Dear Mr. Zook:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of the Bear River Health Department and the final report is enclosed. The scope of the review included fiscal management, substance abuse treatment and prevention services, and general operations.

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Kelly Ovard at 385-310-5118.

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

Sincerely,

Brent Kelsey
Interim Division Director

Enclosure

cc: Jeff Scott, Box Elder County Commission
    Bill Cox, Rich County Commission
    Lloyd Berentzen, Director, Bear River Health Department
    Brock Alder, Director, Bear River Substance Abuse
Site Monitoring Report of

Bear River Health Department
Local Substance Abuse Authority

Local Authority Contract #A03079

Review Date: November 16, 2021

Final Report
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Section One: Site Monitoring Report
Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Bear River Health Department (also referred to in this report as BRHD or the County) on November 16, 2021. The focus of the review was on governance and oversight, fiscal management, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center’s compliance with: State policies and procedures incorporated through the contracting process and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center’s data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center’s efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.
<table>
<thead>
<tr>
<th>Programs Reviewed</th>
<th>Level of Non-Compliance Issues</th>
<th>Number of Findings</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance and Oversight</strong></td>
<td>Major Non-Compliance</td>
<td>None</td>
<td>8-9</td>
</tr>
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<td></td>
<td>Significant Non-Compliance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minor Non-Compliance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deficiency</td>
<td>3</td>
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<tr>
<td><strong>Substance Abuse Prevention</strong></td>
<td>Major Non-Compliance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Significant Non-Compliance</td>
<td>None</td>
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</tr>
<tr>
<td></td>
<td>Minor Non-Compliance</td>
<td>None</td>
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</tr>
<tr>
<td></td>
<td>Deficiency</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse Treatment</strong></td>
<td>Major Non-Compliance</td>
<td>None</td>
<td>13-14</td>
</tr>
<tr>
<td></td>
<td>Significant Non-Compliance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minor Non-Compliance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deficiency</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review remotely with the Bear River Health Department (BRHD) due to current DSAMH policy. The Governance and Fiscal Oversight section of the review was conducted on November 16, 2021 by Kelly Ovard Administrative Services Auditor IV. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center’s own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit was gained. Meeting minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided by the governing board and County.

As part of the review, BRHD sent several files to Kelly Ovard to demonstrate their allocation plan and to justify their billed amounts. The allocation plan is clearly defined and shows how administrative and operational costs are equitably distributed across all cost centers and that the billing costs for services are consistently used throughout the system.

There is a current and valid contract in place between the Division and the Local Authority. BRHD met its obligation of matching a required percentage of State funding.

The Bear River Health Department met its obligation to receive a single audit as a component unit of Cache County’s single audit. The CPA firm Jones & Simkins P.C. performed the audit on the County for the year ending December 31, 2020. The Independent Auditors’ Report dated June 21, 202 expressed an unmodified opinion.

Jones & Simkins P.C. also performed a specific audit on the financial statements of Bear River Health Department as a component unit of Cache County for the year ending December 31st, 2020. In the Independent Auditors’ Report dated May 27, 2021 no deficiencies or material misstatements were reported.
Follow-up from Fiscal Year 2021 Audit:

FY21 Deficiencies:

1) Finding 2019-2021 Information on the Federal Program:
   CFDA 16.575 – Crime Victim Assistance, U.S. Department of Justice, passed through the
   State Office of the Attorney General. Compliance Requirements: Activities Allowed or
   Unallowed, Allowable Costs and Cost Principles, Cash Management, Procurement, and
   Reporting.

   Type of Finding:
   Significant deficiency in internal control over compliance.
   Condition: The County did not strictly enforce its grant management policies related to
   purchase approval and submission of reimbursement requests resulting in several
   unallowable purchases being submitted for reimbursement. Cause: Grant management
   policies and procedures, including monitoring of individual grant program directors,
   were not strictly enforced.

   Effect or Potential Effect: Activities or costs that are not allowed or allowable were paid and
   submitted for reimbursement. Questioned Costs: None. All unallowable costs and amounts
   submitted for reimbursement were subsequently identified and reported to the State agency
   and repaid.

   This item was resolved in the 2020 Financial Audit.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
   None

FY22 Significant Non-compliance Issues:
   None

FY22 Minor Non-compliance Issues:
   None
FY22 Deficiencies:

1) **I-9’s**: There were several I9’s that were either missing the hire date, or the HR department signed them more than the required 3 working days after the hire date.

### County’s Response and Corrective Action Plan:

| **Action Plan:** | Starting immediately, the I-9 form will be completed during the orientation of new employees. In the past, employees would take all of their new hire forms, fill them out, and return them to the HR office. New hires will no longer be able to leave orientation until the form is complete and signed. |
| **Timeline for compliance:** | December 1, 2021. |
| **Person responsible for action plan:** | Sylvia Tello |
| **Tracked at DSAMH by:** | Kelly Ovard |

2) **Conflict of Interest Forms**: All of the C of I forms were signed and dated by the employee, but the supervisor/director portion was not signed or dated.

### County’s Response and Corrective Action Plan:

| **Action Plan:** | Starting immediately, the immediate supervisor will sign all conflict of interest forms, whether a conflict is identified or not. The department director will only be required to sign the form if a true conflict of interest exists. |
| **Timeline for compliance:** | December 1, 2021 |
| **Person responsible for action plan:** | Sylvia Tello |
| **Tracked at DSAMH by:** | Kelly Ovard |

3) **Service Code reports.** The purpose of the service code audit is to verify amounts billed to the Division and to verify client services are classified correctly. The BRHD provided GL account ledgers and those were discussed with Linda Brown. Going forward, BRHD will need to provide spreadsheets for the service codes with totals and services data.
County’s Response and Corrective Action Plan:

**Action Plan:** We are currently looking at new EHR systems with the goal of improving our ability to integrate our client demographics and structured data, services, and account systems and produce the necessary reports.

**Timeline for compliance:** Currently in the RFP/bidding process, timeline will be contingent upon approval, implementation of, and training on the new system.

**Person responsible for action plan:** Brock Alder/Josh Greer

**Tracked at DSAMH by:** Kelly Ovard

**FY22 Recommendations:**

1) The BRHD emergency plan was reviewed by Nichole Cunha, Program Administrator II and Geri Jardine, Program Support Specialist, as part of monitoring. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that BRHD review these suggestions and update their emergency plan accordingly. *There were 3 partial compliance issues and one non-compliance issue that need to be addressed.*

**FY22 Division Comments:**

1) It is imperative with the number of audits of Local Authorities that timelines be followed. The initial letter goes out to the LA’s 4 weeks prior to the audit. Three weeks prior to the audit the information needed for clinical staff to address the charts should be provided. Two weeks prior to the audit, all data should be uploaded. This timeline is important so that the meetings on the Tuesday and Wednesday of the audit address any findings that may arise in the audit. It is even more important in the audits of Cache County/Bear River as essentially there are two audits going on at the same time for one the County.
Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of the Bear River Health Department on November 16, 2021. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from Fiscal Year 2021 Audit

FY21 Deficiencies:

1) The number of EASY Compliance Checks decreased from 185 to 140 from FY19 to FY20, which does not meet Division Directives. Local Authorities are required to increase the number of EASY Compliance Checks by at least one EASY Check each year.

The number of EASY Compliance Checks increased from 140 to 149 from FY20 to FY21, which meets Division Directives.

This issue has been resolved.

Findings for Fiscal Year 2022 Audit

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None
FY22 Recommendations:

1) **Parenting Wisely:** BRHD has experienced success in signing up individuals for the Parenting Wisely classes, but is having a difficult time retaining them in these classes. BRHD said that they could do better in encouraging people to complete the class and have been marketing these classes on Facebook and their website. It is recommended that BRHD continue to find ways to encourage individuals to complete the Parenting Wisely series.

FY22 Division Comments:

1) **Organizational Change:** BRHD merged and consolidated a number of their prevention programs, which has improved efficiency and the delivery of services. Instead of having two different missions for BRHD, there is one integrated prevention team now. There was a leadership change and the addition of staff to their department, which has provided more expertise for their department.

2) **BRHD merged** and consolidated a number of their prevention programs. Instead of having two different missions for BRHD, there is one integrated prevention team now. The intent for this restructuring and leadership change is to provide additional prevention staff and expertise to the prevention department.

3) **Driving Under the Influence (DUI) and Minor in Possession (MIP) Classes:** BRHD has done a good job of integrating virtual classes that meet the DUI administrative rules and requirements. In the past, the number of individuals participating in their DUI classes were declining; however, once the classes became virtual, it provided more access for the community which is spread out in different areas of the county. BRHD has seen an increase in the number of individuals that attended their MIP class since last year to 98 individuals this year. BRHD individualizes DUI / MIP for youth under the age 18.

4) **Coalitions:** BRHD is shifting from a county-wide coalition to smaller local high school cone (communities based on boundaries of a high school and the schools that feed into it) coalitions. They are working towards creating more local coalitions at the community level and are seeking partners to establish these coalitions. Shifting from county-wide coalitions to smaller coalitions was a difficult choice for BRHD and will be difficult to execute; however, they feel like this will benefit their community. BRHD has been using events like the Eccles Ice Center and media campaigns with Parents Empowered to start forming relationships with community partners.
Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the Substance Use Disorders Treatment review for the Bear River Health Department on November 17, 2021. The review focused on compliance with State and Federal law, Substance Abuse Treatment (SAPT) Block Grant regulations, and adherence to DSAMH Directives and contract requirements. The review consisted of an interview with program staff, a review of clinical records and an evaluation of agency policy and procedures. In addition, performance and client satisfaction was measured using the Utah Substance Abuse Treatment Outcomes Measures Scorecard and Consumer Satisfaction Survey Data.

Follow-up from Fiscal Year 2021 Audit

FY21 Minor Non-compliance issues:

1) **Decreased Criminal Justice Involvement** moved from 58.2% to 17.5% from FY19 to FY20 respectively, which does not meet Division Directives.

**Decreased Criminal Justice Involvement** moved from 17.5% to 82.0% from FY20 to FY21 respectively, which meets Division Directives.

*This issue has been resolved.*

2) **Youth Satisfaction Surveys** show that 6.3% of surveys were collected, which does not meet Division Directives.

**Youth Satisfaction Surveys** show that 8.9% of surveys were collected, which does not meet Division Directives.

*This issue is not resolved, which will be addressed in Deficiency #1 below.*

3) **Youth Satisfaction (Family) Surveys** show that 0% of surveys were collected, which does not meet Division Directives.

**Youth Satisfaction (Family) Surveys** show that 8.9% of surveys were collected, which does not meet Division Directives.

*This issue is not resolved, which will be addressed in Deficiency #2 below.*
Findings for Fiscal Year 2022 Audit:

**FY22 Major Non-compliance Issues:**
None

**FY22 Significant Non-compliance Issues:**
None

**FY22 Minor Non-compliance Issues:**
None

**FY22 Deficiencies:**

1) **Youth Satisfaction Surveys** show that 8.9% of surveys were collected, which does not meet Division Directives.

County’s Response and Corrective Action Plan:

**Action Plan:** Last year we were dealing with Covid during the survey time frame, with rotating staff through clinic duties, implementing telehealth, reduced groups, rotating front desk staff, and reduced incentives. This year, we will apply incentives that have been successful in the past, such as: small credit toward client’s account, small reward (snack or candy), staff competitions. We will begin surveys immediately upon the start date set by the State and continue through the length of allotted time to maximize opportunities. We will introduce surveys at all contact points: front desk, treatment sessions, groups, and phone contacts; and utilize interns to contact clients.

**Timeline for compliance:** Upon the next cycle of surveys, beginning December 2021.

**Person responsible for action plan:** Jaylene McNeely

**Tracked at DSAMH by:** Becky King

2) **Youth Satisfaction (Family) Surveys** show that 8.9% of surveys were collected, which does not meet Division Directives.

County’s Response and Corrective Action Plan:

**Action Plan:** Last year we were in the midst of dealing with Covid: staff involved in clinic duties, rotating front desk staff, telehealth, reduced groups, and reduced incentives. This year we will apply incentives that have been successful in the past, such as: small credit applied to client’s account, small reward (snack or candy), staff competitions. We will provide a list of client family information to staff to ensure we attempt to contact all eligible individuals, and will utilize interns to contact parent/families of clients. We will begin surveys immediately upon the
start date set by the State and continue through the length of allotted time to maximize opportunities.

**Timeline for compliance:** Upon the next cycle of surveys, beginning December 2021.

**Person responsible for action plan:** Jaylene McNeely

**Tracked at DSAMH by:** Becky King

### 3) Adult Satisfaction Surveys

Show that 9.6% of surveys were collected, which does not meet Division Directives.

**County’s Response and Corrective Action Plan:**

**Action Plan:** Last year we were in the midst of working around Covid, with clinic duties, telehealth, reduced groups, rotating staff, and reduced incentives. This year, we will utilize incentives that have been successful in the past, such as: small credit applied to client’s account, reward (snack or candy), staff competitions. We will begin surveys immediately upon the start date set by the State and continue for the entire duration of allotted time to maximize opportunities to collect surveys. We will introduce surveys at all contact points: front desk, individual sessions, groups, and phone contacts.

**Timeline for compliance:** Upon the next cycle of surveys, beginning December 2021.

**Person responsible for action plan:** Jaylene McNeely

**Tracked at DSAMH by:** Becky King

### FY22 Recommendations:

1) **State Stimulant and Opioid Response Grant (UT-SSOR) - Government and Performance Results Act (GPRA) Data:** BRHD has done a great job of submitting the SSOR Grant reports on time to DSAMH. BRHD has collected almost 43% of their GPRA intakes to date. DSAMH encourages BRHD to work on increasing the number of GRPA intakes.

### FY22 Division Comments:

1) **Treatment Services:** BRHD reports a significant need for mental health services in their area. BRHD has been able to help fill this gap by providing co-occurring substance use disorder (SUD) and mental health services for their community. They started with six clients in 2016 and are now averaging 160 clients that are receiving co-occurring SUD
and mental health services. BRHD has also expanded the number of counselors certified in Eye Movement Desensitization and Reprocessing (EMDR) from two to five to six EMDR counselors, which has been an effective treatment for trauma.

2) Expansion of Staff: BRHD has struggled with staff recruitment and retention over the years; however, they recently hired two counselors. These positions were open for a year and a half before they were filled. If more funding was available, BRHD could hire two case managers, another counselor and several support staff. BRHD’s Leadership Team is also carrying a caseload to help the treatment team. Despite having a small team over the years, BRHD has continued to provide quality services for their community.

3) Drug Testing: BRHD has been working with the Millennium drug testing lab out of California to provide drug testing services for their clients and monitor the cost for drug tests. BRHD reported that with the recent restriction from Medicaid on the number of drug tests that they will pay for, they have still been able to work out a way to provide two drug tests a week according to Drug Court requirements. Due to the positive relationship that BRHD has built with Millennium, Millennium has absorbed the extra costs for drug tests. This has helped prevent clients from incurring the cost for drug tests.
Section Two: Report Information
Background

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

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

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

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

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

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

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

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.
We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Bear River Health Department and for the professional manner in which they participated in this review.

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

The Division of Substance Abuse and Mental Health

Prepared by:

Kelly Ovard  
Auditor IV  

Date 12/21/2021

Approved by:

Kyle Larson  
Administrative Services Director  

Date 12/21/2021

Brent Kelsey  
Assistant Director Substance Abuse  
Interim Division Director  

Date 12/21/2021
Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY22

Name of Local Authority: Bear River Health Department

Date: November 16, 2021

Reviewed by: Nichole Cunha, LCSW
              Geri Jardine

Compliance Ratings

Y = Yes, the Contractor is in compliance with the requirements.
P = Partial, the Contractor is in partial compliance with requirements; comments provided as a suggestion to bring into compliance.
N = No, the Contractor is not in compliance with the requirements.

<table>
<thead>
<tr>
<th>Monitoring Activity</th>
<th>Compliance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y  P  N</td>
<td></td>
</tr>
<tr>
<td>Preface</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cover page (title, date, and facility covered by the plan)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Confirmation of the plan’s official status (i.e., signature page, date approved)</td>
<td>X</td>
<td>Though no signature page on documents, real time portal access suffices for this requirement.</td>
</tr>
<tr>
<td>Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)</td>
<td>X</td>
<td>Recommend including record of revisions and dates</td>
</tr>
<tr>
<td>Method of distribution to appropriate parties (i.e. employees, members of the board, etc.)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Table of contents</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Basic Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement of purpose and objectives</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Summary information</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Planning assumptions</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Conditions under which the plan will be activated</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Procedures for activating the plan</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan</td>
<td>X</td>
<td>Need to identify and clarify how staff are trained on the emergency management plan.</td>
</tr>
<tr>
<td>List of essential functions and essential staff positions</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Identify continuity of leadership and orders of succession</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Identify leadership for incident response</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>List alternative facilities (including the address of and directions/mileage to each)</td>
<td>X</td>
<td>Clarification on location of alternative facilities to be used, if needed</td>
</tr>
<tr>
<td>Communication procedures with staff, clients’ families, the State and community</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Procedures that ensure the timely discharge of financial obligations, including payroll.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Planning Step**

Disaster planning team has been selected, to include all areas (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)

<table>
<thead>
<tr>
<th>The planning team has identified requirements for disaster planning for Residential/Housing services including:</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Engineering maintenance</td>
</tr>
<tr>
<td>● Housekeeping services</td>
</tr>
<tr>
<td>● Food services</td>
</tr>
<tr>
<td>● Pharmacy services</td>
</tr>
<tr>
<td>● Transportation services</td>
</tr>
<tr>
<td>● Medical records (recovery and maintenance)</td>
</tr>
<tr>
<td>● Evacuation procedures</td>
</tr>
<tr>
<td>● Isolation/Quarantine procedures</td>
</tr>
<tr>
<td>● Maintenance of required staffing ratios</td>
</tr>
<tr>
<td>● Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic</td>
</tr>
</tbody>
</table>

| Need to specify how these functions will be provided in the event of a disaster |
| X |  |

DSAMH is happy to provide technical assistance.