Audit of the Adult Mental Health Division's Management of Contracted Community Services

A Report to the Governor and the Legislature of the State of Hawaii

Report No. 02-06
February 2002

THE AUDITOR
STATE OF HAWAII

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

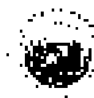
6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds are existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.



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OVERVIEW

Audit of the Adult Mental Health Division's Management of Contracted Community Services

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Summary

The Department of Health's Adult Mental Health Division provides outpatient and inpatient mental health services to individuals 18 years of age and older. Outpatient services are provided by state operated mental health centers and by a network of community providers. The division's recent focus on preparing patients for community reintegration has resulted in significant funding increases for community-based services. During FY2000-01, nearly $48 million was designated for outpatient services. This audit assessed the division's compliance with established procurement rules and principles and the adequacy of the division's oversight of contracted mental health services.

We found the division chief was derelict in her duty to properly manage community-based contract services. We reviewed 20 percent of the service contracts that were open during FY1999-2000 or during the first half of FY2000-01 and found millions of dollars were spent without ensuring the maximum purchasing value of public funds. Contracts were awarded to vendors without assuring that all proposals were fairly evaluated and without following specifications set forth in the request for proposals. Moreover, significant modifications changed the contracts' scopes and circumvented the open competition and fairness principles of the procurement code. The director of health, who approved these contract awards and modifications, overlooked these concerns.

We also found that the division has fostered a quid pro quo environment in which personal gain seems to precede the State's interest. A former acting division chief who participated in key selection decisions later benefited from employment arrangements made with those who were either awarded a contract or selected for a position with the division. The former acting division chief also was paid by the University of Hawaii while working for the division, including serving as acting division chief. Furthermore, the current division chief exercised poor judgment in funneling the former acting division chief's consultant fee through an existing contract with a major provider. The former acting division chief retired from state service but throughout 2001 received four three-month exempt temporary appointments from his successor. Also, the division hired a former official of a division contractor who resigned shortly after an investigation was initiated regarding expenditures she charged against a contract with the division. The duties she performed for the division did not match the position description nor did she have the requisite qualifications for her position. These advantageous arrangements result in the appearance of a conflict of interest and possible collusion.

The division also failed to ensure that the $20 million it paid community services providers between July 1999 and December 2000 was spent prudently. The division's failure to uphold its fiduciary duties resulted in incorrect payments to

private providers. Moreover, the untimely reconciliation of reported expenses against budgeted cost figures, inadequate withholding of contract payments pending final settlement, and inappropriate payments made to contractors for unauthorized services all increased the risk of financial loss.

Poor contract monitoring and follow-up placed patients at risk of harm and provided little assurance that taxpayers' dollars were well spent. For example, the division spent nearly $6 million on assertive community treatment (ACT) services between July 1, 1999 and December 31, 2000 that did not comply with standards established by the National Alliance for the Mentally Ill (NAMI). ACT teams were staffed with individuals who did not have the recommended work experience for the positions they held. The teams also neglected to adequately follow up with patients left in their care. In one case, the team did not meet with a patient for over two months, even though the provider's standards required teams to meet with patients at least twice weekly.

We also found providers may have cared for patients at unlicensed special treatment facilities. The department's Office of Health Care Assurance (OHCA) and the Department of Human Services' Adult Intake and Protective Services Unit both confirmed allegations of residents being placed at risk of harm at these facilities. However, the department obstructed OHCA's investigation and the facilities in question were allowed to continue providing services to patients.

Recommendations and Response

We recommended that the director of health take immediate action to address the division's contracting deficiencies, including developing internal policies and procedures to guide and improve the procurement process. We also recommended that the director ensure the quality and cost-efficiency of contracted mental health services. In addition we recommended that the governor require the director to review and justify all personal service contracts with former employees that give the appearance of cronyism, conflict of interest, and favorable treatment. Finally, we recommended that the division chief improve the stewardship of state funds and property related to contracted mental health services, and that the Legislature consider transferring the functions of the Office of Health Care Assurance from the Department of Health to another state agency.

The department generally agreed with our audit recommendations. However, it failed to specifically address our audit findings, only to challenge or provide background information on some of our assertions.

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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 02-06
February 2002

Foreword

This audit of the Adult Mental Health Division's Management of Contracted Community Services was conducted pursuant to Section 23-4, Hawaii Revised Statutes (HRS), which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions. Our audit focused on the division's procurement and management of contracted adult mental health services.

We wish to express our appreciation for the cooperation and assistance extended to us by the officials of the Department of Health and others whom we contacted during the audit.

Marion M. Higa
State Auditor

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Chapter 1

Introduction

The Department of Health's Adult Mental Health Division plans, coordinates, and promotes integrated mental health services for individuals 18 years of age and older. Public resources provide services focusing on adults with serious mental disorders, individuals in acute and severe mental crises, and persons experiencing distress and trauma from a declared disaster. Based on the level of care needed, individuals may receive outpatient or inpatient services. Outpatient services are provided by mental health centers and a network of community providers. Inpatient services are provided at the Hawaii State Hospital.

The State Auditor initiated this audit to assess whether the division adequately manages contracted mental health services. This audit was performed pursuant to Section 23-4, Hawaii Revised Statutes (HRS), which requires the Auditor to conduct postaudits of the transactions, accounts, programs, and performance of all departments, offices, and agencies of the State and its political subdivisions.

Background

Section 334-3, HRS, states that the Department of Health is responsible for establishing and operating a community-based mental health system within the limits of available funding. State law requires that the system treat and rehabilitate patients in the least restrictive and most therapeutic environment possible.

In recognition of the need to improve rehabilitative services at the state hospital, the 1999 Legislature enacted Act 119 that allowed the department to privatize functions performed at the hospital and to provide comprehensive community-based programs for those individuals who would be either discharged or diverted from the hospital. The department responded by increasing community-based services.

Funding for community-based services has significantly increased

The division's recent focus on preparing patients for community reintegration has resulted in significantly increased funding for such services. Funding for these services nearly doubled from FY1999-2000 when the division received $20,550,303 to FY2000-01 when $39,708,216 was received.

The division reported in its March 2001 service development implementation plan that $60 million in general funds would be needed between FY2001-02 and FY2004-05 in order to fund services for

individuals who are either discharged or diverted from the state hospital. The division requested and received $8 million of this amount for this purpose for FY2001-02.

Although the division initially believed that funding for the state hospital would decrease as community services increased, the increased outpatient services have far exceeded the decreases in the hospital's budget. Funds for hospital inpatient services have remained relatively stable while funding for outpatient services has more than doubled as shown in Exhibit 1.1.

Exhibit 1.1
Adult Mental Health Division, Outpatient and State Hospital Funding, FY1999-2000 through FY2001-02

Service	FY1999-2000	FY2000-01	FY2001-02
Outpatient (HTH420)	$20,550,303	$39,708,216	$47,699,086
State Hospital (HTH430)	$30,533,376	$27,658,878	$28,880,422

Note: Outpatient services include those provided in the community by the division's mental health centers, treatment service sections, and private providers.

Source: Session Laws of Hawaii 2000 and 2001.

Array of services is provided in the community

The division's service development implementation plan identifies 39 services that are categorized into the six following areas: (1) inpatient, (2) crisis intervention, (3) community living arrangements, (4) treatment, (5) rehabilitation/vocational, and (6) community support. See Appendix A for a listing and brief description of each of the 39 services. During FY1999-2000, the division paid 21 private agencies approximately $12 million for outpatient services ranging from crisis intervention to residential arrangements and treatment programs. Exhibit 1.2 identifies the amount the division spent for these community-based services during FY1999-2000 and the first half of FY2000-01.

A little over one-third of the amount spent was for community support services. These services included outreach to the homeless, jail diversion, and Assertive Community Treatment (ACT). Multi-disciplinary treatment teams provide ACT services seven days a week, 24 hours a day. A low staff-to-client ratio allows for continuous contact with the client.

The division spent another half of its funding on crisis and emergency support services and residential living arrangements.

Exhibit 1.2
Adult Mental Health Division's Expenditures for Community-Based Services, FY1999-2000 and July through December 2000

Service	Expenditure FY1999-2000	% of Total	Expenditure July through December 2000	% of Total
Community Support	$4,391,562	36%	$3,007,064	38%
Crisis/Emergency Support	$3,204,952	27%	$2,160,591	27%
Community Living Arrangements	$2,877,982	24%	$2,043,148	26%
Community Living and Treatment	$139,510	1%	$328,488	4%
Treatment Services	$828,349	7%	$163,472	2%
Vocational Rehabilitation	$133,941	1%	$87,715	1%
Other	$474,864	4%	$157,284	2%
TOTAL	**$12,051,160**	**100%**	**$7,947,762**	**100%**

Source: Adult Mental Health Division records.

Previous audit reports

We completed an *Audit of the Adult Mental Health Program*, Report No. 01-13, in July 2001. We reported that the division disregarded long-range planning and instead sought "quick fixes" to resolve outstanding federal court orders stemming from a 1991 settlement agreement that sought to remedy alleged deficiencies in confinement, care, and treatment of patients at the state hospital. That audit also found that the Hawaii Disability Rights Center, a non-profit public interest organization, reported that some privately operated mental health facilities were not licensed or accredited, an issue that we followed up on in this report.

We assessed the adequacy of the division's management of billings and collections for outpatient services in 1995 and 1997. Report No. 95-25, *Audit of the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services,* concluded that the division had weak oversight of its collections and billings. Report No. 97-13, *Follow-Up Audit on the Management of Billings and Collections for the Department of Health's Outpatient Adult Mental Health Services,* found that the division continued to fall short in its management of the billings and collections of its mental health centers.

We also conducted audits of the operation of the state hospital during 1995, 1997, and 2001. These prior audits reported that weak financial controls were also a problem at the hospital.

Objectives of the Audit

1. Assess whether the Adult Mental Health Division complies with established controls and principles governing the procurement of health and human services.

2. Assess the adequacy of the division's management of contracted mental health services by determining whether payments to community providers are proper, and whether programs are adequately monitored.

3. Make recommendations as appropriate.

Scope and Methodology

This audit focused on the Adult Mental Health Division's procurement and management of contracted mental health services. We reviewed approximately 20 percent of the division's contracts that were in effect during FY1999-2000 and the first half of FY2000-01 to assess the division's compliance with the State's procurement code. We also reviewed providers' invoices, contract ledgers, and contract payments to assess whether payments made to providers were proper.

Audit fieldwork also included the review of applicable laws, regulations, and patient records, and interviews with department staff and providers.

Our work was performed from February 2001 through December 2001 in accordance with generally accepted government auditing standards.

Chapter 2

The Adult Mental Health Division of the Department of Health has Been Derelict in its Duty to Properly Manage Community-Based Contract Services

The Adult Mental Health Division's recent expansion of community-based services for adults suffering from severe mental illnesses has occurred in an environment in which requirements for careful stewardship of state funds are overlooked. In its haste to expand community-based services, the division disregarded procurement rules and abandoned sound fiscal management for its contracted services. Moreover, the division has not ensured that the millions of dollars spent on community-based services are cost-effective. Insufficient contract monitoring and the failure to heed program standards and licensing requirements place patients at risk of harm.

Summary of Findings

1. The Adult Mental Health Division does not ensure that contracts are awarded in accordance with the principles of open competition, which promote efficient public spending. Specifically, the practice of significantly modifying contractual terms, coupled with the failure to follow contracting guidelines, is unfair and contrary to the spirit of the procurement law. Moreover, the questionable relationship between a division employee and a major provider that receives over half of the funds spent on contracted community-based services is of serious concern, and weakens the division's credibility.

2. The division chief is lax in managing contracted community-based mental health services. Controls to protect the State against potential loss are disregarded. Also, the requirements for stewardship of public funds are disregarded in the division's haste to increase community services. As a result, incorrect payments are made to service providers and inadequate monitoring of community services places patients at risk of harm.

The Division Failed to Procure Services Competitively and Cost-Efficiently as Mandated by the Hawaii Public Procurement Code

Procurement laws and administrative rules are established to ensure that the State obtains the most advantageous offer when purchasing goods and services. Chapter 103D, Hawaii Revised Statutes (HRS), the Hawaii Public Procurement Code, governs the award of all human services contracts solicited or entered into between July 1, 1994 and July 1, 1998. Contracts solicited or entered into after that date are subject to the provisions of Chapter 103F, HRS, Purchases of Health and Human Services. Chapters 103D and 103F both establish standards for the competitive award of contracts. The division contracts for community-based services using the competitive proposal method established under these chapters.

The procurement process begins when the division solicits a Request For Proposals (RFP). The RFP promotes equity among interested providers by publicly stating the scope of services to be provided and the factors to be considered when proposals are evaluated. Contracts must be evaluated and awarded in accordance with the public information specified in the RFP. Once a provider is selected to deliver the specified services, modifications to the contract's scope are not allowed. State agencies that procure services are obligated to ensure that open competition exists, contracts are evaluated and awarded in accordance with proposal specifications, and contracts are not modified simply to circumvent the procurement process.

We reviewed 20 percent of the community service contracts that were still open during FY1999-2000 or during the first half of FY2000-01 and found that the Adult Mental Health Division spends millions of dollars for community-based services without ensuring the maximum purchasing value of public funds. The division's disregard for procurement rules may be due in part to the lack of internal guidelines for procuring services. Contracts were awarded to vendors without the assurance that all proposals were fairly evaluated and without following specifications as set forth in the RFPs. Moreover, the frequency at which the division significantly modified executed contracts is alarming and circumvents the fairness and open competition principles of the procurement code.

Evaluations of the RFPs are questionable and fail to comply with procurement code requirements

Guidelines for evaluating proposals have been established in Hawaii Administrative Rules to ensure fair and equitable treatment for all providers interested in doing business with the State. Proposals must be evaluated either by the procurement officer or an evaluation committee using the criteria established in the RFP. Written comments or a numerical rating system is used to score the evaluations. Proposals are then ranked from the most to the least advantageous. Members of the evaluation committee must also be identified in the procurement file. Documenting evaluation information is critical to ensure fairness in the selection of proposals.

We reviewed the division's procurement files and found discrepancies in the evaluation process that raise concern. There is no assurance that the staff evaluating proposals are qualified and unbiased. Furthermore, we found numerous errors in the calculation of evaluation scores that could result in the selection of a proposal that is not the most advantageous to the State.

Staff evaluators are not documented in the procurement file

We reviewed 23 proposals that were submitted to the division in response to eight RFPs. The division failed to identify the staff evaluating 22 out of the 23 proposals we reviewed. This creates an environment in which fraud and cronyism would be difficult to detect and track. Furthermore, it offers Hawaii's taxpayers little confidence that those evaluating proposals and awarding contracts received sufficient training and education to fulfill their evaluation duties.

Evaluation scores are inaccurate

Errors in calculating evaluation scores further compromise the integrity of the division's evaluation process. The division incorrectly calculated the scores for 19 of 23 proposals that were submitted in response to the eight RFPs. Although the errors we detected would not have affected the outcome of the contract awards, the frequency at which these errors occurred (83 percent of the proposals reviewed) indicates that the division is not adequately reviewing its scoring calculations. The failure to detect scoring errors could result in wrongly awarding a contract to a provider that does not serve the State's best interest.

In another case, the division awarded a contract for assertive community treatment services to a provider without considering the comments/score of each member of the evaluation team. The division's administrative officer informed us that the division was unable to find a team member's evaluation of the winning proposal. Our review of the summary evaluations revealed that the division averaged seven of the evaluators' scores for two of the proposals received, but averaged only six of the evaluators' scores when calculating the overall score for the winning proposal. This inconsistent methodology may have given the winning proposal an unfair advantage had the seventh evaluator rated the proposal poorly.

Contracts do not follow the specifications of the RFP

RFPs include important instructions and information for interested vendors. The RFP identifies the evaluation criteria and the relative importance of each criterion. The RFP also identifies service specifications, including the minimum or mandatory activities to be performed, the target population and the geographic area to be served, the units of the service to be provided, and the pricing methodology to be used for the services.

The director of health approved contracts awarded by the division that failed to follow specifications established in RFPs. In one case, the RFP for a 24-hour therapeutic group home specified that the vendor would be paid a fixed unit rate of $42 per bed, per day. The division awarded the contract to two different vendors. One vendor was paid in accordance with the RFP's guidelines, but the second vendor was paid on a cost reimbursement basis that resulted in an additional $32 per bed, per day. This was unfair to the first vendor and other providers that may have been interested in providing this service under the cost reimbursement basis not specified in the RFP.

Moreover, the RFP specified that the services were to be provided on the state hospital grounds but one contractor was allowed to provide the therapeutic group home services in Kaimuki. This change in geographic location was again unfair to other providers that might have been able to provide these services at sites other than the state hospital.

In another case, the RFP specified that the contract award would be for a single year. However, the executed contract allowed the division to extend the service for five additional years without resoliciting a new proposal. At the time of our audit fieldwork, the division elected to extend this contract for an additional year.

Significant contract modifications are highly questionable and circumvent the open competition principle of the procurement code

The division further abandoned the principle of open competition that is embodied in Hawaii's procurement laws and rules by significantly modifying the scope of services in six of ten contracts that it amended. The director of health approved these changes. In one case, the contract initially required that crisis stabilization services be provided to the seriously mentally ill in an acute mental health crisis setting over a period of one year. However, the contract scope was later amended to include long-term treatment residential services for patients for three additional years. This change in contract scope also increased the contract amount from $438,000 to approximately $3 million.

The division significantly modified another contract by expanding the geographic area in which services were to be provided. The initial contract specified that assertive community treatment services were to be provided on the island of Hawaii over a six-month period. However, the division agreed to expand services to the island of Oahu only three months after executing this contract. Approximately a year and a half later, the division terminated all services on the island of Hawaii and further increased services on Oahu. These modifications resulted in the contract amount increasing from $193,781 to over $3 million.

Hawaii Administrative Rules for Chapter 103D allow services to be increased by a maximum of 10 percent if the procurement officer makes a written determination that the increase is more economical than

awarding another contract. We found no evidence that such determination was made when services procured under Chapter 103D exceeded this threshold. In order to allow continuity in services contracted under Chapter 103F, administrative rules specify that these contracts may be extended for up to six months until a new contract has been awarded and executed under the procurement process. However, the terms and conditions of the extended contract must remain substantially the same as the original contract. The modified contracts we reviewed changed the scopes substantially by increasing the service units to be provided or by adding new services. We also found that two contracts solicited under Chapter 103F were improperly extended beyond six months of the initial contract's termination date.

Poor planning for service requirements does not exempt the division from procurement rules. If additional services are needed, the department should issue a separate RFP for those services. Adherence to these rules ensures that all interested vendors are given the opportunity to compete. Open competition also helps to assure that taxpayers' dollars are maximized through an open competitive market.

The Department Fosters a Culture of Quid Pro Quo and Favorable Treatment Between Division Employees and a Private Provider

Government employees are obligated to represent the interests of the State, and thereby Hawaii's taxpayers, while carrying out its daily functions and operations. Government employees have fiduciary duties to protect against all forms of corruption, including favoritism, private arrangements between public officials and contractors, thievery, and bribery.

As indicated in the previous section of this report, the division failed to uphold this standard when it disregarded procurement laws and rules that were established to deter favoritism. Of further concern, the division is fostering a quid pro quo environment in which personal gain seems to precede the State's interest. Specifically, the division's relationship with a former acting division chief and a major contractor raises questions of conflict of interest and possible favoritism.

Former acting division chief and those he helped to select mutually benefit

A former acting division chief who participated in key selection decisions later benefited from arrangements made with those who were awarded either a contract or a position. Such advantageous arrangements give the appearance of a conflict of interest and possible collusion. Furthermore, the current division chief exercised poor judgment in funneling the former chief's fee as a consultant through an existing contract with a major provider.

Provider employs the former acting division chief after being selected for a major contract

During 1997, the division initially contracted with Helping Hands Hawaii to provide assertive community treatment services. The contract specified that the division would pay the provider up to $507,222 for services to be provided over a one-year period. Since the contract allowed for a two-year extension, Helping Hands Hawaii received over $2.3 million to continue the services during FY1999-2000. The division awarded another contract to Helping Hands Hawaii during that fiscal year and paid the provider another $1.3 million to continue providing assertive community treatment services.

These contract awards resulted in Helping Hands Hawaii receiving approximately 60 percent of all funds paid to community service providers during FY1999-2000. Of the nearly $7 million that Helping Hands Hawaii was paid during that fiscal year, $3.6 million was for assertive community treatment services.

The acting division chief who approved the selection of Helping Hands Hawaii was later employed by that provider. This former acting chief was hired as a program planner for assertive community treatment services although his position was not in the provider's organizational structure. Helping Hands Hawaii paid the former acting division chief an annual salary of $42,500 even though he directly reported to the current Adult Mental Health Division's chief and physically worked out of the division's office. In fact, the former acting division chief informed us that he neither worked at nor reported directly to anyone at Helping Hands Hawaii. The federal court monitor assigned as a result of the 1991 settlement agreement raised concern that the division was using its contract with Helping Hands Hawaii to pay a division consultant. The provider subsequently terminated its employment relationship with the former acting division chief.

The president of Helping Hands Hawaii informed us that she was unaware of the program planner position until questioned by the court monitor. However, our review of the contract from which the former acting division chief was paid revealed she approved of the position identified in the budget modification she signed. She informed us that this position has since been eliminated.

The former acting and current division chiefs provided a different account of what transpired. They claim that the president of Helping Hands Hawaii was aware of the employment arrangement prior to the court monitor's questions. According to the current division chief, the arrangement allowed the division to facilitate obtaining the assistance of the former chief in developing assertive community treatment services.

The current division chief acknowledged that, in retrospect, it would have been better to delay the hiring of the former acting division chief to avoid the resulting perception of impropriety. We agree. The division should have procured these services properly instead of using its position of influence to arrange payment for its consultant through an existing contract with a major provider. This is deceptive and contrary to the principle of open competition.

Former acting division chief is rehired as a temporary hire by the successor he helped to select

Although the division chief recognized the impropriety of hiring a consultant without following procurement guidelines, she found another questionable way to place her predecessor on the division's payroll. A month after Helping Hands Hawaii terminated the former acting chief, she offered him an exempt temporary assignment as a newly created Department of Justice projects specialist. The former acting division chief accepted the position and is currently paid a monthly salary of $6,066 in addition to receiving his government pension.

The former acting chief denied to us that he was receiving his pension in addition to his temporary appointment pay. However, the Employees' Retirement System confirmed that he received $18,308.12 in pension payments for the period of December 2000 to December 2001. The former acting division chief was also paid an additional $66,692.85 by the division during this same period.

State employees are allowed to collect their pension in addition to pay for a temporary appointment as long as the appointment does not exceed 89 days. The former division chief was allowed to collect both his pension and project specialist pay because his limited term appointment did not exceed the threshold of 89 days. However, the former chief's appointment was renewed four separate times after allowing a few days' break in service each time to enable him to continue to receive his pension. Although the breaks in service may be within the letter of the law, they clearly violate the spirit of the law. Rehiring retirees in this manner establishes a potentially cost-prohibitive precedent. It encourages state workers who have no real intention of retiring to do so and be rehired in a temporary position in order to collect both pension and pay and increase their annual income.

Of further concern, the division was unable to clearly explain how it derived the pay for the Department of Justice projects specialist position. We asked the administrative officer to provide us with documentation that would support the salary review and analysis completed by the division to determine the pay for this position. The division responded that the salary was derived after it completed a comparison between the position and other contracted and exempt positions. However, the

division did not provide us with the supporting documents we requested. Consequently, we were unable to assess the reasonableness of the Department of Justice projects specialist's salary.

Responsibilities of the former acting division chief duplicate that of the current division chief

The former acting division chief was paid to provide services that duplicated the current chief's responsibilities. During the eight-month period in which he was the acting chief, the University of Hawaii paid him through a contract. Although the university had contracted him as a project coordinator, the medical school director allowed him to serve as the division's acting chief upon the request of the Department of Health. After the acting chief assisted in the selection of his successor, the university's chair of the Department of Psychiatry agreed to allow him to assist his successor in directing the daily operations of the division.

A proposal between the university and the division stipulated that the former acting chief would coordinate the allocation of funds for inpatient and outpatient services, direct the development and finalization of all purchase of service contracts, oversee the activities of the state hospital and community mental health centers, and coordinate the development of program and/or funding requests. These duties duplicated the responsibilities that belonged to the division chief and therefore raise questions regarding the current chief's ability to serve in that role. The university terminated this contractual arrangement approximately one year later during September 1999. However, the former acting chief continued to work for the division, as discussed earlier, while being paid through an existing contract with a major provider. A timeline of the employment history of this former acting division chief is noted in Exhibit 2.1.

Division hires a provider's former employee who was investigated for improperly billing the division

The development of obscure relationships between former employees and contractors extends beyond the former acting division chief. Helping Hands Hawaii's former director of program services of behavioral health resigned shortly after an investigation was launched regarding inappropriate expenditures she charged against a contract with the division. Subsequent to her resignation from Helping Hands Hawaii, the department employed her as an emergency hire.

The hiring of this former Helping Hands Hawaii employee is peculiar. According to her position description, she was to primarily provide direct services to patients at the Maui Community Mental Health Center's day program. However, she informed us that she worked out of the division's Oahu office and assisted in the development of a vocational rehabilitation framework. She was not involved in direct

Exhibit 2.1
Employment History of Former Adult Mental Health Acting Division Chief

June 2, 1975	Interagency appointment to the Department of Health's Mental Health Division, Substance Abuse Branch, from the Governor's Office. Appointed as the substance abuse information coordinator II.
July 18, 1981	Appointed as the public health administrative officer in the Mental Health Division's Central Administrative Services Office.
December 20, 1994	Retires from the Department of Health and separates his employment with the State of Hawaii.
December 31, 1994	Begins to collect pension pay from the Employee Retirement System of the State of Hawaii.
January 1995	Contracted by the University of Hawaii's Medical School as a project coordinator responsible for developing a request to the federal government for a shortage designation for psychologists on the island of Hawaii.
June 1997 through January 1998	Serves as the acting chief of the Adult Mental Health Division while continuing to be paid through the University of Hawaii contract.
February 2, 1998	Current Adult Mental Health Division chief is appointed. The former acting division chief sits on her selection panel. Former acting chief assists the current Adult Mental Health Division chief while continuing to be paid through the University of Hawaii contract.
September 1999	University of Hawaii terminates contract with former acting chief.
November 1, 1999	The former acting chief continues to assist the current chief and is paid through a contract with a major community service provider. The provider hires the former chief as a program planner for assertive community treatment services, although the division chief directly supervises him.
November 9, 2000	The provider terminates the employment of the former division chief.
December 21, 2000	Current division chief rehires the former acting chief into the newly created position of Department of Justice project specialist. The exempt temporary appointment was not to exceed March 19, 2001.
March 19, 2001	Appointment as Department of Justice project specialist terminates at the close of the business day.
March 21, 2001	The division rehires the former acting chief as the Department of Justice project specialist. This exempt position was not to exceed June 15, 2001.
June 15, 2001	Appointment as Department of Justice project specialist terminates at the close of the business day.
June 19, 2001	The division rehires the former acting chief as the Department of Justice project specialist. The exempt temporary appointment was not to exceed September 14, 2001.
September 14, 2001	Appointment as Department of Justice project specialist terminates at the close of the business day.
September 18, 2001	The division rehires the former acting chief as the Department of Justice project specialist. The exempt temporary appointment was not to exceed December 14, 2001.
December 14, 2001	Appointment as Department of Justice project specialist terminates at the close of the business day.
December 18, 2001	The division rehires the former acting chief as the Department of Justice project specialist. The exempt temporary appointment is to not exceed March 15, 2002.

Note: The former acting division chief had other appointments within the department's Mental Health Division prior to his appointment as the public health administrative officer.

patient contact nor did she work on Maui. Furthermore, she lacked the recommended three years of experience as a vocational rehabilitation specialist.

When the division was asked to explain the discrepancy between the actual functions of the employee and those specified in the position description, we were told that the division chief "borrowed" the Maui position. However, the department's personnel office reported that when a position is borrowed and job duties change, the position description should be updated to reflect the responsibilities of the newly created position. The failure to do so reflects the division's inability to adequately plan for the staffing infrastructure, and also raises suspicion regarding the circumstances under which the position was filled. We reported this weakness in our *Audit of the Adult Mental Health Program,* Report No. 01-13.

The Division Failed to Adequately Manage Community-Based Contract Services

The division spent approximately $20 million for community-based mental health services between July 1999 and December 2000 without ensuring that these funds were spent prudently. Weak stewardship of state funds resulted in providers being incorrectly paid. Furthermore, sporadic contract monitoring placed patients at risk of harm from services that did not meet standards.

Stewardship over state funds and property is weak

The division pays for community-based services on either a cost reimbursement or fixed unit rate basis. Service contracts that are paid for using a cost reimbursement methodology include approved budgets that identify allowable expenses and spending limits. The division is responsible for reviewing expenditure reports to determine the appropriateness and allowability of reported expenses.

Service contracts that specify a fixed unit rate require providers to collaborate with the division to ensure that only authorized consumers receive services. The division may deny payment for patients the provider is not authorized to serve.

The division's failure to fulfill its fiduciary duties as specified in both cost reimbursement and fixed rate service contracts has resulted in providers receiving incorrect payments. Furthermore, the division's failure to validate providers' invoices, retain final payment pending final settlement of contracts, and maintain an inventory of state property purchased by providers increases the risk of financial loss.

Providers are paid without validation of invoices

The cost reimbursement contracts we reviewed required that payment be made in quarterly advances; however, the division was authorized to adjust advances when questionable expenses in previous quarters occurred. We reviewed providers' invoices and expense reports for five contracts and found that the division did not adjust subsequent advances when the reported expenses were not allowable. In one case, the provider's expense report indicated that funds allocated for long-term residential services were spent instead on crisis stabilization services.

The division also failed to adjust quarterly advances when the providers' expense reports indicated that they failed to meet contracted minimum service requirements. Three of the contracts we reviewed required the providers to maintain minimum service levels. Although two of the providers failed to meet the service requirements, the division did not decrease their payments.

The division also failed to withhold funding when providers failed to meet reporting requirements. We reviewed 21 reporting periods and found that providers did not comply with reporting requirements 43 percent of the time. They either failed to meet the reporting deadlines or did not submit their expenditure reports for the required period. Nevertheless, the division paid for their services without verifying that the reported expenses were reasonable. In one case, the division paid a provider over $1.1 million although the provider failed to submit expenditure reports to support its invoices.

Reconciliation of reported against budgeted expenditures is untimely and ineffective

Reconciliation of reported expense against budgeted cost figures should occur routinely to ensure that discrepancies are identified in a timely manner. Timely reconciliation allows the division to adjust remaining advances appropriately. However, the division has experienced difficulty in reconciling providers' reported and budgeted expenses. Providers' expenditure reports do not align with fiscal quarters, making a comparison of expenditures to quarterly advance payments cumbersome. As indicated earlier, providers failed to submit quarterly expense reports as required. Rather than withholding payments pending submission of quarterly invoices and expense reports, the division continued to pay providers and chose to reconcile reported expenses against the approved budget at the end of the contract period. This practice is fiscally unsound.

Providers are paid for unauthorized services

The division established controls to ensure that those providers reimbursed using a fixed unit rate are paid only for those services

authorized by the division. At the time of our fieldwork, the department's Hawaii Evaluation and Level of Placement (H.E.L.P.) team (now referred to as the utilization management team) received service requests from care managers and determined the appropriateness of the request. The team reviewed clinical data to determine whether or not services would be authorized.

In those cases in which the team decided to authorize services, this information was entered into a purchase of service database. The database generated an authorization number and a letter of authorization, which was mailed to the provider. The database also tracked the remaining fund balances for individual service contracts. When funds were insufficient to cover a service, the system did not generate an authorization number and letter.

The division informed us that the remaining fund balances were not always accurately tracked by the database. Whenever services were authorized, the system would automatically deduct the cost of the services from the contract balance. However, if the patient did not receive the service, the cost was not remitted back to the remaining balance until the fiscal staff reconciled the database with their records. Consequently, the database would not issue authorization numbers even if funds were still available.

Staff responsible for authorizing services believed that if the patient needed the service, it was the division's responsibility to pay for it regardless of funding availability. When the database did not issue an authorization number and letter, the staff wrote their own letters of authorization. They also informed the fiscal staff of the need to make the funding available. This practice seriously weakened the division's ability to control expenditures, and made it difficult for the fiscal staff to identify whether providers received authorization for billed services. Consequently, the division overpaid providers $22,415 when it failed to identify unauthorized services providers billed the division for.

Services are authorized retroactively

The division retroactively authorized services to accommodate contractors who submitted billings for unauthorized services. In one case, the division authorized 11 days of services over two months after the provider had discharged a patient. This practice undermines the purpose of service authorization and should generally not occur. The division should inform all providers who treat patients without prior authorization that they assume the risk of financial loss because the department is not obligated to pay for unauthorized services.

The division's practice of authorizing only high-end (costlier) services further exacerbates the current situation because providers may be confused as to which services are considered "high-end" and require prior authorization. We believe all services, excluding emergency or immediate crisis intervention, should receive prior authorization. This lessens confusion among providers and establishes a fiscal control that discourages providers from submitting false billings. The division should clearly define emergency and crisis intervention services to discourage staff from using these services as a means of convenience and as a way of avoiding the need for prior authorization. Furthermore, all emergency and crisis intervention service referrals should be reviewed by an independent clinical staff person within a reasonable timeframe to ensure that these services are not misused. The division should take corrective action in cases where staff refer patients to these services as a matter of convenience rather than necessity.

Final retainer payment is not withheld

Contract provisions require the division to withhold a specific percent of the total compensation pending final settlement of the contract agreement. The withholding of funds pending final settlement is a control to minimize financial loss that could occur should a provider fail to meet the terms of the contract agreement. However, the division did not withhold adequate funding for 60 percent of the contracts in our sample that were pending final settlement. The total amount the division failed to withhold for these contracts was $646,304.

State property purchased with contract funds is not adequately protected from theft or misuse

Approximately half of the 11 contracts we reviewed required that equipment and unused supplies and materials leased or purchased with state funds become state property upon termination of the contract. However, the division does not maintain an inventory of equipment purchased with contract funds. The failure to keep track of major equipment purchases can result in theft, loss, or misuse of state-owned equipment.

Our review of one provider's equipment purchases revealed that the provider also failed to maintain an inventory of equipment purchased with state funds. Although the division did not identify the provider's poor oversight of state property, the provider informed us it was in the process of conducting its own inventory from which it planned to develop a master inventory list.

The division's monitoring of contracted services is poor

State law and administrative rules require the department to monitor and evaluate mental health and human services to ensure that the community is being provided with high-level services. The division requires that all contracts be monitored annually and that timely follow-up and corrective action be taken in those cases where deficiencies are noted. The division's monitoring team is comprised of fiscal, contract, program, housing, and quality assurance staff. The monitoring staff conduct desk reviews and on-site monitoring.

We reviewed the division's monitoring reports and found that the division did not adequately monitor service providers. Moreover, the division has been remiss in taking appropriate corrective action when staff identify potential concerns or deficiencies.

Contract monitoring and follow-up is weak

At the time of our fieldwork, the division had completed required monitoring for only 40 percent of the contracts in our sample. Furthermore, even when the monitoring was completed, the division was untimely in submitting its letter of findings to providers. The division requires that the letter be submitted within 30 days of completing the site visit. Timely distribution of the division's findings accelerates the process in which corrective action is taken.

During an April 1998 site visit, the fiscal monitoring team was unable to verify expenditures charged to a division contract for two fiscal years. The division drafted a memo to the provider indicating that unless the costs attributed to the division's contract could be substantiated within 30 days, the provider should refund the division $165,458. However, the memo was never sent to the provider. In fact, the provider did not receive written notification of the division's concern until March 2001.

We asked the division chief and administrative officer to explain the delay in communicating this information to the provider. We were told that a fire at the division's office was the cause of the delay. Although a fire did occur at the division's office during 1998, it does not justify the three-year delay in pursuing the questionable charges. Of further concern, the division continued to award contracts to the provider although it was unable to substantiate its reported expenses. The division chief and administrative officer informed us that subsequent contracts were awarded because the division needed the provider's services. This lax attitude is of concern because it undermines the purpose of contract monitoring and assumes that taxpayers will keep contractors in business regardless of their inefficiency or disregard of contract terms.

Millions were spent on assertive community treatment services that did not meet standards

Between July 1, 1999, and December 31, 2000, the division spent nearly $6 million for assertive community treatment services. Assertive community treatment is a service delivery model in which a multidisciplinary team works collaboratively to deliver the majority of treatment, rehabilitation, and support services required by a patient to live in the community. This approach minimizes referrals to outside providers and reportedly increases the likelihood that the patient will live successfully in the community.

However, the National Alliance for the Mentally Ill (NAMI) reports that not all programs of assertive community treatment live up to the model because they are understaffed, under trained, and/or lack key services. To address this concern, NAMI has developed recommended staffing standards with the support of the U.S. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

We reviewed the staffing for two of four assertive community treatment teams to determine whether they complied with NAMI's staffing standards. Both teams did not have a vocational specialist and a full-time peer specialist as recommended by NAMI. Furthermore, the employment applications of some team members indicated they did not have the recommended work experience for their positions.

The provider of the assertive community treatment services also established minimum qualifications for team leaders, psychiatric registered nurses, and caseworkers assigned to treatment teams. We reviewed the personnel files for staff on two of four teams and found that approximately half of the staff did not meet the minimum qualifications for their positions. They primarily lacked the required mental health work experience. We also found that two staff did not meet CPR and/or first aid certification requirements. In one case, the provider informed the employee that if the first aid certification was not turned in by April 2001, the employee would be suspended. Although the certification was not turned in as of June 2001, the employee continued to work on his team.

Of further concern, the provider failed to ensure that two of four nurses on these teams had current nursing licenses. We followed up with the Department of Commerce and Consumer Affairs and confirmed that both employees did in fact have current licenses. An employee in the provider's human resource department informed us that the provider had only begun to track the currency of first aid and CPR certification three weeks prior to our review. She also reported that the provider was not tracking the currency of the registered nurses' licenses. This is a serious

concern since nurses on these teams are allowed to conduct nursing assessments, provide treatment, and dispense medication to patients.

NAMI also recommends that the assertive community treatment team provide an average of three contacts per week for all patients. The provider of these services informed us that case managers should meet with their patients twice weekly. Our review of 28 patient files indicated that only four patients were visited by team members between June 3 and June 9, 2001. Moreover, the team had no contact with ten of the patients in our sample for the one-week period reviewed. In one case, a patient's records indicate that the team did not make face-to-face contact with a patient for approximately two and a half months.

Providers may be operating facilities without proper licensure

Hawaii Administrative Rules define special treatment facilities as those that provide a "therapeutic residential program for care, diagnosis, treatment or rehabilitation services for socially or emotionally distressed persons, mentally ill persons, persons suffering from substance abuse, and developmentally disabled persons." Every special treatment facility must have a current license approved by the director of health.

The department's Office of Health Care Assurance (OHCA) is responsible for ensuring the health, welfare, and safety of individuals residing in residential care facilities throughout the State. OHCA licenses special treatment facilities and inspects them for their compliance with administrative rules. It also investigates complaints regarding care facilities.

During November 1999, OHCA received a complaint alleging that a private provider was operating a special treatment facility without a license at the direction of the division chief. OHCA investigators visited the treatment facility and observed its staff distributing medication to patients. OHCA staff informed us that they believe this act was a form of medication management and that the home should be licensed since staff were providing the patients with direct care. The Hawaii Disability Rights Center, a non-profit protection and advocacy center authorized by federal law, agrees with OHCA's position. The center's director of client services informed us that staff at residential homes monitor their residents' medication intake.

While visiting the treatment facility, OHCA's investigators also observed two patients who required an intermediate level of care that the facility was not licensed to provide. The investigators' notes indicate that they ordered the provider to cease and desist while they were at the site. However, OHCA informed us that a formal notice to cease and desist had not been sent out as of June 2001, a year and a half after the

investigation, because of differences of opinion with the Adult Mental Health Division as to whether or not the facility should be licensed.

The Adult Mental Health Division disagrees with OHCA's assessment and informed us that the contractor is only providing patients with a place to live. However, the division's contract with the provider specifies that the contractor was to provide individual or group therapeutic sessions for each patient to include but not be limited to psychoeducational sessions covering such areas as medication, symptom management, social skills training, supportive counseling, and other skill building training. Since Hawaii Administrative Rules define special treatment facilities as those that provide therapeutic residential programs, we believe that the provider's therapeutic treatment meant the facility operated as a special treatment facility.

OHCA also attempted to investigate two other sites that were reportedly operating as special treatment facilities without proper licenses. In one facility, a former deputy director of health ordered OHCA to stop its investigation because he believed the provider did not pose an immediate health and safety risk, and he had been assured that the Adult Mental Health Division would take an active role in monitoring the facility. However, the Department of Human Services' Adult Intake and Protective Services Unit also investigated this facility and confirmed allegations of residents being placed at continued risk of neglect and maltreatment with the possibility of serious harm due to a lack of appropriate and proper nursing procedures.

In the second facility, the provider refused to allow OHCA's investigators access to its facility. OHCA attempted to obtain a warrant from the attorney general to allow its investigation; however, the warrant was not issued because the Department of the Attorney General believed that OHCA lacked probable cause and evidence. An attorney general representative informed us that the department failed to address questions regarding what type of facility was in question and whether OHCA had the authority to license the facility. We disagree with the attorney general's position because the purpose of OHCA's investigation was to confirm whether or not the facility in question was operating as a special treatment facility. The fact that the Adult Mental Health Division disagreed with OHCA's position is irrelevant. We believe that the Department of Health has obstructed OHCA from performing its function.

The director of health should not allow this issue to remain unresolved. The director should instruct the Adult Mental Health Division to cooperate with OHCA in its investigation and require the division to terminate contracts with all providers that OHCA confirms is operating as a special treatment facility without proper licensure. The division's need for these services should not factor into this decision, as the

purpose of licensing is to protect patients from harm. The Legislature may want to consider transferring OHCA's functions to another agency to avoid future thwarting of OHCA.

Conclusion

The Adult Mental Health Division chief is derelict in her duty to ensure that the State's resources are being well spent on quality patient care. The division has expanded contracted community-based services without ensuring that fiscal controls were in place and properly implemented. Furthermore, the belief that certain services were needed regardless of available funding, licensing requirements, or providers' past performance resulted in poor decision making. In her haste to establish a broad-based community program, the division chief failed to balance responsible fiscal management with the need for expanded community services. Moreover, the division's lack of oversight and weak contract management means the State cannot ensure that patients are benefiting from the services received. The division's goal should be to provide patients with quality services that are cost-effective, rather than to simply place patients in the community.

Recommendations

1. The director of health should take immediate action to address contracting deficiencies that fail to uphold the procurement principle of open competition and that result in poor fiscal management of contracted services. Specifically, the director should:

    a. Require the division to develop internal policies and procedures to guide and improve procurement practices. The director should ensure that staff receive training on procurement policies and he should monitor the procurement process to ensure that applicable laws and rules are followed. Furthermore, the director should direct the division chief to review all proposal evaluations for completeness and to verify the accuracy of computed scores;

    b. Ensure that contractual terms comply with the specifications set forth in the RFP *prior* to signing contract agreements;

    c. Require the division to improve its service planning efforts and discontinue the practice of significantly modifying contracts. The director should disallow amendments that significantly modify contracts and instead direct the division to issue new RFPs when patient needs cannot be met under current contracts; and

   d. Identify all contracts that have been extended beyond the timeframe allowed under procurement rules, and require the division to immediately issue RFPs for these services.

2. The governor should require the director of health to review and justify all personal service contracts with former employees that give the appearance of croynism, conflict of interest, and favorable treatment.

3. The division chief should improve the stewardship of state funds and property by:

   a. Paying providers only when invoices are accompanied by required expenditure reports and when expenses reported on invoices have been determined appropriate by fiscal staff;

   b. Adjusting quarterly advances paid to providers when warranted;

   c. Withholding adequate funding while contracts are pending final settlement;

   d. Requiring that all services billed on a unit rate basis, excluding emergency and crisis intervention, be authorized prior to service delivery. Emergency and crisis intervention should be clearly defined and a clinical staff person, independent from the referral process, should review these service referrals and identify any inappropriate referrals. The department should take corrective action to address any misuse of emergency and crisis intervention services; and

   e. Developing an inventory of state property purchased by providers, and monitoring and testing the application of its providers' inventory controls.

4. The director of health should ensure that both quality and cost-effective contracted services are provided by the division. Specifically, the director should:

   a. Ensure that annual site visits are completed for all contracted services and that monitoring reports are issued within required timeframes;

   b. Require the division chief to follow up on monitors' findings in a timely manner and adjust future payments to providers as warranted;

c. Require the division chief to improve the management of assertive community treatment services by ensuring the multidisciplinary team approach operates as designed and that team members are qualified; and

d. Immediately resolve the licensing requirements for those facilities that the Office of Health Care Assurance believes is operating as special treatment facilities without proper licensure. The director should instruct OHCA to complete its investigation of these facilities and, should OHCA conclude that these facilities are providing a level of service which they are not licensed to provide, the director should remove all patients from these facilities and find alternative care to ensure their safety.

5. The Legislature should consider transferring the functions of the Office of Health Care Assurance from the Department of Health to another state agency to avoid future conflicts of interest.

Appendix A
Adult Mental Health Division's Array of Community Services

Community Living Arrangements (Residential)	
24-Hour Intensive Staff Supervision	Residents receive assistance in developing daily living skills, such as bathing, cleaning, cooking and other self-care tasks. No more than five persons are usually served at a single location that is designed to be the least restrictive. These programs may be short term (less than two years), or used as transitional programs for persons leaving long-term care or hospitalization.
Forensic Residential Service	These programs are similar to the 24-hour intensive staff supervision programs, except that they are for persons who are involved with the courts.
8 to 16-Hour Residential Rehabilitation Program	Provides clients who require moderate staff supervision rather than one-to-one attention, and the verbal structure or support needed to accomplish daily living skills. The goal is to engage individuals in the development of their own internal structure and control in order to allow them to live in the community. Generally, no more than four persons are served at a single location. These programs may be short term (less than two years), or used as transitional programs for persons leaving inpatient psychiatric care and/or substance abuse residential treatment programs.
Semi-Independent Living	Provides scheduled staff visits to clients who require minimum staff supervision, and are capable of handling non-crisis situations for a day or so. During these visits, staff provide assistance, skills training, and consultation with individuals who are part of the resident's natural support network. Usually no more than five persons are served at a single location. Clients may be living in their own homes, with relatives, or with friends in either a home or apartment.
Supported Housing	Provides assistance to individuals who live independently without regularly structured supervision from mental health staff. Individuals may live alone, with a relative, or with a friend. Supports provided by mental health staff are separated from the living arrangements; however, in-home support is encouraged as needed.
Specialized Residential	Provides intensive support and/or skills training usually for no more than four residents who have specialized service needs. Programs are designed to meet the needs of geriatric residents requiring intensive support, residents experiencing severe behavioral symptoms, and residents with physical disabilities.

Service	Description
Crisis/Emergency Services	
Crisis Mobile Outreach	Provides short-term mental health services to individuals during an emergency crisis situation. Services are provided to individuals in their homes, shelters, on the street, and wherever the need arises.
Crisis Emergency Telephone/Walk In/Urgent Care	Provides immediate, short-term mental health services, triage, and support for individuals who are experiencing an emergency or crisis situation. Services include providing medication, crisis intervention, and supportive counseling. Services may be provided up to 24 hours to provide the opportunity for a person to stabilize, secure supports necessary to return home, and/or for staff and the person (and their family) to explore immediate service options in the community.
Crisis Residential	Provides 24-hour supports in a safe and stable setting for individuals in crisis. Programs should be community-based and include continuous and close supervision; medical, nursing, and psychiatric attention (including medical stabilization); support and relief from stress; and referral to community-based services. Residential lengths of stay are generally limited to 14 days or less.
Respite Care	Provides short-term, 24-hour supports for individuals requiring non-crisis care and additional supports either outside or within their primary residence. Respite settings are home like and integrated in the community.

Service	Description
Inpatient Services	
Inpatient General (Community Hospitals)	Provides inpatient care for the seriously mentally ill who have just been admitted or are experiencing an acute phase of their illness in the course of an extended hospitalization. Primary services focus on developing a diagnosis and stabilizing the patient's psychiatric condition.
Inpatient Specialty/State	Serves the seriously mentally ill who require secure care beyond the acute phase of their illness. The courts commit patients for the purpose of determining competency and fitness to proceed, assessing criminal responsibility and providing treatment recommendations. Services focus on patient rehabilitation and may include long-term treatment.
Acute Detoxification-Residential	Provides acute treatment in a residential setting in which a person is monitored while withdrawing from a substance as part of being treated for a substance abuse disorder.

Service	Description
Treatment Services	
Evaluations/Assessment (Diagnosis)	Mental health professionals conduct evaluations of clients for the purposes of intake, treatment planning, eligibility determination, or functional assessment. Services include psychiatric evaluations for diagnostic or disposition purposes, commitment evaluation, psychosocial evaluation, and psychological evaluation.
Court-Ordered Evaluation	An analysis of an individual's medical, psychological, and social condition carried out by the staff of a licensed mental health evaluation agency by order of the court, to determine whether the person is in need of court-ordered mental health treatment.
Somatic Treatment	Services provided by a physician to evaluate, prescribe, and monitor medications for the treatment of psychiatric disorders. Includes medication review and administration services provided by a registered nurse under the order of a physician. Includes visits for the purpose of prescribing medication as well as for medication refills or dosage regulation.
Individual Therapy	Therapeutic interaction by a behavioral health practitioner to address an individual's therapeutic goals by providing emotional support, developing insight, producing cognitive/behavioral change improving decision making, and/or reducing stress. Individual therapy may include education about the management of a behavioral health disorder, including relapse prevention and recovery strategies.
Group Therapy	Therapeutic interaction by a behavioral health practitioner to address an individual's therapeutic goals in a group of unrelated persons by providing emotional support, developing insight, producing cognitive/behavioral change, improving decision-making, and/or reducing stress. May include education about management of a behavioral health disorder, including relapse prevention and recovery strategies.
Family Therapy	Therapeutic interaction or psychoeducation by a behavioral health practitioner with family members or significant others, with or without the presence of the individual. Interaction may be provided to multiple families. The purpose of the interaction is to address therapeutic goals, provide emotional support, develop insight, produce cognitive/behavioral changes, improve decision-making, and/or reduce stress. Interaction may include education about management of a behavioral health disorder, including relapse prevention and recovery strategies.
Partial Hospitalization	A structured short-term intensive day program for persons at imminent risk of hospitalization, or for persons with specific short-term intensive treatment goals upon hospital discharge.

Outpatient Detoxification	An outpatient, non-residential program to systematically reduce dependence on alcohol and other drugs. May require daily contact for administration of medications and monitoring of withdrawal symptoms.
Day Treatment for Persons with Dual Diagnosis	A structured day program for persons with a dual disorder of substance abuse and mental illness. The program focuses on treatment and relapse prevention. Interventions include preparing the client for work, involvement in education, and/or gaining community living and interpersonal skills.
Intensive Outpatient Substance Abuse Treatment (for persons with dual diagnosis)	A structured outpatient treatment program for persons with a dual disorder of mental illness and substance abuse. Programs provide a minimum of three hours of group mental health/substance abuse treatment three times a week that focuses on relapse prevention and recovery.
Psychosocial Rehabilitation	Services or activities providing opportunities to develop functional skills, foster social integration, and make informed life and work choices. Activities include work exploration, volunteering, and actions that lead towards more traditional vocational rehabilitation services or employment.
Supported Employment	Supported employment staff work with employers to create real jobs in the community. Staff provide clients with on the job support, including intensive job training, and frequent follow-up. Supports should be adequate to allow an individual or a group of consumers to work a minimum of 15 hours per week and earn at least a minimum wage in the private sector or in consumer-run businesses.
Supported and Other Education	Provides a full range of educational services to people with severe mental illnesses. Provides necessary supports, such as study skills training and social skills training. Services include intensive college preparatory programs and specialized vocation programs.
Vocational Assessment/Counseling	Provides a comprehensive assessment of an individual's vocational skills, attitudes, behaviors, and interests through a variety of formal and informal methods.

Service	Description
Vocational Rehabilitation	
Consumer Operated Services/Community Support Clubhouse/Transitional Employment Program	A community support clubhouse or service-related operation that provides services ranging from peer advocacy and support to formal services. Staff and members work as teams to perform the tasks necessary for the operation of the clubhouse. Transitional employment programs are designed to provide employment experiences that prepare individuals for competitive employment.

Service	Description
Community Support	
Consumer Advocacy	A program that recruits, trains, and supports volunteers who provide advocacy, friendship, and support to individuals with serious mental illness. Volunteers assist consumers with legal and treatment questions and help consumers to become self-advocates. Drop-in centers and social clubs also provide an informal and welcoming environment for social/recreational activities and peer advocacy.
Homeless Outreach	Trained staff contact homeless persons and encourage them to engage in treatment.
Jail Diversion Services	Professionals or para-professional link persons to needed mental health services in lieu of arrest and/or incarceration.
Representative Payee Services	Professionals, para-professionals or advocacy organizations assume responsibility for being a representative payee for a person who qualifies for and is receiving SSI or SSDI.
Assertive Community Treatment Teams (ACT)	An array of services provided by a community-based, mobile mental health treatment team comprised of a psychiatrist, case managers, nurses, team rehabilitation specialist, employment specialists, housing specialist, independent living skills specialist, and consumer case managers/counselors. Services are provided with a low staff-to-client ratio that allows for continuous contact with the individual. Average caseload of case managers is 10 to 12 clients.
Active Case Management Services	A single case manager or interdisciplinary team provides core treatment and locates other supports for the client. Services that are provided include psychiatric, assessment/evaluation, planning/coordination, advocacy, monitoring, and outcome measurement. Caseload averages are about 18 to 20 clients.
Supportive Case Management/Case Coordination	The least intensive level of case management provided to clients who are able to self-manage their progress. Case managers provide occasional but regular assistance, coordination, monitoring, and resource connection. Caseloads are generally not larger than 40 clients per case manager.
Therapeutic Support and Supervision	Therapeutic aides provide assistance with daily living, including eating, bathing, dressing, toileting, transferring, maintaining continence, personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. The therapeutic aide may either carry out the task or cue the client to perform the task.

Service	Description
Community Support (continued)	
Client Transportation	Provides clients with transportation to services, employment, and other activities.
Family Psychoeducation	Consultation and education to families concerning the nature, consequences, and treatment of severe and chronic mental illness. This service is generally provided to groups of more than one family at a time.
Legal Advocacy	Assists consumers in legal matters related to mental health service needs and rights.

Source: Adult Mental Health Division, *Implementation Plan for Service Development, Fiscal Years 2002-2005,* March 15, 2001, Appendix 1.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on January 30, 2002. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department responded that it generally agrees with our audit recommendations. However it failed to specifically address our audit findings, only to challenge or provide background information regarding our assertions. The department's claim that it "has and will continue to follow procurement guidelines as required by the Hawaii Revised Statutes and the Hawaii Administrative Rules" provides little to explain its poor procurement practices that failed to ensure open competition and efficient public spending. The department also noted its disappointment with the report's characterization of facts using the terms "patients at risk of harm," "favoritism," "thievery," and "bribery." However, we point out that the words "patients at risk of harm" was used to describe the department's weak oversight of its contracts with providers of therapeutic residential programs and the word "favoritism" to describe the department's questionable relationship with a former acting division chief and a major contractor—the substance of which was not disputed by the department in both cases. The words "thievery" and "bribery" were used in the draft report as examples of corruption that government employees have a fiduciary duty to protect against.

The department also provided some information on some of the issues raised in our draft report regarding 1) the relationship of the former acting division chief, 2) the Assertive Community Treatment (ACT) model, and 3) serving the needs of the mentally ill by requiring that all services be pre-authorized.

Regarding the former acting division chief, the department acknowledged that the individual did retire from state service on December 30, 1994, and has been receiving his state pension since December 31, 1994. In its response, the department cites "some significant miscommunication" between the former acting division chief and the staff of the Office of the Auditor. It notes that at no time during his interview with the staff of the Office of the Auditor did the former acting division chief intend to give the impression that he was not receiving his pension. We disagree. Both of our audit staff, as well as their written notes documented in our work papers, confirm that the former acting division chief clearly responded that he was not receiving his state pension. Furthermore, the department failed to address our

finding related to the favoritism and quid pro quo culture fostered by the department between division employees and a private provider.

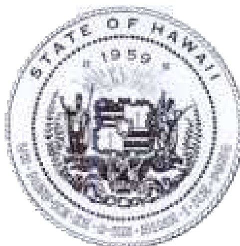
The department also failed to respond to our finding that millions of dollars were spent for assertive community treatment (ACT) services that did not meet standards. Rather, the department stated that the criminal court's involvement with community-based consumers and its forensic population both impacted on its efforts to implement the standard ACT model. The department also provided some background information regarding its implementation of ACT services in Hawaii and noted that the division is currently adhering to clinical standards, inclusive of the National Alliance for the Mentally Ill's guidelines, and ACT services.

The department disagreed with our recommendation that all services billed on a unit rate basis be required to be pre-authorized. The department notes that retroactive services authorization is an acceptable form of utilization management in the health care industry. It believes that our recommendation exposes the State to potential liability in cases where services are not provided timely to consumers. While we generally agree that such a policy may present a liability issue for the State, the department must establish sufficient controls to ensure that crisis and emergency services are not used as a matter of convenience. Moreover, the retroactive authorizations should occur soon after the services are initiated—not months after a patient is discharged. Nevertheless, we amended our draft report to reflect the concerns of the department.

Finally, the department indicated that it has resolved the disagreement between the division and the Office of Health Care Assurance as to whether certain facilities were operating as special treatment facilities without the proper licensure. However, the department did not provide any details as to how this issue has been resolved.

ATTACHMENT 1

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917



MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

January 30, 2002

COPY

The Honorable Bruce S. Anderson
Director of Health
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Anderson:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Audit of the Adult Mental Health Division's Management of Contracted Community Services*. We ask that you telephone us by Friday, February 1, 2002, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Thursday, February 7, 2002.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

ATTACHMENT 2

BENJAMIN J. CAYETANO
GOVERNOR

BRUCE S. ANDERSON, Ph.D., M.P.H.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. BOX 3378
HONOLULU, HAWAII 96801

In reply, please refer to:
File:

February 7, 2002

RECEIVED
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OFC. OF THE AUDITOR
STATE OF HAWAII

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813

Dear Ms. Higa:

The Department of Health appreciates the opportunity to respond to your draft report, Audit of the Adult Mental Health Division's Management of Contracted Community Services. In general, we agree with the Auditor's recommendations. The Adult Mental Health Division (AMHD) has and will continue to follow procurement guidelines as required by the Hawaii Revised Statutes and the Hawaii Administrative Rules. The recommendations serve as further support for AMHD's supplemental budget request for additional infrastructure resources. We believe that some of the recommendations do not take into account a full understanding of the issues presented with the United States Department of Justice Settlement Agreement and the need to bring up community-based services for consumers on an expedited time schedule. Fundamentally, we disagree with any recommendation that all services billed on a unit rate basis be pre-authorized.

The Department is disappointed with the report's characterization of facts using the terms "patients at risk of harm," "favoritism," "thievery," and "bribery." These are strong words. Even more troubling is the lack of specificity and facts to warrant their use in the audit report. The Department and the Division are committed to serving the public interest of the seriously mentally ill in a treatment effective and cost efficient manner.

There are three particular areas discussed in the audit report that need further clarification. The first area concerns the challenge to an individual's professional reputation. The second area challenges the professional fidelity of the Assertive Community Treatment (ACT) model. The third area concerns the basic tenet of serving the needs of the mentally ill by requiring that services be pre-authorized.

The former acting division chief retired from state service as of December 30, 1994, began receiving his state pension as of December 31, 1994, and continues to receive his pension. The

statement on page 11 of the draft audit report to the effect that the former acting division chief denied receiving his pension appears to show some significant miscommunication between the former acting division chief and the staff of the Office of the Auditor. The former acting division chief recalls that he responded in the negative to what he understood was a question about whether his current employment with AMHD would result in additional contributions to his retirement benefits. The correct answer to that question is "no". At no time during his interview with the staff of the Office of the Auditor did the former acting division chief intend to give the impression that he was not receiving the pension to which he is entitled for his prior years of state service.

There is a need to make important distinctions between the standard ACT model for provision of mental health services and the current Hawaii population who are receiving ACT services. The ACT population in Hawaii is made up, primarily, of patients discharged from Hawaii State Hospital. For most of these patients, criminal court orders govern their placement in the community. In many cases, the criminal courts's involvement with community-based consumers has a significant impact on our efforts to implement the standard ACT model, and the draft audit report does not address these forensic issues and their effect on the implementation of the standard ACT model. A review of forensic issues unique to Hawaii would help to clarify some perceptions concerning the practical and logistical problems related to adherence to a "pure" standard ACT model.

There is also a need to discern the difference between the initial phases of the introduction of a model for public mental health care, and later, more sophisticated refinements of that same model. For example, we believe that a reviewer needs to distinguish between services provided during the development of the basic components of a service model necessary to bring essential services into communities and the more complex performance outcomes and specific measures of fidelity, which would be used to analyze a more mature system. The latter requires an assessment of appropriateness, cost efficiency, cost effectiveness, cultural sensitivity, forensic issues, and applicability to the local system of care in Hawaii. The AMHD service development plans, which are readily available, document a sequential momentum to the process. In these plans, AMHD did not commit to bring up immediately and simultaneously an entire comprehensive array of services with all of the needed infrastructure. Clearly, this would be an unreasonable and unrealistic target for any organization. However, the Department and AMHD, in coordination with stakeholders, are progressing steadily toward our plan's stated goals with quality of care as a primary focus.

AMHD initiated basic ACT services for the first time in Hawaii without the benefit of an automated managed care information system. Throughout the development process, AMHD has conferred with the court ordered consulting firm, Technical Assistance Collaborative, Inc. (TAC), which has the necessary expertise in studying measures of fidelity and the appropriateness of select model specificity. TAC has evaluated existing services, and has

provided AMHD with recommended clinical standards. Currently, AMHD is adhering to these clinical standards for quality clinical case management, including ACT services. These clinical standards are inclusive of the National Alliance for the Mentally Ill's guidelines for the frequency of ACT service contacts. Significantly, the recent Request for Proposals (RFP) issued by AMHD for ACT services incorporated the clinical standards provided by TAC, and are also far more comprehensive relative to the full scope of service definitions and standards than earlier RFPs. In addition, AMHD is implementing an automated management information system that links provider information including utilization management and quality management standards.

We would also like to point out that retroactive service authorization is an acceptable form of utilization management in the health care industry. It is also a recognized industry standard to select certain types of services that require pre-authorization because to require pre-authorization of all services is neither cost efficient nor cost effective. If pre-authorization were required for all cases, we would be concerned about the State's potential exposure to liability in cases where services were not provided timely to consumers and the alleged failure to act prudently which resulted in serious consequences to the consumer or the public could be attributed to the delay necessitated by pre-authorization requirements. An example of this is the necessity of providing crisis and emergency services before receiving authorization for such services. To state that retroactively authorizing services "should not occur under any circumstance" fails to recognize the nature of clinical mental health services, which can involve interventions that preserve the life, safety, and well-being of consumers and the public. We believe such a policy exposes the State to unnecessary liability to those who may be harmed by such a shortsighted policy.

I also wish to comment on the recommendation for the Legislature to consider transferring the functions of the Office of Health Care Assurance (OHCA) to another state agency. As Director, I must support many conflicting needs and priorities within the Department of Health. As always in the case of conflicts between programs, representatives from AMHD and OHCA have met and the issue of licensing requirements has been resolved.

Thank you for the opportunity to comment on your draft audit report.

Sincerely,

BRUCE S. ANDERSON, Ph.D., M.P.H.
Director of Health