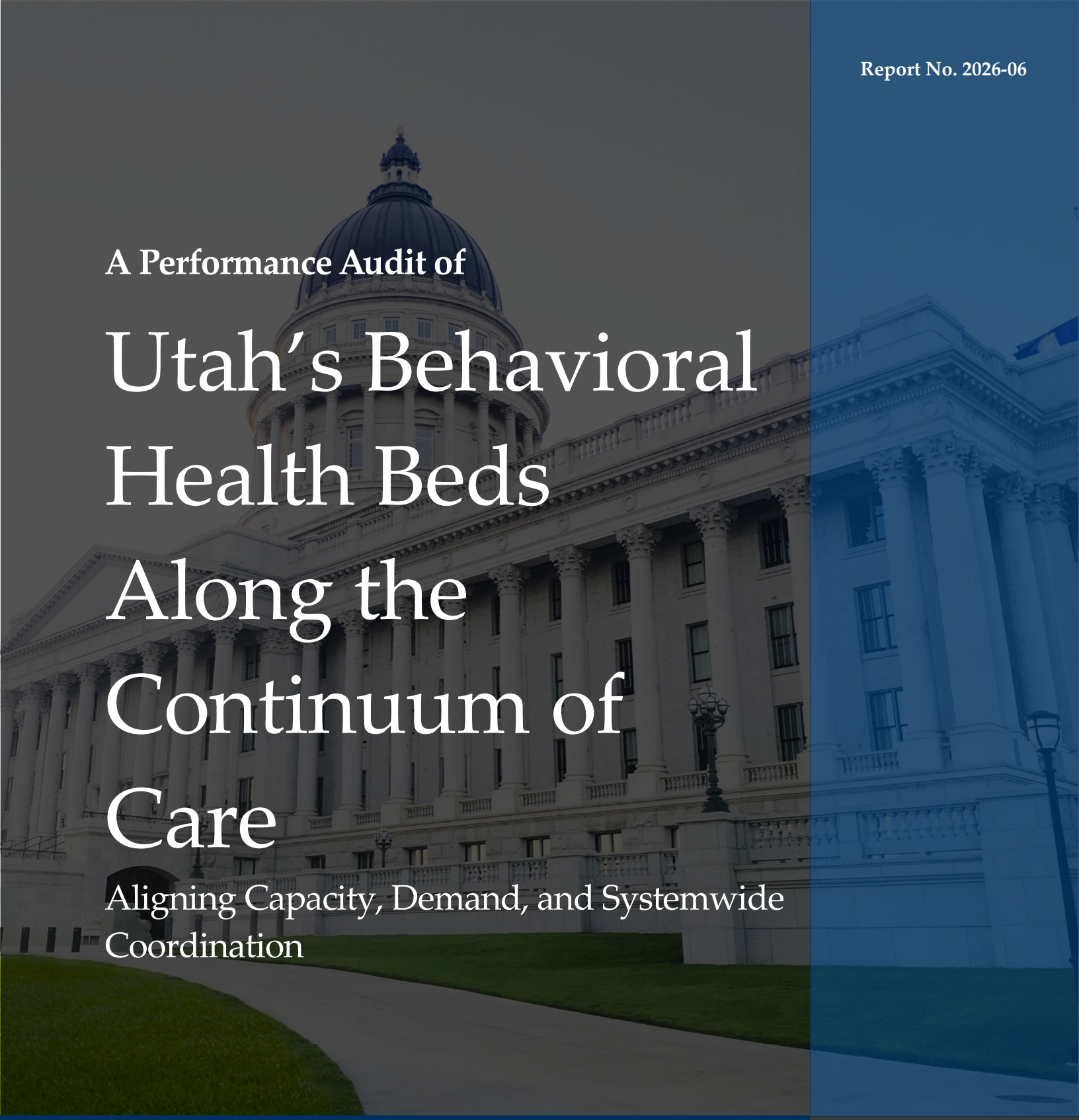
Report No. 2026-06



A Performance Audit of

Utah's Behavioral Health Beds Along the Continuum of Care

Aligning Capacity, Demand, and Systemwide Coordination

Office of the Legislative Auditor General

Report to the **UTAH LEGISLATURE**

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Senator Kirk Cullimore | Representative Casey Snider

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April 16, 2026

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report:

"A Performance Audit of Utah's Behavioral Health Beds Along the Continuum of Care: Aligning Capacity, Demand, and Systemwide Coordination" [Report #2026-06].

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 chief officer for the Department of Health and Human Services is Tracy Gruber. Tracy Gruber 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

LEGISLATIVE AUDITOR GENERAL

AUDIT SUMMARY

REPORT 2026-06 | APRIL 2026

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

PERFORMANCE AUDIT

UTAH'S BEHAVIORAL HEALTH BEDS

AUDIT REQUEST

The Legislative Audit Subcommittee requested an audit of Utah's behavioral health system. As part of our initial risk assessment, we identified bed capacity and availability across the continuum of care as a key contributing factor to broader system challenges. This includes access, patient flow, and resource allocation. Consequently, this audit focuses on Utah's behavioral health beds.

BACKGROUND

Utah's behavioral health system encompasses services for mental health (MH) and substance use disorder (SUD) patients across a continuum of care. However, the system does not understand its behavioral health bed capacity or demand. Availability is essential for ensuring that patients are safe and achieve optimal clinical outcomes. In addition, accurately assessing capacity and demand across these various levels of care is critical for allocating resources, ensuring timely access to care, and minimizing patient length of stay in emergency rooms.

KEY FINDINGS

- Key Governance Concerns Remain Unresolved
- Limited System-Wide Governance Over Behavioral Health Bed Resources Drives Financial, Operational, and Clinical Inefficiencies

RECOMMENDATIONS

- **1.1** The Legislature should consider requiring the Department of Health and Human Service's Office of Substance Use and Mental Health to implement a bed registry and use this registry alongside other data sets to identify areas of greatest need in the system.
- **1.2** In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should implement a real-time and comprehensive bed registry, including the information noted in the report.
- **1.3** In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use a registry of both public and private beds to combine real-time monitoring with long-term needs assessment to provide access to information for stakeholders, providers, and the public and mine data over time to determine need.
- **1.4** In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use information obtained from a bed registry and other data resources, which could include the Healthcare Facility Database, the All Payers Claims Database, and others to conduct a longitudinal study of where patients are "stuck" in the system to identify the specific care levels with the highest unmet demand.

REPORT SUMMARY

Utah Does Not Know Its Behavioral Health Bed Needs

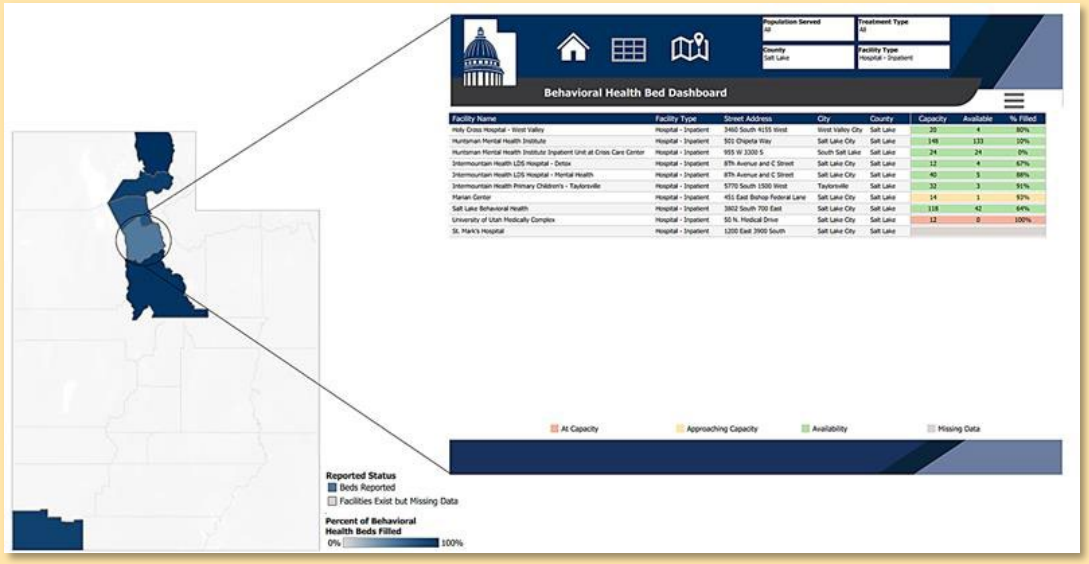
Utah does not have a comprehensive, system-wide understanding of behavioral health bed capacity, availability, or demand across the continuum of care. No entity is responsible for maintaining complete, reliable information on where beds exist, how often they are available, or whether capacity aligns with population needs. This lack of centralized governance and standardized data limits the state's ability to assess system performance, identify unmet demand, and evaluate the effectiveness of past or proposed investments.

As a result, patients may experience delays in placement, prolonged stays in emergency departments, and difficulty accessing care at the appropriate level. Congestion at one level of care can create bottlenecks throughout the continuum, reducing overall efficiency and limiting providers' ability to accept new patients.

In addition, policy makers and other decision-makers lack the information needed to determine whether resources are being directed to the areas of greatest need. Establishing a centralized behavioral health bed registry, used in conjunction with other available data sources, could improve state-wide visibility into bed capacity and availability, support more informed oversight, and strengthen long-term planning and resource allocation.

Utah Behavioral Health Bed Map and Dashboard

This map and dashboard were developed by audit staff to visualize behavioral health bed capacity and availability across Utah's continuum of care. The tool compiles facility-reported information to illustrate where beds are located, how capacity varies by region and level of care, and where gaps may exist. While more comprehensive than prior efforts, the data are not complete and highlight the challenges decision-makers face in the absence of a centralized, system-wide bed registry.



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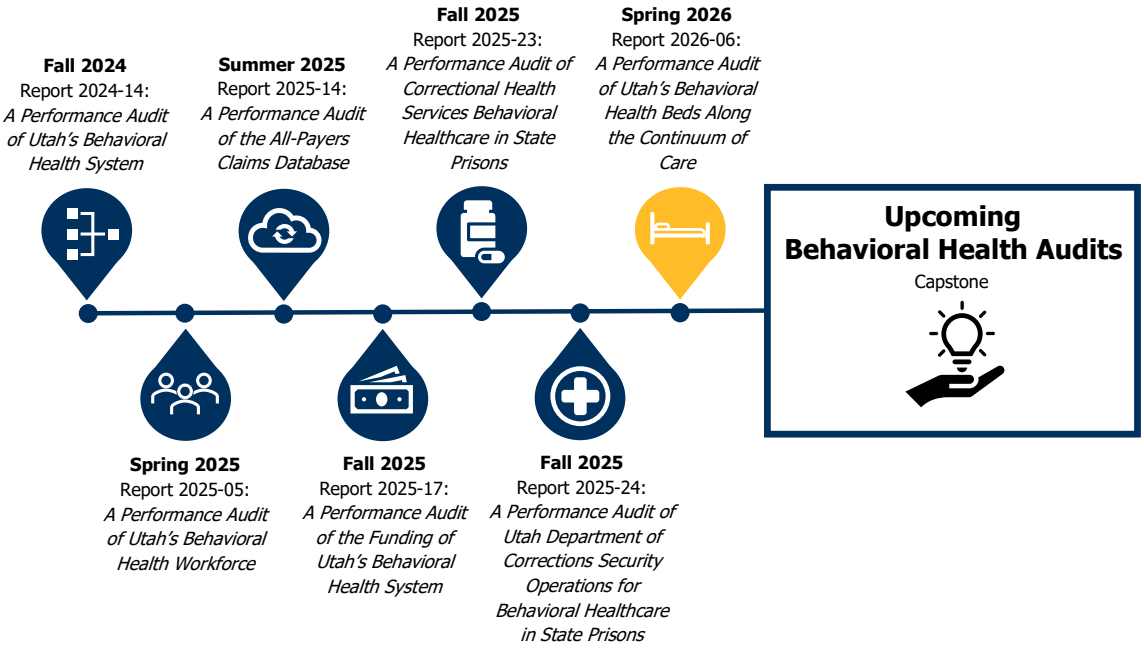
Introduction

Over the last year and a half, we produced a series of audits, each focusing on a different cause of challenges in Utah's behavioral health system. We chose to address these challenge areas because they often create gaps in care and make them worse. This is the seventh audit in the series, and it focuses on understanding behavioral health bed resources across the continuum of care. At its core, it's about bed capacity, demand, and the gaps between them.



Source: Auditor generated.

Key Governance Concerns Remain Unresolved

In the first audit of the series, we highlighted that Utah's behavioral health system evolved over many years and created fragmentation and complicated governance structures.[1] Effective governance is foundational to system success. However, there is still no overarching entity providing unified oversight. Although the Utah Behavioral Health Commission marks progress in fostering collaboration and shared purpose, it doesn't have the regulatory power required to drive meaningful reform. We recognize that resolving these large-scale issues

At its core, this audit is about bed capacity, demand, and the gaps between them.

[1] *A Performance Audit of Utah's Behavioral Health System: A Case for Governance, Strategic Planning, and Accountability* (Report No. 2024-14).

requires long-term effort. Unfortunately, the lack of coordinated governance continues to create barriers for those seeking care. This audit builds on those earlier findings by looking at how governance issues complicate patient movement and limit system-wide transparency, leaving decision-makers blind to critical gaps and trends.

This report continues to call for strengthened governance across Utah's behavioral health system and recommends more effective, coordinated use of data to maximize system-wide impact. The following chapter examines the key consequences of weak governance within the behavioral health system specific to bed capacity and demand.

1 Utah Does Not Know Its Behavioral Health Bed Needs

Chapter 1
Utah Does Not Know Its Behavioral Health Bed Needs

1.1 Limited System-Wide Governance Over Behavioral Health Bed Resources Drives Financial, Operational, And Clinical Inefficiencies

Utah's behavioral health system does not have a system-wide understanding of behavioral health bed capacity and demand across the continuum of care. A continuum of behavioral health care refers to the full range of behavioral health services that allows individuals to receive the right care at the right time. Utah's continuum includes promotion and prevention activities, plus stabilization supports and wraparound services. This includes services for both mental health (MH) and substance use disorders (SUD), where patients require different types of treatment settings to ensure safety and support effective treatment.

Utah's Continuum of Behavioral Health Services and Supports

Source: Auditor generated using the Utah Hospital Association's continuum.
Note: See Appendix A for additional details on the different bed types.

This audit looks at bed capacity and demand, and the gaps between them. It focuses on crisis services, subacute/step-down care, and acute/inpatient care for pediatric, adult and geriatric populations experiencing mental health or substance use issues in both private and public sectors. We couldn't find any existing comprehensive analysis, so we set out to determine if Utah has adequate behavioral health beds to meet its population's needs. However, as we gathered information, it was clear that this objective wasn't possible. Without strong governance in the behavioral health system, no one has previously determined the system-wide capacity, nor could we find that anyone has conducted a comprehensive needs assessment.

No one has previously determined system-wide bed capacity, nor has anyone conducted a comprehensive needs assessment.

Instead, we used a direct approach, contacting all facilities in Utah.

Facilities are generally aware of their individual capacity and availability.[2] But they seldom conduct strategic assessments to evaluate their needs, resulting in limited insight into demand.

These challenges limited what we could do, but we felt it was important to start the discussion about beds. This conversation is important because you must understand these resources across the continuum to understand the system's needs. Ultimately, this area, like many others in the behavioral health realm, would benefit from a system-wide central authority that could collect and maintain behavioral health bed information. Decision-makers should be able to look at behavioral health bed data and understand the following:

- System-wide capacity at all levels of care
- Availability across the continuum of care
- Bed demand resource allocation

Decision-makers cannot currently use data for these purposes.

A Bed Registry Could Strengthen Decision-Making, Improve System Efficiency, and Contribute to Better Clinical Outcomes

It is hard to understand the entire continuum of care because there is no centralized bed registry.

Utah doesn't know its true behavioral health capacity and demand. There is no comprehensive central repository, which makes it difficult to visualize the entire continuum. There are over 500 facilities located in Utah, across the continuum, that all play a role in providing behavioral health services.[3] However, with so many facilities involved, it is challenging to track and monitor each one's resources.

To demonstrate the value of a central registry, we developed a dashboard identifying all currently operating facilities in Utah. The dashboard is intended to show that this is possible. We don't intend this dashboard to be used for decision-making purposes or believe that this is the only information that should be included. The insert on the following page provides just one example of how the dashboard could be used—moving from a statewide view of inpatient bed capacity and availability to a county-level analysis.[4] The dashboard allows users to filter by variables such as treatment population and type, location, capacity, and availability. Because there is no central

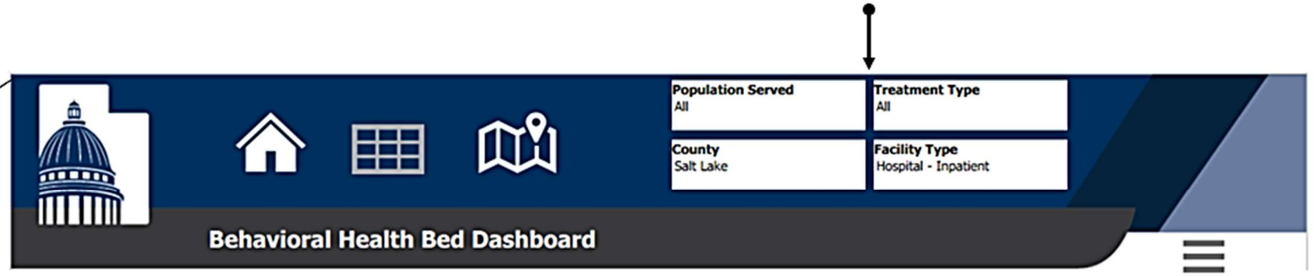
[2] We couldn't verify these numbers and had to rely on facility-reported information.

[3] Services provided at these facilities include MH and SUD treatment in beds for adult, youth, geriatric, and forensic populations. Patients may receive care in crisis, subacute/step-down, or acute/inpatient settings in both private and public sectors.

[4] Clicking on the fold out or scanning the QR code directs you to an interactive version of the dashboard, which allows you to explore different counties and focus on specific categories.

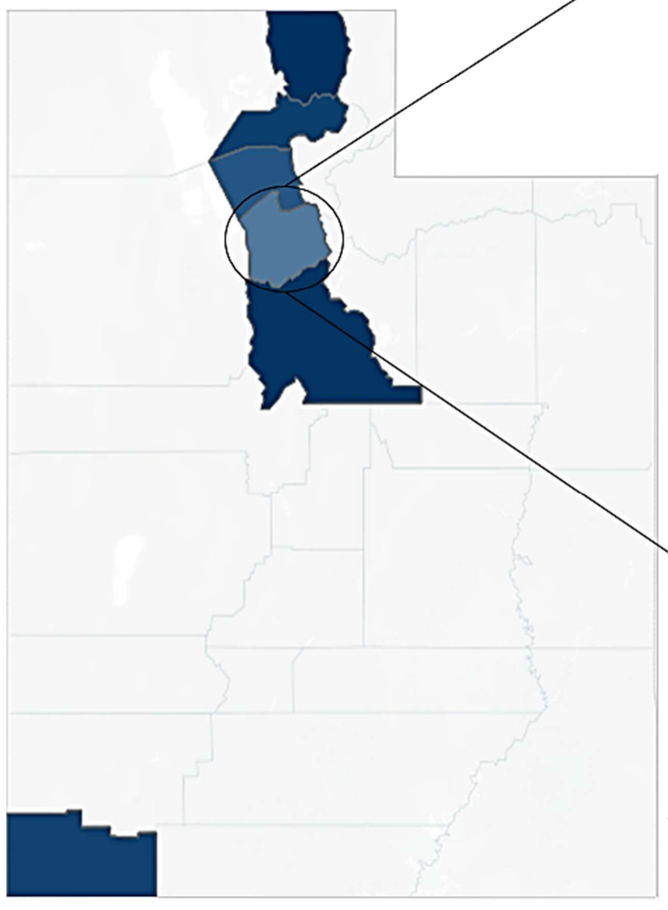
Example For Uses of the Behavioral Health Bed Map and Dashboard

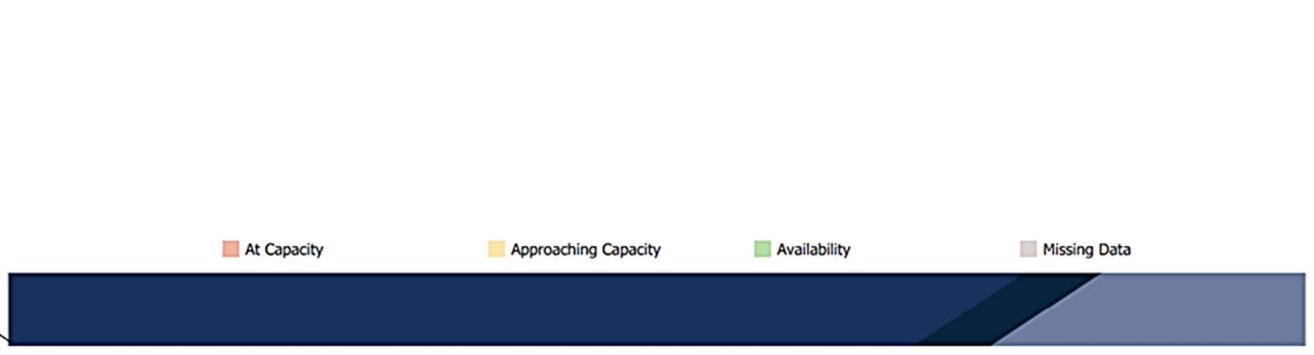
In this example, a provider can use filters in the **Dashboard** and **Map** to identify potential inpatient bed matches in Salt Lake County. This functionality may help facilitate quicker transitions from emergency departments or other crisis settings to appropriate care.



Facility Name	Facility Type	Street Address	City	County	Capacity	Available	% Filled
Holy Cross Hospital - West Valley	Hospital - Inpatient	3460 South 4155 West	West Valley City	Salt Lake	20	4	80%
Huntsman Mental Health Institute	Hospital - Inpatient	501 Chipeta Way	Salt Lake City	Salt Lake	148	133	10%
Huntsman Mental Health Institute Inpatient Unit at Crisis Care Center	Hospital - Inpatient	955 W 3300 S	South Salt Lake	Salt Lake	24	24	0%
Intermountain Health LDS Hospital - Detox	Hospital - Inpatient	8Th Avenue and C Street	Salt Lake City	Salt Lake	12	4	67%
Intermountain Health LDS Hospital - Mental Health	Hospital - Inpatient	8Th Avenue and C Street	Salt Lake City	Salt Lake	40	5	88%
Intermountain Health Primary Children's - Taylorsville	Hospital - Inpatient	5770 South 1500 West	Taylorsville	Salt Lake	32	3	91%
Marian Center	Hospital - Inpatient	451 East Bishop Federal Lane	Salt Lake City	Salt Lake	14	1	93%
Salt Lake Behavioral Health	Hospital - Inpatient	3802 South 700 East	Salt Lake City	Salt Lake	118	42	64%
University of Utah Medically Complex	Hospital - Inpatient	50 N. Medical Drive	Salt Lake City	Salt Lake	12	0	100%
St. Mark's Hospital	Hospital - Inpatient	1200 East 3900 South	Salt Lake City	Salt Lake			

By showing potential bed availability in one place, the **Dashboard** may reduce the administrative time users spend calling multiple facilities when searching for placement.





The Behavioral Health Bed **Dashboard** and **Map** include all licensed mental health and substance use beds throughout the state. It enables users to visualize statewide behavioral health bed capacity and availability. In addition, users can filter by location, treatment type and facility type.

This graphic provides an example of how the dashboard can be used. This specific example focuses on inpatient beds — the map displays the percentage of beds filled in each county, while the dashboard can provide facility-level capacity, availability, and percent-filled information for selected counties. The data is self-reported and not independently verified by the audit team. It is shown for illustrative purposes only and is not intended for real-time decision-making.

Scan Here to View Our Online Dashboard

authority to maintain this information, audit staff spent months contacting each facility and compiling the data manually. While our efforts are much more comprehensive than others in the past, it is still not complete.

At least 17 other states have registries that collect and post information on behavioral health beds, in addition to other information.[5] Some states make this information public, while others make it accessible only to providers.

Maryland Department of Health Behavioral Health Administration

The Behavioral Health Administration Coordination Dashboard has three resource dashboards for providers:

- Psychiatric Bed Availability helps discharge planners locate available beds in real time, without multiple phone calls or unnecessary delays.
- Crisis Bed Facilities shows the availability and location of short-term community-based stabilization services.
- Behavioral Health Walk-In and Urgent Care Centers shows resources that offer walk-in and same-day appointments.

Connecticut Department of Mental Health and Addiction Services

Maintains two websites that are updated daily with available beds:

- The Mental Health Services Bed Availability Website displays availability for inpatient, intensive, group home, supervised, transitional, and respite levels of care.
- The Addiction Services Bed Availability Website displays availability for withdrawal management, residential treatment, recovery houses, and sober houses.

Oregon Health Authority Behavioral Health Division

In addition to showing both current and projected capacity by facility type, the Behavioral Health Housing and Licensed Capacity Investments Dashboard includes a summary of investments and a breakdown of how the investments will increase behavioral health housing capacity in Oregon communities.

Source: Auditor generated based on analysis of other states.

A bed registry could help inform decision-makers, make operations more efficient, and improve clinical outcomes.

An Unclear Understanding of Behavioral Health Beds May Lead To Costly Investments That Do Not Align with Actual Needs

Our previous behavioral health reports warned that policy decisions may be made with significant blind spots—overlooking trends, gaps, and opportunities that data could reveal.[6] Policymakers need evidence of capacity and demand to help inform their

[5] These states include Alaska, Connecticut, Georgia, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Nevada, North Carolina, Oklahoma, Pennsylvania, Tennessee, Vermont, Virginia, Washington, and Wisconsin.

[6] *A Performance Audit of Utah's Behavioral Health System: A Case for Governance, Strategic Planning, and Accountability* (Report No. 2024-14); *A Performance Audit of the All-Payers Claims Database: A Review of Data Accessibility and Data Usage in Utah's Behavioral Health System* (Report No. 2025-14); and *A Performance*

investments. Using a bed registry to combine real-time monitoring with long-term needs assessment could help more accurately estimate Utah's bed shortages. As a result, decision-makers could have a greater understanding of where to best focus resources.

Previous efforts to understand bed capacity focused on acute inpatient care. While this information is important, inpatient care represents only one part of a well-functioning continuum. Decision-makers must understand the full scope and scale of the system, including acuity type and the wide range of individuals who are served.[7] This means it is critical to assess the entire continuum to understand true demand. Optimizing capacity at one level is dependent on the availability at other levels.

Decision-makers must understand the full scope of the system and the wide range of individuals served.

Aligning behavioral health investments with evidence of need can help ensure resources are directed where they are most needed. In 2025, the Utah Department of Health and Human Services (DHHS) requested almost $90 million to open a low-acuity unit at the Utah State Hospital.[8] However, absent system-wide data on capacity and demand, it's difficult to determine whether this funding represents the most effective use of resources.[9]

Stakeholders cannot effectively address bed concerns or achieve needed system-wide impact without a holistic understanding of behavioral health bed demand. It is time for Utah to take a deeper dive and expand its understanding of what the system has and what it needs.

Audit of the Funding of Utah's Behavioral Health System: A Case for Maximizing the Impact of Public Investment (Report No. 2025-17).

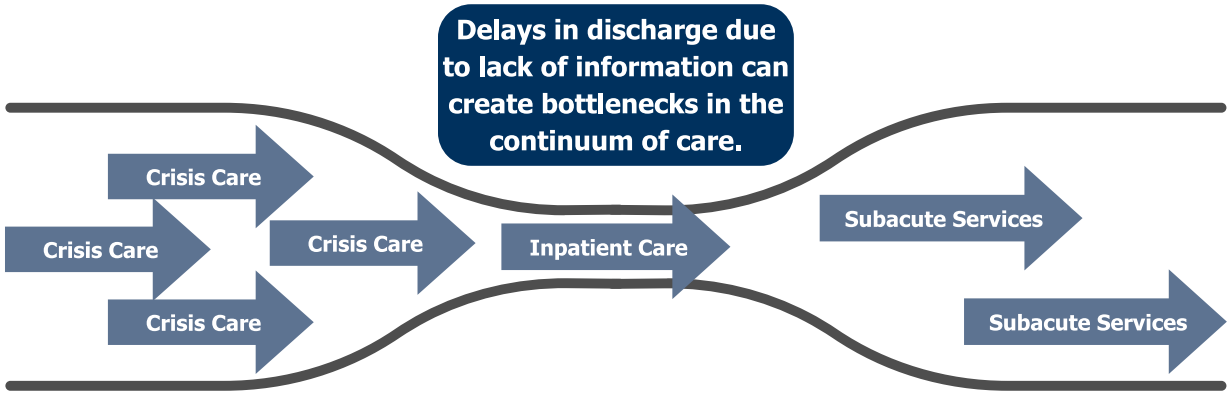
[7] As recommended by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, the Interdepartmental Serious Mental Illness Coordinating Committee, the American Psychiatric Association, Treatment Advocacy Center, and the National Association of State Mental Health Program Directors.

[8] Would have included $88,797,900 in one-time funds for 2026 and also $1,231,700 in ongoing funds.

[9] While DHHS did not receive these funds, we are not asserting that this is—or is not—the right investment. Instead, the Legislature needs further information to evaluate whether it is the most effective use of funds.

Insufficient Information on Behavioral Health Beds Drives Operational Delays Throughout the System

Without essential information on availability, system-wide congestion occurs. Many facilities cannot discharge patients when they are ready, because there is nowhere for them to go.[10] These delays prevent providers from accepting new patients. Specifically, they limit the efficiency of moving patients through the system and the ability of acute and subacute facilities to accept new patients. Ultimately, these delays create system-wide bottlenecks.



Individuals who can't be placed in the appropriate level of care can drop off the radar without system-wide data. These individuals may lose treatment progress or experience poorer health outcomes, homelessness, or incarceration. Many providers believe that discharge delays stem from a lack of available subacute/step-down services. Yet without reliable data, it is difficult to determine where gaps in the system really exist.

Because missing information can drive these delays, improving visibility into the continuum is essential. A bed registry used alongside other data sets can paint a clearer picture of gaps in care while providing real-time information on bed availability. In the absence of data, emergency department (ED) staff, patients, and other providers and caretakers must call multiple facilities to determine if there is an appropriate spot available. Bed registries used in other states, as shown in the figure below, have shown that real-time availability tools help identify open beds far more efficiently, reducing the time spent searching and alleviating avoidable discharge delays.

[10] We asked facilities if they maintained data on delayed discharge. While some had ideas on how to look at delayed discharge, most facilities did not produce data.

Massachusetts — Reducing Wait Times and Identifying Need

Massachusetts reported that Massachusetts Behavioral Health Access provides transparency to where openings exist, improving access and helping the state reduce emergency department wait time. The information collected through the bed registry, and other data systems, also helped to better determine the need for more beds and has contributed to hospitals' willingness to open five new psychiatric inpatient units.

Virginia — Reduced ED Boarding and Faster Placement

The Virginia Acute Psychiatric and Community Service Board bed registry improved the state's ability to locate available beds. Available data allowed for the establishment of standardized placement workflows. This assists clinicians in targeting hospitals to contact first based on bed availability. The data also helped the state identify unmet needs and capacity gaps.

Source: Auditor generated based on analysis of other states.

Failure to Grasp Behavioral Health Bed Capacity Compromises Clinical Care

Beyond operational delays, a limited understanding of Utah's behavioral health bed capacity can undermine clinical care. Many individuals seeking behavioral health services seek treatment in the ED. Experts note health systems don't have enough information or tools to determine where beds are available and how to meet demand.[11] As a result, people with behavioral health conditions can experience unnecessarily long stays (boarding) in the ED.[12]

To analyze ED trends in Utah, we used the Healthcare Facility Database managed by the Office of Health Care Statistics within DHHS to perform a limited analysis on length-of-stay.[13] The data allowed our team to get a deeper view into ED trends of patients with behavioral health (BH) concerns. However, without additional information, we are unable to know the true cause of these trends.

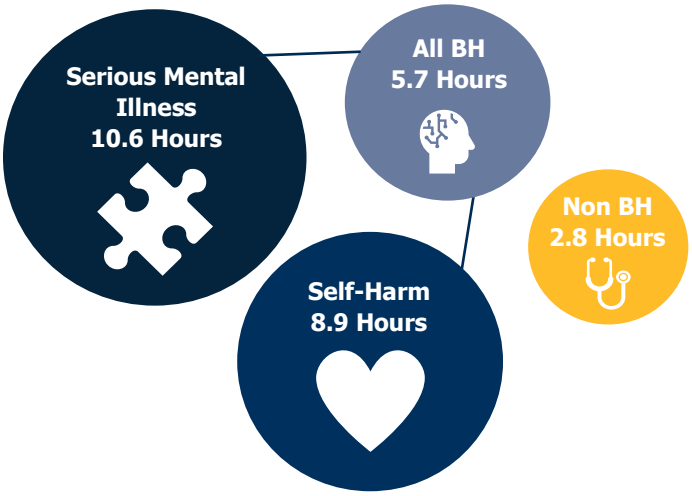
[11] Debra A. Pinals and Doris A. Fuller. *The Vital Role of a Full Continuum of Psychiatric Care Beyond Beds.* Psychiatric Services. 2020 Jul 1;71(7):713-721; American Psychiatric Association Presidential Report on the Assessment of Psychiatric Bed Needs in the United States. *The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions.* American Journal of Psychiatry. 2022 Aug;179(8):586-588.

[12] The Joint Commission (a nationally recognized hospital accrediting organization) defines *boarding* as "the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made."

[13] The Office of Health Care Statistics reviews the submitted data, but some submissions may be incomplete. Our analysis relies on the available data and is limited accordingly.

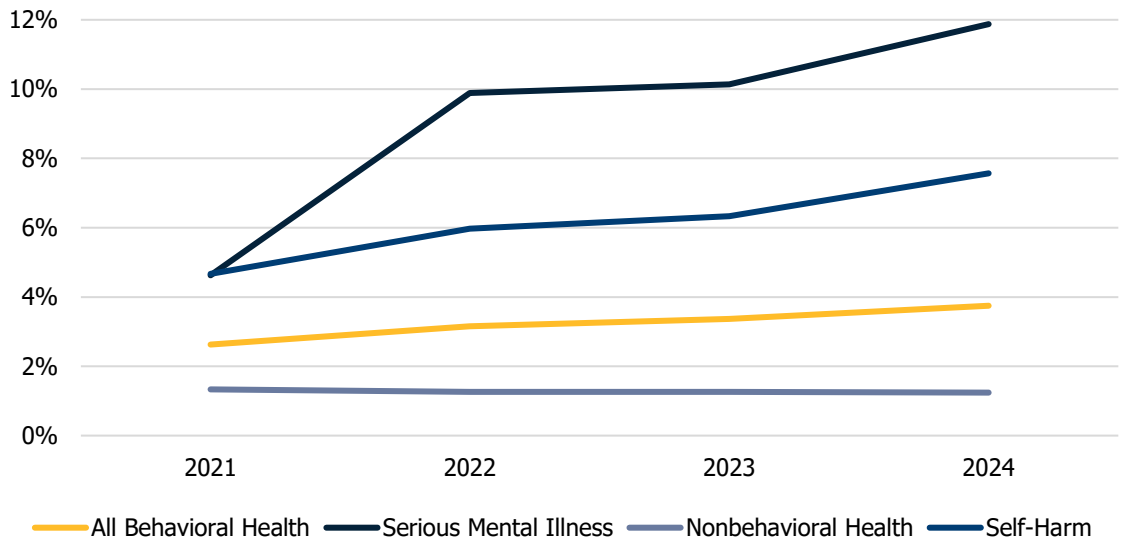
We found that patients in the ED seeking help for a behavioral health-related diagnosis experience higher length of stays on average than patients visiting the ED for nonbehavioral health-related issues.

Between 2021 and 2024, the average length of stay in the ED for behavioral health patients was more than double the average of their nonbehavioral health counterparts. This contrast is even more pronounced when comparing presumably more intensive behavioral health-related cases, such as those who visit the ED for diagnoses related to self-harm or serious mental illness (SMI).[14]



We also found that the percentage of patients staying in the ED for longer than a day is generally higher for behavioral health patients than their nonbehavioral health counterparts. This disparity is shown in Figure 1.1.

Figure 1.1 Patients with Behavioral Health-Related Diagnoses Are Consistently More Likely to Remain in the ED Longer than a Day Compared to Those with Other Diagnoses. Our analysis of the Healthcare Facility Database shows this gap has grown over time, especially among patients presenting with SMI-related conditions.



Source: Auditor generated using DHHS' Healthcare Facility Database.

[14] Using Welch's t-tests, we found statistically significant differences between the behavioral health, SMI, and self-harm groups and the nonbehavioral health group.

The ED does not provide an effective therapeutic environment for people experiencing behavioral health issues.[15] Patients in the ED may be surrounded by chaotic or traumatic situations, which can have a negative impact on their condition. Additionally, longer-than-necessary stays contribute to overcrowding. As a result, patients may leave the ED without being seen, or the ED may have less capacity for treating other patients.[16]

We recognize that multiple factors contribute to longer stays in the ED for behavioral health patients. While we were unable to determine the cause of long stays, individuals with behavioral health diagnoses were six times more likely than other patients to remain in the ED for a week or longer from 2021 to 2024. This data is concerning and additional analysis is needed.

A Central Authority Could Make the System More Effective

Despite the creation of the Utah Behavioral Health Commission in 2024, there is still no entity designated to be ultimately responsible for governance of the behavioral health system. ***Utah Code*** states:

> ***Utah Code** 26B-5-703(1)*
>
> *"The purpose of the commission is to be the **central authority** for coordinating behavioral health initiatives between state and local governments, health systems, and other interested persons, to ensure that Utah's behavioral health systems are comprehensive, aligned, effective, and efficient."*

Although this commission marks progress in fostering collaboration and shared purpose, it doesn't have the regulatory power required to drive meaningful reform.

To address the issues discussed in this report, we reiterate the recommendations made in previous behavioral health reports.[17] Namely, the Legislature should consider creating a central oversight body over the behavioral health system and make the needed statutory changes to existing entities. While the state has made significant efforts,[18] there are additional opportunities to address issues in the system. We understand that changing governance is not a small task and will take some time.

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[15] Noted by entities including the Treatment Advocacy Center and the Utah Hospital Association.

[16] Scala, A., Trunfio, T.A., Majolo, M. et al. *Predicting patient risk of leaving without being seen using machine learning: a retrospective study in a single overcrowded emergency department*. BMC Emergency Medicine. 2025 Jul 15;25(1):121.

[17] *A Performance Audit of Utah's Behavioral Health System: A Case for Governance, Strategic Planning, and Accountability* (Report No. 2024-14) and *A Performance Audit of the Funding of Utah's Behavioral Health System: A Case for Maximizing the Impact of Public Investment* (Report No. 2025-17).

[18] The Legislature has passed multiple behavioral health bills addressing homelessness, treatment, prevention, and workforce issues, while expanding crisis services and problem-solving courts.

Nonetheless, governance is foundational to addressing many of the challenges identified in this and previous audits.

In the absence of a central authority, we make our recommendations to DHHS' Office of Substance Use and Mental Health (OSUMH). OSUMH should implement a comprehensive and hybrid registry—with public and restricted access—in collaboration with hospitals and other behavioral health stakeholders. To assist in these collaborative efforts, we also recommend that the Legislature require the bed registry's creation. A hybrid registry would provide the public with access to relevant bed information while giving providers the detailed data they need to operate efficiently. The registry should include at least the following:

- Public and private facilities that provide crisis services, acute/inpatient care, and subacute/step-down services
- Bed capacity
- Real-time bed availability[19]
- Breakdown of facility type
- Breakdown of treatment type: mental health or substance use
- Breakdown of population served: pediatric, adult, or geriatric
- Payer mix/insurance accepted

In addition, registry data could be mined to determine how often beds are available relative to the need. Understanding the capacity, availability, and demand of behavioral health care beds in a comprehensive way is an important step in making informed investments, improving clinical outcomes, and refining operational efficiency. Other data sources like the Healthcare Facility Database, All Payers Claim Database, and others could be utilized to conduct additional analyses on the system, help identify gaps in care, and improve clinical outcomes.

By forming data-driven partnerships, state and local organizations can develop a more complete understanding of health needs, monitor demand over time, and support more targeted and effective public health interventions.

Together, through the creation of data-driven partnerships, public and private organizations can be powerful partners. They have the potential to develop a more complete picture of health needs and priorities within the state. Additionally, they can create opportunities for further collaboration on more targeted and effective public health interventions. OSUMH attempted to implement a registry. However, it was reportedly unsuccessful due to limited cooperation from participating entities. This experience suggests that future

[19] See Appendix B for reporting timelines used by other states.

efforts should consider whether enforcement authority or other accountability mechanisms are needed to ensure participation and data reporting.[20] This potential coordination represents a good opportunity to expand access to more and better data. We should be able to understand and monitor demand over time.

RECOMMENDATION 1.1

The Legislature should consider requiring the Department of Health and Human Service's Office of Substance Use and Mental Health to implement a bed registry and use this registry alongside other data sets to identify areas of greatest need in the system.

RECOMMENDATION 1.2

In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should implement a real-time and comprehensive bed registry, including the information noted in the report.

RECOMMENDATION 1.3

In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use a registry of both public and private beds to combine real-time monitoring with long-term needs assessment to provide access to information for stakeholders, providers, and the public and mine data over time to determine need.

RECOMMENDATION 1.4

In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use information obtained from a bed registry and other data resources, which could include the Healthcare Facility Database, the All Payers Claims Database, and others to conduct a longitudinal study of where patients are "stuck" in the system to identify the specific care levels with the highest unmet demand.

[20] See Appendix B for examples of how other states require private and public facilities to participate in their respective bed registries and how often facilities must report on bed availability.

Complete List of Audit Recommendations

Complete List of Audit Recommendations

This report made the following four 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

The Legislature should consider requiring the Department of Health and Human Service's Office of Substance Use and Mental Health to implement a bed registry and use this registry alongside other data sets to identify areas of greatest need in the system.

Recommendation 1.2

In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should implement a real-time and comprehensive bed registry, including the information noted in the report.

Recommendation 1.3

In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use a registry of public and private beds to combine real-time monitoring with long-term needs assessment to provide access to information for stakeholders, providers, and the public and mine data over time to determine need.

Recommendation 1.4

In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use information obtained from a bed registry and other data resources, which could include the Healthcare Facility Database, the All Payers Claims Database, and others to conduct a longitudinal study of where patients are "stuck" in the system to identify the specific care levels with the highest unmet demand.

Appendices

A. Behavioral Health Bed Types

This appendix outlines the behavioral health bed types discussed throughout the report. These beds differ in the level and type of care they provide, with each serving a distinct role in treatment or support. Because the effectiveness of the behavioral health system depends on the availability and coordination of these interrelated bed types, we included all of them in our discussion. Each type is grouped under a specific care grouping based on the level of care provided and its role within the continuum. These definitions come from a variety of sources, including the Utah Department of Health and Human Services' Office of Licensing, Utah Code, Utah Association of Counties, U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, U.S. Centers for Disease Control and Prevention, Johns Hopkins Medicine, and the Utah Department of Corrections.

Crisis Services: Services provided to help someone regain a sense of control and achieve stability to the point where they can enter treatment. These services also aim to prevent the escalation of behavioral health issues to the point where patients require subacute or acute inpatient care.

- Receiving Center: A receiving center is a community facility, open 24 hours a day, 7 days a week, staffed by therapists, nursing staff, and peer counselors to provide treatment for individuals experiencing a mental health or substance use crisis. Upon arrival, individuals are assessed, stabilized, and monitored in a recliner for up to 23 hours.
- Emergency Department: A hospital facility that is staffed 24 hours a day, 7 days a week, and provides unscheduled services to patients whose condition requires immediate care.

Subacute/Step-Down Care: Subacute care is long-term services and supports provided in a non-hospital setting for people recovering from an acute issue or who need more targeted care.

- Residential Treatment: Care provided in a licensed residential 24-hour supervised group living environment that offers room or board and specialized treatment for individuals with emotional, psychological, developmental, or behavioral dysfunctions.
- Residential Support: Care provided in a licensed residential program providing, or arranging for, the necessities of life for individuals who are experiencing a dislocation or impairment that is emotional, psychological, developmental or behavioral. To simplify navigation of our behavioral health dashboard, we included the following bed types under residential support.

    - Recovery Residence: A licensed residence providing a living environment for individuals recovering from a substance use disorder, or providing or arranging for residents to receive services related to recovery from a substance use disorder.
    - Permanent Supportive Housing: Offers voluntary, flexible supports to help people with psychiatric disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community. Tenants have access to the support services that they need and want to retain housing.
- Social Detoxification: A licensed program providing 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal. This level of service is not a medically monitored level of care.

Acute/Inpatient Care: Provides medically necessary, intensive assessment, psychiatric treatment and support to individuals with a Diagnostic and Statistical Manual of Mental Disorders diagnosis and/or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The acute inpatient setting is equipped to serve individuals at imminent risk of harm to self or others and in need of a safe, secure, lockable setting. The purpose of the services provided within an acute inpatient setting is to stabilize the individual's acute psychiatric conditions.

- State Hospital: Furnishes individuals with the proper attendance, medical treatment, seclusion, rest, restraint, amusement, occupation, and support that is conducive to their physical and mental well-being. Those that can be admitted are those who meet the criteria necessary for commitment and who have severe mental disorders for whom no appropriate, less restrictive treatment alternative is available; individuals adjudicated and found to be guilty with a mental health condition; individuals adjudicated and found to be not guilty by reason of insanity who are under a subsequent commitment order because they have a mental illness and are a danger to themselves or others; persons found incompetent to proceed; individuals who require an examination under Title 77, Utah Code of Criminal Procedure; and persons in the custody of the Department of Corrections, giving priority to those persons with severe mental disorders.
- Private Inpatient Hospital Facilities: Beds located in privately owned hospitals that provide 24-hour inpatient treatment for individuals with

mental health and/or substance use disorders, typically for acute stabilization and intensive care.

To be as comprehensive as possible, we also included designated behavioral health beds in both jails and community correctional centers.

- Jails: Currently several county jails that house offenders offer substance use and mental health treatment, to both men and women.
- Community Correctional Centers: Community Correctional Treatment Programs and Treatment Resource Centers address substance use and mental health needs of people on probation and parole through fully licensed therapists, licensed substance use counselors, and qualified caseworkers. These programs work to reduce criminogenic risk through therapy, case management, and connection with community treatment providers.

B. Other State Requirements

This appendix outlines a few examples of how other states require private and public facilities to participate in their respective bed registries and how often facilities must report on bed availability.

Iowa CareMatch Inpatient Psychiatric Bed Program

Requirement: *Iowa Administrative Code, rule 441—77.3(3)* requires hospitals to participate in the psychiatric bed tracking system as a condition of participation in the medical assistance program.

Update Frequency: *Iowa Administrative Code, rule 441—77.3(3)* requires hospitals to update the psychiatric bed tracking system at a minimum of two times per day.

Virginia Acute Psychiatric Bed Registry

Requirement: ***Code of Virginia*** *§ 37.2-308.1 D* requires every licensed state facility, community services board, behavioral health authority, and private inpatient provider to participate in the acute psychiatric bed registry.

Update Frequency: ***Code of Virginia*** *§ 37.2-308.1 E* requires every licensed state facility, community services board, behavioral health authority, and private inpatient provider to update the acute psychiatric bed registry whenever there is a change in bed availability or, if no change in bed availability has occurred, at least daily.

North Carolina Behavioral Health Statewide Central Availability Navigator

Requirement: Facilities that have a 3-way contract agreement with the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services are required to use the Behavioral Health Statewide Central Availability Navigator (BH SCAN). All other eligible facilities are highly encouraged to utilize BH SCAN to improve the placement processes statewide.

Update Frequency: BH SCAN was upgraded in March 2026 to provide automated hourly updates of bed availability. Previously, it was updated once per day.

Agency Response Plans

Department of Health and Human Services

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

STACEY BANK, MD
Executive Medical Director

TONYA HALES
Deputy Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

April 6, 2026

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 Beds Along the Continuum of Care* (Report No. 2026-06). This letter includes the response from the Utah Department of Health and Human Services (department), and its Office of Substance Use and Mental Health (SUMH). The public relies on us to help steward and oversee the availability of behavioral health beds throughout the continuum of care. We recognize our responsibility to support a safe and effective system for those in need, and the recommendations provided in this audit will help ensure our operations contribute effectively to these goals.

We appreciate the Office of the Legislative Auditor General for their diligent evaluation of this complex system. Ensuring that individuals have access to secure and appropriate levels of care is an important obligation that we share with our partners across the state. While we are pleased that the audit recognized the professional integrity and dedication of our staff in supporting these efforts, we remain focused on addressing the specific improvements and coordination gaps identified in the report.

On behalf of the department, we formally concur with the recommendations set forth in this report. We are prepared to implement these changes as we work alongside other stakeholders to enhance the stability and oversight of behavioral health services within our purview.

Sincerely,

Tracy S. Gruber
Executive Director

Recommendation 1.1. The Legislature should consider requiring the Department of Health and Human Service's Office of Substance Use and Mental Health to implement a bed registry and use this registry alongside other data sets to identify areas of greatest need in the system.

Department Response: DHHS concurs with this recommendation. A legislative requirement for a bed registry will allow for necessary definitions and system requirements to be specified. Legislative direction will also create appropriate enforcement authority for DHHS.

Recommendation 1.2. In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should implement a real-time and comprehensive bed registry, including the information noted in the report.

Department Response: DHHS concurs with this recommendation.

What: DHHS agrees that the Office of Substance Use and Mental Health (SUMH) is the appropriate operational unit to implement and oversee a comprehensive bed registry for the behavioral health system. The bed registry should include the public and private sectors and each type of bed listed throughout the appendix of the report. A bed registry with public and private sector participation will require legislative action to ensure access to complete information for the entire behavioral health system.

How: DHHS will utilize the information gathered during the previous attempt to implement a bed registry system and evaluate the possible systems that may be used. DHHS will also contact and research other states' bed registries, including the ones listed in the report.

DHHS will also need to work collaboratively with the Legislature to help with drafting appropriate language for any requirements for the bed registry system and the providers who will be utilizing the registry.

After this process, DHHS will begin the contracting process to select and implement the bed registry system that will best meet the needs of Utah and the recommendations in the report.

When: DHHS will evaluate, select, and contract with an appropriate bed registry system. Once completed, implementation, which includes the initial build out of the system and enrolling of partners, will be completed by July 30, 2027.

Responsible Staff: Eric Tadehara, Director, Office of Substance Use and Mental Health; Pam Bennett, Assistant Director, Office of Substance Use and Mental Health

Recommendation 1.3. In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use a registry of both public and private beds to combine real-time monitoring with long-term needs assessment to provide access to information for stakeholders, providers, and the public and mine data over time to determine need.

Department Response: DHHS agrees with this recommendation.

What: Once DHHS has implemented a bed registry, the information will be collected and available based on the needs of stakeholders, providers, and the public. DHHS will also establish data collection requirements and ensure adequate information is available to the different groups based on utilization and privacy standards.

How: DHHS will work with the bed registry contractor, providers, and various stakeholders including the Utah Behavioral Health Commission to establish necessary data collection and utilization standards for the registry. These standards will include: what data to collect, who will be responsible for collecting that data, the levels of access to the data, and what levels of data and information will be available based on the access levels.

When: DHHS will begin this work once a contract has been entered into and the bed registry is implemented. The start date is anticipated to be July 2027, with the established standards to be finalized by the time the bed registry is implemented. It is also expected that the standards will be able to be modified as needed, with annual reviews.

Responsible Staff: Eric Tadehara, Director, Office of Substance Use and Mental Health; Pam Bennett, Assistant Director, Office of Substance Use and Mental Health; Justin Hyatt, Data and Research Team Lead, Office of Substance Use and Mental Health

Recommendation 1.4. In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use information obtained from a bed registry and other data resources, which could include the Healthcare Facility Database, the All Payers Claims Database, and others to conduct a longitudinal study of where patients are "stuck" in the system to identify the specific care levels with the highest unmet demand.

Department Response: DHHS concurs with this recommendation. Currently, there are limited mechanisms to adequately and regularly measure and study issues with levels of care, unmet acute care, and system gaps.

What: DHHS will utilize the data reported through the bed registry and other data resources available to conduct studies and reports to highlight needs of the behavioral health system. This will include reporting that occurs based on annual information available from the registry and other sources. Data will also be used to create a longitudinal study and report to better highlight the system needs. A comprehensive, longitudinal study will be completed after there is enough data collected from the submitted data reports. This type of study may require up to 5 years of data.

How: DHHS will begin analyzing data collected through the registry yearly and research other information available to create the annual reports. DHHS will also research alternative sources of information that may be used for a comprehensive, longitudinal study to supplement any of the registry data. SUMH staff will work collaboratively with other OUs throughout DHHS, the Utah Behavioral Health Commission, and other external stakeholders to ensure a comprehensive report is created and utilized throughout the system. DHHS will work with the Office of the Legislative Auditor General to determine the appropriate amount of time to include in a comprehensive, longitudinal study.

When: DHHS staff will utilize various information sources on a yearly basis to begin the evaluation process. By July 2028, the first annual report will be completed with the bed registry data included. Annual reports will be completed in the same cadence as other data collection reports and studies, which are typically finalized in September of each year.

Responsible Staff: Eric Tadehara, Director, Office of Substance Use and Mental Health; Pam Bennett, Assistant Director, Office of Substance Use and Mental Health; Justin Hyatt, Data and Research Team Lead, Office of Substance Use and Mental Health

Utah Behavioral Health Commission

UTAH BEHAVIORAL HEALTH COMMISSION

Ally Isom
Chair

Tammer Attallah
Vice Chair

Kyle Snow
Second Vice Chair

April 3, 2026

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 Beds Along the Continuum of Care: Aligning Capacity, Demand, and Systemwide Coordination (Report #2026-06)*. 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. The Commission will work closely with the Department of Health and Human Services to analyze behavioral health bed data and integrate findings into the Commission's strategic plan, pending implementation of the bed registry. The Commission is also interested in evaluating policy opportunities to reinforce a centralized bed census platform.

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

1-1: The Legislature should consider requiring the Department of Health and Human Service's Office of Substance Use and Mental Health to implement a bed registry and use this registry alongside other data sets to identify areas of greatest need in the system.

Commission Response

The Utah Behavioral Health Commission concurs with this recommendation. If the bed registry is implemented, the Commission will work with the Office of Substance Use and Mental Health to integrate analyses of registry data and other relevant data sets on the areas of greatest need into the Commission's strategic plan.

1-2: In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should implement a real-time and comprehensive bed registry, including the information noted in the report.

Commission Response

The Commission concurs with this recommendation. The Commission does not have the capacity, staff, or funding to implement a bed registry, and finds the Office of Substance Use and Mental Health is best suited to develop and maintain this registry over time. The Commission will work closely with the Office of Substance Use and Mental Health to integrate relevant data metrics from the bed registry into the Commission's strategic plan and annual recommendations to the Legislature.

1-3: In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use a registry of both public and private beds to combine real-time monitoring with long-term needs assessment to provide access to information for stakeholders, providers, and the public and mine data over time to determine need.

Commission Response

The Commission concurs with this recommendation. As stated above, the Commission plans to work with the Office of Substance Use and Mental Health to analyze these data sets over time and integrate relevant findings into the Commission's strategic plan.

1-4: In the absence of a central authority, the Department of Health and Human Services' Office of Substance Use and Mental Health should use information obtained

from a bed registry and other data resources, which could include the Healthcare Facility Database, the All Payers Claims Database, and others to conduct a longitudinal study of where patients are "stuck" in the system to identify the specific care levels with the highest unmet demand.

Commission Response

The Commission concurs with this recommendation. While the Commission has limited capacity and staffing, the Commission and its staff will work closely with the Office of Substance Use and Mental Health to conduct this study, review findings, and identify appropriate recommendations.

Contact: Mia Nafziger, Administrator, mnafziger@utah.gov, 385-514-2994

Utah Hospital Association

April 6th, 2026

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 Beds Along the Continuum of Care: Aligning Capacity, Demand, and Systemwide Coordination* (Report No. 2026-06). This letter reflects the perspective of the Utah Hospital Association (UHA). We appreciate the work of the Office of the Legislative Auditor General in conducting this important review and advancing the statewide conversation on behavioral health system capacity and coordination.

We commend your office for highlighting the critical challenges related to behavioral health bed capacity, demand, and system-wide visibility. As noted in the report, the absence of a comprehensive, centralized understanding of bed availability across the continuum creates operational inefficiencies, delays in patient placement, and barriers to timely access of appropriate care. Hospitals experience these challenges firsthand, particularly in emergency departments where patients often face extended stays while awaiting appropriate placement.

The Utah Hospital Association agrees with the report's core findings and supports the recommendations aimed at improving data transparency, coordination, and long-term planning. In particular, we recognize the value of developing a real-time, comprehensive behavioral health bed registry. A well-designed registry that is developed collaboratively with hospitals and other stakeholders has the potential to improve patient flow, reduce administrative burden on providers, and support more informed decision-making at both the clinical and policy levels.

UHA also supports efforts to better understand system-wide demand through longitudinal analysis and the integration of existing data sources. As the report notes, without reliable and complete data, policymakers and providers face significant limitations in identifying gaps in care and aligning resources effectively. Hospitals stand ready to partner in efforts that enhance data

sharing, while ensuring that implementation approaches are practical, sustainable, and mindful of provider capacity and administrative burden.

At the same time, we emphasize that successful implementation of these recommendations will require strong collaboration across public and private stakeholders, a clear central governance structure, and appropriate resources to implement and sustain the effort. Hospitals play a central role in the behavioral health continuum, and any successful solution must involve the full system, including crisis services, subacute care, residential treatment, and community-based supports.

We appreciate the report's recognition that improving governance and coordination is foundational to addressing these challenges. UHA supports continued dialogue with the Legislature, the Department of Health and Human Services, and other partners to ensure that policy solutions are data-driven, coordinated, and focused on improving patient outcomes across the continuum of care.

Thank you again for your leadership and for the collaborative approach your office has taken throughout this audit process.

Sincerely,

Francis Gibson, President and CEO
Jordan Sorenson, Director of Behavioral Health Policy
Utah Hospital Association

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