



Utah Department of  
**Health & Human Services**  
Integrated Healthcare

**Office of Substance Use and Mental Health (SUMH)**



**Audit Final Corrective Action Plan (CAP) Final Addendum Report of:**  
**Davis County/Davis Behavioral Health**  
**Contract #A03091**

**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 Davis County/Davis Behavioral Health (DBH) 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](mailto:kovard@utah.gov) or by phone at 385-310-5118.

## Table of Findings

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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
  - - 3% (negative 3%), (urban 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 urban 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:

After reviewing our submission data versus the clinical assessments, we believe we may be providing inaccurate information about tobacco use at admission. The tobacco information is currently being gathered by our intake team. We will provide additional education and training about soliciting this information from clients and accurately documenting their current use.

We will monitor this based on the fiscal year end report, as well as the mid-year report for next fiscal year. If we do not see improvements, we may move the collection of this data element to the clinician completing the initial evaluation.

Additionally, we recognize that some clients may increase their tobacco use as they decrease the use of other substances. We will continue to assess tobacco use throughout treatment and refer to resources such as our tobacco cessation group and NRT as appropriate.

Training and education will begin immediately, with reports monitored as available. We anticipate we will continue to monitor into the next fiscal year.

**Timeline for follow-up or completion:** Documentation regarding staff training and education is due no later than May 31, 2026.

**Local Authority personnel responsible for the action plan:** Kim McComas, Clinical Director

**Tracked at SUMH by:** Becky Johnson

## Finding 2.2 - Adult Mental Health Scorecard

**Criteria:** The [FY25 SUMH Office Directives](#) (H. Service, Satisfaction and Outcome Data, iv. Mental Health Outcomes Data) indicate “SUMH requires 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).”

**Condition:** The [FY25 Adult Mental Health Scorecard](#) indicates 46.8% of SMI clients participated in the OQ.

**Cause:** The LA did not adequately track this metric throughout the fiscal year, to ensure the required percentage was met.

**Effect:** The LA did not collect enough data to accurately evaluate outcomes for the SMI population.

**Recommendations:** It is recommended that the LA review FY26 OQ participation rates to ensure the required percentage will be met for both the SMI and SED populations.

### Local Authority Action Plan:

We have spent a significant amount of time reviewing our data and consulting with the data consultants at SUMH to determine the cause of this. We discovered that many of our clients who participate in medication management only were being pulled into our denominator but we were not routinely administering the OQ. They are being included because we enter services that are associated with a code that pulls them in as a mental health client and not just a medical only client.

After discovering this, we altered our processes to give the OQ to all clients we serve, regardless of what program they are in. Clients are asked to complete it when they come

in for their appointments and we are also sending the link out electronically via text message, as available.

To monitor this, we will pull a random selection of clients from all providers (therapists and medical) each month to check if they have completed an OQ. The results of this will guide further discussion about barriers and additional interventions.

DBH was able to identify the likely cause of the problem in December 2025. We implemented our new process in February 2025 and are monitoring regularly. Because we did not identify the problem and a viable solution until late in the fiscal year, we anticipate we will show improvement but may not fully meet the requirement. Additional monitoring and changes to interventions will likely continue into next fiscal year.

**Timeline for follow-up or completion:** On or before June 15, 2026, DBH should provide an update regarding the percentage of SMI clients that participated in the OQ during the months of March, April and May 2026 (each month reported separately).

**Local Authority personnel responsible for the action plan:** Kim McComas, Clinical Director

**Tracked at SUMH by:** Becky Johnson

## Signature Page

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# Davis FY26 Audit CAP Report - Final Addendum


Final Audit Report


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