Study of Privatizing Adult Mental Health Program Services

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

Report No. 99-11
March 1999

THE AUDITOR
STATE OF HAWAII

OVERVIEW

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Summary

The Department of Health's Adult Mental Health Division is responsible for administering a comprehensive mental health system to care for and improve the mental health of individuals 18 years of age and older. The division provides an array of direct services to help people function in common activities of daily living through state community mental health centers and contracts with private providers. The division is appropriated about $19.5 million each year of which $7.4 million is used for private provider contracts. The 1998 Legislature requested a study to examine the extent to which direct services currently provided in the adult mental health program (HTH 420) could be assumed by private providers.

In this study, we use the definition of privatization set forth by the U.S. General Accounting Office, that is, any process aimed at shifting functions and responsibilities, in whole or in part, from the government to the private sector. The hiring of private-sector firms or nonprofit organizations to provide goods or services for the government through contracts is the most common form of privatization.

A key to the successful privatization of government services is the use of a systematic decision-making process to guide actions taken. Such a process includes an analysis of various factors determinative of the success of privatization efforts. These factors include: 1) Realistic and measurable goals and criteria; 2) Availability of competition; 3) An accurate cost analysis; 4) State employee and union support; 5) Safeguards to mitigate risks; 6) Adequate management controls, monitoring and evaluation; and 7) Controls for maintaining and monitoring quality of service.

Our assessment of whether privatization of current services could be successful is inconclusive because the information and data necessary to perform proper analyses were lacking. For example, the Adult Mental Health Division lacked reliable and complete data necessary to conduct a proper cost analysis. We found insufficient controls over the recording and tracking of staff time as well as inadequacies in the division's computer system.

We also found that the division's existing efforts to manage contracts and coordinate with private providers were inadequate and could not support further privatization. Contract monitoring is inconsistent, performance measures are inadequate for proper evaluation of contractors, and contractual requirements are not enforced. More than half of the division's contracts have not received on-site monitoring visits. We found no evidence of any program evaluation system or program evaluation reports by contractors. The division also permitted contractors to submit financial reports several months late, in violation of contract requirements. Finally, the division's lack of proper operational plans contributes to a poorly integrated mental health system and ineffective use of private providers.

Recommendations and Response

We recommended that the Department of Health report to the Legislature regarding steps taken to improve contract administration practices such as designating a contract administrator, improving monitoring, establishing adequate performance measures, and executing contracts in a timely manner. The department should also ensure contractors are held accountable. We also recommended that the division establish a consistent contract monitoring process, consider the inclusion of a liquidated damages provision, execute contracts on time, and develop operational plans that guide operations toward achieving goals.

The health department responded that its interpretation of privatization of services differed from that used in the report, that there were advantages to having a limited number of vendors, and that the department's efforts to restructure services has been met by strong resistance from its own staff. In addition the department disagreed with a number of our findings and claims to have taken corrective action to address others, but otherwise did not address the report's specific findings and recommendations. Finally, the department took exception to our comments about limiting our access to its information.

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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 99-11
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Foreword

This is a report of our study on privatizing adult mental health program services currently performed by the Department of Health. This study was conducted pursuant to Section 56.1 of Act 116, Session Laws of Hawaii 1998, that directed the State Auditor to examine to what extent the direct services currently provided in the adult mental health program could be assumed by private providers.

We wish to acknowledge the assistance extended to us by the Department of Health during the course of the study. We also wish to express our appreciation for the cooperation and assistance extended by others whom we contacted.

Marion M. Higa
State Auditor

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Chapter 1
Introduction

The Hawaii State Legislature required the State Auditor to conduct a study on privatizing the adult mental health services currently performed by the Department of Health. Section 56.1 of Act 116, the 1998 Supplemental Appropriations Act, specified that the Auditor "shall examine to what extent the direct services which are currently provided in the adult mental health program (HTH 420) could be assumed by private providers."

Neither the proviso nor the adult mental health program specifically defines "direct services." However, the Department of Health's Adult Mental Health Division has generally defined direct services as any service that requires contact with a person suffering from a serious mental illness, where contact includes communicating orally.

The State's Adult Mental Health System

The Department of Health is responsible for establishing a mental health system to care for and improve the mental health of the people of Hawaii. Section 334-2, Hawaii Revised Statutes (HRS), requires the Department of Health to foster and coordinate a comprehensive mental health system and to administer programs, services, and facilities to promote, protect, preserve, care for, and improve the mental health of the people. The Department of Health's Behavioral Health Administration administers mental health programs. Within the Behavioral Health Administration, responsibility for mental health services resides with the Adult Mental Health Division (AMHD) and the Child and Adolescent Mental Health Division (CAMHD). A third division, the Alcohol and Drug Abuse Division, deals with substance abuse.

The Adult Mental Health Division directs, coordinates, and monitors the operations of the State's adult mental health programs, services, activities, and facilities. In accordance with the State's official organizational charts, the division oversees the Hawaii State Hospital, the Oahu Community Mental Health Center Branch, the neighbor island community mental health centers, and the Courts and Corrections Branch. The Hawaii State Hospital is the State's only inpatient psychiatric facility. The State's community mental health centers provide outpatient services. The Courts and Corrections Branch provides evaluative and consultative services to the state court system.

The Adult Mental Health Division promotes, coordinates, and administers a comprehensive, integrated mental health system for individuals 18 years of age and older. The division focuses public resources on three distinct

populations: persons with serious mental illness, persons in severe acute mental health crisis, and persons experiencing stress from disasters. Of the three groups, the division is most concerned with persons with serious mental illness.

The Oahu Community Mental Health Center Branch was created by a 1997 reorganization that consolidated the administrative and fiscal functions of the existing Diamond Head, Leeward, Central, Windward, and Kalihi-Palama Community Mental Health Centers into a centralized branch. The State's official organizational chart places the Hawaii, Kauai, and Maui Community Mental Health Centers under their respective district health offices. However, in practice and in accordance with the department's functional statements, these neighbor island centers report directly to the Adult Mental Health Division. The functional rather than official organizational chart of the State's Adult Mental Health Division is shown in Exhibit 1.1.

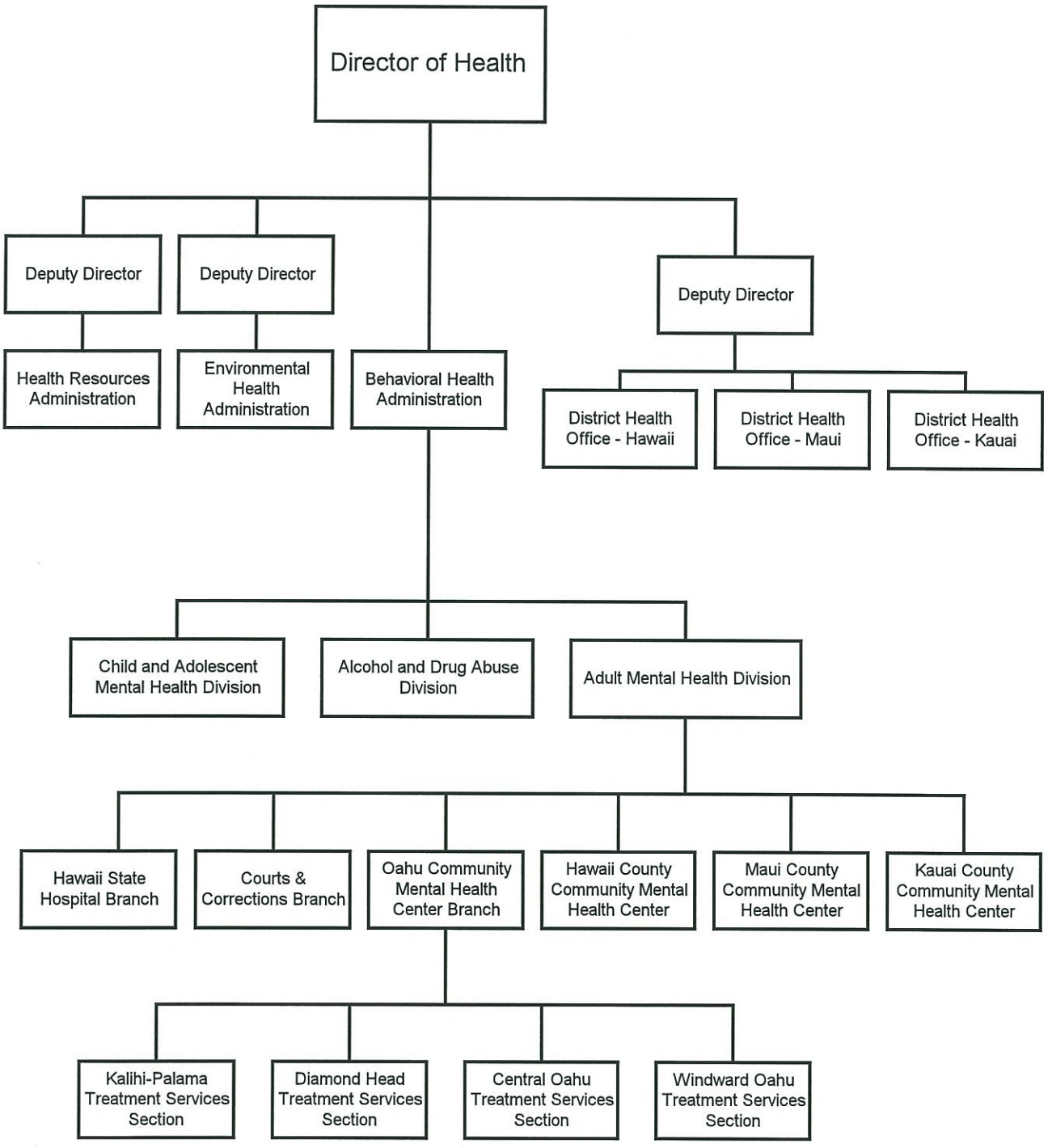
Funding and staffing

The adult mental health program receives most of its funding from the state general fund under the Program ID HTH 420. Funds are allocated to the Oahu treatment services sections, the neighbor island community mental health centers, the Courts and Corrections Branch, and to purchase of services contracts. Although the Hawaii State Hospital falls under the Adult Mental Health Division, the hospital receives funding under a separate designation, Program ID HTH 430. The adult mental health program's administrative functions are also funded separately under Program ID HTH 495. For FY1997-98, HTH 420 received total appropriations of $19.6 million, consisting of $17.6 million in general funds, $864,146 in special funds, and about $1 million in federal grants. Revenues collected for services delivered are deposited into the program's special fund. The federal government provides federal grants to help pay for the delivery of mental health services. Special funds and federal grants account for less than 10 percent of the amount appropriated to operate the adult mental health program.

In the past few years, while funding for the adult mental health program increased slightly, staffing levels declined. In FY1996-97, the program operated with 224 authorized positions, a reduction of 40 positions from the prior fiscal year. Although additional positions were authorized for FY1997-98, the program is currently operating with fewer staff than the 264 positions the division had in FY1995-96. On the other hand, appropriations for FY1997-98 are approximately $1.2 million greater than FY1995-96 appropriations.

Exhibit 1.2 displays the program's method of funding and number of positions for the past three fiscal years.

Exhibit 1.1
Functional Organizational Chart of the Adult Mental Health Division



Source: Department of Health, Adult Mental Health Division

Exhibit 1.2
Legislative Appropriations and Staffing for the Adult Mental Health Division, FY1995-96 through FY1997-98

Fiscal Year	General Funds	Special Funds	Federal Funds	Total	Position Count
1995-96	$16,719,522	$564,146	$1,026,514	$18,310,182	264
1996-97	$13,348,885	$864,146	$1,026,514	$15,239,545	224
1997-98	$17,658,905	$864,146	$1,026,514	$19,549,565	243

Under the adult mental health program, division employees provide outpatient mental health services at the Oahu treatment services sections and neighbor island community mental health centers. On Oahu, treatment services sections are located at Kalihi-Palama, Diamond Head, Central Oahu, and Windward Oahu. On the island of Hawaii, the community mental health center consists of treatment services units in East, West, and North Hawaii. The Kauai Community Mental Health Center includes treatment sites at Lihue and Kapaa. In Maui County, there are treatment sites at Wailuku, Lahaina, and on Molokai and Lanai. Exhibit 1.3 compares the activities and funding of the various community mental health centers for FY1997-98.

Exhibit 1.3
Community Mental Health Centers, FY1997-98

Oahu Community Mental Health Center Branch	Number Served*	Number of Authorized Positions	Appropriations
Central Oahu Treatment Services Section	735	39.0	$1,748,770
Diamond Head Treatment Services Section	537	31.0	$1,358,615
Kalihi-Palama Treatment Services Section	612	34.0	$1,751,535
Windward Treatment Services Section	394	24.0	$1,242,478
Subtotal	**2,278**	**128.0**	**$6,101,398**
Neighbor Island Community Mental Health Centers			
Hawaii County Community Mental Health Center	533	45.0	$2,007,812
Maui County Community Mental Health Center	367	31.6	$1,527,701
Kauai County Community Mental Health Center	411	26.5	$1,202,075
TOTALS	**3,589**	**231.1**	**$10,838,986**

Source: Fiscal Section, Adult Mental Health Division, Department of Health

*Number served from the Fiscal Year 1998 State Plan for Mental Health, Adult Mental Health Division, Department of Health, May 1997.

The division provides mental health services through state centers and private providers

A person with a serious mental illness that results from a mental disorder may exhibit impaired emotional, cognitive, or behavioral functioning. This impaired functioning may interfere with the person's capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. The Adult Mental Health Division provides an array of direct services to help these people function in common activities of daily living, such as maintaining interpersonal relationships, providing self-care, homemaking, employment, and recreation. The division refers to people who are eligible for mental health services as consumers.

A person may enter the adult mental health program's community-based services by being discharged from the Hawaii State Hospital, by order of the courts, or by being admitted on a voluntary basis. A services treatment plan for Hawaii State Hospital patients is developed by the hospital in conjunction with the patient and a care manager before discharge. The treatment plan lays out the type of services the consumer needs, and a case manager works with the consumer to implement the treatment plan.

A person seeking assistance is screened by a community mental health center staff to determine eligibility. The screening center will either assign eligible persons to a state community mental health center or refer them to a private provider that is within the person's access. Once the consumer is admitted to a center, the center forms a treatment team of health professionals, such as a social worker, a nurse, and/or a psychiatrist, to develop a treatment plan with the consumer. The treatment plan may consist of services provided by either the State or a private provider that is under contract with the Adult Mental Health Division.

The State's community mental health centers provide direct services under the general categories of case management, outpatient non-treatment and treatment services, psychiatric rehabilitation, and crisis intervention services. Within each category are a series of options to address consumers' needs. Exhibit 1.4 describes the service options under each major service category provided by the state centers.

The division also contracts with private providers for other types of direct mental health services. These contracts with private providers are usually for services that the State does not provide, such as crisis intervention, residential support options, consumer and family support, bilingual services, and diversion services. Descriptions of these services are provided by Exhibit 1.5. Within the major category of outpatient treatment services, a private provider would provide assertive community treatment (ACT), community-based intervention and support, and partial hospitalization, all of which are not provided by the State. ACT services provide around-the-clock direct interaction with patients. Partial hospitalization provides intensive, short-term psychiatric treatment in a

therapeutic environment. Crisis intervention services consist of an around-the-clock telephone hotline, mobile crisis outreach, and crisis stabilization. Crisis services assist individuals in psychiatric crisis to maintain and resume community function. Residential support options consist of a variety of living and housing services or arrangements that provide varying levels of support and supervision to care for persons with long-term mental illnesses. Exhibit 1.5 shows the types of services that the division provides through contracts with private providers.

Exhibit 1.4
Mental Health Direct Services Provided by State Community Mental Health Centers

Service	Description	Options
Non-treatment Services	To determine the consumer's need for psychiatric services	Screening Referral
Outpatient Treatment Services	To help consumers with serious mental illnesses to manage symptoms, manage medication, recognize signs of relapse, and cope with daily living	Assessment Discharge and treatment planning Care coordination Medication evaluation prescription and maintenance Continuous treatment team Psychotherapy counseling
Case Management	Assists consumers to gain access to needed services through coordination, linkage, and advocacy	Case assessment Case planning Ongoing monitoring and service coordination Case finding and outreach
Psychiatric Rehabilitation Services	To help consumers gain or regain practical skills needed to live and socialize as independently as possible in the community	Clubhouse program Day treatment Skill building and psycho-education
Crisis Intervention Services	To help consumers suffering a severe acute mental health crisis that poses an immediate threat to the person or to others	Walk-ins Telephone crisis hotline (Kauai only) Mobile crisis outreach (Kauai only)

Exhibit 1.5
Mental Health Direct Services Provided through Contracts with Private Providers

Service	Description	Options
Outpatient Treatment Services	To help consumers with long-term mental illnesses to manage symptoms, manage medications, recognize signs of relapse, and cope with daily living	Assertive community treatment (ACT) Forensic assertive community treatment Community-based intervention and support Partial hospitalization Consumer resource fund
Case Management	Assist consumers to gain access to needed services through coordination, linkage, and advocacy	Outreach to the homeless Case management with cultural and ethnic sensitivity
Crisis Intervention Services	To help consumers suffering a severe acute mental health crisis that poses an immediate threat to the person or to others	Telephone crisis hotline Mobile crisis outreach Crisis stabilization residence
Residential Services	To provide consumers with a range of housing options and services. Residential services are alternatives to hospitalization and allow clients to live in the community	Long-term residential rehabilitation Family care Transitional therapeutic group living Semi-independent living Supported housing Community living
Consumer and Family Support, Education and Advocacy Services	To enable and assist the consumers to reach the highest level of functioning possible	Consumer support and education Consumer education and advocacy Respite services Representative payee services Family/collateral support and education
Bilingual Services	To assist consumers with limited or non-English speaking ability	Bilingual interpretation services
Diversion Services	To intervene to prevent incarceration or unnecessary hospitalization of consumers with a serious mental illness who have been arraigned or arrested	Jail diversion services

During fiscal years 1995-96 and 1996-97, the number and cost of contracts with private provider organizations remained relatively stable. However, for FY1997-98, the number of such contracts and the associated cost rose sharply. The total cost for FY1997-98 includes almost $2.6 million for the Department of Justice's lawsuit against the State requiring the State to improve conditions at the Hawaii State Hospital. The $2.6 million was for five new private provider contracts for the following new services: assertive community treatment (ACT), partial hospitalization, supported housing, community-based intervention, and a consumer resource fund. Exhibit 1.6 shows the division's activity with private providers for the past three fiscal years.

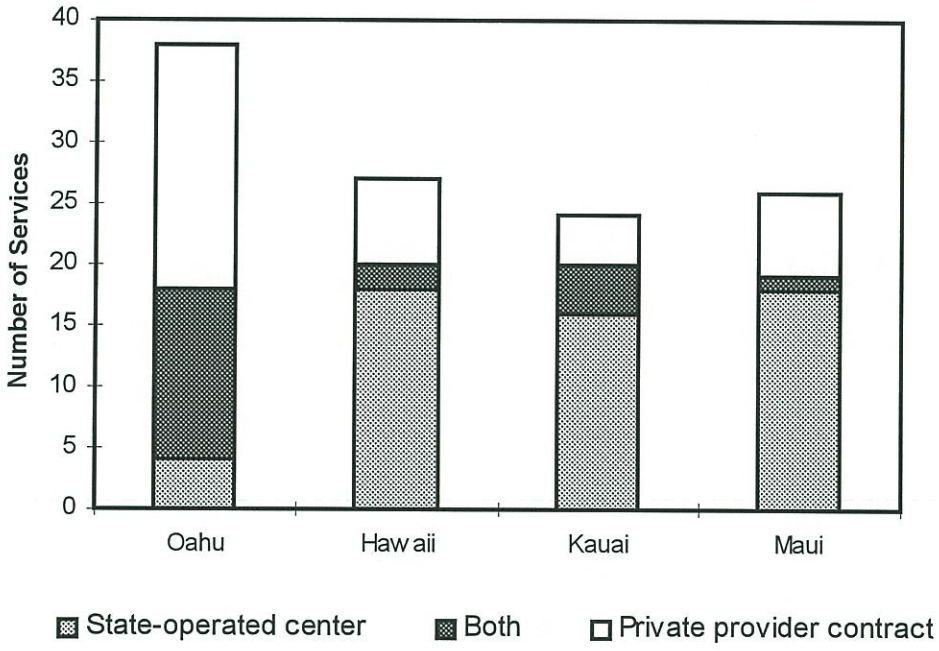
Exhibit 1.6
Private Provider Contracts, FY1995-96 through FY1997-98

Fiscal Year	Number of Contracts with Provider Organizations	Number of Providers	Cost (millions)
1995-96	25	16	$4.2
1996-97	26	16	$4.5
1997-98	32	18	$7.4

In addition to contracts with private organizations, the division also purchases psychiatric services and other professional services. The division currently contracts with individuals and staffing organizations to provide on-call and temporary psychiatric services. Other professional services are obtained through a collaboration project with the University of Hawai'i.

In general, the direct services that state centers and treatment sections provide can be distinguished from services provided through contractors, but there is some overlap; that is, services provided by state community mental health centers and through private providers are not purely unduplicated. For example, both center staff and private contractors provide outreach to the homeless and consumer support groups. On Kauai, the center provides crisis services, which are purchased from private providers on other islands. Also on Kauai, both center staff and private contractors provide case management services. Exhibit 1.7 displays the type of service delivery and number of services by island.

Exhibit 1.7
Type of Service Delivery and Number of Services by Island



Privatization

In this study, we used the definition of privatization set forth by the U.S. General Accounting Office, that is, any process aimed at shifting functions and responsibilities, in whole or in part, from the government to the private sector.[1] Privatization is one of various initiatives pursued by both federal and state governments to change the role of government. Some initiatives have eliminated government functions, while others have restructured a particular function's operations to improve efficiency and/or service quality. Privatization initiatives or processes bring the private sector into the ownership and/or management of public assets or into direct provision of public services.

There are several forms of privatization. Contracting out is the most commonly used. Contracting out is the hiring of private-sector firms or nonprofit organizations to provide goods or services for the government. That is, the State funds the private provision of public services. Contracting allows the government to maintain more control over the delivery of service than other forms of privatization. Exhibit 1.8 briefly describes a number of privatization practices.

Exhibit 1.8
Forms of Privatization

Privatization Form	Description
Asset Sale	Ownership of government assets, commercial-type enterprises, or functions is transferred to the private sector.
Contracting Out	Government enters into agreements with private firms, for profit or nonprofit, to provide goods or services.
Franchising	Government grants a concession or privilege to a private-sector entity to conduct business in a particular market or geographical area.
Managed Competition	A public-sector agency competes with private-sector firms to provide public-sector functions or services under a controlled or managed process.
Public-Private Partnership or Joint Venture	A contractual arrangement is formed between the government and private-sector partners that can include a variety of activities, including development, financing, ownership, and operation of a public facility or service.
Subsidies	Government encourages private-sector involvement in accomplishing public purposes through direct subsidies, such as funding or tax credits.
Vouchers	Government financial subsidies are given to individuals for the purchase of specific goods or services from the private or public sector.

Governments privatize for many reasons, the most common being cost savings. Cost savings from increased privatization are based on the underlying assumption that private companies can be more efficient and less costly in delivering services because they are not constrained by restrictive government rules. The greater use of the private sector is also intended to help trim government deficits and manage revenue shortfalls. Another common reason for privatization is that privatization allows for the speedier implementation of programs or services. According to this argument, governments have used privatization when the government lacks the resources to perform certain functions or lacks the technical skill. Governments also have used the rationale that private providers

offer more effective services due to greater flexibility and less bureaucracy. The private providers' freedom from government civil service rules and cumbersome governmental procurement rules enables private providers to retain the most qualified staff and more easily acquire the necessary equipment. Finally, increasing private-sector participation increases the choices available to the public.

The decision not to privatize a government agency is also supported by several arguments. Diminished accountability of the governmental agency is one concern. No real cost savings is another. Actual cost savings may not be realized when the government agency must increase monitoring or when the cost of contracting is greater than government's provision of the same services. The negative impact on state employees must be considered. Other reasons: privatization does not guarantee a competitive market, thus creating a monopoly in the private sector; and the quality of service may be compromised due to the private provider's profit motives.

Hawaii is one of only five states in the nation to continue being a direct provider of community-based mental health services. In recent years, many states have increased privatization, particularly in areas of mental health, social services, and transportation.

Objectives

1. Analyze the feasibility of privatizing the direct services currently provided by the adult mental health program.

2. Make recommendations as appropriate.

Scope and Methodology

Our work focused on the programs and services within the adult mental health program (HTH 420). Specifically, we focused on the direct services provided by the program's community mental health centers and various private providers of mental health services from FY1995-96 to the present.

We reviewed state laws and rules, the division's policies and procedures, national and state studies on privatization, executive and state council meeting minutes, the division's state plans, and the division's studies on needs assessment, program evaluations, and consumer satisfaction surveys. We reviewed documents and files at the Hawaii County Community Mental Health Center Branch and at the Central Oahu and Kalihi-Palama Treatment Services Sections, which account for the largest caseloads reported to the division. We interviewed division staff, center chiefs, center staff, and private providers. We surveyed 40 private providers of mental health services in the State through a mailed

questionnaire. A total of 25 responded for a 63 percent response rate. We reviewed more than three-quarters of the division's contract files (77 percent).

Although staff from the various centers were very cooperative and helpful, certain division staff exhibited a lack of cooperation sufficient to require mentioning. We recognize that division staff faced unusual circumstances as a result of a fire that affected the division's office space. However, the roadblocks to our obtaining information appeared unrelated to the fire. We eventually obtained a level of access necessary to gather sufficient information for our audit, but this took inordinate effort.

Our work was performed from June 1998 through November 1998 in accordance with generally accepted government auditing standards.

Chapter 2

Lack of Data and Contract Management Inadequacies Hamper Successful Privatization

The decision to privatize government services requires a thorough analysis of pertinent factors to determine the likelihood that privatization will result in the more effective and efficient delivery of those services. An examination of these factors is the fundamental approach taken to address the legislative proviso directing the Auditor to determine what direct services under the Department of Health's adult mental health program could be assumed by private providers. This chapter presents our assessment of the feasibility of privatizing the direct services currently provided under the program. We identify significant issues in privatization and examine the extent to which the Adult Mental Health Division can support further privatization of services.

Summary of Findings

1. The feasibility of privatizing the division's current direct services cannot be adequately determined.

2. The division's coordination and contract management of private providers are currently inadequate to support further privatization of direct services.

Feasibility of Privatizing the Division's Current Direct Services Cannot be Adequately Determined

The feasibility of privatizing the direct services of the Department of Health's adult mental health program cannot be adequately determined at this time. Such a determination should be based on the application of a systematic decision-making process. Information essential for this decision-making process was lacking, preventing a thorough analysis from being conducted. In addition, division data necessary to develop the base costs essential to perform a proper cost analysis of privatization versus continued direct services was often not available and/or lacked reliability. These factors prevented a proper feasibility analysis from being conducted.

Application of systematic decision-making process produced inconclusive results

A key to the successful privatization of government services is the use of a systematic decision-making process to guide actions taken. We reviewed various studies on privatization of other states published by the federal government, independent research organizations, and a mental health resource organization. Based on these studies, we identified a

number of fundamental elements that should be included and considered in the decision-making process to determine the feasibility of privatizing services. However, we found that insufficient information currently exists to permit informed decisions to be made.

Successful privatization requires a systematic process

Privatization studies of other states by the federal government, a national organization,[1] and the Council of State Governments,[2] indicate that using a systematic process for decision making improves the chances for successful implementation of privatization. Such a process establishes and communicates specific objectives to be accomplished and allows for clear accountability of privatization efforts. The studies also noted that such a systematic process collects and considers elements that determine the success of any privatization effort. This step-by-step approach ensures maximum support for the decision, documents that pros and cons are considered, and provides government officials with sufficient information to make informed decisions.

We examined the various studies to determine the applicability of the privatization decision-making processes to our study on privatizing the Adult Mental Health Division's program of direct services. While the various processes differed in some respects, we found that the following common elements or factors were applicable to our study:

1) Realistic and measurable goals and criteria;
2) Availability of competition;
3) An accurate cost analysis;
4) State employee and union support;
5) Safeguards to mitigate risks;
6) Adequate management controls, monitoring and evaluation; and
7) Controls for maintaining and monitoring quality of service.

We applied these common elements to the direct services provided under the adult mental health program to determine the feasibility of further privatizing. Successful privatization depends on an analysis of these factors and their impact.

Realistic and measurable goals are essential. In considering privatization options, the decision maker should set realistic and measurable goals. For example, a realistic goal would be to establish a minimum threshold for cost savings, such as 5 or 10 percent. Such a goal may represent a realistic expectation of the cost savings that should be realized with privatization. At the same time, the goal is measurable, assuming that existing costs can be identified. Agencies that lack measurable goals or objective standards will face difficulty in measuring performance and are unable to evaluate privatized services. The ability of

the agency to specify exactly what it wants and the degree to which objective standards and performance measures can be described enhance the success of privatization efforts.

Competition is essential. The availability of competition is an essential factor in any privatization effort. Having multiple vendors for a particular service ensures competition and fair contract prices. A limited amount or total lack of competition can negatively impact any privatization effort. Without competition, there is little or no incentive for vendors to keep costs down and performance levels up. As a result, costs may increase because a single private provider may unfairly raise the price of services to increase its own profits. Should there be a lack of available providers, the decision maker may consider alternative ways to increase competition. One method would be to separate a particular service into smaller pieces to allow more providers to share the responsibility.

An accurate cost analysis is needed. A proper cost analysis is important to determine whether privatization will be successful. Generating cost savings is often the basis for privatizing a service. However, government agencies often cannot substantiate and even fail to achieve anticipated cost savings goals. This is due to the failure to conduct a complete and accurate analysis of the State's cost of providing the service versus the cost to the State if the service is privatized. Additionally, hidden or inaccurate costs may result in unrealistic contract bids and subsequent failure.

State employee and union support is necessary. Employee resistance to privatization can be a major impediment to success. Privatization can be viewed negatively with the potential for eliminating state jobs or reducing pay and fringe benefits. If the net effect of privatization on affected state employees is perceived as negative, resistance to privatization will be high. Opposition to privatization from employees can come from all levels, from managerial to entry-level support staff. Unions may also oppose privatization if the net effect is viewed as negative. However, privatization can be supported by employees if it is perceived that an improvement in working conditions may result. For example, if privatization is viewed as consistent with agency goals, agency executives may be more open to the idea of privatization. Agency managers can view privatization as a means of overcoming governmental bureaucracy and red tape that hinders their work. Employees may perceive privatization as a means of improving their own working conditions and environment, leading to an improvement in their job. Properly executed and presented, privatization can be viewed as a means of enhancing rather than endangering the positions of state employees. Successful privatization efforts should include studying the impact on state employees, addressing employee concerns, maintaining open communications with employees, and including union representatives in privatization decisions.

Safeguards to mitigate risks are essential. Privatization of governmental responsibilities can result in additional risks for a governmental agency. However, these new risks can be mitigated by initiating adequate safeguards to address them. The contractor's failure to perform is one of the greatest risks. Should service disruption occur, the State may face legal consequences as well as failure to provide for citizens in need.

Another risk of privatizing governmental responsibilities results in cost overruns. In the event of a program going over budget, the State may have to assume financial responsibility. The degree of risk can be mitigated by establishing safeguards. State agencies can require periodic reports designed to signal early warnings, write contracts to include adjustments for inflation and increases in workload, require the contractor to share or bear the risk of cost overruns, develop emergency plans to deal with service disruption or discontinuation, determine the presence of private sources of finance, and use pilot project contracts for high-risk projects.

Adequate management controls are needed. An agency must be able to establish and maintain adequate management control mechanisms over the privatized services to promote the success of privatization efforts. Agencies that establish clear and easily measured performance standards and administer thorough monitoring systems improve the chances for success. In an environment where the level of control needed is very important, agencies with weak monitoring systems are poor candidates for privatization. Weak oversight and administration of contracts make evaluating performance and maintaining quality of service difficult.

Monitoring the quality of service is necessary. The necessity for quality service to either be maintained or improved is also an important consideration in privatization. Privatizing a particular service should not lower its quality. The decision maker needs to determine whether a service to the targeted population will be maintained before it is privatized. The decision maker may consider implementing incentive measures in contracts to ensure high quality service. An analysis of service may also consider the private agency's ability to establish good measures or increase its oversight capabilities, since privatization will require increases in these functions.

Necessary elements to support privatization decisions are lacking

Our analysis to determine what direct services provided by the adult mental health program could be successfully privatized could not be completed due to lack of reliable information. To perform the analysis, we attempted to identify each of the elements noted earlier in order to

project the likelihood that privatization could be successfully implemented. However, we found that several of the necessary elements could not be addressed due to a lack of reliable data.

The Adult Mental Health Division does not adequately monitor and control its contractors. Successful privatization generally requires that an agency be able to effectively manage its contracts and perform cost analyses to measure the performance of the privatization efforts. We found several existing contract management inadequacies that limit the division's ability to privatize successfully. These inadequacies range from untimely execution to poor monitoring of existing contracts. We also found that the division has inadequate data to enable us to perform an accurate cost analysis.

However, we were still able to consider other decision-making elements related to privatization. We first assessed the availability of competition. We found that privatizing the division's current direct services has a greater chance of success on Oahu than on the neighbor islands because of the greater availability of providers on Oahu. We conducted a survey of 40 private providers of adult mental health services to explore the ability and willingness of private providers to assume the current services provided by the division. A total of 25, or 63 percent, of the providers queried responded to our survey. We found that the majority of organizations were favorably inclined to increasing services to the Adult Mental Health Division. However, the specific services likely to be increased were those the organization is already providing. In other words, organizations are likely to increase services only in their areas of expertise. To privatize the division's direct services may thus require separate contracts with numerous providers for each type of service.

Exhibit 2.1 illustrates the likelihood of increasing a service that a provider is currently providing. For example, 12 providers are currently providing assessment services (under outpatient treatment services). Three-quarters (75 percent) of these providers indicated that they would be likely to increase this service compared to only 8 percent of the 13 providers who currently do not provide this service.

In analyzing the providers' ability to provide mental health services, we noted that a majority of the providers were not accredited. The division's contracts require contractors to be accredited by January 1, 1999, in order to receive funding. The division uses the accreditation process to ensure contractors provide quality care to consumers. Of the 25 providers who responded, 76 percent have not achieved accreditation by CARF, the Commission on Accreditation of Rehabilitation Facilities.[3] CARF is an internationally recognized accreditation authority that provides quality standards for rehabilitation organizations to use as guidelines in developing and offering services to consumers. CARF conducts on-site surveys to determine the degree to which an organization meets the

Exhibit 2.1
Probability of Increasing Future Service by Current Provider of the Service

Type of Service	Probability of Increasing Service	Currently Provides Service Yes	No
Outpatient Treatment Services:			
Assessment Services			
	Likely	75%	8%
	Not Likely	25	92
	Number of Respondents	(12)	(13)
Medication, Evaluation, Prescription, and Maintenance	Likely	75%	6%
	Not Likely	25	94
	Number of Respondents	(8)	(17)
Individual/Group Psychotherapy			
	Likely	50%	5%
	Not Likely	50	95
	Number of Respondents	(6)	(21)
Individual/Group Counseling			
	Likely	50%	24%
	Not Likely	50	76
	Number of Respondents	(8)	(17)
Case management services:			
Ongoing Monitoring and Service Coordination	Likely	75%	23%
	Not Likely	25	77
	Number of Respondents	(12)	(13)
Casefinding			
	Likely	88%	18%
	Not Likely	12	82
	Number of Respondents	(8)	(17)
Psychiatric Rehabilitation services:			
Clubhouse Rehabilitation Services			
	Likely	0	16%
	Not Likely	0	84
	Number of Respondents	(0)	(25)
Group/Individual Skill-building and Psycho-education	Likely	100%	35%
	Not Likely	0	65
	Number of Respondents	(5)	(20)

standards. The small number of accredited organizations also limits the number of available providers that are able to assume the direct services currently provided by the division.

An analysis of safeguards to reduce risks associated with privatization of mental health services indicates that privatization is riskier on the neighbor islands than on Oahu. Twice as many private organizations provide any type of case management service on the island of Oahu than on the island of Hawaii. On the islands of Kauai and Maui, often only one or two providers are available for any type of mental health service. When we examined the likelihood that these providers would or could increase services, the number of providers is even more limited. On the island of Maui, there is only one provider present and willing to increase services. On Kauai, none of the providers that currently provide case assessment and planning services are likely to increase those services. Exhibit 2.2 shows a distribution of providers that are currently providing case management services and that are also likely to increase those services.

Exhibit 2.2
Private Providers of Case Management Services and Likelihood of Increasing Service, by Island

	Number of Private Providers			
	Oahu	Hawaii	Kauai	Maui
Services Currently Provided				
Case Assessment	8	4	2	2
Case Planning	8	4	2	2
Ongoing Monitoring and Service Coordination	8	4	2	2
Casefinding	6	2	1	2
Outreach to the Homeless	6	1	1	1
Services Currently Provided and Likely to Increase				
Case Assessment	6	3	0	1
Case Planning	6	3	0	1
Ongoing Monitoring and Service Coordination	6	3	0	1
Casefinding	5	1	0	1
Outreach to the Homeless	5	1	1	1

The division's lack of reliable data prevents a determination of whether privatization of direct services currently provided by the division can be cost-effective

The Adult Mental Health Division's lack of reliable data hampers the ability to perform a proper cost analysis and limits sound decision making on privatization. An accurate cost analysis would enable the government to compare whether the State or the private provider can provide a particular service at a lower cost. Without a proper cost analysis, a decision to privatize a particular service would be based on inadequate information and may not result in cost savings.

A proper cost analysis is essential to the decision-making process

A cost analysis is one of the most important elements in the decision-making process for successful privatization. Information from an accurate analysis enhances an agency's ability to identify cost savings, properly evaluate bid proposals, and compare operating efficiency of service delivery before and after privatization. This enables an agency to verify actual cost savings and to make an informed decision on privatizing the service.

A cost analysis involves comparing the costs of the State providing the service with a contractor's proposed contract price plus the cost of monitoring the contract. The first step in the cost analysis is for the agency to determine what it costs government to provide the service, including salaries and benefits of personnel, material, and equipment. The agency then identifies the contracting cost, including contract fees, development, and monitoring. Contracting costs include the cost of the contract itself and any other ongoing expenditures by the agency. The agency then compares its cost to the contract cost.

Having reliable and complete cost data on government activities targeted for privatization is a critical element in the analysis. The inability to obtain such data diminishes the accuracy of the cost analysis and compromises the privatization decision. The resulting imprecision can have negative consequences. Reported savings may be suspect due to an inadequate cost analysis. In addition, an agency may mistakenly continue to provide a service that could be acquired at a lower cost from a contractor. Or, the agency may unnecessarily contract for a service that it could provide at a lower cost than the private sector.

The division does not have reliable and complete data

In our review, we found that the Adult Mental Health Division's cost data is inadequate to support an accurate cost analysis. Personnel costs are one of the primary costs in a government's provision of a service. Direct service staff distribute their time among tasks that relate to different direct services and on administrative tasks not related to direct services. Calculating the personnel costs of a particular service requires not only knowing the salaries of staff but also the amount of time that each staff member spends on the targeted service. The division does not adequately track this information to enable an accurate cost analysis to be conducted on a particular direct service.

The method for tracking the time that staff spends for each service has produced unreliable and incomplete results. The primary method by which the division tracks this time is through MFASIS, the division's computer system. Staff at the various community treatment centers fill in

forms with the amount of time they spend providing each service or performing an administrative function. The information from the forms is subsequently entered into MFASIS, which generates reports on staff time and on services provided.

We found insufficient controls over the recording and tracking of staff time as well as inadequacies in the computer system. Social workers and center chiefs claimed that some staff members were not diligent in recording their time on the forms. We found that many completed forms were probably not reviewed by supervisors; the supervisor signature lines were blank. At one center, staff did not specify time used for vacation or sick leave. In addition, the computer system's data verification functions do not adequately ensure that data are entered correctly. For example, the computer system will not prevent an erroneous entry, such as the year 1999 for the date of birth. We could not test the computer system for reliability because the system was not operational during our fieldwork. Furthermore, three of the four center chiefs we spoke with claim that MFASIS reports are unreliable, and they do not use them as a basis for management decisions. Based on these factors, it is not possible to perform a cost analysis that would yield accurate information for evaluating the cost of privatizing direct services.

The Division's Efforts at Managing Contracts and Coordinating with Private Providers Are Currently Inadequate to Support Further Privatization

The Adult Mental Health Division lacks the ability to provide the additional backup necessary to support the privatization of direct services. Increasing privatization will require an increased capability to adequately monitor and evaluate contractors. Since the division does not adequately maintain current privatization efforts, additional privatization would also be inadequately supported. The division's contract administration is plagued with several problems. The division's goal of an integrated mental health system of state centers and private providers has not been attained, and ultimately consumers suffer from the lack of a seamless system of care. Increasing privatization will only add to these problems, as more private providers will mean an increase in contract administration functions and coordination efforts.

Contract administration is deficient

The Adult Mental Health Division's contract administration is currently inadequate to support privatization. Contract administration consists of all government activities that take place from contract signing to discharge of contractual obligations by all parties.[4] The role of contract administration is protection of the government's interests by ensuring that the contractor performs in a satisfactory manner. The division's current contract administration efforts fail to carry out this role adequately. Contractors are not consistently monitored; performance measures do not adequately measure contractor effectiveness; contractual requirements are

not enforced; and contracts are routinely executed late. The division must correct these inadequacies to properly protect the State's interest in current contracts before the taxpayer can be assured that increased privatization will be successful.

Contract monitoring is conducted inconsistently

Section 42D-25, Hawaii Revised Statutes (HRS), requires state agencies to perform an annual on-site visit for each purchase of service agreement to ensure that the contractor is fulfilling its responsibilities. On-site monitoring for the Adult Mental Health Division consists of separate fiscal and program monitoring efforts. Fiscal monitoring involves reviewing a contractor's internal controls, verifying the accuracy of expenditure reports, and examining accounting procedures. Fiscal monitoring ensures that contractors do not overcharge the State for expenses incurred and reduces the risk of fraud. The division's fiscal monitoring has been late and does not comply with Chapter 42D requirements.

In conducting program monitoring, division staff follow a protocol and review contractor files for compliance with contract requirements. The program protocol focuses on how well the contractor is satisfying standards for accreditation. Program monitoring efforts vary each year but have generally been decreasing. More than half of the division's contracts have not received either fiscal or program on-site monitoring visits. Some of these contracts amount to several million dollars. On the other hand, some contractors with smaller priced contracts have been monitored by both fiscal and program staff.

The division does not consistently monitor its contractors. Most of the division's purchases of service contracts cover a two-year time period. In the 1995-97 biennium, the division entered into 28 contracts for mental health services; in the 1997-99 biennium, there were 32 contracts. We reviewed 21 contracts from the 1995-97 biennium and 25 from the 1997-99 biennium or approximately 77 percent of the contracts for these two bienniums.

Fiscal monitoring of the division's 1995-97 biennium contracts only began in February 1998, more than six months after the contracts had ended. The division conducts only one site visit for fiscal monitoring for each two-year contract. This practice violates the department's policy, Administrative Services Office Memorandum No. 95-38, which requires fiscal monitoring to be performed annually in accordance with Chapter 42D, HRS. The division claims to have completed fiscal monitoring of all contracts, except for contracts belonging to two contractors. However, these two contractors had contracts totaling more than $4 million, almost half of the total amount spent on contracting for

mental health services. In addition, the 1997-99 biennium contracts will end in four months and not one has received any fiscal monitoring.

While fiscal monitoring began in early 1998, program monitoring has been ongoing. However, many contracts are not monitored. Out of 21 contracts for the 1995-97 biennium that we reviewed, the division conducted only 11 program monitoring visits for FY1995-96 contracts and only 9 visits for FY1996-97 contracts. Out of 25 contracts for the 1997-99 biennium we reviewed, the division conducted only five program monitoring efforts to assess compliance for FY1997-98 contracts. No program monitoring has been done on FY1998-99 contracts.

The division lacks a coherent monitoring system with clear lines of accountability, beginning with a designated contract administrator. The division claims to lack adequate resources and uses a team concept for contract administration. For fiscal monitoring, two accountants perform site visits and report to the lead accountant in the division's fiscal office. On the program side, the division uses staff from various units from the division's Program Support Services Unit. One program monitor doubles as the division's planner; another works in the Research & Evaluation Unit and analyzes division statistics; and several others work in the Clinical Service Standards Unit. Each person is responsible for specified areas, such as housing or crisis services.

While the lack of resources may be a contributing factor, we believe the main cause of inconsistent monitoring is the lack of a coherent monitoring system and the resulting lack of accountability. The fiscal monitors seldom meet with the program monitors to coordinate monitoring efforts. Moreover, the fiscal monitors do not know who all the program monitors are. Under the current system for monitoring contractors, program monitors report to the division chief. This placement of contract administration responsibilities on the division chief does not assure that contract monitoring will receive adequate attention.

The division also does not have a designated contract administrator. A contract administrator is generally responsible for developing the monitoring system, including scheduling site visits and ensuring that the schedules are followed. The contract administrator also coordinates fiscal and program monitors to ensure efficient and cost effective monitoring efforts. For example, a monitoring team visiting a particular contractor could conduct a follow-up on specific issues identified by the previous monitoring team regardless of whether the issues were fiscal or programmatic. Without a coherent contract monitoring system and adequate ongoing monitoring, the State cannot be assured of receiving the services that were contracted.

The division claims that contractors who are accredited require less monitoring. Thus, the division created two separate monitoring protocols

for program monitoring, one for accredited providers and one for nonaccredited providers. The division's protocol for accredited providers contains fewer requirements because the division claims that the accreditation process covers many of the requirements normally covered in program monitoring. However, we note that most providers are still not accredited.

Performance measures are inadequate for proper evaluation

A coherent monitoring system may not assure contractor effectiveness without adequate performance measures. The division's contracts do not have adequate performance measures to properly evaluate the effectiveness of the services being provided. The division's contracts for mental health services require the contractors to submit quarterly written reports of program activities. These reports simply show the number of people served for each type of service during a particular time period. Some contractors provide more detail by including the names of people and the types of service each person received during the time period. Simply providing the number of people served, however, does not answer the question of how well they are being served and what is accomplished through the contracting system, which is the key to proper evaluation.

In the contract files we reviewed, we found no evidence of performance measures, an evaluation system, or quarterly program evaluation reports. Instead of developing its own performance measures, the division has relied on the contractors to develop appropriate performance measures. Contracts for the 1995-97 biennium commonly required contractors to develop a program evaluation system by June 30, 1996. This evaluation system was to include measures of clinical outcome, program effectiveness, and client satisfaction. The contractor was required to submit quarterly written program evaluation reports to the division. We found no evidence of any program evaluation system or quarterly program evaluation reports. For the 1997-99 biennium contracts, the division included a provision that required contractors to jointly develop performance measures with the division no later than January 1, 1998. We found no evidence of performance measures. In two cases we found evidence of a meeting but no evidence of any performance measures.

According to the division's policies and procedures, the purpose of program evaluation is to promote continuous quality improvement in mental health service delivery through the regular provision of information. Without adequate program evaluation data on its contractors, the division has limited knowledge of the quality of mental health service delivery by private providers. The division indicated that its goal to have all contractors accredited would ensure that quality care is provided to consumers because the accreditation process requires the service provider to establish a program evaluation system. However, as indicated previously, only a few providers are currently accredited.

The division indicated that it is currently developing appropriate performance measures in line with national trends. The National Association of State Mental Health Program Directors Research Institute, Incorporated (NASMHPD), recently published a feasibility study on performance measures for state mental health agencies.[5] The feasibility study describes and explains how to measure key indicators, such as increasing the level of functioning, reducing symptoms, and measuring other outcomes. The division's quality management committee has revised these outcome measures to fit the State and claims that its request for proposal (RFP) committee is working on incorporating some of the performance measures into the division's RFPs. These new RFPs will be used to solicit mental health services for the next two-year contract period. We could not comment on the sufficiency of the performance measures in the draft RFP because the division failed to provide a copy of the draft RFP it claims to have developed.

Contractual requirements are not enforced

The Adult Mental Health Division has also failed to diligently enforce existing contract performance requirements. Many of the contracts contained provisions requiring contractors to submit income and expenditure reports, program evaluations, and program activity reports. However, our review of the division's contract files found that most contractors were not in compliance, and there was no evidence that the division had pursued the contractors to comply.

Almost all of the contracts required timely reports with specified information. For example, some contracts required that "the AWARDEE shall provide quarterly written reports of actual expenditures and income, and program activities to the STATE. These written reports shall be due to the STATE within 30 calendar days after the end of each quarter." Other contracts required a monthly submission of specific reports.

In our review, many of the contractors submitted expenditure reports that were several months late. In some instances, three or four reports were submitted on the same date, some for much earlier reporting periods. In addition, many financial reports listed only expenditures and not income or billings as required by the contract. Not one program evaluation report was submitted, and the majority of the program activity reports were submitted without any indication of the date of submission.

These monthly or quarterly reports can be used to detect problems that might interfere with satisfactory completion of the contract. For example, comparing one month's actual volume of service and expenditures to projected monthly service volume and expenditures can provide early indications of whether expenditures are ahead of or behind schedule. In addition, the amount of income collected or billings posted can be

indicative of whether the contractor is able to sustain itself financially. A particular provider that has income significantly lower than previous periods may be in financial trouble and may terminate services. This forewarning allows the division to plan for remedial measures should the provider close down. Allowing contractors to submit reports late keeps the division in the dark about the contractor's financial status.

The division has not enforced the contract provision that requires contractors to submit periodic reports within 30 days of the end of the reporting period. One reason may be the lack of adequate penalty provisions in the contract. To deal with contractors' late submittals of reports, the division's options are to withhold payment or to terminate the contract. From our survey responses and interviews, contractors indicated that the division has withheld payment for late submittals of reports, but eventually makes full payment when the report is submitted. However, our review indicates that withholding payments does not seem to be effective in persuading contractors to submit reports in a timely manner because contractors eventually receive full payment. On the other hand, terminating the contract may be unnecessarily harsh, since clients would suffer if the division could not find a new provider.

In many of the division's contracts, there was no provision for liquidated damages, or it had specifically been removed. The division defends the removal with the claim that liquidated damages apply only to construction contracts and not to the purchase of services. However, literature on service contracts suggests that liquidated damages provisions can be used in service contracts.[6, 7] A liquidated damages provision would allow the State to reduce payments should the contractor fail to meet specific delivery dates. For example, if the contractor does not meet a deadline, the division reduces the fee by a certain percentage for every day that the contractor fails to meet the deadline. This can be a strong incentive for a contractor to adhere to the scheduled report date.

Contracts are frequently executed late

An additional shortcoming in the division's contract management practices is the untimely execution of contracts, which occurs frequently. Of the 46 contracts we reviewed, 37, or approximately 80 percent, were executed *after* the services were expected to be provided to the public. Of those late contracts, 56.7 percent were executed more than 90 days after services were to be provided.

From our review of the contractors' program activity reports, we found that most private providers began providing services before contracts were finalized. This is not in the best interests of the State, the private providers, or the public. Properly executed contracts are essential to ensure that (1) the type and scope of services to be provided have been agreed upon, (2) the services are those for which the Legislature

appropriated moneys, and (3) the roles and responsibilities of the division and the service providers are clearly delineated to avoid confusion or misunderstanding.

Late execution of contracts was previously noted in our *Financial Audit of the Department of Health,* Report No. 92-30. In that report, we found that 90 percent of the contracts reviewed were executed after services were expected to be provided and of those that were late, 20 percent were executed more than 90 days late. We recommended that the Department of Health take steps necessary to ensure that contracts for services are properly executed before delivery of those services by contractors is scheduled. In our 1995 follow-up report, the department reported that it was working on improving timeliness. However, it would appear that after an additional five years, improvements are still lacking.

It is essential that contracts be properly executed before any services are provided. Without the benefit of a contract, there is no assurance that services being provided are either necessary or intended. Additionally, providing services without contractually defined roles and responsibilities puts both the State and the providers in jeopardy should any legal problems arise.

The system of mental health service delivery is insufficiently integrated

The Adult Mental Health Division's overall mission is to achieve an integrated mental health services system of state centers and private providers. Integration requires providing and coordinating the delivery of comprehensive, equitable, and accessible services through public/private partnerships in each community, including rural areas of the State. The division's current system of delivering mental health services is not well integrated. As a result, a seamless system of care is not available to people with serious mental illness. Such a system of care provides a greater likelihood that a consumer receives the necessary treatment. A lack of proper operational plans may be the cause of the current condition. Without such plans to provide sufficient detail on how private providers will participate in the division's health care system, the division may not be effectively using its private providers.

The division lacks appropriate operational plans to implement its strategic goals

Section 334-2, HRS, requires the Department of Health to foster and coordinate a comprehensive mental health system to improve the mental health of the people of Hawaii. Its Adult Mental Health Division's mission is to promote, provide, coordinate, and administer a comprehensive, integrated mental health system for individuals eighteen years of age and older. However, a consultant found that the division's mental health system of state centers and private providers is not well integrated. The division hired the consultant to fulfill the State's

obligations under an agreement between the State and the Department of Justice that resulted from the latter's review of the Hawaii State Hospital. Under the agreement, the State was required to identify all residential and other community supports needed to meet the needs of each hospital patient who is appropriate for discharge. The consultant found a lack of integration, coordination, collaboration, and communication between the Hawaii State Hospital and various elements of the community mental health service system. The consultant added that the State's community program components were also "compartmentalized and uncoordinated." The consultant stated that the division needed to establish an implementation structure and process to include specific staff assignments, timelines, milestones, and performance standards.

Proper operational plans would help the division to establish the recommended implementation structure and process by linking with the division's strategic plans and by providing step-by-step specifics on how strategic goals are to be achieved. An operational plan would assign responsibility for each step to appropriate parties, determine and allocate necessary resources, estimate dates for starting and completing, and assign target dates for completion. In outlining necessary steps and activities, an operational plan would provide the necessary guidance to participants on how they can accomplish the organization's goals.

The division does not currently provide the necessary guidance to participants involved in the delivery of mental health services. To receive federal funding, the division submits to the federal government an annual state plan and an implementation plan that declares goals and objectives. However, these plans contain insufficient information on how the various state centers and private providers will contribute toward those goals. The division's implementation plan seems more like an update of the state plan and does not contain sufficient detail to provide guidance. Private providers indicated that the division does not adequately define its scope and mission of forming an effective partnership to deliver mental health services. Our survey asked providers what areas should be addressed to form a more effective partnership between private and public sectors. Respondents provided such comments as "define roles of public and private sector providers and establish realistic goals", and "increase collaboration in setting priorities for services and determining how these services will be provided." In general, respondents also noted that the division needed to increase its awareness of what services are needed. Other responses were similar in nature and indicate concerns that the mental health system is not adequately providing for the needs of the public.

Without proper operational plans, the division may not be using private providers effectively

The Adult Mental Health Division currently lacks operational plans necessary to implement its annual state plan and strategic goals. The division has attempted to enhance its management of private providers by implementing a strategic planning process, requiring private providers to meet with division quality control committees and requiring providers to submit performance measures reports. However, these steps are not effective because there are no operational plans against which to measure.

As a result, the division may not be using its private providers effectively to provide a coordinated and integrated mental health system. Many of the private providers we surveyed commented that the division needs to improve its communications with private providers. Out of 25 respondents, 11 providers or 44 percent, expressed a need for improved communications and collaboration in planning, needs assessments, or understanding the needs of private providers. When we visited three private providers, two of the three stated that the recently implemented strategic planning process was not useful to private providers. In addition, we found that private providers seldom meet with division staff for planning purposes. The only time private providers meet with division staff on a regular basis is for the benefit of the patient. This ineffective use of private providers will be more problematic should privatization increase the number of private providers that the division must integrate into its system of care.

Conclusion

The decision to privatize government services requires a careful and deliberate process to ensure that the decision is well-supported and reasonable. Use of a systematic decision-making process helps to substantiate the decision. We found that determining whether to privatize the existing direct services of the Department of Health's Adult Mental Health Division is not feasible at this time. Essential information was not available, and data provided was not reliable.

Moreover, before any further efforts at privatization are attempted, the Adult Mental Health Division needs to improve its contract management practices and coordination with private contractors. Increasing privatization in light of the division's current practices will likely result in unsuccessful privatization efforts.

Recommendations

1. The Department of Health should report to the Legislature on steps taken to improve contract administration practices that are necessary to support privatization of direct services. The report should include:

a. Designating a contract administrator to be responsible for establishing a contract monitoring system;

b. Improving its monitoring of contract providers;

c. Establishing adequate performance measures to evaluate the effectiveness of its contractors;

d. Requiring timely submission of monitoring reports by its contractors; and

e. Executing its contracts in a timely manner.

2. The division should establish a systematic process for consistently monitoring contractors. The process should include:

a. Designating a contract administrator to establish the system;

b. Implementing monitoring schedules; and

c. Coordinating fiscal and program monitoring efforts.

3. The Department of Health should ensure that the division holds contractors accountable and enforces the following contract provisions:

a. Submitting reports in a timely manner; and

b. Submitting reports that contain all of the elements required by contract.

4. The division should consider again the inclusion of a liquidated damages provision in its contracts to enforce contractual requirements.

5. The division should take the necessary steps to execute all purchase of service contracts in advance of their effective date.

6. The division should develop operational plans that identify specific staff assignments, timelines, milestones, and performance standards and ensure that day-to-day operations progress toward the division's strategic goals.

Notes

Chapter 1

1. U.S., General Accounting Office, *Privatization: Lessons Learned by State and Local Governments*, GAO/GGD-97-48, March 1997, p. 1.

Chapter 2

1. William D. Eggers, *Designing a Comprehensive State-Level Privatization Program*, Los Angeles, California. Reason Foundation, January 1993.

2. Keon S. Chi and Cindy Jasper, *Private Practices: A Review of Privatization in State Government*, Lexington, Kentucky. The Council of State Governments, January 1998.

3. The division also accepts accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation (COA), but accreditation by CARF is the most common for providers under the Adult Mental Health Division.

4. Peter M. Kettner and Lawrence L. Martin, *Purchase of Service Contracting*, Newbury Park, Calif., SAGE Publications, Inc., 1987, p. 139.

5. National Association of State Mental Health Program Directors Research Institute, Inc., *Five State Feasibility Study on State Mental Health Agency Performance Measures*, Alexandria, Virginia, May 1, 1998.

6. John Short, *The Contract Cookbook for Purchase of Services*, 2nd Ed., Lexington, The Council of State Governments, 1980, p. 38, 44.

7. Donald F. Harney, *Service Contracting, A Local Government Guide*, Washington, D.C., The International City/County Management Association, 1992, pp. 38-39, 56.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on February 5, 1999. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The health department's response included additional comments concerning its perspective on privatization of services and some of the factors identified in the report as needed to properly assess the feasibility of privatization. The department also commented that there were business advantages to limiting the number of vendors and that the department's efforts to restructure services have been met by strong resistance from its own staff.

The department also disagreed with several of our findings and claims to have initiated corrective action in several areas. However, the department did not address the report's specific findings and recommendations. The department also took exception to the statements regarding the limitations to obtaining information.

More specifically, the health department attributed problems with its contract procedures to changes required by the U.S. Department of Justice's Stipulations and Orders. The department stated that its contracted services result from appropriations made to various programs and in response to the Stipulations and Orders, and not specifically to meet needs that the department identifies. We would note, however, that external impetus does not justify the department's poor management of contracted services. Contract monitoring and enforcement are fundamental to the cost effective use of contracts.

The department notes that it makes every effort to analyze and identify costs in its contracts for services and attributes its inability to accurately record and track staff time to employee resistance. In fact the department attributes its efforts to supplement existing services as a means of dealing with its own staff's resistance to change.

The department claims that fiscal monitoring has been ongoing and could be done through desk reviews. However, we found no evidence to support the department's claims that fiscal monitoring through site visits or desk reviews was conducted prior to February 1998. According to the department's Fiscal Monitoring Manual, desk reviews are to be documented by the completion of an "Awardee Audit Report Review." In addition, the manual requires that the division notify the contractor of the

results of its review. We found no such evidence that desk reviews were done for the contract files we reviewed. In addition, staff interviews confirmed that desk reviews were not being performed.

The health department also disagreed with our assessments of Chapter 42D requirements and further noted that not all of the Division's contracts fall within Chapter 42D. Chapter 42D requires that state agencies conduct an annual on-site visit of each program funded by a purchase of service agreement. As noted in the report, more than half of the division's contracts have not received either fiscal or program on-site monitoring visits. We also note that the department's own policies require that fiscal monitoring of purchase of service contracts be in accordance with Chapter 42D, HRS. The department's contention that contracts do not require an on-site visit because they are not Chapter 42D contracts simply ignores the management responsibilities and benefits of conducting on-site visits. We continue to believe that an on-site visit should be mandatory for all contracted services as a way to ensure services are properly evaluated and cost effective.

With respect to program monitoring, the department notes that delays resulted from a loss of staff and efforts to implement corrective actions required by the Stipulation and Order. The department added that it has taken corrective action by filling two program specialist positions and is finalizing new protocols and procedures for monitoring and data collection of contracted services.

The department also stated that both private and state providers of services are unaccustomed to integrating services, but will consider our recommendations in its development of its operational plan to integrate services. The department said it will also consider including a liquidated damages provision in contracts unless limited staff prevents enforcement of contract provisions.

Finally, the department stated that it takes "great exception" to our comments about the effects of a fire that occurred during fieldwork and our attempts to obtain information from the department. The department states that we understate the effects of the fire and that division staff did not attempt to create roadblocks. We disagree. Our staff was fully aware of the extent of the fire and attempted to mutually agree on working arrangements for access to department files and records. However, arrangements made between the division chief and our office concerning time and access to documents were continually contravened by division staff. Despite numerous explanations on the need to review documentation independently, division staff continued to limit and control our access to information.

Requests for working space equivalent to a desk were refused. When work space was finally provided, division staff imposed unreasonable time limits on its use. It was only after repeated complaints to department and division heads that we were granted full access to the records and files. However, while cooperation at the division level was a problem, we point out that staff from the various centers were very cooperative and helpful during the course of our study.

ATTACHMENT 1

STATE OF HAWAII
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February 5, 1999

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, *Study of Privatizing Adult Mental Health Program Services*. We ask that you telephone us by Tuesday, February 9, 1999, 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 Tuesday, February 16, 1999.

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

BENJAMIN J. CAYETANO
GOVERNOR

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

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3376
HONOLULU, HAWAII 96801

In reply, please refer to:
File:

February 16, 1999

Ms. Marion M. Higa, State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

The following is based on our review of findings, comments, and recommendations contained in your draft Study of Privatizing Adult Mental Health Program Services, A Report to the Governor and the Legislature of the State of Hawaii.

First, I wish to comment on the manner in which this Department utilizes the services of private providers. As you are aware, based on your previous studies of our purchase of services, many contracted services were the result of appropriations made to various community programs providing mental health services. As such, the Department was responsible to develop contracts and monitor services, that while needed, did not specifically or immediately meet the identified needs of our mental health program. Over a period of time, we have negotiated and redirected services through the request-for-proposals process to provide for gaps in service and compliment and/or enhance existing services to those seriously mentally ill who might not otherwise receive needed services. Contracted services continue to be modified towards becoming a part of a system of services that is required, and more recently, have been modified or expanded at a rapid pace as part of the State's corrective action in addressing the requirements of the U.S. Department of Justice as presented in a number of Stipulations and Orders filed in U.S. Federal District Court. Procedures which have been developed to date, relative to contracted services in part reflect their evolution and the problems which are currently occurring as we effect those changes required by the recent Stipulations and Orders. Accordingly, we do not view contracted services as the privatization of services that would otherwise be provided by this Department.

We concur that "competition is essential," but with the current limited direct or reimbursement funding for health care services in general, it is difficult to foster "multiple vendors." While initially it would appear that contracting with a few vendors is undesirable, it is precisely the issue of limited funding that makes it economically desirable, as well as appropriate from a business perspective, to contract with a few key providers and eliminate duplicate infrastructure costs which can be redirected to direct service costs.

In developing and issuing RFPs for services, amounts allocated for each category are based on prevailing rates for services within the State. Where new services are identified , prevailing rates, if available, for similar services in comparable sized systems on the mainland are used. The subsequent review of proposals and the negotiation of awards and contracts includes every effort to analyze costs and identify "hidden or inaccurate costs."

While we agree that should the State determine that certain public services are more appropriately provided by private sector resources, "state employee and union support" is desirable. We wish to take this opportunity to point out that when we have or have attempted to implement contracted services that are not being provided by State employees, we have incurred strong reactions based on their view that such contracted services were depriving them of earning additional income through overtime, etc. In addition, when we have attempted to restructure services we have been confronted by a strong resistance to change. It is this resistance to change that has caused the State to supplement existing services towards obtaining the responsiveness, flexibility, accountability, and necessary competencies to provide more effective, efficient services.

I also wish to comment on some of your findings. First, Section 42D-25, Hawaii Revised Statues, does not require both fiscal and program monitoring on-site visits to be conducted annually. It should also be noted that a significant number of the Division's contracts are not Chapter 42D contracts. Therefore, Chapter 42D requirements would not apply to all our contracts.

Second, fiscal monitoring can be performed through desk reviews, site visits, or single audit reviews. Fiscal monitoring of the Division's FB 1995-97 contracts have been conducted on an ongoing basis beginning in the first quarter of FY 1996 and did not begin only in February 1998. The Division conducted fiscal monitoring for all FB 1995-97 contracts in FY 1996 and FY 1997. All of the Division's FB 1997-99 contracts were fiscal monitored in FY 1998 and have already been fiscal monitored in FY 1999.

It should be noted that during the last approximate year and a half, the loss of a number of key staff delayed the scheduled monitoring of some of the programmatic and service aspects relative to contracts. Implementation of additional corrective action as required in the most recent Stipulation and Order further impacted the coordination and quality of our monitoring activities. The speed with which services needed to be brought on line unfortunately did not allow the development of appropriate performance measures. But as was shared with your audit staff, new protocols and procedures to enhance the monitoring and data/information collection of contracted services are being finalized and will be implemented for the period beginning

July 1, 1999. Contracts will also reflect relevant performance measures. Many vendors have complained and continue to complain about the burden and intrusiveness of our monitoring and information requirements, and such complaints are likely to increase with the implementation of the new protocols and requirements. It must be emphasized that the new protocols and requirements which will be implemented are intended to better review contracted services and are not intended to "support further privatization."

As indicated previously, we have and continue to incur resistance when attempts are made to develop more flexible, responsive, and accountable services within our programs. To a great extent, our inability to accurately record and track staff time is a result of that resistance. Obviously, the accurate computerization of such information is dependent on the accuracy of information inputted and not necessarily a reflection of a particular computer system.

A concerted effort to integrate center services and contracted services began in November 1998. Integration is unfortunately foreign to both public and private services. Because centers were the primary source of services to the seriously mentally ill, they were not required nor did they find it necessary to closely coordinate their services. Until recently, private providers sought and received funding which for all intents and purposes were grants-in-aid needed to continue their operations, and did not seek to closely coordinate their services beyond accepting referrals from centers or obtaining additional funding. We are in the process of developing an operational plan to integrate all our services which will also define the system of services over the next few years. During this process, we will take your recommendations into consideration as specific procedures are developed.

The Division will consider the inclusion of liquidated damages in its contracts to enforce contractual requirements. However, we are inclined not to include contractual requirements that we will be unable to uniformly enforce due to the lack of adequate staffing.

The Division has already begun to take corrective action by the filling of two program specialist positions within the past eight months. The primary functions of the program specialist positions include ensuring the timely submission of complete contract required reports, implementing monitoring schedules, and processing contracts to allow for their execution in advance of their effective dates.

We take great exception to your statement that "...roadblocks to our obtaining information appeared unrelated to the fire." First and foremost, Division staff did not attempt to create roadblocks. Second, the inference of your statement that the "...fire...[only] affected the Division's office space" is an understatement that would lead the reader to assume the fire's effects were minor. The fire's heat, smoke, and resulting soot and water damage did much more than "affect" office space. All programs on the affected floor experienced difficulty retrieving

materials and documents. In addition, staff were, understandably, reluctant to have to continually go on to the floor.

While the methodology used by your office may indeed be appropriate relative to privatized healthcare services, the many statements and conclusions do not seem to reflect an earlier statement in your report that our ability to integrate services towards developing a seamless system of services is determined by "...government civil service rules and cumbersome governmental procurement rules...to obtain the most qualified staff and more easily acquire the necessary equipment."

Thank you for the opportunity to review the draft report.

Sincerely,

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