

Weber Human Services

FORM A - MENTAL HEALTH BUDGET NARRATIVE

3 Year Plan (FY 2024-2026)

Local Authority: Weber Human Services

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) Inpatient Services

Adult Services

Pam Bennett

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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. Twenty-one 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 coordinate 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 looks to utilize our Crisis Transition Unit whenever appropriate versus Inpatient Care. WHS utilizes McKay-Dee's 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 focus 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. Case managers work to track clients that are new to Weber when they are released from the hospital. Their responsibility is following up with these clients and to assist in getting them engaged in services within 7 to 30 days. If the client has not participated in an intake after two phone outreaches a case manager will complete a physical outreach. If an existing client does not show up to their

scheduled appointment upon release from the hospital, the therapist will complete a phone outreach during that scheduled time. If the phone outreach is not successful, they will make another attempt within 7 business days. If at that time we still have not made contact with the client, we will have a case manager complete a physical outreach. We have supervisors on the adult mental health team that monitor this process.

Children's Services

Leah Colburn

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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. 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.

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 has a case manager who follows up on each individual transitioning from the inpatient unit to outpatient care. While on the inpatient unit, youth are staffed at a weekly coordination of care meeting where a prescriber, case managers, psychologists, supervisors, and SMR attend. They are again staffed post discharge 2-3 weeks to ensure attendance with follow up care. Phone and/or face to face contacts are made by the case manager to caregivers to ensure attendance at follow-up appointments. The CM is assigned to these clients at least 6-8 weeks post-inpatient to address barriers to attending treatment, access additional resources, and monitor compliance with follow-up care. Upon discharge, WHS will update the level of care needed for the client..

2) Residential Care

Adult Services

Pam Bennett

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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 also has the capacity to offer a 23 hour bed program for clients in crisis who need short-term support to refocus and stabilize. CTU staffing is maintained for clinical coverage seven days per week including support from MCOT. Clients meet with their primary clinician three times per week. They meet with the prescriber at least weekly.

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. [Up to 2 beds can be used for clients coming from the Access center who are non-Medicaid. MCOT workers](#) utilize the CSSRS, the LOCUS and the CALOCUS to help determine the level of care of crisis clients. [MCOT workers are cross-trained to assist the CTU program as needed.](#)

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, [additional crisis response planning is completed and reviewed with clients during CTU placement to help determine ongoing need.](#)
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. [The benefit of CTU placement is considered daily through interdisciplinary discussion involving treatment team partners.](#)

[The CTU supervisor focuses on communicating to others in WHS of CTU accessibility ways and means via email, specific team training, supervisor training, and having community liaisons communicate regarding access criteria \(i.e. inpatient liaison, MCOT, USH liaison, case management supervisors\) to community partners.](#)

Children's Services

Leah Colburn

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. [Please identify your current residential contracts. 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 Community-based Residential Treatment Settings (i.e. Utah Youth Village, Chrysalis, and Rise). Weber Human Services recently contracted with Wasatch Behavioral to access their youth residential program for youth ages 12-17. 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 has experienced difficulty in contracting with a residential facility. WHS recently initiated a contract with Wasatch Behavioral Health for Youth residential services to provide an option if that level of care is needed.

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 higher levels of care 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.

3) Outpatient Care

Adult Services

Pam Bennett

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Define the process for referring an individual to a subcontractor for services. Include any planned changes in programming or funding.

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 use disorder 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, DBT, and Unified Protocol. 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 now has a therapist that goes to all the skilled nursing facilities in Weber County. Visits occur several times a month in each facility. There is 1 therapist and 1 case manager who help with the mental health needs in the different facilities. We also have a prescriber assigned to help with the medication needs of the clients in the SNF. Weber has a liaison that helps to coordinate SNF referrals and checks to see if they have Weber County Medicaid. If not, she helps SNFs get the paperwork completed and sent to DWS so we can serve the client. The SNFs staff reach out to the assigned

therapist if there are concerns with client's behaviors between visits. The number of individuals served in nursing homes has increased significantly over the past year.

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, especially those that are unfunded and work with them to get connected to Medicaid or funding when possible.

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 support 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 Council, the local Coordinated Entry Committee, and the Weber County Reentry Coalition. 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 have 30 vouchers for the chronic homeless population that WHS clients could apply to use.

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. WHS also provides residential and group home services to address needs for different levels of care. [WHS offers several evidenced based practices that address individuals who have complex behavioral health needs such as Illness Management Recovery, Dialectical Behavior Therapy, Multi-Family Group Therapy, Unified Approach, and Prolonged Exposure Therapy. We have a robust supervision plan that monitors fidelity to these models and looks at outcomes.](#)

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.

We generally have two programs to which civilly committed clients are assigned.. For clients that are

unfunded and do not have Medicaid they are assigned to the AOT team which includes a therapist and a case manager. Those that have Medicaid are assigned to a therapist and the CTI case management program. Each of these programs have extensive case management services that can provide outreaches multiple times a week as needed. When appropriate these clients are referred to the EBP's that are appropriate to their diagnosis and as a result they are having multiple contacts each week. Each of these teams have a weekly staffing. These clients are added to the outreach list if they have not had an IT session within 30 days which helps hold everyone accountable. During these meetings we can brainstorm barriers and identify next steps.

Children's Services

Leah Colburn

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. Define the process for referring an individual to a subcontractor for services. Include any planned changes in programming or funding. *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) [1,2,3 Magic \(a parenting approach\)](#), and 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 age population. [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. Weber Human Services utilizes tangible incentives and praise to encourage active participation by clients and guardians. Case Managers and FPSS can be assigned to address any treatment barriers with families.](#)

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 monthly group supervision for all EBP models. Audio recordings and "direct line of sight" supervision are used to ensure adherence to the model/s.

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 coordination of care meeting where clinicians, supervisors, psychologists, Family Peer Support Specialists, SMR and CM's 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. The Youth Team also offers a variety of evidence based practices that address complex behavioral health issues. These EBPs include but are not limited to Aggression Replacement Therapy (ART), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) 1,2,3 Magic (a parenting approach), and MATCH (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems) across the youth team. The supervision model on the Youth Team includes fidelity monitoring for each of the practices.

4) 24-Hour Crisis Care

Adult Services

Nichole Cunha

Please outline plans for the next three years for 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 currently provided in your area, 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 DHHS systems of care, law enforcement and first responders, for the provision of crisis services. Include any planned changes in programming or funding.

Emergency services are provided by the Utah Crisis Line 7 days a week (988), 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. This 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 hospital authorizations when needed to help determine an appropriate level of care and make authorization decisions if medical necessity is met. MCOT works expeditiously to make these decisions and to utilize community supports when needed. 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 continues to communicate and provide access training to law enforcement, EMS services, and other community partners on how to access and utilize MCOT services,

Describe your current and planned 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 and key performance indicators are available if needed, please describe any areas for help that are required.

Weber Human Services will continue to utilize state-wide data requirements related to MCOT to evaluate the effectiveness of our crisis services. Data is collected from calls that are received from the crisis line (988) and from local dispatch. [Several data points are gathered for every contact. The WHS MCOT Team will remain in place over the next three years with ongoing funding. WHS may need to increase personnel on the MCOT team depending on volume of calls and the ability to respond in a timely manner \(according to MCOT guidelines\).](#)

Children's Services

Nichole Cunha

Please outline plans for the next three years for 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 currently provided in your area, 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 Crisis Outreach Teams, facility-based stabilization/receiving centers and In-Home Stabilization Services](#)). Including if you provide SMR/Youth MCOT and Stabilization services, [if you are not an SMR/Youth MCOT and Stabilization 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 for services to include the Utah Crisis Line, JJYS and other DHHS systems of care, law enforcement and first responders, schools, and hospitals for the provision of [crisis](#) services to at-risk youth, children, and their families. Include any planned changes in programming or funding.

Emergency services are available 24 hours a day through the Utah Crisis Line (988), 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 988, 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 current and planned 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 and key performance indicators are 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. Data requirements for MCOT will be utilized to help determine effectiveness of the team.

5) Psychotropic Medication Management

Adult Services

Pam Bennett

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. *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.

WHS coordinates with other medical providers to ensure a smooth transition between levels of care for our clients. WHS has an Inpatient Coordinator who coordinates all medication management issues with our outpatient and residential teams. WHS has a prescriber and nurse who coordinate care at our

Crisis Transition Unit (Adult MH residential facility). WHS also has a primary care clinic and coordinates care with our behavioral health prescribers. Our Medical Team staff work diligently to ensure that our clients receive the best coordination of care when other providers are involved.

Children's Services

Leah Colburn

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. *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. WHS coordinates with other medical providers to ensure a smooth transition between levels of care for our clients. WHS has a Youth Inpatient Coordinator who coordinates all medication management issues with our outpatient and residential teams. WHS also has a primary care clinic and coordinates care with our behavioral health prescribers. Our Medical Team staff work diligently to ensure that our clients receive the best coordination of care when other providers are involved.

6) Psychoeducation Services & Psychosocial Rehabilitation

Adult Services

Pam Bennett

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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 4 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 worker who works afternoons 12:00 PM to 8:00 PM Saturday through Wednesday 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 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.

Children's Services

Leah Colburn

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

Psycho-education Services and Psycho-social Rehabilitation Services are offered in early intervention programs as well as traditional outpatient mental health programming. We will continue to partner with the three area school districts; Ogden City Schools, Weber County School District and Morgan School District as well as Pediatric clinics to provide these services. We partner with Weber State University BSW students via their internship which provides them the opportunity to work directly with our clients in the school and/or community setting. WHS will continue to offer a year round weekly skills development group and individual skills development.

Updated on 7/6/2023—We have re-initiated an adolescent skills development group over the past month. This group will provide ongoing psycho educational material and can be a resource for respite care (2 hour group in which parents can leave adolescents). This group also includes a practice component in the community.

We expect to increase the participation in our children's skills group as we implement the family first model in conjunction with our women and children's residential (Tranquility Home). We also continue to use Archway for respite services up to 24 hours.

No expected changes to budget or numbers served. Weber Human Service does want to increase the number of clients served.

Describe how clients are identified for Psychoeducation and 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. It is also measured by clients being connected to community resources that clients can continue to engage in even upon discharge from treatment.

Clinical charts are routinely audited for services. Part of which is looking at access and utilization of this service.

7) Case Management

Adult Services

Pete Caldwell

Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.

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

Children's Services

Pete Caldwell

Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.

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 and FPSS 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.

There are no planned changes in funding. Weber Human Services does expect to increase the number of clients served.

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).

Over the next three years, each client referred to Skills Development Services or Respite will be asked to complete a thorough needs assessment with clients and/or guardians.

8) Community Supports (housing services)

Adult Services

Pete Caldwell

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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 130 beds in the community that WHS has been able to access. 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 case manager who monitors clients on a daily basis and conducts daily groups there. 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 and women's group homes. A part-time position was established so the home monitors are paid positions.

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](mailto: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, the CSSRS and do UA's on a regular basis to indicate progress and outcomes. DLA scores indicate areas of need and are reviewed regularly to determine continued need.

Children's Services (respite services)

Leah Colburn

Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.

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 ages 10 and up. They continue to provide needed Respite for our youth and families in need.

There are no planned changes in funding. Weber Human Services does expect to increase the number of clients served.

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.

9) Peer Support Services

Adult Services

Heather Rydalch

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

WHS has a total of 4 peer support staff for adult mental health services. The AOT program has 1 peer, the MCOT program also has 1 peer, and the STEPS program has 2 peers on staff. 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. The AOT PSS works with AOT clients, Mental Health Court clients and clients referred over by the Adult Team Therapists. The AOT PSS has started to do a PSS group with the clients living in our

Secure Housing Initiative Program (SHIP). They will provide both individual and group services.

Describe how clients are identified for Peer Support Specialist 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 peer support services are needed, a referral form is sent to our PSS supervisors who assigns the case to a PSS. The assigned PSS completes a needs assessment and provides services based on need

Children's Services

Leah Colburn

Describe the activities you propose to undertake over the three year period 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, DJJYS, DSPD, and HFW. Include any planned changes in programming or funding.

The Youth Team currently employs 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 as well as attend meetings with community partners at families request..

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

Over the next three years Weber Human Services will hire and train a FPSS that specializes with the early childhood population 0-5. This FPSS would work closely with both the youth outpatient team and the Women and Children Substance Abuse program.

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.

10) Consultation & Education Services

Adult Services

Pam Bennett

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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 Multi-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 available at several community events where difficult circumstances (primarily suicides) are being processed.

Children's Services

Leah Colburn

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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 area school districts. We provide clinical consultation and support to area schools. 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 will continue to 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. 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.

11) Services to Incarcerated Persons

Pam Bennett

Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.

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.

12) Outplacement

Adult Services

Pam Bennett

Describe the activities you propose to undertake over the three year period with outplacement funding, and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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.

Children's Services

Leah Colburn

Describe the activities you propose to undertake over the three year period with outplacement funding, and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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.

Outplacement funds will be used to assist parents/guardians with transportation to USH. Step down/transition to home options may include: day treatment programming, recreational activities, respite services. Services are both with WHS and contracted providers.

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

13) Unfunded Clients

Adult Services

Pam Bennett

Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.

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 4 sessions of therapy for those who do not have Medicaid. Family Counseling Services has a grant to help fund ongoing sessions if needed. 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.

Weber Human Services complete screenings for unfunded clients and provides vouchers for these clients to receive up to four therapy sessions at family counseling services.

Children's Services

Leah Colburn

Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.

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 and Pediatric Clinics we have been able to serve their unfunded population with the Early Intervention Funding. Children and Youth who are unfunded can also be referred to Family Counseling Center for up to 4 sessions via a voucher from WHS. The Family Counseling Center has some funding to provide ongoing services if needed.

There are no expected changes in funding.

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

Weber Human Services reviews eligibility in-house/out of house. We typically utilize early intervention dollars for those who are not covered. CMs, FPSSs will assess coverage needs and help connect as needed to Workforce Services.

14) First Episode Psychosis (FEP) Services

Jessica Makin

Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.

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.

Community education on the FEP program, referral process, and available services are throughout the year by the clinician and case manager.

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.

Describe plans to ensure sustainability of FEP services. This includes: financial sustainability plans(e.g. billing and making changes to CMS to support billing) and sustainable practices to ensure fidelity to the CSC PREP treatment model. Describe process for tracking treatment outcomes. [Technical assistance is available through Jessica Makin at jmakin@utah.gov](mailto:jmakin@utah.gov)

WHS has appreciated the funding for FEP services over the past several years. WHS has built a sustainable model for providing FEP services through Medicaid dollars and may utilize early intervention dollars in the future. We have several team members who are familiar with screening tools and the population serviced. WHS utilizes the YOQ to track treatment outcomes for this population. WHS appreciates assistance from The Office in fidelity monitoring for the PREP tx model. We hope that ongoing fidelity monitoring will continue even in the absence of specific grant dollars.

15) 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. Include any planned changes in programming or funding.

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 two 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.

16) Quality & Access Improvements

Identify process improvement activities over the next three years. Include any planned changes in programming or funding.

Please describe policies for improving cultural responsiveness across agency staff and in services, including "Eliminating Health Disparity Strategic Plan" goals with progress. Include efforts to document cultural background and linguistic preferences, incorporate cultural practice into treatment plans and service delivery, and the provision of services in preferred language (bilingual therapist or interpreter).

Weber Human Services has worked closely with the Health Disparities Committee at the State level to help reduce/alleviate health disparities and improve cultural responsiveness. WHS recently hired a Diversity Officer who will help to adopt policy and provide clarity/direction to the agency and community on cultural responsiveness. We have placed more culturally sensitive artwork and messaging throughout the building in an effort to help all clients feel welcome. WHS also has an Inclusion and Diversity Committee that works closely with our Diversity Officer in providing education and culturally responsive activities for employees and the community. WHS has worked on recruitment of Spanish speaking clinicians through a scholarship at Weber State University and also provides a differential in pay for those who speak Spanish with a higher differential for those who are native Spanish speakers. When WHS is not able to provide treatment in the client's preferred language, an interpreter is offered.

Diversity & Inclusion Goal and Objectives

All objectives center around the four pillars that were created based off of the goal to ultimately create a sense of belonging for all employees, clients, and volunteers here at the agency.

The four pillars are: Focused Training, Engagement of Staff and Clients, Community Outreach, and WHS Policies and Protocols. Through these four pillars, we will create a sense of belonging.

Under each pillar, there are a set of objectives, under which are the initiatives that will be implemented in order to reach those objectives.

Focused Training:

Objective: Complete agency-wide training in key areas.

Initiative#1: Overview/Introduction to Diversity and Inclusion Training

Initiative#2: Implicit/Unconscious Bias Training

Initiative#3: Microaggressions Training

Initiative#4: Requesting SO/GI (sexual orientation and gender identity) information from Clients Training

Engagement of Staff and Clients

Objective: Create an environment where staff, clients and volunteers feel like they belong and are being treated with care and respect.

Initiative #1: BIPOC art in all buildings.

Initiative #2: Focus group with clients to understand their experiences here at the facility.

Initiative #3: Listening tours to understand employees' experiences here at the agency in terms of feeling valued, respected and ultimately feeling like they belong.

Initiative #4: Diversity and inclusion component in New Hire Orientation.

Community Outreach

Objective #1: To educate the youth and their parents about careers as Mental Health, Substance Use Counselors and Prevention Professionals.

Initiative #1: Go to church and community youth groups, as well as middle schools and high schools to educate the youth and their parents about the various careers here at WHS, as well as the educational requirements needed to obtain careers as Mental Health, Substance Use Counselors and Prevention Professionals.

Objective #2: Educate all demographics on the services that we provide at WHS.

Initiative #1: Community Art Show/Contest during the Ogden City Art Walk.

Initiative #2: Attend the LUPEC Event.

Objective #2: Brand WHS as an agency that celebrates diversity in its employees.

Initiative#1: Offer incentives for employees to complete company reviews on Glassdoor, Indeed and Facebook.

Initiative #2: Create a diversity and inclusion mission statement and values to post on website and Facebook page

Initiative#3: Offer a language incentive of \$1 per hour for clinicians and \$2 per hour for native-speaking clinicians.

WHS Policies and Protocols

Initiative #1: Audit job descriptions to ensure that the language is inclusive to all demographics and delete any exclusive language.

Initiative #2: Add diversity, inclusion, and sense of belonging questions to the exit interview.

Initiative #3: Audit and increase equity in salaries and promotions for all employees.

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. Please describe how the end of the Public Health Emergency and subsequent unwinding is expected to impact the agency's services and funding.

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 and USU to both train and recruit master's level clinicians. WHS has a recruitment and retention committee that is focused on competitive wages and benefits, flexible schedules, and overall job satisfaction. Our clinical training/supervision model in addition to our client outcomes are two areas on which we will focus in our efforts to recruit and retain staff.

It has been difficult to assess the impact of the unwinding process due to lack of data. WHS provided notices to clients regarding the unwinding process. We have a CM team that is attempting to reach out to clients when we have data indicating those who will be discontinued from Medicaid the following month. The CM team will help the clients communicate with DWS and complete necessary review paperwork when indicated. WHS has developed a transition plan for those who no longer qualify for Medicaid. This includes a referral to the Family Counseling Center with a voucher for 4 sessions. The FCC has grant funds to continue treatment if needed.

Describe how mental health needs and specialized services 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. During the pandemic, 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. Face to face contact with clients has resumed unless there is an outbreak of COVID 19 in the facilities.

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 bad 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

Weber Human Services has a designated Maternal Mental Health specialist (Rachel Hopkins). WHS has two staff members who are working on education related to maternal mental health. With the co-located medical clinic, education related to health and wellness is provided routinely to staff from medical personnel.

Weber Human Services is addressing early childhood mental health needs by providing a specific EBP for that population, participating in monthly group supervisions and fidelity reviews for that EBP. As needed WHS Child psychologists will be involved in that monthly supervision. Clinicians have access to staffing with Child psychologists at weekly Coordination of Care Meeting. Clinicians have access to attend Children’s Center of Utah Webinars as well as training by our in house Child Psychologist. Infants (1-17 months) of parents who are in the Women’s Substance Abuse Residential have access to a brief developmental evaluation with Dr. Singleton.

Weber Human Services Youth Team Supervisor participates on the Early Childhood Network in Weber County which will expand WHS knowledge of community services for this population.

Describe how you are addressing services for transition-age youth (TAY) (age 16-25) in your community. Describe how you are coordinating between child and adult serving programs to ensure continuity of care for TAY. Describe how you are incorporating meaningful feedback from TAY to improve services. Technical assistance is available through Jessica Makin, jmakin@utah.gov, and Theo Schwartz, aschwartz@utah.gov

WHS has worked to become more flexible in treatment options for TAY. Our PREP team is an example of how Youth and Adult team providers have come together to provide for the unique needs of this population. Our Youth Team prescriber also works with the adult population and is able to provide flexibility in treatment for TAY. Our youth and adult team supervisors work closely together if there are issues related to transfers from one team to another. This is an area in which we could use some technical assistance. We don't have a great transition process from our Youth Team to the Adult Team. Would like to learn more about how other centers are working with the population.

Other Quality and Access Improvement [Projects](#) (not included above)

WHS has adopted the Modular Approach to Treating Children in the last year, and has started training on the Unified Protocol for adult clients in the coming year. Each is an EBP that provides relief from symptoms of depression and anxiety.

17) 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. WHS also has monthly meetings with two ACOs to coordinate care for the members.

Describe your efforts to integrate care and ensure that children, youth and adults have [both their physical and behavioral health](#) needs met, including training, screening and treatment and recovery support (see [Office Directives Section E.viii](#)). [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.

We have therapists on each team that specialize in perinatal and postnatal care. On the AMH team that individual is Rachel Hopkins.

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?

We currently have two staff members who are working on education related to maternal mental health. With our co-located medical clinic, we routinely have education related to health and wellness provided to staff from medical personnel. Our providers consult with staff members on a daily basis regarding medical issues. We have a prescriber and nurse assigned to our adult residential unit who make daily rounds.

We can make the education more formal by having our medical staff provide training on health and wellness in team meetings.

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 intellectual/developmental disabilities. 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. Shauna Williams will be the agency representative for the IDD/MH population.

18) Mental Health Early Intervention (EIM) Funds

Please complete each section as it pertains to MHEI funding utilization.

School Based Behavioral Health: Describe the School-Based Behavioral Health activities or other OSUMH approved activity your agency proposes to undertake with MHEI funding over the three year period. 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. Include any planned changes in programming or funding.

Please email Leah Colburn ljacolburn@utah.gov a list of your FY24 school locations.

Weber Human Services has MOU's with area school districts to provide early intervention services to referred students. These services are done via telehealth or the family can attend services at the main WHS building. These clients have access to the medical necessary services that WHS outpatient clients have access to. Family involvement is very important in these services and Families are expected to be involved in treatment. Schools are encouraged to utilize the 988 crisis line, WHS crisis walk in services and are connected to SMR when appropriate.

Weber Human Services has MOU's with IHC Northern Pediatric Clinics and Midtown Community Health Clinic. Therapists are integrated in their clinics. Family Participation is important in these clinics. Families are provided the option of doing Telehealth services.

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

We have a designated case manager that assists with data collection. Therapists make it a regular practice to ensure YOQ's are completed. Our Youth Customer Service Supervisor assists with intakes and referral collection. MHEI quarterly reporting should be sent to Anna Lopez annah@weberhs.org and Kentin Fautin kentinF@weberhs.org

Family Peer Support: Describe the Family Peer Support activities your agency proposes to undertake with MHEI funding over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. For those not using MHEI funding for this service, please indicate "N/A" in the box below.

The Youth Team currently employs 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 as well as attend meetings with community partners including school meetings at families request..

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

Over the next three years Weber Human Services will hire and train a FPSS that specializes with the early childhood population 0-5. This FPSS will work closely with both the youth outpatient team and the Women and Children Substance Abuse program. They will help support social emotional readiness to enter the school system and/or to be able to stay in their current preschool and/or childcare setting.

Mobile Crisis Team: Describe the *Mobile Crisis Team* activities your agency proposes to

undertake with MHEI funding over the three year period and identify where services are provided. Include any planned changes in programming or funding. For those not using MHEI funding for this service, please indicate "N/A" in the box below.

N/A

19) 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 align 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 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 Stanley 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, PEMFG and we are in the process of bring on the Unified Protocol as our newest EBP to help in management of mental illness and suicidality.

Identify at least one staff member with suicide prevention responsibilities trained in the following OSUMH Suicide Prevention programs. If a staff member has not yet been identified, describe the plan to ensure a staff member is trained in the following:

- 1. Suicide Prevention 101 Training**
- 2. Safe & Effective Messaging for Suicide Prevention**

3. Suicide Prevention Gatekeeper training, such as Question-Persuade-Refer (QPR), Mental Health First Aid (MHFA), Talk Saves Lives or Applied Suicide Intervention Skills Training (ASIST)

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.

Describe all current strategies in place in suicide postvention including any grief supports. Describe your plan to coordinate with Local Health Departments and local school districts to develop a plan that identifies roles and responsibilities for a community postvention plan aligned with the Utah Suicide Coalition for Suicide Prevention Community Postvention Toolkit. Identify existing partners and intended partners for postvention planning. If available, please attach a localized suicide postvention plan for the agency and/or broader local community or link to plan.

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 the 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 a 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 is 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

For Local Authorities participating in the Comprehensive Suicide Prevention grants describe your implementation plans for primary prevention programs, suicide intervention supports including gatekeeper training, and community postvention planning. (note: this can be done in

the box below, or by linking/attaching your most current report).

If any of the following project deliverables are currently available, please link them here or attach them to your submission.

1. **By year 2, funding recipients shall submit a written comprehensive suicide prevention plan that is in alignment with the Utah Suicide Prevention State Plan and by year 2, funding recipients shall submit a written postvention response plan and communication protocol for their organization.**
2. **By year 3 funding recipients shall submit a written community postvention response plan.**

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

N/A

20) 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. Evidence based treatments are a priority of this program for the participants.

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, JJYS, 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.

21) 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. Include any planned changes in programming or funding. 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.

22) Disaster Preparedness and Response

Nichole Cunha

Outline your plans for the next three years to:
Identify a staff person responsible for disaster preparedness and response coordination. This individual shall coordinate with DHHS staff on disaster preparedness and recovery planning, attending to community disaster preparedness and response coalitions such as Regional Healthcare Coordinating Councils, Local Emergency Preparedness Committees (ESF8), and engage with DHHS in a basic needs assessment of unmet behavioral health disaster needs in their communities.

In addition, please detail plans for community engagement, to include partnership with local councils and preparedness committees as well as plans for the next three years for staff and leadership on disaster preparedness (to include training on both internal disaster planning and external disaster preparedness and response training). Please detail what areas your agency intends to focus on with training efforts and timeline for completing training.

Please see the Emergency Plan included at the end of this document. Most of the information listed above is included in that document. Jeff Stark is our agency Emergency Preparedness Specialist. He is on the board for the Northern Utah Healthcare Coalition and is actively involved with the Weber County Emergency Preparedness Committee.

23) Required attachments

- List of evidence-based practices provided to fidelity and include the fidelity measures.

List of evidence based practices provided to fidelity

Name of Program	*Fidelity Measure in Place	Number of Years in Use
1 2 3 Magic	Yes	5
Adolescent Community Reinforcement Approach	Yes	10
Aggression Replacement Training	Yes	21
Cognitive Behavioral Treatment for Substance Abusers	Yes	6
Critical Time Intervention	Yes	6
Dialectical Behavior Therapy	Yes	8
Family Check-Up/Everyday Parenting	Yes	1
Illness Management Recovery	Yes	11
Modular Approach to Treating Children with Anxiety, Depression, Trauma, and Conduct	Yes	2
Matrix Model	Yes	15

Moral Reconciliation Therapy	Yes	23
Motivational Interviewing	Yes	14
Outcome Questionnaire - Analyst	Yes	13
Prolonged Exposure	Yes	2
Psycho-Education Multi-Family Group	Yes	10
Seeking Safety	Yes	9
Skills Training for Adults in the Criminal Justice System	Yes	6
Trauma-Focused Cognitive-Behavioral Therapy	Yes	10
Unified Protocol	Yes	6 months

Fidelity measures are EBP specific and provided by the purveyors of the individual EBP.

- **Disaster Preparedness and Recovery Plan to coordinate with state, regional, and local partners in Disaster Preparedness Planning and Supporting Disaster Behavioral Health Response.**
See below
- **A list of metrics used by your agency to evaluate client outcomes and quality of care.**
 - WHS uses the Outcome Questionnaire, Youth Outcome Questionnaire, and the SURE to evaluate client outcomes. Other outcome measures are used with specific EBPs, e.g., GAD-7.
 - Quality of care is monitored by direct observation methods such as individual supervisor review of audio recorded sessions of the therapist conducting therapy. Fidelity feedback is provided to the therapist in both verbal and written form.

- A list of partnership groups and community efforts (ie. 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 including Mental Health Court, Regional Healthcare Coalitions, [Local Homeless Councils](#), [State and Local government agencies](#), and other partnership groups relevant in individual communities)

WHS has identified staff who are involved in the following coalitions, planning groups, and councils: Weber County Community Reentry Coalition, Weber-Morgan Criminal Justice Coordinating Council, COSSUP for Weber County, Behavioral Health Community Network, Ogden CAN, Opioid Task Force, Weber/Morgan Local Homeless Coordinating Council, PAC with USARA, OWCAP Health Services Advisory Committee, Weber/Davis Employment Committee, and the Weber/Morgan DV Coalition.

EMERGENCY PLAN

WEBER HUMAN SERVICES

237 26TH STREET

Ogden, Utah 84401

Signature of Authority

This plan is approved by the following entities:

Weber Human Services Jeff Stark/Jeremy Hirschi

Weber County Emergency Services

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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 Frequency 462.725, channel 22 on FRS radios 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 Safety 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 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 it is also comprised of 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 MCOT team 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. Will be a member of the Northern Utah Health Care Coalition, and member of Weber/Morgan County Emergency Managers.

- 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 emergency supplies and make recommendations as needed to the 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 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.

2.6.6 Client/family outreach

- Family members of clients, with an identified emergency contact in the paper or electronic chart, will be contacted by WHS staff (Customer Care, Case Management, Clinicians.)

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

In the event of a county-wide emergency, WHS falls under the responsibility and direction of Weber County Emergency Center (EOC) Facility. This facility will be located at the Sheriff's Complex, 1400 Depot Dr. 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.

2.8 Coordination of financial and payroll obligations

Financial data will be stored on redundant backup systems to ensure that data is housed in space protected from natural disasters. Such measures include:

Redundant data server stored in off-site location

All policies and procedures are stored on the server as well as all programs that contain financial information or used in daily operations.

Paper check stock will be stored onsite in case of short to long-term server disruption

2.8 Procedure for Protection of Healthcare Information Systems and Networks

Healthcare data will be stored on redundant backup systems to ensure that data is housed in space protected from effects of natural disasters and emergencies.

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.
- Attempt 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 a 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 AIM at 801-866-8139 or to Security 801-336-6325 before 10pm 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 closest exits as for a fire drill and carefully proceed outside to the Designated Area. 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 (most of which have turned out to be hoaxes) 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 ensure 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 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 to 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 buildings through main public doors, or through locked doors if they are provided with 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

Emergency Contacts

AIM Incident Manager	Primary Contact:	Jeff Stark
	Number:	801-866-8139
	Secondary Contact:	Kevin Eastman

	Number:	801-540-8717
Security/Facilities	Primary Contact:	Dane Mortensen
	Number:	801-234-9195
	Secondary Contact:	Travis Meyerhoffer
	Number:	801-726-2561
PIO	Primary Contact:	Darin Carver
	Number:	801-644-1022
	Secondary Contact:	Kevin Eastman
	Number:	801-540-8717
Pharmacy	Primary Contact:	Nate Adams, Pharmacist
	Number:	801-821-6552
	Secondary Contact:	Jenipher Hatch
	Number:	801-888-3940
Medical Clinic	Primary Contact:	Dr. Jeffery David, M.D.
	Number:	435-592-0449
IT	Primary Contact:	Kurt Kidman

	Number:	801-388-1621
Clinical	Primary Contact:	Jed Burton
	Number:	801-644-9127
Finance	Primary Contact	Jeremy Hirschi
	Number:	385-319-1661
HR	Primary Contact	Kristen Mechem
	Number:	435-740-4676
Customer Care Manager	Primary Contact:	David Barron
	Number:	801-791-1761

Changes and Updates 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.

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.

Distribution list

Distributed to all WHS employees upon hire and annually thereafter.