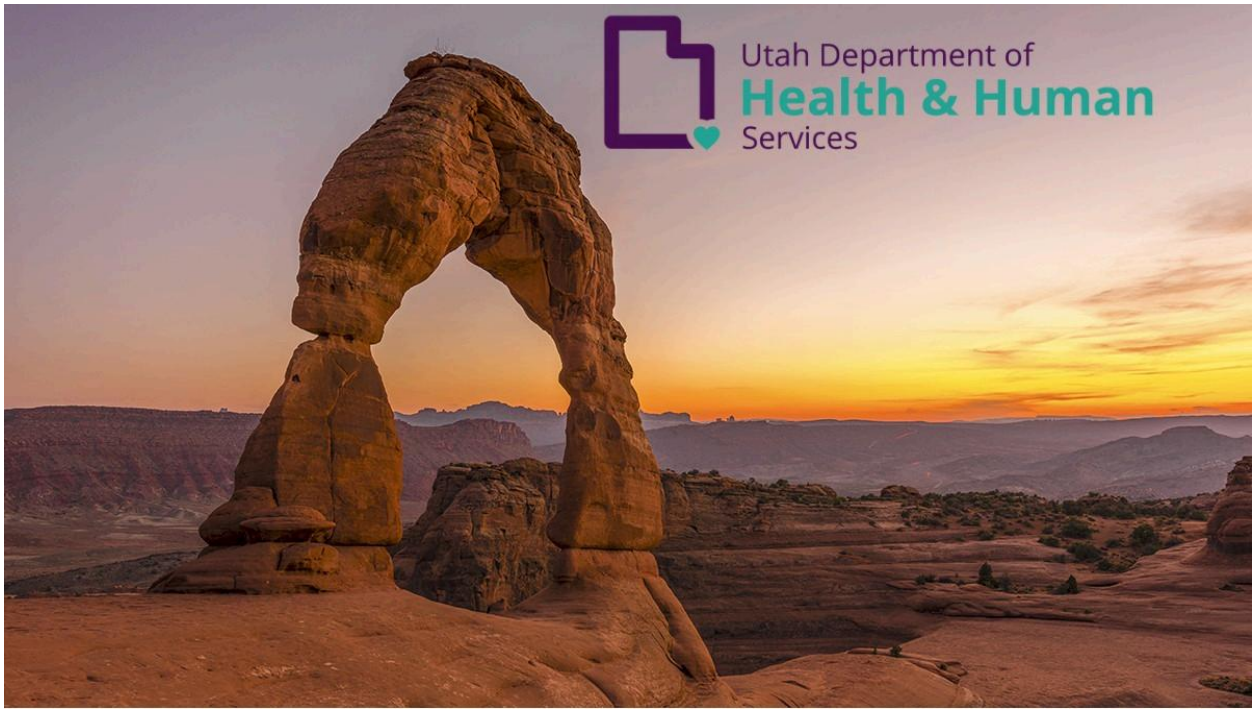
Utah Department of
Health & Human Services
Integrated Healthcare

Office of Substance Use and Mental Health (SUMH)



Audit Corrective Action Plan (CAP) Report of:
Salt Lake County
Contract #A03082

Audit Review Date: February 17, 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 Salt Lake County (SLCo). The official date of the review was February 17, 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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Table of Findings

Governance & Fiscal Findings

None

Program Findings

Finding 2.1 - Data User Gateway System (DUGS) data entry

Criteria:
The FY25 SUMH Office Directives (H. Service, Satisfaction and Outcome Data, vi. Prevention Data Requirements) indicate that the LA must enter prevention data into the SUMH approved system, Data User Gateway System (DUGS), within 45 calendar days of the delivery of service.

Condition:
During FY25, the LA entered DUGS within the required 45 day timeframe 65% of the time.

Cause:
The LA subcontracts with providers who are responsible to provide the data to the LA, and the LA in-turn enters the data in DUGS. The LA reported difficulty with getting data from all of the subcontractors timely, and therefore the LA was unable to enter the data timely. The LA indicated this requirement is included in its contracts with subcontractors.

Effect:
Data entry was not completed in accordance with SUMH's requirements.

Recommendations:

(1) It is recommended that the LA identify and implement strategies to encourage, and in fact require, its subcontractors to submit data on time. The LA should provide the strategies to SUMH, and provide an update to the SUMH audit team regarding progress with implementation.
(2) In the past few weeks, SUMH has implemented a new process (State Prevention Activity Recording Query System - SPARQS) for Prevention services data entry, and the DUGS system will no longer be used. It is recommended that the LA ensure all personnel who enter Prevention data are aware of and receive training regarding the new process.

Local Authority Action Plan: (See Page 7)

Timeline for follow-up or completion:
No later than April 15, 2026

Local Authority personnel responsible for the action plan:
Caroline Moreno, Salt Lake County Prevention Bureau Manager

Tracked at SUMH by:
Becky Johnson

Finding 2.2 - Consumer Satisfaction Surveys, Youth Satisfaction Survey (YSS)

Criteria:
The FY25 SUMH Office Directives (H. Service, Satisfaction and Outcome Data, iii. Consumer satisfaction data, d., 2., c.) indicate "Providers who receive less than 75% of the established target for the outcome domains may receive a finding in the audit report."

2025 Mental Health Statistics Improvement Program Report

Condition:
The LA had one FY25 Youth Satisfaction Survey (YSS) item for which the outcome is less than 75% of the established target:

- Participation in treatment planning - 59% (state average 80%)

Cause:
As the LA does not directly provide substance use disorder treatment services to youth, and has a significant number of subcontractors, it is believed that there is more than one cause, which likely includes:

(1) some providers may refer to the "treatment plan" by terminology, such as "care plan" or "goals", and
(2) some providers didn't review the treatment plan with the youth.

Effect:
41% of the youth who were surveyed did not indicate a positive response regarding "participation in treatment planning".

Recommendations:
It is recommended that the LA communicate this finding to its providers, and discuss with the providers strategies to improve youth perception of engagement in treatment planning and evaluation of treatment progress.

Local Authority Action Plan: (See Page 7)

Timeline for follow-up or completion:
No later than April 15, 2026

Local Authority personnel responsible for the action plan:
Brian Currie, Salt Lake County, Behavioral Health Services, Associate Director of Treatment Services

Tracked at SUMH by:
Becky Johnson

Finding 2.3 - Mental Health Scorecards

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).

Adult Mental Health Scorecard

Youth Mental Health Scorecard

Condition:
For the adult Mental Health Scorecard, Adult Clients with Serious Mental Illness (SMI) - OQ Measures, the percentage of clients that participated was 65.4%, which is less than SUMH's requirement of 75%.

For the Youth Mental Health Scorecard, Youth with Serious Emotional Disturbance (SED) - OQ Measures, the percentage of clients that participated was 43.6%, which is less than SUMH's requirement of 75%.

Cause:
The LA does not directly provide mental health services, rather the services are provided via a significant number of subcontractors, For Medicaid members, the services are provided via Optum Salt Lake, who contracts with providers. It appears that there may be breakdown in monitoring provider compliance with this requirement.

Effect:
The data indicates that the LA did not fulfill its responsibility to ensure OQ/YOQ measures were administered to the SMI and SED population at the required percentage, and therefore decreased clinical outcomes information is available to the LA for these populations. The SMI and SED populations are 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/YOQ at the required rate, the LA should submit their 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 April 15, 2026

Local Authority personnel responsible for the action plan:
Brian Currie, Salt Lake County, Behavioral Health Services, Associate Director of Treatment Services

Tracked at SUMH by:
Becky Johnson

Salt Lake County Responses

Finding 2.1 - Data User Gateway System (DUGS) data entry

During FY25 and the first three quarters of FY26, the Salt Lake County Health Department Substance Use Prevention Program prioritized improving data quality and program fidelity by requesting and submitting improved data from providers. This review and improvement of past data submissions gave the impression that reporting timeliness had significantly decreased. Between October and December 2025, site visits were conducted with each subrecipient to review reporting expectations and provide coaching to support both data quality and timeliness moving forward.

It is important to note that the current measurement approach may inadvertently disincentivize high-quality reporting. Subrecipients facing punitive action for late or out-of-window reporting may be less likely to report certain activities. Conversely, a lack of reporting may result in no corrective action since the absence of data is not recorded.

The SLCoHD Substance Use Prevention Program Manager and team have identified subrecipients who are not in compliance with reporting requirements. Current contract terms require subrecipients to submit data in the County's Quickbase reporting system within 30 days to ensure submission to the state reporting system within the 45-day deadline.

For the remainder of FY26, several subrecipients have been identified as high-risk due to noncompliance with reporting timelines. Targeted training and technical assistance are provided to improve reporting timeliness.

For FY27, contract language will be revised to clarify reporting requirements, and updated expectations will be communicated to all subrecipients. Additional training will be available upon request.

Subrecipients will be evaluated quarterly based on reporting compliance. Those falling below the 80% compliance threshold will be placed on a 90-day monitoring plan, which may include additional training, increased technical assistance, and, in severe cases, withholding of payments.

Finding 2.2 - Consumer Satisfaction Surveys, Youth Satisfaction Survey (YSS)

For Medicaid, we are required to complete a Performance Improvement Project (PIP), a clinical and a non-clinical PIP.

The non-clinical PIP for SLCo focuses on distributing provider specific YSS responses to providers, with the end goal of increasing participation in treatment planning. Those included in the study population received member and/or guardian feedback regarding the youth's engagement in the treatment planning process. In addition, Optum created virtual training to guide providers through the feedback report and how they might interpret the results and create plans for improvement. The "participation in treatment planning" questionnaire item was used as an example for the provider training to outline the steps to create a plan to improve the member experience.

This non-clinical PIP is ongoing and various data has to be gathered and reported back to Medicaid to determine, in the end, if the goal has been achieved. Upon request, we would be happy to keep OSUMH updated as new data becomes available.

Finding 2.3 - Mental Health Scorecards

At the end of CY2025, Optum sent reports to 71 providers identifying which OQ® Analyst client identification numbers were missing or entered incorrectly. Step-by-step instructions were included for providers to make corrections. Of those providers, 24% made corrections. We have yet to know the impact to the SAMHIS encounter match, as there have been challenges with the SAMHIS data. Once that information is available, Optum departments will meet internally to design a plan of action. In addition, Optum is attempting to use claims data to identify which individuals should have a completed OQ® or Y-OQ® but do not.

Finally, there are issues outside of the control of SLCo and Optum which impact the administration of questionnaires and capturing needed data for the match. A meeting has been requested with DHHS to discuss these challenges and to problem solve ways scorecard may capture a more accurate percentage of participating clients. Becky Johnson has scheduled this meeting for April 2, 2026.

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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SLCo FY26 Final Audit CAP Report

Final Audit Report 2026-03-24

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By:	Kelly Ovard (kovard@utah.gov)
Status:	Signed
Transaction ID:	CBJCHBCAABAA5XlbavY4ucBsCz2nfV2TfPQ8p0rCYekv

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