

**State of Washington
Joint Legislative Audit and Review Committee (JLARC)**



**Follow-up: 2000 Mental Health
Performance Audit**

Briefing Report 01-7

June 27, 2001

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Under the direction of the Legislative Auditor, committee staff conduct performance audits, program evaluations, sunset reviews, and other policy and fiscal studies. Studies focus on the efficiency and effectiveness of agency operations, impact of state programs, and compliance with legislative intent. As appropriate, recommendations to correct identified problem areas are included. The Legislative Auditor also has responsibility for facilitating implementation of effective performance measurement throughout state government.

**FOLLOW-UP: 2000 MENTAL
HEALTH PERFORMANCE AUDIT**

BRIEFING REPORT 01-7

DIGEST
JUNE 27, 2001



STATE OF WASHINGTON
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**FOLLOW-UP: 2000 MENTAL HEALTH PERFORMANCE
AUDIT**

Background: The 1999 Legislature mandated a broad performance audit of Washington's public mental health system to include the roles and responsibilities of the different organizations involved, the cost and outcomes of mental health services, and the allocation of funding to the 14 county-operated Regional Support Networks (RSNs). JLARC completed its mandated performance audit of the mental health system in 2000 and made 14 recommendations geared to improving the performance of our mental health system.

JLARC will periodically follow-up with the Department of Social and Health Services, Mental Health Division (MHD), about their progress in implementing these recommendations. On June 27, 2001, the Mental Health Division presented their progress to JLARC on the following—

- Their implementation of recommendations 1-8
- Their progress on implementing the other recommendations (9-14); and
- Any problems they have encountered in implementation to date.

Overall the Division has begun a number of initiatives that begin to address implementation of recommendations 1-8 which were due to be implemented by June 2001. *The Division will need to continue these efforts over the next several months to ensure their approaches translate into improvements in system efficiency and effectiveness.*

An area of concern is the Division's efforts to implement Recommendation 4. This recommendation follows a 1995 legislative mandate to improve system efficiency and measure outcomes. Formal coordination with the federal Health Care Financing Administration (HCFA) is not scheduled until mid-July 2001, and the Division reports that HCFA appears to be increasing its process-oriented accountability requirements. The MHD will need to be assertive in working with the federal government so that the state's objectives can be met.

The Mental Health Division's June 27, 2001 status report of their progress to date on these recommendations follows. Appendix 1 includes the digest of the December 2000 JLARC report and a listing of the 14 JLARC recommendations. JLARC staff will continue to work with the Mental Health Division over the next several months as they continue their activities. They will provide another status report to JLARC in December 2001.

Mental Health System Performance Audit

**Status report to JLARC
June 27, 2001**



EXECUTIVE SUMMARY

This report has been written to respond to the request of the Joint Legislative Audit and Review Committee (JLARC) for a status report on the implementation of the recommendations made in the Performance Audit of the Mental Health System. The request was made in the form of a committee addendum to the original report. The specific language is as follows:

COMMITTEE ADDENDUM

Mental Health System Performance Audit

The Joint Legislative Audit and Review Committee (JLARC), in its usual practice of following-up on the implementation of recommendations in its reports, will expect the Department of Social and Health Service and its Division of Mental Health to report to JLARC at its June 2001 meeting on:

- How it has implemented those recommendations by June 2001 (i.e., Recommendations 1-8);
- How it is progressing in the implementation of the other recommendations (i.e., Recommendations 9-14) due at a later date; and
- Problems it has encountered in implementation to date.

Subsequent follow-up will occur at such times as determined by JLARC.

The JLARC performance audit made fourteen recommendations for improved management of the mental health system. The recommendations were in the areas of coordination of services, fiscal accountability, and moving towards an outcome-based system. The department has made progress in each of these areas.

Coordination of services is a priority for DSHS. To that end, the department has initiated the 'No Wrong Door' project. This research-based effort is expected to suggest coordinated service models for DSHS programs. The department expects to pilot one or more of these models in the coming year. Several other initiatives are occurring at the Mental Health Division (MHD) level and are briefly described in this report.

In the area of fiscal accountability, the department has reduced and simplified reporting requirements. These changes are expected to increase consistency and reliability of data. Efforts have been made to clarify definitions and to separate expenditures made on direct client services.

Finally, the department has incorporated 12 of the JLARC performance indicators into the FY 01-03 Regional Support Network (RSN) contracts and has a work plan for development of a full outcome-based system. The department has also made progress in the area of reducing audit duplication.

Following is a listing of each of the JLARC recommendations with a report of the accomplishments to date and plan for future progress, including a discussion of any obstacles to implementation.

The JLARC performance audit continues to be helpful in system development.

<p>1. Coordinate allied services provided to mental health clients and implement strategies for resolving organizational, regulatory and funding issues at all levels of the system.</p> <p><u>Agency Position:</u> <u>Concur</u></p>	Accomplishments
	<ul style="list-style-type: none"> • MAA – RSN – Healthy Options: coordination activities • MHD research projects with allied systems
	Plan
	<ul style="list-style-type: none"> • Promoting the ‘A Team’ concept – a successful multi-system model • Implementing ‘No Wrong Door’ – DSHS research on case coordination models • Developing performance indicator/ outcome system • Health Care Finance Administration (HCFA) systems change grants
	Obstacles
	<ul style="list-style-type: none"> • Resources for populations with special needs

ACCOMPLISHMENTS

- **MAA – RSN – Healthy Options: coordination activities** – The Mental Health Division (MHD) and the Medical Assistance Administration (MAA) have conducted five joint informational meetings in local areas to facilitate Healthy Options and Regional Support Network (RSN) coordination. MAA is developing contract language for calendar year 02 to address coordination. MHD has also proposed language in the 01-03 RSN contract to address consumer education, dispute resolution and service coordination protocols. This effort is expected to benefit consumers by clarifying eligibility and reducing confusion about who is responsible for treatment.
- **MHD Research projects with allied systems** - MHD, MAA, and the Division of Alcohol and Substance Abuse (DASA) are involved in a federally financed study of mental health services, substance abuse services, and Medicaid payments to look at service delivery and cost patterns. Another study, being conducted at Harborview Medical Center, will look at the benefit of Naltrexone in treating individuals with co-occurring mental health and substance abuse disorders. Other collaborations include training for case managers on co-occurring disorders in youth and adults. Studies are intended to identify best care practices for multiple needs clients. MHD will use results of studies as part of designing an incentive program for RSNs.

PLAN - There are a number of efforts throughout DSHS in which the MHD is playing an active role:

- **The ‘A Team’ concept – a successful multi-system model** - MHD and Aging and Adult Services (AASA) are working together to promote the use of the ‘A-team concept’ an Everett-based best practice effort, in other regions. This concept creates a team of cross system partners including AASA, RSNs, County Designated Mental health Professionals (CDMHP), the Division of Developmental Disabilities (DDD), DASA, and the Department of Corrections (DOC) to staff challenging multi-need cases. The cross system staffing has resulted in a reduction in inpatient hospitalization and a reduction in the use of emergency services. Dispute resolution terms proposed for the 01-03 RSN contract related to service and payment responsibility are expected to support development of systems like the A-Team. AASA has included formation of A-Teams in all regional performance agreements. Pierce County is starting an A-Team program in May 2001. DSHS will continue to promote this approach based on known results.
- **No Wrong Door – DSHS research on case coordination models** – The DSHS executive cabinet is sponsoring the No Wrong Door project to research and propose case coordination models for multiple needs clients. Included in the project are several DSHS administrations and divisions: AASA, MAA, DASA, DDD, MHD, Children’s Administration (CA), Economic Services Administration (ESA), Juvenile Rehabilitation Administration (JRA), Division of Vocational Rehabilitation (DVR), Division of Research and Data Analysis (RDA), and Information Systems Service Division (ISSD). The project’s initial focus is on clients with multiple disabilities, troubled children, youth and their families and long-term TANF families. Models will be proposed to the DSHS Cabinet by June 30, 2001. The Cabinet will select model(s) and set up a process to implement pilots by August 31, 2001.
- **Performance indicator/ outcome system** – Partial implementation of JLARC performance indicators is planned in the 01-03 RSN contracts. When the performance indicator/outcome system is in place, client outcomes will be used to evaluate the value/success of these collaborative efforts. MHD is working with RDA to identify cross-system performance indicators. (See recommendations 9 and 10, p. 9-10)

- **Systems change grants** - MHD and AASA along with other DSHS partners are exploring the HCFA “Real Choice Systems Change” grants that provide federal funding for systemic improvements allowing individuals to be served in community rather than institutional settings. The focus of these grants is on removing systemic barriers to service for clients who have multiple needs. Applications for these grants are due July 2001. After the federal guidelines are published, DSHS will consider ways to coordinate the grant(s) with the ‘No Wrong Door’ effort.

OBSTACLES

- **Resources for populations with special needs** - The lack of community resources for individuals with behavioral issues related to organic brain disorders such as dementia and traumatic brain Injury is a challenge. These clients are often involved in multiple systems such as state hospitals and community geriatric care facilities.

<p>2. Require RSNs to collaborate and work with allied service provider agencies in providing mental health services and identify RSN responsibilities to achieve collaboration. MHD should enforce the provisions of those contracts.</p> <p><u>Agency Position:</u> <u>Concur</u></p>	Accomplishments
	<ul style="list-style-type: none"> • Proposed RSN contract terms • Addressing dispute resolution • Addressing RSN non-compliance
	Plan
	<ul style="list-style-type: none"> • HCFA review of contract • Complete contracting process
	Obstacles
	None noted

ACCOMPLISHMENTS

- **Proposed contract terms** – MHD has proposed RSN contract language related to coordination of services. RSNs are required to develop service delivery protocols for children, including but not limited to Native American/Indian children and children served by JRA and CA, and adults served by AASA. Protocols are to be submitted to MHD by June 1, 2002. Completed plans must include time lines, goals, and a method to demonstrate progress for the areas listed below. Plans must be reviewed by the RSN quality management process, the RSN advisory board, and approved by the Governing Body. Plans must include at least the following:
 - ⇒ clarification of roles and responsibilities of stakeholders in serving multi-need consumers
 - ⇒ information sharing related to eligibility and access procedures
 - ⇒ identification of needed local resources including initiatives to address those needs
 - ⇒ facilitation of returning consumers of all ages from out-of-home placements, e.g. state hospitals, children’s long-term inpatient facilities, JRA facilities, foster care, nursing homes, acute inpatient settings
 - ⇒ a process or format to address local complications or disputes related to service or payment responsibility
 - ⇒ a method to evaluate progress in cross-system coordination and integration of services, e.g. decreased detentions, expedited community re-integration
- **Addressing dispute resolution** - Contract language also has been proposed to identify a state-level resolution process for disputes unresolved at the community level. These disputes are primarily related to care or payment decisions.
- **Addressing RSN non-compliance** - MHD has proposed contract language for tempered, progressive, and relevant responses to non-compliance by RSNs. Current contract language (99-01) leaves us with only one consequence, termination of the contract. Proposed language gives MHD a range of options for response including corrective action, modification of RSN policies, denial of incentive payments, and withholding of a portion of the monthly capitation payment pending resolution of the problem.

PLAN

- **HCFA Review** – Per federal regulations that are issued related to the Balanced Budget Act (BBA), MHD contracts with RSNs must be reviewed and approved for compliance with Medicaid law and regulations. MHD met with HCFA on April 19, 2001 and received general support for the draft contract along with some requests for changes/additions.
- **Contracting** – 01-03 RSN contracts are expected to be signed and in effect within the next few months.

OBSTACLES

None noted

3. MHD, AASA, state hospitals, and RSNs should ensure hospital discharge and community placement for eligible clients occur in a timely manner. <u>Agency Position:</u> concur	Accomplishments
	<ul style="list-style-type: none"> • Enhanced community services (ECS) proposal
	Plan
	<ul style="list-style-type: none"> • Develop discharge protocols for the state hospitals • Finalize timeline/goals for ECS • Evaluate ECS - discharge study
	Obstacles
	None noted

ACCOMPLISHMENTS

- **Enhanced community services** – DSHS has proposed the enhanced community services project to address the issues of timeliness of discharge, coordinated service planning, and adequate community resources. The project has identified patients in the state hospitals who could be more appropriately served in community settings. The proposal to transition these patients to the community is being coordinated through a steering committee consisting of representatives from AASA, DSHS Health and Rehabilitative Services Administration (HRSA), MAA, Regional Support Networks (RSN), the Department of Health (DOH) and patient family members. DSHS is aware that successful implementation requires continued efforts to work collaboratively as the majority of individuals involved require services from more than one system of care. The project will include evaluation based on outcomes for individual clients, DSHS, and community service systems.

PLAN

- **Discharge protocols** - Eastern and Western State Hospitals are working with AASA, RSNs, and CDMHPs to clarify discharge and community placement protocols. The projected completion date is October 15, 2001.
- **Timelines/goals for ECS** – Transition of patients is expected to occur over the next two biennia. The evaluation will track individuals as they are discharged using service utilization patterns, cost data, consumer satisfaction surveys, and medical chart review. The dates of transition of individuals into community settings reflected in current proposed budgets are as follows:
 - ⇒ **October through December, 2001 (30 Adult Psychiatric Patients)**
 - ⇒ **May through July, 2002 (30 Adult Psychiatric Patients)**
 - ⇒ **October through December, 2002 (30 Geriatric Psychiatric Patients)**
 - ⇒ **February through April, 2003 (30 Adult Psychiatric patients)**

Previous to each of these dates, involved systems will develop the necessary community capacity and evaluation components.

- **ECS evaluation - discharge study** - A study, involving MHD, DASA, AASA, and MAA, will evaluate individuals who return to the community after discharge from Western State Hospital. Outcomes that will be evaluated include:
 - ⇒ Provision of services in the least restrictive setting possible
 - ⇒ Prevention of unnecessary or lengthy hospitalizations
 - ⇒ Increase of community support/transition services
 - ⇒ Improved quality of life for consumers
 - ⇒ Cost savings to DSHS
 - ⇒ Improved placement and diversion alternatives

OBSTACLES

None noted

<p>4. Streamline and reduce process-oriented accountability activities. Negotiate with HCFA regarding how to replace process-oriented system accountability requirements with system and client outcomes reporting.</p> <p><u>Agency position:</u> <u>Partially concur</u></p>	Accomplishments
	<ul style="list-style-type: none"> • Reducing audit duplication - Systems Improvement Group (SIG) II
	Plan
	<ul style="list-style-type: none"> • Exploring deeming - Systems Improvement Group (SIG) III • Appointment with HCFA
	Obstacles
	<ul style="list-style-type: none"> • Balanced Budget Act • Licensing

ACCOMPLISHMENTS

- **Systems Improvement Group (SIG) II** – This broad stakeholders group, including representation from MHD, RSNs, providers, consumers and advocates was established to streamline and reduce audit duplication for RSNs and mental health providers. The outcome of the work group was three pilot projects. The pilots combined visits from MHD licensing, MHD RSN review, and RSN review of provider agencies. New audit protocols for advance work with each RSN were instituted to collaborate on review timelines, elements to be reviewed, and tool development. Three reviews are now combined into one resulting in reduced audit duplication, improved quality processes, and increased consistency. Evaluation of pilots found a 94 percent approval from recipients of reviews.

PLAN

- **Systems Improvement Group (SIG) III** – In March 2001, the Systems Improvement Group (SIG) III was established to set up protocols and standards for deeming national accreditation for licensed service providers. With deeming in place, a provider could meet state minimum standards through accreditation by a recognized behavioral health accrediting body. This would reduce and simplify audit visits for licensing by the state. The expected completion date is August 1, 2001.
- **Appointment with HCFA** – MHD has scheduled a meeting with HCFA on July 18, 2001 regarding this recommendation. It should be noted that the application for renewal of the federal waiver is due August 1, 2001. The waiver renewal process will take precedence in terms of timing.

OBSTACLES

- **Balanced Budget Act (BBA)** - HCFA is moving toward *more* process-oriented accountability in the BBA. The BBA has several new managed care regulations related to notifications to enrollees, advance directives, grievance procedures, quality strategies, screening, assessment, and credentialing. **Note: This is a sample. The actual requirements are lengthy and will take further study to implement.**

- **Licensing** – MHD has reviewed licensing activities and will focus on those primarily related to health and safety. MHD believes that it is important to continue these licensing activities to assure some uniformity among licensed service providers.

<p>5. The legislature should clarify its intent that the system be “efficient and effective” by amending RCW 71.24.015.</p> <p><u>Agency position:</u> Concur</p>	<p>The legislature accomplished this in Chapter 334, Laws of 2001 (ESSB 5583a).</p>
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<p>6.1 Reduce the number of reported cost elements to those directly linked to the accountability process.</p> <p><u>Agency position:</u> Partially concur</p>	<p style="text-align: center;">Accomplishments</p> <ul style="list-style-type: none"> • 2000 reporting instructions document decreased reportable elements
	<p style="text-align: center;">Plan</p> <ul style="list-style-type: none"> • Link cost elements to the performance indicator/outcome system
	<p style="text-align: center;">Obstacles</p> <ul style="list-style-type: none"> • Addressing other information requests

ACCOMPLISHMENTS

- **2000 reporting instructions document** – In the 2000 reporting instructions document for RSNs, three reported cost element codes were combined to create outpatient treatment. Two reported cost element codes were combined to create utilization management and quality assurance. One code was eliminated.

PLAN

- **Performance indicator/outcome system** - Once the performance indicator/outcome system is complete, cost information collected will be reassessed to ensure linkage to the accountability process.

OBSTACLES

- **Other information requests** - Some cost elements may need to be collected that are not part of the accountability process. These cost elements identify how much RSNs spend on certain activities, such as Evaluation and Treatment Centers, residential and employment. MHD uses the information for research projects, to complete grant applications, and to respond to requests for information from legislators and persons interested in specific programs.

6.2 Clarify the definition of “provider administration” to improve consistency in reporting. <u>Agency position:</u> <u>Concur</u>	Accomplishments
	Plan
	Obstacles
	<ul style="list-style-type: none"> Defined in 2000 reporting instructions document Improve consistency of reporting Variation among providers

ACCOMPLISHMENTS

- 2000 reporting instructions document** – Provider administration was defined and separated from RSN administration in the 2000 reporting instructions document. The definition included costs allowable for administration.

PLAN

- Consistency of reporting** - In FY 2002, MHD fiscal staff will study RSN and provider accounting and reporting activities to identify consistency issues and reporting difficulties. Recommendations for clarity and consistency are expected to be complete by April 30, 2002.

OBSTACLES

- Variation among providers** - As more detail is reviewed and more provider staff interviewed, issues become technically complex. Before changes are made, additional research is needed to avoid administrative burden, and inconsistency.

6.3 Instruct RSNs to report cost information so it reconciles with county-maintained RSN records. <u>Agency position:</u> <u>concur</u>	Accomplishments
	Plan
	Obstacles
	<ul style="list-style-type: none"> FY 01 and 02 instructions clarified required information Continuing research to improve consistency None noted

ACCOMPLISHMENTS

- FY 01 and 02 instructions** – In FY 01, the first year that MHD asked providers to report only the expenditures of funds originating from MHD. This was not fully successful and MHD engaged the RSN in a discussion of the issues. In FY 02, specific instructions clarified providers’ reporting requirements.

PLAN

- Continuing research** - In FY 02, MHD fiscal staff will continue to identify what was unclear and to identify other factors that impede consistency. Recommendations for clarity and consistency will be made by May 2002.

OBSTACLES

None noted

6.4 Collaborate with State Auditor's Office to ensure RSNs segregate revenues, fund balances and reserves from other county funds. <u>Agency position:</u> Partially concur	Accomplishments
	Plan
	<ul style="list-style-type: none"> Discuss with the State Auditor by September 1, 2001
	Obstacles

- Discuss with State Auditor** – MHD will develop a plan based on discussions with the State Auditor's Office

6.5 Explore the feasibility of Local Government Financial Reporting System to assist MHD with monitoring and streamlining the cost reporting process. <u>Agency position:</u> Partially concur	Accomplishments
	Plan
	<ul style="list-style-type: none"> Discuss with the State Auditor by September 1, 2001
	Obstacles

- Discuss with State Auditor** – MHD will develop a plan based on discussions with the State Auditor's Office

6.6 Develop a process to quantify and report costs of RSN utilization of state hospitals and integrate with other RSN cost information. <u>Agency position:</u> Concur	Accomplishments
	<ul style="list-style-type: none"> Completed - Reporting process in place
	Plan
	Obstacles

ACCOMPLISHMENTS

- Reporting process** - Reporting will be consistent with the Revenue and Expenditure report issued twice a year. Method of including RSN utilization of state hospitals will be the same as the method JLARC used. Reporting begins with the June 2001 revenue and expenditure report.

7.1 The definition of direct services should be narrowed to include only those expenditures directly related to client services. <u>Agency position:</u> Concur	Accomplishments
	<ul style="list-style-type: none"> FY 01 reporting instructions narrowed this definition
	Plan
	Obstacles

ACCOMPLISHMENTS

- FY 01 reporting instructions** – This reporting instructions document removed the following elements from the definition of direct service: patient tracking system, utilization management, quality assurance, and public education.

7.2 Create a new expenditure category to include direct services support. Expenditures. <u>Agency position:</u> concur	Accomplishments
	<ul style="list-style-type: none"> Completed in FY 01 reporting instructions
	Plan
	Obstacles

ACCOMPLISHMENTS

- FY 01 reporting instructions** – The new expenditure category was created in July 2000. The category includes four types of costs and definitions for each.

7.3 Include in the fiscal accountability standard the reporting of administrative and support costs of MHD, state hospitals and community hospitals. <u>Agency position:</u> Partially concur	Accomplishments
	<ul style="list-style-type: none"> Completed in FY 01 reporting instructions
	Plan
	Obstacles

ACCOMPLISHMENTS

- FY 01 reporting instructions** - This can be reported on a statewide basis as part of the Revenue and Expenditure report issued twice a year. The method of including these costs will be the same as the method JLARC used. Reporting will begin with data as of June 2001.

8. MHD should develop uniform client and client service data definitions to address the inconsistencies noted in this report. <u>Agency position:</u> Concur	Accomplishments
	<ul style="list-style-type: none"> Data dictionary revised per JLARC
	Plan
	Obstacles

ACCOMPLISHMENTS

- Data dictionary revision** - The data dictionary, MHD’s published manual of data elements and definitions, has been reviewed and revised in meetings with RSNs, providers, and consumers. Service definitions have been revised to increase reporting consistency and assure compliance with the Health Insurance Portability and Accountability Act.

PLAN

- 01-03 contract** - Data dictionary revisions will be in place for the FY 01-03 contract scheduled to be in effect on July 1, 2001. RSNs will be required to report using the new dictionary starting November 1, 2001. MHD will develop field-training protocols to instruct RSN and provider staff on the new codes.

9. Use outcomes/implement a uniform performance measurement system required by RSN contracts. <u>Agency position:</u> <u>Concur</u>	Accomplishments
	Plan
	Obstacles

ACCOMPLISHMENTS

- **Performance indicators** – MHD has incorporated twelve of the JLARC performance indicators into the 01-03 RSN contracts, with plans to develop four more over the course of the contracts. The selection of the indicators was based on data sources currently available. This is not the comprehensive system envisioned by JLARC (see recommendation 10, p. 12).

For the following measures, MHD will gather and report baseline data for FY 01. During FY 02 MHD will apply incentives and/or requests for management plans to improve performance when an RSN is below standard or the mean of RSNs.

1. Penetration rates for services by race/ethnicity, age, gender, and Medicaid eligibility
2. Utilization rate for services by race/ethnicity, age, gender, and priority population
3. Recipient perception of access
4. Recipient perception of quality/appropriateness of services
5. Recipient perception of active participation in decision making regarding treatment
6. Percentage of service recipients age 16 and above who are employed
7. Average annual cost per recipient served
8. Average annual cost per unit of service; cost per hour for community services
9. Percent of revenues spent on direct services
10. Percent of recipients who were homeless in the last 12 months by age and priority population
11. Percent of children who live in “family-like” settings
12. Percent of children and adolescents receiving services in natural settings outside of a clinicians office

The following measures will be under development during this contract period and will be included in the contract. Data will be gathered and reported throughout the contract period to refine the indicators.

1. Percent of recipient who are maintained in the community without a psychiatric hospitalization during the last 12 months
2. Percent of recipients who receive services by both MHD and DASA in the previous 12 months
3. Percent of consumers who access physical healthcare
4. Percent of service recipients living in stable environments

PLAN

- **Data consistency** - Ensuring report compliance and consistency will be the focus of FY 01. Quarterly reports will be generated and disseminated to RSNs to increase data consistency.
- **Use of data** – MHD expects data consistency and reliability will be established by November 1, 2002. At that point, data can be analyzed on a regular basis and used for management purposes.

<p>10. Implement an outcome-based performance measurement system consistent with the framework described in this report. Report back to JLARC on the status of the system's implementation on an annual basis over the next five years and indicate how it is using the information to manage the system.</p> <p><u>Agency position:</u> Partially concur</p>	Accomplishments
	<ul style="list-style-type: none"> Increased compliance/consistency of current data
	Plan
	<ul style="list-style-type: none"> Monitoring to assure standards of data reliability Comprehensive system development
	Obstacles
	<ul style="list-style-type: none"> Requires funding

ACCOMPLISHMENTS

- Compliance/consistency** - MHD has completed preliminary work to increase the compliance and consistency of currently collected outcome information (i.e. employment, living situation, educational activity, and consumer perceptions of positive outcomes).

PLAN

- Monitoring and reporting** - Data compliance will be closely monitored from October 2001 through September 2002. If reporting compliance and standards of data reliability are established, MHD will begin reporting these outcome data in October 2002.
- Comprehensive system development** - The development of a comprehensive consumer outcome system will take a minimum of three years. The following proposal lists the steps and timelines MHD will take to develop the consumer outcome system:
 - 1) Request for Information: convene a stakeholder workgroup; including RSNs, providers, MHD staff, consumers and advocates to review the information and make decisions on which system best meets Washington State's needs. *July-December, 2001*
 - 2) Designing Consumer Outcome System: work with contractors to design a consumer outcome system that detects consumer changes over time. *December-June, 2002*
 - 3) Training on Selected Consumer Outcome Measure: develop and provide training to providers about the measure that is selected. Formats for submitting data will be developed and disseminated. *January-May, 2002*
 - 4) Data collection begins: Collect data on the Consumer Outcome Measure. Reports will be generated every 90 days to provide feedback on reporting quality and compliance to RSNs and providers. *June, 2002-December, 2003*
 - 5) Once reporting compliance meets standards of reliability, MHD will begin reporting these outcomes. RSNs will receive performance reports every 90 days, with annual reports generated for broader stakeholder groups. *January, 2004*
 - 6) Reports will be used by MHD to monitor contract compliance, inform planning, and to implement quality improvement through incentives.

OBSTACLES

- Requires funding** – Developing outcome measures and designing the required data system will require funding.

11a-c. Change the payment methodology to use the same allocation for federal and state outpatient funds; eliminate the distinction between inpatient and outpatient funding; reduce the disparity in rates per Medicaid eligible person <u>Agency position:</u> Concur	Accomplishments
	<ul style="list-style-type: none"> Produced a proposal consistent with RCW 71.24 Implementation to begin July 1, 2001 unless the legislature supercedes it
	Plan
	Obstacles

11d. Allocate funding for state hospital beds to the RSNs <u>Agency position:</u> Partially concur	Accomplishments
	<ul style="list-style-type: none"> Preliminary analysis completed
	Plan
	Obstacles
	<ul style="list-style-type: none"> Federal funding streams; union contracts; state funding streams

ACCOMPLISHMENTS

- Preliminary analysis** – MHD completed preliminary analyses of this issue in 1996 and 2000 and identified major issues.

PLAN

- Continuing technical assessment** – MHD will continue to explore ways to make the RSNs responsible for state hospital bed usage. A status report, including recommendations for further action, will be produced by December 2002.

OBSTACLES

- Federal funding streams; union contracts; state funding streams** – Earlier analyses of this recommendation show the major issue to be how to preserve federal funds which, at this time, are paid directly to hospitals that serve indigent persons. There are also significant issues with union contracts and state hospital funding streams.

12. Conduct periodic studies of the estimated regional prevalence of mental illness. <u>Agency position:</u> Partially concur	Accomplishments
	Plan
	<ul style="list-style-type: none"> Support if funded by the legislature
	Obstacles

PLAN

- Support if funded** – MHD recommends that such a study, if funded, be conducted by an independent entity.

13. Restrict all RSN fund balances and reserves at maximum of 10 percent of annual revenue <u>Agency position:</u> Concur	Accomplishments
	<ul style="list-style-type: none"> Implemented in FY 02 contract
	Plan
	Obstacles

ACCOMPLISHMENTS

- Implemented** – Fund balances and reserves, except risk reserves, are restricted in FY 2002 contract. Actuaries identify the specific percent of risk reserve necessary for the viability of each RSN. For this reason MHD did not include risk reserves in the restriction.

14. Periodically analyze performance information from RSNs and providers so as to identify and disseminate information on efficient and effective operations and best practices. MHD to create a pool of incentive funds and distribute them as incentives for efficient and effective services. <u>Agency position:</u> Concur	Accomplishments
	Plan
	<ul style="list-style-type: none"> Develop performance measure system
	Obstacles

PLAN

- Performance measures system** –When the outcome system is developed and starts generating reliable data, it will be possible to implement this recommendation. The system will be partially implemented by June 2003. Anticipated date of complete implementation is January 2004. (See recommendations 9 and 10, p. 9-10)

TERMS AND ACRONYMS

AASA	Aging and Adult Services Administration, DSHS
Balanced Budget Act	Federal law that, (among other things), increased certain requirements of pre-paid health plans
CDMHP	County Designated Mental Health Professional
CMHS	The Center for Mental Health Services is a division of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Federal government. CMHS oversees and funds the state mental health block grants as well as various research projects related to mental health services research
DASA	Division of Alcohol and Substance Abuse, DSHS
Data Dictionary	The MHD’s published manual of data elements and definitions. RSNs, by contract, are required to report data that is listed in MHD’s data dictionary.
DDD	Division of Developmental Disabilities, DSHS
Deeming	Agreement that certain licensing requirements are met if a provider is accredited by a nationally recognized behavioral health accrediting body.
DOC	Department of Corrections
E&T Center	Evaluation and Treatment Center – community-based facilities for short term treatment and stabilization of acute episodes of mental illness
HCFA	Health Care Financing Administration
Healthy Options	A Medicaid managed care plan
HIPAA	Health Insurance Portability and Accountability Act
MAA	Medical Assistance Administration, DSHS
MHD	Mental Health Division, DSHS
Naltrexone	Opiate antagonist approved by the FDA for treatment of alcohol dependence
RDA	Research and Data Analysis, DSHS
RSN	Regional Support Network
TANF	Temporary Assistance for Needy Families

Appendix

- Mental Health System Performance Audit 00-8 Report Digest; and
- Recommendations

MENTAL HEALTH SYSTEM PERFORMANCE AUDIT

REPORT 00-8

REPORT DIGEST

DECEMBER 13, 2000



STATE OF WASHINGTON
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MENTAL HEALTH SYSTEM PERFORMANCE AUDIT

The public mental health system in Washington spends almost \$1 billion per biennium and serves approximately 106,000 people per year. The system is administered by the Mental Health Division (MHD), of the Department of Social and Health Services (DSHS), which also operates the two state mental hospitals. The MHD contracts with 14 county-operated Regional Support Networks (RSNs) for the provision of community-based mental health services and allocates federal and state funding to the RSNs. The RSNs administer mental health services at the local level and contract with private and public providers of community mental health services.

This study was required by the Legislature via a proviso in JLARC's 1999-01 Biennial Budget. The Legislature required JLARC to conduct a broad review of the performance of the public mental health system to include:

- An analysis of the roles and responsibilities of the MHD, RSNs, and community mental health providers.
- An analysis of funding of the RSNs through contracts let by the MHD.
- An analysis of service levels, outcomes, and costs for RSNs.
- An analysis of contracts between RSNs and community mental health providers.
- Recommendations for modifying the basis on which RSNs and community mental health providers are funded.

MAJOR FINDINGS

1. There are problems with coordination of services between the MHD and other DSHS divisions including the Developmental Disabilities Division (DDD), Division of Alcohol and Substance Abuse (DASA), the Aging and Adult Services Administration (AASA), and between the state mental hospitals and the RSNs.
2. The MHD has made efforts to streamline burdensome activities to promote system accountability. However, these accountability activities are focused on processes of service, rather than on outcomes of service. There is almost no information collected on a statewide basis on client or system outcomes.
3. The fiscal, client, and service data collected by the MHD to promote system accountability are not consistently reported by providers and RSNs.
4. Because of the inconsistencies in the reporting of fiscal, client, and service data, comparisons of the *efficiency* of services provided by RSNs and providers are suspect. Because of the lack of statewide outcome data, comparisons of the *effectiveness* of services provided by RSNs and providers are impossible.

5. The MHD's method of providing capitated funding to RSNs under a managed care approach creates incentives for RSNs to provide services in a cost-efficient manner. However, there are wide disparities in the amount of resources allocated to the RSNs. These resources include funding for community mental health services as well as the allocation of state hospital beds among the RSNs. The disparity in resources is not associated with differences in the prevalence of mental illness, the severity of the clients served, or geographic cost differences among RSNs.
6. The disparity in funding to RSNs leads to disparities in the amount of service provided to clients. Higher-funded RSNs have higher expenditures per client served than lower-funded RSNs.
7. There are wide differences in how RSNs operate. Some RSNs pass on almost all of their funding to community mental health providers and exert relatively little oversight over their providers. Other RSNs spend considerably more money at the RSN level and provide more oversight over their providers. However, without information on client or system outcomes, whether one approach is more effective than another is impossible to determine.

resources to RSNs, and operation of the state hospitals. We believe the MHD has been taking appropriate steps to improve the system, for example, by instituting a capitated method for allocating resources and by streamlining its activities to promote system accountability. However, we believe further improvements are needed to better coordinate services for clients, to ensure resources are allocated equitably among the RSNs, and to promote accountability by measuring the outcomes of service, rather than the processes of service. The report includes 14 recommendations intended to achieve the following:

- Improve the coordination of services between the MHD and other DSHS divisions, and improve the coordination of state hospital discharge planning between the state hospitals and the RSNs.
- Improve the consistency of fiscal, client, and service data collected by the MHD.
- Further streamline and eliminate process-oriented accountability activities to be replaced with a system for measuring client and system outcomes.
- Change the resource allocation methodology to simplify the methodology, provide further incentives for the provision of services in a cost-effective manner, and improve the consistency of services to clients around the state.
- Promote the identification of best practices among providers and RSNs in order to facilitate the cost-effectiveness of the public mental health system.

CONCLUSIONS AND RECOMMENDATIONS

Due to the decentralized administration of community mental health services, the MHD's role is limited to statewide planning and policy direction, system oversight, allocation of

COMMITTEE ADDENDUM

Mental Health System Performance Audit

The Joint Legislative Audit and Review Committee (JLARC), in its usual practice of following-up on the implementation of recommendations in its reports, will expect the Department of Social and Health Services and its Division of Mental Health to report to JLARC at its June 2001 meeting on:

- How it has implemented those recommendations by June 2001 (i.e., Recommendations 1-8);
- How it is progressing in the implementation of the other recommendations (i.e., Recommendations 9-14) due at a later date; and
- Problems it has encountered in implementation to date.

Subsequent follow-up will occur at such times as determined by JLARC.

MENTAL HEALTH SYSTEM PERFORMANCE AUDIT (2000)

RECOMMENDATIONS

Recommendation 1

The Department of Social and Health Services should comply with legislative intent and coordinate allied services provided to mental health clients. It should implement strategies for resolving organizational, regulatory, and funding issues at all levels of the system—state, regional, and local.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 2

In its contracts with Regional Support Networks (RSNs), the Mental Health Division (MHD) should require RSNs to collaborate and work with allied service provider agencies in providing mental health services and identify RSN responsibilities to achieve collaboration. The MHD should enforce the provisions of those contracts.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 3

The Mental Health Division, Aging and Adult Services Administration, state hospitals, and Regional Support Networks should meet legislative intent to ensure hospital discharge and community placement for eligible clients occur in a timely manner. This will require developing an understanding of both the hospital discharge and the community placement criteria and how they relate to one another on a case-specific basis.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 4

The Mental Health Division (MHD) should continue to streamline and reduce process-oriented accountability activities. The MHD should negotiate with the Health Care Finance Administration regarding how to replace process-oriented system accountability requirements with system and client outcomes reporting.

Legislation Required:	None
Fiscal Impact:	Unknown amount of cost reductions for MHD, RSNs, and providers
Completion Date:	June 2001

Recommendation 5

The Legislature should further clarify its intent that the mental health system should be efficient and effective by amending RCW 71.24.015 as follows:

71.24.015 Legislative Intent and Policy. It is the intent of the Legislature to establish a community mental health program which shall help people experiencing mental illness to retain a respected and productive position in the community. This will be accomplished through programs which provide for....

(2) Accountability of efficient and effective services through statewide standards for monitoring and reporting of information that bears directly on system and client outcomes;....

Legislation Required:	Yes
Fiscal Impact:	None
Completion Date:	2001 Session

Recommendation 6

The Mental Health Division (MHD) should implement the following Sterling Associates recommendations to improve the consistency of cost reporting:

- 6-1 MHD should reduce the number of reported cost elements to those directly linked to the accountability process.
- 6-2 MHD should clarify the definition of the “provider administration” cost category to improve the consistency of assigning organizationally complex items to either administrative or non-administrative categories.
- 6-3 MHD should issue instructions to Regional Support Networks (RSNs) to ensure that reported cost information is collected in a manner that reconciles with actual county-maintained (RSN) fiscal records.
- 6-4 MHD should collaborate with the State Auditor’s Office to ensure that all RSNs are using appropriate accounting procedures to segregate RSN revenues, fund balances, and reserve accounts from other county funds.
- 6-5 MHD should work with the State Auditor’s Office and counties to explore the feasibility of using the Local Government Financial Reporting System to assist MHD with monitoring and streamlining the cost reporting process.
- 6-6 MHD should develop a process for quantifying and reporting the costs of RSN utilization of state-operated mental hospitals. This data should be integrated with other cost information collected from the RSNs.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	June 2001

Recommendation 7

The Mental Health Division (MHD) should change its fiscal accountability standard (which requires 75 percent of revenues to be spent for direct services) to provide uniform definitions that reflect the following:

- 7-1 The definition of direct services should be narrowed to include only those expenditures directly related to client services.
- 7-2 A new category of expenditures should be created to include direct service support expenditures (e.g., patient tracking system, quality assurance activities, and training) that are currently categorized as direct service.
- 7-3 The reporting of the standard should include the administrative and support costs of the MHD, the state hospitals, and community hospitals that are currently either not part of the calculation or are counted as direct services.

Legislation Required: No
 Fiscal Impact: None
 Completion Date: June 2001

Recommendation 8

The Mental Health Division should develop uniform client and client service data definitions to address the inconsistencies noted in this report.

Legislation Required: No
 Fiscal Impact: None
 Completion Date: June 2001

Recommendation 9

The Mental Health Division (MHD) should comply with legislative intent and Health Care Finance Administration requirements to use outcomes information in managing the state’s public mental health system. Implementation of a uniform performance measurement system should be a requirement of each contract between the MHD and Regional Support Networks.

Legislation Required: No
 Fiscal Impact: None
 Completion Date: November 2001

Recommendation 10

The Mental Health Division (MHD) should implement an outcome-oriented performance measurement system consistent with the framework described in this report. In addition, the MHD should report back to the Joint Legislative Audit and Review Committee on the status of the system’s implementation on an annual basis over the next five years and indicate how it is using the information to manage the system.

Legislation Required: No
 Fiscal Impact: \$730,000 to \$950,000 start-up costs in first biennium, \$250,000 annual costs thereafter; to be offset by cost savings as a result of the implementation of Recommendation 4.
 Completion Date: November 2001 and ongoing

Recommendation 11

The Mental Health Division should continue to use a capitated payment methodology for allocating funds to Regional Support Networks (RSNs). However, the following changes should be made:

- Eliminate the separate methodologies for the allocation of federal and state outpatient funding.
- Eliminate the distinction between outpatient and community inpatient funding.
- Substantially reduce the disparity in funding per Medicaid-eligible person.
- Allocate funding for state hospital beds to the RSNs.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	2001-03 Biennium

Recommendation 12

The Mental Health Division should conduct periodic studies of the estimated regional prevalence of mental illness in order to determine whether the association between the number of Medicaid-eligible persons in a Regional Support Network and the number of people needing service remains intact. Future prevalence studies should address shortcomings of the Prevalence Estimation of Mental Illness and Need for Services study, including a methodology for capturing the homeless and the prevalence of mental illness among those incarcerated in county jails, and should utilize a broader range of diagnoses and the weight the diagnoses by severity.

Legislation Required:	No
Fiscal Impact:	\$500,000
Completion Date:	November 2004

Recommendation 13

The Mental Health Division should require that Regional Support Network fund balances (including all reserve funds and undesignated fund balances) be restricted to a maximum of 10 percent of annual revenue. This policy should be implemented over time so as not to create a “bow wave” of unsustainable spend-down of fund balances.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	2001-03 Biennium

Recommendation 14

Concurrent with the implementation of the data and performance measurement recommendations of this report, the Mental Health Division (MHD) should periodically analyze performance information to identify providers and Regional Support Networks (RSNs) that operate efficiently and effectively and the best practices used by such RSNs and providers. The MHD should disseminate these practices to all RSNs and providers, and create a pool of incentive funds to provide financial incentives for efficient and effective service.

Legislation Required:	No
Fiscal Impact:	None
Completion Date:	December 2001 and ongoing

COMMITTEE ADDENDUM

Mental Health System Performance Audit

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