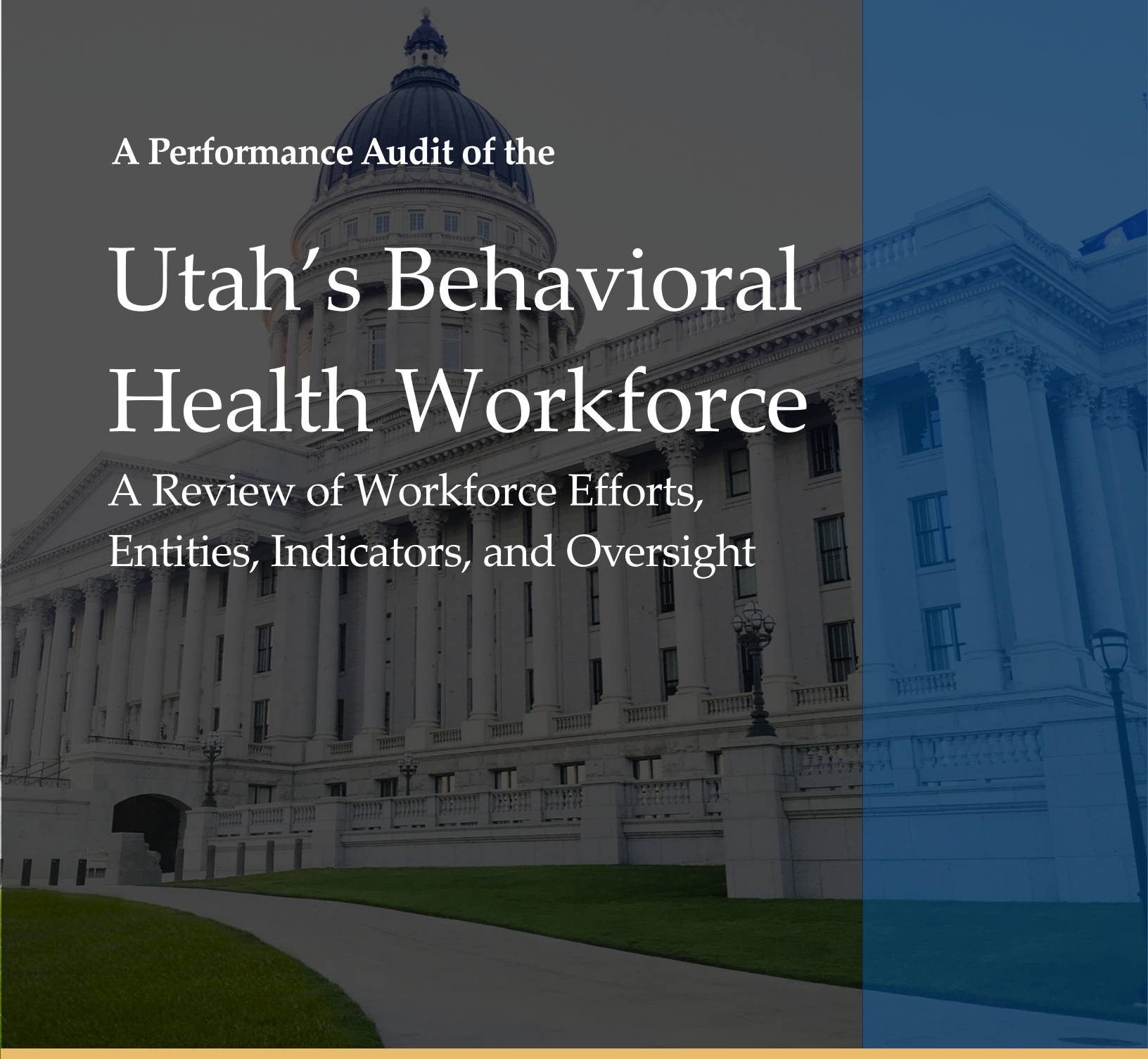
Report No. 2025-05



A Performance Audit of the

Utah's Behavioral Health Workforce

A Review of Workforce Efforts, Entities, Indicators, and Oversight

Office of the Legislative Auditor General

Report to the **UTAH LEGISLATURE**

LEGISLATIVE AUDITOR GENERAL
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April 15, 2025

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report:

"A Performance Audit of Utah's Behavioral Health Workforce: A Review of Workforce Efforts, Entities, Indicators, and Oversight" [Report #2025-05].

An audit summary is found at the front of the report. The scope and objectives of the audit are included in the audit summary. In addition, each chapter has a corresponding chapter summary found at its beginning.

***Utah Code* 36-12-15.3(2)** requires the Office of the Legislative Auditor General to designate an audited entity's chief officer. Therefore, the designated officers are

- Executive Director Tracy Gruber, Department of Health and Human Services
- Chair Ally Isom, Utah Behavioral Health Commission

Each designated chief officer has been notified that they must comply with the audit response and reporting requirements as outlined in this section of ***Utah Code***.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade Minchey

Kade R. Minchey, CIA, CFE

Auditor General

kminchey@le.utah.gov

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LEGISLATIVE AUDITOR GENERAL

AUDIT SUMMARY

REPORT 2025-05 | APRIL 2025

Office of the Legislative Auditor General | Kade R. Minchey, Auditor General

PERFORMANCE AUDIT

UTAH'S BEHAVIORAL HEALTH WORKFORCE

AUDIT REQUEST

The Legislative Audit Subcommittee requested an audit of Utah's behavioral health system. Our office conducted an initial risk assessment and identified workforce challenges as a contributing factor to broader issues within the behavioral health system. Consequently, this audit focuses on Utah's behavioral health workforce.

BACKGROUND

Nationwide, the demand for behavioral health services has surged due to increasing mental health and substance use needs. This has created a critical need for more providers to meet the growing demand.

A recent Utah report indicated that the state requires an additional 8,000 behavioral health professionals to adequately meet the current need for care. Despite this urgent need, much of Utah's understanding of its behavioral health workforce relies on national measures, which may not fully capture the state's unique challenges.

KEY FINDINGS

- **1.1** Utah's Behavioral Health Workforce Entities Lack Formal Coordination and Data Sharing
- **2.1** Lack of Quantitative Data Limits Stakeholders' Ability to Make Informed Workforce Decisions
- **2.2** DHHS Should Address Barriers That Hinder Workforce Hiring for Public Behavioral Health Sector Providers
- **3.1** Lack of State Guidance on Mental Health Staffing Roles and Services Leads to Underutilization of Clinical Mental Health Services in Schools
- **4.1** Network Adequacy Challenges May Result in Decreased Access to Care

RECOMMENDATIONS

- **1.5** The Health Workforce Advisory Council, with input from the Behavioral Health Commission, should develop a strategic plan for behavioral health workforce efforts and determine the effectiveness of these measures.
- **2.1** The Office of Substance Use and Mental Health should require local authorities to indicate if service deficiencies are related to workforce challenges as part of their annual audit process.
- **3.5** The Legislature should consider requiring the Utah Behavioral Health Commission to create a framework for school-based mental health services, with the input of the Office of Substance Use and Mental Health, the Utah State Board of Education, and Local Education Agencies.
- **4.1** The Legislature should consider updating ***Utah Code*** for online provider directories, including accuracy requirements and the role of state oversight.

REPORT SUMMARY

While Utah Has Made Investments to Its Behavioral Health Workforce, Better Coordination and Strategy Among Efforts and Entities Are Still Needed

State entities should better evaluate behavioral health efforts to provide policymakers with data-driven strategies for effective workforce development. Without strategies, resources may be allocated to ineffective efforts.

There Is Insufficient Data to Quantify Behavioral Health Public Sector Workforce Challenges and Inform Hiring Barriers

Workforce indicators such as vacancies, salaries, and employment numbers were scattered, inconsistent, and difficult to obtain from local authorities. However, existing processes can better identify and document hiring challenges, and provide more quantifiable information on local staffing trends.

There Are Opportunities to Improve Utah's School-Based Mental Health Services

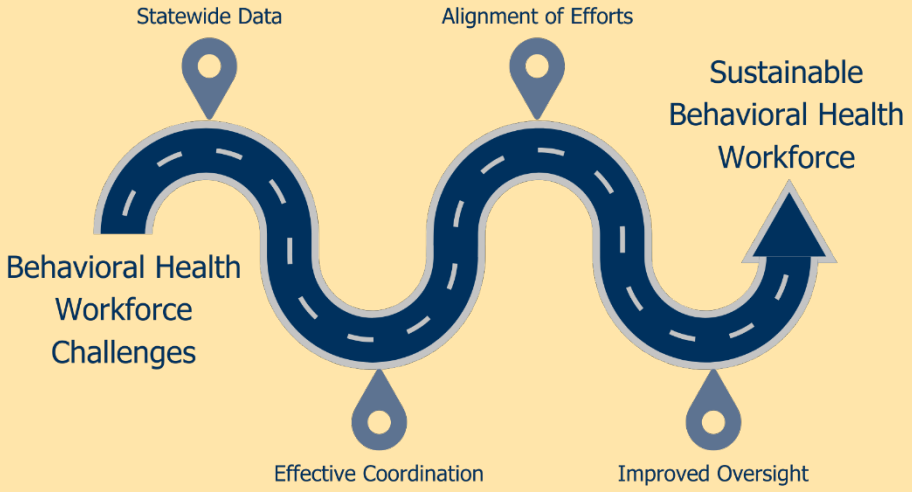
USBE's School-Based Mental Health Qualifying Grant Program lacks a focus on mental health outcomes and does not define roles for school-based mental health staff and services. The increase of school-based mental health professionals—without required coordination between community-based services—may have further siloed the public behavioral health workforce.

Inaccuracies in Utah's Commercial Health Provider Directories May Limit Access to Care

There are numerous inaccuracies in Utah's commercial insurance directories, making it difficult for residents to contact providers or set up appointments. These inaccuracies may delay care and may even cause individuals to forgo care altogether, even with insurance.

Several Factors Contribute to Workforce Challenges

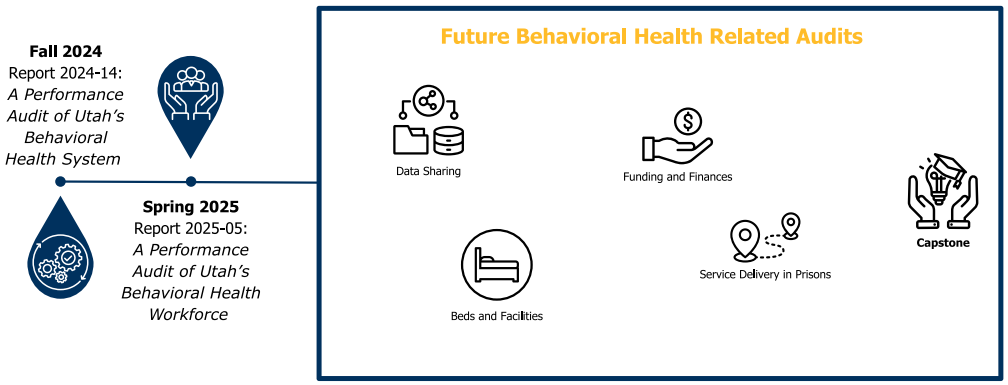
While these solutions are not comprehensive, addressing statewide data limitations, tackling challenges with coordination, aligning workforce bosltering efforts, and improving oversight can help lead to a sustainable behavioral health workforce.



Introduction

The behavioral health workforce plays a critical role in addressing the mental health and substance use challenges faced by individuals and communities across Utah. Currently, the state's demand for behavioral health services outpaces the limited number of providers. Therefore, those in need of services cannot always receive them. This is part of a broader national workforce crisis driven by the rising demand for behavioral health services. Building a sustainable, robust, skilled, and resilient workforce is even more imperative in Utah because the state has the highest rates of adult mental illness and suicide ideation in the U.S.[1] This workforce is the backbone of delivering critical services—without it, access to care and support for those in need becomes impossible.

This is the second in our series of audits that focus on challenges in Utah's behavioral health system. Further audits will address the funding, facilities, and quality of behavioral health services.[2] This report will focus on the workforce that administers and delivers those resources and services.[3] Although OLAG's audits do not cover every aspect of Utah's behavioral health system, they highlight the key priorities and recommendations we identified as essential for improvements.



[1] National Survey on Drug Use and Health (NSDUH)

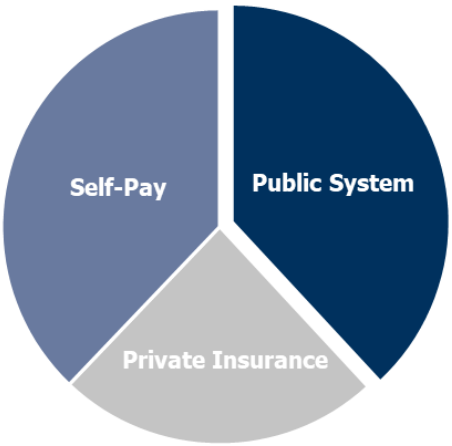
[2] The scope of future audits in this series may vary.

[3] The behavioral health workforce encompasses a range of professionals dedicated to addressing mental health and substance use challenges. This workforce includes licensed professionals such as social workers, psychiatrists, psychologists, clinical mental health counselors, and substance abuse disorder counselors, as well as state-certified paraprofessionals such as case managers and peer support specialists. Primary care providers are also one of the main providers of behavioral health services.

This report builds upon several recent efforts, including the *Utah Behavioral Health Assessment & Master Plan* and the Office of Professional Licensure Review (OPLR) Periodic Review of Behavioral Health, to address problems within Utah's behavioral health workforce. Our report provides additional information on Utah's behavioral health care workforce and the entities involved in studying its growth and sustainability.

Documenting the Supply and Demand of the Behavioral Health Workforce Is Complex

Understanding the behavioral health workforce is complicated. Determining workforce supply is challenging because of the variety of provider types and their overlapping scopes of practice (different providers can carry out similar duties). Documenting demand for services is also difficult due to patient need, service delivery, and access, with measures that often rely on survey data or population ratios. Workforce data does not exist in a state level repository but instead exists in several different sources.[4] Licensing boards, departments of health, educational institutions, employers, and professional organizations often maintain their own data on providers and staff. These multiple collection points do not allow for a systemic review of the behavioral health workforce.



Source: Auditor generated from DOPL survey data

Behavioral health workforce challenges may also arise from a misalignment between where providers work and accept insurance and how patients seek and access care. Nearly two-thirds of the state receives behavioral health coverage through private insurance, yet only a quarter of surveyed providers accept private insurance. Private insurance and self-pay systems are harder to study and, aside from licensing, are largely outside state regulatory oversight. Chapter Four of this report does provide insights and recommendations for future study of the private insurance system. However, most of our analysis centers on the public system, given its direct connection to state-level oversight.

A reoccurring theme in this audit is the lack of quantitative data analysis on the workforce to fully and accurately define workforce challenges. Addressing the complexities of the behavioral health workforce demands sustained commitment

[4] Discussion of state level data on the workforce will be discussed in future chapters.

from state entities (detailed in Chapter One) to enhance data, policy, and definitions, thus ensuring a sustainable, effective workforce to serve citizens' needs.

This Audit Focuses on Improving Systems and Entities Tasked With Workforce Data and Sustainability

Recently, significant work has been done to document the behavioral health workforce and its challenges in the state. The OPLR Periodic Review of Behavioral Health in Utah provides the most recent and comprehensive data on the state's workforce. The report concluded that the state requires 8,000 more providers in the workforce to meet the needs of Utah residents. The audit team chose not to recalculate the workforce gap number in the report. Instead, we chose to focus on how systems and entities can better quantify the workforce, and recruit and retain providers to improve access and reduce Utah's unmet need. Below are some national and state level indicators of Utah's behavioral health workforce.

Shortage Areas	Workforce Projections	Unmet Need
27 of Utah's 29 counties, are designated as a health professional shortage area for mental health providers.	Of the behavioral health related occupations with available adequacy projections, 6 occupations are projected to be below 100% adequacy in 2035.	8,000 more providers, including advanced specialists, clinicians, and paraprofessionals are needed to meet Utah's unmet need for services.

Source: Utah Office of Primary Care and Rural Health, Health Professional Shortage Areas (HPSA), National Center for Health Workforce Analysis, and OPLR Periodic Review of Behavioral Health

Utah ranked 15th in mental health workforce availability, while ranking 46th for adult mental health outcomes.

In a comparative analysis of 50 states, Utah ranked 15th in mental health workforce availability, while ranking 46th for adult mental health outcomes.[5] This suggests that while workforce quantity is one crucial factor, access, insurance acceptance, and quality of the workforce are other important pieces in solving challenges in the state's behavioral health system.

[5] Mental Health America (2023). The State of Mental Health in America. This report compiles data from national surveys to answer questions about all 50 states and the District of Columbia on behavioral health outcomes. The adult rankings are based on 7 measures. The mental health workforce availability measure includes ratios of psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care.

Utah Behavioral Health Assessment & Master Plan:

"We cannot continue to do the same things in terms of treatment, workforce, and access if we want to move the needle."

This audit builds on existing knowledge and seeks to document the state's efforts to eliminate workforce shortages, enhance ongoing initiatives, and improve the evaluation, measurement, and coordination of workforce strategies. We also acknowledge the constraints of what the state can realistically achieve within the context of broader national challenges, such as insurance enforcement, reimbursement policies, and market forces. By examining both supply and demand dynamics, evaluating the state's alignment with national best practices, and providing targeted recommendations, this report aims to enhance Utah's ability to develop and maintain a sustainable behavioral health workforce that meets the needs of its residents.

We want to note that the recommendations made in this report are based on the system in its current form. A previous audit recommended that the Legislature consider options to create a strong central authority over the behavioral health system. If this were to take place, any recommendations from this audit would pass on to that entity. The following chapters analyze some of the causes behind behavioral health workforce challenges in Utah:

1. While Utah Has Made Investments in Its Behavioral Health Workforce, Better Coordination and Strategy Among Efforts and Entities are Still Needed
2. There Is Insufficient Data to Quantify Behavioral Health Public Sector Workforce Challenges and Inform Hiring Barriers
3. There Are Opportunities to Improve Utah's School-Based Mental Health Services
4. Inaccuracies in Utah's Commercial Health Provider Directories May Limit Access to Care

CHAPTER 1 Summary

While Utah Has Made Investments to Its Behavioral Health Workforce, Better Coordination and Strategy Among Efforts and Entities Are Still Needed

BACKGROUND

The Legislature has shown clear and explicit interest in utilizing expert input to create solutions for the healthcare workforce. Over the past 30 years, Utah has established several entities to study and address the healthcare workforce. In recent years, they have added entities to study the behavioral health workforce.

FINDING 1.1
Utah's Behavioral Health Workforce Entities Lack Formal Coordination and Data Sharing

RECOMMENDATION 1.1
The Department of Health and Human Services should ensure the Health Workforce Information Center has adequate access to behavioral health workforce data sources for workforce evaluation.

RECOMMENDATION 1.2
The Health Workforce Information Center should evaluate all behavioral health providers in its analysis of the behavioral health workforce.

RECOMMENDATION 1.3
The Health Workforce Advisory Council and the Utah Substance Use and Mental Health Advisory Committee should evaluate their legislative review processes for the behavioral health workforce and eliminate any duplicative efforts.

RECOMMENDATION 1.4
The Legislature should consider formalizing the reporting structure between the Behavioral Health Commission and the Health Workforce Advisory Council on behavioral health workforce analysis and policy related recommendations.

FINDING 1.2
Workforce Entities Should Identify and Prioritize Effective Workforce Strategies

RECOMMENDATION 1.5
The Health Workforce Advisory Council, with input from the Behavioral Health Commission, should develop a strategic plan for behavioral health workforce efforts and determine the effectiveness of these measures.

CONCLUSION

HWAC should bolster strategic planning for the behavioral health workforce by quantifying effective workforce strategies and efforts to help direct resources into the most impactful areas. In order to comprehensively address statewide workforce challenges, these strategies should focus on all sectors that hire behavioral health professionals.

Chapter 1
While Utah Has Made Investments in Its Behavioral Health Workforce, Better Coordination and Strategy Among Efforts and Entities Are Still Needed

Utah's Health Workforce Advisory Council, Health Workforce Information Center, and Behavioral Health Commission should better evaluate behavioral health workforce efforts. This will provide policymakers with data-driven strategies for effective workforce development. Without better coordination and strategy, decision-makers may allocate resources to ineffective efforts. In recent years, Utah policymakers have taken steps to strengthen the state's behavioral health workforce. They established three new entities, enacted nearly 50 legislative measures, and allocated multiple appropriations to bolster the behavioral health workforce.

Recognizing Utah's finite resources, this chapter examines workforce related entities and evaluates key workforce efforts.

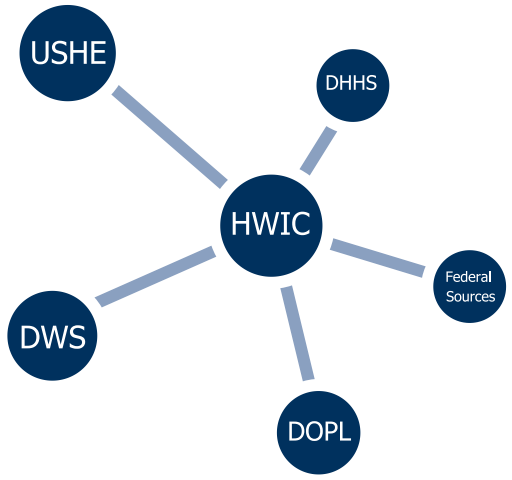
Amid national behavioral health workforce shortages and rising demand for services, unified strategies are essential to break down existing silos. This chapter examines workforce related entities and evaluates key workforce efforts. It sets the stage for how state entities can better understand workforce challenges and inform solutions for different sectors that employ behavioral health providers, such as education and public and private systems (as discussed in future chapters of this report). Recognizing Utah's limited resources, our audit aims to ensure that processes and structures are effective and deliver the most value to citizens as the state works to improve behavioral health outcomes. We recommend the continuation of developing data-driven strategies with clearly defined evaluation metrics to further advance workforce initiatives and increase coordination among stakeholders and entities involved in creating a sustainable workforce.

1.1 Utah's Behavioral Health Workforce Entities Lack Formal Coordination and Data Sharing

Various entities collect, house, and analyze behavioral health workforce data in Utah, making coordination essential for effective analysis and decision-making.

Several of these entities are shown in the graphic to the right.[6] Housing and analyzing data within different entities makes it difficult to determine how many behavioral health providers are needed or which types of providers are in greatest demand.[7] The recently created Health Workforce Information Center (HWIC) is uniquely positioned to be the state's central repository and analysis hub for not only behavioral health workforce data, but also for other health professions.

HWIC Can Be a Central Repository for Workforce Data



Source: Auditor generated

The Office of Professional Licensing and Review (OPLR) estimates that Utah requires at least 8,000 additional providers to meet the state's behavioral health needs. While the report detailed what types of providers are likely needed (e.g., advanced behavioral health specialists, clinical therapists, and behavioral health support), it did not speak to where those providers should be employed to meet demand. Additionally, a lack of coordinated data sharing makes it difficult to track where these providers are trained, where they practice, and whether they are accessible to those in need.

A lack of coordinated data sharing makes it difficult to track where these providers are trained, where they practice, and whether they are accessible to those in need.

Improvements Could Be Made to State Entities Addressing Behavioral Health Workforce Challenges

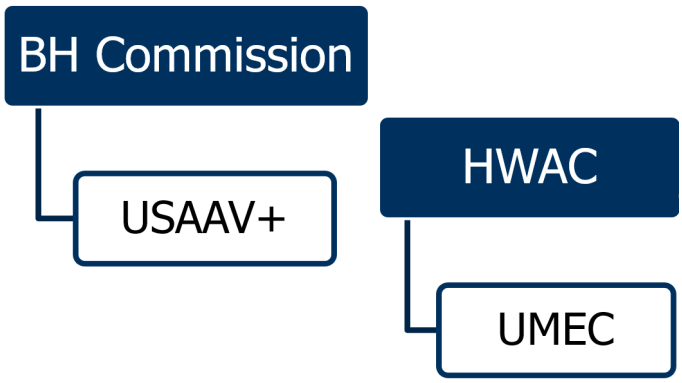
The Legislature has shown clear and explicit interest in utilizing expert input to create solutions for the healthcare workforce. Over the past 30 years, Utah has established several entities to study and address the healthcare workforce. In recent years, they have added entities to study the behavioral health workforce. existing organizations. These new entities created structural changes that shifted

[6] Health Workforce Information Center (HWIC), Utah System of Higher Education (USHE), Department of Workforce Services (DWS), Division of Professional Licensing (DOPL), and Department of Health and Human Services (DHHS)

[7] The workforce contains a wide range of professionals, from peer support specialists and psychiatric technicians to primary care doctors and psychiatrists—all of whom play a critical role in delivering mental health and substance use treatment across Utah.

duties and reporting lines, integrating new entities into established frameworks while redefining roles and responsibilities across the system.

- **1997**—Utah Medical Education Council (UMEC): Legislation authorized UMEC to conduct healthcare workforce research, to advise on Utah's healthcare training needs, and to influence graduate medical education strategies and policy initiatives.
- **2016**—Utah Substance Use and Mental Health Advisory Committee (USAAV+): Aims to reduce and eliminate the impact of substance use and mental health disorders in Utah. The Council has a subcommittee dedicated solely to the behavioral health workforce.
- **2022**—Health Workforce Advisory Council (HWAC) and Health Workforce Information Center (HWIC): The Council is charged with convening workforce experts to provide information and recommendations to help expand and strengthen Utah's health workforce. HWIC is the data arm to the Council to inform its policy recommendations.
- **2024**—Utah Behavioral Health Commission: Created to be the central authority for coordinating behavioral health initiatives across the state. The Commission is required to cooperate with stakeholders to oversee the creation and implementation of behavioral health workforce initiatives for the state.



Source: Auditor generated

HWIC Should Better Implement its Codified Role to Analyze Data From Any Available Source Regarding Utah's Health Workforce

In 2022, the Legislature specifically recognized the need to better understand and strengthen the health workforce, and to better coordinate efforts among state

workforce entities with the creation of HWAC.[8] They also created institutional data support for HWAC in the form of the Health Workforce Information Center (HWIC). HWIC intends to offer specialized expertise in healthcare workforce data collection, research, analytics, and reporting.[9] The relationship between the two entities is detailed below.

Health Workforce Information Center Goal:

"Under the guidance of the HWAC, the HWIC works with stakeholders across the state to assess the supply, demand, distribution, and retention of healthcare providers. It also helps determine progress toward the goal of Utah having a diverse, well-qualified, and sustainable workforce that fairly meets the needs of all its residents."

Current behavioral health workforce data largely comes from federal sources. This limits the state's ability to react swiftly to new challenges and assess the effectiveness of its own policies. HWIC has an opportunity to harness not only federal data, but additional state specific resources for analysis. While this report does not fully explore all existing data sources,[10] we believe there are untapped state-level data sets that could provide deeper insights into workforce trends. However, data sharing challenges may further inhibit access to these sources. Without a coordinated approach to data collection and analysis, policymakers lack the necessary tools to assess workforce gaps accurately and allocate resources efficiently.

At the time of this audit, HWAC and HWIC had been operational for a little over two years, and the Behavioral Health Commission for only six months. Given their roles in addressing behavioral health workforce concerns, we focused our evaluation on their structures, processes, and work. We believe that HWIC's codified role to "analyze data from any available source regarding Utah's health workforce" makes it the primary entity on behavioral health workforce data in the state. However, several improvements are needed to enhance its effectiveness, particularly in refining processes, strengthening coordination with

[8] As noted in H.B. 176, statutory duties of HWAC include providing recommendations to strengthen the workforce serving Utahns, commenting on legislation related to the health workforce, and providing guidance to state entities on health workforce related matters.

[9] Statutory duties of HWIC include analysis to ascertain the number and mix of providers (physicians, advanced practice nurses, physician assistants, dentists, pharmacists, podiatrists, etc.) in Utah's healthcare workforce; provider demographic, geographic, and employment distributions; and projections for the future supply and demand for healthcare workers across the state.

[10] A future audit on data sharing and availability will discuss this.

HWAC and the Behavioral Health Commission, and ensuring clear implementation strategies. Additionally, staffing turnover may have contributed to challenges in execution, underscoring the need for greater stability and continuity in operations. While we could not fully assess the effectiveness of HWIC due to its relatively recent establishment, we documented current processes and structures and identified key areas for improvement.

Data Sharing Among State Entities Responsible for Workforce Analysis Must Be More Efficient and Effective. In 2024, data-sharing challenges prevented Division of Professional Licensing (DOPL) from submitting collected survey data to HWIC in a timely manner, delaying HWIC's analysis and reporting to HWAC by several months. This, in turn, slowed HWAC's ability to provide critical recommendations to policymakers and stakeholders. Additionally, HWIC analysts may have limited access to key Department of Health and Human Services (DHHS) datasets, which may hinder their ability to fully assess workforce challenges. While the DOPL data sharing challenges were addressed, DHHS must ensure that all data-sharing agreements are clearly defined and functional to prevent future delays. Given the significance of these issues, a future audit of data-sharing practices may be necessary to ensure lasting improvements and accountability.

HWIC analysts may have limited access to key DHHS datasets, which may hinder their ability to fully assess workforce challenges.

HWIC Should Expand Its Analysis and Include All Identified Behavioral Health Provider Types. Currently, HWIC intends to provide analysis based on data collected through the license renewal process for DOPL licensed providers. A significant portion of the state's behavioral health workforce consists of DOPL-licensed providers. However, this excludes other providers, like DHHS-certified paraprofessionals. Because of this, HWIC is not evaluating the full breadth of the behavioral health workforce, including professions that are set to increase and alleviate some of the documented workforce shortages. As HWIC is tasked with workforce analysis, including all state identified behavioral health provider types in future analyses will allow them to provide a more complete, informed, and accurate picture of workforce challenges.

The HWAC and USAAV+ Legislative Review Process May Be Duplicative for the Behavioral Health Workforce. HWAC's main goal is to provide information and recommendations to help expand and strengthen Utah's health workforce. One mechanism for this is through its legislative review subcommittee, whose statutory purpose is to "review and comment on legislation related to the health workforce." The legislative intent for HWAC was to be the vetting entity of any

workforce-related bills and provide insight to the Legislature. On the other hand, USAAV+ as an entity has tracked and provided insight into behavioral health legislation for years. This tracking includes workforce bills. We observed both processes for the 2025 Legislative Session and saw significant overlaps in the tracking of behavioral health workforce-related bills. While both entities track bills related to the behavioral health workforce, HWAC, lacking a behavioral health focus, often uses USAAV+ positions to inform its stance on bills. Because of this, USAAV+ and HWAC should streamline operations by making it clear which entity should spend time and resources tracking and vetting potential legislation.

There Should Be More Formal Coordination Between the Behavioral Health Commission and HWAC. The Behavioral Health Commission is an independent entity with a statutory requirement to cooperate with HWAC on behavioral health workforce issues. On the other hand, HWAC is an entity housed within DHHS. The commission's highest-ranking staff member and the Director of USAAV+ serve on HWAC and its legislative review subcommittee. However, there's no formal mechanism for HWAC to transmit its behavioral health workforce recommendations to the commission. Formal reporting structures should be created to address possible duplication of efforts and to allow the commission to utilize the expertise and data resources available on the behavioral health workforce from HWAC and HWIC.

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RECOMMENDATION 1.1

The Department of Health and Human Services should ensure the Health Workforce Information Center has adequate access to behavioral health workforce data sources for workforce evaluation.

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The Health Workforce Information Center should evaluate all behavioral health providers in its analysis of the behavioral health workforce.

RECOMMENDATION 1.3

The Health Workforce Advisory Council and the Utah Substance Use and Mental Health Advisory Committee should evaluate their legislative review processes for the behavioral health workforce and eliminate any duplicative efforts.

RECOMMENDATION 1.4

The Legislature should consider formalizing the reporting structure between the Behavioral Health Commission and the Health Workforce Advisory Council on behavioral health workforce analysis and policy related recommendations.

1.2 Workforce Entities Should Identify and Prioritize Effective Workforce Strategies

Identifying and solving challenges related to Utah's behavioral health workforce is paramount due to the state's high prevalence of mental health and high levels of unmet need. The behavioral health workforce is the first line of defense when providing care and services to Utahns struggling with behavioral health challenges. Because of this, Utah entities have studied and offered recommendations to create a sustainable and resilient workforce for several years. Yet, the Legislature's creation of entities to study and provide additional recommendations to improve workforce challenges highlights the ineffectiveness of previous efforts. We found that legislative solutions to behavioral health workforce challenges may not have been aligned with recommendations due to lack of strategy and assignment of responsibility by the recommending entity. We believe there is room for better strategic planning, evaluation, and data informed solutions for behavioral health workforce recommendations.

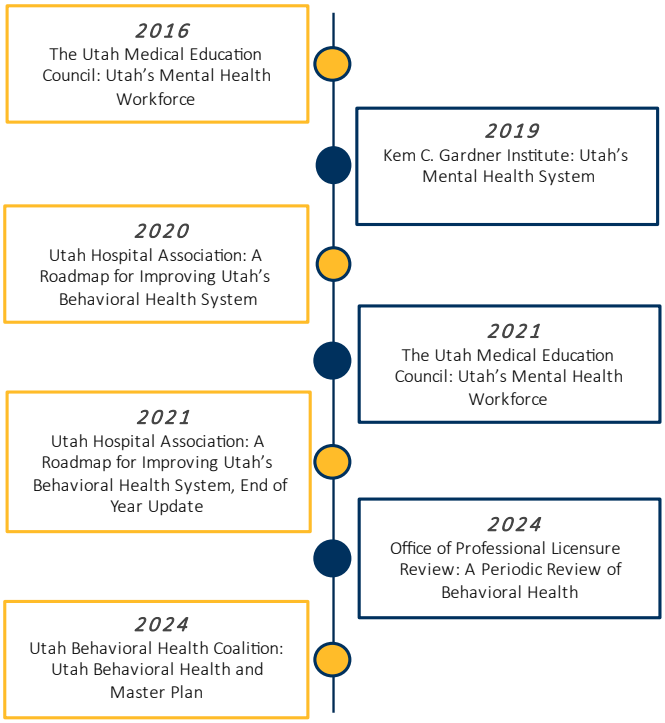
Behavioral Health Workforce Recommendations Were Not Always Implemented Through Legislative Solutions

For nearly a decade, Utah entities and stakeholders (some of which are mentioned above) have studied behavioral health workforce challenges and information, yet recommendations from these studies may lack implementation. In 2016, the Utah Medical Education Council (UMEC)[11] published the first

[11] The mission of the Utah Medical Education Council is to conduct health care workforce research, to advise on Utah's health care training needs, and to influence graduate medical education (GME) financing policies.

report[12] we found relevant to the mental health workforce. This report provided quantitative data analysis via survey results on a portion of mental health providers in the state, as well as several recommendations on how to boost the workforce. Since 2016, several other entities have published reports with recommendations relating to the behavioral health workforce in Utah.

In reviewing these reports, we documented 75 recommendations related to the behavioral health workforce. Nearly half of these recommendations fit into categories related to licensure, data collection, and education. Most of these recommendations were not directed at a specific entity for implementation, which does not align with best practices. We echo this finding from our previous audit on the governance of the behavioral health system.[13]



Source: Auditor generated from various state reports

To understand the implementation of workforce-related recommendations, we categorized recommendations into ten distinct categories. We also analyzed enrolled legislation from the last six years (2019–2024) and categorized them into the same ten categories.[14] Figure 1.1 demonstrates that of the 50 bills we analyzed, legislative solutions largely aligned with recommendation categories related to licensure, healthcare integration, and telehealth. Meaning the proportion of recommendations related to this topic was similar to the proportion of legislative behavioral health workforce related efforts of the same

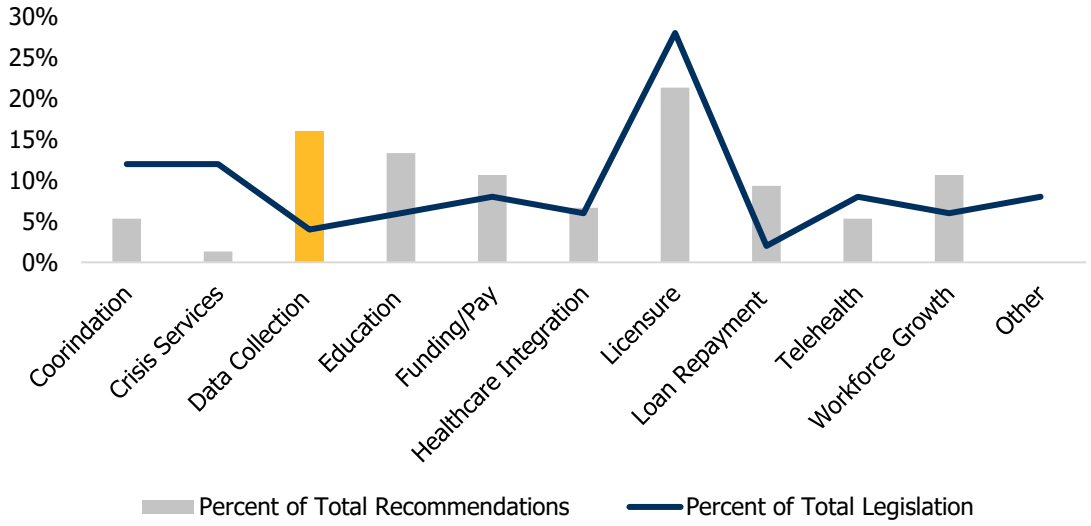
[12] There may be other more historical reports about this workforce, but our research did not turn them up or find them relevant to this analysis.

[13] *A Performance Audit of Utah's Behavioral Health System A Case for Governance, Strategic Planning, and Accountability*

[14] This analysis is a subjective review of both policy recommendations and enrolled legislation for common categories.

topic. However, our analysis also documented misalignment of legislative solutions in areas such as data collection and education. On the other hand, the Legislature has made more enhanced efforts towards coordination and crisis services. This may be attributed to lack of entity specific recommendations and the Legislature's determination to prioritize certain efforts. We acknowledge that legislation may cover multiple recommendations. The purpose of this analysis was to capture general trends in legislative solutions.

Figure 1.1 Behavioral Health Workforce Legislative Solutions Do Not Always Align With Recommendations From Various Behavioral Health Workforce Reports. In a review of workforce-related recommendations (2016–2024) and legislation (2019–2024), we found that there is some misalignment between policy recommendations and policy solutions.



Source: Utah behavioral health reports (2016−2024) and enrolled legislation (2019−2024).

Improving data collection and analysis on the behavioral health workforce is crucial. (We will address data in future chapters of this audit, and in future audit reports.) Challenges with data sharing limited our ability to analyze the state's workforce in a more innovative and informative way for this report. The entities discussed in the previous section of this chapter should continue to broach the topic of analysis, using existing state data to better inform indicators of workforce challenges. Quantitative as well as qualitative data should inform the state's continued policy efforts as they review current efforts and determine new efforts to pursue.

Given Limited State Resources, Effective Workforce Strategies Should Be Prioritized and Invested In

Despite ongoing efforts to strengthen Utah's behavioral health workforce, the pressing need and limited resources make it essential to invest in the most effective strategies.

Despite ongoing efforts to strengthen Utah's behavioral health workforce, the pressing need and limited resources make it essential to invest in the most effective strategies. For example, in the last 10 years, the number of behavioral health licenses issued increased by 100 percent. However, while DOPL has reported an increase in behavioral health related licenses, they do not identify how legislative changes may impact license numbers. Additionally, DOPL data is limited in its ability to determine if Utah licensed providers are practicing in Utah. To better understand how the increase in licensed providers is impacting Utah's workforce, further analysis is needed. The examples below provide two policy efforts that have helped expand and retain the workforce. Continued evaluation of effective efforts is imperative with limited resources.

Capacity at Higher Education Institutions Is a Documented Constraint, Yet Targeted Program Funding Has Increased the Number of Licensed Providers. During the 2020 General Session, the Legislature appropriated over $1 million in funds to the Behavioral Health Workforce Reinvestment Initiative. This targeted funding increased the capacity of Utah State University's and University of Utah's Master of Social Work programs. With this targeted funding, both institutions increased admissions into these programs. Furthermore, these graduates are now showing up in the licensed workforce. DOPL data shows a marketed increase in Certified Social Workers (CSW)[15] from 2020 to 2023 from these institutions.

Figure 1.2 DOPL Data Shows Increases of Licensed Associate Level Social Workers from the University of Utah and Utah State University After Expansion of Their Master of Social Work Programs. Both institutions expanded their programs in 2021, and those graduates are now showing up in Utah's licensed population.

Graduating Institution	DOPL Certified Social Workers	
	2020	**2023**
University of Utah	149	319
Utah State University	74	163

Source: Division of Professional Licensing.

[15] CSWs require a master's degree in a social work program accredited by the Council on Social Work Education or by the Canadian Association of Schools of Social Work, or doctoral degree that contains a clinical social work concentration and practicum. After 3000 hours of training under supervision and an exam, a CSW may apply to be a Licensed Clinical Social Worker.

The growth of these programs and subsequent increases in licensed providers from them demonstrate that targeted funding is effective. In speaking with behavioral health-related programs throughout the Utah System of Higher Education, we documented continued challenges in program expansion. These challenges to expand programs included staffing, student funding, supervision and accreditation (all related to funding).

Behavioral Health Providers Continue to Participate in State Loan Repayment Programs at Increasing Rates and May Remain in Utah. The Office of Primary Care and Rural Health (PCRH) oversees several loan repayment programs for health providers in the state. These programs are meant to encourage participation in community health clinics and rural areas. In 2020, the Behavioral Health Workforce Reinvestment Initiative, which expanded the Master of Social Work programs, also created a loan repayment program specifically for behavioral health providers.[16] PCRH reported that of the 77 behavioral health providers that have participated in state loan repayment programs, 75 of them are still practicing in Utah.[17] While only a small portion of Utah's behavioral health providers participate in loan repayment, this effort may help retain providers in the state. PCRH provided these retention numbers at the request of the audit team. We believe that additional longitudinal tracking of loan recipients would demonstrate and measure further effectiveness of this program.

Most behavioral health providers who participate in state loan repayment remain in the state.

Utah Can Also Rely on State and National Strategies for Behavioral Health Workforce Bolstering Efforts

National and state studies offer many examples of strategies to address behavioral health workforce challenges. The National Conference of State Legislatures (NCSL) produced a report that discusses policy options and innovative strategies state legislators and stakeholders are employing to recruit, train, and retain behavioral health professionals.[18] This framework documented five key categories of strategies:

- Understanding workforce needs
- Increasing the supply of professionals

[16] Advanced Practice Registered Nurses (APRN), Licensed Clinical Social Workers (LSCW), Marriage and Family Therapist (MFT), Clinical Mental Health Counselors (CMHC), and Psychologists

[17] Most of these providers are licensed clinical social workers and clinical mental health counselors.

[18] NCSL's State Strategies to Recruit and Retain the Behavioral Health Workforce.

- Expanding the reach of existing professionals
- Addressing the distribution of professionals
- Retaining professionals in the workforce

Several other states have set forth strategic documents with goals to increase and stabilize their behavioral health workforce. We identified at least eight states that have published strategic workforce plans or guides to help direct policy makers in their efforts to create well-formed decisions in workforce development. Below are some examples.

Goal: Facilitate the expansion of the behavioral health workforce.

- **Short Term**: Identify professional mentoring programs
- **Medium Term**: Establish new and expand existing partnerships to increase quality internship opportunities for students
- **Long term**: Expand or develop professional mentoring programs

Objective: Conduct comprehensive reviews of provider rates within the Medicaid funded behavioral health network.

- **Measure:** Behavioral health provider rate review is part of the Medicaid review process
- **Task:** Review provider rates for all behavioral health providers

Source: Idaho's Behavioral Health Workforce Plan 2022–2024, Nevada's Behavioral Health Workforce Pipeline Development Plan

The UMEC reports represent Utah's most significant effort toward a strategic plan for the behavioral health workforce; however, they do not have the essential characteristics of a comprehensive strategic plan. Notably, these reports do not provide a holistic view of the workforce, as they fail to capture the full scope of behavioral health providers. Moving forward, with analysis from HWIC, HWAC should bolster strategic planning for the behavioral health workforce by quantifying effective workforce strategies and efforts to help direct resources into the most impactful areas. In order to comprehensively address statewide workforce challenges, these strategies should focus on all sectors that hire behavioral health professionals.

RECOMMENDATION 1.5

The Health Workforce Advisory Council, with input from the Behavioral Health Commission, should develop a strategic plan for behavioral health workforce efforts and determine the effectiveness of these measures.

CHAPTER 2 Summary

There Is Insufficient Data to Quantify Behavioral Health Public Sector Workforce Challenges and Inform Hiring Barriers

BACKGROUND

Utah primarily relies on qualitative information and national estimates to shape behavioral health workforce policy, including for public sector providers. During this audit, we aimed to document the behavioral health public sector workforce to better understand staffing patterns and challenges. However, we found that critical data were scattered, inconsistent, and difficult to obtain from local authorities. Existing processes and entities can systematically quantify public sector workforce challenges and collect additional statewide workforce indicators.

FINDING 2.1
Lack of Quantitative Data Limits Stakeholders' Ability to Make Informed Workforce Decisions

RECOMMENDATION 2.1
The Office of Substance Use and Mental Health should require local authorities to indicate if service deficiencies are related to workforce challenges as part of their annual audit process.

RECOMMENDATION 2.2
The Health Workforce Information Center should consider additional data collection models to ensure its analysis captures the entirety of the behavioral health workforce.

FINDING 2.2
DHHS Should Address Barriers That Hinder Workforce Hiring for Behavioral Health Public Sector Providers

RECOMMENDATION 2.3
The Office of Substance Use and Mental Health should ensure accurate tracking of paraprofessionals and trainings to determine if RBA tactics have been achieved.

RECOMMENDATION 2.4
The Office of Substance Use and Mental Health should improve the certification process for the peer support specialist workforce.

RECOMMENDATION 2.5
The Department of Health and Human Services's Office of Background Processing should evaluate and improve current background check processes for better efficiency and clarity.

CONCLUSION

While public sector staffing challenges fluctuate with time and demand, the state should look for ways to build a resilient and sustainable workforce. This includes understanding the pain points of the workforce and the effect of workforce focused initiatives using quantifiable measures.

Chapter 2
There Is Insufficient Data to Quantify Behavioral Health Public Sector Workforce Challenges and Inform Hiring Barriers

Utah has largely relied on qualitative information and national estimates to shape behavioral health workforce policy, including for public sector providers. To better understand the state's public workforce and its impact on service delivery, we attempted to collect data from local authorities on employment, vacancies, and pay. We wanted to make concrete recommendations on specific workforce challenges to public sector entities; however, data limitations at the local level and inconsistently defined fields hindered analysis. Despite these challenges, we found that maintaining the clinical workforce is crucial to expanding paraprofessional roles. Our findings also suggest that delayed training and unclear background check processes create hiring barriers for paraprofessionals. We recommend further identification of workforce challenges, improved tracking, and streamlined certification processes. Without Utah-specific workforce data, the state cannot accurately assess needs, address hiring barriers, or allocate resources effectively.

2.1 Lack of Quantitative Data Limits Stakeholders' Ability to Make Informed Workforce Decisions

Very little workforce indicator data has been documented or reported for Utah's behavioral health public sector entities, including key metrics such as vacancies and staffing levels. In contrast, other states have more systematic workforce data collection, enabling them to quantify trends and make more informed policy decisions. During this audit, we sought to document the behavioral health public sector workforce to better understand staffing patterns and challenges. However, we found that critical data—such as vacancies, salaries, and employment numbers—were scattered, inconsistent, and difficult to obtain from local authorities. This lack of quantifiable data makes it challenging to assess workforce needs and inform policy decisions. Therefore, we recommend leveraging existing oversight processes to systematically quantify public sector workforce challenges and collect additional statewide workforce indicators.

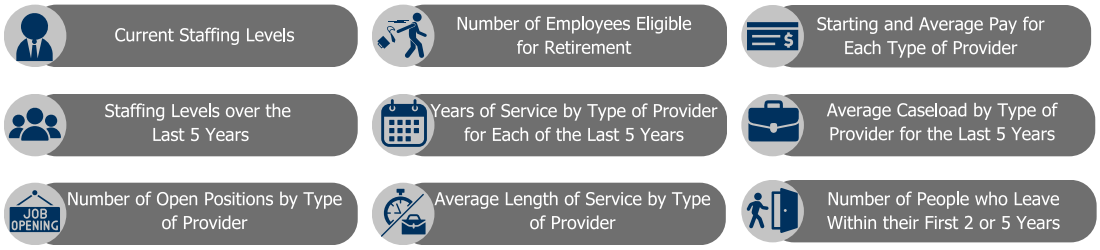
We found that critical data—such as vacancies, salaries, and employment numbers—were scattered, inconsistent, and difficult to obtain from local authorities.

Due to limitations in available workforce data, our analysis focuses on a subset of the state's public sector providers. To gain better insights into workforce indicators, we analyzed a portion of the local authority system.[19] Local authorities (LAs) provide mental health and substance use services in their geographic areas and operate under the oversight of the Office of Substance Use and Mental Health (OSUMH). To document reported challenges in this sector, we requested workforce data, including vacancies and salaries. The challenges associated with this data collection process are detailed below.

The Current LA System Does Not Systematically Identify Service Delivery Challenges Related to the Workforce

Workforce challenges are commonly talked about among the LAs but are not often quantitively documented. OSUMH does not collect or document workforce challenges, meaning there is no centralized source for workforce data. For this audit, we requested workforce indicators from the LA system of in-house and contracted providers, including pay, retention, and vacancies, as detailed in the graphic below. However, due to the complex and decentralized nature of the LA system, we were only able to obtain partial data.

Workforce Indicator Data Requested from Local Authorities



Source: Auditor generated

Of the thirteen LAs, ten provide many services through a single in-house provider. In contrast, the Salt Lake, Summit, and Tooele local authorities rely on a network of contracted organizations to provide services. Most in-house providers were able to fulfill the data request, but some were not able to document indicators like average caseloads. We also asked a small sample of contractors representing Salt Lake, Summit, and Tooele local authorities to provide us with similar data. While we were able to gather some information,

[19] Local authorities include local mental health and substance use authorities, with a majority of their clients either insured through Medicaid or unfunded. The authorities may have a centralized provider, may contract out for services, or use a combination of both.

contracted providers also faced challenges in collecting workforce indicators, and consequently our understanding of staffing for those local authorities is limited.[20]

OSUMH does not oversee staffing at local authorities but does monitor service delivery through annual audits that identify deficiencies. However, as a previous legislative audit discussed, the OSUMH audit process does not determine the root causes of deficiencies.[21] Local authorities frequently fail to provide case management, psychosocial rehabilitation, and peer support services. Without being able to identify workforce challenges as a possible contributing factor, it is difficult to target resources and solutions effectively. While staffing shortages might directly cause these service gaps, the absence of root cause analysis obscures the connection between understaffing and service deficiencies.

Without being able to identify workforce challenges as a possible contributing factor, it is difficult to target resources and solutions effectively.

Because of this, we believe that using OSUMH's audit process to identify and document hiring challenges at the local authorities can provide more quantifiable information and detail local staffing trends. We recognize the information gathered through the OSUMH audit process will only be relevant to a portion of the public sector. However, documenting staffing challenges at the LAs can provide insight into public sector workforce issues and their impact on behavioral health services. This information may position OSUMH to better advocate for workforce resources.

RECOMMENDATION 2.1

The Office of Substance Use and Mental Health should require local authorities to indicate if service deficiencies are related to workforce challenges as part of their annual audit process.

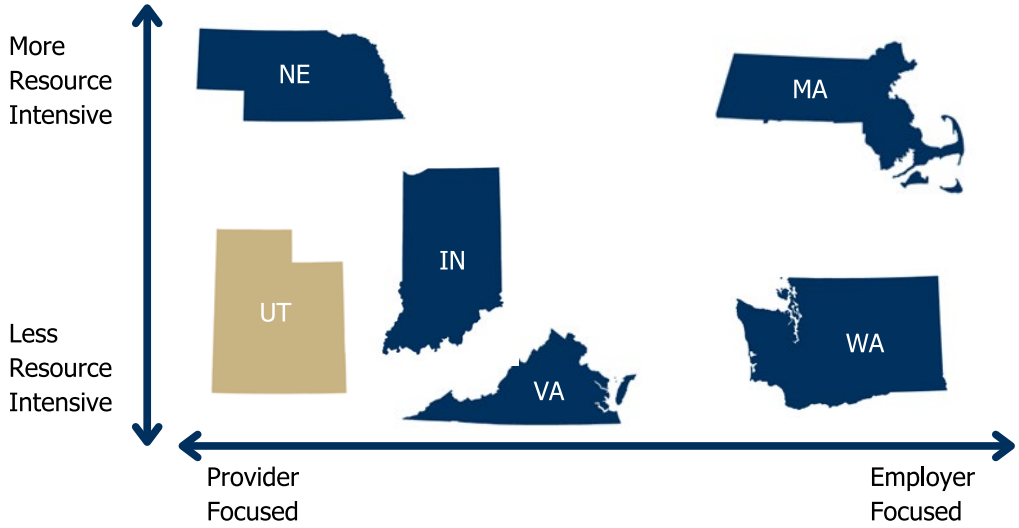
As discussed in Chapter One, the Legislature has indicated an interest in better understanding workforce challenges and streamlining policies and solutions. To do this, they created the Health Workforce Advisory Council and the Health

[20] We provide analysis on some of the data collected in Finding 2.2 of this chapter. Additional details on the data collection process and specific responses are available in Appendix A.

[21] *A Performance Audit of Utah's Behavioral Health System: A Case for Governance, Strategic Planning, and Accountability*

Workforce Information Center (HWIC).[22] While HWIC collects and analyzes some data on licensed providers via survey, there is an opportunity to enhance its data collection by adopting models utilized by other states. We recognize that HWIC is not focused solely on behavioral health but that it is one of many prioritized health professions. Figure 2.1 identifies several states that systematically collect and report behavioral health staffing data and workforce indicators—as detailed in Appendix B. These states are better positioned to make informed decisions and implement targeted strategies to strengthen their public sector behavioral health workforce. The approaches, as detailed in the figure below, represent a sliding scale of collection—from provider based to employer based, and from more to less resource intensive.[23]

Figure 2.1 Several States Systematically Collect Behavioral Health Workforce Data in a More Robust Way Than Utah. Other states can collect and report on workforce trends and indicators. Some methods are less resource intensive than others. Both Massachusetts and Nebraska have dedicated centers for the collection and study of the behavioral health workforce.



Source: Auditor generated from other state workforce strategies

[22] HWIC was established to serve as the state entity for health workforce data analytics. It helps determine progress toward the goal of Utah having a diverse, well-qualified and sustainable workforce that fairly meets the needs of all its residents.

[23] **Provider Focused**: These states collect survey data from providers themselves, often during licensure renewal that include information on practice, location, and hours worked.
Employer Focused: These states survey organizations about their staffing. Employers can provide entity level details on topics like vacancies and salaries.
Less Resource Intensive: These states do not have staff dedicated to behavioral health data collection or analysis.
More Resource Intensive: These states have dedicated centers to follow up on data or have dedicated behavioral health data centers.

Currently, HWIC collects data through a revised version of the cross-professional minimum data set.[24] This survey is administered through the Division of Professional Licensing (DOPL) renewal process. It only collects responses from licensed professionals and is not mandatory. Without more robust data collection on the behavioral health workforce, Utah may be at a disadvantage to solving workforce challenges and understanding trends. HWIC should consider the adoption of other workforce data collection models to ensure it captures the entirety of the behavioral health workforce including both the DOPL licensed provider population and other DHHS licensed providers.

RECOMMENDATION 2.2

The Health Workforce Information Center should consider additional data collection models to ensure its analysis captures the entirety of the behavioral health workforce.

2.2 DHHS Should Address Barriers That Hinder Hiring for Behavioral Health Public Sector Providers

The behavioral health workforce crisis is due to patient demand outpacing provider availability. While expanding clinical providers remains vital, national and state solutions emphasize strengthening the paraprofessional workforce—trained but non-clinical staff who can extend clinical capacity—as a faster, short-term response.

Clinicians	Paraprofessionals
Clinicians diagnose and treat behavioral health conditions. This group includes providers such as clinical social workers and clinical mental health counselors.	Paraprofessionals assist in treating behavioral health conditions. This group includes providers such as peer support specialists and crisis workers.

Source: Auditor generated from the OPLR Periodic Review: Behavioral Health

The Legislature and other stakeholders have worked to expand the behavioral health workforce, but our analysis shows that paraprofessionals may face hiring barriers. While clinicians are essential, this finding focuses on paraprofessionals due to their national emphasis, role in improving patient outcomes, and ability to

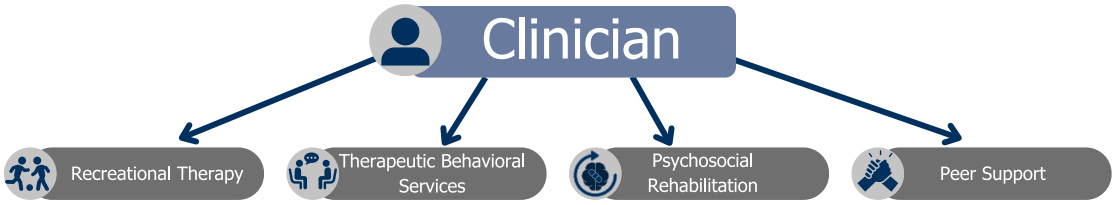
[24] The cross-professional minimum data set is a set of core questions, created through collaboration between national organizations, for collecting data considered to be the minimum necessary for health workforce planning.

extend clinical care. To address barriers to entry, we recommend streamlining certification processes and improving tracking to assess workforce expansion efforts.

Without a Strong Clinical Workforce, Paraprofessional Roles Remain Moot

Clinical positions such as therapists, counselors, psychologists, and psychiatrists are vital to the public health system. They provide psychotherapy, assessments, and access to other crucial services. Many public entities serve Medicaid clients and are regulated by the Center for Medicare & Medicaid Services (CMS). These providers must follow specific guidelines when providing clinical services. Other non-clinical services necessitate a therapist's referral, as displayed below.

Services Requiring a Clinician Referral



Source: Auditor generated from the CMS Provider Manual

Although local authorities reported the clinician workforce has rebounded post-COVID-19, ensuring its long-term sustainability is crucial for service delivery. Because of this, we note several well-known and well-documented challenges to maintaining the clinical workforce in the public sector that state efforts should continue to target:

Although local authorities reported the clinician workforce has rebounded post-COVID-19, ensuring its long-term sustainability is crucial for service delivery.

- Public sector providers serve populations with high prevalence of serious mental illness
- Public sector oversight and accountability comes with additional documentation that is less likely to be found in the private sector
- Medicaid reimbursements are often not sufficient for public sector employers to recruit and retain providers with pay

Recent Workforce Efforts Focus on the Paraprofessional Workforce

Recent Utah reports related to the behavioral health workforce advocate for the increased and expanded use of paraprofessionals. Paraprofessionals are the non-clinical workforce that assist in treating mild to severe behavioral health conditions such as substance use disorder counselors, crisis workers, and peer support specialists. National studies have illustrated the positive client outcomes and the potential impact paraprofessionals have on the clinical workforce. Utah and other states have promoted the paraprofessional workforce through the creation of new licenses and formalized certification processes. For example, in 2024, the Legislature created two new paraprofessional licenses.[25] Because there are only a handful of people in the state with these new licenses, we did not evaluate them, but future analysis should.

Paraprofessionals act as extenders for the clinical workforce to work at the top of their license by supporting task shifting and helping with care navigation.

Paraprofessionals act as extenders for the clinical workforce to work at the top of their license by supporting task shifting and helping with care navigation. Studies on the impact of paraprofessionals like case managers and peer support specialists demonstrate improved outcomes for patients with behavioral health challenges. These paraprofessionals bring significant value to communities and patients, such as:

- Better patient outcomes, including decreased hospitalizations and inpatient days, improved engagement with services, and reduced cost of services[26]
- Lower readmission rates to substance use disorder facilities and reduced psychiatric emergency visits[27]

[25] These include the behavioral health technician certification and the behavioral health coach.
[26] SAMHSA, "Growing and Strengthening the Behavioral Health Crisis Response Workforce" (SAMSHA 2024)
[27] Shari L. Hutchison, Amy D. Herschell, et al, "Care Management Intervention to Address Determinants of Health for Individuals With Multiple Behavioral Health Readmission," *Professional Case Management* no. 27 (March/April 2022): 47–57.
Mark D. Fleming, Crystal Guo, et al, "Impact of Social Needs Case Management on Use of Medical and Behavioral Health Services: Secondary Analysis of a Randomized Controlled Trial," *Annals of Internal Medicine* no. 176 (August 2023): 1139–1144.

Statute mandates LAs to provide case management and OSUMH requires them to provide peer support services, yet OSUMH audits often document deficiencies in these services. OSUMH data also indicates that case management services have declined since 2021. Because of this we focus on case managers and peer support specialists[28] to evaluate a portion of the paraprofessional workforce. However, documenting trends in the OSUMH certified case managers and peer support specialist workforce are limited due to recent system changes that resulted in the loss of historical data. Because of this, we were not able to document any workforce trends before 2023. Additionally, paraprofessionals may hold multiple, overlapping certifications, but historic systems made it difficult to distinguish between some of them. As a result, previously reported numbers of paraprofessionals may be overestimated. However, OSUMH recently switched to a new system and will likely be able to track paraprofessionals with multiple certifications.

Understanding the paraprofessional workforce is particularly important because OSUMH has prioritized increasing the workforce in its Results Based Accountability Plan (RBA). Tactics to do this include the following:

- Increasing local authorities' use of case management services
- Continuing to develop the peer support system
- Increasing training to increase the paraprofessional workforce

If OSUMH wants to continue to increase the number of paraprofessionals in the workforce and expand the utilization of their services, we believe it is important to continue to accurately track certification numbers to understand the effect of efforts to bolster the workforce.

RECOMMENDATION 2.3

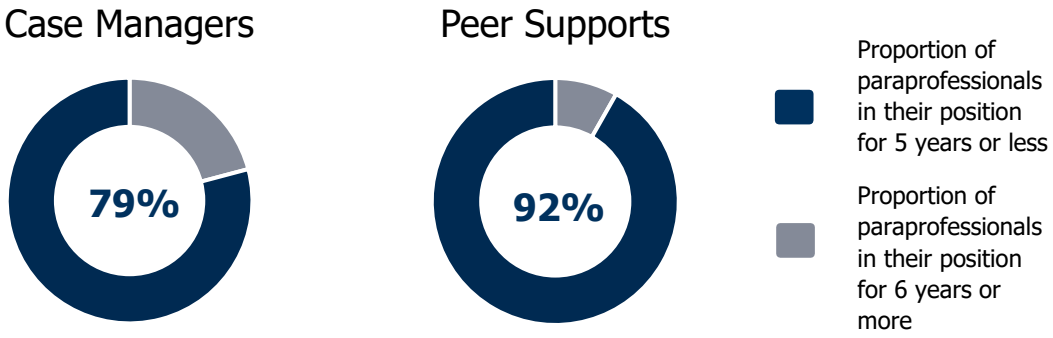
The Office of Substance Use and Mental Health should ensure accurate tracking of paraprofessionals and trainings to determine if RBA tactics have been achieved.

[28] Other paraprofessionals include crisis workers, substance use disorder counselors, social service workers, and the newly created behavioral health technician and behavioral health coach.

Improving Pay, Training, and the Background Check Process Will Ease Hiring Barriers for the Paraprofessional Workforce

Local authorities commonly reported difficulties in hiring paraprofessionals; our data collection validated these concerns. Vacancies for case manager positions in the LAs have been as high as 28 percent over the last five years. Peer support specialist positions have seen vacancies as high as 50 percent in local authorities. Figure 2.2 depicts the proportion of case managers and peer support specialists with five or fewer years of service (blue) or six or more years of service (gray).

Figure 2.2 The Vast Majority of Case Managers and Peer Support Specialists Have Been in Their Position Less Than Five Years. The blue sections of the chart below indicate the proportion of paraprofessionals in their position for five years or less. The gray sections show the proportion of paraprofessionals in their position for six or more years.



Source: Auditor generated from local authority data

While people in these positions might be retained within the local authority system, we were not able to document those cases given the limited workforce data provided by the LAs.

Low Pay Is Cited as a Barrier in Retaining Peer Support Specialists. Peer support pay has been identified by the Behavioral Health Commission as a concern for sustaining this workforce. The 2024 Legislative Report recommended increasing peer support Medicaid rates by 35 percent. In response, the Legislature passed House Bill 491 Behavioral Health Modifications in the 2025 Legislative Session. This bill appropriates $24,000 in ongoing funding to increase Medicaid rates for peer support specialist services.

Prolonged Certification of Peer Support Specialists Delays Payments. While LAs can hire peer support specialists who have not completed their OSUMH certification, the services provided by these specialists cannot be billed to Medicaid until they complete certification. OSUMH noted challenges in contracting with peer support training providers. As of September 2024, it took

an average of four and a half months[29] for a peer support specialist to receive training and certification after they applied. While OSUMH has increased the number of certified peer support specialist training offered, we believe that further efforts can be made to shorten certification times for peer support specialists.

RECOMMENDATION 2.4

The Office of Substance Use and Mental Health should improve the certification process for the peer support specialist workforce.

Unclear Background Check Processes May Make it Difficult for Paraprofessionals to Participate in the Public Sector Workforce. ***Utah Code*** requires DHHS's Office of Background Processing (OPB)[30] to perform a background check on all individuals employed at a DHHS licensed facility who have or will have direct access to vulnerable clients. Employees may not work unsupervised until their background check is cleared. The passing of HB 468 Employment Screening Requirements in 2023 changed the process for individuals with charges who meet certain criteria, such as providing peer support services, having lived experience, or being a mental health professional. Now, instead of automatic denial, they can receive an internal DHHS review.[31] The change was intended to improve the process for those with minor or old offenses with experience and qualifications. However, current systems lack the ability to document the effect of the changes and the time it takes for specific providers to go through the background check process.

Current systems lack the ability to document the effect of the changes, and the time it takes for specific providers to go through the background check process.

[29] At the time we requested the information, OSUMH was in the process of reviewing new contracts with training agencies, so the number of available training spots was limited.

[30] The DHHS Office of Background Processing processes and monitors background checks for each type of program licensed by the DHHS Office of Licensing.

[31] The internal review process involves a committee comprised of individuals from divisions and offices within DHHS. This committee evaluates applicants denied after the initial background check to determine if the applicant poses a risk of harm to children or vulnerable adults.

RECOMMENDATION 2.5

The Department of Health and Human Services's Office of Background Processing should evaluate and improve current background check processes for better efficiency and clarity.

While public sector staffing challenges fluctuate with time and demand, the state should look for ways to build a resilient and sustainable workforce. This includes an understanding of the workforce and the effect of workforce focused initiatives using quantifiable measures. Because this chapter captures only a fragment of the public workforce, further insight into a larger portion of the public sector workforce and its indicators may require additional resources. The next chapter details an example of how insufficient data collection prevents an understanding of the effectiveness of workforce initiatives.

CHAPTER 3 Summary

There Are Opportunities to Improve Utah's School-Based Mental Health Services

BACKGROUND

The Legislature has undertaken commendable efforts to address the mental health needs of youth in Utah. This chapter focuses on one of these efforts, House Bill 373, which provides $26 million in ongoing funds to the Utah State Board of Education to help increase targeted mental health supports in LEAs.

FINDING 3.1
Lack of State Guidance on Mental Health Staffing Roles and Services Leads to Underutilization of Clinical Mental Health Services in Schools

RECOMMENDATION 3.1
The Legislature should consider requiring the Utah State Board of Education to coordinate with the Office of Substance Use and Mental Health to define provider roles and mental health services in schools.

FINDING 3.2
Without Clear Measures, School-Based Mental Health Services Will Remain Difficult to Evaluate and Lack Necessary Collaboration

RECOMMENDATION 3.2
The Legislature should consider requiring the Utah State Board of Education to develop and implement a plan that helps Local Education Agencies align with the School Behavioral Health Toolkit and best practices.

RECOMMENDATION 3.3
The Legislature should consider requiring the Utah State Board of Education to report performance metrics and goals on the school-based mental health grant that measure accurate staffing levels and outputs as they relate to school-based mental health services.

RECOMMENDATION 3.4
The Legislature should consider integrating school-based mental health services into the comprehensive continuum of care through collaboration between the local authorities and Local Education Agencies.

RECOMMENDATION 3.5
The Legislature should consider requiring the Utah Behavioral Health Commission to create a framework for school-based mental health services, with the input of the Office of Substance Use and Mental Health, the Utah State Board of Education, and Local Education Agencies.

CONCLUSION

Due to USBE's current practices, we were unable to evaluate the impact of this funding on mental health services or behavioral health staffing in schools.

Chapter 3
There Are Opportunities to Improve Utah's School-Based Mental Health Services

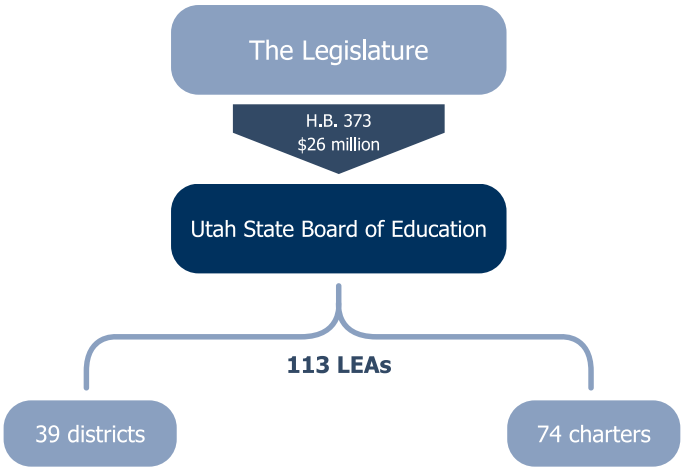
With better planning and collaboration, school based mental health services can improve outcomes for school children in Utah. To increase mental health support and address youth mental health concerns in the state, the Legislature invested heavily in behavioral health initiatives within schools. Because of this, there is an opportunity to determine how those funds can be maximized to improve outcomes. This chapter focuses specifically on the School-Based Mental Health Qualifying Grant Program (or the grant) and how it attempts to increase the number of people providing mental health services in schools. However, due to current practices, we were unable to evaluate the impact of this funding on services or behavioral health staffing. These practices include a lack of focus on mental health outcomes and undefined roles for school-based mental health staff and services. This report does not comment on the quality of services provided but instead on the efficient use of clinical mental health professionals in schools. Given that academic growth is the primary focus within schools, the increase of school-based mental health professionals—without required coordination between community-based services—may have further siloed the public behavioral health workforce. With a limited behavioral health workforce, state efforts that impact their availability need to be reviewed for effect and unintended consequences.

3.1 Lack of State Guidance on Mental Health Staffing Roles and Services Leads to Underutilization of Clinical Mental Health Services in Schools

The Legislature has undertaken several commendable efforts and strategies to address the mental health needs of students and youth, and it continues to do so. This chapter examines the School-Based Mental Health Qualifying Grant Program (the grant) and explores how insufficient state guidance limits school mental health staff, hindering their ability to meet increasing service demands. To clarify, our concern is not with the grant itself or school-based mental health services; rather, our focus is to ensure that state programs are aligned with best practices and that the Legislature's goals and intended outcomes are maximized. This is important due to the state's limited workforce and the increasing number of youth reporting high mental health treatment needs.

With Students Reporting High Treatment Needs, the Legislature Has Actively Supported School-Based Mental Health Services

The Legislature expanded school-based efforts to address youth mental health in 2019 through House Bill 373 Student Support Amendments, which appropriated $26 million in ongoing funding to the Utah State Board of Education (USBE) to fund school-based mental health supports. The funds were for hiring qualifying personnel[32] or contracting with community providers. These personnel would offer clinical and trauma-informed care in Local Education Agencies (LEAs),[33] including public school districts and charter schools. With this appropriation, USBE created the grant to distribute the funding to LEAs. In fiscal year 2024, 113 LEAs were awarded grant funding.[34] In our interviews, school districts mentioned that prior to the grant, they relied on local authorities[35] (LAs) to provide targeted mental health services. However, some LEAs shared that their ability to see all students was limited by the LAs workforce.



Source: Auditor generated from USBE data

The Legislature expanded school-based efforts to address youth mental health by appropriating $26 million in ongoing funding to USBE to fund school-based mental health supports.

Similarly, in 2023, the Legislature passed House Concurrent Resolution 6, expressing support for the unique role that mental health professionals play within schools to help children develop healthily. This resolution stated that mental health services provide strong support for students and families. Additionally, it stated the Legislature's commitment to exploring staffing ratios

[32] ***Utah Code*** 53F-2-415 defines qualifying personnel as a school counselor, school psychologist, school social worker, or a school nurse.

[33] In cases where we distinguish between these entities, we refer to them as either "districts" or "charter schools."

[34] USBE also awarded grant funding to four regional education service agencies (RESAs). In total, there were 117 grant recipients in fiscal year 2024.

[35] Local mental health and local substance abuse authorities.

and the role of student mental health supports to ensure that the best services are delivered to students. This chapter attempts to further that effort.

Despite focused efforts from the Legislature, results of the Student Health and Risk Prevention (SHARP) survey show that Utah students' treatment needs for mental health[36] have increased from 2019 to 2023.[37] Statewide, one in four students report high treatment needs, with over 20 percent of these students having attempted suicide in the past year. As mental health concerns in Utah's youth appear to be getting worse, ensuring that students have access to mental health services is crucial to addressing these concerning trends.

Despite Concerning Trends in Youth Mental Health, Many LEAs Hire Mental Health Staff Without Clearly Addressing Roles, Gaps, and Services

While the grant has funded the expansion of mental health professionals in schools starting in 2019, USBE does not currently define and clarify the roles of those providers. Without definition, schools may have hired providers with no clear planning on mental health scope of practice, leading to possible silos, gaps in services, and workforce concerns among public health organizations. ***Utah Code*** and *Administrative Rule*, respectively, define mental health therapy and counseling.

Therapy	Counseling
The treatment or prevention of mental illness including professional intervention in accordance with professional standards. **Designed to treat more severe mental health conditions like depression, anxiety, and suicidal behaviors and ideations.**	A method to assist individuals and groups in learning how to solve problems, develop coping strategies, and make decisions about emotional, behavioral, educational, and other interpersonal concerns. **Typically focused on specific solutions to short-term behavioral concerns.**

*Source: **Utah Code** 58-60-102(17) and Administrative Rule R277-313-2*

The distinction is important, because only some professionals[38] hired through this grant may provide school-based mental health therapy. These mental health providers also play a role in connecting students and families to community resources, which maximizes access to services.[39] Therapy, in particular, is

[36] Moderate and high treatment need increased; however, low treatment need decreased.

[37] The SHARP survey is administered by the Department of Health and Human Services every two years to identify trends in the youth prevalence of substance use and mental health in Utah.

[38] ***Utah Code*** 58-60-102

[39] When discussing the types of providers hired in schools with grant funds, we classify positions that involve providing therapy as mental health therapists, while all others providing counseling and similar services are considered mental health support staff. School psychologists and school

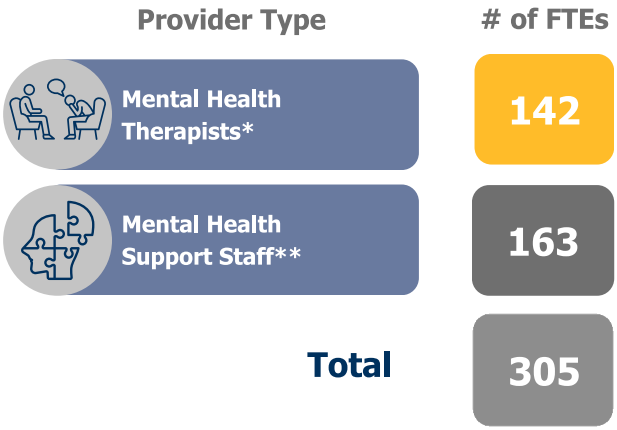
important since the rate of youth in Utah reporting seriously considering, planning to commit, and attempting suicide along with cases of purposeful self-harm have all increased since 2019. Given the high suicide death rates among Utah's youth, school-based mental health therapists are qualified and uniquely positioned to identify and help students with the greatest need.

As part of the grant application, LEAs are required to

- List the personnel they plan to hire
- List the services they will perform
- Establish measurable goals, and submit a yearly report on progress

Based on these yearly reports, LEAs reported in 2024 that there are 305 mental health service providers[40] currently employed[41] with grant funding. The infographic below shows the breakdown of providers hired through the grant.

Grant-funded Staff Hired by LEAs in 2024



*LCSW/CSW, Clinical Mental Health Counselor, Marriage and Family Therapist, and School Psychologist (if they are licensed with DOPL)

**Social Service Worker, School Counselor, School Nurse, Board Certified Behavior Analyst, and other behavioral supports

Source: Auditor generated from USBE's yearly report

As noted, mental health support staff, such as school nurses and counselors, comprised the majority of those reported as hired. Although individuals in these positions play a crucial role, they are neither qualified nor able to provide direct school-based mental health therapy services. With rising rates of high mental health needs in schools, it is important that schools hire providers with adequate scopes of practice so they can focus on addressing these high needs by delivering appropriate levels of care.

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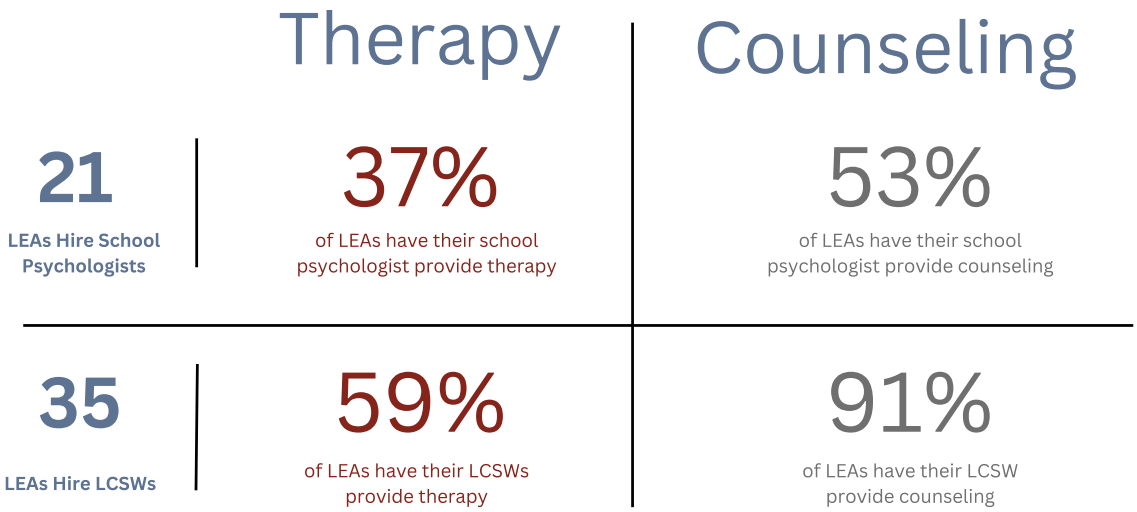
social workers are licensed through USBE; however, a separate license from the Division of Professional Licensing is required to provide mental health therapy. We attempt to separate these providers, where possible, by their DOPL license to clearly define providers that are qualified to practice therapy.

[40] Measured in Full-time Equivalents (FTEs).

[41] USBE only tracks positions by grant funding each year, which leads to duplicates when comparing across years. Due to this, our office could not determine how many unique individuals were hired since the grant was established.

To assess the impact of the grant's funding on mental health workforce expansion and use within LEAs for mental health services, our office conducted a survey of 2023 grant recipients.[42] The survey explored the specific responsibilities of each staffing position hired with the grant, as well as how LEAs determined the positions they hired. We sent the survey to 102 LEAs that received grant funding in 2023 and received responses from 59. We break down the focus on counseling and therapy below.



Source: Auditor generated from survey data. Services are not mutually exclusive, so our analysis counted providers that delivered both therapy and counseling services.

To be clear, counseling is an important service and can be delivered by a wide range of mental health staff. However, LCSWs and psychologists are both qualified and licensed to offer more targeted interventions that incorporate evidence-based treatment while school counselors and other mental health support staff are not. Yet, USBE does not provide state guidance on school-based mental health staffing roles or services, leaving LEAs to determine these roles for themselves and potentially affecting the level of services offered in schools. Given current concerns about workforce shortages in behavioral health, it's important to prioritize staff working at the top of their license to maximize their impact.

Utah Code 53F-2-415(2)

"…the state board shall distribute money appropriated under this section to LEAs to provide targeted school-based mental health support, including clinical services and trauma-informed care…"

[42] We sent a survey to fiscal year 2023 grant recipients to ensure that LEAs had adequate time to plan, develop, and implement their school-based mental health programs.

The purpose of the grant was to provide targeted mental health interventions by hiring more qualifying personnel in schools to improve youth mental health outcomes. Yet, we found that hired personnel are likely to deliver less-intensive services, as indicated by their focus on counseling services. The lack of clear definitions for school-based mental health roles may enable clinically licensed staff to work below their licensing level. This focus on counseling services may negatively affect students struggling with serious mental health concerns, such as suicidal ideations, who require more intensive interventions like therapy. Similarly, schools hiring their own staff and underutilizing them could lead to exacerbated workforce challenges and concerns with individuals potentially leaving community-based organizations for a similar, less-intensive role in schools.

RECOMMENDATION 3.1

The Legislature should consider requiring the Utah State Board of Education to coordinate with the Office of Substance Use and Mental Health to define provider roles and mental health services in schools.

3.2 Without Clear Measures, School-Based Mental Health Services Will Remain Difficult to Evaluate and Lack Necessary Collaboration

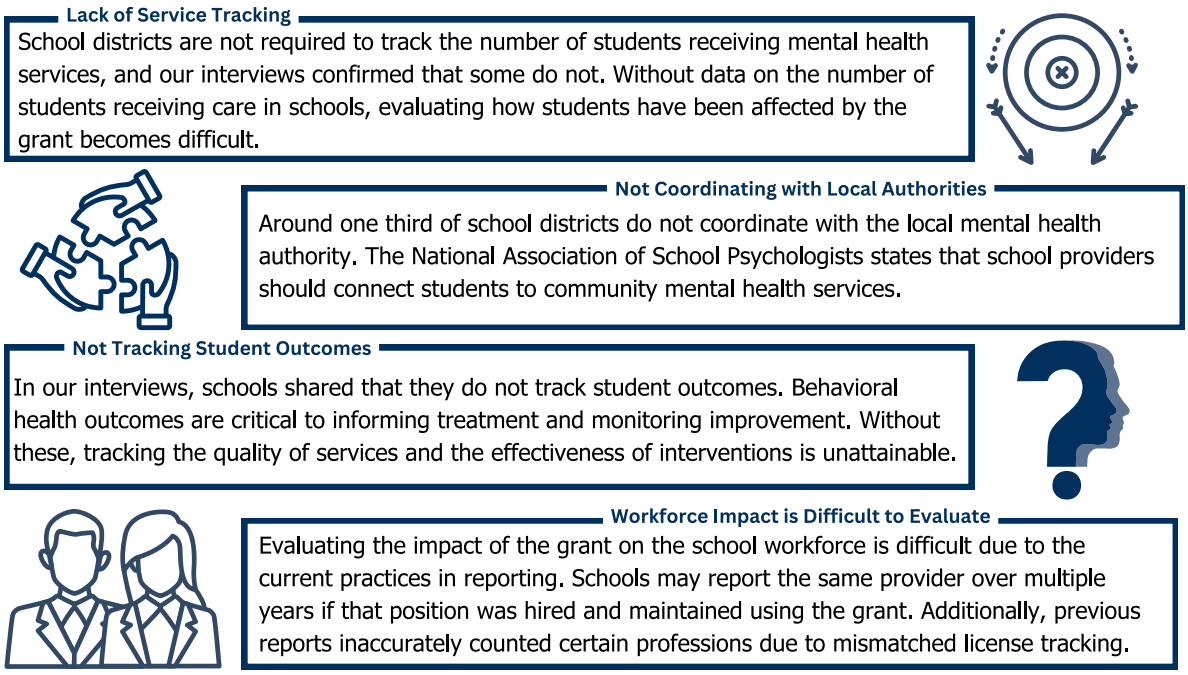
While studies demonstrate that school-based services are effective in treating youth mental health concerns, we cannot determine whether these services have had these same effects in Utah. The U.S. Surgeon General, along with several other national institutions, recommend expanding student mental health workforce and treatment access. When designed and implemented correctly, school-based mental health services can lead to positive impacts on emotional and behavioral problems, mental health outcomes, and higher needs treatment access. Furthermore, our office's 2024 *A Performance Audit of Utah's Behavioral Health System* pointed out the prevalence of silos in the behavioral health system, leading to possible duplication of services. The lack of structured needs assessments and resource maps in schools may lead to inefficiencies in the use of state money and resources as the system becomes more fragmented. In addition, schools may choose to establish their own programs rather than using established community

When designed and implemented correctly, school-based mental health services can lead to positive impacts on emotional and behavioral problems, mental health outcomes.

resources. We believe that this may exacerbate workforce concerns as schools hire their own staff to provide similar services.

The Impact of State Funds on School Behavioral Health is Unclear

Tracking outcomes is notoriously difficult in mental health,[43] so greater planning and accountability could help in this area. As the grant's reporting currently works, no one can determine whether it has been effective at improving mental health in students. It is not even possible to accurately determine whether the ratio of students to mental health therapists[44] has improved. USBE could not provide us with the retention numbers of those positions. The infographic below details other evaluation concerns.



Source: Auditor generated from USBE's yearly report and field interviews

The concerns listed above highlight gaps in understanding how the grant has increased qualifying personnel in schools and improved access to mental health services.

[43] A future audit will discuss behavioral health outcomes in more depth.

[44] USBE reporting groups LCSWs and Social Services Workers (SSWs) into one category—school social workers. However, only LCSWs are allowed to practice school-based mental health therapy, which leads to a limited understanding of how ratios impact access to mental health services.

Historically, staffing ratios have been the focal point of state legislation and recommendations. Concern over Utah's high ratio of students to school psychologists, social workers, and counselors compared to the national recommendation led to the passage of the grant. However, USBE has not actively monitored staffing reports to assess the effect of ratios on mental health access in the past five years. Additionally, staffing reports from USBE in prior years may have inaccurately counted school providers.[45] It is likely that the state does not have an accurate understanding of how staff have increased since the grant's establishment. To be clear, we believe that school-based mental health services likely have a positive outcome in some areas; however, we cannot determine that impact.

LEA Grant Goals Need to Be Improved to Measure the Impact on Students Receiving Mental Health Services

Performance measures influence activities and decisions while driving an organization to obtain its goals and objectives. Goals and measures help improve overall effectiveness, efficiency, and accountability. Grant recipients are required to submit a yearly report to USBE with details on their progress toward goals. Under this grant, LEAs are allowed to establish their own goals within four large categories: student safety, student engagement, school culture, or academic achievement. These categories are not defined in ***Utah Code*** or *Administrative Rule,* however, ***Utah Code*** states that this money should be used to provide targeted support to students. Although nearly 47 percent of personnel hired with grant money are mental health therapists, we found that goals do not align with these providers working at the top of their licensure.

We reviewed the 250 goals submitted in 2024 by 115 grant recipients[46] to determine the degree to which they focused on the intent of the grant to provide targeted school-based mental health services. As seen in the breakdown of goals on the next page, only a quarter of all goals measured improving mental health outcomes[47] or services in schools. Thus, two-thirds of the goals did not focus exclusively on students receiving these services or associated outcomes. If an

[45] Since a mental health therapist may obtain licenses from both USBE and DOPL to perform therapy in schools, both records are kept in their independent registries. According to USBE, the two data sets were combined in 2019 to establish a benchmark for staffing levels, but a recent review of the data showed multiple duplicates.

[46] Grants were awarded to 111 LEAs and 4 regional education service agencies (RESAs). Two LEAs did not submit a yearly progress report despite requirements to do so.

[47] Goals related to attendance or grades for students receiving mental health services were counted as mental health focused.

LEA wasn't meeting its goals, the bill sponsor mentioned that tracking goals would allow USBE to reallocate the funding to another LEA with a greater need. This reallocation has never happened.

Goals Breakdown of the School-Based Mental Health Grant

*Goals focused on targeted mental health services, referrals, or outcomes
**Goals focused on addressing mental health stigma and perception, or raising awareness
***Goals not focused on targeted mental health supports or awareness; common themes included attendance rates, grades, or improving behaviors schoolwide

Source: Auditor generated from USBE's yearly report

In evaluating these goals, we noted some additional concerns. For example,

- Most goals dealing with attendance and grades were focused on the entire LEA's student population, instead of those receiving services or targeted interventions
- Nearly 35 percent of LEAs reported at least one goal with no progress

In addition, USBE shared that schools not meeting their goals are contacted to see if they need assistance measuring or adjusting their goals. However, these meetings are not documented outside of a note in the grant tracking system, nor are they required. USBE also stated that ***Utah Code*** does not provide a basis for rejecting grant applications even when a school district is not meeting their metrics. The lack of accountability mechanisms is concerning.

A needs assessment helps LEAs understand available resources in the community, while identifying barriers and gaps in access.

Goals may not be linked to grant intentions because many LEAs lack a needs assessment to determine the level and necessity of services. According to USBE's School Behavioral Health Toolkit, the first step in establishing a school-based mental health program is conducting a needs assessment. Our survey showed that most LEAs did not conduct structured needs assessments for hiring decisions. A needs assessment helps LEAs understand available resources in the community, while identifying

barriers and gaps in access. As a result, LEAs can evaluate their workforce, prioritize which services are highly needed, and plan accordingly. Instead, we found that school districts mostly used community feedback to guide their assessment process. Although community feedback provides valuable qualitative information, the lack of quantitative data in decision-making may lead schools to overlook or misunderstand gaps in care and the need for services.

A developed needs assessment should also produce a resource map that details available services and resources in the community, preventing the duplication of efforts and services. A well-designed resource map extends beyond simply providing an inventory of available organizations or services in the area; instead, its use determines probable barriers to mental health services and provides context on how to effectively use available resources. We believe a structured needs assessment will help LEAs hire appropriate mental health providers to meet their goals, while addressing accountability and collaboration concerns.

RECOMMENDATION 3.2

The Legislature should consider requiring the Utah State Board of Education to develop and implement a plan that helps Local Education Agencies align with the School Behavioral Health Toolkit and best practices.

RECOMMENDATION 3.3

The Legislature should consider requiring the Utah State Board of Education to report performance metrics and goals on the school-based mental health grant that measure accurate staffing levels and outputs as they relate to school-based mental health services.

Collaboration Between LEAs and Local Mental Health Authorities Should Be Expanded

State and local behavioral health entities could have an expanded role in school-based mental health services. We believe that a collaboration between these entities, USBE, and LEAs could establish a framework for school-based mental health that is both accountable and flexible for local implementation. Each of these organizations offers a unique perspective that could help establish outcomes consistent with best practices.

Virginia's Model for a Similar Grant May Provide Valuable Insight Into Restructuring School-Based Mental Health Services. The Virginia School-Based Mental Health Services Grant is administered through a collaboration at both the

state and local level. First, the state's Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Education coordinate over how to administer the grant. Because of this, Virginia's DBHDS can attach outcome metrics to the grant, set up quarterly meetings, and aid school districts as needed on mental health services. Second, school districts are required to coordinate and contract with Virginia's community services boards (CSBs), the local entities responsible for delivering community-based mental health services. CSBs hire school psychologists, social workers, and other support staff to work exclusively in school districts, which adds much needed expertise into service delivery. This allows schools to remain focused on integrating these services into the school setting rather than providing them.

Policymakers Could Require LEAs to Collaborate with Local Authorities and OSUMH

We believe that a similar, collaborative model could be implemented in Utah between LEAs and the local authorities. Since ***Utah Code*** mandates that LAs follow state directives on tracking outcomes, the state's approved outcome questionnaire could be used to track the effectiveness of interventions and guide treatment while increasing parental involvement. Furthermore, LAs are responsible for delivering mental health and evidence-based prevention services to local children and youth. This includes a comprehensive continuum of care to connect children and families to appropriate services, regardless of need.

Despite LAs providing local mental health services, some have shared that coordination has decreased between them and the local education authorities since the grant's inception. This decline is attributed to LEAs acting independently of the community-based mental health system. Additionally, during our field interviews, several organizations expressed concern about whether students were receiving care during summer or raised issues regarding competition for the workforce between organizations and LEAs. This is concerning as students may be experiencing a gap in services during those transitional periods. Competition between entities for the same workforce may also lead to a shortage of providers and services, as noted in the previous

chapter. We believe that a model requiring collaboration and communication may resolve many of these concerns—real or perceived.

RECOMMENDATION 3.4

The Legislature should consider integrating school-based mental health services into the comprehensive continuum of care through collaboration between the local authorities and Local Education Agencies.

Policymakers Could Task the Behavioral Health Commission With Developing and Implementing a Comprehensive Framework

Lastly, the Utah Behavioral Health Commission is the central authority for coordinating behavioral health initiatives across the state. It is tasked with providing recommendations to the Legislature on matters related to behavioral health and is entrusted to hold the state's system accountable for clear, measurable outcomes. As such, the commission plays a pivotal role in reforming the state's behavioral health system to ensure a comprehensive continuum of care across all entities for Utah's student population. While there is no public education representation on the commission, the commission has additional options it should explore to include education perspectives.

Because the primary role of schools must be academic growth achievement, we believe the commission should work with USBE, LEAs, and OSUMH to develop a framework for comprehensive school-based mental health services.

RECOMMENDATION 3.5

The Legislature should consider requiring the Utah Behavioral Health Commission to create a framework for school-based mental health services, with the input of the Office of Substance Use and Mental Health, the Utah State Board of Education, and Local Education Agencies.

We understand that schools may vary depending on community needs and culture. However, the lack of statewide definitions, goals, and measures has led to minimal understanding of the program's overall effectiveness. At a minimum, the state's data collection related to the grant should include student service numbers, service types, referrals to public and private community providers, and impact assessments.

CHAPTER 4 Summary

Inaccuracies in Utah's Commercial Health Provider Directories May Limit Access to Care

BACKGROUND

There are numerous inaccuracies in Utah's commercial insurance directories, making it difficult for residents to contact providers or set up appointments. We determined this through network adequacy tests on insurance providers that are regulated by the state. These inaccuracies may delay care and may even cause individuals to forgo care altogether, even with insurance.

FINDING 4.1
Network Adequacy Challenges May Result in Decreased Access to Care

RECOMMENDATION 4.1
The Legislature should consider updating ***Utah Code*** for online provider directories, including accuracy requirements and the role of state oversight.

RECOMMENDATION 4.2
The Utah Behavioral Health Commission should analyze the options presented to monitor and improve the adequacy and accuracy of commercial health plan networks, with input from the Utah Insurance Department, and provide this analysis to the Legislature.

RECOMMENDATION 4.3
The Legislature should consider the results of the Utah Behavioral Health Commission's analysis from Recommendation 4.2 and make a policy decision on implementation.

CONCLUSION

We believe that improving the workforce and expanding access to providers is an important first step to improving mental health outcomes. This includes ensuring that Utahns are empowered to find the appropriate level of care when they need it most. Due to this, we believe that other issues warrant further consideration by Utah's public health organizations and the Behavioral Health Commission. These entities should investigate reasons for Utah's high number of self-pay providers, high-deductible health plans, paneling, federally regulated plans, access to specialty providers, and other issues impacting access for Utahns not covered by the public system.

Chapter 4
Inaccuracies in Utah's Commercial Health Provider Directories May Limit Access to Care

There are numerous inaccuracies in Utah's commercial insurance directories, making it difficult for residents to contact providers or set up appointments. We determined this through network adequacy tests on insurance providers that are regulated by the state.[48] These inaccuracies may delay care and may even cause individuals to forgo care altogether, even with insurance. Without coordinated initiatives or statutory changes to increase oversight and enforcement, Utahns may encounter difficulties in finding an appropriate provider who can see them in a timely manner—leading to worse mental health outcomes.

4.1 Network Adequacy Challenges May Result in Decreased Access to Care

We found many inaccuracies in commercial mental health insurance directories, which may limit access to Utahns covered by those plans. The primary issue is that there are providers listed as accepting new patients who are not. These insurance plans cover 23 percent of the state's population.[49] The behavioral health workforce is distributed among providers that contract with public or private insurance plans to provide services. Utahns can get health insurance plans through several avenues, including government, employers, and insurers. Among the private sector, Utah's ability to monitor and evaluate providers is limited.

Only 23 percent of the state's population is covered by an insurance plan regulated by Utah's Insurance Department.

[48] The state's ability to regulate private health insurance providers is limited, yet the majority of Utahns receive behavioral health services through private insurance coverage. Only a small portion of those private insurance plans are regulated by the state's Insurance Department. This leads to a lack of data about the private insurance industry, such as the distribution of providers. Because of this we focused on the availability of providers, as determined by provider directories, as a proxy for access to mental health services.

[49] This chapter focuses primarily on commercial insurance, a subset of private insurance. See the infographic on page 53 for a detailed composition of health insurance types in Utah.

Inaccuracies in Network Directories for Utah Commercial Health Plans Are Common

Nationally, nearly 50 percent of consumers have used online provider directories[50] when selecting a provider for their mental health needs. However, multiple secret shopper surveys from across the country have found that online directories are consistently inaccurate. Our own audit test[51] found that these issues are present within Utah's commercial market at a significant rate. These inaccuracies create a major obstacle for consumers seeking necessary care.

Secret shopper surveys involve an individual calling a provider and posing as a potential consumer to understand challenges of access to healthcare that are otherwise difficult to measure. These studies have consistently uncovered the prevalence of "ghost providers."

Definition of "Ghost Providers"

Providers listed in a health plan's directory as accepting new patients but are effectively unavailable to enrollees.

In some cases, inaccuracies in directories may cause individuals to delay care. One national study[52] cited that over 72 percent of parents reported problems getting an appointment as a primary reason for not getting their child needed health care for their mental disorder.

Access to behavioral health care can be defined in terms of the "Six A's": whether services are available, affordable, accessible, acceptable, and adequate, and whether patients are aware of services.

The Office of Professional Licensure Review defines access to behavioral health care in terms of the "Six A's": whether services are available, affordable, accessible, acceptable, and adequate, and whether patients are aware of services.[53] In an attempt to measure some of the accessibility of Utah's private sector, we focused on whether services were available.

To assess the accuracy of mental health provider directories and the prevalence of ghost providers in Utah, we conducted an audit test of commercial

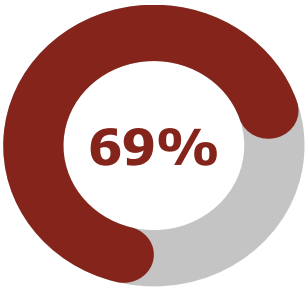
[50] Online directories are a readily accessible list of providers who accept the consumer's insurance, commonly referred to as "in-network".

[51] For this report, our office conducted a secret shopper study that we refer to as our audit test.

[52] Meng JF, Wiznitzer E. *Factors Associated With Not Receiving Mental Health Services Among Children With A Mental Disorder in Early Childhood in the United States*, 2021–2022.

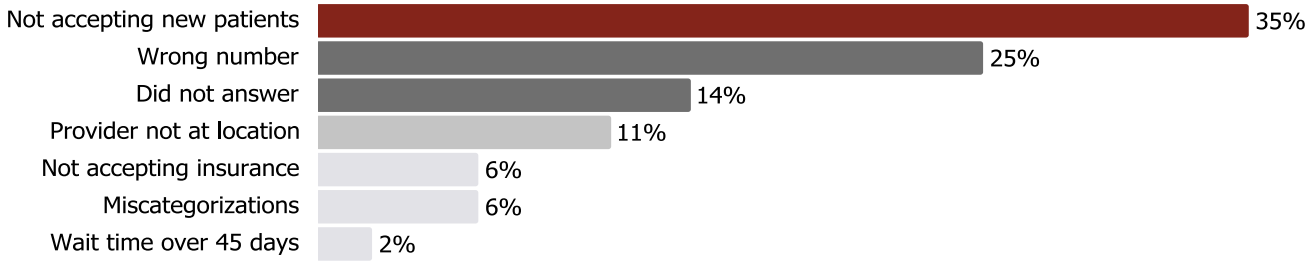
[53] The Office of Professional Licensure Review's 2023 *Periodic Review: Behavioral Health*.

health plans. For statistically significant results based on the commercial provider network, the team randomly selected[54] and called 180 mental health providers[55] posing as individuals seeking mental health care for ourselves or a close family member.[56] Many mental health providers listed as accepting new patients for depression were not easily accessible when we contacted them. This phenomenon is commonly referred to as "ghost providers." Our audit test found that 69 percent of providers could be classified as "ghost providers." The infographic below summarizes our findings.



"Ghost Providers"

Common Reasons We Couldn't Schedule an Appointment*



*Our audit team called only those providers who were accepting new patients, as listed in each health plan's online directory.

Source: Auditor generated from the results of our audit test

These results show that commercial plan directories are largely inaccurate and may present a significant barrier to Utahns with commercial health insurance looking for a mental health provider. It is important to recognize that in some cases, providers offered to connect us to services through another provider if they were unavailable or not accepting new patients. However, this was not the case with most providers we contacted, which may impact individuals seeking

[54] Providers chosen were proportional to each health plan's market share.

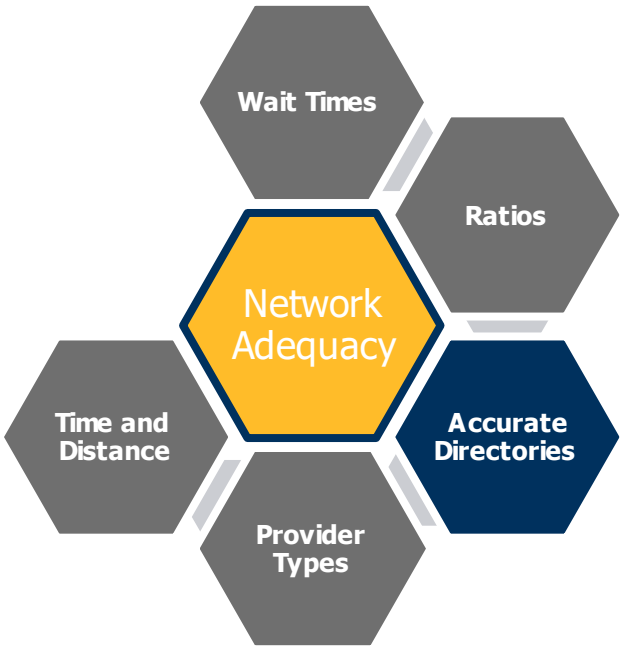
[55] Our audit team chose the top six commercial health plans and filtered for those qualified to treat depression. Most plans were filtered to only include commercial health providers; however, other types of private health providers may have also been included, due to the directories' filtering options. Other filters included accepting new patients, within 50 miles of Salt Lake City, and, if available, specializing in treating adults.

[56] A complete methodology can be found in Appendix C.

care. Despite focusing on adult mental health providers, our study also included some children's providers, revealing similar concerns.

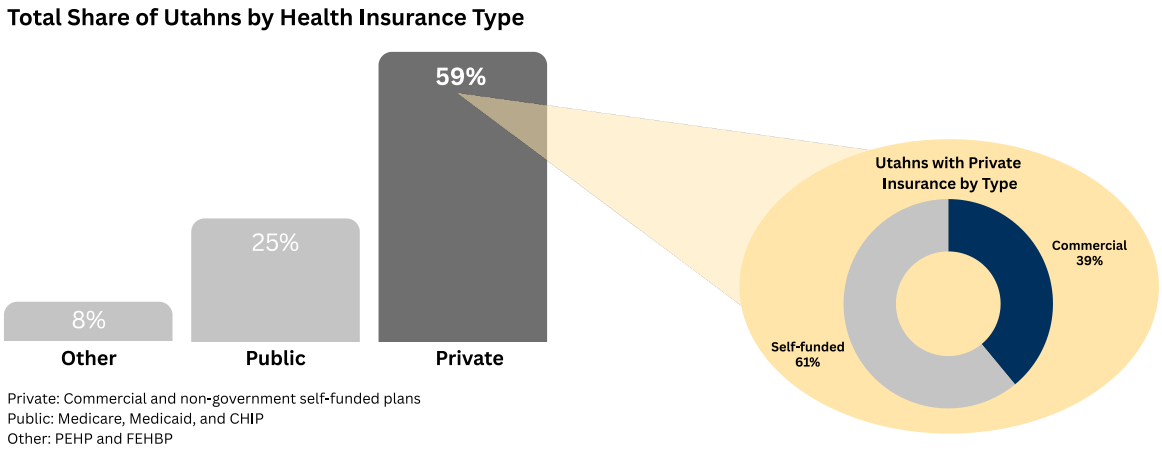
Insurance plans both cover benefits to maintain health and treat illness and improve access to care and health monitoring. This is done in part by connecting consumers to providers that can help them. A health insurance plan's "network adequacy" ensures enrollees can access needed medical and mental health services.

Multiple criteria can be used to evaluate the sufficiency of networks, such as wait times, ratios, and medical specialty. However, at a minimum, maintaining accurate directories should be a network adequacy requirement. This includes monitoring basic information such as the provider's current phone number, address, and whether they are accepting new patients. There are many elements to network adequacy, as seen in the figure. Our audit test, along with other state reports and national studies, suggest that provider directories remain vastly inaccurate for many patients. This is concerning because networks should be monitored by state governments.



Source: Auditor generated

While this chapter addresses challenges in behavioral health within commercial health plans, it is important to note that only 23 percent of the state's population are covered under commercial plans. Unlike these commercial plans, which are regulated by Utah's Insurance Department, most private plans are regulated only by federal code. As such, efforts to address Utah's network adequacy concerns should not only address the Insurance Department but also include communication and collaboration with other stakeholders. This would include federal agencies responsible for regulating self-funded insurance plans. The infographic depicts the share of Utahns by health insurance type and the composition of private plans that are subject to state regulation (in dark blue).



Source: Auditor generated from Utah's 2024 Health Insurance Market Report. An estimated 8 percent of Utah's population is uninsured, which explains why the total does not add up to 100 percent.

Research shows that delays in mental health treatment can lead to increased mortality and morbidity, including the adoption of life-threatening or life-altering self-treatments such as substance abuse. Thus, challenges in receiving mental health care may have long-standing impacts on quality of life for both children and adults. We believe that the high prevalence of inaccuracies in provider directories may hinder access to mental health services and lead to worsened mental health outcomes.

We Found Similar Concerns in PEHP's Network. In conducting a limited network adequacy test for the Public Employees Health Program[57] (PEHP), we found similar concerns with directory accuracy.[58] In our discussions, PEHP emphasized that it is the providers' responsibility to maintain accurate information and thus inaccuracies are due to providers, not PEHP. Due to past inaccuracies, PEHP decided to remove the filter that allowed enrollees to view providers accepting new patients. They recognized the absence of a filter may lead to enrollees making more calls before securing an appointment. Because of this, our audit test focused mostly on whether we were able to schedule an appointment and noted the reasons for each unsuccessful attempt.

We conducted a brief study of 15 mental health providers listed on PEHP's online directory. Providers were filtered for those specializing in mental health services. Of our 15 phone calls, our office was unable to obtain an appointment

[57] PEHP provides health benefits to Utah's public workforce, including employees of the state, educational institutions, and political subdivisions.

[58] ***Utah Code*** requires PEHP to contract directly with medical providers to provide services to covered individuals. While the state insurance department does not oversee PEHP, it is a division of Utah Retirement Systems and subject to state law.

60 percent of the time from PEHP providers.[59] In most of these cases, the provider was either not at the listed location (33 percent) or did not answer our calls (22 percent). Only 11 percent were not accepting new patients. The existence of directory inaccuracies may cause some public employees to delay or forgo mental health care.

Ideally, there should be no gap between an individual seeking care and being able to secure an appointment. However, inaccurate directories interrupt this process and may cause some individuals to stop seeking services.

Increasing Directory Accuracy Is an Important Way to Improve Access

Encountering inaccuracies is more than an inconvenience for consumers; some individuals may delay crucial health care or forgo it entirely.

Increasing the accuracy of provider directories may help reduce surprise bills associated with care, along with improving access to adequate mental health care. Encountering inaccuracies is more than an inconvenience for consumers; some individuals may delay crucial health care or forgo it entirely. Even in cases where consumers can locate a provider, they may be subject to "coerced billing"—situations where consumers knowingly receive out-of-network care due to difficulties finding an in-network provider. Nationally, research shows that patients are three to six times more likely to seek out-of-network care for behavioral health services than other medical services. This is concerning since the cost of seeing an out-of-network provider is typically higher, and, in some cases, may be several times more expensive than an in-network provider.

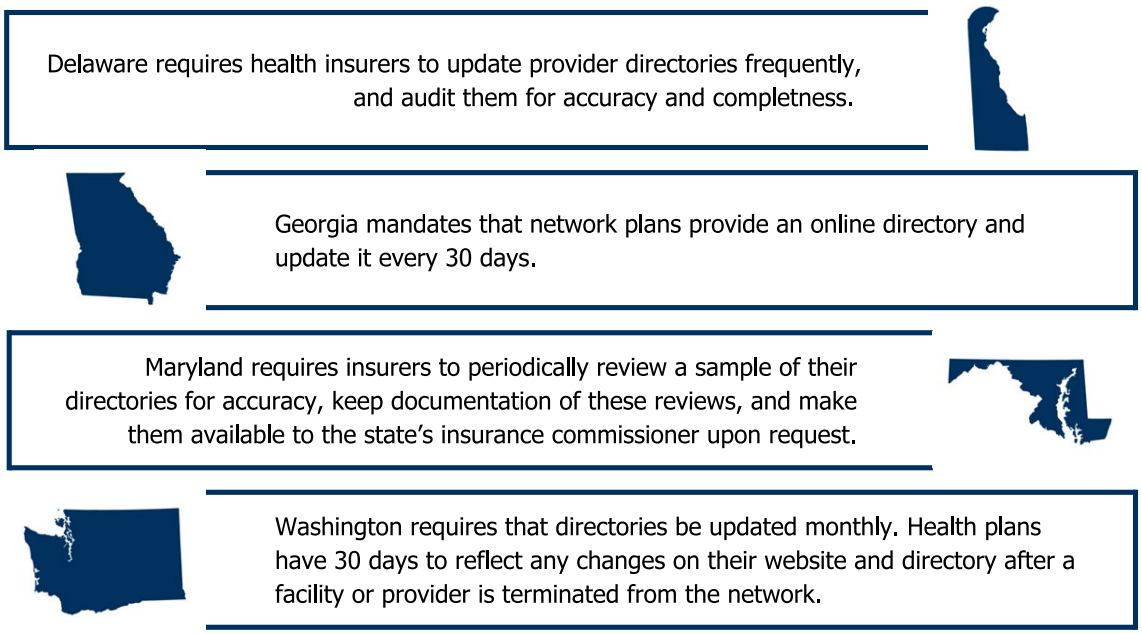
Although our audit test focused on Utah's urban areas, we recognize that there are profound differences in access between rural and urban regions. Rural areas have a higher percentage of individuals on medication for mental health concerns but a lower rate of those receiving counseling or therapy. Coupled with the low availability of mental health providers, rural areas may see the effect of access issues more pronounced and require additional policy considerations. Ultimately, inaccurate directories affect Utahns seeking care for themselves or a loved one which may result in negative outcomes.

[59] No appointment was scheduled. Once an available appointment date was confirmed, our audit team members ended the call by stating that they would need to check their schedule.

Utah Has Multiple Options to Address Inaccurate Directories

Federal code[60] requires commercial health plans to verify and update the information on directories every 90 days. Health plans must update inaccuracies within two business days of receiving updated contact information from a provider. Additionally, federal code defers enforcement to the states; however, ***Utah Code*** is currently silent on this topic. The Insurance Department shared that it only investigates directory inaccuracies when it receives a consumer complaint. They mentioned that the department would need additional authority and resources to have more explicit oversight to address network adequacy concerns. A complaint-based approach that relies on consumers to make the state aware of any errors means that most errors are likely to escape notice.

Thirty-eight states have some form of network adequacy requirements overseeing the accuracy of provider directories. From these, we chose to highlight examples from Delaware, Georgia, Maryland, and Washington to present a range of options for the Legislature to consider. The Legislature could choose to implement one or more of these strategies to increase oversight of commercial insurance plans.



Source: Auditor generated from other state statute

We recognize that maintaining the accuracy of online directories is a shared responsibility between health plans and providers. Health plans are responsible

[60] 42 ***United States Code*** §300gg-115

for collecting the information, while providers must supply updates when their information changes. If either party fails to fulfill their duties, it may lead to inaccurate directories. While this chapter specifically focuses on health plans, we recommend that potential solutions also include ways to incentivize and require providers to submit timely updates.

Health plans are responsible for collecting the information, while providers must supply updates when their information changes. If either party fails to fulfill their duties, it may lead to inaccurate directories.

Multiple organizations point to state government as the primary leader in regulating commercial health plans. This can take numerous forms as legislative intent can influence priorities and actions. However, research has shown that even the most stringent statutory requirements in the nation have resulted in limited effectiveness when not combined with an adequate enforcement framework. Any legislation passed to address network adequacy should include requirements, incentives, and enforcement measures necessary to enact change.

RECOMMENDATION 4.1

The Legislature should consider updating ***Utah Code*** for online provider directories, including accuracy requirements and the role of state oversight.

There Are Alternative Solutions if the Legislature Decides Additional Involvement Is Necessary

The Utah Behavioral Health Commission is the central authority for coordinating behavioral health initiatives across the state. They are tasked with providing policy recommendations to the Legislature and advising the Governor. Given its role and purpose, the commission should evaluate additional options to analyze and address network adequacy. The following examples may provide insights into potential solutions. Based on their findings, the commission should inform policymakers of the benefits, challenges, and cost of each initiative.

Policymakers Could Consider Using All-payers Claim Data to Analyze and Monitor Network Adequacy

Other states have documented network adequacy inaccuracies through additional methods. A recent study of mental health prescribers in Oregon's Medicaid program found that roughly 67 percent of mental health prescribers

and 59 percent of mental health non-prescribers[61] were "ghost providers," which they defined as providers seeing less than five unique beneficiaries within a year. These inaccuracies may contribute to delays and disruptions in care as consumers struggle to find an available provider for their mental health needs.

To address similar issues, New Hampshire began utilizing all-payers claim data. This allows the state to analyze adequacy based on actual service volume, rather than solely relying on the number of providers in a network. Additionally, New Hampshire compares a provider's listed specialty in the directory to actual claims data. This has allowed regulators to identify errors in the directory such as misclassifications or identify providers that are no longer participating in a health plan's network.

Policymakers Could Consider Requiring Navigation Service Tools to Connect Patients to Providers

In 2020, Intermountain Health began offering a free Behavioral Health Navigation Service for anyone that needed mental health support due to the COVID-19 pandemic. This service provides individuals with self-care tools, peer support, crisis resources, and treatment options. Patients are connected to healthcare resources and service options that align with their health needs. We encountered the navigation service several times during our audit test and found that they could be useful in directing patients to available providers. Similarly, the *Utah Behavioral Health Assessment and Master Plan* recommends establishing a central location where behavioral health care organizations can refer individuals to resources.

Policymakers Could Consider Establishing a Centralized Provider Directory

The average mental health provider contracts with multiple health plans, typically between 8 and 20 depending on specialty. Each of these plans may contact a provider every quarter to verify their information, making it potentially difficult for solo providers to keep up with reporting requirements necessary for accurate directories. Because of this, some states have chosen to explore the option of a centralized provider directory. A centralized directory would collect

[61] Mental health prescribers included psychiatrists and mental health nurse practitioners, whereas non-prescribing mental health specialists included therapists, counselors, psychologists, and social workers.

a provider's information along with all of their contracted health plans and send one comprehensive request for verification. Providers are more likely to respond to one request from a centralized directory rather than the multiple they receive from multiple health plans, which we believe would help address inaccuracies in provider directories as the information is more likely to be updated.

The Behavioral Health Commission Could Work With Payers to Address Adequacy Concerns

Bringing payers to the table is necessary for implementing changes that may improve access to mental health care. The Legislature attempted to address this challenge when it created the Behavioral Health Commission and tasked it with engaging private sector payers, providers, and businesses in the commission's work.[62] Given that part of the commission's purpose is to ensure that Utah's behavioral health systems are aligned and efficient, the commission should identify priorities and innovations that address network adequacy concerns. Without understanding the intricacies that payers may face, it is difficult to determine initiatives and efforts that will balance effective regulatory actions with a health plan's determination to remain in the state market.

We believe that improving the workforce and expanding access to providers is an important step to improving outcomes for mental health. This includes ensuring that Utahns are empowered to find the appropriate level of care when they need it most. As such, the concerns in this chapter present opportunities for Utah to become a national leader in cost-efficient, innovative healthcare. Although this audit focused primarily on access to care through the workforce, future audits will investigate the current quality of care and facilitate better outcome tracking.

Healing by Dr. Thomas Insel

"…better outcomes require improvement in quality of care as well as access to care."

Lastly, we recognize that the issues presented in this audit report are primarily focused on the public sector, apart from this chapter. Because of this, we believe that other issues warrant further consideration by Utah's public health organizations, the Utah Insurance Department, and the Behavioral Health Commission. These entities should investigate Utah's high number of self-pay

[62] ***Utah Code*** 26B-5-703(2)(e)

providers, high-deductible health plans, paneling challenges, federally regulated plans, access to specialty providers, and other issues affecting Utahns not covered by the public system. These entities' efforts should address the causes impeding access to behavioral health services and focus on potential solutions

RECOMMENDATION 4.2

The Utah Behavioral Health Commission should analyze the options presented to monitor and improve the adequacy and accuracy of commercial health plan networks, with input from the Utah Insurance Department, and provide this analysis to the Legislature.

RECOMMENDATION 4.3

The Legislature should consider the results of the Utah Behavioral Health Commission's analysis from Recommendation 4.2 and make a policy decision on implementation.

Complete List of Audit Recommendations

Complete List of Audit Recommendations

This report made the following eighteen recommendations. The numbering convention assigned to each recommendation consists of its chapter followed by a period and recommendation number within that chapter.

Recommendation 1.1

We recommend the Department of Health and Human Services ensure the Health Workforce Information Center has adequate access to behavioral health workforce data sources for workforce evaluation.

Recommendation 1.2

We recommend the Health Workforce Information Center evaluate all behavioral health providers in its analysis of the behavioral health workforce.

Recommendation 1.3

We recommend the Health Workforce Advisory Council and the Utah Substance Use and Mental Health Advisory Committee evaluate their legislative review processes for the behavioral health workforce and eliminate any duplicative efforts.

Recommendation 1.4

We recommend the Legislature consider formalizing the reporting structure between the Behavioral Health Commission and the Health Workforce Advisory Council on behavioral health workforce analysis and policy related recommendations.

Recommendation 1.5

We recommend the Health Workforce Advisory Council, with input from the Behavioral Health Commission, develop a strategic plan for behavioral health workforce efforts and determine the effectiveness of these measures.

Recommendation 2.1

We recommend the Office of Substance Use and Mental Health require local authorities to indicate if service deficiencies are related to workforce challenges as part of their annual audit process.

Recommendation 2.2

We recommend the Health Workforce Information Center consider additional data collection models to ensure its analysis captures the entirety of the behavioral health workforce.

Recommendation 2.3

We recommend the Office of Substance Use and Mental Health ensure accurate tracking of paraprofessionals and trainings to determine if RBA tactics have been achieved.

Recommendation 2.4

We recommend The Office of Substance Use and Mental Health should improve the certification process for the peer support specialist workforce.

Recommendation 2.5

We recommend the Department of Health and Human Services's Office of Background Processing evaluate and improve current background check processes for better efficiency and clarity.

Recommendation 3.1

We recommend the Legislature consider requiring the Utah State Board of Education to coordinate with the Office of Substance Use and Mental Health to define provider roles and mental health services in schools.

Recommendation 3.2

We recommend the Legislature consider requiring the Utah State Board of Education to develop and implement a plan that helps Local Education Agencies align with the School Behavioral Health Toolkit and best practices.

Recommendation 3.3

We recommend the Legislature consider requiring the Utah State Board of Education to report performance metrics and goals on the school-based mental health grant that measure accurate staffing levels and outputs as they relate to school-based mental health services.

Recommendation 3.4

We recommend the Legislature consider integrating school-based mental health services into the comprehensive continuum of care through collaboration between the local authorities and Local Education Agencies.

Recommendation 3.5

We recommend the Legislature consider requiring the Utah Behavioral Health Commission to create a framework for school-based mental health services, with the input of the Office of Substance Use and Mental Health, the Utah State Board of Education, and Local Education Agencies.

Recommendation 4.1

We recommend the Legislature consider updating ***Utah Code*** for online provider directories, including accuracy requirements and the role of state oversight.

Recommendation 4.2

We recommend the Utah Behavioral Health Commission analyze the options presented to monitor and improve the adequacy and accuracy of commercial health plan networks, with input from the Utah Insurance Department, and provide this analysis to the Legislature.

Recommendation 4.3

We recommend the Legislature consider the results of the Utah Behavioral Health Commission's analysis from Recommendation 4.2 and make a policy decision on implementation.

Appendices

A. Local Authority Data Collection

Local Authority Data Request

The following two pages depict the data request sent to local authorities.

Workforce-Related Data Request

Defined Positions: For each of the questions about positions, we will include information on therapists, prescribers, RNs, case managers, peer supports, and psychologists—only those that provide direct services to clients.

Number of open positions by provider type over the last 5 years
For each July 1 of the last five years (or if you only have two or three years, include what you can), the number of open positions (unfilled, posted positions) for each of the defined positions.

Current staffing levels, and staffing levels over the last 5 years
Headcount of each in defined position each year for past five years on July 1. (Larger organizations will obviously have more of each type.) Include both outpatient and residential/in-patient (if you have those services) but separate those numbers out. If you have psych techs, include them for this question. You can include a footnote regarding turnover and staffing level variations.

Average case load (or other productivity measurement) by provider types, by year, over the last 5 years
On July 1 for each of past five years, for each of the provider types above, number of clients in provided service divided by the number of providers providing that service (the number of clients in therapy served divided by number of therapists, the number of clients in caseload divided by number of caseworkers, etc.).

Number of employees eligible for retirement within the next 5 years by provider type
Anyone over 62 or with 25 years of service, or if you know they are retiring, by provider type listed above.

Retention Request

Year over year retention rates by provider type, by year, for the last 5 years
How many of each type of provider stay for the following number of years? For July 1 of each of last five years.
-Under 1
-1-2
-3-5
-6-10
-11+

Average length of service by provider type
Average tenure by defined provider type, at July 1 for 2024 only (not past 5 years).

Attrition Request

Over the last five years, the number of people who leave within their first 2 years and first 5 years, by provider type
Using the defined provider types, include a headcount of individuals by using each individual's hire and termination dates. Over the last five years, not a point in time or for each year.

If you are willing to provide any additional context or circumstances that contributed to attrition, please document that here
Include whatever has been affecting your center(s), whether that's higher salaries elsewhere (although our benefits package is better and often they regret leaving), data/documentation requirements, etc.

Policy and Procedure Request

Pay ranges for each position, including current pay ranges and pay ranges for the past 5 years
Provide starting pay and average pay by defined provider type for each July 1 for last five years. Only include pay, not bonuses, on-call pay, etc. You can include those in your answer for the question below.

Internal recruitment and retention policies (What incentives/programs help you attract employees and keep them around? Please include information on when they were implemented and any metrics that might evaluate the success of the programs.)
Include recruitment and retention policies and procedures, other items that you have tried that otherwise the auditors would come back and suggest. E.g. telehealth, bonuses, loan repayment, etc. Feel free to share your unique ideas.

Federal and state recruitment and retention policies (Include utilization measures and any evaluation metrics)
Any usage of federal/state grant monies for bonuses, positions, etc.

Number of employees by provider type who utilize state or federal loan repayment programs
Number of employees by defined provider type beginning enrollment each year over the last five years. This should be an unduplicated count.

Data Point Completion

The chart below depicts how many of the data points we collected and the completeness of the data. Something marked as N/A is because we did not request that data point from an organization, typically a contractor.

Data Point	Complete	Incomplete	Partially Complete	N/A
Current Staffing Levels	13	1	0	1
Staffing Levels over the Last 5 Years	12	1	1	1
Number of Open Positions by Provider Type	10	1	3	1
Average Caseload by Provider Types for the Last 5 years	9	2	3	1
Number of Employees Eligible for Retirement	12	1	1	1
Number of the provider types stay for the year brackets	12	1	2	0
Average Length of Service by Provider Type	10	4	0	1
Number of People who leave within their first 2 and 5 years	9	3	1	2
Starting and Average Pay for Each Provider Type	9	2	3	1

B. Other State Data Collection Processes

Other State Data Collection Processes

Indiana

Indiana's Bowen Center for Health Workforce and Research Policy collects information from behavioral health and human services professionals when they renew their license every two years. This data includes demographic, education, and employment information. The Bowen Center is able to use this data to write provider specific reports to inform policy and identify workforce needs.

Massachusetts

Massachusetts's Center for Health Information and Analysis collects data from community based mental health and treatment provider organizations through surveys. Their data includes employment composition and vacancies, hard to fill roles, retention challenges, and recruitment strategies. Future studies through the Health Policy Commission's Behavioral Health Workforce Center may attempt to include providers in and outside community based mental health and establish baseline workforce needs. They plan to develop recommendations and strategies to meet those needs.

Nebraska

The Behavioral Health Education Center of Nebraska (BHECN) works with the Nebraska Health Professions Tracking Service (HPTS). HPTS supplements licensure data through an annual survey of licensed behavioral health providers. The survey asks questions about practice locations, details, work status, and educational background and the data is entered into a database. BHECN analyzes the data and uses it to inform new policies and programs in Nebraska.

Virginia

Virginia's Healthcare Workforce Data Center administers voluntary surveys to providers regulated by the Department of Health Professions at the time of their licensure renewal. Their data collection includes demographics, income, hours working per week, common workplace settings, and location.

Washington

Washington's Sentinel Network surveys partners across the state. Every six months, the network of employers input data into a web portal. The partners are asked qualitative questions about workforce demands, such as if an organization has experienced vacancies, has experienced demand, and recruitment and retention challenges. Information from this data has been used in reports prepared for the governor's office.

C. Ghost Network Adequacy Test: Secret Shopper

Methodology:

Use the following script for calling commercial health plan providers:

For self:

"I recently moved to the area and have [Insert Health Care plan]. I used to see a mental health specialist for depression. I reviewed the online directory for [Insert Health Care plan], and it says you are an accepting new patients. Do you accept my insurance and if so, when is the earliest I would be able to get an appointment?"

For family members:

"My brother recently moved to the area and has [Insert Health Care plan]. He used to see a mental health specialist for depression. I reviewed the online directory for [Insert Health Care plan], and it says you are an accepting new patients. Do you accept his insurance and if so, when is the earliest he would be able to get an appointment?"

In many instances the person answering the phone was not the provider, in this case, we **asked for the provider by name**.

Phone Call Procedures:

- Asked for the provider by name.
- Primarily focused on talk therapy or medication management. However, if a provider specialized in another mental health service then we called that provider under a different phone number to verify their appointment availability.
- If a provider required a referral before scheduling, our team asked whether the provider had any availability for referrals to ensure we did not go through the process.
- Our team did not make any appointments and ended the phone call by thanking the provider and citing scheduling concerns or time constraints.
- If the provider did not answer, we left our name and phone number. All providers were called at least twice.

Reasons for classifying a call as being unable to set up an appointment:

Phrases that classified as "no" under 'new patient' related:

Provider verified through call (or returned voicemail) that they are not accepting new patients, and/or they do not know when their availability would open up to accept new patients.

Phrases that classified as "no" under 'insurance' related:

Provider verified through call (or returned voicemail) that they do not accept the insurance health plan that we were calling under.

Phrases that classified as "no" under 'wait time' related:

Provider verified through call (or returned voicemail) that their earliest appointment is later than 90 days (3 months out).

Phrases that classified as "no" under 'wrong number' related:

Receptionist verified through call (or returned voicemail) that they are not aware of the provider, nor do they know how to contact the correct provider.

Phrases that classified as "no" under 'not at location' related:

Receptionist verified through call (or returned voicemail) that they are aware of the provider's name, but the provider has retired or moved from the location. Additionally, if the provider's location of practice is outside the 50-mile radius in our study then this was marked as “not at location.” In other words, a provider would be marked as "yes" if they were providing therapy in another location if their provider location still falls within the radius; otherwise, they are a "no."

Phrases that classified as "no" under 'did not answer' related:

Providers that were called at least twice, and at least one voicemail was left with the provider. The provider did not answer our phone calls nor return our voicemails.

Phrases that classified as "no" under 'mis-categorization' related:

Provider verified through call (or returned voicemail) that the number is correct, and verified the name. However, they do not accept mental health patients (i.e. provider only works with retirement centers and does not provide mental health services).

Agency Response Plan

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

DR. STACEY BANK
Executive Medical Director

NATE CHECKETTS
Deputy Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

April 7, 2025

Mr. Kade Minchey
Utah Legislative Auditor General
Utah Capitol Complex
P.O. Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Minchey,

Thank you for the opportunity to respond to the recommendations in *Utah's Behavioral Health Workforce: A Review of Workforce Efforts, Entities, Indicators, and Oversight* (Report No. 2025-05). This letter includes the response from the Utah Department of Health and Human Services (DHHS) and its Office of Substance Use and Mental Health. We appreciate the work of the Office of the Legislative Auditor General in providing this performance audit.

Once again, you and your staff have been professional and collaborative as we work together to improve Utah's behavioral health system. The department appreciates the guidance the audit provides in identifying the workforce challenges that exist within the behavioral health system.

On behalf of the department, we agree with the recommendations in this report relevant to DHHS and the response outlines our actions and timelines to demonstrate our agreement. The department is committed to ensuring a proper workplace that meets the needs of the residents of Utah.

Sincerely,

Tracy S. Gruber
Executive Director

State Headquarters: 195 North 1950 West, Salt Lake City, Utah 84116
telephone: 801-538-4001 | email: dhhs@utah.gov | dhhs.utah.gov

Recommendation 1.1. The Department of Health and Human Services should ensure the Health Workforce Information Center has adequate access to behavioral health workforce data sources for workforce evaluation.

Department Response:
The department concurs with this recommendation.

What: The department will ensure all HWIC data-sharing agreements are clearly defined and functional to prevent any potential delays in data collection and transmission to the HWIC.

How: DHHS will review all HWIC data sharing agreements and practices to identify potential improvement opportunities and maintain accountability.

When: November 30, 2025

Responsible Staff: Kyle Lunt, Director, Data, Systems and Evaluation

Recommendation 1.2. The Health Workforce Information Center should evaluate all behavioral health providers in its analysis of the behavioral health workforce.

Department Response
The department concurs with this recommendation.

What: To the extent that data is available from DHHS sources, the HWIC will include DHHS-certified paraprofessionals (e.g., peer support, case managers, and crisis workers) in its future supply data analyses.

How: The HWAC and HWIC will coordinate with the Behavioral Health Commission to identify specific priority paraprofessionals for review, and will share the HWIC's evaluation with the Commission.

Under UCA 26B-4-705-3(a), the Health Workforce Information Center (HWIC) "under the guidance of the HWAC (council), works with the Department of Commerce, to

collect and analyze data from any available source (including DOPL data) that helps to identify workforce shortages, labor market indicators, determine the educational background of a licensee, and determine whether Utah is retaining a stable health workforce." HWIC accomplishes part of this requirement through the collection of data from DOPL through the HWAC-adopted Utah Cross-Profession Minimum Data Set (UCPMDS) during the re-licensure process for health workforce professionals. The HWIC will continue to work with DOPL to access and analyze information on health workforce professionals gathered during the re-licensure process.

When: December 31, 2025

Responsible Staff: Holly Uphold, HWIC Manager

Recommendation 1.3. The Health Workforce Advisory Council and the Utah Substance Use and Mental Health Council should evaluate their legislative review processes for the behavioral health workforce and eliminate any duplicative efforts.

Department Response
The department concurs with this recommendation.

What: The HWAC will engage USAAV+ to further streamline the current legislative review process for the behavioral health workforce.

How: USAAV+ already has an established legislative review process for behavioral health workforce legislation, and it will take the lead in reviewing proposed behavioral health workforce legislation beginning with the 2026 General Session. USAAV+ also has a statuorily-designated seat on the HWAC and participates in the HWAC's legislative review subcommittee, and it will share USAAV+'s positions with the HWAC. For any bills that have implications for the broader health care workforce (i.e., beyond just the behavioral health workforce), USAAV+ will also review and identify any bills whose impact potentially extends beyond the behavioral health workforce for the HWAC's legislative review subcommittee's consideration.

When: January 20, 2026

Contact: Kendyl Brockman, Health Workforce Policy Analyst; Mia Nafziger, Administrator of the Utah Behavioral Health Commission

Recommendation 1.4. The Legislature should consider formalizing the reporting structure between the Behavioral Health Commission and the Health Workforce Advisory Council on behavioral health workforce analysis and policy related recommendations.

Department Response
Although this recommendation is directed to the Legislature, the department concurs with the recommendation.

What: The department will work with the Governor's Office and Legislature to update and modernize Utah Code, specific to identifying and addressing Utah's behavioral health workforce needs. In the interim, the HWAC has prioritized enhancing coordination as an area for strategic implementation in 2025. This means ensuring synergy, connection and alignment with existing entities and initiatives that support Utah's health workforce to maximize resources and impact for Utahns.

How: The Commission will work with HWAC to develop formal communication and reporting structures. These structures will ensure that the Commission and HWAC are aware of and supporting each others' efforts and avoid duplicative activities. For example, Commission meetings could have a standing agenda item for the HWAC every six months to update the Commission on their recent behavioral health workforce analyses and policy-related recommendations. The Commission also plans to integrate HWAC feedback and ongoing activities into its strategic plan, in consultation with HWAC.

When: March 31, 2026

Responsible Staff: Kendyl Brockman, Health Workforce Policy Analyst; Mia Nafziger, Administrator of the Utah Behavioral Health Commission

Recommendation 1.5. The Health Workforce Advisory Council, with input from the Behavioral Health Commission, should develop a strategic plan for behavioral health workforce efforts and determine the effectiveness of these measures.

Department Response
The department concurs with this recommendation.

What: The Health Workforce Advisory Council, with input from the Behavioral Health Commission, will develop a strategic plan for behavioral health workforce efforts, including an evaluation structure.

How: As noted above in 1.4, as part of its draft 2025 Health Workforce Action Plan, the HWAC's priority areas of focus for 2025 include licensed interns, associates, and professionals in a range of behavioral health license types and psychology professionals. By the end of 2025, the HWAC intends to determine the top issues and priorities for these professions. During Q1 2026, the HWAC will present its findings to the Behavioral Health Commission. During Q2 2026, the HWAC will collaborate and coordinate with the Behavioral Health Commission to develop a strategic plan and identify a method for reviewing its effectiveness.

When: June 30, 2026

Responsible Staff: Kendyl Brockman, Health Workforce Policy Analyst; Mia Nafziger, Administrator of the Utah Behavioral Health Commission

Recommendation 2.1. The Office of Substance Use and Mental Health should require local authorities to indicate if service deficiencies are related to workforce challenges as part of their annual audit process.

Department Response
The Office of Substance Use and Mental Health (SUMH) concurs with this recommendation.

What: SUMH will require local authorities to indicate if service deficiencies identified during SUMH annual audits are related to workforce challenges.

How: Beginning September 1, 2025, local authorities will be required to submit a corrective action plan (CAP) that includes root cause analysis for all audit findings. In cases where the local authorities indicate a service deficiency is related to workforce challenges, the CAP will provide a thorough analysis of the contributing factors that led to the workforce shortage. The CAP will require the local authority to describe the workforce shortage and identify the contributing factors that increased the likelihood of the workforce shortage. This information will assist SUMH in quantifying public sector workforce issues and their impact on behavioral health services. All audit reports will be made public and posted online beginning in September 2025.

When: September 1, 2025

Responsible Staff: Brent Kelsey, Director, SUMH

Recommendation 2.2. The Health Workforce Information Center should adopt additional data collection models to ensure its analysis captures the entirety of the behavioral health workforce.

Department Response
The department concurs with this recommendation.

What: For the DHHS-licensed paraprofessionals identified for analysis in Recommendation 1.2, HWIC will analyze available data.

How: HWIC will coordinate with the DHHS operational units who manage the data for the DHHS-licensed paraprofessionals identified in response to Recommendation 1.2 to set up data sharing agreements and transfer methods.

When: June 30, 2026

Responsible Staff: Holly Uphold, HWIC Manager

Recommendation 2.3. The Office of Substance Use and Mental Health should ensure accurate tracking of paraprofessionals and trainings to determine if RBA tactics have been achieved.

Department Response
SUMH concurs with this recommendation.

What: SUMH is committed to using the UCLAPP system to accurately track certifications.

How: SUMH recognizes the importance of tracking certifications and strives to provide accurate data. Since 2023, SUMH has tracked peer support and case manager certifications in the Utah Certification & Application (UCLAPP) system. This system allows SUMH to accurately track certifications and document workforce trends. Before 2023, SUMH used two different certification tracking systems. Prior systems were implemented in collaboration with other state licensing agencies. However, limitations in these systems precipitated a change to the current system. Each time SUMH changed systems, data was lost. Also, SUMH did not enter expired certifications from the historical systems into the new system. The UCLAPP system, in use since 2023, allows SUMH to accurately identify the number of individuals certified at a set point in time as well as the number of individuals who have multiple certifications (peer support, case management, crisis worker).

When: July 1, 2025

Responsible Staff: Brent Kelsey, Director, SUMH

Recommendation 2.4. The Office of Substance Use and Mental Health should improve the certification process for the peer support workforce.

Department Response
SUMH concurs with this recommendation.

What: SUMH is continually working to expand the number of training courses, the number of trainers and the number of peers employed in the workforce.

How: SUMH recently implemented changes to increase awareness of training opportunities and decrease the complexity of the application process. In August 2024, SUMH updated the website to make it easier for the public to find and access key information, improved training descriptions and included a frequently asked questions section. Documents on the website have been translated into Spanish. In addition, the website now includes information on how to report ethical violations.

In October 2024, SUMH launched an online application for certifications. This has decreased the time it takes to process applications. The online system now makes it possible for an office specialist to initially review and ensure an application is complete. The online system can also be used to organize the waitlist and improve communication with applicants.

SUMH is also working to improve the quality of peer support training and actively seeks out input from peers to improve this process. A Peer Support Steering Committee meets monthly to advise SUMH. In April 2024, SUMH revised the curriculum requirements to meet national standards. Existing contracts with peer training agencies were updated and current trainers began using this curriculum in the fall of 2024. Also, in January 2025, SUMH hosted a convening with peer support leaders from across the state to discuss training, certification and other issues related to the peer workforce.

To increase the number of peers in the workforce, SUMH is working with the Peer Support Steering Committee to create a tool kit for employers interested in hiring PSS. This tool kit should be ready by June 2026. In addition, the Utah Behavioral Health Commission recommended and House Bill 491 Behavioral Health System Amendments, sponsored by Representative Steve Eliason, directed the Division of Integrated Healthcare to increase the Medicaid reimbursement rate for peer support services starting July 1, 2025.

In addition to the improvements SUMH has already made, SUMH will make the following additional improvements in state fiscal year 2026:

- Develop and distribute a peer support video to increase community awareness of peer support services.

- Contract with at least one new training agency.
- Schedule peer support specialist certification trainings with the goal to have at least one training per month.
- Develop a family peer support supervisor training.
- Establish a Spanish Family Peer Support Specialist (FPSS) training, and a Youth Peer Support Specialist training in Spanish and English.
- Update the Utah Peer Support Supervision guide.

When: June 30, 2026

Responsible Staff: Brent Kelsey, Director, SUMH

Recommendation 2.5. The Department of Health and Human Services' Office of Background Processing should evaluate and improve current background check processes for better efficiency and clarity.

Department Response

The department concurs with this recommendation. Efficiency and effectiveness are central to the DHHS strategic plan, and a streamlined background check process is crucial. The Office of Background Processing (OBP) is taking concrete steps to improve the process. These actions include updating the rule, modifying the processing system, and adding staff.

What: Improve the background check process to be more efficient and clear.

How: OPB is actively addressing these areas through the following key initiatives:

1. System Modifications: OBP is implementing system modifications to streamline the application initiation process. These modifications will:
    a. Simplify the process for providers, reducing the amount of data entry required.
    b. Enable more automated funneling based on selected options.
    c. Improve reporting capabilities regarding the type and purpose of background checks.

    d. Training for providers on these new system modifications will be held May 20, 2025.
2. Rule Implementation: By July 1, 2025, OBP will develop an updated rule will significantly enhance both efficiency and clarity. This rule will:
    a. Provide clearer guidance and interpretation for the comprehensive review process.
    b. Optimize the review process for improved efficiency.
    c. Explicitly clarify that traffic offenses are excluded from our background checks.
    d. Clearly define the responsibilities of providers.
3. Staff Augmentation: By July 1, 2025, OBP will add one staff member to its team to ensure the successful implementation and ongoing support of these changes that will lead to improved efficiency.

When: The system modification will be completed by May 31, 2025. The rule implementation and staff augmentation will be complete by July 1, 2025.

Responsible Staff: Daphne Lynch, Director, Office of Background Processing

UTAH BEHAVIORAL HEALTH COMMISSION

Ally Isom
Chair

Tammer Attallah
Vice Chair

Kyle Snow
Second Vice Chair

April 7, 2025

Mr. Kade Minchey
Utah Legislative Auditor General
Utah Capitol Complex
P.O. Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Minchey,

Thank you for the opportunity to respond to the recommendations in *A Performance Audit of Utah's Behavioral Health Workforce: A Review of Workforce Efforts, Entities, Indicators, and Oversight (Report #2025-05)*. This letter includes the response from the Utah Behavioral Health Commission.

On behalf of the Utah Behavioral Health Commission, we concur with the recommendations in this report and the response outlines our actions and timelines to demonstrate our agreement. The Commission is committed to its statutory obligations to coordinate behavioral health initiatives and ensure Utah's behavioral health systems are comprehensive, aligned, effective, and efficient.

Sincerely,

Ally Isom
Chair of the Utah Behavioral Health Commission

Tammer Attallah
Vice Chair of the Utah Behavioral Health Commission

Kyle Snow
Second Vice Chair of the Utah Behavioral Health Commission

Recommendations

1-3: The Health Workforce Advisory Council and the Utah Substance Use and Mental Health Advisory Committee should evaluate their legislative review processes for the behavioral health workforce and eliminate any duplicative efforts.

Commission Response

The Commission concurs with this recommendation. The Utah Substance Use and Mental Health Advisory Committee (USAAV+) is a subcommittee of the Utah Behavioral Health Commission (Commission). The Commission is committed to supporting efficient and effective councils and committees that use state resources appropriately.

USAAV+ and HWAC have responded to the findings of this audit and determined that moving forward, USAAV+ will track all behavioral health workforce legislation to avoid duplicative efforts between the two groups. USAAV+ staff will continue to participate in HWAC Legislative Review meetings, present on relevant behavioral health workforce bills to HWAC members, and solicit input and questions on workforce-related bills. HWAC will provide input on bills that impact both the behavioral health and broader health care workforce. The Commission will support USAAV+ in these collaborative efforts.

1-4: The Legislature should consider requiring the Health Workforce Advisory Council to report to the Behavioral Health Commission on behavioral health workforce analysis and policy related recommendations.

Commission Response

The Commission concurs with this recommendation. The Commission is charged with cooperating with the Utah System of Higher Education, the State Board of Education, the Division of Professional Licensing, HWAC, and the Department of Health and Human Services (DHHS) to oversee the creation and implementation of behavioral health workforce initiatives for the state. The Commission supports closer collaboration between the Commission and HWAC and sees this collaboration as part of its statutory responsibilities.

The Commission will work with HWAC to develop formal communication and reporting structures. These structures will ensure that the Commission and HWAC are aware of and supporting each others' efforts and avoid duplicative activities. For example, Commission meetings could have a standing agenda item for the HWAC every six months to update the Commission on their recent behavioral health workforce analyses and policy-related

recommendations. The Commission also plans to integrate HWAC feedback and ongoing activities into its strategic plan, in consultation with HWAC.

1-5: The Health Workforce Advisory Council, with input from the Behavioral Health Commission, should develop a strategic plan for behavioral health workforce efforts and determine the effectiveness of these measures.

Commission Response

The Commission concurs with this recommendation.

As part of its draft 2025 Health Workforce Action Plan, HWAC's priority areas of focus for 2025 include licensed interns, associates, and professionals in a range of behavioral health license types and psychology professionals. By the end of 2025, the HWAC intends to determine the top issues and priorities for these professions. During Q1 2026, HWAC will present its findings to the Commission. During Q2 2026, HWAC and Commission will collaborate to develop a strategic plan and identify a method for reviewing its effectiveness.

The Commission is in the process of developing a five-year behavioral health strategic plan for the State of Utah. This strategic plan may include objectives and tactics related to the behavioral health workforce. The Commission will collaborate with HWAC to ensure that the two strategic plans are not duplicative. The Commission will delegate components of its strategic plan to HWAC, as appropriate.

3-5: The Legislature should consider requiring the Utah Behavioral Health Commission to create a framework for school-based mental health services, with the input of the Office of Substance Use and Mental Health, the Utah State Board of Education, and Local Education Entities.

Commission Response

The Commission concurs with this recommendation. The Commission recognizes the need to improve school-based mental health services in Utah and will integrate this issue into its strategic plan, which the Commission will complete in July 2025. Aligning the Commission's activities with schools will ensure that solutions in school-based mental health are aligned and support schools' mission and vision. The Commission will build collaboration with the Office of Substance Use and Mental Health, the Utah State Board of Education, and Local Education Entities into its strategic plan.

The Commission is also currently revising its subcommittee structure and will incorporate a greater focus on children, youth, and young adults into its subcommittees. This structure will support the Commission in addressing the needs of the school-based mental health system. The Commission will solicit input from the State Board of Education on the subcommittee structure to ensure the Commission is well aligned with our state education system.

4-2: The Utah Behavioral Health Commission should analyze the options presented to monitor and improve the adequacy and accuracy of commercial health plan networks, with input from the Utah Insurance Department, and provide this analysis in its yearly report to the Legislature.

Commission Response:
The Commission concurs with this recommendation. The Commission recognizes inaccuracies in commercial health provider directories create a significant barrier to accessing behavioral health care and agrees that the Commission plays a unique role in its ability to work with the private sector to address this issue.

What: The Commission will integrate the proposed analysis into its five-year strategic plan as a short-term tactic for improving the adequacy and accuracy of commercial health plan networks. The Commission identifies responsible units in its strategic plan and will include the Utah Insurance Department as a partner for this tactic. As part of this analysis, the Commission will reach out directly to commercial payers to engage with these stakeholders, better understand their challenges, and identify solutions together.

How: DHHS staff support the Commission in research and analysis. These staff will complete this analysis, with input from the Utah Insurance Department. Staff will present the analysis to commissioners for their review, input, and ultimate approval.

When: The Commission will complete this analysis by December 31, 2025, and include the analysis in the annual report submitted to the Legislature in September 2026.

Contact: Mia Nafziger, Administrator, mnafziger@utah.gov, 385-514-2994; Brent Kelsey, Director, bkelsey@utah.gov

April 4, 2025

Office of the Legislative Auditor General
W315 House Building
State Capitol Complex
Salt Lake City, UT 84114

Subject: Response to the Behavioral Health Workforce Performance Audit

Dear Legislative Auditor General,

On behalf of the Utah Behavioral Health Committee, we appreciate the opportunity to respond to the Behavioral Health Workforce Performance Audit and express our support for the continued efforts to strengthen the behavioral health workforce in our state. We recognize the critical role that a robust and sustainable workforce plays in ensuring that Utahns have access to quality mental health and substance use disorder services.

We strongly support the tracking of workforce issues through a few simple and reasonable data points that can effectively indicate whether service deficiencies are directly related to workforce challenges. By implementing a targeted data collection approach, we may be better able to assess workforce shortages and develop informed strategies to address gaps in service delivery. We are committed to collaborating with state agencies to ensure that data-driven solutions lead to meaningful improvements in behavioral health care access and outcomes.

Additionally, we look forward to working with local education authorities to enhance the integration of school-based mental health services within the broader continuum of care provided by local mental health authorities. Strengthening these partnerships will help create a seamless system of care for students and families, ensuring that those in need receive timely and appropriate support. We believe that improved coordination between schools and county providers will not only enhance service delivery but also contribute to better overall mental health outcomes for Utah's youth.

We appreciate the work of the Office of the Legislative Auditor General in conducting this important audit and value the opportunity to engage in these discussions. The Utah Behavioral Health Committee remains committed to supporting policies and initiatives that strengthen our workforce and enhance the availability of behavioral health services across the state.

Thank you for your attention to these critical issues. We look forward to continued collaboration as we work to improve behavioral health care for all Utah residents.

Sincerely,

Kyle Snow
Chair
Utah Behavioral Healthcare Committee

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