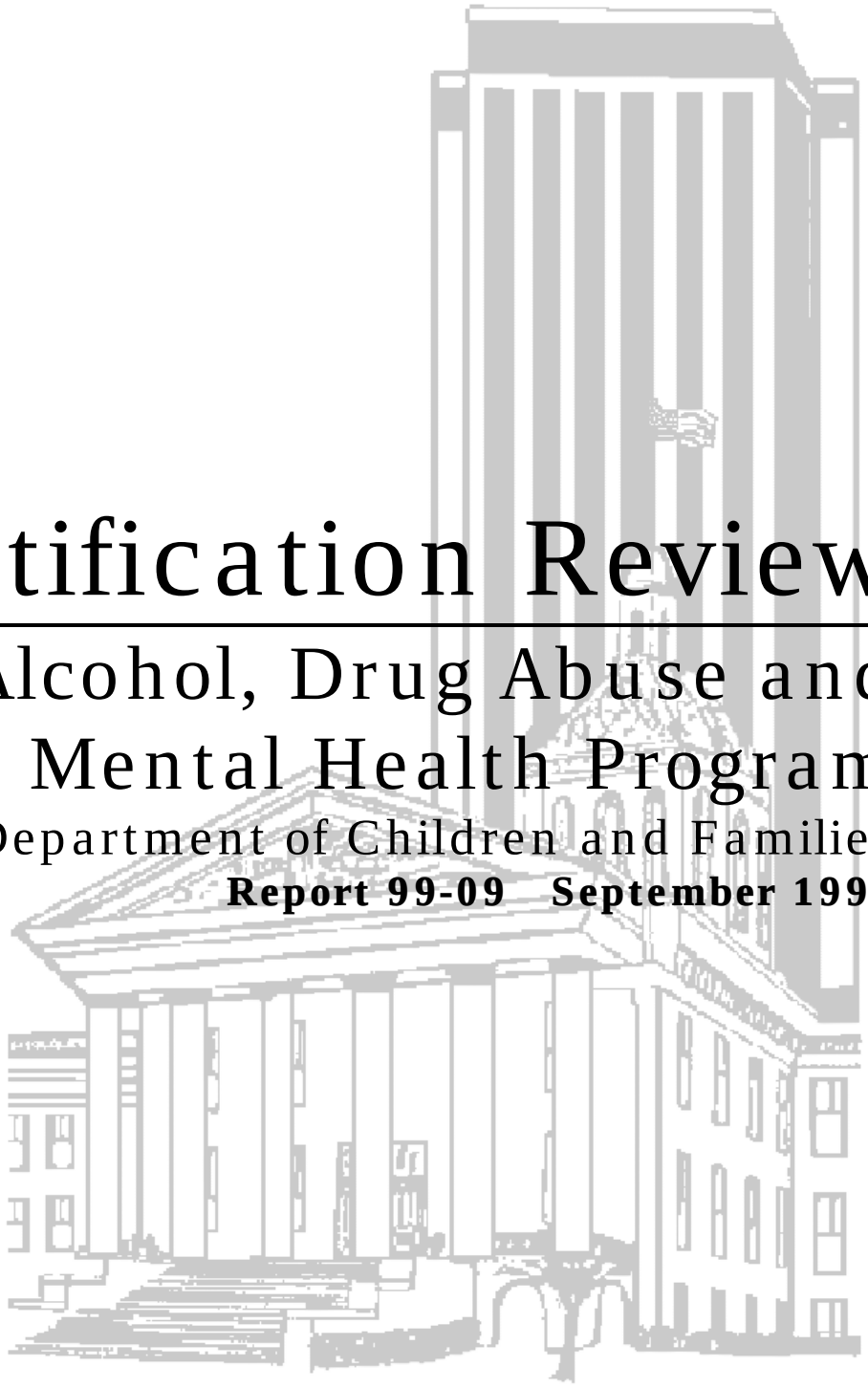

Justification Review

Alcohol, Drug Abuse and Mental Health Program

Department of Children and Families

Report 99-09 September 1999

Office of Program Policy Analysis and Government Accountability

an office of the Florida Legislature

The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

John W. Turcotte, Director

September 1999

The President of the Senate,
the Speaker of the House of Representatives,
and the Joint Legislative Auditing Committee

I have directed that a program evaluation and justification review be made of the Alcohol, Drug Abuse and Mental Health Program administered by the Department of Children and Families. The results of this review are presented to you in this report. This review was made as a part of a series of justification reviews to be conducted by OPPAGA under the Government Performance and Accountability Act of 1994. This review was conducted by Sibylle Allendorff, Richard Dolan, Marti Harkness, Steve Harkreader, and Jim Russell under the supervision of Frank Alvarez.

We wish to express our appreciation to the staff of the Department of Children and Families for their assistance.

Sincerely,

John W. Turcotte
Director

111 West Madison Street ■ Room 312 ■ Claude Pepper Building ■ Tallahassee, Florida 32399-1475
850/488-0021 SUNCOM 278-0021 FAX 850/487-3804

Table of Contents

Executive Summary

Alcohol, Drug Abuse and Mental Health Program

Purpose

This is second of two reports presenting the results of our Program Evaluation and Justification Review of the Department of Children and Families' Alcohol, Drug Abuse and Mental Health Program. State law directs OPPAGA to conduct justification reviews of each program during its second year of operating under a performance-based budget. Justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs.

Background

The Alcohol, Drug Abuse and Mental Health Program provides prevention, intervention, and treatment services to reduce the occurrence, severity, and disabling effects of mental health and substance abuse problems. The department is charged with treating program clients with the most appropriate services in the least restrictive setting. The Department of Children and Families contracts for client services with approximately 280 private for-profit and not-for-profit providers that deliver a variety of services, such as residential treatment, outpatient treatment, and case management services. During Fiscal Year 1997-98, the program reported providing services to approximately 351,000 clients.

Program Benefit, Placement, and Performance

The program is a benefit to Florida taxpayers and should be continued

The program provides beneficial services to clients and a cost benefit to Florida's citizens. In the absence of program services, individuals with mental illness or substance abuse problems may engage in criminal activity or be prone to hospitalization,

unemployment, homelessness, and dependence on welfare, all of which represent an economic burden on society. Children who are not treated for mental illness or substance abuse problems may experience problems such as school failure, family discord, violence, or suicide. Many children and adolescents who do not receive treatment end up in the juvenile justice or foster care systems.

The program should remain within the Department of Children and Families

The Alcohol, Drug Abuse and Mental Health program should remain within the Department of Children and Families. Although program stakeholders have suggested moving the program to the Department of Health, we believe there are no compelling reasons for transferring the program. A primary obstacle to making this change is the county-based administrative structure of the Department of Health. It would be difficult for many smaller county public health units to administer contracts with provider agencies due to staffing limitations. In addition, because many providers contract to provide program services in more than one county, the possibility of having these providers contract with each county would increase administrative costs and may adversely affect service delivery.

The program is already highly privatized

With the exception of its administrative oversight functions and activities, the program is essentially fully privatized. Although it is theoretically possible to privatize department functions, it would not be desirable to do so because oversight of public monies is an appropriate government activity.

The program is generally effective in achieving its goals

Data from the first half of Fiscal Year 1998-99 shows that the program was generally effective in keeping clients in the community where they receive less expensive care. For example, chronically mentally ill adults spent an average of 342 days in the community, an improvement over the two previous fiscal years. Program services were also effective in maintaining or improving the functioning of most clients. The functional level of 79% of the adults receiving program services either remained the same or improved during the first six months of the 1998-99 fiscal year. In addition, clients who received substance abuse treatment had better employment outcomes that those who did not complete treatment.

Options for Improvement

Service delivery is not well coordinated for some clients

We found two deficiencies in the program's service delivery system that impair client success and diminish program effectiveness. First, some clients served by more than one provider may not be getting the treatment they need to function better due to insufficient coordination of services between providers. Second, services for program clients who also receive services from other

department programs, such as Family Safety and Preservation, or other social services agencies, such as the departments of Juvenile Justice, Education, and Corrections, are not efficiently and effectively coordinated to help clients achieve positive outcomes. We recommend that the department expand the use of provider networks and, in some areas, independent case management to improve service coordination. The department should also explore strategies such as pooled funding and formalized collaboration procedures to improve interagency coordination.

Further improvements needed to the program's accountability system

The program's accountability system has a number of deficiencies that hinder the Legislature's and the department's oversight responsibilities. Continuing data problems preclude the department's assessment of the forensic client subprogram and some service providers. In addition, problems with the department's monitoring system impede efforts to assess provider performance. We also concluded that performance standards should be flexible to better assess providers who serve more severe clients and that additional intermediate and process measures are needed to better assess provider performance. To improve monitoring efforts, we recommend that the department modify its monitoring process to focus on clinical practices to determine effects of treatment services on clients. In addition, the department should identify best practices used by providers and disseminate these practices for use in other service districts. To improve the assessment of provider performance, we recommend that the department adopt different performance standards for which providers would be held responsible and adopt additional performance measures that would focus on specific treatment services.

Legislative and department actions needed to expand use of managed care contracts

The department currently uses unit cost contracts to purchase services for mental health and substance abuse clients. Managed care initiatives have been successfully implemented in several service districts and there are advantages to expanding the use of managed care contracts. For example, managed care contracts shift the financial risk to the managed care organization. However, we recommend that the Legislature consider a number of issues prior to expanding the scope of managed care contracts, such as which clients will be eligible for services and how managed care will be funded.

Agency Response

The Secretary of the Department of Children and Families provided a written response to our preliminary and tentative findings and recommendations. She generally agreed with our

findings and recommendations and outlined actions that the department plans to take to improve the program. The Secretary also provided updated Fiscal Year 1998-99 data for the children's substance abuse target group. (See Appendix B, page 52, for her response.)

Chapter 1

Introduction

Purpose

This is the last of four reports presenting the results of OPPAGA's Program Evaluation and Justification Review of the Department of Children and Families' Alcohol, Drug Abuse and Mental Health (ADM) Program. These reports assess the department's community-based services that have been included in a performance-based budget for the 1997-98 fiscal year. [1] The 1994 Government Performance and Accountability Act directs OPPAGA to conduct justification reviews of each program during its second year of operation under a performance-based budget. Justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs.

In January and February 1999, we published three reports presenting our analyses of the program's performance measures and standards.[2] Each of the three previously published reports deals with a subprogram of the Alcohol, Drug Abuse and Mental Health Program. The three subprograms are Children's Mental Health, Children and Families' Substance Abuse, and Adult Community Mental Health.

This report analyzes policy alternatives for improving program services and reducing costs for the three subprograms. Appendix A is a summary of our conclusions regarding the nine issue areas the law requires OPPAGA to consider in a program evaluation and justification review.

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[1] The department's state mental health institutions will be discussed in a subsequent review.

[2] OPPAGA Report No. 98-43, January 1999; Report No. 98-49, February 1999; and Report No. 98-52, February 1999, addressed the program's performance based on its performance-based program budgeting measures and standards and made recommendations for improving these measures and standards. Together, these four reports address the areas the law requires be addressed in a justification review.

Background

The major goals of the Alcohol, Drug Abuse and Mental Health Program are to provide

- prevention, intervention and treatment services to meet the needs of substance abusers and reduce the financial consequences of substance abuse;
- mental health services to support adults with mental illness in the community; and
- services to enable children and adolescents with mental health problems to live with their families or in the least restrictive setting.

For Fiscal Year 1997-98, the program reported providing services to approximately 351,000 clients. Total appropriations and allocations for program services were approximately $630 million in the 1998-99 fiscal year.

Client Services

The program provides a variety of services that are briefly described below.

- **Case management services** involve identifying clients' needs, planning and coordinating the services they need, monitoring service delivery, and evaluating service effectiveness.
- **Outpatient services** include providing therapeutic counseling and medications management to improve functioning or prevent further deterioration of mental health or a relapse into substance abuse.
- **Community support services** include a variety of non-residential care services that include crisis support, day treatment, in-home services, medical care, sheltered and supported employment services, and supported housing services.
- **Inpatient and crisis stabilization services** include acute care services for intensive treatment of persons exhibiting violent or suicidal behaviors or other severe disturbances due to mental illness, and detoxification services for substance abusing individuals.
- **Residential services** include a range of assessment, support, and therapeutic services in a supervised, non-hospital setting. Four levels of residential services provide varying degrees of supervision and support. The most intensive, Level 1, provides a structured setting with 24-hour supervision. The least

intensive, Level 4, provides less than 24-hour supervision and primarily supports independent living.

Exhibit 1-1 shows the cost per day for each of four levels of residential care, along with the average length of stay and the number of clients served in those facilities for the 1997-98 fiscal year.

Exhibit 1-1
The Program Provided Four Levels of Residential Care in Fiscal Year 1997-98

Residential Level	Cost Per Day	Average Length of Stay, Number of Days	Number of Clients
1	$204.09	46	5,131
2	154.34	74	14,901
3	96.87	134	3,637
4	44.09	137	1,536

Source: Department of Children and Families.

Program Organization

Program services are provided by private mental health centers and substance abuse treatment agencies. The Department of Children and Families' 15 service districts contract with these providers for service delivery. In addition to monitoring contracts with providers, district office program staff monitor provider performance. Central office program staff oversee state level planning and policy development.

For Fiscal Year 1998-99, the department assigned 183.5 full-time equivalent (FTE) positions to administer the program. Of these positions, 62 FTEs were central office program staff and 121.5 FTEs were district office program staff.

Program Resources

The ADM Program receives funding from several sources. Two major sources are state general revenue and Medicaid funding, with federal grants and other state trust funds accounting for the remaining resources allocated to the program. Exhibit 1-2 reflects resources by major source for the 1998-99 fiscal year.

Exhibit 1-2
ADM General Revenue, Trust Fund, and Medicaid Appropriations and Allocations for Fiscal Year 1998-99

Funding Source	Administration (Districts and Central Office)	Children's Mental Health	Adult Community Mental Health	Alcohol and Substance Abuse	Total
General Revenue	$6,203,054	$ 60,082,981	$158,285,956	$ 46,778,593	$271,350,584
Trust Funds	2,544,400	19,772,493	21,110,887	77,283,414	120,711,194
Medicaid		137,279,990	91,562,258	9,020,904[1]	237,863,152
Total	**$8,747,454**	**$217,135,464**	**$270,959,101**	**$133,082,911**	**$629,924,930**

[1]Agency for Health Care Administration analysis of 1997-98 paid claims with a primary diagnosis of substance abuse.

Source: Department of Children and Families and the Agency for Health Care Administration.

Provider Contracts

The Department of Children and Families contracts for client services with approximately 280 private for-profit and not-for-profit providers that deliver a variety of services. Providers may be not-for-profit or for-profit entities and include community mental health centers, substance abuse treatment and prevention centers, public and private psychiatric hospitals, and private mental health professionals.

The program provides services through six types of providers.

- **Comprehensive providers** provide case management, outpatient, community, and residential services. Some comprehensive providers also provide acute care services.
- **Community providers** provide one or more community-based services (day treatment, in-home, sheltered employment, supported employment, supported housing, crisis support, etc.) These providers do not offer acute care, residential, or outpatient services.
- **Residential care providers** provide primarily residential services. In connection with the residential services many but not all also provide some community, case management, or outpatient services.
- **Non-comprehensive acute care providers** provide crisis stabilization, inpatient, or de-tox services. Most of these providers also provide some type of community and case management service. About one-half also provide outpatient and residential services.

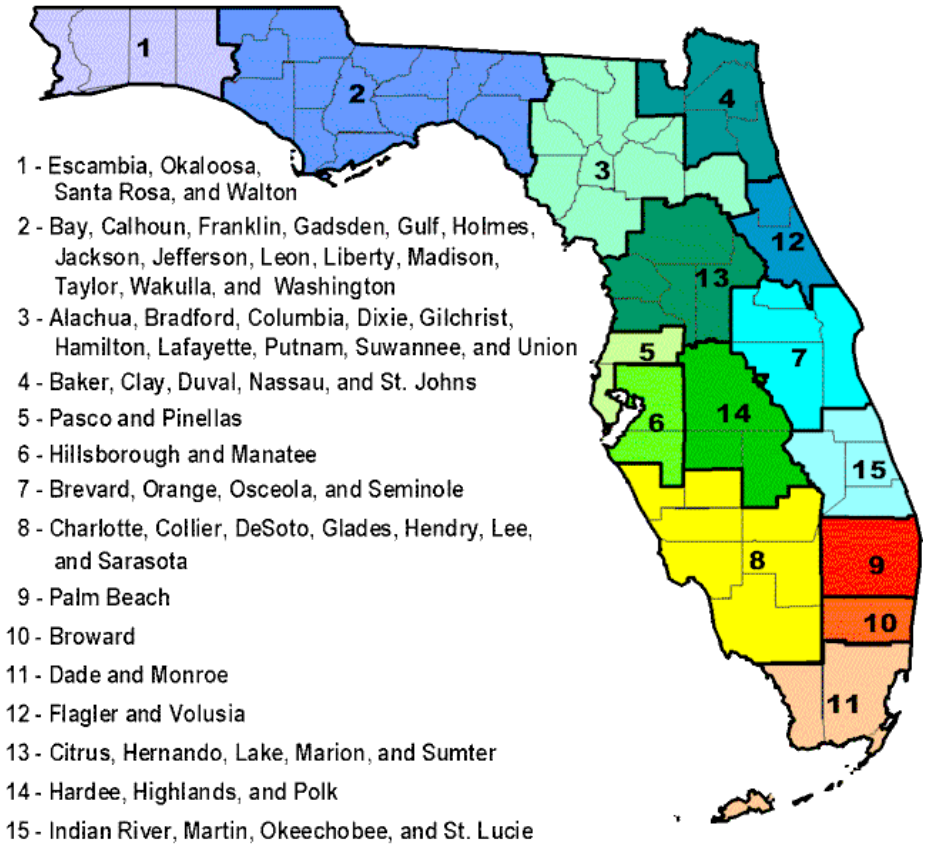
- **Outpatient service providers** provide only outpatient medical services, behavioral therapy, and medication management from primarily clinic locations.
- **Specialty providers** provide limited types of services, usually involving only 1 of the 27 potential service cost centers. About one-half of specialty providers are residential providers (primarily levels 1 and 2). About one-third provide a specific community service (e.g., day treatment, in-home services).

The number and type of specialty providers varies among the 15 department districts, ranging from 8 in Districts 3 and 13 to 59 in District 11. (See Exhibit 1-3.) Many specialty providers offer services in more than one district. For the 1998-99 fiscal year, SAMAS and agency reports indicate that

- 37% provide services in more than one of the three ADM programs,
- 25% provide only substance abuse services,
- 24% provide only children's mental health services, and
- 13% provide only adult mental health services.[3]

[3] Percentages do not add to 100% due to rounding.

Exhibit 1-3
Department of Children and Families, 15 Districts



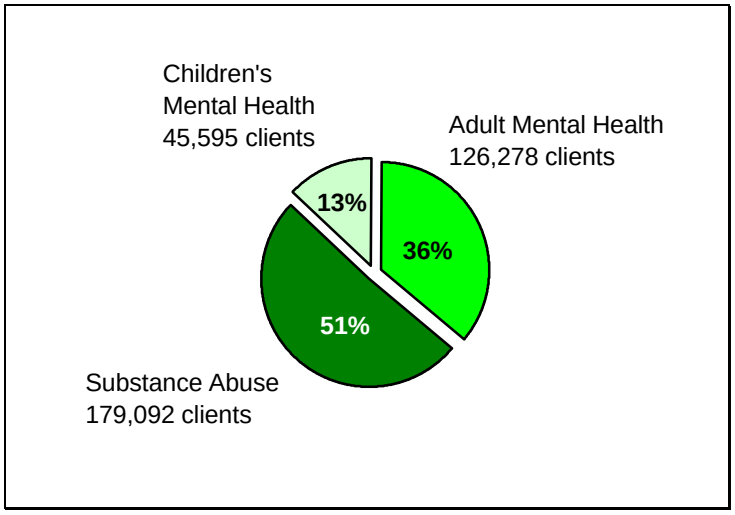
1 - Escambia, Okaloosa, Santa Rosa, and Walton
2 - Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
3 - Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Putnam, Suwannee, and Union
4 - Baker, Clay, Duval, Nassau, and St. Johns
5 - Pasco and Pinellas
6 - Hillsborough and Manatee
7 - Brevard, Orange, Osceola, and Seminole
8 - Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
9 - Palm Beach
10 - Broward
11 - Dade and Monroe
12 - Flagler and Volusia
13 - Citrus, Hernando, Lake, Marion, and Sumter
14 - Hardee, Highlands, and Polk
15 - Indian River, Martin, Okeechobee, and St. Lucie

Source: Department of Children and Families.

Clients Served

The program reported providing services to approximately 351,000 clients in the 1997-98 fiscal year. (See Exhibit 1-4.)

Exhibit 1-4
The Program Served 350,965 Clients in Three Subprograms During Fiscal Year 1997-98



Source: OPPAGA analysis of Fiscal Year 1997-98 performance data.

Each subprogram includes specified target groups.

Adult Mental Health Subprogram—126,278 clients

Adult Mental Health Target Populations

- **Adults with severe and persistent mental illness** includes individuals whose chronic psychiatric disabilities make them eligible for disability income.
- **Adults in mental health crisis** includes individuals who do not have a chronic psychiatric disability, but, due to a recent severe stressful event, meet the admission criteria of a psychiatric facility.
- **Adults with forensic involvement** includes individuals the court has placed in a community mental health program as a condition of their release.

Children's Mental Health Subprogram—45,595 clients

Children's Mental Health Target Populations

- **Seriously emotionally disturbed** - includes children under the age of 18 years who meet one of the following criteria.
  - Diagnosis of schizophrenia or other psychotic disorder, major depression, mood disorder or personality disorder

  - Diagnosis of another allowable *Diagnostic and Statistical Manual* diagnosis and a Children's Global Assessment Scale of 50 or below[4]
  - Currently classified as student with serious emotional disturbance by a local school district
  - Currently receiving Supplemental Security Income benefits for a psychiatric disability
- **Emotionally disturbed** - includes children under the age of 18 years who meet one of the following criteria.
  - Diagnosis of another allowable *Diagnostic and Statistical Manual* diagnosis and a Children's Global Assessment Scale of 51 to 60[4]
  - Currently classified as a student with an emotional handicap by a local school district
- **At risk** - includes children under the age of 18 years who meet one of the following criteria
  - Current referral for placement in a program for students with emotional handicaps in accordance with the Individuals with Disabilities Education Act
  - Verified maltreatment per the Department of Children and Families' Family Safety and Preservation Program or similar program or agency in another state

Substance Abuse Subprogram--179,092 clients

Adult Substance Abuse Target Populations (118,755 clients)

- **Criminal Justice involved** includes individuals with a primary or secondary diagnosis or diagnostic impression of psychoactive substance use disorder and the court has mandated substance abuse treatment services or the individual is under the community supervision of a criminal justice entity
- **Parents putting children at risk** includes pregnant women, parents with children, and parents referred by Family Safety and Preservation
- **Dually diagnosed** includes individuals with a primary or secondary diagnosis or diagnostic impression of psychoactive substance use disorder combined with a mental illness
- **Intravenous drug users** includes individuals with a primary or secondary diagnosis or diagnostic impression of psychoactive substance use disorder and using or having a history of intravenous drug use

[4] Allowable diagnoses are mental retardation, pervasive developmental disorder (including autism), substance abuse, communication disorders, learning disorder, and other factors as specified in the *Diagnosis and Statistical Manual.*

- **Other** includes individuals with a primary or secondary diagnosis or diagnostic impression of psychoactive substance use disorder or determined to be at risk of abusing alcohol or other drugs

Children's Substance Abuse Target Populations (60,337 clients)

- **Children under state supervision** includes Department of Juvenile Justice or Department of Children and Families' Family Safety and Preservation Program involvement
- **Children not under state supervision** includes referrals from schools, other community agencies, and self or family referrals
- **Children at risk** includes individuals or groups identified as having behavioral, biological or environmental characteristics that place them at risk for using alcohol, tobacco, or other drugs

Chapter 2

General Conclusions and Recommendations

Introduction

The Department of Children and Families established its community-based Alcohol, Drug Abuse and Mental Health Program under performance-based program budgeting in Fiscal Year 1997-98. The program provides prevention, intervention, and treatment services to reduce the occurrence, severity, and disabling effects of mental health and substance abuse problems. The department is charged with treating program clients with the most appropriate services in the least restrictive setting.

Program Need

The Program Is Beneficial and Should Be Continued

The program provides beneficial services to clients and a cost benefit to Florida's citizens. In the absence of program services, individuals with mental illness or substance abuse problems may engage in criminal activity or be prone to hospitalization, unemployment, homelessness, and dependence on welfare, all of which represent an economic burden on society. Children who are not treated for mental illness or substance abuse problems may experience problems such as school failure, family discord, violence, or suicide. Many children and adolescents who do not receive treatment end up in the juvenile justice or foster care systems. For example, 19% of the children and adolescents admitted into a residential commitment facility within the Department of Juvenile Justice during the 1997-98 fiscal year were diagnosed as having severe or moderate mental illness.

Several national studies indicate that treating mental illness and substance abuse problems is cost effective. A 1994 study conducted by the RAND Corporation concluded that for every $1 invested in substance abuse treatment taxpayers received a $7 return in savings. These cost savings were realized primarily

through reductions in criminal activities and hospitalizations. Another 1994 national study concluded that emergency room admissions for a targeted population were reduced by one-third after these substance-abusing individuals received substance abuse treatment.[5] Similarly, national studies estimated that cost savings ranged from $3 to $8 for every $1 spent on mental health treatment. Maintaining a client in a state mental institution in Florida is almost 13 times more costly than providing services in a community setting.

The Program Is Appropriately Administered by the Department of Children and Families

Although some persons have advocated transferring the program to the Department of Health, we do not believe this change is needed. Some private provider staff we interviewed expressed the opinion that the Legislature should transfer the administration of program services from the Department of Children and Families to the Department of Health. Proponents indicated that the primary advantage to making this change would be to encourage the public to view mental illness and substance abuse as health problems rather than problems requiring social services.

Opponents counter with the argument that service delivery for this program has been traditionally based in the Department of Children and Families because it offers a broader spectrum of care than the Department of Health. Opponents have concerns that placing the program within the Department of Health would shift attention away from the counseling aspects of treatment and would emphasize the use of drugs to treat mental illness and substance abuse problems.

We believe there are no compelling reasons for transferring the program. A primary obstacle to making this change is the county-based administrative structure of the Department of Health. It would be difficult for many smaller county public health units to administer contracts with provider agencies due to staffing limitations. In addition, because many providers contract to provide program services in more than one county, the possibility of having these providers contract with each county would increase administrative costs and may adversely affect service delivery.

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[5] *Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA),* July 1994.

Potential for Privatization

Program Is Already Highly Privatized

The program has an appropriate level of privatization. The program operates with a mix of state employees who provide administrative functions and private providers who provide direct services to clients. The department's 15 service districts contract with nonprofit mental health centers and substance abuse agencies for program services. Because of a high level of privatization, the department employs a low number of staff relative to its $629.9 million budget. For Fiscal Year 1998-99, the department assigned 183.5 full-time equivalent (FTE) staff positions to the program (62 staff at the central office and 121.5 staff in district offices). In addition to managing contracts with service providers, district program staff monitor provider performance. Central office program staff oversee state level planning and policy development.

With the exception of its administrative oversight functions and activities, the program is essentially fully privatized. Although it is theoretically possible to privatize department functions, it would not be desirable to do so because oversight of public monies is an appropriate government activity.

It also would not be desirable for the state to take over the functions currently performed by private provider agencies. The department has contracted with private providers for service delivery since the program's establishment in the 1960s. Through the years the state has made a substantial investment in funding this program, some of which has gone to help build mental health and substance abuse treatment centers. As of June 1999, 280 community mental health centers and substance abuse treatment agencies were providing services to program clients. It would not be practical to dismantle the structure that is in place and replace it with a large state entity. Doing this would create an unnecessary state bureaucracy, may also diminish the involvement of local entities in the planning and delivery of program services, and hinder the program's ability to respond to local service needs. Further, under the current system local government and charitable agencies provide funding and in-kind services to community mental health centers and substance abuse treatment agencies. This local funding may not be made available if the state were to take over functions performed by private providers.

Ways to Improve Performance

Although the Alcohol, Drug Abuse and Mental Health Program has been reasonably successful (see Chapter 3), we identified problems with how the department has implemented the program that impede its ability to improve client outcomes. These problems involve deficiencies with the program's service delivery, accountability, and contracting systems.

- Problems with the program's service delivery system impair client success and diminish program effectiveness. Services for clients served by more than one provider agency or by multiple social services programs, such as child welfare and juvenile justice, generally are not effectively coordinated. This is problematic because clients may not receive the services they need to benefit from the program, and the state may be paying more for services than is necessary due to duplicative and inefficient practices. The Legislature has passed initiatives and the department has implemented demonstration projects intended to improve coordination of services for these client populations. These demonstration projects appear to be effective and could be implemented statewide. The department should implement more formal coordination mechanisms in districts where they currently do not exist. (See Chapter 4.)
- Deficiencies with the program's accountability system continue to hinder the Legislature's and the department's oversight responsibilities. Continuing concerns about data reliability limit the Legislature's ability to confidently assess program effectiveness for the adult mental health target group and adults with forensic involvement. In addition, problems with department monitoring impede efforts to efficiently and effectively monitor provider performance in order to improve client outcomes. Although the department has taken corrective action to improve data reliability and improve its monitoring system, it should take additional action to make further improvements. (See Chapter 5.)
- During the 1990s the Legislature authorized and the department implemented the use of unit cost or performance contracts, which are an improvement over previous contracting methods because they contain performance requirements. However, the program's current contracting system has drawbacks that limit its effectiveness. One option to address the limitations of the current unit cost contracting system is to implement managed care contracts. Managed care contracts offer important benefits, but the Legislature and the department need to address several issues in order to be prepared to implement a managed behavioral health care system.

The department needs to address the issues discussed above in order to more efficiently and effectively use program resources and to achieve better client outcomes. To maximize client outcomes and minimize state costs, the department needs to correct deficiencies with its service delivery, accountability, and contracting systems. Many of the recommended solutions to these problems are components of a managed behavioral health care system, which the department should take the necessary prerequisite steps to implement. (See Chapter 6.)

Issue for Further Study

The Department Needs to Study Post-Release Outcomes for Clients Served in the Children's Mental Health Subprogram

The department does not track clients after their release from the Children's Mental Health subprogram to determine whether they are successfully living in the community or whether they are incarcerated or hospitalized. This information is critical in light of district office and staffs' concerns that the Children's Mental Health subprogram does not adequately prepare adolescents discharged from the program for transition into independent living. At age 18, Children's Mental Health subprogram clients are ineligible to receive services. If these clients subsequently meet eligibility criteria for the adult mental health subprogram, they may be admitted into that subprogram and continue receiving services. However, the adult program is designed to meet different needs, and program services are oriented towards the target population of severe and persistent mentally ill. Adult clients are typically diagnosed with schizophrenia, bipolar or psychotic disorders, which are characteristically not typical for clients of the Children's Mental Health subprogram.

Staff had concerns that adolescents who are not referred to the adult system are released into the community without the necessary support to enable them to function appropriately. If clients do not receive needed services, staff believe that after their release from the children's program some of these adolescents will either commit crimes or their mental conditions will deteriorate to the point that they will require more intensive and costly services to stabilize them. Some staff believe that post-release services such as group homes and supported independent living may offer adolescents a structured environment that would facilitate their transition into independent living and are less costly than incarceration or hospitalization.

The department has not systematically collected information that would help it determine the magnitude of this perceived problem and whether it merits further department action. The department should collect and analyze information to determine the post-release outcomes of adolescents released from the Children's Mental Health subprogram. (See Chapter 3.) This information should include information from discharge plans such as level of functioning and the need for particular types of services. In addition, the program should track these clients' involvement with the Corrections and Health departments and the Department of Children and Families' Family Safety and Preservation Program. This information would help department managers and policymakers to better plan for and evaluate the cost-effectiveness of providing different or additional services to achieve improved outcomes with this population.

Chapter 3

The Program Is Generally Effective in Achieving Its Goals

Introduction

We were able to assess program effectiveness for only the first six months of the 1998-99 fiscal year. Historically, the department has not had effective performance accountability systems to assess the efficiency and effectiveness of community-based mental health and substance abuse services. In OPPAGA Report No. 97-61, we identified four factors that have limited the program's ability to establish mechanisms to hold community mental health providers accountable for program performance. First, the program was originally established as a grant-in-aid mechanism with very limited state oversight. Providers were not required to report information on the number of clients they served, the services provided to individual clients, the costs of these services, and how these services benefited clients. Second, the state did not establish any eligibility criteria regarding the clients that mental health centers were to serve. Third, confidentiality requirements were interpreted to forbid mental health providers from disclosing information about individuals with mental illness without the clients' informed consent. Finally, community mental health service delivery has been highly decentralized. Although the program's central office promulgates rules governing the program in general, each of the department's 15 service districts contracts with providers for service delivery. As a result of these factors, community mental health centers operated relatively autonomously and the state had a limited ability to hold providers accountable for client outcomes.

A factor that continues to impede the department's ability to hold some providers accountable for their performance is the lack of reliable information about client outcomes. In our prior reports addressing program performance, we identified problems with data reliability that limited our ability to make conclusions about program effectiveness for the 1997-98 fiscal year. (See OPPAGA Report Nos. 98-43, 98-49, and 98-52.)

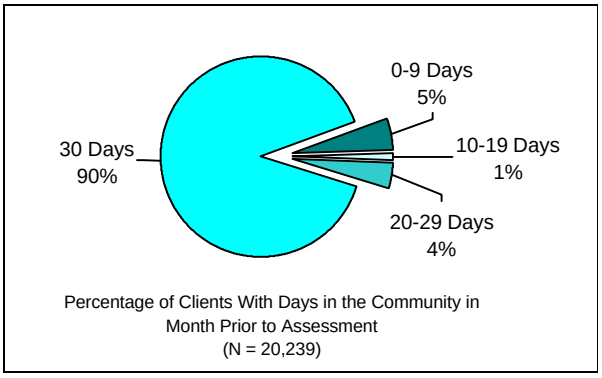
For the 1998-99 fiscal year the department took steps to improve the reliability of its program performance data. These corrective

actions are addressed more fully in Chapter 5 of this report. Due to the improvements in data quality for the 1998-99 fiscal year and the timing of this review, we were able to do a limited assessment of program performance for the first six months of the 1998-99 fiscal year. Our conclusions about the performance of the three subprograms are presented below.

Adult Community Mental Health Services Are Reasonably Effective in Keeping Adults With Mental Illness in the Community

A primary goal of the program is to maintain adults with mental illness in a community setting and avoid placement in expensive crisis stabilization or in-patient facilities, such as psychiatric hospitals. Program performance data for the first six months of Fiscal Year 1998-99 indicate that treatment for the most chronically ill adults helped to keep these clients in the community for a projected annualized average of 342 days. This level of performance is short of meeting the department's Fiscal Year 1998-99 standard of 345 days, but suggests an improvement over prior years. Although the data from prior fiscal years were incomplete, the estimated number of days that clients spent in the community for the 1996-97 and 1997-98 fiscal years was 324 and 333, respectively. As shown in Exhibit 3-1, 90% of this client population (i.e., adults with severe and persistent mental illness) spent all their time in the community rather than in crisis stabilization units, short-term residential facilities, mental health hospitals, jail, or homeless.

Exhibit 3-1
Mental Health Treatment Effective in Keeping Chronically Mentally Ill Adults in the Community



Source: OPPAGA analysis of Fiscal Year 1998-99 performance data.

Program services are also successful in maintaining or improving the functioning of most clients. To ascertain each client's functional level, the department uses an assessment instrument called the Global Assessment of Functioning. This instrument measures how well the individual functions in performing routine daily activities, such as interacting socially with others and performing typical work tasks. The functional level of 79% of adults receiving program services either remained the same or improved during the first six months of the 1998-99 fiscal year. The department does not have a performance standard or report historical information that could be used to assess whether this outcome has improved over time. However, given the chronic debilitating nature of severe and persistent mental illness, the program's performance in this area appears to be reasonable.

In addition to days in the community and clients' abilities to function, the department tracks the clients' abilities to live independently in the community using measures of employment and financial support. The subprogram seeks to improve clients' financial situation and obtain employment by improving client functioning and, where program resources allow, by providing sheltered and supported employment services.

For the first six months of the 1998-99 fiscal year the average monthly support for these clients was $569, successfully exceeding the department's target of an average of $550. Although only at a subsistence level, the department's target is reasonable and surpassing the target indicates positive performance.

Increasing the average monthly support of clients is difficult because most of the clients are disabled by their illness and receive disability income. Sixty-three percent receive at least some of their monthly income from government programs (e.g., Social Security, Social Security Disability Income, and public assistance). The median monthly income/support of these clients is $494 a month, approximately what eligible clients would receive from Social Security Disability Income. Only 17% of the clients worked for pay in the month prior to their most recent program assessment.

The program was also reasonably effective in treating clients in the Adults in Mental Health Crisis target group. The department uses the Global Assessment of Functioning instrument to track changes in client functioning and reports an average change score. Global Assessment of Functioning scores range from 1 to 100 with higher scores indicating better functional status. For example, scores from 1 to 10 indicate a persistent danger of hurting self or others, scores between 51 and 60 indicate moderate symptoms such as difficulty in social or occupational functioning, and scores from 91 to 100 indicate superior functioning in a wide range of activities. For clients who were

admitted and discharged within the first six months of Fiscal Year 1998-99, Global Assessment of Functioning scores improved by 17.8 points on average. For clients not discharged during this time period and having at least two assessments during the time period, scores improved by an average of 11.3 points. These numbers translate into 89% of clients included in the analysis improving on their Global Assessment of Functioning scores. The department's target for the 1998-99 fiscal year was an overall average change of 14.7 points.

Adults in mental health crisis do not have a chronic psychiatric disability, but meet the admissions criteria for a psychiatric facility as a result of a recent stressful event in their lives. They have some of the same psychiatric diagnoses (e.g., schizophrenia, bipolar disorders, and depression) as adults with severe and persistent mental illness but their symptoms are usually not as debilitating.

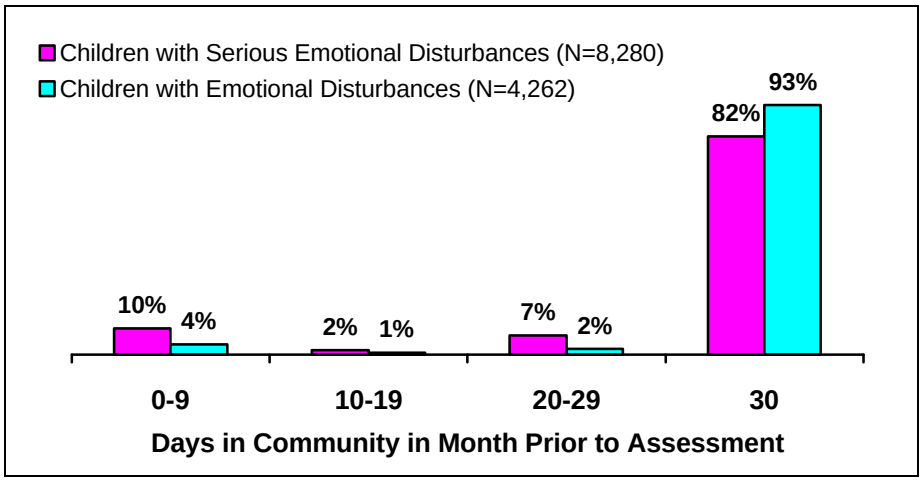
For Fiscal Year 1999-00, a new performance measure for this target group is the percentage of adults in mental health crisis that is re-admitted to a crisis stabilization unit within 30 days. Although most are treated in the community, 27% of the clients in this target group received acute crisis stabilization and inpatient services in the first six months of the 1998-99 fiscal year. Nine percent were re-admitted within 30 days of their release. Typically, adults in crisis were released from these facilities in three days or less. Eighty-one percent stayed a week or less.

Children's Mental Health Services Are Reasonably Effective in Keeping Children in the Community

The goal of providing children's mental health services is to enable children and adolescents to live with their families or in the least restrictive setting and to function in school at a level consistent with their abilities. The subprogram tracks performance measures for two target populations, Children with Serious Emotional Disturbances and Children with Emotional Disturbances. Program performance data for the first six months of Fiscal Year 1998-99 indicate that treatment for the most severely ill children and adolescents, Children with Serious Emotional Disturbances, helped to keep these clients in the community for a projected annualized average of 324 days. This level of performance is short of meeting the Fiscal Year 1998-99 target of 337 days. Although incomplete, data from two prior fiscal years suggests that meeting the target of 337 is reasonable and would indicate an improvement in keeping these clients in the

community. The estimated number of days in the community for the 1996-97 and 1997-98 fiscal years was 312 and 331, respectively. As shown in Exhibit 3-2, 82% of this client population spent all their time in the community rather than in detention or other facilities, homeless, or as a runaway. Even though the subprogram is not meeting its Fiscal Year 1998-99 target, these results show that the program was successful for a large majority of seriously emotional disturbed children in meeting its goal to provide treatment to enable clients to live with their families or in the least restrictive setting.

Exhibit 3-2
Children's Mental Health Services Are Effective in Keeping Children in the Community



Source: OPPAGA analysis of Fiscal Year 1998-99 performance data.

The program was reasonably successful in placing less severely mentally ill children and adolescents in the community. Children served in the emotionally disturbed client population spent a projected annualized average of 347 days in the community. This level of performance meets the department's Fiscal Year 1998-99 target of 345 days. Although incomplete, data from prior fiscal years suggest that the target of 345 days is a reasonable standard for judging program effectiveness. The estimated number of days in the community for the 1996-97 and 1997-98 fiscal years was 324 and 346, respectively. Exhibit 3-2 shows that 93% of this population spent all their time in the community.

In addition, program services were reasonably successful in maintaining or improving the functioning of children served in the seriously emotionally disturbed and emotionally disturbed client populations. To determine the functional level of each client, the department uses an assessment instrument known as the Children's Global Assessment of Functioning Scale (C-GAS). The functional level of 78% of the children and adolescents served in

both of these client groups either remained the same or improved during the first six months of Fiscal Year 1998-99.

The department does not have a standard or report historical information by which to judge if it is reasonable to expect services to maintain or improve the functioning of a larger proportion of these clients. For Fiscal Year 1999-00 the department is tracking and developing targets for a new measure that indicates improvement in emotional conditions and behavior recorded in children's initial assessment.

Adult Substance Abuse Clients Have Reasonably Positive Employment Outcomes

Substance abuse treatment is intended to enable adults with substance abuse problems to be stable, economically self-sufficient, and drug free. An important measure of the success of adult substance abuse services is the percentage of enrolled clients who successfully complete treatment. For the first six months of Fiscal Year 1998-99, 55% of clients discharged from treatment programs were deemed to have successfully completed treatment. The department has defined successful completion as a completed episode of care with no drug use in the 30 days prior to discharge. The subprogram is not meeting the 1998-99 fiscal year standard of 68% of clients successfully completing treatment. In our interviews with substance abuse service providers they questioned the reasonableness of the standard. The nature of the illness is that substance abuse is re-occurring. It is typical for clients to begin treatment and have relapses of substance use while in treatment. Although incomplete, data from the previous fiscal year indicated a successful completion rate of 55%. Additional longitudinal data is needed to establish a reasonable target for this measure.

Another important measure of the effectiveness of adult substance abuse services is whether the person is employed at discharge. The subprogram provides treatment services to primarily low-income, under-employed or unemployed adults. Fifty-eight percent of clients discharged from the program for the period of July through December 1998 were unemployed or not in the labor force at the time they were admitted into the program. The typical client had a personal annual income or family income of less than $10,000.

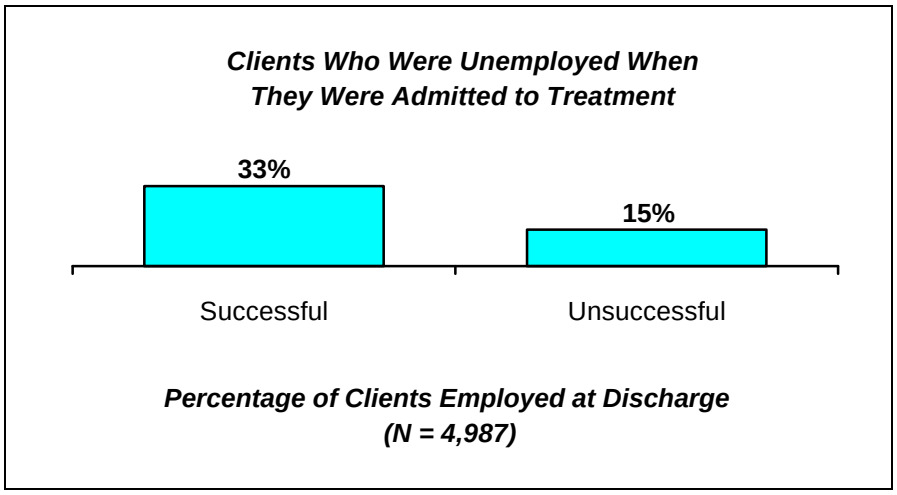
Program data for the first six months of Fiscal Year 1998-99 indicate that 52% of clients were employed at the time of discharge, which is an increase from the 42% who were employed at the time they were admitted in the program. This increase can

be attributed primarily to clients who successfully completed their treatment programs.

Program data for the first six months of Fiscal Year 1998-99 indicate that substance abuse treatment services were reasonably effective in helping clients obtain or maintain employment. Although the employment status of most clients (81%) did not change from their admission to their discharge dates, those clients who successfully completed treatment had better employment outcomes. Clients who successfully completed treatment were more likely to be employed at discharge, whether or not they were employed at admission.

As indicated in Exhibit 3-3, clients who successfully complete treatment have better employment outcomes that those clients who do not successfully complete treatment. For clients who were unemployed at the time they were admitted to treatment, 33% of those clients successfully completing treatment were employed at the time of discharge from the program. This compares favorably to the 15% of clients who did not successfully complete treatment who were employed at the time of discharge.

Exhibit 3-3
Substance Abuse Clients Who Successfully Complete Treatment Have Better Employment Outcomes

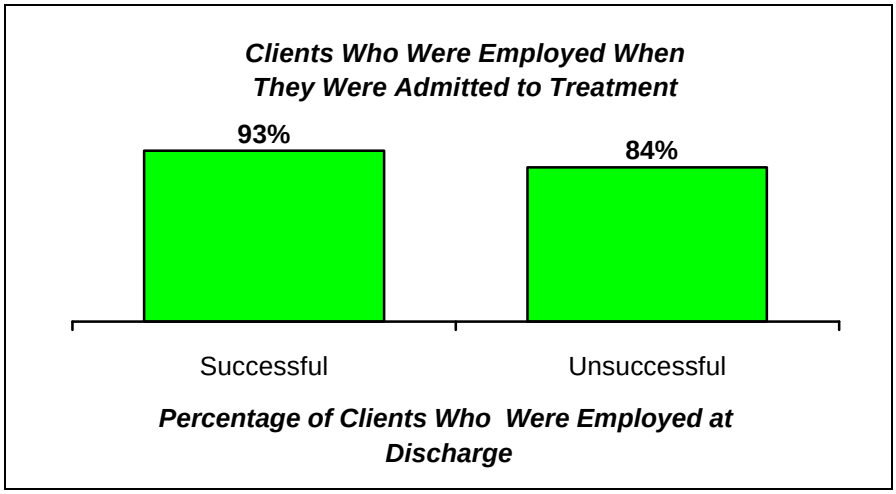


Source: OPPAGA analysis of Fiscal Year 1998-99 performance data.

As indicated in Exhibit 3-4, program services were also effective in helping clients maintain employment. For clients who were employed when they were admitted to treatment, 93% of the clients who successfully completed treatment were employed at the time of discharge, compared to 84% who did not successfully complete treatment who were employed at discharge. Program

data indicate that clients who successfully complete treatment are more likely to obtain and maintain employment than those clients who do not successfully complete treatment.

Exhibit 3-4
Substance Abuse Clients Who Successfully Complete Treatment Have Better Employment Outcomes



Source: OPPAGA analysis of Fiscal Year 1998-99 performance data.

While performance data indicate that program services have helped clients in the short-term, the department has not collected information on the long-term effects of substance abuse treatment on program clients. However, the department will begin collecting data in Fiscal Year 1999-00 that will enable it to make conclusions about whether clients who successfully complete treatment remain substance free. For Fiscal Year 1999-00, the department proposed and the Legislature adopted a measure on the percentage of clients who are drug free at six months following completion of treatment. The department will propose a standard for this measure after establishing a baseline level of performance in Fiscal Year 1999-00.

Chapter 4

Improved Coordination of Services Would Result in Better Client Outcomes

Introduction

An effective service delivery system is essential to ensure that public monies are used to achieve desired outcomes. To ensure optimal outcomes, program services should meet client needs and be provided at the least cost to the state. To meet client needs, services should be comprehensive and should be provided with minimal disruption to the client. One of the critical components of a good service delivery system is the efficient and effective coordination of services between providers and social services agencies involved in providing treatment to program clients.

We identified two coordination problems with the service delivery system that impair client success and diminish program effectiveness.

- Clients served by more than one provider may not be getting the treatment they need to function better due to poor coordination of services between providers.
- Services for program clients who also receive services from other department programs, such as Family Safety and Preservation, or other social services agencies, such as the departments of Juvenile Justice, Education, and Corrections, are not efficiently and effectively coordinated to help clients achieve positive outcomes.

Need for Coordinating Services for Clients Served by Multiple Providers

The first weakness we identified in the program's service delivery system is the integration of services for clients receiving treatment by more than one provider agency. Many program clients have needs that require services from more than one provider. For

example, clients who have mental illness and substance abuse problems may need the services of a mental health provider as well as a substance abuse provider. For Fiscal Year 1997-98, 12% of all substance abuse subprogram clients were diagnosed as being both mentally ill and substance abusers. Overall, approximately 7% of the program clients (9,085 individuals) served during the first six months of the 1998-99 fiscal year received services from two or more providers.[6] The percentage of clients served by multiple providers varied among districts, ranging from a low of 3.2% of all clients in District 3 to a high of 11% of all clients in District 4. (See Exhibit 4-1.)

Exhibit 4-1
The Percentage of ADM Clients That Receive Services From Two or More Service Providers Varies by District

District	Percentage of Clients Receiving Services from: One Provider	Two or More Providers
1	93.9%	6.1%
2	96.3%	3.7%
3	96.8%	3.2%
4	89.0%	11.0%
5	91.2%	8.8%
6	95.4%	4.6%
7	92.2%	7.8%
8	94.6%	5.4%
9	92.9%	7.1%
10	91.1%	8.9%
11	95.0%	5.0%
12	90.8%	9.2%
13	94.2%	5.8%
14	94.0%	6.0%
15	94.1%	5.9%
Statewide Average (N=127,273)	**92.9%**	**7.1%**

Source: OPPAGA analysis of Fiscal Year 1998-99 program data.

District staff indicated that services for clients with multiple providers are often not well coordinated primarily due to case management problems. Case managers are responsible for directing clients to appropriate providers to receive the services they need and for monitoring clients' progress. The program contracts with mental health providers for case management

[6] Because the data for the first six months of Fiscal Year 1998-99 includes only 71% of providers (198 of 279), these numbers may understate the number of clients served by multiple providers.

services, and these providers typically deliver direct client services as well as case management.

The current case management system creates conflicts of interest that can inhibit the effective coordination of services for these clients. When case management resides with an agency that also provides direct services, case managers may not refer clients to another provider agency because it may lead to a decrease of services provided by the case management provider.[7]

Available data suggest that clients who are served by multiple providers are the most severely ill and require more intensive and costly services. For example, an analysis conducted by department staff in Fiscal Year 1997-98 concluded that clients served by multiple providers have lower average admissions scores for functionality than clients served by one provider. This suggests that clients served by multiple providers have more serious problems at the time they are enrolled in the program and thus are more difficult to serve. Therefore, although this population of clients represents only 7% of the entire population served, effective service delivery can be critical for these clients because they have greater needs and may represent a proportionately larger share of the program's budget.

The Legislature has passed initiatives and the department has implemented demonstration projects intended to help the program better coordinate services for this client population. These initiatives are promising and could be expanded in appropriate districts. These initiatives and demonstration projects include local provider networks that provide comprehensive care across agencies and a case management process that is independent of service providers.

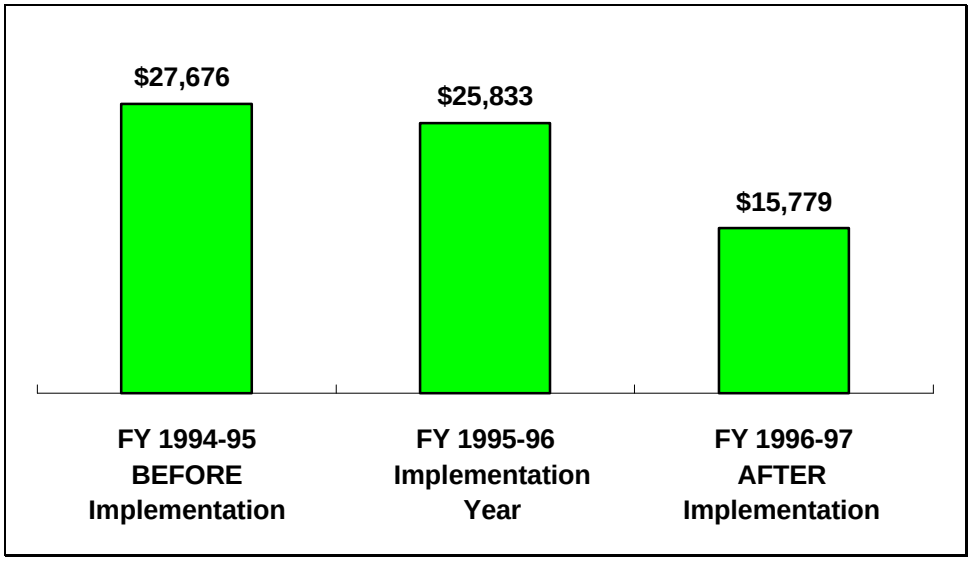
District 6 implemented a provider network system in 1996. Provider networks are formal, legal arrangements between provider agencies for service delivery. The district office contracts with the Central Florida Behavioral Health Network, which subcontracts with one provider agency for the provision of administrative services, including fiscal operations, quality improvement, and evaluation, and with other provider agencies for program services. The network system differs from the systems used in other districts in that the department contracts with the network rather than with individual provider agencies for all program services. Major advantages of the network system are that it provides for a more efficient system for coordinating services due to a central point of access for service delivery and shared planning, decision making, and shared accountability for client outcomes among provider agencies. Although the

[7] District and provider staffs also cited concerns about time constraints on case managers handling large caseloads, thus limiting their ability to coordinate service placements.

department has not conducted any formal analyses of the effectiveness of this system, many provider agency and department staffs we interviewed said that implementing this system in District 6 has helped to better coordinate and expand service delivery.

In Fiscal Year 1995-96, District 7 phased in the implementation of an independent case management system. The system centralizes case management activities within one entity that delivers case management but does not provide direct client services. According to a department report, this system was implemented in part to address problems related to a continuity of care for children's case management and treatment services and a fragmentation of service delivery between community-based services and residential care. An analysis done by district office staff indicated that cost savings have been achieved since the implementation of independent case management. (See Exhibit 4-2.) District staff also identified positive client outcomes, including averages on post-admission scores and consumer satisfaction scores that exceeded the statewide averages.

Exhibit 4-2
Average Cost of District 7 Residential Treatment Services Was Reduced After Implementation of Independent Case Management



Source: OPPAGA analysis of District 7 data.

Need for Coordinating Services for Clients Served by Multiple Programs

Although the Legislature and the department have taken steps to improve coordination within the Alcohol, Drug Abuse and Mental

Health Program, a similar problem exists for program clients who are also served by other social services programs. This fragmentation of service delivery can result in clients not receiving needed integrated services that would prevent worsened mental conditions and the need for more costly intensive care. In addition, the lack of a coordination mechanism between programs creates a potential for duplication of services, which is inefficient and more costly to the state.

Many program clients have needs that often require services from other department programs, such as Family Safety and Preservation, or other social services agencies, including Juvenile Justice, Corrections, and Education. For example, children and adolescents who receive mental health treatment also receive counseling, educational, vocational, life skills, and cognitive training services from the Department of Juvenile Justice. The Department of Corrections reported that drug offenders represented 24% of all Florida prison admissions in Fiscal Year 1997-98. Children of substance abusers are three times more likely to be abused and four times more likely to be neglected than other children. In addition, the program reports a high number of children with a history of parental abuse or neglect in mental health, who are also clients of the department's Family Safety and Preservation Program.

Provider agency and district office staff said that coordinating services for this population is difficult for several reasons. First, logistical problems exist because programs and agencies may be located geographically far from one another. Treatment staff said that face-to-face meetings with representatives of various programs were most effective, but travel time may make it inconvenient for them to meet in person. Second, collaboration among different social services agencies may be difficult due to differing and sometimes conflicting agency missions. For example, the Department of Children and Families is concerned primarily with delivering social services, while the Department of Corrections is concerned primarily with custody and control of persons convicted of criminal offenses. Third, the inability to electronically share and track information across agencies further impedes the development of individual treatment plans based on a holistic approach, one which considers the wide variety of problem areas affecting client well-being.

Coordination between the Department of Children and Families and other state agencies is problematic because there is no designated lead agency for clients served by multiple agencies. District and provider staffs noted that they cannot mandate staff from other state agencies to collaborate on client issues.

The Legislature and the department's central program office have initiated efforts to implement formal coordination mechanisms,

including interagency funding agreements and multidisciplinary planning teams. To better coordinate services for clients enrolled in the children's mental health program, the program has developed an information sharing network of representatives from several social services agencies and a

multi-agency network for students who are seriously mentally ill.[8] The Together Everyone Achieves More (TEAM) was established in Fiscal Year 1995-96 to provide technical assistance to "community facilitators" for the Family Preservation efforts, coordinate cross-program planning, establish an information network, and address system reform issues. A multi-agency network for Students with Serious Emotional Disturbances (SEDNET), established pursuant to s. 230.2317, F.S., provides a partnership between the Education, Juvenile Justice, and Children and Families departments. This network provides screening, referral, and case management services to enhance services provided to program clients who are severely mentally ill. Another program effort to better coordinate services for children's substance abuse clients is the Treatment Accountability for Safer Communities (TASC) Program, which provides screening, assessment, and tracking of clients who have drug-related charges and are referred by the Department of Juvenile Justice. Districts with juvenile assessment centers typically incorporate TASC programs as a service component.

In 1995, Congress appropriated $60 million in grants to states to improve mental health services through "systems of care." [9] The system of care approach acknowledges the involvement of numerous publicly funded systems in the delivery of services and the need for the coordination of these services. A multi-million-dollar initiative supports Comprehensive Community Health Services for Children and Their Families Program throughout America. This program is designed to coordinate a system of care including agencies in mental health, child welfare, juvenile justice, education, and other agencies involved with children with serious emotional disturbances. An evaluation of 31 original grant sites by the Florida Mental Health Institute (1999) identified promising strategies in the implementation of interagency collaboration. These include the creation of formal collaborating committees and boards, multi-level involvement of staff, common problem-solving procedures, and shared decision-making. Results of collaboration showed improvements in relationships between child-serving agencies, better understanding of system-of-care principles,

[8] Member agencies include the departments of Children and Families, Education, Labor and Employment Security, Juvenile Justice, Community Affairs, and Health; the Governor's Office; and the Agency for Health Care Administration.

[9] The Hillsborough County Children's Board was awarded a federal grant of $1.5 million per year for five years to create an interagency structure that would facilitate the integration of services for seriously emotionally disturbed children and their families.

increased relevance of mental health services, improved service delivery, and improved relationships between families and service providers.

The 1998 Legislature in Ch. 98-5, Laws of Florida, Comprehensive Child and Adolescent Mental Health Services Act, also recognized the need for improving service coordination in the program by supporting the establishment of Interagency System of Care Demonstration Models in several districts. These projects encourage the use of provider networks and other principles of managed care. The goal of these projects is to provide a design for an effective interagency strategy for delivering services to children and adolescents who have serious emotional disturbances and for their families. One major essential element of this system consists of creating a consortium of purchasers, including agencies in ADM, juvenile justice, child welfare, the school system, and the Agency for Health Care Administration. In addition, the service of case managers was defined to include the responsibility of linking service providers to a client and to monitor those services. [10]

In response to legislative concerns about the lack of an integrated drug control strategy, a Drug Summit Preplanning Committee convened in December 1998. Participants included representatives of law enforcement and judiciary, the Departments of Children and Families, Health, Corrections, and Juvenile Justice, as well as individuals from the community and associations. Recommendations from the preplanning summit included the creation of a state Drug Coordinating Office and the development of a system of coordination of effort, recognizing addiction as an issue requiring multi-agency solutions. In addition, the office needs to better coordinate efforts to share data among agencies.

While the Legislature has authorized the department to explore different efforts at improving behavioral health care, it acknowledged that the management of the state's substance abuse and mental health services system has not been systematically reviewed and updated in over 15 years and has not kept pace with improvements in the field. Accordingly, the 1999 Legislature in Ch. 99-396, Laws of Florida, created a Commission on Mental Health and Substance Abuse. The commission is mandated to review and evaluate the management and functioning of the existing publicly supported mental health and substance abuse systems and services in the Department of Children and Families, the Agency for Health Care Administration, and all other departments that administer mental health and substance abuse services. This commission and the other recent initiatives hold promise towards resolving the coordination of care

[10] Districts 3, 6, 7, and 13 are presently participating as demonstration sites.

problems, but it is too early to determine whether these steps will be effective in resolving these problems.

Recommendations

To more effectively coordinate services between provider agencies, we recommend that the department expand provider networks in districts where there are numerous providers. In addition, the department should encourage implementation of independent case management in districts where the need for better coordination of provider services warrant this approach. Because there are differences among districts, there is no one option that will meet the needs of all the districts.

To improve the coordination of services for clients served by multiple programs and agencies, the department should assess the current coordination mechanisms to identify those that work. The multi-agency consortiums mandated by the Legislature in the Interagency Systems of Care demonstration models will provide useful information on particular procedures aiding interagency coordination. In addition, a study by the Florida Mental Health Institute on Interagency Collaboration set forth promising strategies such as the use of pooled funding, shared decision-making, formalizing collaboration procedures in writing, and the establishment of short and long-term goals. Successful coordination strategies, once tested at the participating model sites in the state, should be implemented on a statewide basis.

Districts vary in terms of the availability of resources regarding funding, staff and community support, and established relationships between agencies. Therefore, the department should explore alternatives to accommodate these differences.

Chapter 5

Further Improvements Needed in Program's Accountability System

Introduction

A good accountability system provides quality information to help policymakers and program managers ensure that public monies are spent to achieve desired outcomes and to improve public services. The Alcohol, Drug Abuse and Mental Health Program's accountability system should provide two types of information. First, it should provide the Legislature with information on the program's overall impact on clients, which will assist the Legislature in making informed budget and policy decisions. Second, the accountability system should provide program managers with detailed information on the performance of individual providers to enable the program to identify best practices and take action to improve program services and client outcomes. A good accountability system will also ensure that performance information is sufficiently reliable. The program and the Legislature must have full confidence in the data's reliability in order to assess program results and manage the program.

Past Limitations of the Program's Accountability System

Historically, the program's accountability system has been insufficient to ensure quality information. First, the program has not traditionally provided information on the program's impact on clients or the performance of providers. In OPPAGA Report No. 97-61, we concluded that the Adult Mental Health Program has historically not had an effective performance accountability system to assess the effectiveness and efficiency of community-based mental health services. For example, prior to 1994, the department did not require providers to report information on the numbers of clients they served or the services they provided. Providers were also not held accountable for client improvement.

Second, the program's performance data has not been reliable. In our prior reports, we identified problems with the reliability of

program performance data for Fiscal Year 1997-98 that limited conclusions about program results and effectiveness. Data for all three subprograms were incomplete and data for the substance abuse subprogram were inaccurate. The most serious problem was that providers did not collect and report data on large percentages of enrolled clients. For example, providers reported data for only one-fourth of the clients enrolled in the Adult Mental Health Crisis target group. Also, for Fiscal Year 1997-98, the department's inspector general did not validate the accuracy of program performance data as required by law. In an effort to assess data reliability for the substance abuse subprogram, department staff assigned to the subprogram conducted a limited analysis and found that one-third of the data elements checked against client records were inaccurate.

The Department and the Legislature Have Taken Several Steps to Improve the Program's Accountability System

Throughout the 1990s, the Legislature and the department have taken steps discussed below to improve program's accountability system.

- Beginning in 1994, the department required providers for the first time to submit information on the number of clients they served and to categorize these clients into populations based on factors such as severity of illness and duration of need for services. This initiative enabled the department and the Legislature to identify client populations being served and to establish priorities for program services.
- As part of performance-based program budgeting, the department developed and proposed measures and standards for the program which were adopted by the Legislature for the 1996-97 fiscal year. This initiative required providers to collect and report client outcome data, which enhanced the Legislature's oversight responsibility and provided program managers with information to monitor provider performance.
- In 1996, the department implemented unit cost contracting, which improved its ability to track the types, quantities, and costs of services rendered to clients. This method of contracting allows the department to specify which services it will pay providers to render. Previous contracting methods did not provide the department with information on the costs for services, specific services, and which clients received services.
- Beginning with the 1998-99 fiscal year, providers were reimbursed only for services provided to clients enrolled in the program rather than other non-state clients being served by

the provider. This initiative enabled the department to spend program resources only on the priority clients identified by the Legislature.

- To improve data quality, the department developed better quality control procedures and data entry software and implemented training to help providers reduce data entry errors. Through these efforts, the department required providers to report data only for enrolled program clients rather than follow the previous practice of reporting data for other non-state clients that these providers also served. This enabled the department to capture in its database more accurate information about program clients.
- The department also established a workgroup whose primary function was to identify and correct problems with the department's database. The work group first convened in February 1998 and has implemented several changes to improve data submitted by contracted providers. As a result, the quality of program performance data for the 1998-99 fiscal year contained in the department's database has improved.

Due to these improvements, we concluded that the Legislature can use the program's performance data to assess the program's overall effectiveness for the 1998-99 fiscal year. The data are also complete enough to allow assessments on most of the program's target groups (e.g., adult and children's mental health and substance abuse).

Continuing Problems Limit the Program's Accountability System

Despite these improvements, we identified continuing deficiencies noted below with the program's accountability system that hinder the Legislature's and the department's oversight responsibilities.

- Data for the forensic subprogram are incomplete, limiting the Legislature's ability to confidently assess its effectiveness.
- Software and data reporting problems preclude assessment of some providers.
- Problems with the monitoring system impede department efforts to assess provider performance in order to improve client outcomes.
- Performance standards are set flexible enough to assess providers who serve clients with more severe impairments.
- Additional intermediate and process measures are not sufficient to assess provider performance.

Forensic Subprogram Data Are Incomplete

Despite the improvements in the program's performance measures, the department's data are too limited to allow assessments of its effectiveness in treating one of its target populations—persons with forensic involvement (persons the court has placed in a community mental health program as a condition of their release). Program data were available for only 709 clients for the first nine months of Fiscal Year 1998-99, although 5,638 clients were enrolled in the forensic involvement target group for Fiscal Year 1997-98. The reason for the decline in the forensic population is unknown. Program officials speculate that changes in data reporting procedures may account for some of the decline. The program's enrollment process for Fiscal Year 1998-99 requires providers to capture forensic data more specifically than was required in Fiscal Year 1997-98. Regardless of the cause, program officials acknowledged that the department has incomplete data for the forensic population, which would hinder the Legislature's ability to make conclusions about program effectiveness for this target group.

Software and Data Reporting Problems Preclude Assessment of Some Providers

Due to stricter quality control procedures, the department rejected a significant proportion of data that providers submitted and did not enter these data in its database. According to the providers, one of the primary reasons for this problem involved the department's data entry software, which was issued to providers and was often incompatible with certain provider's data systems. This software was not available, in some cases, until well into the 1998-99 fiscal year. Some providers did not receive data entry software until August or September of 1998, two to three months after new data reporting requirements went into effect. A related problem was that providers submitted outcome data without client enrollment and demographic information; these incomplete data were then rejected by the department. Some providers indicated they had not been informed that clients enrolled in the previous fiscal year had to be re-enrolled for Fiscal Year 1998-99. Other providers said they were confused as to whether demographic data must be re-submitted for clients who had been enrolled in the prior fiscal year. As a result of these problems, our initial analysis of program data found that approximately 30% of providers had not submitted data for the first half of Fiscal Year 1998-99. Without this data, the program may be unable to assess provider performance on client outcome measures.

Monitoring System Does Not Provide Information Needed to Effectively Assess Provider Performance

A third problem that hinders the program's accountability system is that the department's monitoring efforts focus largely on compliance and program administration issues rather than critical aspects of treatment. Currently, department monitoring of providers consists of determining whether providers are complying with department rules. For example, program staff examine client files to determine whether clients signed treatment plans, if proper documentation exists in case notes, and whether service plans contain measurable goals and objectives.

While compliance monitoring is important, it provides only part of the information the department needs to effectively manage the program. Some district office staff and most provider staff we interviewed indicated that spending too much time on compliance monitoring wasted staff resources because these efforts did not result in improvements to program services. These staff noted that department monitoring efforts would be more effective if they included a review of provider-specific programs and practices that resulted in improved client outcomes for specific target populations. For example, district staff could determine whether the practice of conducting a follow-up meeting with adult mental health clients within one week of their release from crisis stabilization units is effective at keeping them from returning to these facilities. In addition, staff could determine whether increased supervision for substance abuse clients results in better client outcomes. If these practices prove to be effective, department staff would encourage other providers to implement these practices.

Some districts have developed innovative monitoring practices that provide program managers with more useful information to make decisions about modifying program services to improve client outcomes. For example, in consultation with the Florida Mental Health Institute, District 7 developed a system to monitor providers by validating decisions made by clinicians about client assessments. Monitoring focused on determining service appropriateness and identifying treatment effects on clients. These staff said that this type of review provided them with better information to assess provider performance and can be used to make decisions about modifying program services.

One of the primary impediments to the department's ability to implement this type of monitoring statewide may be the lack of qualifications of some district office staff to conduct clinical monitoring. Many provider agency staff we interviewed expressed concerns that district staff lacked the expertise to question

decisions made by clinical staff. Therefore, this type of review may be inappropriate to implement in all districts.

To address this problem, the department could develop a peer review system that would involve provider staff from other districts evaluating provider practices and performance. The 1999 Legislature in Ch. 99-396, Laws of Florida, directed the department to include peer reviews as part of its quality assurance program. These reviews should be conducted by staff with expertise in service areas, such as residential or case management services. Although peer review has not been implemented in any district as of June 1999, it could help to enhance staff expertise in clinical monitoring.

To supplement compliance monitoring efforts, the department may also want to use information about provider performance obtained from accreditation agencies such as the Joint Commission on the Accreditation of Healthcare Organizations and the Commission on the Accreditation of Rehabilitation Facilities. These agencies monitor provider clinical practices to improve service quality and treatment outcomes and to demonstrate accountability. Generally, large mental health and substance abuse providers are already accredited by one of these agencies. For Fiscal Year 1998-99, 38% of 279 providers were accredited by one of these agencies. These providers served 54% of the 351,000 enrolled clients. To enhance the efficiency of the monitoring process, district staff could accompany accreditation agency staff when they conduct accreditation surveys.

Performance Standards Need to Be Flexible to Better Assess Providers Who Serve Clients With More Severe Impairments

Another deficiency with the department's monitoring efforts is that using statewide standards in contracts may not provide district office staff with useful information about the performance of some providers. Department contracts require providers to meet the statewide standards for 80% of the statewide performance-based program budgeting measures, such as number of days in the community and client functional levels. All providers are currently held to meeting the same standards, even though there are differences in the characteristics of clients that providers serve.

However, providers who serve clients with more severe impairments may have difficulty meeting these standards because their clients are less stable and thus less likely to remain in the community. These providers could be serving this population effectively, but may not be performing at a level comparable to

providers who serve less severely impaired clients. Providers who fail to meet contract requirements risk having their contracts terminated. This creates a disincentive for providers to serve more severely impaired clients. Providers who want to increase their performance rating could decide to serve only less severely ill clients. Some provider staff we interviewed said that they would be inclined to serve less severely ill clients in order to increase their performance outcomes. This is problematic because it conflicts with the state goal of treating the most severely ill clients in order to keep them stable and functioning in the community.

As a result, the current use of a single performance standard can give program managers a distorted picture of provider performance. If districts had the flexibility to lower standards for providers who serve clients who are more severely impaired, then program managers would have a more accurate picture of each provider's performance. However, to achieve the statewide standards, the standards for providers serving less severely impaired clients would need to be raised in order to accommodate the lower standards for providers serving clients who are more severely impaired.

Additional Intermediate and Process Measures Are Needed to Better Assess Provider Performance

Another weakness in the program's accountability system is that the department lacks intermediate and process measures to effectively assess an individual provider's performance. These types of measures are most needed for specialty contractors who do not provide a comprehensive range of services and thus cannot be effectively assessed by the program's current performance measures which assess clients' overall status. For example, it may not be appropriate to hold a provider agency accountable for an employment outcome if the agency offers only residential treatment. Treatment staff are less able to address a client's employment needs in a residential setting compared to an outpatient setting where a client can search for a job. Intermediate measures could focus on the effectiveness of particular services like outpatient, case management or day treatment and whether these services improve client stability and functioning. Process measures could focus on client access and service quality issues. For example, the length of time it takes for mental health institution or crisis clients to access services from a community mental health center would provide an assessment of the client's continuity of care and access to community services.

Recommendations

To improve its program monitoring practices, we recommend that the department implement one or more of the following options in each of its 15 service districts.

- Modify monitoring practices to focus on clinical practices as well as administrative and compliance issues to determine effects of treatment services on clients. First, districts with qualified staff could validate decisions made by provider clinical staff to determine service appropriateness and identify treatment effects on clients. Second, districts should develop and implement a peer review system, as mandated by Ch. 99-396, Laws of Florida. The department should promulgate rules to ensure that peer review and monitoring staff are licensed and have behavioral healthcare clinical expertise. The department can provide oversight regarding monitoring schedules, formatting of monitoring information, and how this information will be used to evaluate providers. In implementing the peer review system, the department must also ensure that monitoring staff are not from the same service district in order to avoid providers from competing agencies monitor one another. Third, districts could use the Joint Commission on the Accreditation of Healthcare Organizations and the Commission on the Accreditation of Rehabilitation Facilities monitoring information to supplement department efforts to evaluate providers. Providers monitored by multiple entities would then have the opportunity to determine treatment aspects that assist the state's clients in achieving positive client outcomes while satisfying multiple evaluation criteria.
- Develop a system to identify best practices used by contracted mental health and substance abuse treatment providers. This system should be based on available program data and reviews of clinical practices or other factors that lead to better client outcomes. District and provider staff we interviewed identified a number of innovative practices that they believe resulted in positive outcomes for clients and gained efficiencies for the provider agency. However, the department has done limited systematic evaluation to identify provider-specific practices that result in better client outcomes or in cost savings for the state.
- Document and disseminate identified best practices for potential use in other service districts and conduct follow-up reviews to determine long-term effects of positive practices.

The department should continue requiring providers to report data on performance-based program budgeting measures. These data

allow the Legislature and other policymakers to make informed policy and budgetary decisions. However, to improve efforts to assess individual provider performance, we recommend that the department adopt one or both of the following options.

- District staff should adopt different standards for which providers would be held accountable. For example, for adult mental health providers who serve more severely impaired clients, the department might want to use lower standards than the 1998-99 fiscal year standards of 345 days in the community or 30 annual days worked for pay. However, if these standards are lowered for these providers, providers who serve less severely impaired clients would need to have a higher level of expected performance in order for the department to meet the statewide standard of 345 days. The advantage of this option is that it does not require data collection on additional performance measures.
- District staff should develop intermediate, or process, measures that focus on the effectiveness of specific services such as outpatient, case management, or day treatment and whether these services improve client stability and functioning. Because these types of measures are particularly important to assess the performance of specialized provider agencies, they should also focus on client access and service quality issues.

Chapter 6

Legislative and Department Actions Needed to Expand the Use of Behavioral Managed Care Initiatives

Background

The Alcohol, Drug Abuse and Mental Health Program contracts with behavioral health care providers throughout the state to deliver mental health and substance abuse services to Florida's citizens. These contracts establish legally binding agreements between the department and providers that clearly define the responsibilities and expectations of each party. They are the legal mechanisms by which the state can achieve the basic goal of the behavioral health care system—to promote and improve the mental health of Florida's citizens. One of the primary objectives of a contract is to ensure financial and performance accountability for taxpayer dollars that are paid to providers.

Prior to the 1990s, the program's contracts with behavioral health providers focused on financial accountability but not performance accountability. At the program's inception, the state used a grant-in-aid system to fund program services. The primary advantage of this contracting system was that it offered providers great flexibility in service provision. The problem with this system was that the providers could receive payment without regard to the quantity or quality of services provided. In 1976, the state began using cost reimbursement contracts in an attempt to achieve greater fiscal accountability over the grant-in-aid system. Under cost reimbursement, providers were paid for services based on the documented cost of providing them. The primary advantage of this contracting system was that through its invoicing process the department could have greater financial accountability over provider spending. Although cost reimbursement contracts allowed the department to monitor how dollars were spent, there were no performance requirements.

The unit cost contract is the predominant method of contracting for mental health and substance abuse services

In 1992 the Legislature authorized the use of unit cost, or performance, contracts which are an improvement over previous contracting methods because they contain performance requirements. These contracts stipulate that contractors must serve a specific number of clients in each of the department's target populations as well as meet performance standards for performance-based program budgeting (PB²) measures. Contractors must provide a negotiated number of specified treatment services at a fixed unit cost. This unit cost cannot increase and the total budget amount remains fixed. Unit cost contracts provide the department with better information about how state dollars are spent, thereby improving provider accountability.

Limitations of the Current Contracting System

The current system does not promote cost efficiency

Despite these advantages, the current contracting system has four primary drawbacks. First, unit cost contracts may discourage providers from providing services in a cost efficient manner. The rates in these contracts are based on the cost to reimburse provider expenses. As a result, the contracts do not offer an incentive for the provider to reduce costs and improve efficiency. Providers who reduce expenses from the prior year may be penalized because district staff could reduce their future payment rates.

The current system rewards delivery of billable services and does not promote cooperation

Second, unit cost contracts focus on payment for units of service rendered and not necessarily on meeting client needs. Under unit cost contracting, providers are encouraged to deliver services for which they will be reimbursed regardless of client needs. Providers have a financial incentive to produce the most expensive billable units rather than to provide services that meet clients' needs. In addition, unit cost contracting does not encourage providers to cooperate with one another or coordinate services for clients served by multiple providers. Providers have no financial incentive to send clients to other providers who may be able to provide more appropriate services. (For a more detailed discussion of problems with the coordination of services, see Chapter 4.)

Performance measures and standards are of limited use for assessing the performance of some providers

Third, the use of performance-based budgeting measures and standards in unit cost contracts may be inappropriate for assessing individual provider performance. The performance measures are appropriate for assessing the effectiveness of treatment on a statewide basis and for providers who offer a full continuum of treatment services. However, statewide measures are too broad and high-level for assessing the performance of providers who offer fewer services or specialized services. For example, a performance measure of post-treatment employment

success may not be appropriate for a provider that offers specialized treatment for elderly clients. In addition, contract performance standards are not modified in the contract to reflect the illness severity of clients served by the provider. (For a more detailed discussion of the limitations of the performance accountability system, see Chapter 5.)

Unit cost contracts reimbursement provisions might be in conflict with Florida law

Fourth, the reimbursement provisions of unit cost contracts might be in conflict with Florida law and might result in the program serving fewer clients. Providers are allowed to use program funds to supplement the cost of Medicaid services when they determine that Medicaid rates are insufficient to cover treatment costs. In effect, this widespread practice allows providers to be reimbursed for Medicaid services at the program's rate because the Medicaid reimbursement rate is generally lower than the program's rate. For example, the Medicaid rate for one unit of individual therapy is $45.10 while the program rate for the same unit of service is $75.02. According to the department's inspector general, this practice is not in compliance with Florida statutes, which require that Medicaid rates be payment in full for Medicaid services. If program funds are used to supplement Medicaid services, fewer program dollars are available to serve the program's non-Medicaid eligible clients.

Another problem with unit cost contracts is that reimbursement provisions permit providers to be compensated for the same service from multiple funding sources. Under unit cost contracting, providers are allowed to collect payment for services from clients and local government agencies and also bill the department for the same services rendered. If program dollars are used to pay for services that are already paid for by individual clients or local governments, the program may, overall, serve fewer clients.

Thus, while the program's current unit cost contracts are an improvement over previous contracting arrangements because they provide for greater accountability for funding, the current contracting system still has a number of drawbacks that limit its effectiveness. (See Exhibit 6-1.)

Exhibit 6-1
Although Unit Cost Contracts Are an Improvement Over Previous Contracting Methods, They Have a Number of Drawbacks

Type of Contract	Advantages	Disadvantages
Grant-in-aid and cost reimbursement	• Providers could offer an array of treatment services • No significant data reporting requirements • Allowed providers to build service capacity / infrastructure • Fiscal accountability through invoicing process	• Lack of accountability for services provided or client improvement • No incentive to make clients well or provide services in an efficient or effective manner
Unit cost (Performance)	• Required provider to serve a specified number of clients and provide a specified number of services • Required providers to meet statewide and district performance standards	• No incentive to deliver services efficiently • Incentive to provide more services than the client needs • Performance measures and standards may be inappropriate for assessing performance of some providers • Reimbursement practices may not be legal and cost efficient

Managed Care Contracts Offer Advantages Over Unit Cost Contracts

One option to address the limitations of the current unit cost contracting system is the use of managed care contracts. Managed care is an organized system of managing health care designed to control costs while ensuring accessible, effective, and efficient care of clients. In a managed care system, a managed care organization (MCO) is typically paid a fixed rate for each client served. For this rate, the MCO provides all services necessary for client success. Managed care models typically use a single point of entry for clients to receive treatment. As discussed in Chapter 4, another managed care concept involves the use of provider networks for service delivery.

Managed care contracting provides a number of potential advantages over unit cost contracting. First, the MCO is financially responsible for providing the necessary services to

improve client functioning. The MCO is held accountable for client outcomes regardless of the amount of services needed to serve the client. Under unit cost contracting, the department assumes the financial risk for serving program clients. Second, managed care contracts may be less costly than traditional contracting arrangements. One strategy that the MCO uses to reduce costs is to limit client access to expensive, traditionally overused services, such as residential treatment. Third, managed care arrangements provide an expanded and flexible array of services to meet individual client needs. The current unit cost contracting system allows payment to providers for traditional services in narrowly defined cost centers. Managed care contracts focus on improving client functioning while unit cost contracting is based on specifying the number of clients served and the units of services provided to program clients.

The State's Experiment With Managed Care Contracts Seems to Be Working Well

Florida's most comprehensive use of managed care in behavioral health is the Medicaid managed care demonstration project, administered by the Agency for Health Care Administration (AHCA). In the demonstration area (Department of Children and Families Districts 6 and 14), Medicaid enrollees can have their mental health services provided through the traditional fee-for-service method or through one of two managed care models. [11] The first is a behavioral health care "carve out" model in which a specialty behavioral health managed care organization (the Florida Health Partnership) provides all mental health services for plan participants. In this arrangement, the partnership is paid by the Agency for Health Care Administration through a fixed monthly fee per enrollee. The partnership organizes a network of providers to deliver an array of treatment services. In the second arrangement, Health Maintenance Organizations (HMOs) receive a premium that includes both general health and specialty mental health component. This is known as a "carve in" arrangement.

An independent evaluation of the Medicaid managed care demonstration project found that managed care arrangements, particularly the "carve out" model, resulted in cost savings without diminishing the quality of services or client outcomes. The Florida Mental Health Institute found that the two managed care organizations showed a greater decrease in per member per month costs than the fee-for-service arrangement. For Fiscal Year 1997-

[11] Fee-for-service reimbursement is the traditional method of billing AHCA for Medicaid services. Like unit cost contracts, fee-for-service pays the provider a set fee for each unit of service delivered.

98, the costs for the "carve out" model were 12% lower than the pre-project costs and the costs for the "carve in" were 9% lower. The researchers concluded that the cost containment objectives of the project had been met.

The study also concluded that some client groups had better outcomes under the managed care arrangements. The "carve in" model appeared to have the best performance for a small sample of children served in the seriously emotionally disturbed target group and with clients who had more severe disorders. According to the study, the primary drawback of the managed care options was limited client access to services. For example, only 58% of adults with severe mental illness in the "carve out" received services compared to 70% of the clients in the "carve in" model. Despite concerns about client access, the study's results suggest that managed care arrangements do have cost savings potential and could be expanded beyond the demonstration site.

The Legislature and the Department Should Address Several Issues Before Expanding the Scope of Managed Care Contracts

Managed care initiatives have already been piloted in several districts across the state. As described in Chapter 4, the Legislature has authorized and the department has implemented several demonstration projects using managed care concepts, including local provider networks that will provide comprehensive care across agencies and a case management process that is independent of service providers. However, these initiatives have been limited to selected districts and client populations. For example, only 4 of 15 service districts are participating in the Interagency Systems of Care Demonstration Project and only one district had implemented an independent case management system as of June 1999. In addition, these initiatives were limited to children's mental health program clients. The Medicaid managed care project is limited to serving only Medicaid eligible mental health clients.

The Medicaid managed care project demonstrated that managed care has the potential for reducing mental health care costs and improving client outcomes. However, provider and district staff expressed concerns that the mental health and substance abuse program is not currently prepared for statewide implementation of managed care contracts. We identified a number of issues that the department and the Legislature should address before expanding the scope of a behavioral managed care system.

The department should continue to improve client data to develop accurate contract rates

First, the department should continue to collect and analyze data in order to develop accurate and appropriate rates for use in managed care contracts. The service utilization and client characteristics (e.g., severity of illness) data collected under the unit cost contracting system is the basis for determining accurate managed care rates. To develop accurate managed care rates, the department has to identify the mix of services that result in the best client outcomes and the cost of those services. For example, to determine the rate the department will pay providers for children served in the severely emotionally disturbed population, the department needs to analyze cost data for the types of services associated with the clients who had the best outcomes. As of June 1999, the department was conducting a study on examining the relationship between the mix of services that result in the best client outcomes. The department should continue to analyze these data in order to enable it to develop accurate and appropriate managed care rates.

The department and Legislature should define the eligible client population

Second, the department and the Legislature will need to establish eligibility criteria to more clearly define the population to be served under a managed care system. According to department officials, to accurately determine the number of eligible clients in the covered population, the eligibility criteria must be clearly defined. Current client eligibility enrollment criteria are insufficient because they permit all clients with presenting needs to be served, regardless of the severity of their illnesses or their ability to pay for services. Under the Medicaid demonstration project, eligibility criteria limit enrollment to the program based on client income. As a result, the Agency for Health Care Administration can forecast more accurately the number of clients to be served. To move to a managed care system, the Legislature needs to develop eligibility criteria specifically defining who can receive services under the managed care plan. These criteria may be based on a number of factors including clinical diagnosis, severity of illness, or income level. Once eligibility criteria are established, it will be possible to develop estimates of the number of eligible clients. This is essential because without an estimate of the total number of clients to be served the department can not accurately determine an appropriate rate to pay managed care organizations.

The Legislature should determine how managed care will be funded

Third, the Legislature should determine which funding streams will be included in the managed care system. Once the covered population is defined, the state should determine how its various funding sources should be used to serve the population. For the Alcohol, Drug Abuse and Mental Health Program, the Legislature will have to determine how to coordinate Medicaid and state funds to ensure that all state clients are sufficiently served. This includes addressing the reimbursement practices under the current system that result in Medicaid subsidization and dual compensation. One way to coordinate funding is to set up

contracting arrangements that clearly stipulate which services will be paid for by which funding source. For example, in the prepaid mental health demonstration project, Medicaid dollars are used to fund Medicaid services for eligible clients. The program's dollars pay for certain services that Medicaid will not cover as well as other specified optional services. Under this arrangement, known as complementary contracting, the reimbursement responsibilities are clearly articulated.

The department should determine readiness for managed care

Fourth, the department should assess each district's capacity to move to managed care contracting in order to establish an implementation timetable. Some districts may be more prepared to move to a managed care system than other districts. Districts with a large portion of service provision coming from smaller and specialized provider agencies may have a more difficult time implementing managed care contracting because they do not provide comprehensive services, have limited financial bases, and lack sophisticated information systems. According to an independent evaluation of the substance abuse subprogram conducted in 1997, many small and medium size provider agencies have insufficient financial resources and information system capacity to participate in a managed care system. The department should develop an assessment tool to identify which districts or combination of districts would be good candidates for managed care contracts.

The department should limit provider risk in early implementation of managed care

Fifth, the department needs to establish acceptable parameters for limiting the profits and losses to providers in initial managed care contracts. Because the department has limited experience in setting rates for behavioral health populations, it would need to protect the interests of the state and providers. The department may set initial rates too high, which would reduce the program's cost efficiency, or it may set the initial rates too low, which would create a financial hardship for providers that may reduce services to clients. Therefore, the department should protect state and provider interests by limiting the managed care organizations' exposure to loss and potential for profits. For example, losses and profits might be limited to 5% or 10% of the payment made to providers.

The department should consider impact of managed care on existing providers

Sixth, the department should consider the impact of managed care on the existing behavioral health care providers. Under a managed care arrangement, the MCO makes the decision about which providers it will contract with to provide client services. The MCO could choose not to contract with the current set of providers who may have traditionally provided services in the community. The department should ensure that managed care contracts initially include all existing providers for the specified contract period (e.g., one year), which would allow the existing providers to adjust to a managed care system. Subsequent

contracts would then permit the MCO to select providers on a competitive basis based on cost and quality of services.

Advantages to Implementing a Managed Behavioral Health Care System

As shown in Exhibit 6-2, there would be advantages to Florida implementing a managed care model for behavioral health care because the current behavioral health care system does not offer certain important benefits. For example, while the current system does not have a mechanism to control the costs of program services, there are built-in incentives under a managed care system to provide program clients with less intensive and less costly services. In addition, although there are inherent problems with the current system that impede efforts to hold providers accountable for their performance, the managed care organization or network under a managed care system is held directly accountable for achieving desired client outcomes.

Exhibit 6-2
There Are Advantages to Moving to a Managed Care System

Issue	Current Behavioral Healthcare System		Managed Care System
Program costs (Refer to Chapter 6)	No built-in incentives for providers to reduce expenses and increase efficiency	→	Incentive to provide less intensive, less costly services
Service provision (Refer to Chapter 4)	State purchases services based primarily on historical patterns rather than meeting client needs	→	Emphasis on providing treatment continuum to individual client
Coordination of services among providers (Refer to Chapter 4)	No incentive to promote coordination among provider agencies	→	Development of networks promotes coordination between providers
Risk (Refer to Chapter 6)	Department assumes financial risk	→	Risk is shared with managed care organization
Accountability (Refer to Chapter 5)	Diffused accountability: Contract and monitoring processes hinder department's ability to hold Individual providers accountable for performance	→	Centralized accountability: Managed care organization or network is held accountable for achieving desired outcomes

Source: OPPAGA analysis based on interviews with department staff.

The Legislature should consider expanding the use of managed care initiatives. A managed behavioral health care system would provide important benefits and few significant drawbacks. However, before the department is ready to fully implement a managed behavioral health care system, the Legislature and the department would need to address issues discussed in this chapter.

Alternatively, the Legislature could authorize the expansion of current demonstration projects into other districts. However, even if these initiatives were implemented statewide, they have been limited to certain target populations. Therefore, the department would need to expand their use to serve populations not currently served. This option would enable the department to incrementally experiment with and reap some of the benefits of managed care concepts while minimizing the risks associated with wholesale changes to the current system.

Appendix A

Statutory Requirements for Program Evaluation and Justification Review

Section 11.513(3), F.S., provides that OPPAGA Program Evaluation and Justification Reviews shall address nine issue areas. Our conclusions on these issues as they relate to the Department of Children and Families' Alcohol, Drug Abuse and Mental Health Program are summarized in Table A-1.

Table A-1
Summary of the Program Evaluation and Justification Review of the Alcohol, Drug Abuse and Mental Health Program

Issue	OPPAGA Conclusions
The identifiable cost of the program	In Fiscal Year 1997-98, the expenditures for the Alcohol, Drug Abuse and Mental Health Program totaled $591,443,163, which included $360,492,789 from general revenue and trust funds and $230,950,374 from Medicaid.
The specific purpose of the program, as well as the specific public benefit derived therefrom	The program provides prevention, intervention, and treatment services in order to reduce the occurrence, severity, and disabling effects of mental health and substance abuse problems. The department is charged with treating program clients with the most appropriate services in the least restrictive setting. The program provides beneficial services to clients and a cost benefit to Florida's citizens. In the absence of program services, individuals with mental illness or substance abuse problems may engage in criminal activity or be prone to hospitalization, unemployment, homelessness, and dependence on welfare, all of which represent an economic burden on society. Without appropriate services, children may experience school failure, family discord, or suicide.
Progress towards achieving the outputs and outcomes associated with the program	The program has been effective at keeping adults with severe and persistent mental illness and children with mental health problems in the community where they can receive less expensive care. The substance abuse subprogram has also been effective in helping clients obtain or maintain employment. Program data for the first six months of Fiscal Year 1998-99 indicate that 52% of clients were employed at the time of discharge, which is an increase from the 42% who were employed at the time they were admitted in the program. For clients who were employed when they were admitted to treatment, 93% of the clients who successfully completed treatment were employed at the time of discharge, compared to 84% who did not successfully complete treatment who were employed at discharge.
An explanation of circumstances contributing to the state agency's ability to achieve, not achieve, or exceed its projected outputs and outcomes, as defined in section 216.011, F.S., associated with the program	Due to incomplete data reporting by provider agencies, we could not assess program performance for most client target groups for the 1997-98 fiscal year. In addition, the program used unreliable data when establishing performance. The department has made significant progress in improving data reliability for Fiscal Year 1998-99. However, we could not compare output and outcome data against the program's performance standards because reliable data were available for only the first six months of the 1998-99 fiscal year. The department will report its ability to achieve, not achieve, or exceed its projected outputs and outcomes in its Fiscal Year 2000-2001 Legislative Budget Request.
Alternative courses of action that would result in administering the program more efficiently and effectively	To more effectively coordinate services between provider agencies, we recommend that the department expand provider networks in districts where there are numerous providers. In addition, the department should encourage implementation of Independent Case Management on a statewide basis. Because there are differences among districts, there is no one option that will meet the needs of all the districts. To improve the coordination of services for clients served by multiple programs and agencies, the department should assess the current coordination mechanisms to identify those that

Issue	OPPAGA Conclusions

work. The multi-agency consortiums mandated by the Legislature in the Interagency Systems of Care demonstration models will provide useful information on particular procedures aiding interagency coordination. In addition, a study by the Florida Mental Health Institute on Interagency Collaboration indicated promising strategies such as the use of pooled funding, shared decision-making, formalizing collaboration procedures in writing, and the establishment of short and long-term goals. Successful coordination strategies, once tested at the participating model sites in the state, should be implemented on a statewide basis.

To improve its program monitoring practices, we recommend that the department implement one or more of the following options in each of its 15 service districts.

- Modify monitoring practices to focus on clinical practices as well as administrative and compliance issues to determine effects of treatment services on clients. First, districts with qualified staff could validate decisions made by provider clinical staff to determine service appropriateness and identifying treatment effects on clients. Second, districts should develop and implement a peer review system, as mandated by Chapter 99-396, Laws of Florida. The department should promulgate rules to ensure that peer review and monitoring staff are licensed and have behavioral healthcare clinical expertise. The department can provide oversight regarding monitoring schedules, formatting of monitoring information, and how this information will be used to evaluate providers. In implementing the peer review system, the department must also ensure that monitoring staff are not from the same service district in order to avoid having providers from competing agencies monitor one another. Third, districts could use as the Joint Commission on the Accreditation of Healthcare Organizations and the Commission on the Accreditation of Rehabilitation Facilities monitoring information to supplement department efforts to evaluate providers. Providers monitored by multiple entities could then have the opportunity to determine treatment aspects that assist the state's clients in achieving positive client outcomes while satisfying multiple evaluation criteria.

- Develop a system to identify best practices used by contracted mental health and substance abuse treatment providers. This system should be based on available program data and reviews of clinical practices or other factors that lead to better client outcomes. District and provider staff we interviewed identified a number of innovative practices that they believed resulted in positive outcomes for clients and gained efficiencies for the provider agency. However, the department has done limited systematic evaluation to identify provider-specific practices that result in better client outcomes or in cost savings for the state.

- Document and disseminate best practices. Department district staff should encourage implementation of best practices among service districts or providers and conduct follow-up reviews to determine long-term effects.

The department should continue requiring providers to report data on performance-based program budgeting measures. These data facilitate informed policy and budgetary decisions by the Legislature and other policymakers. However, to improve efforts to assess individual provider performance, we recommend that the department adopt one or both of these options:

District staff should adopt different standards for which providers would be held accountable. For example, for adult mental health providers who serve more severely impaired clients, the department may want to use lower standards than the 1998-99 fiscal year standards of 345 days in the community or 30 annual days worked for pay. However, if these standards are lowered for these providers, then in order for the department to meet the statewide standard of 345 days, providers who serve less severely impaired clients would need to have a higher level of expected performance. The advantage to this option is that it does not require data collection on additional performance measures.

District staff could also develop intermediate or process measures that focus on the effectiveness of specific services such as outpatient, case management, or day treatment and whether these services improve client stability and functioning. Process measures should focus on client access and service quality issues. These types of measures are particularly important to assess the performance of specialized provider agencies. We believe the Legislature should consider expanding the use of managed care initiatives. A managed

Issue	OPPAGA Conclusions
	behavioral health care system would provide important benefits and few significant drawbacks. However, before the department is ready to fully implement a managed behavioral health care system, the Legislature and the department would need to address issues discussed Chapter 6 of this report. Alternatively, the Legislature could authorize the expansion of current demonstration projects into other districts. However, even if these initiatives were implemented statewide, they have been limited to certain target populations. Therefore, the department would need to expand their use to serve populations not currently served. This option would enable the department to incrementally experiment with and reap some of the benefits of managed care concepts while minimizing the risks associated with wholesale changes to the current system.
The consequences of discontinuing the program	In the absence of program services, individuals with mental illness or substance abuse problems may engage in criminal activity or be prone to hospitalization, unemployment, homelessness, and dependence on welfare, all of which represent an economic burden on society. Several national studies indicate that treating mental illness and substance abuse problems is cost-effective. A 1994 study conducted by the RAND Corporation concluded that for every $1 invested in substance abuse treatment taxpayers received a $7 return in savings. These cost savings were realized primarily through reductions in criminal activities and hospitalizations. Another 1994 national study concluded that emergency room admissions for a targeted population were reduced by one-third following substance abuse treatment. Similarly, national studies estimated that cost savings ranged from $3 to $8 for every $1 spent on mental health treatment.
Determination as to public policy; which may include recommendations as to whether it would be sound public policy to continue or discontinue funding the program, either in whole or in part	The program provides beneficial services to clients and a cost benefit to taxpayers. This review identifies several alternatives for improving program operations and eliminating duplicative or unnecessary activities.
Whether the information reported pursuant to section 216.03(5), F.S., has relevance and utility for the evaluation of the program	In our prior reports dealing with the program's performance (OPPAGA Report Nos. 98-43, 98-49, and 98-52), we identified problems with the reliability of program performance data for Fiscal Year 1997-98 that limited conclusions about program results and effectiveness. The department has made significant progress in improving the quality of its reported data. As a result, the Legislature can use reported data for the 1998-99 fiscal year to make conclusions about program performance.
Whether state agency management has established control systems sufficient to ensure that performance data are maintained and supported by state agency records and accurately presented in state agency performance reports	The department has taken steps to improve the reliability of its program performance data. For example, the department has tested samples of program performance data to validate data accuracy, developed better quality control procedures and implemented training to help providers reduce data entry errors. In addition, the department has established a workgroup whose primary function is to identify and correct problems with the department's database.

Appendix B

Response from the Department of Children and Families

In accordance with the provisions of section 11.45(7)(d), F.S., a draft of our report was submitted to the Secretary of the Department of Children and Families for her review.

The department's written response is reprinted herein beginning on
page 53.

FLORIDA DEPARTMENT OF
CHILDREN
& FAMILIES

Jeb Bush
Governor

Kathleen A. Kearney
Secretary

September 10, 1999

Mr. John W. Turcotte, Director
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street Room 312,
Claude Pepper Building
Tallahassee, Florida 32301

Dear Mr. Turcotte:

Thank you for your August 20 letter regarding the preliminary performance-based program budgeting measures standards report for The Department of Children and Families' Alcohol, Drug Abuse and Mental Health Program.

We concur with the review team's observations and findings and acknowledge the efficacy of their recommendations. The following are our specific comments on the six chapters addressed in the report.

Chapter 1

Mental Health Program Office Response:

Page 7 contains information that might help decision-makers. During FY 1997-98, the Department reported all individuals served, including those not funded by the state. As the result of a previous OPPAGA report recommendation, this practice has changed. Now, only those individuals whose services are funded by the state are reported.

Chapter 2

Mental Health Program Office Response:

The Department is pleased that the reviewers reported the program as beneficial, and that it should be continued and administered by the Department. The improvement recommendations are well founded, and the Department will continue to improve in those areas.

Substance Abuse Program Office Response:

Page 13 contains comments regarding previous and current weaknesses in departmental data reliability and its effect on programmatic decision-making. The report acknowledges recent major improvements in data reliability and integrity, and eventually concludes (on page 34) that the data is now suitable for basing legislative decisions concerning the program's overall effectiveness. Current data quality is even greater than indicated in the report. A recent Department of Children and Families Inspector General sample of data quality in four districts tested Department data against provider case files. The review found an accuracy rate of 96 percent.

Chapter 3

Mental Health Program Office Response:

The Department concurs with the observations noted in this chapter.

Substance Abuse Program Office Response:

The FY 1998-99 performance accomplishment for completion of treatment was 64.4 percent for adults (up from 55.3% in FY 1997-98) and 65.9 percent for children (up from 53.9% in FY 1997-98). (Page 21, Second Paragraph).

There is discussion of the adult substance abuse target population, but no mention of the children substance abuse target population. We recommend adding wording to include some of the following key information for FY 1998-99 children target populations (Page 21-23).

Children at Risk of Substance Abuse Problems

Number of children served in targeted prevention—4,571
Percent of children in targeted prevention programs who perceive substance abuse to be harmful at the time of discharge compared to admission—77.4 percent
Percent of children in targeted prevention programs who achieve the expected level of improvement in math—74.7 percent
Percent of children in targeted prevention programs who achieve the expected level of improvement in reading—73.2 percent

Children With Substance Abuse Problems

Number of children served—51,322
Percent of children who complete treatment—68.9 percent
Percent of parents of children receiving services reporting average or above average level of satisfaction on the Family Centered Behavior Scale 85.2 percent
Percent of community partners satisfied, based on survey—78.5 percent
Percent of children receiving services who are satisfied, based on survey—78.2 percent

Chapter 4

Mental Health Program Office Response:

The Department concurs with the observations and recommendations noted in this chapter. The community-based care model the Department is currently developing is one method of coordinating services, and would fit well with the network model recommended.

Substance Abuse Program Office Response:

The percentage of persons in the Protective Supervision Program who were identified in case records as needing, and who received substance abuse services during FY 1998-99, was 47 percent. This percentage of success was achieved through new efforts of coordination between the Family Safety and Preservation and the Substance Abuse programs. Our goal is to increase the percentage to 53 percent by FY 2000-01. (Page 24, Introduction, Second Bullet.)

The Department will examine the feasibility of establishing cooperative provider networks in districts where there are sufficient numbers of providers. This regional networking is viewed as an interim step in the progression toward behavioral health managed care. (Page 30, Last Paragraph.)

Chapter 5

Mental Health Program Office Response:

The Department generally concurs with the observations and recommendations noted in this chapter. Managed care, as well as independent case management, are certainly two alternatives that need to be considered in order to improve the community mental health system. However, before expanding either, additional study is needed to determine the aspects of each that could be employed to best improve the current statewide system. One aspect that both offer is a lead

agency for service provision. Developing lead agencies, as well as uniformity in making community-based care available in local areas are active departmental goals. The employment of technological advances and the development of standards are essential to ensure that there is conformity in service availability for a person regardless of location. The Department accepts the recommendation to go to a network or community-based care model of service delivery instead of a purchase of service method. In so doing, there would be a need to revisit the performance measurement process. We believe that we need to refine the measures and maintain client base measures, but limit them to a "critical few."

Substance Abuse Program Office Response:

Recognizing that the type, and severity, of the clients' presenting substance abuse problems affect treatment outcomes, the Department contracted for a case-mix study that should be completed in the latter part of 2000. (Page 34, Next to Last Bullet.)

Districts are encouraged to judiciously tailor contract performance measures for the client mix and treatment modality of each provider. All statewide performance measures should not be placed in all provider contracts. Providers that serve more difficult clients may have lower performance standards than providers that serve easier, more compliant clients. (Page 37, Last Two Paragraphs.)

The Department will examine the feasibility of monitoring clinical practices, as well as contract compliance issues. (Page 39, First Bullet.)

The Department will examine options to identify and publish best practices by providers. (Page 39, Second Bullet.)

Chapter 6

Mental Health Program Office Response:

The Department generally concurs with the observations and recommendations noted in this chapter. Means testing can create problems. Several services such as residential or Crisis Stabilization Unit services are often clinically or legally required. These services are often only available by the state provider and the average cost for such services is beyond what most families can afford.

Substance Abuse Program Office Response:

The hypothetical payment scenario presented in the report, where the Department supplements Medicaid payments is prevented by system edits. The hypothetical situation does not represent widespread practice. Medicaid is the payer of last resort. (Page 43, Second Paragraph.)

The Department will examine the feasibility of expanding the Florida Health Partnership, in which a network of providers deliver (carve out) managed behavioral health care, and the Medicaid managed care demonstration project (carve in) model of behavioral health care. (Page 45, Second and Last Paragraphs.)

The Department will examine the cost-benefits of moving to behavioral health managed care in selected districts where population and provider inventory support that type of health care delivery. (Page 47, Last Paragraph.)

Thank you for your assistance in the continued improvement of our alcohol, drug abuse and mental health system. We appreciate the opportunity to comment on this draft report. We wish to commend the review team for their noteworthy dedication and remarkable thoroughness.

If I may be of further assistance, please let me know.

Very truly yours,

/s/
Judge Kathleen A. Kearney
Secretary

cc: John Bryant, Assistant Secretary, Mental Health Program Office
Ken DeCerchio, Assistant Secretary, Substance Abuse Program Office
Fotena Zirps, Director, Mission Support and Planning