State of Utah
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Lieutenant Governor

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Executive Medical Director
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NATE WINTERS
Deputy Director

Date: January 19, 2024

David Zook
Cache County Executive
199 North Main
Logan, UT 84321

Dear Mr. Zook:

In accordance with Utah Code Annotated 26B-5-102-2(f), the Office of Substance Use 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 Office 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 (Jan 19, 2024 17:42 MST)
Brent Kelsey
Office Director

Enclosure
cc: Jeff Scott, Box Elder County Commission
Bill Cox, Rich County Commission
Jordan Mathis, Director, Bear River Health Department
Brock Alder, Director, Bear River Substance Abuse

Utah Department of
Health & Human Services
Integrated Healthcare

Site Monitoring Report of

Bear River Health Department
Local Substance Abuse Authority

Local Authority Contract #A03079

Review Date: November 14, 2023

Final Report

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 26B-5-102-2(f), the Office of Substance Use and Mental Health (also referred to in this report as OSUMH or the Office) conducted a review of Bear River Health Department (also referred to in this report as BRHD or the County) on November 14, 2023. 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.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	7-9
	Deficiency	1	9
Substance Use Disorders Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Substance Use Disorders Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	2	14-15

Governance and Fiscal Oversight

The Office of Substance Use and Mental Health (OSUMH) conducted its annual monitoring review in person with the Bear River Health Department (BRHD). The Governance and Fiscal Oversight section of the review was conducted on Date November 14, 2023 by Kelly Ovard Administrative Services Auditor IV. Overall cost per client data was analyzed and compared to the statewide Local Authority average. State licensing and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit 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 Office 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, 2022. The Independent Auditors' Report dated September 28, 2023 expressed an unmodified opinion with three findings. The Covid Relief Fund was audited as a major program.

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 31, 2022. In the Independent Auditors' Report May 3, 2023 Bear River Health Department complied, in all material respects, with the state compliance requirements referred to above for the year ended December 31, 2023. There were no reported findings.

Follow-up from Fiscal Year 2023 Audit:

There were no findings in FY23

Findings for Fiscal Year 2024 Audit

FY24 Major Non-compliance Issues:
None

FY24 Significant Non-compliance Issues:
None

FY24 Minor Non-compliance Issues:

1) **Findings in the County Audit: Pages 100-103**
    a) **Finding 2022-001:**
    Criteria: Procurement policies and procedures and appropriate approval of purchases is an important control activity needed to adequately ensure that all purchases made by the County are acceptable and in compliance with County policies and other external compliance requirements.
    Condition: Although the County has implemented procurement policies and procedures, controls have not been established to identify noncompliance with procurement policies and procedures in a timely manner. Specifically, bids have not been obtained when required for certain purchases during the year.
    Cause: Review and approval of large purchases is not always performed within a timely basis. In addition, employees with the ability to enter into contracts have not received adequate training regarding procurement policies and procedures.
    Effect or Potential Effect: Without timely controls over procurement, the risk increases significantly that errors and fraud, including misappropriation of assets, could occur.
    Recommendation: County management should ensure that procurement policies and procedures are being followed by all County personnel. In addition, we recommend that County management provide training related to procurement policies and procedures to all County personnel with the ability to enter into a contract.
    b) **Finding 2022-002:**
    Criteria: Policies and procedures related to employee time entry and appropriate approval of said time entry is an important control activity needed to adequately ensure that all employee time being submitted in reimbursement-basis grant situations is allowable.
    Condition: It was noted that time keeping software is not being used by each County department for salary employees resulting in estimates being regularly made by County employees when submitting grant reimbursement requests. This was especially significant in grant reimbursement requests submitted by the County Attorney's office.

Cause: The County has not required the use of time keeping software for salary employees.
Effect or Potential Effect: Costs submitted for reimbursement to federal and state granting agencies may be considered unallowable.
Recommendation: County management should require the use of time keeping or time management software for all employees throughout the County. In addition, we recommend that County management provide training related to grant reimbursement requests and the need to support all expenditures for which reimbursement requests have been submitted. 100 CACHE COUNTY SCHEDULE OF FINDINGS AND QUESTIONED COSTS Year Ended December 31, 2022 Findings and questioned costs related to federal awards required to be reported in accordance with the Uniform Guidance.

c) **Finding 2022-003:**
Information on the Federal Program: Assistance Listing Number 21.027 – Coronavirus State and Local Fiscal Recovery Funds.
Compliance Requirement: Procurement and Suspension and Debarment.
Type of Finding: Significant deficiency in internal control over major federal programs.
Criteria: Uniform Guidance requirements indicate recipients must follow the procurement standards in 2 CFR sections 200.318 through 200.327, including ensuring that the procurement methods used for the contracts are appropriate based on the dollar amount and conditions specified in 2 CFR section 200.320.
Condition: We noted one expenditure for which general procurement policies and procedures related to obtaining a bid were not followed prior to entering into a contract with a vendor.
Cause: County staff are not familiar enough with County procurement policies and procedures.
Effect or Potential Effect: The County has a significant deficiency in internal control with respect to its procurement policies and procedures which could result in significant noncompliance or questioned costs in the future.
Recommendation: County management should ensure that procurement policies and procedures are being followed by all County personnel. In addition, we recommend that County management provide training related to procurement policies and procedures to all County personnel with the ability to enter into a contract.

County's Response and Corrective Action Plan:

Action Plan:
Response to finding 2022-001
The County Council and County Executive will work through the Audit Committee and Policy Review Committee to review, update, and strengthen policies and internal controls related to procurement policies. The County will provide sufficient training and resources for staff to make sure all procurement policies are followed correctly. The County will also monitor these processes through internal audit procedures.

Response to finding 2022-002
The County Council and County Executive will work through the Audit Committee and Policy Review Committee to review, update, and strengthen policies and internal controls related to employee time entry and approval when employee time is being submitted for grant reimbursements. The County will provide sufficient training and resources for staff to make sure all time entry policies are followed correctly. The County will also monitor these processes through internal audit procedures.
Response to finding 2022-001 The County Council and County Executive will work through the Audit Committee and Policy Review Committee to review, update, and strengthen policies and internal controls related to County and Federal procurement policies. The County will provide sufficient training and resources for staff to make sure all County and Federal procurement policies are followed correctly. The County will also monitor these processes through internal audit procedures.

Timeline for compliance: 12/31/23

Person responsible for action plan: David Zook County Manager

Tracked at OSUMH by: Kelly Ovard

FY24 Deficiencies:

1) The financial audit for Cache County was not uploaded to the **Federal Audit Clearinghouse**. At a minimum, the Cache County audit must be uploaded to the FAC no later than 9 months after the end of the year or 30 days after the audit is finalized, whichever day is earlier.

County's Response and Corrective Action Plan:

Action Plan: Uploaded to FAC

Timeline for compliance: Uploaded on December 20, 2023 waiting for verification.

Person responsible for action plan: Jared Bohman, Josh Greer and David Benson

Tracked at OSUMH by: Kelly Ovard

FY24 Recommendations:

1) **The SAPT grants** are not audited as a major program. It is recommended that this be included in the BRHD annual financial audit report.
2) **Emergency Plan:** Thank you for providing your plan for the audit.
    a) The Emergency Plan Audit Team highly recommends the development of a procedure to protect their healthcare information system and networks (i.e., ransomware attack) or include where this procedure is located if it has already been developed as this item was not addressed this year.
    b) We also encourage you to participate with your regional healthcare coordination council.

FY24 Office Comments:

1) Thank you to Jared Bohman and his staff for their efforts in getting all the documents uploaded for the audit and for taking on all the new responsibilities for those in new positions. Next year there will be a full year of data in Credible and the payment spreadsheets will be up to speed with the other local authorities. As usual, please feel free to contact the auditors, program managers and finance team with any questions that you come across as you settle into your new responsibilities.

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of the Bear River Health Department on November 14, 2023 . The review focused on the requirements found in State and Federal law, Office 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 2023 Audit

There were no findings in FY23

Findings for Fiscal Year 2024 Audit

FY24 Major Non-compliance Issues:
None

FY24 Significant Non-compliance Issues:
None

FY24 Minor Non-compliance Issues:
None

FY24 Deficiencies:
None

FY24 Recommendations:

1) **Student Health and Risk Prevention (SHARP) Survey:** BRHD is working on setting up a SHARP data training with Bach Harrison. It is recommended that BRHD continue with these efforts. OSUMH/Office of Health Promotions (OHPP) can provide technical assistance and support as needed.

2) **Community Anti-Drug Coalitions of America (CADCA) Training:** BRHD is looking into providing a CADCA training for their coalitions. They are planning to work collaboratively with other Local Authorities to set up this training at different times of the year in Virginia. It is recommended that BRHD continue with these efforts. OSUMH/OHPP can provide technical assistance and support as needed.

FY24 Office Comments:

1) **Increasing Capacity:** Coalitions are encouraged by BRHD to follow the Communities that Care (CTC), CADCA and Strategic Prevention Framework (SPF) model. Support is offered to all coalitions in assessment, capacity building, planning, implementation, evaluation and in creating action plans, directly from the Local Substance Abuse Authority (LSAA) and through coaching from the Regional Director and the state system. BRHD provided opportunities for staff and coalition

coordinators this past year to participate in the CTC Training of Facilitators. BRHD also provided additional training opportunities by sending staff, coalition coordinators, and coalition members to Fall Conference, Bryce Canyon Coalition Summit, Universal Prevention Curriculum (UPC), and Substance Abuse Prevention Skills Training (SAPST). The Bear River area has significantly increased the number of coalitions and hired two prevention staff which has helped increase prevention efforts in their local area.

2) **Coalition Efforts:** Box Elder Safe Communities Coalition has been adopting parts of the CTC process and has established a Key Leader Board (Phase I) while implementing and evaluating their action plan (Page 5). This coalition has been doing great work in the community where they have developed relationships and contacts, including with Box Elder School District, local law enforcement, and the County Commissioner. Box Elder Safe Communities was awarded the Parents Empowered Grant, where they were able to provide messaging and resources for parents to help prevent substance misuse in their community. They also hosted an event where they showcased messaging in the library and a few parks. Several key leaders were involved and spoke at press events, which helped mobilize the community. Box Elder Safe Communities Coalition has the right people in this coalition and trusted partnerships that have helped them get things done that they weren't able to do in the past.

3) **Eliminating Alcohol Sales to Youth (EASY) Compliance Checks:** Bear River increased the number of EASY Compliance checks from 172 to 209 from FY22 to FY23. BRHD schedules the checks and rides along with law enforcement to collect the data. Depending on the agency, BRHD sometimes provides the buyer for these checks. BRHD is one of the only Local Authorities that works closely with law enforcement to ensure that the EASY Compliance checks are done, which has contributed to their success in completing these checks each year.

Substance Use Disorders Treatment

Becky King, Program Administrator, conducted the Substance Use Disorders Treatment review for the Bear River Health Department on November 14, 2023. The review focused on compliance with State and Federal law, Substance Abuse Treatment (SAPT) Block Grant regulations, and adherence to OSUMH Directives and contract requirements. The review consisted of an interview with program staff, BRHD's internal review of their 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 2023 Audit

FY23 Deficiencies:

1) **The Treatment Episode Data (TEDS) shows:**

   a) BRHD has a **low percentage of adults participating in self-help or support groups at the end of treatment** (10% of BRHD clients; 26% of other clients across the state). This low percentage of clients was also noted at last year's review (11% in FY21; 10% in FY22).

   This issue has been resolved. In FY23, 1 in 5 clients are using social recovery support at discharge. This is slightly lower than the state and rural averages; however, this is a strong improvement over previous years. It was noted last year that social recovery support at discharge was 11% in FY21 and 10% in FY22.

   b) **No youth at BRHD have been connected to self-help or support groups since November of 2019** (also noted at last year's visit).

   This issue has been resolved. In FY23, there were youth that participated in social support groups in the past month and at discharge 4 (17.4%) had participated in social support groups.

2) **American Society of Addiction Medicine (ASAM):** In the chart review, it was found that there were no ASAM reviews. ASAM reviews should be completed when there is a change in level of care, discharge or at crucial junctures in a clients life. It is recommended that BRHD continue providing training for their clinical team on ASAM. OSUMH can provide support and technical assistance as needed.

   BRHD has been reviewing the ASAM's in the clinical charts in the EHR at least quarterly to ensure that they are being done. Through this review process, BRHD found that there has been improvement with the ASAM reviews being completed.

   This Issue has been resolved.

Findings for Fiscal Year 2024 Audit:

FY24 Major Non-compliance Issues:
None

FY24 Significant Non-compliance Issues:
None

FY24 Minor Non-compliance Issues: FY23 Recommendations:
None

FY24 Deficiencies:

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

   a) BRHD had 6% of old charts that were open that should be closed. This does not meet Office Directives, which requires that less than 4% of old charts should be open at any given time.
   b) BRHD had a lower dropout rate but a higher termination rate than the state and rural averages in FY2023. This was noted last year as well.
   c) As noted in the last two years (FY22 & FY23), clients who are Black, Indigenous, and People of Color (BIPOC) are more likely to be terminated by the facility and less likely to complete than clients who are white.
   d) There was an increase in justice-involved clients not being assessed for criminogenic risk from 0 in FY22 to 23% in FY23, which does not meet Office Directives. There needs to be less than 10% of criminogenic risk data that is not collected at any given time.

County's Response and Corrective Action Plan:

Action Plan:

a) The closing of old charts fell in large part due to transitions between electronic health records. As old files are reconciled and updated in the new system the prevalence of old files which remain open should drop.

b) It is uncertain why our drop out rate would be lower, while our termination rate would be higher. We have noted that with regard to Justice-involved clients, sanctions for non-compliance under JRI are limited and clients may get terminated when they fail to attend as a part of a treatment sanction. They are almost always welcome back but in order to maintain productivity in staff scheduled time, we cannot continue to schedule clients for appointments repeatedly when they have a pattern of non-attendance without an intervention.

c) This phenomenon is concerning but it should be noted that we have a policy of nondiscrimination and anti-racism. There is no practice at BRHD BHS that would give

discriminatory favor or sanction based upon race, creed, nationality, gender, sexual orientation or any other protected class.

d) we will place higher emphasis on training this year to include RANT testing for all Justice involved individuals. Our intake process has changed over this past year to centralize the gathering of this information and should result in less absent data.

Timeline for compliance: this year. through this audit period.

Person responsible for action plan: Jared Bohman LCSW, Joel Downs CMHC

Tracked at OSUMH by: Becky King

2) **The Adult Consumer Satisfaction Surveys:** The consumer satisfaction surveys show that 9.3% of surveys were collected, which does not meet Office Directives. There needs to be at least 10% of surveys collected to produce accurate data results.

County's Response and Corrective Action Plan:

Action Plan:
We will endeavor to target adults in treatment through a more active campaign at our front desk and in treatment and group sessions to raise this number in the new year. We will reward clients for filling out MHSIP Surveys with a small treat for surveys completed.

Timeline for compliance: during the MHSIP survey gathering period Jan to Mar.

Person responsible for action plan: Jared Bohman LCSW, Josh Barson LCSW

Tracked at OSUMH by: Becky King

FY24 Recommendations:

1) **TEDS Data:**
    a) The use of Medication Assisted Treatment (MAT), has been decreasing at BRHD. Whereas 41% of SUD clients benefitted from MAT in FY22, only 20% in benefitted in FY23.
    b) There was a slight increase in tobacco / nicotine use from admission to discharge in FY2023.

    It is recommended that BRHD check their data for accuracy and look for ways to increase the use of MAT as an evidence-based practice and decrease tobacco/nicotine use.

FY24 Office Comments:

1) **TEDS Data:**
    a) BRHD has a lower rate of drug overdose deaths (16/100,000) than the state overall (20/100,000), but follows a similar pattern.
    b) BRHD's rate of suicide deaths (20/100,000) is also lower than the state overall (22/100,000), but has been increasing since 2006-10 (also similar to the state pattern).
    c) Youth need for Alcohol and Drug (AOD) treatment has been lower than the state, and showed a decrease in 2023.
    d) BRHD has a rate of successful completion of SUD treatment that is higher than both the state and rural averages.
    e) Increased alcohol abstinence in Bear River (77%) is higher than the state and rural averages (26% and 45%, respectively).
    f) Increased drug abstinence at BRHD (158%) is higher than the state and rural averages (108% and 100%, respectively).
    g) BRHD clients had a greater decrease in criminal justice involvement than the state or rural average.

2) **Promoting the Integration of Primary and Behavioral Health Care Grant (PIPBHC):** BRHD received the Substance Abuse and Mental Health Services Administration (SAMHSA) PIPBHC Grant, which brought the Tremonton office, the l three community health centers and BRHD together to provide a Hub and Spoke model to provide prevention, behavioral and physical health services. This model addresses an individual's needs before they become a larger issue. After hours, the line staff is available to everyone, including the prevention team. Dexter Pierce is one of the community partners. The Cache Valley Unified Support Program (CVUSP) team is operating under a grant to coordinate services between law enforcement, Mobile Crisis Outreach Team (MCOT), Behavioral Health, and Substance Use Services for individuals that are involved in criminal justice services who need triaged services.

3) **Youth Services:** BRHD increased the number of youth that they are serving in their program. The youth therapist reached out to judicial staff and probation officers to provide training on youth services, which increased the number of referrals to the program. BRHD provides individual therapy and outpatient treatment services. They also provide a youth group, Minor in Possession class, and Moral Reconation Therapy for the youth. BRHD coordinates closely with probation services, which has been beneficial to their program. When a youth is not participating well in the program and is discharged from the program, BRHD then contacts probation who will recommend court ordered services for the youth, where the youth is then referred back to treatment at BRHD. This process has been helpful with youth who may need the oversight of probation and the court to help them through their treatment program.

Section Two: Report Information

Background

Utah Code Section **26B-5-102** outlines duties of the Office of Substance Use and Mental Health. Section 2(c) states that the Office 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 Office 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 Office 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 Office is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Office 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 Office of Substance Use and Mental Health

Prepared by:

Kelly Ovard
Auditor IV

Kelly J. Ovard

Date 01/19/2024

Approved by:

Kyle Larson
Administrative Services Director

Kyle Larson

Date 01/19/2024

Eric Tadehara
Assistant Director

Eric Tadehara (Jan 19, 2024 10:03 MST)

Date 01/19/2024

Brent Kelsey
Office Director

Brent Kelsey (Jan 19, 2024 17:42 MST)

Date 01/19/2024

Attachment A

UTAH OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY24

Name of Local Authority: **Bear River Health Department**

Date: **November 8, 2023**

Reviewed by: **Nichole Cunha, LCSW**
Geri Jardine

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

Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)	X			
Confirmation of the plan's official status (i.e., signature page, date approved)	X			
Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)		X		Recommend including record of revisions and dates
Method of distribution to appropriate parties (i.e. employees, members of the board, etc.)	X			
Table of contents	X			
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan		X		Need to identify and clarify how staff are trained on the emergency management plan.

Functional Annex: The Continuity of Operations (COOP) Plan to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.				
List of essential functions and essential staff positions	X			
Identify continuity of leadership and orders of succession	X			
Identify leadership for incident response	X			
List alternative facilities (including the address of and directions/mileage to each)		X		Clarification on location of alternative facilities to be used, if needed
Communication procedures with staff, clients' families, state and community stakeholders and administration	X			
Describe participation in and coordination with county and regional disaster preparedness efforts, which could include participation in Regional Healthcare Coordination Councils (HCC)	X			
Procedures that ensure the timely discharge of financial obligations, including payroll.	X			
Procedure for protection of healthcare information systems and networks		X		We highly recommend development of a procedure to protect their healthcare information system and networks (i.e., ransomware attack) or include where this procedure is located if it has already been developed.
Planning Step				
Disaster planning team has been selected, to include all areas (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)	X			

The planning team has identified requirements for disaster planning for Residential/Housing services including: • Engineering maintenance • Housekeeping services • Food services • Pharmacy services • Transportation services • Medical records (recovery and maintenance) • Evacuation procedures • Isolation/Quarantine procedures • Maintenance of required staffing ratios • Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic		X		Need to specify how these functions will be provided in the event of a disaster. If these services are contracted out, please indicate how authority monitors for emergency preparedness in these areas. *Upon review with monitoring team and leadership, Brent Kelsey, This was left as partial for the year 2023. BRHD should evaluate and document their relationship with their contractor and document this within their plan. NC 12/6/2022.*

SUMH is happy to provide technical assistance.

OSUMH BRHD FY24 Final Report - Google Docs

Final Audit Report 2024-01-20

Created:	2024-01-19
By:	Kelly Ovard (kovard@utah.gov)
Status:	Signed
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