



Utah Department of
Health & Human Services
Integrated Healthcare

Office of Substance Use and Mental Health (SUMH)



**Audit Corrective Action Plan (CAP) Addendum Report of: Central
Contract #A03081
Addendum Audit Review Date: April 6, 2026**

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Corrective Action Plan Addendum Summary

This is the Corrective Action Plan (CAP) report for the Central Utah Mental Health Substance Abuse Center audit report addendum. The addendum was necessary because FY25 SUMH Scorecard data and substance use provider chart data were not available at the time of the initial audit (which included a site visit) as the Local Authorities (LAs) are provided time to submit final data and year-end data corrections after the end of the State Fiscal Year. In addition, finalization of SUD data requires an additional 30 days after the data correction period. At the time of the initial audit the LA was informed that a desk audit would be conducted following finalization of the data indicated above, and this was indicated in the initial audit report.

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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Program Findings

Finding 2.1 - SUD Episode Outcomes

Criteria: The [FY25 SUMH Office Directives](#) (H. Service, Satisfaction and Outcome Data, d., 1.) indicate “Results that do not meet federal or internal benchmarks may show as red on the scorecards and may result in audit findings.”

Condition: The item below is less than 75% of the national percentage improved, and is indicated in red on the [FY25 Substance Use Disorder \(SUD\) Outcomes Measures Scorecard](#):

- Using tobacco (in the past 30 days) - % improved
 - - 8% (negative 8%) (rural average 1%)

Cause: The cause is unclear and the LA should provide an explanation in their response.

Effect: The data indicates that clients who were served by the LA have a lower percentage of improvement with tobacco use than the rural average.

Recommendations: It is recommended that the LA review this data point and establish a plan to increase the percentage of decreased client tobacco use.

Local Authority Action Plan:

Cause Response: Data entry errors may be occurring at admission. Specifically, nicotine use prior to an individual entering a controlled environment may not be consistently or accurately documented, which may be impacting outcome reporting. CUCC is also concerned that variability in who is entering the data may be contributing to inconsistencies.

Plan: CUCC Team Leaders will provide guidance and feedback to clinical teams on proper procedures for documenting nicotine use at intake and will reinforce that therapists are responsible for entering this data as part of the evaluation process.

CUCC will discuss these reporting concerns and additional strategies to reduce tobacco use and improve DIMENSIONS program visibility/access, during Central Administrative and QAPI Meetings.

Timeline for follow-up or completion: May 31, 2026

Local Authority personnel responsible for the action plan: Jared Kummer, Clinical Director

Tracked at SUMH by: Becky Johnson

Finding 2.2 - Youth Mental Health Scorecard, Mandated Services

Criteria: The [FY25 SUMH Office Directives](#) (H. Service, Satisfaction and Outcome Data, ii. Service Data) indicate: “Results that do not meet federal or internal benchmarks may show as red on the scorecards and may result in audit findings.”

Condition: The items below were indicated in red on the [FY25 Youth Mental Health Scorecard](#):

- Utilization of Mandated Services (percentage of clients receiving services)
 - Peer Support
 - 0.0% (rural average 0.7%)
- Time in Service for Mandated Services (days or hours)
 - Peer Support
 - 0.0 median (rural median 2.0)
 - 0.0 average (rural average 3.5)

Cause: The cause is unclear and the LA should provide an explanation in their response.

Effect: The data indicates the LA didn't provide Peer Support services, which is a mandated service and must be provided for individuals who are in need of the service.

Recommendations: It is recommended that the LA review FY25 provision of Peer Support services and determine why this service was not provided in FY25. The LA should review provision of this service in the current fiscal year (FY26) to evaluate if services are being provided for clients for whom the service is clinically indicated.

Local Authority Action Plan:

Cause Response:

In FY2025, CUCC did not provide Peer Support services due to the absence of a Certified Family Peer Support Specialist. This was the result of a staff departure, which left CUCC without qualified personnel to deliver this service.

Plan: CUCC will identify and select an appropriate staff member to apply for Family Peer Support Specialist training. Upon approval, the selected individual will complete the

required training to become a Certified Family Peer Support Specialist, ensuring future capacity to provide this mandated service. Progress on this corrective action and the provision of Peer Support services will be reviewed at QAPI meetings, which occur on a generally monthly basis.

Timeline for follow-up or completion: June 30, 2026

Local Authority personnel responsible for the action plan: Jared Kummer, Clinical Director

Tracked at SUMH by: Becky Johnson

Finding 2.3 - Percentage of Substance Use Provider Open Admissions

Criteria: The [FY25 SUMH Office Directives](#) (H. Service, Satisfaction and Outcome Data, ii. Service data) indicate “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, with no services in the fiscal year, is 21%.

Cause: The LA did not close charts when clients were no longer receiving services.

Effect: Outcome measurements are inaccurate.

Recommendations: The LA should review charts per the standard indicated in the FY25 SUMH Office Directives and close charts as required.

Local Authority Action Plan:

Corrective Action Plan:

CUCC has initiated an audit of open clients in the SAMHIS system and is comparing them to internal records to identify discrepancies (e.g., clients closed in the CUCC EHR but not closed in SAMHIS).

Proper discharge documentation procedures are being reinforced with clinical staff and teams.

A monthly report will be generated and distributed directly to involved clinical staff and team leaders, identifying clients requiring closure. Progress will be monitored through QAPI meetings.

Timeline for follow-up or completion: June 30, 2026.

Local Authority personnel responsible for the action plan: Jared Kummer, Clinical Director

Tracked at SUMH by: Becky Johnson

Signature Page

The Office of Substance Use and Mental Health:

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Central FY26 Audit CAP Report - Final Addendum


Final Audit Report


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