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MEMORANDUM

DATE: April 29, 1998

TO: Beverly Stein, Multnomah County Chair
Gary Hansen, Commissioner, District 2
Sharron Kelley, Commissioner, District 4

FROM: Gary Blackmer, Multnomah County Auditor

SUBJECT: Follow-up Report on Audit of Alcohol and Drug Treatment System

The attached report covers our review of the efforts of the Department of Community and Family Services to implement the recommendations of our audit Alcohol and Drug Treatment: Manage the system. As the title suggests, our 1993 audit found that the County was not fulfilling its role of managing treatment efforts to ensure that clients receive the most cost–effective services. Five years later, despite some improvements, the County has less ability to ensure that treatment services are appropriate to our community's needs. The efforts funded by the Target Cities grant may be a step in the right direction, but the County has lost ground in managing the state-funded services for most of its clients.

We have discussed our findings and recommendations with managers in the Department of Community and Family Services and the Chair's Office. Their response is included in the back of the report.

As part of our follow-up procedures, we asked the Department of Community and family Services to report its progress toward achieving specific milestones for effectively managing all alcohol and drug treatment services. This response should be circulated to the Board of Commissioners. If the Department cannot accomplish these management responsibilities, we recommend that the board of Commissioners examine the benefits and liabilities of passing state monies to contractors without adequate oversight.

We appreciate the cooperation and assistance extended to us by the management and staff of the Department of Community and Family Services.

Auditor: Suzanne Flynn, Deputy Auditor

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Summary

We reviewed County efforts to manage alcohol and drug treatment services in order to determine whether the recommendations made in our 1993 audit *Alcohol and Drug Treatment: Manage the System* had been implemented. In the audit we recommended improvements in planning, organizing, monitoring, and taking necessary corrective action to ensure that the most appropriate treatment services were provided at the least cost.

Since the audit was released, there have been significant changes in the funding and delivery of treatment services. Over the past four years the County has received a total of $7.7 million in federal Target Cities funding. Several reorganizations in the County have divided management responsibilities among sections in the Department of Community and Family Services. In addition, the Oregon Health Plan (OHP) weakened the County's ability to manage the system by funding seven independent health plans to deliver selected services to only some of the population. Total annual funding for alcohol and drug treatment, when corrected for inflation, has increased from $10.2 million in FY91-92 to $12.9 million, a 27% increase.

While we found some improvements, many of the audit recommendations have not been fully implemented or resolved. Management has not adequately overseen the delivery of treatment services to contractors as part of an intergovernmental agreement with the state. Progress has been made in assessing and placing clients in the most appropriate treatment as a result of state efforts and the grant-funded Central Intake Unit. A better data collection system has been developed but not all the treatment contractors submit data about clients and services. This data may still have value in day-to-day monitoring of contractor efforts and results, but management has not used it to direct treatment efforts, set priorities, or allocate resources.

The Target Cities grant is paying for central intake and a data system to support a stronger management system. Due to the fragmentation of service delivery these management tools may never be fully utilized and may be eliminated when grant funding runs out next year.

Our 1993 audit found that a better managed system could improve client access to services, ensure more appropriate treatment decisions, reduce costs, and increase accountability. Due to fragmented funding and delivery of treatment, the County may not be able to significantly influence the quality and cost of services for the benefit of the community. The Health Department and Mental Health program have addressed similar circumstances by integrating client services and building collaborative

efforts among contractors. The design of the Oregon Health Plan limited County A & D's ability to create strong collaboration.

However, if the alcohol and drug treatment delivery system cannot be influenced by local concerns and priorities then the County should eliminate any appearance of responsibility for it by discontinuing administration of the State IGA funding for alcohol and drug treatment and of the panel of contractors for CareOregon and ODS.

Background

In june 1993, we examined adult alcohol and drug treatment programs and concluded that more could be done to manage the treatment system in Multnomah County. We found opportunities for County A&D to improve treatment services and reduce costs with additional efforts in planning, monitoring contractors, improving the reimbursement system, coordinating contractor activities, and taking corrective actions.

At that time, County A&D was one of five units within the Mental Health, Youth and Family Services Division of the Social Services Department and contracted with 20 agencies to provide a variety of adult treatment services. Roughly 72% of the funds supporting the adult system were revenues administered by the State Office of Alcohol and Drug Abuse Programs (OADAP) and allocated to the County in a biennial agreement. Most of the remaining funding (23%) in the system was Medicaid derived. The County did not have direct responsibility for Medicaid funds, but was responsible for certifying contractors as eligible to receive Medicaid and monitoring the services delivered.

Scope

This review was a follow-up to previous recommendations from the audit *Alcohol & Drug Treatment: Need for a managed system*, completed in June, 1993 . Its objective was to determine how successful management had been in resolving or implementing recommendations in the four years since the audit.

In the previous audit we found weaknesses in the County's management of the contracted service system in the areas of:

- ◊ Inadequate staff allocation to the functions of managing the contracting process, on-site review, contract monitoring and biennial planning.
- ◊ Deficiencies in management systems designed to ensure that program objectives are achieved.

- Improved methods were needed to better coordinate contractor activities and more effectively move clients through the system
- Data was not used to evaluate and plan for system-wide efficiency and effectiveness, monitor contractor performance or to assess past performance and relative costs in the contract award process.
- Fiscal monitoring information was not routinely incorporated into program monitoring and linked to the quality of service provided.
- Clear and specific expectations had not been developed for the contractors or the treatment system to assess progress towards program goals.

◊ More corrective action and technical assistance was needed when administrative, program delivery or fiscal weaknesses were discovered.

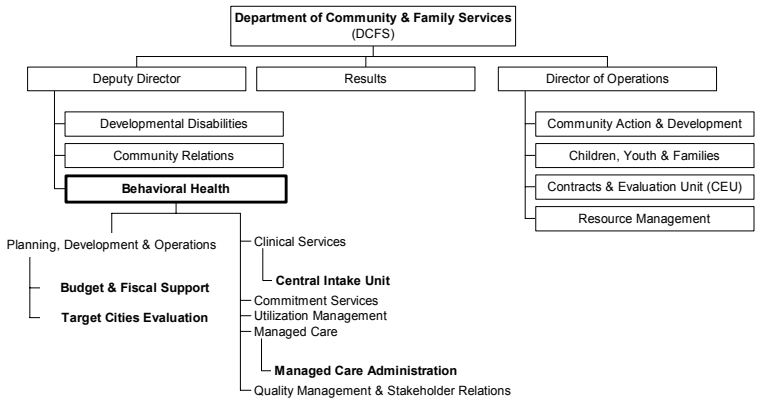
For this follow-up Behavioral Health and CEU program staff were interviewed to gain an understanding of both stated and performed roles and responsibilities. We also interviewed the DCFS Deputy Director and Director of Operations, MIS manager, the Behavioral Health Program Manager and Operations Manager. We spoke to several agency directors of County contracted services to gain their perspective of changes that had occurred. We reviewed budget and planning documents, evaluation work plans and preliminary reports, statutes, policies and procedures, and automated system manuals, documentation and reports. In some cases we reviewed CEU staff files and documentation of methods. We also studied the literature on purchasing of services, evaluation, managed health care and the Oregon Health Plan.

Results

Major Changes Impede County A&D's Ability to Manage

Since 1993, reorganizations and the Oregon Health Plan have impaired County A&D's ability to manage the service delivery system. Soon after the audit was completed, the County Chair created the Department of Community and Family Services (DCFS) by merging the Housing and Community Services Division and the Mental Health, Youth, and Family Services Division. In 1994, DCFS centralized some contracting and evaluation functions with the creation of the Contracts and Evaluations Unit (CEU). In FY95-96, the Adult Mental Health, Children's Mental Health and Alcohol and Drug Divisions, previously separate divisions within DCFS, were merged to form the Behavioral Health Program. As a result, County A&D was no longer a separate unit with clearly identifiable goals and activities. These reorganizations also resulted in the fragmentation of elements of the contracting and monitoring process between Behavioral Health and the CEU.

Organization of County Alcohol and Drug Management 1997



In May, 1995, the State implemented Phase II of the Oregon Health Plan (OHP) which included coverage for alcohol and drug outpatient and methadone services. The OHP de-centralized the delivery of insured (Medicaid funded) alcohol and drug treatment services in Multnomah County. Currently seven health plans operate in Multnomah County and oversee within their own organizations what had traditionally been two of the several components of the treatment continuum - outpatient and methadone. Residential treatment, a more expensive alternative, and detoxification, both part of the treatment continuum, remain funded by the State contract. The State contract also funds outpatient services for those uninsured by OHP.

County A&D now serves two roles. First, County A&D entered into a contract with CareOregon and ODS, health plans under the OHP, to administer a group of alcohol and drug contractors to serve CareOregon and ODS health plan members. The County became responsible for ensuring services are accessible to members and that appropriate services are delivered and are of an acceptable quality. Under this agreement, County A&D receives a percentage of the Plans' chemical dependency revenues to cover administration. Second, County A&D is responsible for managing outpatient, residential, and detox services for clients who are not eligible for the OHP. This component of the treatment system is funded by the State through an intergovernmental agreement with the County. The seven plans were not required to cooperate with County A&D to provide a continuum of alcohol and drug treatment for County residents.

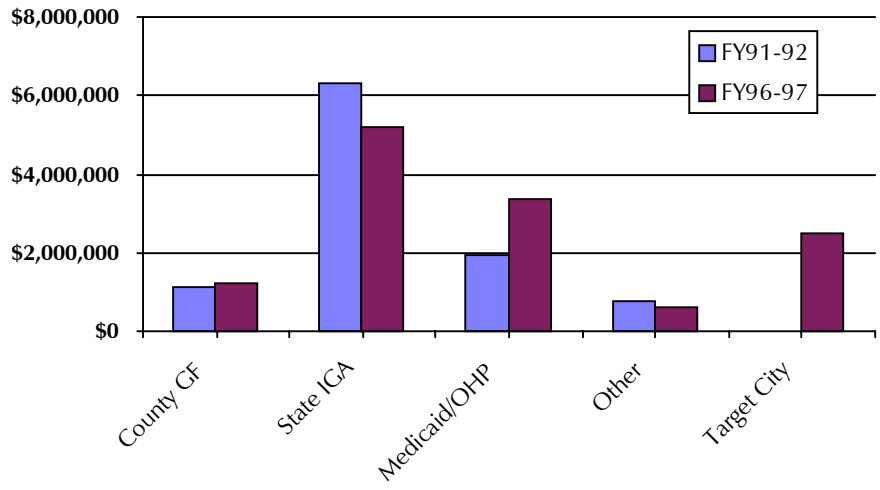
The OHP significantly weakened County A&D's ability to systematically manage the continuum of treatment for those eligible for services within the OHP (the insured), and those that need public subsidy (the uninsured). Many of the same contractors continue to operate in the community. Most contract with more than one health plan to provide services for the OHP insured and also contract with Multnomah County for treatment for the

uninsured. The multiplicity of relationships without an established means of integration or coordination severely weakens the County's ability to achieve local control.

Although the system has become de-centralized and fragmented, the total funding for alcohol and drug treatment in the County has increased. In FY91-92 total system expenditures, adjusted for inflation, were $10.2 million. In FY96-97, expenditures were $12.9 million, a 27% increase. Current funding includes payments made to health plans on a per member basis, state administered funds allocated to County A&D in a biennial agreement, the Target Cities grant, County general fund and several small varied sources. While State funding decreased during this time, primarily for outpatient services, this was more than offset by the increase in OHP funded outpatient services.

Source: County and State financial records

Expenditure by Funding Source, FY91-92 and FY96-97



After our audit County A&D decided to pursue Target City federal funding. Many of the goals of the grant reflected our audit recommendations. The grant was awarded to the State and County and was intended to increase access to treatment, increase effectiveness of treatment services, to foster coordination between treatment services and other related services systems and to develop methods for continually improving treatment effectiveness. Already in the grant's final year, the County has received a total of $7.7 million to date. Over the past four years County A&D developed a management information system, staffed a centralized intake unit and supported evaluation of the effects of treatment system improvements on client outcomes with Target City funding.

Many Audit Recommendations are Not Implemented or Resolved

In the 1993 audit we recommended improvements in all areas of management - planning, organization, monitoring, and corrective action. We found inadequate staff allocation to management functions, deficiencies in management systems to ensure that program objectives were achieved and an inadequate level of corrective action. In 1997, we found the same problems to different degrees in the management of services to both the insured and uninsured populations.

Staff spend very little time managing the delivery of the State contract funded services for the uninsured. The CEU staff managed the procurement process, prepared contracts, and participated in State on-site compliance reviews for services funded through the biennial agreement with the State. Although evaluation was a CEU responsibility, none were completed of A&D contractors. Staff in County A&D were not assigned to technical assistance or corrective action for contracted state-funded services. The only significant assessment of contractor performance occurred during the procurement process for outpatient services. Other data such as State performance indicators and utilization were not routinely monitored.

Staff within the Managed Care Unit in Behavioral Health, separate from CEU and other County A&D staff, were assigned to payment authorization and more recently to quality control activities designed to fulfill administrative responsibilities for CareOregon and ODS. As a result, County staff in three different operational units: CEU, Managed Care, and Planning, Development and Operations were assigned to management responsibilities. Corrective action responsibilities for both uninsured and insured services were either unassigned or not fully defined.

Despite fragmented management activities there have been improvements at the state and local level in areas identified in the audit. In 1995, the state OADAP mandated standardization of assessment and placement criteria. Contractors, whether serving the OHP-insured or uninsured, must meet these requirements. All contractors were also required to submit client data to the state regardless of the funding source for the services delivered. With analysis and subsequent planning, these changes could improve coordination of contractor activities and more effectively use services.

At the local level, County A&D used Target City funding to expand centralized intake, develop a County wide uniform client assessment and an automated information system, and increase treatment coordination for clients in jail. The Central Intake Unit had previously performed DUII assessment and referral. In 1995, County A&D hired additional staff and expanded capacity for outpatient and residential service assessment and referral at central and other locations. A MIS system was designed to improve the quality of management information available both for the contractor and the County and tracks assessment, referral and treatment client data. Finally, an intervention and pre-treatment program was implemented in the jail to increase treatment effectiveness and coordination of criminal justice client movement within the treatment continuum. These

mechanisms improve the capacity for system-wide coordination, client movement in the treatment continuum and the cost-effectiveness of the mix of services provided because of increased data analysis capabilities.

Although these accomplishments have been significant, their potential has not been fully realized. The Central Intake Unit does not have the funding or capacity to centrally assess and refer all clients seeking treatment in the publicly funded system. Further, some health plans operating under the OHP have their own intake and referral process. One contractor estimated that only about 25% to 30% of its non-DUII referrals come from the Central Intake Unit.

County A&D also has not obtained complete contractor participation in the County's automated information system. Some providers who contract with the County for services funded through the State IGA and contractors who sub-contract with health plans not administered by the County have not submitted data. County Counsel believes that the County cannot compel submission of this data. This lack of data has limited the County's ability to evaluate effectiveness in a systematic way.

The link between information and corrective action was also weakened by insufficient information and planning. The planning body for the alcohol and drug treatment system, the Multnomah Council on Chemical Dependency, became inactive. Information on client profiles, length of stay, types of services delivered, outcomes and treatment costs was not disseminated or used in planning or reviewing system effectiveness except for use in selecting contractors.

At the end of the Target City grant early in FY98-99, the County may benefit from extensive evaluation of client outcomes, service delivery patterns and comparative costs. The Project tried to provide on-going management information, but was limited by its primary commitment to the federal grantor to ensure that outcome evaluations are completed. Any on-going information was reported to the Project's Steering Committee which did not include representation from the health plans other than Care Oregon and ODS.

The 1993 audit criticized the reimbursement system because of weaknesses that lessened accountability over contracted treatment services. Nonetheless, the State OADAP has continued to fund contractors based on "slots" with very general service expectations. A Behavioral Health manager stated that the state rejected several proposals to adopt a fee-for-service system of reimbursement. County A&D did not develop additional criteria to define those expectations but did clarify a "double billing" policy in its most recent RFP. However, the State and County do not have the ability and capacity to routinely monitor whether double billing is still occurring. Contractors we interviewed indicated that the OHP required internal accounting systems that reduced the likelihood of billing two separate funds for the same client.

County Needs to Examine Its Role in A&D Treatment

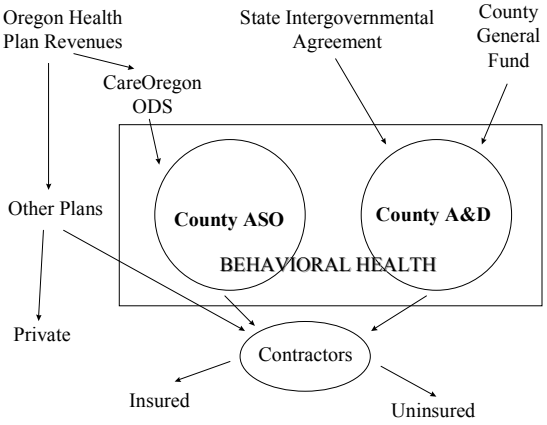
Currently, County A&D does not have adequate system wide administrative or management control over treatment funds. The OHP makes it difficult for the County to manage treatment efforts as a system. DCFS, Behavioral Health and A & D have not committed enough resources to address the changes in service delivery and funding. The current role is two-fold, one as an administrator of a portion of the insured services offered in the County, and the other, as a conduit of State contract funds and treatment policies. Integration of these two roles may be difficult and opportunities for collaboration are limited.

The state's design of the OHP limited County A&D's role in the changed environment. The OHP mandated that some chemical dependency services be offered by health plans. As a result, eligible County A&D clients began receiving their treatment services through one of the seven health plans. To maintain influence over department services, the County obtained a contract as an administrative services organization (ASO) for two of seven health plans. County A&D manage client access to these services and the service quality. To cover these costs the County receives a percentage of the plan's revenues.

In 1993, the original role of County A&D was to plan, manage and coordinate treatment services. At that time, major funding sources added complexity to the system, but it was our belief that County A&D could manage most of the publicly funded system. County A&D was responsible for State funds received through an intergovernmental agreement. While the State contract contained some restrictions on the types and quantities of services to be delivered in the County, County A&D had sufficient latitude to plan and ensure that services were responsive to local needs. The other major funding source at that time was Medicaid fee-for-service. Although not directly involved in service reimbursement, County A&D was responsible for certifying and contracting with Medicaid contractors. With the implementation of the OHP the County only remains responsible for state contract funded treatment.

Management of alcohol and drug treatment services for the OHP insured and the uninsured has not been integrated. While County A&D staff in one unit of Behavioral Health developed the capacity to review and analyze service delivery and utilization of insured services, capacity was not developed to examine the information in context to services delivered to the uninsured. Further, Behavioral Health and CEU staff had limited access to analysis available through the Target City Behavioral Unit for routine management use. The Central Intake Unit achieves some integration of services for insured and uninsured service delivery, but has limited capacity and contractor cooperation.

County A&D Role in Publicly Funded Treatment Services



We compared County A&D to the two other County programs impacted by the OHP from three different perspectives - the organizational role, the integration of service delivery to uninsured and insured, and collaboration with other contractors and plans operating in the County. Each responded differently.

The Health Department uses general fund dollars to provide services to the uninsured. To preserve their traditional contractor position in the OHP-insured market, the department, along with the Oregon Health Sciences University, Clackamas County Health Department and private non-profit Community and Migrant Health Centers across Oregon, formed CareOregon, a health plan. CareOregon spun off from the County in April, 1997 and is a non-profit corporation. About 31% of the DOH's Primary Care Clinic income is received from CareOregon. Out of a total 99,000 annual visits 47% were covered by the Oregon Health Plan and 31% had no source of health insurance.

The Health Department increased its ability to impact health care in the County with participation in the Oregon Health Systems in Collaboration (OHSIC). The OHSIC is a public-private partnership of all the major health systems operating in the Tri-County area. Members seek solutions for problems that jointly affect their operations.

Mental Health, also part of Behavioral Health along with County A&D, took a different approach. County Mental Health competed with other private health plans under a state RFP and was awarded a portion of the County's eligible population to operate as a mental health plan. County Mental Health will serve approximately 60% of the OHP insured population and will enter into risk sharing partnerships with contractor network(s) to deliver the services to members.

Mental Health also receives funds through a State IGA to provide services to the uninsured for services not covered by the Health Plan. Behavioral Health's final design of the delivery of mental health services to the uninsured and insured is not yet finalized. The Behavioral Health manager believes that the County has little ability to impose local direction on "pass-through" funds.

County Mental Health, assisted by state contracting requirements, made a strong collaborative effort. During the State application process the DCFS convened a public planning process which included all health plans which had submitted letters of intent. These participants developed local RFP award criteria which included a commitment to system-wide coordination, planning and evaluation. Behavioral Health will convene a Health Plan Coordinating Council which will include management from the County's Mental Health Organization (health plan) and the state IGA funded Mental Health Program, all other health plans operating in the County, consumers, and advocates.

Comparison of County Participation in Oregon Health Plan

	Role	Integration of Services for Insured & Uninsured	Collaboration Among Providers
Health Department	Provider	Yes	Yes
Mental Health	Plan	Under design	Yes
A&D	Administrative Services Organization	No	No

Unlike Health and Mental Health, County A&D has less State support to achieve its objectives in this new environment. County A&D no longer has direct responsibility for the majority of the publicly funded outpatient alcohol and drug treatment services offered in the County. Its role as an administrator of some of the Health Plans may be adequate but we believe that two other key components of effectiveness are lacking.

OHP fragmented funding for insured and uninsured service delivery. The Behavioral Health Division increased this fragmentation by not aligning these two systems within its own organization. Further, County A&D does not have a strong collaboration that includes the insured and uninsured plans and contractors. The Multnomah Council on Chemical Dependency has not operated since 1995. County A&D convened a Chemical Dependency Quality Management Committee to monitor the quality of treatment but only for CareOregon members. We believe collaboration and service integration are important elements in achieving County objectives.

Recommendations

The Department of Community and Family Services and the Behavioral Health Division should clearly describe its objectives, plans, actions, and performance measures for managing alcohol and drug treatment services for insured and uninsured populations. The description should include specific dates of planned accomplishment. Within this description of a management framework, the Department should also:

- Identify the specific objectives and outcomes which can only be achieved by County administration;
- Identify specific County powers and functions that are necessary to accomplish its objectives;
- Identify the personnel and other resources needed to accomplish its objectives;
- Identify specific monitoring objectives and analyses, corrective actions, and follow-up procedures to monitor and adequately respond to contractor and treatment system issues of efficiency and effectiveness;
- Evaluate the feasibility of achieving its objectives.

On or before September 15, 1998 and annually thereafter, the Department of Community and Family Services and the Behavioral Health Division should prepare a status report for the Auditor's Office and Board of Commissioners providing:

- Specific evidence of progress toward accomplishing each of its objectives, plans, and actions in managing alcohol and drug treatment services for insured and uninsured populations;
- Data analyses of client, contractor, and treatment system outcomes;
- An evaluation of adherence to the planned dates of accomplishment; and
- A re-evaluation of the feasibility of achieving it objectivesn evaluation

Responses to the Audit

Beverly Stein, Multnomah County Chair

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MEMORANDUM

TO : Gary Blackmer
Suzanne Flynn
FROM : Beverly Stein
DATE : April 24, 1998
RE : Follow Up Report on 1993 Alcohol and Drug Treatment Services Audit

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Thank you for your thoughtful and challenging follow up report on the management of Alcohol and Drug Treatment Services in Multnomah County. I understand your concerns about the lack of apparent progress the County has made in the planning, organizing and monitoring of alcohol and drug treatment services. You correctly point out how the Oregon Health Plan's method of funding seven independent health plans to deliver services and the changes attempted through Target Cities have impeded our ability to make changes.

When we met with you and Department staff regarding your follow up report, we identified a number of issues to pursue with the State. The issues include adequate reimbursement for administrative costs at the local level and the potential for combining funds and creating a flexible fund based on outcomes like the Legislature has granted Deschutes County. I have discussed these matters with DHR Director Gary Weeks. He assures me we will make progress and I will continue to follow up on this.

In part because of the impetus provided by your follow up report, I believe the County is in a better position to advocate with the State for the flexibility and administrative support necessary to achieve the kind of local management and advocacy that I believe is essential to provide quality services.

Your report and the expiring Target Cities grant (in October 1998) helped crystallize the policy issue the Board will have to address in my executive budget. What level of financial support should the County provide for the administration and delivery of alcohol and drug services?

In my executive budget I opted for stronger involvement, funding both administrative positions previously funded by the Target Cities grant, and stabilizing and expanding alcohol and drug services in the public safety arena. We are evaluating what worked well from the Target Cities experience and are trying to incorporate and expand the good work of that effort including the planning of the Local Public Safety Council's Alcohol and Drug workgroup headed by Commissioner Sharron Kelley. Specifically, in my budget I added components dealing with relapse prevention, dual diagnosis clients, and alcohol and drug- free housing, and a new effort aimed at hard to reach juvenile offenders.

The difficulty of doing this work well and the need for local advocacy with the state has been greatly exacerbated by the fragmentation of the system caused by the Oregon Health Plan (OHP). The February 1998 edition of the *Oregon Health Forum*, reported information from the State concerning utilization of alcohol and drug services by private OHP providers. The threshold for usage was set at 2% with the original expectation of 2% to 4%. Some plans fell below that target, including Providence at 1.60%. This contrasts sharply with Care Oregon's experience of 4.38% enrolled in services. County officials were quoted as stating the adverse selection was leading to an unfair rate structure. Compounding that issue was the apparent inability of some plans to actually see that their clients get services once referrals were made.

The issues of adverse selection and better follow through with referrals must be addressed at a State level. Without local advocacy, these changes will not come. This is a dramatic example of why I believe the County needs to maintain a local presence in the delivery of this crucial service.

I appreciate your determination to stick with these issues. Your prodding will help in our advocacy with the State DHR and with the State Legislature should the Board seek broader flexibility in the administration of behavioral health funds, following the Deschutes County model.

Your office continues to provide an important outside perspective on what the County's role should be in insuring quality services are delivered. Depending on the State's response this fall and during the legislative session, we may want to reexamine the issue of local control next year.

Cc: Commissioner Gary Hansen
Commissioner Sharron Kelley
Lolenzo Poe, DCFS Director
Floyd Martinez, Alcohol & Drug Program Director