and Staley Brown. WHS does not have an EBP for suicide specific treatment. WHS continues to promote EBPs for all clients including DBT, IMR, CBT-SA, Prolonged Exposure, Motivational interviewing and PEMFG to help in management of mental illness and suicidality.

WHS has a couple of identified staff to address suicide prevention responsibilities. WHS has maintained a suicide prevention committee since 2014 which is currently led by John Evans. Our representative for community events regarding suicide prevention/postvention is Kimalee Crookston. Anna Lopez is also a representative for suicide prevention. Previously Anna and Kimalee have attended Safe & Effective Messaging for Suicide Prevention trainings. Anna was previously trained as a QPR instructor although that has lapsed but she is currently trained in Safeside prevention. Kimalee provides Creating Safety training for our CM/FPSS. WHS offers Mental Health First aid.

The WHS MCOT has become proficient in postvention. We have been called on regularly to provide grief support for those who have lost loved ones in the community. MCOT is called on by law enforcement, schools, and other community agencies to provide this type of support. MCOT has worked with Prevention to develop a Coping with Sudden Death pamphlet to give out to families on calls.   WHS has established a community work group to develop a community postvention plan

Supervisors also provide postvention support to staff members who have clients pass away.

Guidelines

Response After A Completed Suicide of a Client

The following guidelines have been developed to aid surviving family members, other clients, and staff in the event of a death by suicide. Every case is unique and presents its own issues including legal parameters we must follow.

There are three groups who need assistance following a client suicide:

• The family

• Other clients (if they were acquainted with the deceased)

• Staff

Surviving Family Members

There is no greater anguish or suffering than that brought on by the suicide of a loved one. Clinical experience suggests family members are suffering the greatest shock and grief during the first few hours to days after a suicide. When allowed by law, we will need to gauge their receptiveness to telephone calls or visits from providers regarding their need for support, referral or treatment.

Recommended steps:

a. Upon learning of a client's death/suicide via family, obituary or in any way notify your Program Director and/or Clinical Director. The clinical director or designee will check client's record to see if there are any Releases of Information for any of the client's family.

b. If there is a Release of Information on record the Clinical Director or designee will consult with all Weber Human Services providers who have seen the client in the last 90 days. If designee does this they will brief the Clinical Director who will make the decision on whether it is appropriate to reach out to any family members where there is a Release of Information.

c. If the decision is made to contact any of these family members the Clinical Director or their designee shall call to express condolences and offer support. This call should be sincere and brief using simple, heartfelt language.

d. In addition to condolences, the family members may be offered a telephonic or face-to-face appointment (free of charge) to discuss the aftermath of the suicide. The appointment may either be with the client's former treatment provider or another Weber Human Service provider, depending upon clinical judgment. This is a time to evaluate the family members need for support services, or to determine if anyone is experiencing suicidal ideation - a frequent occurrence in survivors of suicide.

e. The family members should be offered available resources for suicide survivors including Survivors-of-Suicide Support Groups.

f. The Clinical Director, Clinical Supervisor, Clinician, or MCOT should again call to check in with the family between three and four weeks following the suicide unless sooner contact has been requested.

g. When there is no Release of Information in the client record for family members but family member(s) of the deceased client contact Weber Human Service about the suicide then staff this with your program director or Clinical Director.

h. In cases where there is no Release of Information and the deceased client's

family does not contact Weber Human Services, we are not to make any contact with the family, attend the funeral, or send flowers.

The following considerations are strongly recommended:

Ø Do not blame the family members for the suicide or in any way imply that they may have had an unseen hand in their family member's death.

Ø Do not imply or state that more could have been done. In the event it appears there may have been some negligence, do not suggest a treatment failure or preventable error occurred.

Ø Avoid becoming defensive and be prepared for anger that may be directed at you. Anger following a death by suicide is quite common, and should be understood and responded to therapeutically.

Ø Staff should only attend the memorial/funeral upon invitation and with approval. Confidentiality resides with the deceased.

Ø However badly any staff may feel about the client's death, it is important the family members not be exposed to the clinician's pain and grief. The family members may then feel obliged to be of help to the clinician, thereby avoiding their own necessary grief work.

Ø Because a person has completed a suicide does not give any staff permission to divulge harmful or personal clinical details to the family members.

Ø Since a completed suicide within a family increases suicide risk in the survivors, it is important to be proactive in our contacts with the family members, and to do everything we reasonably can to remove the curse and taboo of a completed suicide. If possible, surviving family members should be assessed for complicated grief reactions, depressive disorder and suicidal ideation.

 *Staff must record in the client record all interactions with family members

 Fellow Patients as Survivors

In some instances, a suicide will create "survivors" among other patients. Clearly, this death creates a risk factor for other patients who may already be suicidal. Therefore, staff should be cognizant of this fact and to take all reasonable action to forestall and prevent any "contagion" of suicidal ideation or action on the part of surviving patients as follows:

a)   Staff should try to avoid the spreading of rumors regarding the suicide. This can be done by containing the source of information about the suicide to a single authoritative person, preferably the Clinical Supervisor.

b)   Following a suicide leadership of the program should schedule a meeting of staff as soon as possible to discuss a plan for informing other clients as applicable and to debrief the incident.

c)   Clinicians whose patients know of the suicide should provide for this emotional crisis in their scheduled session, or schedule additional sessions so that this shock/grief can be expressed and dealt

with in a therapeutic fashion. A current suicide risk screening/assessment via the Columbia Suicide Severity Rating Scale should be completed

d)   The family should be consulted regarding any desire on the part of other patients or staff to have a memorial, donate money/flowers/food to the family.

e)   For previously suicidal or actively suicidal clients, the following steps are indicated, a) increase the number of sessions as desirable and b) investigate suicidal ideation and any exacerbation of risk. Generally, such extra efforts and attention need to be in place for at least 60 days following the death of a patient, and should be reviewed again at six months.

f)   Lastly, it is important to return to routine as quickly as possible and be reminded that the structure and usual comings and goings of staff and clients are both comforting and reassuring. Staff members may wish to use their own emotional barometers as a guideline for the interval at which time we are back to "normal routine." Clearly, a suicide by a person well known by other patients is hardly "business as usual," and we should never treat it this way.

 Staff as Survivors

 As mental health professionals, we are no different than others with respect to being survivors of suicide. We experience many of the same emotions as family members and friends, some of them even more acutely. For our own mental health and wellbeing, we need to be tolerant of each other's needs during these times and to be understanding, kind, and supportive.

 The following guidelines are suggested:

a)   Help your colleagues and yourself. The loss of a client to suicide is never an easy subject to discuss, but avoiding an obvious clinical fact is seldom helpful. Following a suicide, staff involved may experience feelings of guilt, or fear that their professional reputation has been damaged. It important to discuss these feelings with your supervisor or trusted colleague. It is important to support your colleagues and report any concerns you have about others following the death of one of their clients to program leadership so that we can reach out to him/her.

b)   Should staff begin to experience persistent ideation about the death, intrusive memories about the suicide, guilt, anger, numbing, avoidance or other potentially negative emotional reactions to the loss of a patient through suicide, consultation with your Clinical Supervisor is recommended. Otherwise, it is possible these post-traumatic emotional states *may impair clinical response and therapeutic judgment when working with other patient's at-risk for suicidal behaviors.* Following a client death by suicide, we have a personal and professional responsibility to work through these powerful residual emotions and come to a healthy resolution of them.

c) Staff may receive time off for bereavement as needed. Human Resources can also assist staff members with information related to EAP options for dealing with grief.

   **American Association of Suicidology has helpful resources for clinician survivors and others
    www.suicidology.org

N/A

Prevention Team (Samantha Tilton) Our implementation and sustainability plans involve continued collaboration among various community partners and local coalitions to spread suicide prevention messaging and resources, including connecting with resources, reducing access to lethal means, promoting connectedness, reducing stigma associated with asking for help and more. During year one of the Live On mini grant, we installed messaging in local grocery stores, hardware stores, schools, local businesses, and events throughout Weber and Morgan counties. We are also partnering to support the Suicide Survivors Day in our area, and providing materials to be distributed at the 4th Annual Utah Ride to Fight Suicide. For year two, we are leveraging our existing membership in the Weber Center of Excellence in building new partnerships with local agencies that provide opportunities for youth and families to experience the outdoors, in order to spread awareness of protective factors such as connectedness, family bonding, healthy lifestyles, as well as utilizing the events to share resources and information for suicide prevention, intervention, and postvention available in our community. Our messages of hope, help, and recovery are found throughout the community, and they continue to spread. We anticipate these types of partnerships with local coalitions, agencies, and

businesses will continue to allow us to sustain these efforts beyond the life of the grant. As more people become aware, more people want to get involved and help spread that awareness to others.

Plans for training those in the community and at WHS in Creating Safety and Playworks are underway. Interviews are underway with First Responders and MCOT to find out more about current postvention functions and identifying resources being used and those that are needed. WHS is also working with the organization of Bach Harrison to improve our data collection. The draft comprehensive suicide prevention plan is below:

https://docs.google.com/document/d/1OFBhBUtmakFjQyK7A2z_CGquER-C8sILT652zY2y4aM/edit?usp=sharing

For Local Authorities receiving mini grant funding for the Live On Utah statewide suicide prevention campaign, summarize your implementation and sustainability plans for the implementation of culturally appropriate suicide prevention messaging in your area.

For those not participating in this project, please indicate, "N/A" below.

These funds were allocated to our prevention team. In partnership with Weber Morgan Health Department and Northern Utah HOPE coalition, WHS is holding a Live On Night at the Ogden Raptors Game to increase messaging and information targeting adult males and the friends/family that support them, street flags displaying Live On messaging will be hung along Washington Blvd and Kiesel Ave in Ogden during the month of June, along with messaging in UTA buses during that time. We also have signage hung in local Morgan parks. As we've built partnerships, the messaging has spread. The Ogden Raptors have adopted Live On as their theme for the season and will include messaging throughout every home game. We have also bolstered partnerships with various community stakeholders who have interest in suicide prevention, and believe that these partnerships will sustain beyond the short-term grant funding.

35) Justice Treatment Services (Justice Involved)   *Thom Dunford*

What is the continuum of services you offer for justice involved clients and how do you address reducing criminal risk factors?

Weber Human Services has a Mental Health Court program to address those with legal charges and qualifying mental health diagnoses. With this they are offered individual therapy, group therapy, medication management, urinalysis testing, case management, and resources to connect them to housing.

Describe how clients are identified as justice involved clients

Lawyers can refer to the program for their clients if they feel they may have a mental health diagnosis. Clinicians at Weber Human Services can also refer if they find out their client has legal charges. Some referrals come from the jail as well if clients are identified that have a mental health diagnosis and could use the extra support.

How do you measure effectiveness and outcomes for justice involved clients?

Outcomes are measured by OQ scores as well as an exit interview completed at the end of their Mental Health Court treatment. These are tracked in an excel sheet with data from all participants.

Identify training and/or technical assistance needs.
Ongoing training is completed every year through attending a summit for different courts in order to receive updated training for all agencies involved in the Mental Health Court.
Identify a quality improvement goal to better serve justice-involved clients.
WHS is implementing the LSV tool that can be used across teams. Contacts have been made with community partners such as AP&P, and County Prosecuting Office, and the new Public Defender Director to coordinate screenings and referrals to MHC as well as coordinate care with clients who may be justice involved. The WHS Case Manager working in the jail on the reentry team has been able to assist with coordinating screenings and linking individuals to services. One option for individuals entering MHC from jail is upon release from jail, the client is transported by WHS staff to CTU to begin services.
Identify the efforts that are being taken to work as a community stakeholder partner with local jails, AP&P offices, Justice Certified agencies, and others that were identified in your original implementation committee plan.
All of our community partners are heavily involved in the clients' treatment as well as meeting every week that Mental Health Court meets. The different agencies work well together and communicate outside of court to help provide the best treatment for the clients involved.
Identify efforts being taken to work as a community stakeholder for children and youth who are justice involved with local DCFS, DJJS, Juvenile Courts, and other agencies.
WHS leads/attends the MAC meetings, recently began attending the DCFS 24 hour meetings, and we also attend MAS regularly with the above listed entities.

36) Specialty Services   *Pete Caldwell*
If you receive funding for a speciality service outlined in the Division Directives (Operation Rio Grande, SafetyNet, PATH, Behavioral Health Home, Autism Preschools), please list your approach to services, how individuals are identified for the services and how you will measure the effectiveness of the services. If not applicable enter NA

PATH-clients are identified through the following criteria— 1. Clients who are facing eviction from their home and are at risk of being homeless 2. Clients who are homeless and need assistance with initial expenses (deposit, first month's rent) to be able to get into an apartment Referrals come through a case manager, clinician or Midtown Health Center. This is tracked through UHMIS which documents how long the client has been homeless, barriers that they are facing, and placement in a stable housing environment.

Northern Utah Autism Program
NUAP serves clients in both Ogden and Davis school districts. Davis families make a referral to the program and are put on a waitlist. It is based on a first come first serve basis. We have a partnership with Ogden school district and clients are found through "child find". If it's determined that they are on the autism spectrum the district makes a referral to us. Once the client enters the program an individual recovery plan is created for the child and multiple tests and observations are tracked quarterly to ensure effectiveness of services. S.T.A.R, ELAP and LAP have been used but moving forward PEP-3 will be used. Daily record of precision commands is used to watch for progress.

List of evidence based practices provided to fidelity

Evidence-Based Programs within WHS as of June 2022

Name of Program	Fidelity Measure in Place	Number of Years in Use
1 2 3 Magic	Yes	4
Adolescent Community Reinforcement Approach	Yes	9
Aggression Replacement Training	Yes	20
Cognitive Behavioral Treatment for Substance Abusers	Yes	6
Critical Time Intervention	Yes	6
Dialectical Behavior Therapy	Yes	8
Family Check-Up/Everyday Parenting	Yes	3 months
Illness Management Recovery	Yes	10

Modular Approach to Treating Children with Anxiety, Depression, Trauma, and Conduct	Yes	1
Matrix Model	Yes	14
Moral Reconation Therapy	Yes	22
Motivational Interviewing	Yes	13
Outcome Questionnaire - Analyst	Yes	12
Prolonged Exposure	Yes	1
Psycho-Education Multi-Family Group	Yes	10
Seeking Safety	Yes	8

Policies for improving cultural responsiveness across agency staff and in services

WEBER HUMAN SERVICES

Medicaid Quality Assessment and

Performance Improvement Program

A. <u>Policy Making Body</u>: Executive Director, Chief Financial Officer, Director Clinical Services, Director Community Services, HR Director, Director of Compliance and Quality.

   1. Responsibilities

      a) Oversee the Quality Assessment and Performance Improvement Program (QAPIP)

      b) Appoints an official for administration of the program

  Current Appointment: Kevin Eastman, Executive Director

      c) Reviews quality improvement activities and minutes from all QAPIP sub-committees at meetings that are regularly scheduled once per week.

      d) Maintains written documentation of meetings.

      e) Reports regularly to the WHS Board of Directors about current quality and outcome activities.

      f) Other QAPI Responsibilities: Review all requirements of the WHS Prepaid Behavioral Health Plan Contract Special Provisions, determine WHS level of compliance with each provision, and make improvements. Areas of oversight:

           i. Performance Improvement Projects

           ii. Peer Review

           iii. Cultural Competency

           iv. Performance Measures

           v. Capacity

      vi. **Staff Selection & Retention**

      vii. **Staff Credentialing**

      viii. **Confidentiality**

      ix. **Fraud & Abuse**

      x. **Client Satisfaction**

      xi. **Preferred Practice Guidelines**

      xii. **Client Outcomes**

2. **Subcommittees**

   a) **Corporate Compliance Committee (CCC)**

      1) **Oversight: The CCC will keep minutes of each meeting.**

      2) **Members: See Corporate Compliance Plan.**

      3) **Meeting Schedule: Every working Monday (compliance topics taken up as needed)**

      4) **QAPI Responsibilities: The WHS Corporate Compliance Committee will review information derived from Medicaid Appeals and Grievances, specifically regarding any trends or barriers, and make recommendations regarding the improvement in the quality of services. At a minimum, the CCC will review Appeals and Grievances data for trends specifically related to individual employees, particular departments or programs, or specific business processes.**

   b) **Clinical Record Improvement Team (CRIT)**

1) **Oversight: The CRIT will keep written documentation of activities and make written reports to the QAPIP Policy Making Body bi-annually. All documentation is subject to review by State and Federal Officials.**

2) **Members: See Medicaid Peer Review Policy and Procedure**

3) **Committee will meet monthly.**

4) **Report of Findings:**

    i.   **A summary of all reviews will be developed by the CRIT and will be reported to the QAPIP policy making body at least bi-annually. Their findings will include the following components and specifically address the consistent application across all WHS personnel of these components.**

        1) **Accessibility of services**

        2) **Quality of services**

        3) **Adequacy of services**

        4) **Outcomes of services**

        5) **Under and over utilization of services**

        6) **Assess and verify that services were provided**

          7) **Implementation of preferred practice guidelines as developed by the Division of Substance abuse and Mental Health**

5) **Internal Development of Preferred Practice Guidelines:**

    i.   **WHS may develop or use preferred practice guidelines in addition to those developed by the DSAMH.**

    ii. **WHS will ensure that:**

        1) **They are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;**

        2) **They consider the needs of WHS's Enrollees**

3) They are adopted in consultation with contracting health care professionals; and

4) They are reviewed and updated periodically as appropriate.

c) Inclusion & Diversity (Cultural Competency) Committee

1) Oversight: The Inclusion & Diversity Committee will keep minutes of each meeting and make reports to the QAPI Policy Making Body at least annually.

2) Members appointed by the Executive Director.

3) The Inclusion & Diversity Committee will meet at least quarterly.

4) Responsibilities:

i. Develop a written Inclusion & Diversity Plan that includes at a minimum the following components:

1. Overall systems issues, including the establishment of a cultural competency committee to promote cultural competency, and participation in collaborative efforts with the Division of Substance Abuse and Mental Health and other providers to enhance cultural competency;

2. Human resource development, including staff recruitment and retention and staff training; and

3. Clinical issues, including treatment planning and delivery, and linguistic support.

ii. Oversee the implementation of the Inclusion & Diversity Plan.

iii. Report progress of the Inclusion & Diversity Plan to the QAPIP Policy Making Body at least annually.

B. Client Satisfaction

1. **Quality and Accessibility**

   a) **Instrument**

      1) **Youth: YSS, YSS-F**

      2) **Adult: MHSIP**

   b) **Procedures: Each year a sample of active clients will be surveyed using the MHSIP or YSS/YSS-F client satisfaction survey.**

   c) **Review and Reporting: The results of these instruments will be analyzed by the CQI Team and reported to the QAPIP policy making body and the WHS Board of Directors at least annually for review and action.**

C. <u>Performance Improvement Projects</u>: The QAPI Policy Making Body will oversee the implementation of clinical and non-clinical Performance Improvement Projects according to established Medicaid PIP protocols. As needed, the QAPI Policy Making Body will complete the following tasks related to the implementation of the PIPs.

   1. As required, conduct a study of current deficiencies in quality and access to care in order to select new PIP topics.

   2. Monitor the on-going process of the PIP to ensure that progress is being made sufficient to produce substantive improvements in the quality of care each year. This review will include a review of the most recent version of the PIP Project Completion Form.

D. <u>Performance Measures</u>: The QAPIP policymaking body will ensure that WHS maintains an initial contact data system that allows for tracking, monitoring, calculating, and reporting adherence to performance standards for first face-to-face services with initial contacts are made during WHS regular business hours, excluding initial contacts made to crisis services after-hours and on weekends.

   1. Initial Contacts: The QAPIP policymaking body will also ensure that WHS adheres to the Medicaid Performance Measure as they relate to timely access to first face-to-face services as outlined in the Medicaid contract and as described in the Initial Contact protocols. At a minimum, those protocols include the following components.

a) If the enrollee requires emergency services, WHS will respond to the enrollee within 30 minutes. If after this first response WHS determines that the enrollee still requires emergency services, WHS will offer a face-to-face emergency service within one hour.

b) If the enrollee requires urgent care, WHS will offer face-to-face services within a maximum of five working days.

c)   If the enrollee requires non-urgent care, WHS will offer face-to-face services within 15 working days.

d) When Medicaid Enrollees seek services from a subcontractor of WHS the client will first be assessed by WHS staff to determine treatment needs and eligibility; this first face-to-face appointment will be tracked by WHS according to the performance standards and reported to Medicaid. The performance standards will not apply when a client's request for face-to-face services is made directly with a subcontractor. They will also ensure that the Notice of Action Policies and Procedures and Notice of Action Protocols are followed as it relates to Notices of Action regarding performance measure deficiencies. It should be noted (see Notice of Action Protocol) that it is a policy of WHS not to maintain a waiting list for client appointments; the Notice of Action Protocol addresses staff responses to timely access to services. The following policies will govern the QAPI policy making body's oversight of the performance measures:

2.   Documentation: WHS will document all of the following components as a part of our performance measure compliance monitoring.

a) The date and time of all initial contacts.

b) Whether initial contacts requiring emergency services are by telephone or on a walk-in basis.

c)   The date and time of 30-minute follow-up clinical screenings for emergencies.

d) Whether WHS is able to offer a first face-to-face service within the required time frame and if not, the reason.

e) The date and time of any scheduled face-to-face appointments for outpatient emergency services, urgent care, or non-urgent care.

f)   For enrollees needing urgent care, information on getting emergency services was given to the enrollee with instructions to contact WHS if more immediate services are needed.

g) The status of scheduled first face-to-face appointments: if they are kept, broken, canceled, and/or rescheduled by the enrollee, or rescinded and rescheduled by WHS due to WHS limitations, and the date of any rescheduled appointments.

3.   Monitoring:

a) Appointed staff will monitor Emergency contact performance results on a regular basis and will notify the QAPIP policy making body of any non-compliance. Supervisors will also monitor employees' task list items that include information on performance measure non-compliance. Any trends by individual employees will be immediately addressed by supervisors. On a bi-annual basis, the QAPI Policy Making Body will review a written report outlining WHS compliance with performance standards for timely access to services and all Notices of Actions related to performance measures for the previous 6 months.

b) The QAPIP policy making body will be responsible for taking corrective action where appropriate for failure to comply with performance standards for timeliness of access to services.

c) WHS will measure and report to the UDOH as requested its performance on the timely access standards for the provision of face-to-face services.

4.   CMS, in consultation with states and other stakeholders, may specify performance measures. WHS will report on any and all performance measures required by CMS or the UDOH.

Inclusion & Diversity

2021 Report

Weber Human Services implements the following strategies in order to cultivate our agency's cultural awareness:

1.   We work to recruit and retain a diverse workforce, across all disciplines, which is reflective of our community.

a.   2021 Report: In 2021, WHS gave all employees significant salary increases to compensate for the drastic cost-of-living increases the area is experiencing. In July WHS gave a 4% increase. In December, WHS gave a $2000 bonus ($1000 to PT), and an additional $1.00/hr wage increase to all employees, which equated to about a 10% increase for the employees on the bottom end of the pay scale. This wasn't targeted specifically to improving the diversity of our workforce but it does make us an attractive place to work all types of employees.

2. We aim to establish and maintain a work environment that is welcoming and supportive to all employees and volunteers from all different backgrounds.

    a. 2021 Report:

        i. We identified 2 individual private bathrooms that are located in the basement for staff to use if they prefer.

        ii. We revamped our Cultural Competency Committee, now the Inclusion & Diversity Committee, to also include 2 Directors as a part of the committee to provide high level organizational support and visibility. We also opened up the committee membership to allow individuals to volunteer to be a part of the committee. We also created 5 Diversity and Inclusion "Aims" for WHS as an organization and as a guiding vision for the committee.

        iii. Presentation was given regarding transgender education and inclusion by Dr Candice Metzler.

        iv. Created a "Thanks to our Veterans" board where staff got to write their thanks to WHS Veterans.

        v. We added the ability to store and use a "Preferred Name" for employees.

3. We aim to establish and maintain a treatment environment that is welcoming and supportive to all clients from all different backgrounds.

    a. 2021 Report:

        i. We identified 2 bathrooms that are located on the main floor that we converted to family style bathrooms that can be locked for privacy.

        ii.   We revamped our Cultural Competency Committee, now the Inclusion & Diversity Committee, to also include 2 Directors as a part of the committee to provide high level organizational support and visibility. We also opened up the committee membership to allow individuals to volunteer to be a part of the committee. We also created 5 Diversity and Inclusion "Aims" for WHS as an organization and as a guiding vision for the committee.

        iii.   Presentation was given by Dr. Faith Thomas regarding person-centered communication and services while working with people with disabilities.

        iv.   Presentation was given by Cristina Neufeld, LCSW regarding Hispanic inclusion in clinical practice.

        v.   We have implemented a "Preferred Name" option for clients.

        vi.   WHS Website Changes:

    1.   More inclusive pictures were added to the website.

    2.   Language translation into Spanish was added.

    3.   Information about how to access ADA accommodations was added.

    4.   An Inclusion & Diversity landing page was added with our 5 "Aims."

4.   We work to identify and breakdown institutionalized racism and other forms of discrimination, and enrich the resources available to employees, volunteers, and clients of color and others from underrepresented groups, within established legal and budgetary constraints.

5.   We try to identify and break down barriers to accessing our services for underrepresented groups, and enhance that access through education and outreach.

a. **2021 Report: We provided office space right off of our main lobby to Latino Behavioral Health. We are working together to improve knowledge about and access to WHS (Behavioral Health and Aging resources) within the LatinX community.**

Weber Human Services

Cultural Competency Committee Goals for 2022

1. **Presentations for the year to include presenters from Urban Indian Center, Weber State University, and Jenny Taylor for Veterans. Panel discussion from different agencies regarding LGTBQ+ community.**

2. **Continue quarterly celebrations to include Cinco de Mayo.**

3. **Working on meeting Medicaid requirements regarding cultural and diversity inclusivity. Continue making changes within the agency to meet these requirements.**

Eliminating Health Disparity Strategic Plan" goals with progress

Health Disparities Goals and Action Plan

Weber Human Services

___Goal 1:___ **By the end of January 2022, WHS will update its website to better meet the needs of   the 4 target populations.**

	Please list all steps you will take to achieve this goal:	**The expected completion date for that step**	**Date the step was completed**
1	Increase the number of photos that more accurately reflect the increasingly diverse population living in Weber and Morgan Counties. At least one photo from each of the following populations will be represented: Transition-aged youth, LGBTQ+, People of Color, and individuals with developmental disabilities.	3/3/2022	

2	**The WHS website will use gender neutral language.** **Have IT go through the website and make changes where they he/she to they; may need to have Board approve language changes**	**3/3/2022**	
3	**The WHS website will be presented in plain language (6th grade reading level).** **Test WHS website to see current reading level; have IT update the language to 6th grade reading level; have board approve changes; finalize updates on website**	**3/3/2022**	
4	**Talk to Jed about posting Trevor Project flyer with suicide hotline in lobby; Look for Trevor Project flyer to post; post flyer** **WHS website will include LGBTQ+ hotline with crisis hotline. Trevor Project: 1-866-488-7386**	**3/3/2022**	**2/25/2022**

Goal 2: _Increase representation by giving office space that is accessible from the lobby to Latino Behavioral Health by the end of Sept. 2021_

Please list all steps you will take to achieve this goal:	The expected completion date for that step	Date the step was completed
1 Latino Behavioral Health will have office space accessible from lobby at WHS	9/30/2021	2/1/2022

Goal 3: _To foster an environment of inclusivity for the LGBTQ+ community, WHS will convert the two gendered bathrooms on the main floor into gender-neutral/family bathrooms as well as removing the gender identifiers from the two youth bathrooms by the end of March 2022._

Please list all steps you will take to achieve this goal:	The expected completion date for that step	Date the step was completed

1	**Within 6 months, WHS will convert two main floor standard gender-conforming bathrooms to non gender specific bathrooms.**	**1/1/2022**	**2/25/2022**
2	**Within 3 months, the two bathrooms on the youth team will be converted to Family Bathrooms**	**1/1/2022**	**2/25/2022**
3	**Going to talk to leadership if we can switch the signage on the bathrooms away from "family bathroom"**	**3/4/2022**	

Goal 4: **TENTATIVE: Create clear and easy statement on how to contact for accommodations**

before the first appointment and throughout services

Steps for Goal 4:

	Please list all steps you will take to achieve this goal:	The expected completion date for that step	Date the step was completed
1	Get approval to post instructions on websites	10/8/2021	2/25/2022
2	Add email to get an accommodation	4/1/2022	2/25/2022
3	Make the accommodation more noticable	5/20/2022	
4	Add an accommodation example	5/20/2022	

Goal 5: **Update lobby with more welcoming art for the target populations**

Please list all steps you will take to achieve this goal:	The expected completion date for that step	Date the step was completed

1	Talk to leadership about updating lobby for different groups	10/11/2021	10/11/2021
2	Look into art for different groups	11/1/2021	
3	Get feedback from workgroups	11/15/2021	
4	Send to Jed for approval & talk to Jed about budgeting	12/6/2021	
5	Purchase artwork		
6	Place in lobby		

Goal 6: Add Trevor Project line to website

	Please list all steps you will take to achieve this goal:	The expected completion date for that step	Date the step was completed
1	Place Trevor project flier in lobbies	12/31/2021	2/25/2022

Disaster Preparedness and Recovery Plan to coordinate with state, regional, and local partners in Disaster Preparedness Planning and Supporting Disaster Behavioral Health Response.

EMERGENCY PLAN

WEBER HUMAN SERVICES

237 26TH STREET

TABLE OF CONTENTS

SECTION 2 4

EMERGENCY OPERATIONS
……………………………………………………………………

SECTION 3

EMERGENCY SITUATIONS

APPENDICES

OVERVIEW

1.1 Introduction

This Emergency Plan provides procedures to be implemented when hazardous and other conditions affecting normal operations in the Weber Human Services (WHS) buildings either exist or are reported to be impending. These procedures are designed to minimize disruption of operations, injuries, or possible loss of life for employees, clients, and visitors. Any actions taken should be orderly, timely, and with consideration for the life and property of others.

1.2 Objectives

· To document procedures for dealing with emergency situations and conditions affecting the WHS clients, staff, and buildings.

· To define roles and responsibilities for key individuals in dealing with emergency situations and conditions affecting the WHS Buildings.

· To outline and define the communication procedure between WHS. Weber/ Morgan County Emergency Operations, and Weber/ Morgan Health.

· To ensure continuity of services, this includes an efficient and timely resumption of business processes.

1.3 Plan Structure

The Emergency Plan identifies both natural and man-made hazards which may impact employees and clients of WHS. It outlines the response and recovery activities that employees should follow if a disaster occurs. Employees should become familiar with this plan to facilitate an agency-wide integrated approach to emergency response, recovery, and mitigation.

Section 1   Overview: Provides introductory comments including objectives of the Emergency Plan.

Section 2   Emergency Operations: Provides instructions for notification and activation of key emergency response personnel, to include their roles and responsibilities. Additionally, this section includes a general evacuation plan.

Section 3   Emergency Situations: Defines potential emergency situations and interruptions to normal business processes and the appropriate response for each one.

Appendices: Provide additional information related to the Emergency Plan, including Building Security Procedures, the assigned Agency Incident Manager, a list of Area Response Managers, Building Evacuation Plan Drawings, and the Employee Information Line.

1.4   Assumptions

The Emergency Plan has been developed using the following assumptions:

· **Level of Detail:** A sufficient number of trained personnel will be available during and after the emergency to execute the Emergency Plan. The Emergency Plan is written at a level of detail that requires personnel familiar with WHS operations. Key staff will be trained in this plan two times per year and the plan will be reviewed and updated (as necessary) annually.

· **Common Responses:** The basic considerations in any emergency action plan are applicable for all types of interruption. These include a need for immediate notification and activation of the Emergency Plan, and a coordinated response.

· **Availability of Staff:** Employee welfare extends not only to the employee, but also to the welfare of the employee's family. Since WHS emergency response is dependent upon the employees, it is imperative that the employees' families are prepared in advance of emergency situations.

EMERGENCY OPERATIONS

2.1   Protocol for WHS Emergency Notification

2.1.1 Business Hours

· Any staff aware of a life-threatening emergency at any of the WHS facilities should call "911" to report the emergency.

· After contacting 911, Security should be notified and given the location and details of the emergency.

· Staff unable to call 911 should click on the Green Button icon at the bottom of their computer screen if accessible. This will notify Customer Service, who will attempt to contact staff and send Security to their location.

· Security will be trained in risk assessment and have the responsibility to contact the appropriate personnel as indicated by the level of hazard. Those incidents deemed by Security to be a threat to staff, clients, or property will be reported to the Agency Incident Manager (AIM). The AIM, after obtaining as much information as possible from Security and personally assessing the situation, has the responsibility of relaying that information to the Security Office at 801-336-6325 or two-way radio Channel #22.0 and activating the AIM Team if necessary.

2.1.2 Non-Business Hours

Any staff aware of any emergency situation involving imminent danger at any of the WHS facilities should call "911"and report the details of the situation. After contacting 911 and for all other after-hour emergency situations after 10:00 pm, the on-call crisis worker should be immediately contacted at 625-3700, and the Facility Manager Jeff Stark 801-866-8139 workers will then notify appropriate Administrative staff according to the phone list provided to them.

2.2 Activation of the AIM Team

Under the direction and authorization of the WHS Administration, the AIM will activate the AIM Team to meet in the designated Emergency Operation Center (EOC). This policy-making team would be retained to assist in the continuing incident action planning/response process. Members of the AIM Team are listed in the Appendices Section of this emergency plan.

2.3 Activation of Other Staff

In an emergency situation the AIM has the authority to activate other staff to stand ready to respond as directed.

2.4 General Evacuation Procedure

· In the event of an emergency, all occupants will proceed in a quick and calm manner out the nearest exit. Employees will assemble in the designated area outside of the building. Designated Assembly area is listed in the Appendices Section of Emergency Plan

· Upon notification of an emergency, staff will assist occupants to evacuate the building and assemble in the designated safe location outside of the building.

· After the building has been evacuated, staff will proceed to the Designated Assembly area and take a headcount of employees, and clients, then report the count to the AIM.

2.5 *Location of Emergency Operations Center*

In the event of an emergency, the AIM will immediately proceed to the designated EOC and contact the AIM Team. The center will have radio communication capability and other equipment deemed necessary for communication in emergency situations. The following locations are recommended:

· The first option will be the Admin Conference Room.

· The alternate location will be Room 128 in the main building.

- If neither of these locations are accessible, the AIM will determine the safest location for the EOC and notify the AIM Team and other necessary staff of its location.

2.6 Roles and Responsibilities

2.6.1 Director of Weber Human Services

The director of WHS is a member of Weber County EOC. The Weber County EOC is not only a location, but also has personnel with specific functional assignments. The County EOC comprises two teams: 1) Policy and 2) Coordination/Operations. The director of WHS serves on the Policy team and is the liaison between Weber County Emergency Services and WHS. The director assigns personnel from WHS to serve on the Weber County EOC's Coordination/Operations team. The on-call Crisis worker will be coordinating with AIM and WHS at the EOC on any request for additional crisis workers.

2.6.2 Agency Incident Manager (AIM) and AIM Team

Responsibilities prior to Emergency

- Oversee yearly training of emergency plans and evacuation procedures.

- Maintain a list of all employees who need to be assisted in an evacuation. This list shall summarize the accommodations made to assist these employees. This information must be kept current. The disabled person will be the best resource for the development of this plan.

·   Appoint an adequate number of individuals to assist each disabled person during an evacuation and arrange for them to receive the proper training for the purpose. In addition, plans must be made for the evacuation of visitors and temporarily disabled employees.

·   Oversee regular inventory of emergency supplies and make recommendations as needed to Administration for replacement or additional supplies.

Responsibilities during an emergency

·   Under the direction of Administration, the AIM will alert and activate the AIM Team. This will be accomplished by phone, radio, or via messenger.

·   AIM Team members will assemble in the EOC where an assessment of the situation will take place and assignments made. Members of the AIM Team are listed in the Appendices of this emergency plan.

·   Select staff to assist in emergency response.

·   Maintain communication with AIM Team, Security, and other assigned staff to ensure appropriate and safe care of all staff and clients impacted by an emergency.

AIM Team Responsibilities

·   The AIM Team, under the direction of the AIM, will be responsible for evaluating the overall impact of the incident based upon an initial assessment by Security and the AIM. They will assist in the continuing incident action response process as well as instruct other staff to aid in the response process.

· If the incident requires activation of the EOC, other staff will be contacted by telephone, radio, or messenger and informed that the EOC has been activated and that they should be ready to assist in the emergency response.

· Following the initial assessment of the incident, the AIM will brief the Administrative Office and recommend further response actions.

· The AIM will communicate directions and status to the building occupants, through assigned staff and actions to be taken. Updates will be provided as the situation warrants.

· When the emergency response situation has been resolved, the AIM will convene a meeting with appropriate personnel and Administrative officials to conduct an after-action review and make recommendations to improve future responses.

2.6.3 Staff Assigned by AIM

· Follow direction of AIM and AIM Team in an emergency.

· Keep open lines of communication with AIM and Security via phone, two-way radio, or messenger.

· Keep AIM appraised of status during an emergency response.

2.6.4 Medical Team

In the event that the WHS Emergency Operations Plan is activated, the medication management clinic and pharmacy will respond with the following protocol:

· Medical Team Staff will follow general evacuation plans as directed. They will gather together outside in South East Parking, and wait to assist with any medical needs.

· The Med Room (Room 170) will become the Triage Area if it remains intact and out of danger. The Medical Director (or designee) will designate an alternate location for the Triage area if the Med Room cannot be utilized. The Medical Director (or designee) will become the Triage Officer.

· If the Triage Area is designated outside the Med Room, the nursing supervisor (and/or designee) will transport Emergency Medicine supplies and all injectable medications from the Med Room (if accessible) to the Triage Area.

· The Medication Management staff will remain in and around the Triage Area and serve as directed by the Medical Director until they are released.

· Pharmacy Staff will gather the filled pill boxes in bins for mobilization; they will then exit quietly out of the building with the bins and wait for further instruction and be accounted for.

· The pharmacist will mobilize any emergency medications deemed appropriate, ensure all pharmacy staff are evacuated, lock the pharmacy, and report to the designated Triage Area.

2.6.5   Employees

· All WHS staff are expected to be familiar with evacuation procedures.

· All WHS staff are expected to be familiar with the emergency plan and available to aid in response in any emergency if requested by the AIM.

· WHS staff are expected to take necessary steps to prepare their families for emergencies, allowing them to be available to respond.

· If an employee is the first to become aware of an emergency situation, and the employee thinks that there is imminent danger to employees or clients, he/she should immediately follow the Protocol for WHS Emergency Notification.

· If there is an emergency but it does not pose a threat of imminent danger, he/she should notify Security at 801-336-6325, or 801-866-8139.

· After making proper notification of the emergency situation, employees should assist others. This may involve caring for injured workers or clients. Employees will then follow the directions provided through the AIM or designated staff.

· In the event of evacuation, employees will exit out the nearest exit and gather in their Designated Assembly area.

2.7   Coordination of Emergency Services between Weber Human Services and Weber County Emergency Operation Center (EOC)

In the event of a county-wide emergency, WHS falls under the responsibility and direction of the Weber County Emergency Center (EOC) Facility. This facility will be located at the Sheriff's Complex, 721 West 12th Street. The Weber County EOC comprises two teams: Policy Team and Coordination/Operations Team. The Director of WHS serves on the Policy Team. The Director will assign a representative from WHS to serve on the Coordination/Operations Team. The Policy Team will meet in the Sheriff's Conference Room. The Coordination/Operations Group will meet in the Training Room and will utilize the alternate dispatch center for operational communications.

A backup or alternate County EOC will be located at the Weber Center, 2380 Washington Blvd., Ogden, Utah, in the Commission Chambers. The Policy Group would meet in the Breakout Rooms on the south side of the chambers. Coordination/Operations would also meet there as well. The Conference Room (room #108), on the north side of the chambers would be used for a Joint Information Center (JIC). Computers in the adjacent training room would be available to support both the JIC and the EOC. Telephone lines to both areas are in place and could be used to help support the communications function.

EMERGENCY SITUATIONS

Staff aware of emergency situations should follow the Protocol for WHS Emergency Notification (Section 2.1). There are a number of situations that may occur and require the activation of this Emergency Response Plan. Some situations may be weather/nature related while others will result from the actions of individuals. Due to the nature of the business conducted by employees of WHS, there exists the potential threat of activities which may be harmful to employees and/or buildings. While impossible to predict or prepare for every emergency situation, we must be aware of those most likely to affect WHS business operations. An appropriate response to any emergency situation is essential to the safety and security of employees.

Following are the situations which are most likely to occur and the appropriate response for each. Essential to the timely response to any emergency situation, are the actions of the agency's trained emergency managers and the cooperation of every employee in the WHS buildings.

3.1   Hostage/Hostile Client Situation

Hostile client situations may develop in several ways. An employee may be aware of a client making threats against the WHS employees or other clients. These threats may be conveyed over the telephone or in person.

An employee who becomes aware of a client visiting the office who has made threats against employees or other clients must:

- Notify Security of the situation. Security will contact the AIM.

- Give the date and time of the expected office visit.

· Give other details as known, such as names of meeting participants and the

circumstances of the meeting.

· Assist in isolating the incident from other persons in the building.

When the AIM has been informed that there is a potential for a Hostile Client situation, or that a Hostage/Hostile Client situation is in progress, the AIM will:

· Take immediate emergency actions deemed appropriate and notify Administration.
· Assist in isolating the incident from other persons in the building.
· Arrange for appropriate announcements to be made to building employees.

If an employee is taken hostage, the employee should:

· Keep Calm.

· Do what the hostage taker/hostile person tells them to do.

· Not argue/antagonize the hostage taker/hostile person.

· Remember that it is important that the hostage taker/hostile person see the employee as an individual.

· Attempts to set up a positive bond between themselves and this person.

3.2 Bomb Threat

A bomb threat may be received by telephone, messenger, or mail. The following actions should be followed:

- TELEPHONE CALL

    - Handle the telephone call calmly and courteously. DO NOT ATTEMPT TO PLACE THE CALLER ON HOLD. DO NOT ATTEMPT TO TRANSFER THE CALL.

    - LISTEN FIRST. Ask questions later.

    - TAKE NOTES on the content of the call. Questions that should be asked:

1. When will the bomb explode?

2. Where is the bomb located?

3. What kind of bomb is it?

4. What does the bomb look like?

    5. Why was the bomb placed?

    - After the caller has hung up, call Security. Security will immediately contact the AIM.

    - Complete the "Bomb Threat Call Checklist" which should be kept close to the telephone.

- BY MESSENGER.

    - Ask the messenger the following questions:

1. When will the bomb explode?

2. Where is the bomb located?

3. What kind of a bomb is it?

4. What does the bomb look like?

5. Why was the bomb placed?

> · Call Security and notify their supervisor.

> · Complete the "Bomb Threat Call Checklist" which should be kept close to the telephone.

· BY MAIL. Report the information to Security. Security will contact the AIM.

· SUSPICIOUS ARTICLES. A person finding a suspicious article, such as a briefcase or backpack, left unattended should avoid touching or handling it and should immediately notify Security. If the suspicious article cannot be identified after several minutes of checking with other employees, Security will treat it as a bomb and alert the AIM.

· RESPONSES TO BOMB THREAT SITUATIONS.

> · When a report of bomb threat affecting the WHS Buildings is received by the AIM, he/she will immediately determine what actions have been accomplished so far, complete any necessary notifications and recommend to the Administrative Office that the building be evacuated as soon as it is safe to do so.

> · All evacuation routes should be searched for suspicious items. Supervisors should assist in this effort because they are familiar with the building and can assist in identifying unusual or suspicious objects.

· The order to evacuate the building will be authorized through the AIM and announced to employees through assigned staff.

· Employees MUST leave the building in a calm and orderly manner, and report to their Designated Area to be accounted for and await further instruction.

3.3   Earthquake

Earthquakes have a strong probability of occurrence in Utah and take place with little or no warning. Preparation for their occurrence is important including informing employees to comply with the following directions:

· IF YOU ARE INSIDE, STAY INSIDE Drop Cover Hold.

· IF YOU ARE OUTSIDE, STAY OUTSIDE away from buildings and power lines.

· AFTER THE QUAKE STOPS, STAY IN THE BUILDING. Secondary shock waves may make hallways and exits hazardous. The Administrative Office and Property Management staff will determine building damage.

· WHEN IT IS SAFE TO EXIT THE BUILDING,

· If the fire alarm sounds, proceed quickly to your assigned exit as for a fire drill and carefully proceed outside, watching for falling objects.

· All staff should report structural or window damage to Administration at 625-3601 or to Security 801-336-6325 who will forward the information as appropriate. Minor interior breakage will be noted during a complete inspection and need not be reported.

3.4 Tornado

A tornado affecting the WHS Buildings is most likely to occur during the time period from late spring to early fall (April through September). Generally, there will be little, if any, warning. At best, weather forecasters may warn of violent thunderstorms and/or conditions that may be conducive to forming tornadoes. These warnings should be taken seriously. Following simple common sense and directions can help to prevent injuries.

·   **IF YOU ARE INSIDE, STAY INSIDE** in a permanent doorway or under a desk and away from windows which may shatter.

·   **IF YOU ARE OUTSIDE, TAKE COVER** in the nearest permanent building. If it is not possible to get into a building, stay away from non-permanent buildings, trees, and power lines. Do not try to outrun a tornado in an open area; rather, lie flat on the ground in the lowest spot available until the tornado has passed.

·   **AFTER THE TORNADO HAS PASSED, STAY IN THE BUILDING.** The threat of additional tornadoes, as well as downed power lines and other debris, may make leaving the building hazardous. The Administrative Office and Property Management will determine building damage.

·   **WHEN IT IS SAFE TO EXIT THE BUILDING,** an announcement will be made by the AIM to calmly exit the building.

·   The AIM, Property Manager, or any staff noticing structural or window damage should report damage to the Security or Administrative Office at 801-336-6325.

3.5 Fire

A fire affecting the WHS Buildings may occur at any time, and without warning. Consequently, there is little that can be done to prepare, but following simple, common sense and directions can help to prevent injuries.

· When the fire alarm sounds, ALL employees and visitors must proceed quickly to the closest exits as for a fire drill and carefully proceed outside <u>to Designated Area.</u> Once outside, employees shall gather in the assigned areas for accounting and remain outside until given further instruction from the AIM or designated staff.

· Once outside the building and staff are in the designated Assembly Areas, staff will coordinate with the AIM to aid in accounting for all employees and visitors.

· The Ogden City Building Inspector and/or Fire Marshall will determine when it is safe to re-enter the WHS Buildings.

· The AIM or designated staff will inform staff when it is safe to re-enter the building.

· Employees will be notified through their supervisors of alternate work locations if the WHS Buildings are not fit for occupancy.

·

3.6   Possible Exposure to Anthrax

In recent times, there have been incidents (<u>most of which have turned out to be hoaxes</u>) involving the distribution of Anthrax bacteria. This bacterium has been distributed through the mail in the form of a crystalline or powdery substance. Anthrax is a deadly disease that may be spread by contact. Since such an incident may occur at any time without warning, there is little that can be done to prepare. However, complying with the following simple procedures will prevent further contamination:

If an employee opens an envelope or a package containing a message indicating that they have been exposed to anthrax (a crystalline or powdery substance may or may not be seen or noticed), they should do the following:

- Remain calm.

- If in a room/office, immediately close all doors.

- If in a cubicle area, ask others in the immediate area to leave the area, but not the floor.

- Notify Security. Security will contact the AIM to report an anthrax threat has been received. Also, inform Security whether the substance was in an envelope or package, and how many employees possibly have been exposed. Office location and phone number should also be reported.

- Move away from the envelope or package and any suspected substance, but do not leave the room or cubicle area. Notify the supervisor and ask that entry to the work area be restricted until Security and/or the AIM arrives. Other employees should stay away from the contaminated area, but remain in the building until told otherwise.

· If an employee suspects that they have been exposed to a powder or other substance, they should not touch their face or attempt to clean up their desk or countertop. If a sink is available in the area, the employee should wash their hands, arms, and face with soap and water.

· Wait for instructions from the AIM.

Security when informed of the anthrax threat will:

· Immediately notify the AIM of the anthrax threat, giving as much information as obtained from the employee.

· Restrict entry to the affected work area until AIM arrives.

· Request that other employees remain in the building until told to evacuate.

· Await further instructions from the Building AIM, or other emergency responders.

The AIM, when notified of a possible exposure to anthrax, will immediately do the

following:

· Request to secure the area. A decision should also be made as to evacuation of employees from the rest of the floor to minimize the possibility of contamination, but employees should not leave the building.

· Notify the Administrative Office (625-3601) that an anthrax threat has been received, and the actions being taken.

· **If possible, shut down the building air handling units to minimize the possibility of contamination.**

· **Wait for instructions from outside emergency responders.**

There is a high probability that the anthrax threat is only a hoax, but every precaution will be taken to insure the safety and well-being of employees.

· **It may be necessary to decontaminate employees at the scene; this will be done by professionals, or employees may be given an opportunity to shower. If this occurs, employees will be provided with clean clothing.**

· **Employees may also be sent to a designated hospital for evaluation. Antibiotics may be recommended until laboratory tests are completed (normally within 24 to 72 hours).**

3.7   Other Emergency Situations

There may be situations occurring outside of the WHS Buildings, but which may affect the ability of the building occupants to carry out normal business operations. In the past, such incidents have occurred in buildings and areas in close proximity to the WHS Buildings. There have also been incidents involving noxious fumes being brought into the building by the ventilation system. It is imperative that an appropriate response for these incidents take place to avoid injuries and ensure an efficient resumption of normal business operations.

Any employee who becomes aware of a situation outside of the WHS Buildings that may have an affect on the ability of building occupants to perform normal business functions should report that information immediately to Security. Security will contact the AIM.

The AIM will immediately attempt to confirm the situation and determine the response level necessary for the situation. The AIM will then apprise the Administrative Office of the situation, including recommendations for an appropriate response.

Upon approval of the Administrative Office, the AIM will inform the building occupants of the situation, through a general communication system or through assigned staff, the course of action to be followed.

APPENDIX 1

BUILDING SECURITY

The WHS building is designated as a public building and is a Weapon Free Facility. Controlled access is accomplished in the following ways:

BUILDING ACCESS:

- **Access for visitors and clients is limited to the public access doors by Customer Service.**
- **Staff can access the building through main public doors, or through locked doors if they are provided with the appropriate key/fob to enter.**

EMPLOYEES: Issuance of an employee identification badge is distributed through the Administrative Office. Employees will also receive the appropriate keys from Security. (Cost for replacement of a lost identification badge is $3.50 and the key is $10.00)

CLIENTS: Clients are expected to check in at the front desk for appointments with staff. Customer Service will give them a slip to take to the staff they are meeting with. Any clients showing for an appointment without a slip from Customer Service should be escorted back to Customer Service to check in by the staff they came to see.

APPENDIX 2

AIM, AIM Team, and Designated Evacuation Area

APPENDIX 3

WEBER HUMAN SERVICES

BUILDING EVACUATION PLANS

APPENDIX 4

EMPLOYEES MESSAGE LINE

In the event of a global emergency affecting Weber County as well as WHS, the following system has been established to facilitate communication between entities. All Weber County offices have access to this domain.

Evacuation procedures should be followed:

     Step 1: You will be asked to leave the facility.

     Step 2: Call forward your department's main line to .

     Step 3: Leave the building through the closest exit, gather in the Designated Assembly Area, assist in accounting for staff in the assigned area, and check in with the AIM or assigned staff.

     Step 4: Staff should Text   every 30 minutes for updates on the situation. There is only one line reserved for this function. Frequent busy conditions should be expected.