



Utah Department of
Health & Human Services
Integrated Healthcare

Office of Substance Use and Mental Health (SUMH)



**Audit Corrective Action Plan (CAP) Report of:
Wasatch Behavioral Health
Contract #A03080**

**Audit Review Date: January 20, 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 Wasatch Behavioral Health/Utah Co (WBH). The official date of the review was January 6, 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

Program Reviewed	Finding Number	Page(s)
Governance & Fiscal	None	
Programming	2.1	3
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Governance & Fiscal Findings

None

Program Findings

Finding 2.1 - 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 a policy regarding response to suicide risk, “24-Hour Crisis/Emergency Response Services”, which was approved 02/07/2022 and was updated 02/07/2025. This policy addresses crisis/emergency response services, including partnership with the statewide crisis line, WBH mobile crisis outreach team, receiving centers (juvenile and adult) and inpatient psychiatric treatment.

Cause:

It appears that this may have been an oversight on the part of the LA.

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. It is acknowledged that it appears that the LA has historically provided training for personnel regarding screening for and responding to suicide risk, and that clinical documentation generally supports that this has occurred.

Local Authority Action Plan: (See Page 7)

Timeline for follow-up or completion:

No later than March 31, 2026

Local Authority personnel responsible for the action plan:

Randy Huntington, CEO

Tracked at SUMH by:

Becky Johnson

Finding 2.2 - SUD Episode Outcomes Scorecard**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.”

[FY25 Substance Use Disorder \(SUD\) Outcomes Measures](#)**Condition:**

The LA’s percentage of “Arrested (in the past 30 days) - percent improved” was 4%. This is less than 75% of the national percentage improved (38%) and is also significantly below the Utah urban average (70%).

Cause:

At the site visit, the LA made the point that their percentage at admit and percentage a discharge were both very low, compared to other urban LAs. The LA indicated they believe the low admission percentage does not allow much room for improvement.

Effect:

There was minimal change in the percentage of individuals receiving services who were arrested.

Recommendations:

It is recommended that the LA review the data for accuracy. If the data is accurate, though the LA made a valid point that there is not much room for improvement given the admit and discharge percentages, it is recommended that the LA determine if a strategy can be implemented to further improve this metric.

Local Authority Action Plan: (See Page 7)

Timeline for follow-up or completion:

No later than March 31, 2026

Local Authority personnel responsible for the action plan:

Randy Huntington, CEO

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).

[FY25 Adult Mental Health Scorecard](#)

[FY25 Youth Mental Health Scorecard](#)

Condition:

Regarding the Adult Mental Health Scorecard, the 57% clients with Serious Mental Illness (SMI) participated in completion of OQ measures, which is less than SUMH's requirement of 75%.

Regarding the Youth Mental Health Scorecard, 57% of clients with Serious Emotional Disturbance (SED) who participated in completion of OQ measures, which is less than SUMH's requirement of 75%.

Cause:

The root cause needs to be thoroughly explored by the LA. Upon receipt of the audit report, the LA has indicated a discrepancy regarding the data. However, as the SUMH data team provided the LA an opportunity to review the data and provide feedback prior to finalization of the Scorecard, the finding will remain and the LA can address the discrepancy in this report.

Effect:

The data indicates that the LA did not complete OQ/YOQ measures with 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 7)

Timeline for follow-up or completion:

No later than March 31, 2026

Local Authority personnel responsible for the action plan:

Randy Huntington, CEO

Tracked at SUMH by:

Becky Johnson

Wasatch Behavioral Health/Utah County Responses

Finding 2.1 - Policy regarding screening for and responding to suicide risk

WBH developed and approved a policy for Screening and Responding to Suicide Risk in December 2025 that formalized our existing procedures. Following the recommendations of the Office, all WBH staff were informed of this policy via email on March 19th, 2026.

Finding 2.2 - SUD Episode Outcomes Scorecard

WBH thoroughly reviewed the data point 'Arrested in the past 30 days' at both intake and discharge and found that it was largely correct. With a measurement 'N' of approximately 55 individuals, improvement on this metric may be difficult. It is possible that our processes of reviewing outcomes at discharge may be such that sufficient attention is not given to documenting any change of this particular data point. Therefore, WBH will give specific training to staff on reporting outcomes and paying particular attention to documenting any changes at regular intervals and at discharge.

Finding 2.3 - Mental Health Scorecards

As referenced in the Audit Corrective Action Plan Report of Wasatch Behavioral Health, we believe that the vast majority of the discrepancy between the requirement that 75% of SPMI/SED clients receive outcome measures and the observed FY25 performance at WBH is due to a discrepancy in the data, which admittedly, Wasatch Behavioral Health (WBH) should have identified sooner when the preliminary scorecard data was distributed. Upon further investigation, the discrepancy appears to be due to a large number of clients who received questionnaires in the OQ Analyst system who did not "match" with any client that we submitted data for in FY25. There were 2210 unique clients in that category. Based on scorecard estimates showing 73.7% of WBHs client population as being SMI/SED, we would estimate that about 1,630 of the 2210 unmatched clients would fall into the SMI/SED category. If we distribute that between adult and youth based

off the percent served (67% of our clients served in FY25 were adults), we can assume that without any OQ mismatches, we would have ended up with an YOQ administration rate of about 74% for youth and about 80% for adults. Thus, our first corrective action during the coming year will be to carefully review scorecard data and cure any mismatches in the system before the data are finalized. As is likely apparent, this action would have resolved the vast majority of the discrepancy between the requirement and observed performance on this item, but would have left WBH 1% below the standard for youth. To ameliorate this deficiency, WBH has planned quarterly meetings with the executive and management teams during which Y/OQ collection performance will be reviewed in order to maintain focus on improving collection rates during the current and future fiscal years.

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

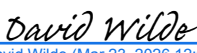
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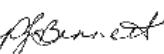
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Wasatch Behavioral Health FY26 Final Audit CAP Report

Final Audit Report


2026-03-24


Created:	2026-03-23
By:	Kelly Ovard (kovard@utah.gov)
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Transaction ID:	CBJCHBCAABAA4QF0kPcLcwo_bJkSZLnemmDG2h5BbtBg


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