

oppaga

Progress Report



August 2001

Report No. 01-34

Alcohol, Drug Abuse and Mental Health Program Taking Steps to Implement Recommendations

at a glance

In response to our 1999 report, the Department of Children and Families' Alcohol Drug Abuse and Mental Health Program has taken steps to implement our recommendations. The department has

- put into practice new service arrangements to better coordinate client services in a few districts;
- expanded its use of case rate contracts with its assertive community treatment initiative;
- revised program rules to emphasize quality of care in its monitoring of substance abuse providers; and
- improved its data reporting procedures.

The department should continue to implement our recommendations. The department should extend service arrangements that effectively coordinate services into other districts. The department should continue to focus its monitoring of service providers on the quality of care they provide. It can do so by developing practice guidelines and performance measures and standards appropriate to the type of services provided and the severity of clients' illness.

Purpose

According to state law, this report describes action by the Department of Children and Families in response to a 1999 OPPAGA report.^{1,2} It assesses the extent to which the department has addressed findings included in our report.

Background

The Alcohol, Drug Abuse and Mental Health Program provides prevention and treatment services that reduce the occurrence and disabling effects of mental health and substance abuse problems. State law directs the department to provide appropriate services in the least restrictive setting.

The department's 15 service districts contract with private mental health and substance abuse treatment centers for services. In Fiscal Year 2000-01, the department contracted with 234 service providers. Program services include case management, outpatient, community support, inpatient and crisis stabilization, and residential treatment.

For Fiscal Year 2001-02 the Legislature appropriated \$519.8 million for the program and authorized 215 full-time equivalent positions to administer the program.³ Sixty-one percent of the program's budget, \$316.5 million, is general revenue. The program serves over 359,000 clients annually.

¹ Section 11.45(7)(f), *F.S.*

² *Justification Review of the Alcohol, Drug Abuse and Mental Health Program within the Department of Children and Families*, [Report No. 99-09](#), September 1999.

³ Appropriations for Medicaid services for program clients are not included.

Prior Findings

In our prior report, we concluded that the program was generally effective in meeting its performance goals. Services helped to keep adults and children with mental illness out of in-patient treatment facilities. The program helped to improve and maintain clients' abilities to do routine activities. Services helped to improve employment for adults with substance abuse problems.

We concluded that the program provided beneficial services and was cost-effective for Florida's citizens. In the absence of program services, individuals with mental illness or substance abuse problems may be prone to the societal economic burdens of hospitalizations, criminal activities, unemployment, homelessness, and dependence on welfare.

Although we found the program was reasonably successful, we identified deficiencies with the program's service delivery, contract monitoring, and accountability system. We recommended several options to improve performance in these areas.

Coordinating Client Services

We identified coordination problems for clients treated by more than one service provider and clients in more than one state program. These problems reduced program effectiveness.

Treatment by more than one provider can lead to poor coordination and conflicts of interest. For example, clients with a mental illness and a substance abuse problem may require services from a mental health provider and a separate agency providing substance abuse services. The clients' case managers, employed by one of the agencies, potentially have less control over scheduling client's appointments at other agencies. Further, the case managers have a potential conflict of interest. Case managers may be more prone to schedule services from their agencies even though more appropriate services are available from other agencies. Fourteen percent of clients receive services from more than one provider.

We also found coordination problems for clients served by more than one state program. Problems with scheduling meetings, different and sometime

conflicting agency missions, and the inability to electronically share client information made coordinating services difficult.

To better coordinate services in districts with many specialty providers, we recommended the department contract for independent case management services and with provider service networks. Provider service networks are formal arrangements between specialty providers that can provide a comprehensive set of client services.

To improve the coordination of services between state programs, we recommended the department identify and copy successful practices in its 15 districts. Further, we recommended that the department explore pooling funding, sharing decision making, and formalizing collaboration procedures across state programs.

Expanding Managed Care Contracts

The department mostly uses unit cost contracts with service providers. In our prior report, we identified limits to unit cost contracts for providing mental health and substance abuse services. Unit cost contracts that reimburse expenses do not provide a financial incentive for providers to reduce expenses or limit unnecessary services.

In contrast, managed care contracts using prepaid per capita rates or case rates provide such an incentive. Providers are paid a fixed rate to deliver a comprehensive array of services to meet clients' needs. The fixed rate provides a financial incentive to provide effective services.

While managed care contracts have advantages, we concluded that the program was not prepared to use managed care contracts in many districts. We noted several conditions that need to be met. First, to develop appropriate per capita rates or case rates, the department needs to

- determine eligibility criteria based on clinical diagnosis, severity of illness, and income and
- analyze expenditures for services by clients' severity of illness.

Second, the department and the Legislature have to determine how to coordinate state funds and Medicaid funding. The Legislature can designate the pooling of state funds to purchase bundles of services. However, Medicaid funds are typically earmarked for specific services.

Third, the department needs to assess districts' capability for managed care contracting. Providers must offer a complete set of services and have the resources to assume the financial risk of managed care contracts. Districts that lack provider service networks or providers that offer a comprehensive set of services may have a difficult time implementing managed care contracting.

Improving Contract Monitoring and Accountability

In our prior report, we identified three areas in the department's procedures for monitoring contracts that could be improved.

First, we noted that the department could more effectively assess the quality of provider care. We suggested that the department use clinical peer reviews or criteria from accreditation reviews that focus on clinical practices to monitor the quality of care. We recommended that the department disseminate information on best practices that are related to positive client outcomes.

Second, the department includes meaningless performance measures and inappropriate performance standards in some contracts. The department puts statewide performance measures and standards in contracts regardless of the services provided or the severity of clients' illnesses. In addition to the statewide measures and standards, we recommended that the department use measures appropriate for specific services and standards based on the severity of clients' illnesses.

Finally, we identified reporting problems for information important to the management of the program. The department was implementing a centralized data warehouse during our prior review. The department designed the warehouse to track enrollments, admissions, services, and performance. As the new system matured, we expected these problems to be corrected.

Current Status ---

The department has made progress addressing our recommendations. The department has improved its coordination of client services. It has expanded its use of managed care contracts and has improved its contracting and accountability systems.

Department districts have put into practice new service arrangements that better coordinate services. Initiatives include provider service networks and independent case management. These may better coordinate services for clients served by more than one provider. They also include pooling state, local, and federal funding and formal collaboration procedures to improve coordination between state programs. Some of these initiatives are highlighted below.

- ***Assertive Community Treatment.*** Multi-disciplinary treatment teams (23 are planned to be operating in 2001) provide a variety of medical, therapeutic, and support services for up to 100 clients. These services would be provided through federal Medicaid and state general revenue funds.
- ***Central Florida Behavioral Health Network.*** This non-profit collaboration among providers in a six-county region provides case management, mental health and substance abuse outreach, intervention, treatment, and aftercare.
- ***Independent case management.*** Independent case managers coordinate mental health care services for children in Districts 7, 10, 13, and 15.
- ***Co-location of substance abuse detoxification and mental health crisis stabilization services in District 4.***
- ***Children's demonstration provider networks.*** Local cooperative arrangements in Districts 7 and 9 will pool federal, state, and local dollars to provide mental health and substance abuse services for children.⁴
- ***Collaboration with the department's Family Safety Program.*** Involves co-locating substance abuse family intervention specialists with child protective investigations and supervision staff.

The department's strategic goal is to organize regional systems of care. The department plans to contract with provider service networks or administrative service organizations.⁵ An administrative service organization provides independent case management of client care. It will contract with mental health and substance

⁴ The demonstration projects are in the planning stage and are scheduled to begin providing services in January 2002.

⁵ *State Mental Health and Substance Abuse Plan; 2000-2003*, Florida Department of Children and Families, April 2001.

Progress Report

abuse providers in the community to provide appropriate services. As of June 2001, the department has not contracted with an administrative service organization.

The department plans to manage clients' care with provider service networks, administrative service organizations, performance contracts, and case rate contracts. Contracting with provider service networks or administrative service organizations addresses many of the concerns in our previous report.

- Provider service networks and administrative service organizations have resources and expertise for managing care not available in the department.
- Limiting the over-use of services based on clinical guidelines to reduce costs is an integral part of both models of service delivery.
- The disruption of the existing provider system should be minimal.
- Both service delivery models improve accountability by having a single point of accountability for client outcomes.

The department has taken steps to expand its use of case rate contracts. The department has completed an analysis of the types of services and costs associated with treating individuals with various abilities to function in the community. This analysis is critical to setting appropriate rates for bundles of services. Further, the department has expanded its use of case rates. Through its assertive community treatment initiative the department contracts for medical, therapeutic, and community support services for a single hourly rate.

The department has improved its contract monitoring and accountability systems; but, it should take additional steps. The department has taken steps to emphasize the quality of care provided in monitoring service providers. The 2000

Legislature directed the department to compare program regulations with clinical practice guidelines and accreditation standards. The department identified rules that need to be revised. For mental health providers, the regulations need to include standards for credentials for non-licensed staff, medication management services, mobile crisis services, and case management services.

Revising the rules according to recognized practice guidelines would improve contract monitoring. Revised rules would provide clear authority for the department's staff to monitor critical clinical elements of its providers' treatment programs.

The department revised regulations for substance abuse providers in May 2000. The revision clarified standards for clinical services, staff credentials for supervisors of clinical services, and training for staff having direct contact with clients.

The department has not improved its use of performance measures and standards in contracts. Despite recognizing its limits, the department continues to promote including statewide performance measures and standards in providers' contracts regardless of the services provided or the severity of the illness of clients served.

The department has improved its data systems. Two-thirds of service providers can report information electronically. Electronic reporting reduces the time to report and correct information. In addition, the department has developed a data validation process for substance abuse contracts. The process allows contract managers to verify information in the department's database with on-site client records. The department is currently expanding electronic data reporting to the rest of its service providers. It is also implementing a data validation process for mental health contracts.

OPPAGA provides objective, independent, professional analyses of state policies and services to assist the Florida Legislature in decision making, to ensure government accountability, and to recommend the best use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). **Florida Monitor:** <http://www.oppaga.state.fl.us/>

Project conducted by Steve Harkreader (850/487-9225) and supervised by Frank Alvarez (850/487-9274)

John W. Turcotte, OPPAGA Director