State of Utah
SPENCER J. COX
Governor
DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services
TRACY S. GRUBER
Executive Director
NATE CHECKETTS
Deputy Director
DR. MICHELLE HOFMANN
Executive Medical Director
DAVID LITVACK
Deputy Director
NATE WINTERS
Deputy Director

Date: March 25, 2025

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

Dear Mr. Zook:

In accordance with Section 26B-5-102, 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 use treatment and prevention services, and general operations.

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

SUMH appreciates the cooperation and assistance of the staff and looks forward to a continued professional relationship.

Sincerely,

Brent Kelsey (Mar 26, 2025 18:16 MDT)
Brent Kelsey
Director

Enclosure
cc: Jeff Scott, Box Elder County Commission
Bill Cox, Rich County Commission
Jordan Mathis, Director, Bear River Health Department
Jared Bohman, 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: January 7, 2025

Final Report

Table of Contents

Section One: Site Monitoring Report

Executive Summary

In accordance with Section 26B-5-102, the Office of Substance Use and Mental Health (also referred to in this report as SUMH) conducted a review of the Bear River Health Department (also referred to in this report as BRHD or the County) on January 7, 2025. The focus of the review was on governance and oversight, fiscal management, substance use prevention and treatment services and general operations.

The nature of this examination was to evaluate the local authority'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 local authority's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the local authority'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	7-8
	Significant Non-Compliance	None	
	Minor Non-Compliance	1	
	Deficiency	None	
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	None	

Governance and Fiscal Oversight

The Office of Substance Use and Mental Health (SUMH) 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 January 7, 2025 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 local authority'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 local authorities and that the billing costs for services are consistently used throughout the system.

There is a current and valid contract in place between SUMH 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, 2023. The Independent Auditors' Report dated September 28, 2023 expressed an unmodified opinion with three findings. The three findings from the 2022 audit were resolved. There are, however, three new findings of a different nature in the 2023 audit at the county level that will be addressed in this audit.

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, 2023. In the Independent Auditors' Report May 3, 2024 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 2024 Audit:

FY24 Minor Non-compliance Issues:

1) Findings in the 202 County Audit: Pages 100-103
   These audit Items have been resolved. There are, however, two new findings in the 2023 Financial Audit for Cache County.

FY24 Deficiencies:

1) The County audit was not uploaded to the Federal Audit Clearinghouse.
   This was uploaded to the FAC for 2022 and for 2023 on August 14, 2024 and is now resolved.

Findings for Fiscal Year 2025 Audit

FY25 Major Non-compliance Issues:

None

FY25 Significant Non-compliance Issues:

None

FY25 Minor Non-compliance Issues:

1) **There were two new findings in the Cache County audit for 2023. They are noted below:**
   a) **Finding 2023-001 Criteria**: The State Compliance Audit Guide requires County management to prepare and present a Fraud Risk Assessment each year to the County Council. In addition, the State Compliance Audit Guide requires County management to ensure that proper and timely notice and information is provided to the public related to budget hearings, public meetings, and the results of all public meetings by posting notices, agendas, and minutes for all public meetings to the Utah Public Notice Website. Specifically, meeting minutes are required to be posted within three days of the minutes being approved and budget hearing notices are required to be posted at least seven days prior to the budget hearing.
   b) **Finding 2023-002 Criteria:** State statute limits the County's unrestricted general fund balance to 25% of total revenues of the general fund for the current fiscal period and total revenues from property taxes for the current fiscal period.

County's Response and Corrective Action Plan:

Action Plan: March 21, 2025
Jordan Mathis
Director/Health Officer
Bear River Health Department
655 E 1300 N
Logan, UT 84341
Dear Director Mathis,
In response to your request regarding the FY25 Minor Non-compliance Issues identified in the Cache County audit for 2023, specifically Finding 2023-001 and Finding 2023-002, please find our response below.
Regarding Finding 2023-001, which pertains to the State Compliance Audit Guide requirements for preparing and presenting a Fraud Risk Assessment annually to the County Council and ensuring proper and timely public notice for budget hearings and meetings, we acknowledge this finding. Cache County will ensure that a Fraud Risk Assessment is prepared and presented annually. Additionally, we will implement procedures to ensure all public meeting notices, agendas, and minutes are posted to the Utah Public Notice Website within the required timelines, specifically posting meeting minutes within three days of approval and budget hearing notices at least seven days prior to the hearing.
Additionally we have provided the County Council with the fraud risk assessment when it was completed this last August of 2024. We also have an elected County Auditor separate from a County Clerk and he has been tasked with completing the 2024 Fraud Risk Assessment and I anticipate it will be completed in the near term.
Regarding Finding 2023-002, which relates to the state statute limiting the County's unrestricted general fund balance to 25% of total revenues, we are reviewing our general fund balance. We will take the necessary steps to ensure compliance with this state statute and maintain the general fund balance within the prescribed limits.
While we have exceeded the 25% balance, we anticipate this issue will correct itself in the coming years. We have seen some substantial uses of the fund balance and have seen additional needs in the near future, including capital projects.
We are committed to addressing these findings promptly and will provide further updates on our progress as needed. We appreciate your collaboration and the opportunity to clarify these matters.

Timeline for compliance: When the 2024 County Audit is released.

Person responsible for action plan: Jared Bohman, Cache County

Tracked at OSUMH by: Kelly Ovard

FY25 Deficiencies:

None

FY25 Recommendations:

1) **Emergency Plan:** SUMH encourages at least biennial review of the Emergency Plan to ensure accuracy. Participation in Regional Healthcare Coalitions, if not currently being done, is also encouraged. It is also recommended that BRHD provides evidence of a policy/procedure that is in place to protect the healthcare information system and networks (i.e., ransomware attack).

2) **Review Unspent Funding:** SUMH recommends that the local authority discuss unspent funding with BRHD to determine how these funds could be used effectively in future fiscal years.

Program	Service Code	Awarded Amount	Spent Amount	Unspent Amount
SUD	BJA - BJA Federal Grant	$28,886	$0	$28,886
	CMF - Covid Mitigation Fund	$26,969	$22,226	$4,743
	PTR - ATR Corrections	$45,957	$32,837	$13,120
	RSS - Recovery Support Services	$18,303	$15,747	$2,556
	UPP2 - SAMHSA Integration Grant (MH BRHD)	$210,014	$85,590	$124,424
	UPP1 - SAMHSA Integration Grant (MH BRHD)	$13,786	$13,160	$626
	Total SUD	**$343,915**	**$169,560**	**$174,355**
Prevention	OPG - State Opioid Settlement	$205,750	$204,165	$1,585
	PFS2 - Partnerships for Success	$32,900	$22,228	$10,672
	PFS1 - Partnerships for Success	$29,355	$11,000	$18,355
	PXP - Prevention Prepared Communities	$110,000	$97,942	$12,058
	SOP1 - State Opioid Prevention	$45,000	$31,055	$13,945
	Total Prevention	**$423,005**	**$366,390**	**$56,615**
	Total	**$766,920**	**$535,950**	**$230,970**
Grand Total Funding for LA in FY24		**$3,007,007**	**$2,776,037**	**$230,970**
Total Spent/Unspent %			**92.3%**	**7.68%**

FY25 Comments:

1) The audit was recently completed. The **Certification of Audit Review** will be completed by Jared as soon as possible.

Substance Use Disorders Prevention

David Watkins, Program Administrator, conducted the annual prevention review of the Bear River Health Department on January 7, 2025 . The review focused on the requirements found in State and Federal law, SUMH 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 2024 Audit

There were no findings in FY24

Findings for Fiscal Year 2025 Audit

FY25 Findings:

There are no findings in FY25

FY25 Recommendations:

1) **Evidence-based programs:** The BRHD is implementing or supporting at least two programs that do not meet the Office's definition of evidence-based programs. SUMH reccomends BRHD submit the Catch my Breath and Check and Connect program to the Utah Evidence Based Workgroup for review. There is an opportunity to partner with other LAs on the Catch my Breath submission. SUMH recommends working with the Regional Director in identifying peer reviewed journal articles for each program that have identified outcomes for a substance misuse prevention risk or protective factor.

FY25 Comments:

1) **Collaboration:** SUMH recognizes the growth in coalition work recently within the BRHD. The health department has managed to build and maintain partnerships across the Local Authority to expand the amount of coalitions. The BRHD has gone from 2 county wide coalitions to 7 coalitions that have been established or are in early development stages. Of note, the LA has fostered partnerships with Utah State University along with the rural population in Rich County.

2) **Take-back events:** This past year the BRHD held successful take-back events. The success of take-back events within the BRHD are in large part due to the efforts of the police agencies within Cache County. With coalitions collaborating with the various police agencies on these events, the BRHD saw 141.2 pounds of medication collected during 2024.

3) **Coalition support:** With the growth of coalitions within the catchment area, BRHD has partnered with Weber Human Services to hire a specific coalition coach/support person. Having the capacity to support new coalitions along with new coalition coordinators is vital for the success of community coalitions. SUMH appreciates that the LA is mindful of the need to fill coaching support at the local level and the willingness to develop creative solutions with other LA's.

Substance Use Disorders Treatment

Becky King, Program Administrator, and Becky Johnson, Auditor III, conducted the Substance Use Disorders Treatment review for the Bear River Health Department on January 7, 2025. The review focused on compliance with State and Federal law, Substance Abuse Treatment (SAPT) Block Grant regulations, and adherence to SUMH Directives and contract requirements. The review consisted of an interview with program staff, review of BRHD's Drug Court 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

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 SUMH Directives, which requires that less than 4% of old charts should be open at any given time.

    This issue has not been resolved, which will be addressed in Recommendation #1 below.

    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.

    This issue has been resolved. The percentage of clients who successfully completed SUD treatment at BRHD in the FY24 is higher than the state and rural averages.

    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.

    This issue has been resolved. Fewer clients from BIPOC backgrounds were terminated by the facility in 2024 than in 2023, but it is still higher than clients from white, not Hispanic backgrounds. More clients from BIPOC backgrounds completed treatment successfully in 2024 compared to 2023, but it is still lower than successful completion by clients from white, not Hispanic backgrounds.

    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.

This issue has been resolved. The percentage of justice-involved court clients who do not get assessed for criminogenic risk must be below 10%. Bear River assessed 94% of justice referred adults in FY2024, which meets Office Directives.

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

   This issue has been resolved. The FY24 consumer satisfaction surveys show that 13% of surveys were collected, which meets Office Directives.

Findings for Fiscal Year 2025 Audit:

FY25 Major Non-compliance Issues:
None

FY25 Significant Non-compliance Issues:
None

FY25 Minor Non-compliance Issues:
None

FY25 Deficiencies:
None

FY25 Recommendations:

1) **The Treatment Episode Data Set (TEDS) Shows:**
   a) 13% of clients in the served data are from old open admissions (meaning they have not had any reported events in the past year). BRHD did not report any SUD events in FY24. SUMH reccomends BRHD review old open admissions, identify any data issues, and close the old charts. SUMH can provide support and technical assistance as needed.

   b) Use of medication assisted treatment (MAT) for SUD clients with opioids as their primary, secondary, or tertiary substance declined from 42% in 2023 to 39% in 2024. ***Please note that last year this was reported as MAT for clients for whom opioids were the <u>primary substance</u>.****)*

      SUMH recommends that BRHD check their data for accuracy and remedy any data entry issues. It is also recommended that BRHD continue providing MAT / MOUD for their clients through their clinic and by referring clients to community providers.

Table 2. Bear River SUD Served

Source: TEDS data *(each client is counted only once)*

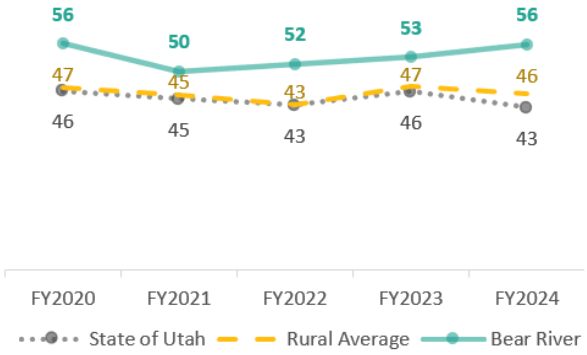
	FY22	FY23	FY24
Total	1096	1056	1211
Drug Court	118	104	100
MAT (Med. Assisted Tx)	446	207	182
Methadone	12	10	8
Naltrexone	27	35	28
Buprenorphine	409	166	146
Any opioid use	186	152	168
% opioid users receiving MAT	42%	42%	39%
Women	296	299	366
Youth	83	97	106
Justice Referred	961	919	1048
Old Open Admissions	4%	6%	13%
Priority Groups			
Pregnant IV Users	0	1	2
Female IV Users	53	64	65
Male IV Users	113	89	91

FY25 Comments:

1) **TEDS shows that BRHD is doing well in the following areas:**
   - **a)** The percentage of clients who successfully completed SUD treatment at BRHD (56%) is higher than the state (43%) and rural averages (46%). BRHD provides individualized treatment and focuses on the client's goals to ensure that they are successful in treatment.

Figure 4. % of clients successfully completing SUD treatment

Source: TEDS data, SUD Scorecard



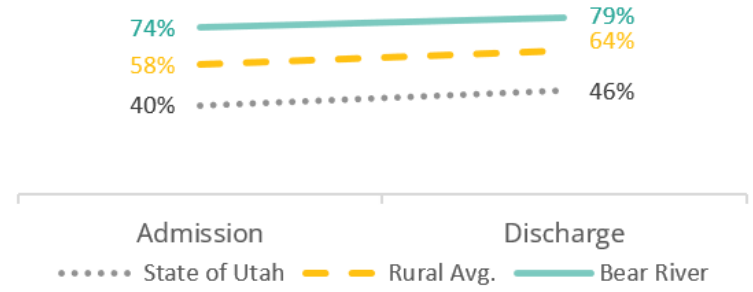
   - **b)** Abstinence rates from alcohol and drugs at BRHD started low (Alcohol - 46%, Drugs - 27%), but showed a high rate of improvement (Alcohol - 82%, Drugs - 70%). BRHD uses evidence-based methods in treatment, which help their clients remain abstinent from alcohol and drugs.

c) Stable housing was high at both admission (100%) and discharge (99%) at BRHD. BRHD helps connect their clients to affordable housing, which helps clients find stability in their lives and have a safe place to live so that they can be successful in treatment.

d) The percentage of SUD clients employed or in school was higher at BRHD (Admission - 74%, Discharge - 79%) than the state (Admission - 40%, Discharge - 46%) and rural averages (Admission - 58%, Discharge - 64%).

Figure 8. % Employed or in School

Source: TEDS data, SUD Scorecard



2) **Innovative Health Initiatives:** BRHD recently initiated the Clean Needle Exchange Program which offers a no-cost, confidential way to exchange used needles for clean, sterile ones. This program is available in Logan and surrounding areas. Individuals can come to BRHD any time during business hours and speak to a healthcare professional. This harm reduction program is designed to prevent various public health issues. Utah State University (USU) is working with BRHD on this initiative by doing a point in time count of individuals experiencing homelessness. BRHD also partnered with the prevention team in the Great American Smokeout in November and signed up 40 clients for Way to Quit. They doubled the number of clients that they enrolled in this program from 16 clients last year to 40. There has been positive feedback from participants regarding both programs.

3) **Expansion of Quality Services:** BRHD continually looks for ways to expand services in the community and provide quality services. They recently implemented a new QR code to gather feedback from the public to ensure better service delivery and increase awareness of public perception and needs. They have partnered with Qualtrics to work on new initiatives targeting key performance indicators (KPIs) and productivity standards. BRHD recently received a domestic violence (DV) Grant where they will be providing DV classes, which are not available anywhere else in the community. They will start these classes once the billing has been established. BRHD will be collaborating with a Mobile Opioid Treatment Provider (OTP) which provides Medication for Opioid Use Disorder (MOUD) for the community. BRHD has a designated area for the Mobile OTP in their parking lot at the Clinic in Logan. This Mobile OTP service will expand MOUD services in Cache County which will benefit individuals in Logan and surrounding areas.

Section Two: Report Information

Background

Section **26B-5-102** outlines duties of the Office of Substance Use and Mental Health. Section 2(c) states that SUMH 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 SUMH 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 SUMH 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

SUMH appreciates the cooperation afforded SUMH 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 03/25/2025

Approved by:

Kyle Larson
Administrative Services Director

Kyle Larson

Date 03/25/2025

Eric Tadehara
Assistant Director

Eric Tadehara (Apr 1, 2025 21:59 MDT)

Date 04/01/2025

Brent Kelsey
Director

Brent Kelsey (Mar 26, 2025 18:16 MDT)

Date 03/26/2025

Attachment A

OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY25

UTAH OFFICE OF SUBSTANCE USE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY25

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

Date: **January 7, 2025**

Reviewed by: **Jennifer Hebdon-Seljestad, 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		It does not appear this document has been revised/reviewed since 2019. It is recommended at least biennial review for accuracy. If it has been reviewed, it is recommended including a record of reviews/revisions with 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			
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			
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		SUMH 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				**N/A**

SUMH staff is happy to provide technical assistance.