



Utah Department of
Health & Human Services
Integrated Healthcare

Office of Substance Use and Mental Health (SUMH)



**Audit Corrective Action Plan (CAP) Report of:
Northeastern
Contract #A03088**

**Audit Review Date: March 3, 2026
Final Report**

Executive Summary

In accordance with Section 26B-5-102, the Office of Substance Use and Mental Health (SUMH) conducted a local authority (LA) audit of Northeastern Counseling Center (Northeastern). The official date of the review was March 3, 2026 for FY25 (July 1, 2024 - June 30, 2025).

The focus of this examination was to evaluate the LA's compliance with contract requirements, SUMH Directives, mandated mental health services, and Preferred Practice Guidelines. During the examination, the review teams evaluated the reliability and integrity of the LA's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the LA's use of financial resources.

This corrective action plan (CAP) report will be due back with input and responses from the LA within 14 calendar days from receipt of the signed audit report. For additional information about this process, please review the [FY26 Office Directives G&O Monitoring Process #4-5 pages 3-4](#).

If you have questions regarding this audit, please address them to Kelly Ovard by email at kovard@utah.gov or by phone at 385-310-5118.

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Governance & Fiscal Findings

None

Program Findings

Finding 2.1 - Written policy regarding screening for and responding to suicide risk

Criteria:

The [FY25 SUMH Office Directives](#) (E. Mental Health Services) indicate “iii. LAs shall have a policy for screening for and responding to suicide risk. Records must contain a suicide screener, suicide risk assessment, and a suicide/crisis safety plan, when indicated, that includes indication of lethal means counseling when clinically indicated.”

Condition:

During FY25, the LA did not have a policy in place regarding screening for suicide risk. The LA did provide the policy “Suicide Risk and Response Policy (December 2025)”, however NECC indicated this policy was not in effect during FY25.

Cause:

It appears that this may have been an oversight on the part of the LA. It is acknowledged that it appears that the LA has historically provided training for personnel regarding screening for and responding to suicide risk.

Effect:

The LA did not have an internal policy for screening for and responding to suicide risk, therefore there wasn’t a formal policy that could be utilized to train new personnel, as well as for personnel to reference as needed.

Recommendations:

Upon the audit request for this policy, the LA created a policy in December 2025. It is recommended that the LA provide evidence that all personnel have been informed of the policy.

Local Authority Action Plan: (See page 8)

Timeline for follow-up or completion:

No later than May 30, 2026.

Local Authority personnel responsible for the action plan:

Kyle Snow, CEO

Tracked at SUMH by:

Becky Johnson

Finding 2.2 - Adult Mental Health Scorecard - OQ measures**Criteria:**

The [FY25 SUMH Office Directives](#) (H. Service, Satisfaction and Outcome Data, iv. Mental Health Outcomes data) require outcome assessments for 75% of unduplicated clients with more than five years of age for whom mental health service data are submitted that experience serious mental illness (SMI) or serious emotional disturbance (SED).

Scorecard link: [Adult Mental Health Scorecard](#)

Condition:

The LAs Percentage of SMI clients that participated in OQ measures was 65%, which is less than SUMH's requirement of 75%.

Cause:

The LA indicated they believe a contributor to this deficiency is turnover with front desk staff. In addition, it appears that clinicians may need to be reminded of this requirement.

Effect:

The data indicates that the LA did not fulfill its responsibility to ensure OQ/YOQ measures were administered to the SMI population at the required percentage, and therefore decreased clinical outcomes information is available to the LA for these populations. The SMI population is inherently vulnerable, and it is imperative that treatment progress is measured.

Recommendations:

It is recommended that the LA thoroughly review the data that was submitted to SUMH. If the LA maintains a position that the data that was submitted is incorrect, the LA must work with the SUMH data team to determine if the data can still be corrected. In that event, the LA should inform the SUMH audit team of the new percentages, so they can be evaluated against SUMH's required percentage.

In the event that the cause is not that the data was incorrectly reported, and the cause is that the LA did not administer the OQ at the required rate, the LA should submit a plan to ensure the standard will be met during the current fiscal year (FY26).

Local Authority Action Plan: (See page 8)

Timeline for follow-up or completion:

No later than May 30, 2026.

Local Authority personnel responsible for the action plan:

Kyle Snow, CEO

Tracked at SUMH by:

Becky Johnson

Finding 2.3 - Percentage of open substance use treatment admissions

Criteria:

The [FY25 SUMH Office Directives](#) (H. Service, Satisfaction and Outcome Data, ii. Service data) indicate "d. Service data submitted through the file utility to SUMH will be prepared by the SUMH data team for submission to the Federal Government. Data will be analyzed and used for the Mental Health Block Grant, for annual reporting on the scorecard, and to assess numbers and types of clients served, numbers and types of services provided, and to assess changes in social determinants of health and other outcomes. 2. Data findings may result for substance use disorder providers when non-methadone outpatient or intensive outpatient admissions, opened more than 2 years prior with no services in the fiscal year, account for more than 4% of clients served in the fiscal year, or for any residential or detox admissions open for more than 2 years without service records."

Condition:

The LA's percentage of FY25 charts that were opened more than two years prior to FY25, with no services provided in FY25, is 7%, which exceeds SUMH's requirement of no more than 4%.

Cause:

The LA did not ensure that no more than 4% of charts, per the requirements indicated above, remained open.

Effect:

Data continues to be reported on the open charts, which contributes to inaccuracies with data reporting.

Recommendations:

It is recommended that the LA review charts and close charts that were opened more than two years prior to FY25, with no services provided in FY25.

Local Authority Action Plan: (See page 8)**Timeline for follow-up or completion:**

No later than May 30, 2026.

Local Authority personnel responsible for the action plan:

Kyle Snow, CEO

Tracked at SUMH by:

Becky Johnson

Finding 2.4 - Substance Use Treatment (SUD) Outcomes Measures Scorecard - Using tobacco**Criteria:**

The [FY25 SUMH Office Directives](#) (H. Service, Satisfaction and Outcome Data, ii. Service data) indicate “d. Service data submitted through the file utility to SUMH will be prepared by the SUMH data team for submission to the Federal Government. Data will be analyzed and used for the Mental Health Block Grant, for annual reporting on the scorecard, and to assess numbers and types of clients served, numbers and types of services provided, and to assess changes in social determinants of health and other outcomes. 1. Results that do not meet federal or internal benchmarks may show as red on the scorecards and may result in audit findings.”

Scorecard link: [Substance Use Treatment Outcomes Scorecard](#)

Condition:

The LA’s percentage of “Using tobacco (in the past 30 days)” is -3% (negative 3%), which is less than 75% of the benchmark, which is the state rural percentage improved (1%).

Cause:

The LA indicated they believe the negative percentage may be a function of clients not providing full transparency about their tobacco use at the time of admission, and the treatment team later learns of their actual use (at admission and during treatment), which may result in a negative percentage.

Effect:

The data suggests that clients are using tobacco at a higher rate upon discharge than upon admission, which has a negative impact on their health. However, as indicated above, the issue may in fact be that clients do not accurately report their tobacco use at admission.

Recommendations:

It is recommended that the LA explore this finding with the treatment team, and include the team's perceptions in the Action Plan.

Local Authority Action Plan: (See page 8)**Timeline for follow-up or completion:**

No later than May 30, 2026.

Local Authority personnel responsible for the action plan:

Kyle Snow, CEO

Tracked at SUMH by:

Becky Johnson

Northeastern Responses

Programming

Finding 2.1 - Written policy regarding screening for and responding to suicide risk

Northeastern Counseling has a policy regarding screening and responding to suicide risk. The policy has been shared with all staff including non-clinical staff in 2026. Clinicians have been aware and previously trained on suicide screening, safety planning and documentation requirements.

Finding 2.2 - Adult Mental Health Scorecard - OQ measures

Northeastern Counseling Center has studied OQ participation under the new format involving individuals living with a Serious Mental Illness (SMI). In SFY2025 78.5% of all adult clients participated in the OQ. The smaller category of adults identified with the SMI data flag participated at a lower level of 65%. The smaller SMI population presents OQ administration challenges that result in a lower percentage of participation.

These include but are not limited to:

- Clients that do receive regular medication, case management, PRS, etc., but do not participate in regular therapy. These individuals miss the opportunity to complete the OQ through the normal process at the clinic's front desk.
- There is an increased likelihood that select SMI clients are not willing or able to complete an OQ without assistance.

Northeastern Counseling Center will formally remind staff of the OQ requirement with special focus on the SMI population. Nurses, case managers, therapists and front desk staff will assist individuals in completing OQ measurements. Including offering paper OQ measurements and motivational interviewing techniques to encourage measurement completion. This will include offering paper copies of the measurement in client homes, at medication appointments, day treatment, etc. Efforts will also include the use of the SOQ 2.0 for individuals that chose to not complete a measure.

Finding 2.3 - Percentage of open substance use treatment admissions

Northeastern Counseling Center has an internal process for closing SUD cases that do not have services over a period of time. This process will continue with data staff taking the lead. Three percent more of the cases needed to be closed to meet the standard. This did not occur due to cases not being closed expeditiously by a small number of therapists and residential cases not being on the report to close. Residential cases have been added

to the report and cases closed the week this document was submitted. NCC will monitor the open admits report which has been assigned to IT staff for tracking and reminders to clinical staff.

Finding 2.4 - Substance Use Treatment (SUD) Outcomes Measures Scorecard - Using tobacco

We believe the negative percentage may be a function of clients not providing full transparency about their tobacco use at the time of admission, and the treatment team later learns of their actual use (at admission and during treatment), which may result in a negative percentage. Clients mark their own tobacco use on intake forms which may contribute to data integrity challenges. Tobacco/Nicotine question will be migrated to evaluation collection instead of client self report. This will be operational by May 30, 2026. The Center offers tobacco cessation services, but participation is not high. This includes offering NRT out of our clinics under a state grant program in addition to NRT prescription services as needed.

Signature Page

We appreciate the cooperation afforded SUMH monitoring teams by the management, staff and other affiliated personnel of Tooele County 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

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Northeastern FY26 Final Audit CAP Report

Final Audit Report


2026-04-07


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By:	Kelly Ovard (kovard@utah.gov)
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