

# ALASKA STATE LEGISLATURE

## LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



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SUMMARY OF: A Special Report on the Department of Health and Social Services, Division of Behavioral Health, Select Issues, October 1, 2003.

### PURPOSE OF THE REPORT

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, we conducted a performance audit of select issues related to Department of Health and Social Services' (DHSS), Division of Behavioral Health's (DBH) administration of substance abuse grants.

Our objectives included determining whether clients are receiving adequate and appropriate services from substance abuse grantees and to identify areas for improving program management. We were also asked to evaluate the grant award process and determine whether conflicts of interest existed between the Division of Alcoholism and Drug Abuse (ADA) staff and recipients of grant funds.

In FY 03, DHSS' mental health section was merged with ADA to form the Division of Behavioral Health. Throughout this report, we refer to ADA as the entity audited. However, recommendations are made to DBH in recognition of the department's current organizational structure.

### REPORT CONCLUSIONS

ADA needs an operational plan to ensure the effective use of limited resources. ADA has not identified the state's substance abuse needs nor communicated the state's priority for addressing the needs. Consequently, the division is in a poor position to ensure its limited resources are used effectively. General planning efforts by the Advisory Board on Alcoholism and Drug Abuse, the Mental Health Trust Authority, and the Mental Health Board are hindered by ADA's lack of an operational plan. Such a plan would ensure the delivery of substance abuse services was conducted in accordance with general guidance from these entities.

DHSS needs to improve internal controls over reporting and investigating ethics complaints. Conflicts of interest did exist at ADA and complaints alleging unethical behavior (undue influence over the grant process) were not reviewed and investigated as required by statute. Two letters were submitted to DHSS' commissioner's office alleging unethical behavior on the part of an ADA employee. These letters were not forwarded to DHSS' designated ethics officer for review/investigation. The designated ethics supervisor did become aware of complaints concerning actions taken by a spouse of an ADA management level employee involving an ADA grantee.

However, no official investigation was conducted and the Department of Law was not informed of the complaint as required by statute.

While we found that, in general, ADA appropriately awarded grants, several errors were made during the FY 02 and FY 04 grant award process. Errors included missing documentation, lack of required approvals, and inconsistent application of minimum requirement criteria. Additionally, we found one ADA grantee was overpaid \$273,000 in error.

Changes to the grant regulations improved the competitive grant proposal review process. Under the new regulations, 80% of substance abuse grants were awarded under a noncompetitive process.

ADA effectively monitors its grantees. Grantees perceive ADA fiscal and program staff to be fair, responsive, competent, objective, and easy to work with. Standards used to certify substance abuse treatment facilities are outdated and may fail to adequately protect the public. The certification standards were adopted in the mid 1970s and have not been updated to reflect best practices.

ADA's MIS system is functionally inadequate and difficult to use. The system does not collect the information necessary to evaluate the effectiveness of ADA's programs and it does not provide information useful to grantees in managing their programs. The division is working on a collaborative project with other states to develop a new MIS system.

#### FINDINGS AND RECOMMENDATIONS

1. The Division of Behavioral Health's (DBH) director should create a comprehensive program for prevention and treatment services to guide the delivery of substance abuse services.
2. DBH's director should take steps to improve its working relationship with the Advisory Board on Alcoholism and Drug Abuse.
3. DBH's director should take steps to improve the grant award process.
4. The DHSS commissioner, in cooperation with the Department of Law, should pursue recoupment of the FY 03 overpayment to an ADA grantee.
5. The DBH director should ensure the new MIS system is designed to address the deficiencies of its current system and collect the information necessary to evaluate the effectiveness of its programs.
6. The DHSS commissioner must implement internal controls over investigating and reporting of potential ethics violations to comply with statutes.
7. The DBH director should implement policies and procedures to guard against potential ethics violations.
8. The DBH director should develop and implement written policies and procedures to ensure compliance with state regulations governing subcontracts of grantees.
9. The DBH director should update the standards for treatment facilities to reflect current practices and technology.
10. We recommend DHSS' internal auditors provide training to DBH program managers and grant administrators to ensure that federal/state single audits of grantees are utilized to the greatest extent possible.

October 23, 2003

Members of the Legislative Budget  
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
DIVISION OF BEHAVIORAL HEALTH  
SELECT ISSUES

October 1, 2003

Audit Control Number

06-30023-03

The purpose of this audit was to review administration of substance abuse grants by the Division of Alcoholism and Drug Abuse (ADA) including: 1) determining whether clients are receiving adequate and appropriate services from grantees, 2) ascertaining whether conflicts of interest exist between ADA staff and recipients of grant funds, 3) identifying areas for improving management of the program.

The mental health section of the department was merged with ADA to form the new Division of Behavioral Health (DBH), effective July 1, 2003. Throughout the report we refer to ADA as the entity audited. However, recommendations are made to DBH in recognition of the department's current organizational structure.

The audit was conducted in accordance with generally accepted government audit standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology section.

Pat Davidson, CPA  
Legislative Auditor

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# OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, we conducted a review of the State of Alaska's substance abuse prevention and treatment programs as administered by the Department of Health and Social Services (DHSS), former Division of Alcoholism and Drug Abuse (ADA).

## Objectives

Specific objectives of this audit include:

- Review ADA's grant administrative practices for compliance with laws and regulations and identify areas for increasing efficiency and effectiveness.
- Determine whether clients are receiving adequate and appropriate services from grantees and subcontractors.
- Conduct a survey of grantees to measure the fairness and quality of ADA's grant administrative practices and a survey of clients to measure satisfaction with ADA funded treatment services.
- Determine whether conflicts of interest exist between ADA staff and recipients of grant funds.
- Determine whether the Commissioner's office received charges alleging ADA grantees were subjecting clients to behavior contrary to treatment objectives and the actions it took to investigate and eradicate the conduct.

## Scope

The primary focus of our review was ADA's administration of the state's alcohol and substance abuse programs during FY 02 and FY 03. In order to evaluate the impact of a change in the department's grant regulations, we compared the FY 02 grant award process to the FY 04 process. Our evaluation of conflicts of interest covered July 1999 through June 2003.

During the time this review was performed, ADA was merged with the department's mental health section into a new Division of Behavioral Health (DBH), effective July 1, 2003. Our review focused on ADA's management practices but our recommendations are addressed to DBH.

## Methodology

Our evaluation involved the review and analysis of the following documents:

### Laws and regulations:

- Relevant Alaska Statutes (AS), including AS 39.52, AS 47.30.470 – 500 and AS 47.37.010 – 270.
- Relevant regulations of the Alaska Administrative Code (AAC) including 7 AAC Chapter 28 (Community Grant-In-Aid Program for Alcoholism), 7 AAC Chapter 29 (Uniform Alcoholism and Intoxication Treatment), and 7 AAC Chapter 78 (DHSS Grant Programs).
- The Health Insurance Portability and Accountability Act (HIPAA) of 1996.

### Reports and Publications:

- 1998 performance audit by the Division of Legislative Audit of the Division of Alcoholism and Drug Abuse.
- 1993 report by the State of Alaska, Office of the Ombudsman concerning the Division of Alcoholism and Drug Abuse.
- 1998 report by the State of Alaska, Office of the Ombudsman concerning the Department of Health and Social Services handling of potential violations of the Executive Branch Ethics Act.
- *Results Within our Reach*. The Alaska State Plan for Alcohol and Drug Abuse Services 1999 – 2003.
- The Alaska Advisory Board on Alcoholism and Drug Abuse annual reports for 1999 and 2000.
- *In-Step*. DHSS' Comprehensive Integrated Mental Health Plan for fiscal years 2001-2006.
- *Economic Costs of Alcohol and other Drug Abuse in Alaska*. A 2001 report prepared by the McDowell Group.
- *Final Report of the Steering Committee Substance Abuse/Mental Health Integration Project June 2000 – August 2001*. A 2001 report prepared by C & S Management Associates.
- *An Integrated Substance Abuse Treatment Needs Assessment for Alaska*. A 2002 report prepared by North Charles Research and Planning Group for the U.S. Substance Abuse and Mental Health Services Administration.

Other documents:

- FY 03 DHSS budget documents.
- Commissioner and director correspondence files for calendar years 2002 and 2003.
- The Joint Commission on Accreditation of Healthcare Organizations' 1974 accreditation manual (Alaska minimum standards) and state approval checklist.
- The Division of Alcoholism and Drug Abuse MIS user manual.
- Documentation supporting the FY 02 and FY 04 grant award processes.
- DHSS' operating grant books for FY 02 and FY 03.
- The Division of Alcohol and Drug Abuse grant plans for FY 01 through FY 04.
- Federal application for the state incentive grant.
- FY 02 and FY 03 substance abuse grant files.
- FY 02 and FY 03 logs of ethics complaints.
- Human resource staff interview notes.
- Quarterly ethics reports submitted by DHSS to the Department of Law.

We also conducted interviews with the following individuals:

- Alaska Advisory Board on Alcoholism and Drug Abuse's executive director and planning staff.
- Alaska Mental Health Trust Authority staff.
- Staff of the Division of Behavioral Health (formerly with the Division of Alcoholism and Drug Abuse).
- DHSS' Division of Administrative Services' grant administrators.
- Management level staff from 19 substance abuse grantees.
- State substance abuse program administrators from Washington, Oregon, Idaho, Montana, and South Dakota.

Further, we conducted a survey of substance abuse grantees. Out of a total of 67 grantees who were asked to participate, 24 responded – a response rate of 36%.

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## ORGANIZATION AND FUNCTION

### Department of Health and Social Services

Created under Alaska Statute (AS) 18.05.010, the Department of Health and Social Services (DHSS) was established to administer the laws and regulations relating to the promotion and protection of public health. The department is responsible for a wide variety of health and social service programs. Traditionally, health programs include medical assistance, nursing services, vital statistics, emergency medical services, infectious disease control, and maternal and child health programs. Social services programs include temporary cash assistance, food stamps, child protection services, foster care, child residential care, preventative services to the developmentally disabled, and prevention and treatment services for substance abuse.

As a result of a reorganization affecting several state departments which became effective July 1, 2003, DHSS took over administration of several new programs that included senior assistance, assisted living licensing, adult protective services and senior services.

### Division of Alcoholism and Drug Abuse

The Office of Alcoholism and the Office of Drug Abuse were created as separate agencies in 1972. In 1977, they were merged into the State Office of Alcoholism and Drug Abuse. In 1990, by Governor's Executive Order No. 76, the office was assigned division status.

The *Uniform Alcoholism and Intoxication Treatment Act* (the act), AS 47.37.010, declares the state policy in regard to alcoholism and its treatment:

*It is the policy of the state to recognize, appreciate, and reinforce the example set by its citizens who lead, believe in, and support a life of sobriety. It is also the policy of the state that alcoholics and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment that can introduce them to, and help them learn, new life skills and social skills that would be useful to them in attaining and maintaining normal lives as productive members of society.*

Among its powers and duties as enumerated in the act, ADA administers an extensive grant program to provide for substance abuse prevention, intervention, and treatment series. These grants are awarded to local government and nonprofit organizations that provide alcohol and drug abuse treatment and counseling services. ADA was merged into the new Division of Behavioral Health, effective July 1, 2003.

## Division of Behavioral Health

On July 1, 2003, the Division of Alcoholism and Drug Abuse and the mental health section of DHSS merged creating a new Division of Behavioral Health (DBH). Services previously administered by ADA are now carried out under DBH (services provided by ADA are discussed on the previous page). In addition, DBH is responsible for implementing state laws which protect and promote the well-being of Alaskans who experience mental illness. The mental health section of DBH includes the Alaska Psychiatric Institute.

## Advisory Board on Alcoholism and Drug Abuse

The Advisory Board on Alcoholism and Drug Abuse was established by statute and consists of 15 members; 14 are public members appointed by the governor and the 15<sup>th</sup> is the director of ADA who acts in an ex officio capacity. The advisory board is charged with the responsibility for the development and maintenance of a state plan for treatment and prevention services. It operates independently of ADA and acts in an advisory capacity to the legislature, the governor, and state agencies on issues related to alcohol and drug abuse. The advisory board also represents alcohol and drug abuse related issues in proceedings of the Alaska Mental Health Trust Authority.

The following mission statement was adopted by the advisory board:

*In partnership with the public, the Advisory Board on Alcoholism and Drug Abuse plans and advocates for policies, programs and services that help Alaskans achieve healthy and productive lives, free from the devastating effects of the abuse of alcohol and other substances.*

## Alaska Mental Health Trust Authority

In 1994, the Alaska Mental Health Trust Authority (the trust authority) was created to administer the Alaska Mental Health Trust (the trust). As part of the Alaska mental health trust settlement the trust was to receive \$200 million and nearly one million acres of land. The Alaska Permanent Fund Corporation holds and invests the cash assets of the trust under the same guidelines used by the permanent fund. The Trust Land Office in the Department of Natural Resources manages and develops the land assets on behalf of the trust. The income from the trust is available for the trustees to disburse on behalf of the trust's beneficiaries. The trust authority has established its mission as:

*The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect The Trust and to provide leadership in advocacy, planning, implementing and funding of a comprehensive integrated mental health program to improve the lives and circumstances of its **beneficiaries**. (Emphasis added).*

The comprehensive integrated mental health program provides services and support to Alaskans who are beneficiaries of the trust. Trust beneficiaries are people with mental illness, developmental disabilities, Alzheimer's disease and related dementia, and chronic alcoholism with psychosis. Since part of ADA's client caseload is defined as a trust beneficiary and the trust provides funding for substance abuse programs, ADA programs are linked to the trust's mission.

### Alaska Mental Health Board

The Mental Health Board was established by the legislature in AS 47.30.661. The board consists of 12 to 16 members appointed by the Governor and is the state planning and coordinating agency for federal and state laws relating to mental health programs of the state. The board prepares a comprehensive plan of treatment and rehabilitation services and annual implementation plan, advocates for the needs of persons with mental disorders, and provides a public forum for mental health issues. It advises various state agencies, the Legislature, Governor, and the trust authority regarding the development and evaluation of services for persons with mental disorders. In addition, the board provides recommendations to the trust authority concerning the integrated comprehensive mental health program for the mentally ill and the use of mental health trust income funds.

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## BACKGROUND INFORMATION

### Substance abuse is a serious problem in Alaska

Substance abuse is a serious problem in all geographic areas of the state. It is costly, both economically and socially. A study conducted in 2001 estimated the economic costs of alcohol and other drug abuse in Alaska to be \$614 million annually.<sup>1</sup> Socially, Alaska suffers through the breakup of families, higher crime rates, substance abuse related deaths, and increases in the need for incarceration.

The following statistics demonstrate the negative impacts of substance abuse in Alaska:

- National research indicates substance abuse is implicated in 70 percent of all cases of child abuse and that 80 percent of the men and women behind bars are there because of a drug or alcohol related crime.<sup>2</sup>
- According to data gathered between 1991 and 1993, when compared with other states, Alaska ranked first in the number of deaths with alcohol involvement, second in the percentage of residents who are chronic drinkers, and fifth in the nation for severity of alcohol problems.<sup>1</sup>
- In Alaska, seven percent of all traffic accidents and 44 percent of all traffic fatalities occurred in alcohol related vehicle crashes.<sup>1</sup>
- When combining death from alcohol related disease and injury, alcohol use was the seventh leading cause of death in Alaska in 1998.<sup>1</sup>
- In 1995, 22 percent of Alaska high school students reported that they had sniffed an inhalant to get high. Inhalants cause permanent damage to the brain, heart, kidneys and liver, and can cause death.<sup>1</sup>
- The prevalence of alcohol dependence and alcohol abuse in Alaska is just about twice the national average.<sup>3</sup>

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<sup>1</sup> Data taken from the report entitled *Economic Costs of Alcohol and Other Drug Abuse in Alaska Phase Two* prepared by the McDowell Group for the Advisory Board of Alcoholism and Drug Abuse, dated November 13, 2001.

<sup>2</sup> *In Step – The Plan 2001-2006*, Department of Health & Social Services, November 2001.

<sup>3</sup> *Alaska's Greatest Hidden Tax: The Negative Consequences of Alcohol & Other Drug Abuse and Dependence*, Alaska Advisory Board on Alcoholism and Drug Abuse, Annual Report, February 2000.

- Alaska has one of the highest incidences of Fetal Alcohol Syndrome (FAS) in the world. Lifetime costs associated with treating individuals affected with FAS are high.<sup>2</sup>
- As many as half of people with serious mental illness develop alcohol or other drug problems at some point in their lives.<sup>2</sup>

### Division of Alcoholism and Drug Abuse (ADA) mission and responsibilities

The mission of ADA is straightforward, to reduce alcoholism and substance abuse. ADA is responsible for the administration and maintenance of programs for the prevention and treatment of alcoholism, drug abuse, and the misuse of hazardous volatile materials and substances by inhalant abusers. State statutes also give ADA the duty of educating, training, planning, and coordinating efforts necessary to accomplish its mission. Very little of the prevention and treatment services are provided directly by the division. Instead, ADA awards grants to nonprofit organizations who work directly with clients and the general public.

In order to become an approved provider of a substance abuse treatment program, state regulations require that a program meet the state standards for treatment programs. ADA is directed by statute to establish the standards and must inspect, on a regular basis, public and private treatment facilities.

Generally, ADA staff resources are dedicated to three main functions: certification of treatment facilities, awarding substance abuse grants, and monitoring grantees. On-site certification reviews and on-site grant condition reviews are conducted by health facility surveyors. Grant administrators guide the grant solicitation/award process and monitor grantees to ensure that actual expenditures comply with budgeted amounts. ADA employs four main program directors: one for treatment programs, one for prevention programs, one for the fetal alcohol syndrome program, and one for the alcohol safety action program.

### ADA certifies substance abuse facilities but not counselors

By statute, ADA is responsible for establishing standards for public and private treatment facilities. Further, ADA is responsible for inspecting the facilities for compliance with the prescribed standards.

Regulations prescribe the *1974 Accreditation Manual for Alcoholism Programs*, of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), as the state certification standards. A waiver of the state standards may be granted for agencies that have received accreditation by JCAHO or the Commission on Accreditation of Rehabilitation Facilities (CARF).

Part of the approval process includes an on-site survey of the facilities to determine if they are in compliance with the state standards. The on-site surveys are performed at least once every two years by division health facility surveyors. The division bears the entire cost associated with the approval of facilities.

JCAHO standards require substance abuse counselors to be “qualified.” Since ADA does not require substance abuse counselors to be certified, the division ascertains the qualifications of a facility’s staff by reviewing the position description, the individual's resume, and the staff training plan.

Many substance abuse programs require their counselors to be certified counselors, meeting the standards of the Alaska Commission for Chemical Dependency Professional Certification (ACCDPC). The ACCDPC standards are based on the national standards for the field, established by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). ADA does not require substance abuse counselors to be certified by ACCDPC or NAADAC due to the lack of uniform access to training around the state. However, the division would consider certification as a good indicator that the counselor is "qualified."

#### ADA grants cover treatment, prevention, and safety

During FY 03, ADA awarded funds through 21 grant programs. In general, the programs are aimed at the prevention of substance abuse, the treatment of substance abuse, or the safety of substance abuse clients. Appendix B shows the programs funded in FY 03, along with a description of each program.

#### The Advisory Board provides guidance to ADA

The Advisory Board on Alcoholism and Drug abuse has the responsibility for planning and coordinating, with respect to federal and state laws related to alcohol and drug abuse. In 1999, ADA and the advisory board worked with other stakeholders to produce a coordinated state plan for alcohol and drug abuse services. The plan focused on achieving the desired result “that Alaskans live free from the negative consequences of alcohol and other drug use.” In this effort, specific indicators were created to track progress over time. Further, 18 strategies were developed to implement the plan. Each strategy was accompanied by performance measures designed to track progress. An essential part of the plan was the accumulation and evaluation of data. The advisory board was designated the responsibility for gathering data that indicated the progress in achieving the desired result. ADA was designated the responsibility for gathering data to measure performance.

At the time the plan was written, performance measure data was not available. The plan envisioned that ADA would, over the first two years of the plan, examine the specific measures and explore means for obtaining supporting data. For the performance data that was available, ADA was to consolidate data from individual grantees and provide an assessment of statewide effort.

The Alaska Mental Health Trust Authority (AMHTA) also provides guidance

In 1994, the Alaska Mental Health Trust (the trust) was reconstituted and the Alaska Mental Health Trust Authority (AMHTA) was created. The income from the trust is available for the trustees to disburse (in accordance with the trust's disbursements/payout policy) on behalf of the trust's beneficiaries. Trust beneficiaries are people with mental illness, developmental disabilities, Alzheimer's disease and related dementia, and chronic alcoholism with psychosis.

Since a portion of ADA's clients (chronic alcoholics with psychosis) are trust beneficiaries, the trust funds a portion of ADA's grants. A comprehensive integrated mental health plan was created to guide the delivery of services to trust beneficiaries. The plan includes a section for chronic alcoholics with psychosis and identifies strategies for accomplishing goals and indicators to measure progress.

ADA strongly encouraged grantees to utilize Medicaid

Medicaid is a medical insurance program which assists Alaska's low-income families. It is financed jointly by the federal and state governments. The medical services for which Medicaid will pay are defined in the state regulation. Since February 1994, substance abuse treatment services are an eligible service. Treatment can be provided on a residential or outpatient basis. Pregnant women requesting treatment receive priority consideration. Several treatment programs are designed specifically for women.

Medicaid will reimburse eligible treatment providers for specific services delivered to eligible clients. The substance rehabilitation services for which Medicaid will reimburse are assessment and diagnostic services; individual, family, and group counseling; care coordination services; rehabilitation treatment services; intensive outpatient services; intermediate services; and, medical services. The aforementioned service titles are those used by the Division of Medical Assistance for billing purposes. Service component titles vary from program to program.

In the State of Alaska, the Division of Medical Assistance administers Medicaid;<sup>4</sup> and, ADA certifies providers for treatment. For clients that are not Medicaid-eligible, programs offer a sliding fee. Inability to pay does not prevent any Alaskan from seeking treatment services for substance abuse problems.

Division of Behavioral Health – created by the merger of ADA and the Department of Health and Social Services' (DHSS), Mental Health Section

Various studies performed over the past few years led DHSS management to the belief that instances of co-occurring disorders in Alaska are greater than previously thought and that a

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<sup>4</sup> The department-wide reorganization spread the administration of Medicaid to multiple divisions.

significant treatment gap exists.<sup>5</sup> The process of estimating prevalence and providing effective treatment for co-occurring disorders in the state is problematic because there is no established strategy or structure in place for diagnosing, treating, and reporting co-occurring disorders.

### Exhibit 1

Beginning FY 04, as part of a department-wide reorganization, ADA and the mental health section of Division of Mental Health and Developmental Disabilities combined to form the new Division of Behavioral Health (DBH). DHSS views the merger as the first step in the implementation of the Comprehensive, Continuous, Integrated System of Care co-occurring disorder treatment model. This model requires the development of an integrated planning and implementation structure. DHSS anticipates that consolidation and enhanced collaboration, and information sharing, will significantly increase the effectiveness of service delivery.

Specifically, DHSS believes the newly created DBH will:

- facilitate the development of a statewide comprehensive policy for the treatment (including screening and assessment) of individuals with co-occurring psychiatric and substance disorders (ICOPSD).
- facilitate the development of a statewide comprehensive training plan that will enhance the professional skills of clinical staff from both fields.
- facilitate the development of an integrated grant program to appropriately and effectively deliver services to ICOPSD.

One of the more difficult challenges of DBH will be developing the ability to provide integrated services in Alaska's wide geographic dispersal and cultural diversity; services, heretofore, provided through separate agencies. The division has created integration teams who are working towards meeting this challenge.

**Co-occurring Disorders**

The federal Substance Abuse and Mental Health Services Administration defines co-occurring disorders as:

*individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other.*

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<sup>5</sup> Based on the 1998 prevalence data published by the federal Substance Abuse and Mental Health Services Administration, the Alaska Mental Health Board estimates that approximately 40,000 Alaskans suffer from a major or severe mental/emotional disorder. A 1997-1998 Center for Substance Abuse study estimated that 12.6% of the adult Alaska population needs treatment for alcoholism and 1.2% needs treatment for alcoholism and other drug-related abuse. According to a survey conducted as part of a 2001 Substance Abuse/Mental Health Integration Project, 66.7% of mental health providers and 41.7% of substance abuse providers report that 25-75% of their clients experienced co-occurring disorders. This variance underscores the inconsistent screening methodology inherent in Alaska's historical (separate) approach to co-occurring disorder treatment.

Their specific objectives include:

- overcoming any regulatory barriers to providing integrated services through review and revision of mental health and substance abuse grant regulations.
- developing an integrated services request for proposal for consolidated grants to combine previously separate funding sources.

### DHSS-revised grant regulations

In July 2002, DHSS revised its grant regulations. Both DHSS grantees and staff complained that the request for proposal (RFP) and grant award processes were too complicated. Regulations needed to be simplified and clarified. Grant changes placed a greater emphasis on measuring the performance of grantees in achieving program goals, thereby increasing accountability.

Significant changes include:

### **Exhibit 2**

- an additional section standardizing the process for receiving commissioner approval to solicit grant services – the grant procurement authorization process. To receive procurement authorization, agencies must provide specific information regarding funding, description of services and delivery area, assessment of the need, allocation methodology, and a justification for the proposed method of solicitation (7 AAC 78.040).
- expanded sections prescribing, in detail, the RFP and proposal review processes, and responsibilities of the grant agency in the review process, and introducing a new section requiring proposal evaluation committee members to comply with applicable provisions of the Executive Branch Ethics Act (7 AAC 78.050 and .090).
- an expanded section detailing alternative methods of procurement including requirements and justification for waiving the competitive process. Also prescribes the Request for Letters of Interest (RFLOI) process (7 AAC 78.095) – See Exhibit 2.
- an expanded section prescribing the specific criteria to be used when reviewing proposals with enhanced emphasis on program performance (7 AAC 78.100).
- an expanded section detailing appeal process procedures (7 AAC 78.305 and 310).
- removal of dated and/or obsolete content and references.

#### **Requests for Letters of Interest**

Request for letters of interest are appropriate when a single or limited number of grantees are capable of providing the needed services in a specific area. If response indicates competition, an RFP is issued. In 2004, ADA utilized this method to procure services for the following major programs: Residential & Outpatient Treatment, Rural Services, Suicide Prevention, Services for Youth and Women with Children.

### Exhibit 3

Another significant change was the addition of a new chapter - 7 AAC 81 *Grant Services for Individuals*. This chapter prescribes the process and requirements for obtaining grant program services for program eligible individuals through the use of provider agreements rather than traditional grants.

#### Funding for substance abuse programs was cut in FY 04

Through the governor's line-item veto, DBH received approximately \$6 million dollars in funding cuts in FY 04. All programs were affected by the cuts except for the fetal alcohol syndrome program and the rural services and suicide prevention programs. One of the ways DBH allocated the cuts to programs and grantees was to increase the local match requirement from 10% to 25%. The grant awards were reduced accordingly. In August 2003, approximately \$3 million of DBH funding was reinstated.

A major change in the funding of substance abuse grants was the utilization of private hospital refinancing. Private hospital refinancing is described in Exhibit No.3. Based on information provided by DBH, approximately 39% of the FY 04 substance abuse grants were funded through private hospital refinancing - \$4,240,262 paid by the state and \$6,632,205 paid by the federal government as an allowable Medicaid expenditure.

#### Federal-needs assessment highlights the treatment needs in Alaska

The U.S. Substance Abuse and Mental Health Services Administration, in

#### **Private Hospital Refinancing**

Private hospital refinancing is an expansion of DHSS' proshare program. Under Medicaid law, hospitals cannot be paid more than what would have been paid if the services would have been paid by Medicare. This is referred to as the upper payment limit. An analysis is done to quantify hospital services paid by Medicaid, in terms of the Medicare upper payment limit, and a determination of under/overpayments is made for each hospital. For Alaska, the net difference between the amount paid and the upper payment limit is the amount available to the state as "proshare" revenue.

The federal government attempted to restrict the amounts available under the upper payment limit law by requiring the analysis to be separated into three main groupings: private hospitals, state hospitals (the Alaska Psychiatric Institute), and public hospitals. Alaska's state plan amendments that permitted the receipt and use of revenue under the upper payment limit was limited to public hospitals. Most of the upper payment limit underpayments were classified as private hospitals. Therefore, the change severely limited the availability of proshare revenue to the State of Alaska.

Private hospital refinancing was a way to utilize the private hospitals' share of the total aggregate amount available under proshare. The federal Medicaid agency approved an amendment to the state Medicaid plan that allowed for private hospital refinancing. The amendment identifies the refinancing of grants for health care, including substance abuse treatment facilities, as eligible uses of the proshare revenues.

Under private hospital refinancing, state grants for health care services are restructured as contracts: One between the state and a private hospital specifying that the hospital will pay grantees a specific amount and receive a fee for this service; and, another contract between the hospital and grantees specifying that grantees will provide services as outlined in the notice of award between the state and the grantee. The state pays the private hospital, who in turn pays the grantee the amount specified by the state. The state is then reimbursed by the federal Medicaid agency for an amount approximately equal to 60% of the payment to the private hospital.

association with ADA and the Division of Public Health, conducted a needs assessment. The final report, *Integrated Substance Abuse Treatment Needs Assessment*, was issued January 2002. The report combined a series of methodologies to estimate the overall level of treatment needs in the state by region. The methods included examining national trends and comparing the level of needs and services of Alaska with other states. In addition, it used integrated estimates of treatment need and services, which resulted in a statewide estimate of the number of people who had a substance-use disorder in the past year, how many of them have not received treatment, and how many would seek treatment if it were readily available.

**Exhibit 4**

The report recommended that the state use the results of the analysis, provided in the report, to guide them in their decision-making process for allocating services. Part of the analysis included an estimate of the recommended number of new admissions for substance abuse treatment. The recommended number of new admissions was derived from the estimate of Alaskans that both needed and wanted treatment. The report contends that if the number of substance abuse treatment admissions increased by the recommended number of new admissions, the gap between services provided and services desired would be closed. See Exhibit No. 4.

Region	Recommended Number of New Admissions
North Central	108
Yukon Delta	184
Kenai Peninsula Prince William Sound Copper River Kodiak	283
Bristol Bay Aleutians	55
South Central	496
Central	5
Northwest	4
Southeast	0
North Slope	0

## REPORT CONCLUSIONS

We were asked to conduct an audit of ADA. As part of a complete reorganization of DHSS, ADA was merged with the department's mental health section into a new Division of Behavioral Health (DBH), effective July 1, 2004. The merger is further discussed in the Background Information section of this report.

Throughout this report we will refer to ADA as this was the entity which was audited; however, recommendations will be made to DBH in recognition of the current organizational structure.

Our objectives included determining whether clients are receiving adequate and appropriate services from substance abuse grantees and to identify areas for improving program management. We were also asked to evaluate the grant award process and determine whether conflicts of interest existed between ADA staff and recipients of grant funds.

We were specifically asked to survey both substance abuse treatment clients and ADA grantees regarding their satisfaction with treatment services received or with program administration by ADA. Appendix A summarizes the ADA grantee survey responses.

ADA requires grantees to implement quality assurance programs that include client surveys to monitor satisfaction. During the course of our audit we reviewed copies of several grantees' client surveys and followed up with ADA staff to ensure the division reviewed grantee quality assurance programs. We also questioned grantees regarding the clients' ability to complain about the quality of services. Based on this review, we concluded that ADA adequately monitors client satisfaction. Consequently, no survey of clients was conducted during our review.

### ADA lacks an operational plan that ensures the effective use of limited resources

ADA is responsible for managing the delivery of substance abuse prevention and treatment services in Alaska. The state does not provide services directly. Rather, it funds prevention and treatment services through grants to nonprofit entities. As discussed in the Background Information section of this report, in FY 03 ADA paid approximately \$27 million through 21 grant programs to 136 grantees.

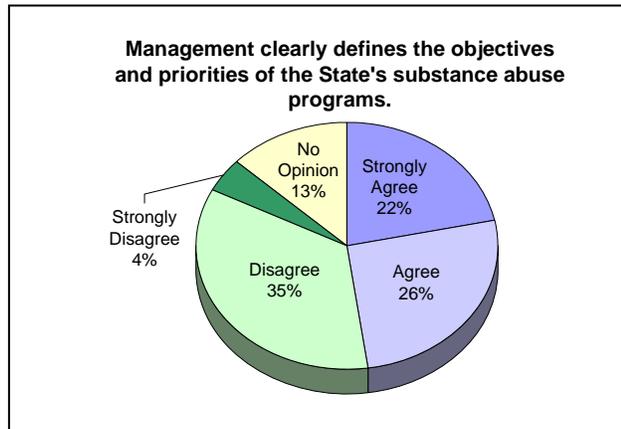
Alaska Statutes 47.37.120 and 47.37.130 require ADA to carry out its responsibilities according to a comprehensive program. The program/plan guides ADA's actions to ensure its program development and funding decisions address the state's need for services. We found ADA is not operating under a comprehensive plan for providing substance abuse services. The division has not identified the state's substance abuse needs nor communicated the state's priority for addressing the needs with its limited resources. Rather, the division

has operated according to historical funding patterns and guidance provided by the Advisory Board, Mental Health Board, and the Alaska Mental Health Trust Authority.

We surveyed ADA grantees and asked whether ADA clearly defined their objectives and priorities. Of those grantees that responded, 39% disagreed or strongly disagreed that management clearly defines the objectives and priorities of the state’s substance abuse programs – see Exhibit No. 5.

**Exhibit 5**

The ADA grant award process requires grant applicants to communicate the need for services and their means/method of addressing the need. The grantee-led determination of needs makes it difficult to ensure that grant-funded services are addressing the state’s overall need for services. It also leaves ADA in the position of choosing from what is offered rather than requiring providers to fulfill a specific need for services as a condition of funding. Grantees are likely to propose



services that they are already equipped to provide rather than services which might be most needed. Generally, ADA annually funds the same grantees for the same services.

Another weakness in ADA’s funding method is the increased likelihood of underutilization of services in some areas and lack of adequate services in other areas. Without a clear plan that identifies funding priorities by substance, geographical area, and population; service delivery is haphazard. The agency awards funding to each grantee based on its ability to meet its own specified goals rather than funding grantees based on their ability to address the state’s need for services. Whether or not this funding methodology is effective, is unknown, since ADA has not identified and prioritized the state’s need for substance abuse services.

Planning efforts by the Advisory Board, the Alaska Mental Health Trust Authority (AMHTA) and the Mental Health Board do not adequately serve as operational plans for the division

The *State Plan for Alcohol and Drug Abuse Services*, published by the Advisory Board on Alcoholism and Drug Abuse, and DHSS’ comprehensive integrated mental health plan prepared in partnership with the AMHTA, the Advisory Board on Alcoholism and Drug Abuse, and the Mental Health Board, identifies statewide substance abuse treatment and prevention goals. However, both plans are not specific enough to serve as an operational plan for managing the delivery of services. A comprehensive plan for prevention and treatment services is needed at the division level to set out how the state will accomplish the goals identified in these two planning documents.

As we discuss in Recommendation No. 1 in the Findings and Recommendation section of this report, the state should assess the need for substance abuse prevention and treatment services on a statewide basis. The needs should be prioritized, in collaboration with stakeholders, including the Advisory Board, the AMHTA, and the Mental Health Board. Based on this assessment, DBH should draft a comprehensive program for prevention and treatment services to guide its allocation of limited funding.

#### ADA and the Advisory Board have not effectively worked together

The planning efforts by the Advisory Board and other entities are hindered by ADA's inability and/or reluctance to implement the planning documents.<sup>6</sup> Further, the Advisory Board cannot accomplish its statutory mandate to evaluate the effectiveness of alcoholism and drug abuse programs without the availability of relevant information from ADA. We recommend that DBH's director take steps to improve its working relationship with the Advisory Board (see Recommendation No. 2).

The Advisory Board is the designated planning and coordinating body for purposes of federal and state laws relating to alcohol, drug, and other substance abuse prevention and treatment services. It acts in an advisory capacity to the legislature, the governor, and state agencies. Alaska Statute 44.29.140(c) states that the board shall prepare and maintain a comprehensive plan of services for the prevention and treatment of alcohol, drug, and other substance abuse.

In 1999, the board worked with various stakeholders, including ADA, to create "*Results Within Our Reach*" the state plan for alcohol and drug abuse services. The plan was a major accomplishment in moving towards results-based service delivery. A detailed description of the plan is included in the Background Information section of this report.

Collaboration and accountability are key elements in the plan. ADA and the Advisory Board must effectively work together to measure progress. The ability to measure progress is tied to the ability to consistently collect reliable data. Much of the data envisioned in the plan was not collected by ADA (see Recommendation No. 5 for more information regarding ADA's MIS system). Further, the data ADA did collect was not consistently shared with the Advisory Board.

#### Complaints alleging unethical behavior were not reviewed and investigated as required by statute

We were asked to determine whether DHSS' Commissioner's office received allegations that ADA grantees were subjecting clients to behavior contrary to treatment objectives and actions it took to investigate and eradicate the conduct. We reviewed the commissioner's and ADA director's correspondence files and found no indication that the commissioner's office

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<sup>6</sup> The planning documents include *Results Within Our Reach – Alaska State Plan for Alcohol and Drug Abuse Services* and *In Step* – the comprehensive integrated mental health plan.

received complaints alleging improper behavior by specific ADA *grantees*. We did find two different letters alleging unethical behavior (undue influence over the grant process) by an ADA management-level *employee*. Both letters, addressed to the Commissioner, were not forwarded to the department's designated ethics supervisor for review as required by statute. Further, we found no indication that the commissioner's office took action to investigate the complaints other than to send a copy of the letters to ADA's director – see Recommendation No. 6.

Alaska Statute 39.52.960 defines the designated ethics supervisor as the commissioner of each department in the executive branch. The commissioner of DHSS delegated these duties to the department's human resource manager.

We reviewed the FY 02 and FY 03 complaint logs maintained by DHSS' designated ethics supervisor. No complaints against ADA grantees were logged. However, we did obtain and review interview notes taken by a human resources staff member during a meeting with an ADA grantee. The meeting was held during the spring of 2002 and concerned the actions of an ADA employee's spouse. Apparently, the spouse questioned an ADA grantee's treatment methods and requested detail treatment information for specific clients in an effort to secure alternative treatment. The grantee was aware that the person was the spouse of an ADA management-level employee. This created a situation whereby the grantee may have been pressured to release confidential information for fear of potential repercussions by the ADA employee. However, the grantee did not release the information.

While it appears an interview did take place, no formal investigation was conducted and the allegations that generated the interview did not appear on the complaint logs. No determination regarding the grantee's treatment methods was made. Further, no investigation of a potential conflict of interest between the ADA management-level employee and the recipient of grant funds was conducted. We recommend that the commissioner implement procedures to ensure the adequate reporting and investigating of ethics complaints and take action to address the ethics-related complaints. Without such controls in place, DHSS risks the loss of public confidence in the fairness of its grant process.

#### Conflicts of interest did exist in ADA

We found one instance in FY 00 where an ADA management-level employee's spouse served as a subcontractor and was paid with an ADA grant. This clear conflict of interest was not repeated in the next grant cycle when ADA's director prohibited the grantee from paying the subcontract with ADA grant funds. While this action can be viewed as removing the conflict, we question whether the remedy was the most appropriate action. The state is charged with ensuring that its employees do not exert undue influence over the grant award process and do not benefit, improperly, through the grant administration process. Had the ADA employee properly disclosed the conflict, the designated ethics supervisor could have made a determination as to the appropriate remedy under the Ethics Act. Since the conflict of interest was focused on the ADA employee's influence over the award process, it would

follow that an appropriate remedy would be to change the level of influence the employee had over the process rather than to deny a grantee from contracting with a specific individual.

Although the spouse has not been engaged as an ADA-funded subcontractor since FY 00, the perception of a conflict may still exist since the spouse is still active in the substance abuse prevention and treatment field. Grantees may feel pressure to maintain a positive relationship with the spouse because of the ADA employee's important role in the funding process. These findings are further discussed in Recommendation Nos. 7 and 8 in the Findings and Recommendations section of this report.

#### Majority of FY 04 grant awards were noncompetitive

As discussed in Background Information, DHSS revised its grant regulations, effective FY 03. Since ADA uses a two-year grant solicitation cycle, FY 04 was the first grant solicitation/award process subject to the new regulations. We interviewed 19 grantees and asked, in part, how the regulation changes had impacted their organization. Most grantees were pleased with the changes. The new regulations allowed the division to avoid the cumbersome and costly request for proposals (RFP) process, if there was an indication that only one provider exists in a specific location.

The change in grant regulations also led to awarding approximately 80% of substance abuse grants through the noncompetitive Request for Letter of Interest (RFLOI) process.<sup>7</sup> In contrast, approximately 20% was awarded under the noncompetitive waiver provision of the old regulations during FY 02. According to ADA staff, there is no competition for many of the ADA grant programs. Often only one entity applies to serve a specific population.

#### Improvements are needed in the grant award process

While most grants were awarded appropriately by ADA/DBH in FY 02 and FY 04, several errors were made. The grant award findings are discussed, in detail, in Recommendation No. 3 and include missing documentation, lack of required approvals, and inconsistent application of minimum requirement criteria. Additionally, we found one ADA grantee was paid \$273,000 in error. This finding is discussed in Exhibit No. 6 (on the next page) and in Recommendation No. 4.

Overall, a change in grant regulations improved the proposal evaluation committee (PEC) process by providing greater specificity. New regulations require PEC members to participate in a pre-meeting conference which gave members the opportunity to ask questions and better understand their role and responsibilities. We contacted several members of FY 02 and FY 04 PECs. Those that participated in both cycles stated that the FY 04 process was

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<sup>7</sup> The RFLOI process is utilized when the department does not anticipate more than one provider is capable or interested in providing the service. Less information is required to be submitted under RFLOI than through the RFP process.

more professional and better organized. However, as we have already discussed, only 20% of substance abuse treatment grants were awarded through the competitive PEC review process.

The departmental merger of its mental health section and ADA created unique challenges to the FY 04 grant cycle and led to errors in the award process. DBH intended to combine mental health grants, and substance abuse outpatient treatment grants, into integrated health grants. However, the new division was not ready to implement a grant solicitation process for the new grant program. Consequently, ten grantees were given nine-month grant extensions. DBH plans on soliciting applications, reviewing, and awarding behavioral health integrated grants for the final quarter of FY 04 and for FY 05.

The division also awarded extensions to grantees when RFLOIs demonstrated competition for grants. After it became apparent that more than one entity was interested in the grant program, the division was not prepared to issue a request for proposals (RFP). Consequently, three-month extensions were awarded to two grantees.

Outdated certification standards may fail to adequately protect the public

The division established standards for treatment facilities through the adoption of *Components 1 through 8 of the 1974 Accreditation Manual for Alcoholism Programs* of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). These standards are almost 30 years old and, according to both ADA grantees and staff, are not reflective of current business practices. Yet, the state continues to certify facilities based on the standards. Given the outdated condition of the standards, we question the state's ability to comply with statute and recommend the state revise the standards – see Recommendation No. 9.

**Exhibit 6**

**\$273,000 Overpayment to ADA Grantee**

During the FY 03 grant award process, ADA awarded \$562,389 to the Alaska Women's Resource Center (AWRC), a women and children substance abuse center located in Anchorage. In November 2002, state officials decided to refinance AWRC's grant using the new "private hospital financing" procedure. The refinance process led to the overpayment of \$273,000 to AWRC.

Under private hospital refinancing, state grants for health care services are restructured as contracts that are paid to the grantee via a private hospital. The state pays the private hospital, who in turn pays the grantee the amount specified by the state. This process requires two contracts, one between the hospital and state, and one between the hospital and grantee. A payment to a hospital under this program is reimbursable by the federal government at the rate agreed to under the federal Medicaid program.

When the decision to refinance AWRC's grant occurred, AWRC was due \$281,194 under the original grant award. The contract signed by the hospital and AWRC, under the state's guidance, awarded \$555,034 to AWRC rather than the \$281,194 owed to the entity. The scope of services required in the contract was the same as that identified in the original grant award. Because of this oversight, AWRC was paid \$273,000 more than was warranted. As of the date of this report, no action had been taken by the department to recoup the overpayment.

The use of the outdated standards was identified as a finding in our 1999 audit of ADA.<sup>8</sup> The division concurred with the finding and began a project to revise the standards. However, the project stalled when the director position became vacant and never restarted under the new leadership.

The statutes are clear regarding the state’s responsibility for establishing standards for substance abuse treatment facilities that provide for the protection of the health, safety, and well-being of clients. ADA staff that uses the outdated standards as a basis for certifying facilities and the grantees themselves expressed frustration with the standards because they do not reflect how services are currently provided. The outdated standards may not adequately protect the health, safety, and well-being of clients.

ADA staff effectively monitors grantees

ADA staff conduct on-site reviews of each treatment grantee every two to three years. Often, grant reviews are conducted in conjunction with certification reviews. On-site review reports are provided to grantees which include detail descriptions of the findings and recommendations. Grantees must complete a corrective action plan within a specified timeframe. We reviewed the on-site review reports and determined that ADA actively followed up findings to ensure corrective action had occurred. Further, we found that ADA staff actively review grantees’ quarterly reports to monitor performance. Grant payments are withheld if required reports are not filed.

**Exhibit 7**

Survey Statement	Agreed or Strongly Agreed
Surveyors are fair.	67%
Surveyors respond to questions quickly.	61%
Surveyors provide reliable information.	61%
Surveyors are easy to work with.	63%
Surveyors have the skills necessary to do their job.	75%
Grants administrators are objective.	74%
Grant administrators respond quickly to questions.	78%
Grant administrators provide reliable information.	78%
Grant administrators are easy to work with.	82%
Grant administrators have the skills necessary to do their job.	83%

Monitoring by ADA is carried out by health facility surveyors and grant administrators. Health facility surveyors review grantees’ programmatic operations. Grant administrators monitor the fiscal operations.

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<sup>8</sup> A Special Report on the *Department of Health and Social Services, Division of Alcoholism and Drug Abuse, December 18, 1998 – Audit Control # 06-4570-98.*

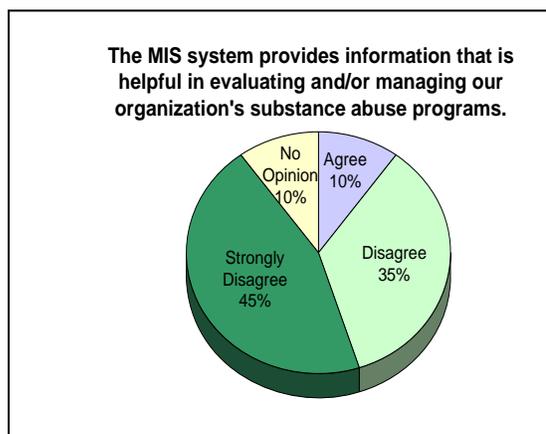
Both health facility surveyors and grant administrators are perceived favorably by grantees. Responses to the survey of grantees highlighted agreement that both surveyors and grant administrators were fair, competent, responsive, provided reliable information in a timely manner, and were easy to work with. Appendix A summarizes responses to each question of the survey. Exhibit No. 7 on the previous page shows the percentage of respondents that either agreed or strongly agreed with positive statements about the health facility surveyors or grant administrators.

### Division needs new MIS system

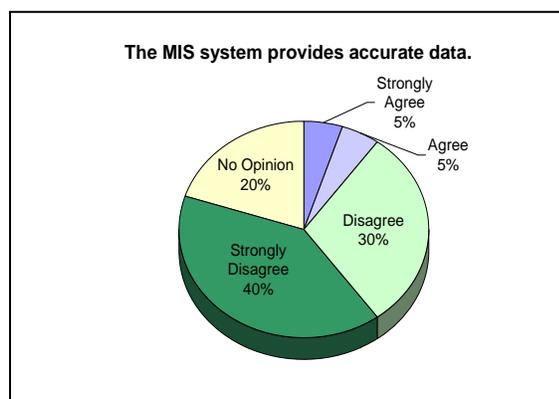
We surveyed grantees to help measure their satisfaction with ADA services. The biggest area of dissatisfaction was the division's management information system (MIS). Grantees consider the MIS system cumbersome and difficult to use. They question the accuracy of the data. Further, they do not believe the system provides useful information to manage their individual programs. Survey responses are summarized in Exhibits 8, 9, and 10.

#### **Exhibit 8**

We discussed the need to improve the system's capabilities during an audit of ADA that our agency released in FY 99.<sup>9</sup> At that time, funding had been approved to enhance the MIS system to develop and implement the collection of post-treatment outcome measures. The enhancement was not successful. Further, the enhancement strained the system to the point that the amount of data input into MIS had to be reduced to ensure the system would run accurately. Currently, MIS collects limited demographic information related to clients and statistical information regarding clients treated (for example the number of clients admitted, treated, and discharged).



#### **Exhibit 9**

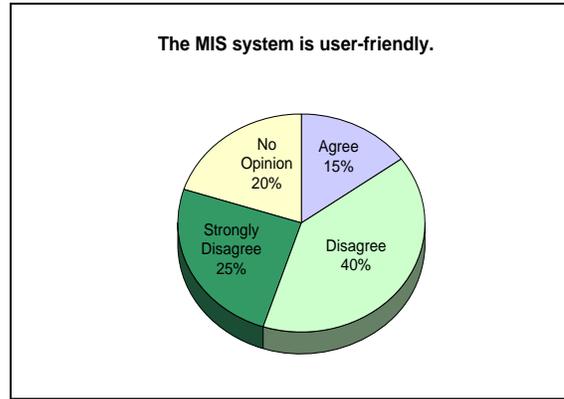


Since the MIS system was originally installed in 1982, there have been no major upgrades. The system does not provide the data necessary to evaluate the effectiveness of planning efforts by the Advisory Board. It does not provide information that is perceived as useful to the grantees for managing their programs. Reporting capabilities are limited and resource intensive. The usefulness of MIS data is limited to providing the information necessary for federal reporting – see Recommendation No. 5.

<sup>9</sup> A Special Report on the *Department of Health and Social Services, Division of Alcoholism and Drug Abuse, December 18, 1998 – Audit Control # 06-4570-98.*

**Exhibit 10**

The division is working on a collaborative project with other states to develop a new MIS system. The project is referred to as the Alaska Automated Integration Management System (AKAIMS). The new system is intended to be a full-service system allowing users the ability to account for daily business activities, as well as management of clinical treatment functions.



AKAIMS is based on a working prototype that states can customize to their needs for improving information about treatment services while complying with various federal requirements for processing and reporting health-related information. There are ten states currently in the planning and/or implementation phases.<sup>10</sup>

AKAIMS is a web-based system that will be accessed by providers through the internet. The target date for the first pilot test site is November 2003. Anticipated deployment will continue through all of FY 04 and into FY 05 for full implementation of the new system.

DBH envisions that through its participation in this project, the state will be able to collaborate with a variety of other states to deploy new capabilities, including treatment improvement techniques, provider management functions, and state analysis of treatment services. Further, DBH believes the system will reduce the reporting burden for providers by eliminating the need for separate reporting activities and/or double entry of data. It will also support providers in becoming compliant with security, privacy, and data exchange aspects of new federal confidentiality requirements.

<sup>10</sup> The system is based on a project sponsored by the Federal Center for Substance Abuse Treatment.

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## FINDINGS AND RECOMMENDATIONS

### Recommendation No. 1

The Division of Behavioral Health's (DBH) director should create a comprehensive program for prevention and treatment services to guide the delivery of substance abuse services.

ADA has operated without a comprehensive program for substance abuse treatment services. The division has not identified the state's overall need for prevention and treatment services by substance, region, or population nor has it identified the State's priority for addressing its needs. Further, ADA's grant funding methodology may not efficiently utilize limited resources. Without a statewide plan to guide the division's program development and funding allocation decisions, ADA may not maximized the effectiveness of substance abuse treatment and prevention services in Alaska.

Alaska Statutes 47.37.120 and 47.37.130 require the division to create a comprehensive program. Statutes encourage the program to address how services will be provided to the various regions of the state.

Historically, ADA requires grant applicants to identify the need for substance abuse treatment or prevention services and specify how the entity will use the funds to address the need. Without a well-defined statewide plan to guide the grant solicitation process, ADA cannot ensure that the grantees are adequately addressing the state's overall need for services. Underutilization of services by region and/or grantee may lead to the inefficient use of limited resources.

Planning efforts led by the Advisory Board on Alcoholism and Drug Abuse, the Alaska Mental Health Trust Authority, and the Mental Health Board give direction on the need for substance abuse services in the state. These planning efforts are hampered by the lack of implementation at the division level.

We recommend DBH's director create a comprehensive program for prevention and treatment services. The program should be based on a thorough inventory of the state's substance abuse needs. The program should guide the delivery of prevention and treatment services including a way to track progress and measure effectiveness. Further, the plan should be created in partnership with stakeholders and prioritize needs to guide the allocation of limited funding.

## Recommendation No. 2

DBH's director should take steps to improve its working relationship with the Advisory Board on Alcoholism and Drug Abuse.

Statutes designate the Advisory Board as the planning and coordinating body for purposes of federal and state laws relating to alcohol, drug, and other substance abuse prevention and treatment services. It is also responsible for evaluating the effectiveness of alcoholism and drug abuse programs in the state. Both of these statutory mandates cannot be fulfilled without information sharing and open communication between the board and ADA. The Advisory Board's state plan for alcohol and drug abuse services recognizes the importance of this relationship. It requires extensive data accumulation and sharing between the entities and collaboration in evaluating effectiveness.

ADA has not worked effectively with the Advisory Board. Much of the data envisioned in the board's state plan for services was not accumulated – see Recommendation No. 5 for more information regarding ADA's inability to gather data. Data that was available was not openly shared with the board. ADA has demonstrated a general reluctance to provide the board, and more specifically the board's executive director and planning staff, with information about ADA's operations.

Overall we found little evidence that the Advisory Board's state plan for services guided ADA's operational decisions. We also found no indication that the Advisory Board evaluated the effectiveness of ADA's alcoholism and drug abuse programs. See Recommendation No. 1 for more discussion on ADA's need for a divisional level implementation plan to guide the delivery of substance abuse treatment services.

We recommend DBH's director take whatever steps are necessary to improve its working relationship with the Advisory Board. The importance of this recommendation is heightened by two essential projects that require collaboration by the two entities: (1) the revision of the Advisory Board's state plan and (2) the design and implementation a new MIS system. Without effective communication and collaboration, the success of both projects is jeopardized.

## Recommendation No. 3

DBH's director should take steps to improve the grant award process.

Several errors occurred during the FY 02 and FY 04 grant award processes. In general, errors include increases to certain grants without requisite approval, incorrect scoring methodology by proposal evaluation committees (PECs), inequitable treatment of applications, inaccurate/unsupported funding level recommendations, and missing documentation. The findings discussed below collectively impair the objectivity and fairness of the grant award process.

***Increases to Grant Amounts:*** During the FY 02 grant period, approximately \$201,000 in additional funds was distributed among four grantees through amendments made to original grant agreements. These amendments were made without proper approval or adequate documentation. The Department of Health and Social Services (DHSS) division directors are delegated authority to amend grants within defined limits. The four amendment amounts were in excess of this delegated authority and therefore required commissioner approval.

DHSS has policies and procedures regarding granting authority and delegations to ensure compliance with Alaska statutes and the administrative code. As stated in their policy and procedures manual *...the commissioner retains approval authority for all operating grant awards and approval authority for all amendments exceeding 20% of the total grant or \$25,000 within a fiscal year, whichever is less.* This ensures compliance with 7 AAC 78.090 (e) *the commissioner will make a final decision with respect to a grant application.* By providing funding outside the process, the division circumvented controls established to ensure compliance with grant regulations.

***PEC scoring methodology:*** PEC members did not use the same scoring methodology when reviewing grant proposals received in response to FY 02 requests for proposals (RFP) for the rural human services, community prevention services, and adult outpatient treatment programs. Further, not all PEC members read and scored each proposal under review at their respective PEC meetings.

It is DHSS' policy to conduct PEC meetings to help establish grant funding recommendations to the commissioner. This independent review is an important part of the competitive grant award process. To ensure this process is fair, effective, and accurate, and per department procedures, the division is to *provide each PEC member with evaluation instructions that include their role, how to evaluate proposals, and how to document their scores.* The regulations effective during FY 02 did not specifically address the proposal review process. However, DHSS procedures dictate, and an effective review process requires, that PEC members be sufficiently prepared and enabled to perform their PEC role. An inconsistent PEC review process decreases the effectiveness of the review in general and the accuracy of the average scores in particular.

***Inequitable treatment of grant applicants:*** The first step in the proposal review process is the staff technical review. An ADA grants administrator reviews each proposal to determine whether the proposal meets technical criteria published in the RFP. Applicants not meeting the minimum technical requirements are eliminated from consideration. Those meeting requirements are forwarded to a PEC for review.

During the FY 02 grant process, one technically nonresponsive proposal was forwarded to the PEC for review. One nonresponsive proposal not reviewed by the PEC was recommended by the division to receive funding and was awarded a grant.

In one RFP solicitation, we could not determine if staff conducted the required minimum responsiveness technical review. During the FY 04 grant solicitation process, one proposal was rejected for not meeting a specific technical requirement. However, two other applicants that also failed to meet the same requirement were forwarded to the PEC and received funding. The subjective treatment of applications by ADA does not comply with 7 AAC 28.030 and 7 AAC 78.090 (b) which defines the rules for processing applications.

***Incorrect/unsupported funding recommendations:*** During FY 02, funding recommendation information presented by ADA to the DHSS commissioner was inaccurate. The recommendations were represented as PEC funding recommendations but were actually ADA staff recommendations. Also, the PEC scores for two programs were not summarized accurately.

ADA presents summary recommendation information to the commissioner for approval and award authorization. This summary approval sheet contains the following data: (1) the final average score of each proposal; (2) the PEC recommended funding; and, (3) the division director recommended funding. The inclusion of the staff recommendation, in place of the PEC, appears to have been an isolated error. The problem may have been caused by the lack of uniformity between prevention PEC and treatment PEC forms. The unsupported final scores were caused by mathematical errors or formula errors in the spreadsheet used to calculate the scores.

***Missing documentation:*** ADA's FY 02 funding recommendations were not supported by adequate proposal and program review documentation. ADA could not provide the documentation of PEC scoring for various proposals.

For the FY 04 grant award process, the documentation and performance of staff reviews was inadequate. Under the request for letter of interest process there is no PEC review – only a staff review. The staff is required to use two different forms for the review. We found that not all of the staff used both forms and not all forms were completely filled out. It was difficult to determine from the documentation the extent of the review performed. Regulation 7 AAC 78.100 identifies the criteria that should be used to conduct the review. We could not determine from the available documentation if the criteria used by staff complied with regulation.

We recommend DBH's director improve the grant award process to ensure that the solicitation, review, and award of grants is fair, objective, and complies with state law. The numerous errors noted above indicates a need for improvement. Without improvement, DBH risks the perception that the DBH's grant award process is biased and/or unfair.

Recommendation No. 4

The DHSS Commissioner, in cooperation with the Department of Law, should pursue recoupment of FY 03 overpayment to an ADA grantee.

During the FY 03 grant award process, ADA awarded \$562,389 to the Alaska Women's Resource Center (AWRC), a women and children substance abuse center located in Anchorage. In November 2002, state officials decided to refinance AWRC's grant using the new "private hospital financing"<sup>11</sup> procedure. The refinance process led to the overpayment of \$273,000 to AWRC.

Under private hospital refinancing, state grants for health care services are restructured as contracts that are paid to the grantee via a private hospital. The state pays the private hospital, who in turn pays the grantee the amount specified by the state. This process requires two contracts, one between the hospital and state, and one between the hospital and grantee. The hospital charges a fee for this service. A payment to a hospital under this program is reimbursable by the federal government at the rate agreed to under the federal Medicaid program. At the time the FY 03 payment was made to AWRC, the federal reimbursable rate was 57.38%. Private hospital refinancing effectively replaced 57.38% of state general funds paid to AWRC with federal funds.

When the decision to refinance AWRC's grant occurred, AWRC was owed \$281,194 under the original grant award. The contract signed by the hospital and AWRC, under the state's guidance, awarded \$555,034 to AWRC rather than the \$281,194 owed to the entity. The scope of services required in the contract was the same as the original grant award. Because of this oversight, AWRC was paid \$273,000 over the amount justified by the grant award.

Although state regulations were being drafted to allow for private hospital refinancing, the regulations were not approved/effective until April 2003, approximately five months after the transactions occurred. Consequently, it appears the refinancing of AWRC's grant may not have been allowable under state law. We were unable to determine why the substance abuse grantee was refinanced before state regulations became effective.

In our opinion, amounts paid inappropriately to AWRC should be recouped to the greatest extent possible. We recommend DHSS' commissioner consult the attorney general to determine the state's ability to recoup the overpayment. Further, we recommend DHSS' finance officer take the necessary steps to ensure the federal government is repaid for the unallowable payment.

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<sup>11</sup> Private hospital refinancing is described in detail on page 15 in the Background Information section of this report.

## Recommendation No. 5

The DBH director should ensure the new MIS system is designed to address the deficiencies of its current system and collect the information necessary to evaluate the effectiveness of its programs.

ADA's MIS system is functionally inadequate and difficult to use. The MIS system does not collect the information necessary to evaluate the effectiveness of ADA's programs. Additionally, it does not provide information useful to grantees in managing their programs.

Under Alaska Statutes 47.30.477, 47.37.030, and 47.37.040, the division is responsible for keeping records, conducting research, and collecting relevant statistical information. In order to meet these accountability requirements, the division developed the MIS system. Regulations 7 AAC 23.150, states:

*The intent of the MIS is to collect, process, and provide to program administrators and staff relevant programmatic and client information, as well as to provide programmatic information to the public and the legislature.*

The MIS system was originally installed by ADA, in 1982, to track basic program demographics and employee and client statistics. The system was intended to be a full service system for substance abuse programs. However, the design of the system has not kept pace with technology. The division attempted to update the system in 1999 to incorporate outcome data; however, the enhancement failed.

The division is working on a collaborative project with other state stakeholders to develop a new MIS system. The project is referred to as the Alaska Automated Integration Management System (AKAIMS). The new system is intended to be a full-service system allowing users the ability to account for daily business activities, as well as management of clinical treatment functions. DBH anticipates the new system will be able to deploy new capabilities, including treatment improvement techniques, provider management functions, and state analysis of treatment services.

We recommend the DBH director ensure the new MIS system is designed to address the deficiencies of its current system and collect the information necessary to evaluate the effectiveness of its programs. We also recommend the new MIS system incorporate control objectives for information and related technology (COBIT) framework. This framework is published by the Information Technology Governance Institute. The objectives are designed to help meet the multiple needs of management by bridging the gaps between business risks, control needs, and technical issues.

Recommendation No. 6

The commissioner of DHSS must implement internal controls over investigating and reporting of potential ethics violations to comply with statutes.

DHSS staff failed to file the statutorily-required quarterly ethics violation reports with the Department of Law in FY 02 and for one quarter in FY 03. In addition, the department failed to investigate possible ethics violations that were brought to their attention. The commissioner's office received two separate letters from entities voicing concerns over improper influence by an ADA employee. The letters were not forwarded to the departments designated ethics supervisor for review. We also found that the designated ethics supervisor's staff became aware of potential ethics violations involving the same ADA employee, yet no investigation was conducted.

The Alaska statutes provide guidelines for persons to file complaints of perceived wrong doing by state employees:

AS 39.52.230 states:

*Reporting of potential violations. A person may report to a public officer's designated supervisor, under oath and in writing, a potential violation of AS 39.52.110 – 39.52.190 by the public officer. The supervisor shall provide a copy of the report to the officer who is the subject of the report and to the attorney general, and shall review the report to determine whether a violation may exist. The supervisor shall act in accordance with AS 39.52.210 or 39.52.220 if the supervisor determines that the matter may result in a violation of AS 39.52.110 – 39.52.190.*

AS 39.52.260 states:

*Designated supervisor's report and attorney general review. (a) A designated supervisor shall quarterly submit a report of the attorney general which states the facts, circumstances and disposition of any disclosure made under AS 39.52.210 – 39.52.240.*

Alaska Statute 39.52.960 defines the designated supervisor position as the commissioner of each department in the executive branch. The commissioner of DHSS delegated the duties of designated supervisor to the human resource manager of the department.

Without strong internal controls over investigating and reporting of potential ethics violations, such violations could increase, leading to possible misuse of state resources, conflicts of interest, and a negative public perception of the governmental process. Strong controls are important for maintaining the public's confidence in the grant award process.

We recommend the commissioner's office forward all potential ethics violations to the department's designated ethics supervisor for review. We recommend written procedures be developed and implemented to guide department staff in carrying out their responsibilities to investigate and report ethics violations under the Alaska Executive Branch Ethics Act. Additionally, procedures should ensure all department staff are aware of their responsibility to disclose ethics violations or possible ethics violations and the methods for disclosing. We further recommend DHSS immediately submit the required reports to the Department of Law and ensure the complaints noted in this report are reviewed by the designated ethics supervisor.

### Recommendation No. 7

The DBH director should implement policies and procedures to guard against potential ethics violations.

A potential ethics violation was not reported to the department's designated ethics supervisor for determination. Specifically, we found a situation where a spouse of an ADA management-level employee entered into a subcontract funded by an ADA grant in FY 00. This relationship was not disclosed by the ADA employee. Further, we found that several grantees perceived that the spouse's activity in the substance abuse field created a conflict of interest between the ADA employee and recipients of grant funds.

Alaska Statutes (AS 39.52) governing policies over ethics of state employees were intended to: (1) discourage ethical violations by public officers, (2) improve standards of public service, and (3) promote and strengthen the faith and confidence of Alaskans in their public officers. These statutes specify guidelines for public employees when a potential conflict of interest may exist:

AS 39.52.150 defines improper influence:

*Improper influence in state grants, contracts, leases, or loans. (a) A public officer, or an immediate family member, may not attempt to acquire, receive, apply for, be a party to, or have a personal or financial interest in a state grant, contract, lease, or loan if the public officer may take or withhold official action that affects the award, execution, or administration of the state grant, contract, lease or loan.*

AS 39.2.150 (d) provides guidance for disclosing potential conflicts:

*A public officer shall report in writing to the designated supervisor a personal or financial interest held by the officer, or an immediate family member, in a state grant, contract, lease, or loan that is awarded, executed, or administered by the agency the officer services.*

Without strong policies and procedures over ethics, instances of improper influence are more likely to occur. We recommend the director of DBH implement policies and procedures to promote and ensure public faith and confidence in the division's administration of grant programs. The director should ensure division staff is clearly informed as to what constitutes potential ethics violations. Policies and procedures should specify steps to be taken to remedy a potential conflict of interest. Additionally, those policies and procedures should ensure all potential ethics violations are properly disclosed and forwarded to the department's designated ethics supervisor for determination.

#### Recommendation No. 8

The DBH director should develop and implement written policies and procedures to ensure compliance with state regulations governing subcontracts of grantees.

ADA controls, over the approval of grantee subcontractors, are inadequate. During the course of our audit we found the division did not have written policies and procedures to guide their staff in the review and approval of grantee subcontracts. Consequently, we found little or no documentation of division approval of subcontracts nor did we find documentation that ensured subcontracts were reasonably competitive.

State regulations allow ADA grantees to subcontract with third parties for performance of grant activities provided the subcontract meets certain conditions. Regulation 7 AAC 78.180 states:

*Subcontracts. The grantee may enter into a subcontract for the performance of an activity required by the grant only if the grantee (1) remains administratively and financially responsible for the activity and is responsible for the performance of the subcontractor; and (2) obtains the approval of the grant agency before entering into the subcontract and demonstrates to the satisfaction of the grant agency as part of the approval process that the method of procurement to be used to identify the subcontractor will be reasonably competitive.*

Without written policies and procedures to guide ADA, staff is in a poor position to ensure that subcontractors are solicited through a competitive process and subcontracts are for purposes allowable under the conditions of the grant. Additionally, conflicts of interest may exist and go unnoticed by the division.

We recommend the division develop and implement written policies and procedures to guide staff in the review and approval of all subcontracts. The approval process should document that the grantee has demonstrated the method of procurement was reasonably competitive and that the contract is for purposes allowable under the conditions of the grant. The division should communicate to grantees their responsibility to inform the division of all subcontracts and obtain approval before entering into such arrangements.

## Recommendation No. 9

The DBH director should update the standards for treatment facilities to reflect current practices and technology.

The division continues to use standards that are almost 30 years old, as guidelines for certification and approval of alcohol and drug abuse treatment programs. ADA staff and grantees claim that the standards do not reflect current practices. Some of the standards are impossible to apply to providers. The outdated standards were identified as a finding in our FY 99 audit of ADA.

Alaska Statute 47.37.140(a) requires ADA establish standards for treatment facilities which provide for the protection of the health, safety, and well-being of clients as well as for the protection of the treatment facility (and the State of Alaska) from exposure to malpractice and liability actions. These standards, which have been in place since 1976, are established under Alaska Administrative Code (AAC) 7 AAC 29.030, which states:

*ADOPTION OF STANDARDS BY REFERENCE. Component 1 through 8 of the 1974 Accreditation Manual for Alcoholism Programs of the Joint Commission on Accreditation of Hospitals [JCAHO] are adopted by reference as the standard for management and treatment in the private and public treatment facilities or programs to which this chapter applies.*

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), formerly the Joint Commission on Accreditation of Hospitals, is an independent nonprofit organization. JCAHO establishes standards and provides evaluation and accreditation services to a variety of health care organizations including behavioral health care organizations that provide chemical dependency treatment services. These standards are continuously updated for state-of-the-art best practices. However, the State of Alaska continues to subscribe to standards adopted in 1974.

Consequently, substance abuse treatment providers are being approved as public and private treatment facilities based on standards that may not be applicable to today's practices. The outdated standards may not ensure the health and safety of clients being treated by the facilities. In addition, use of outdated standards may not protect the facilities from potential malpractice and liability actions.

We recommend the division update the standards for facilities to reflect current practices. The division may want to consider developing their own standards rather than adopting those established by an outside entity which may not fit the unique needs of Alaska. Further, the division may want to pursue the establishment of behavioral health standards to reflect the integration of its mental health and substance abuse programs.

## Recommendation No. 10

We recommend DHSS' internal auditors provide training to DBH program managers and grant administrators to ensure that federal/state single audits of grantees are utilized to the greatest extent possible.

Single audits for ADA grantees were not being utilized effectively in the monitoring process. Single audit findings were not followed up by ADA program staff. Further, timeliness of single audits is not considered during the grant award cycle.

ADA's grant administrator did not understand the division's responsibility to follow-up with grantees to ensure that corrective action had been made to address single audit findings. DHSS' internal auditor does not consider monitoring the timeliness of single audits to be the department's responsibility – procedurally, this is accomplished by the Office of Management and Budget (OMB). OMB maintains a database, which is accessible via the internet, that allows grant administrators to check whether single audits have been received. ADA's grant administrator was unaware of the single audit receipt information available through OMB's website. ADA health facility surveyors do check for the single audit when testing grant conditions. ADA continues to award federal and/or state financial assistance to grantees regardless of whether the required single audit reports have been completed and submitted.

Federal OMB circular *A-133 Subpart D – Federal Agencies and Pass-Through Entities 400(d)* specifies the state's responsibility in regards to the federal funds passed through to ADA grantees. The state must “*issue a management decision on audit findings within 6 months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.*” DHSS did not issue a management decision within six months and failed to ensure that subrecipients took appropriate and timely action.

Further, regulation 2 AAC 45.010(h) states:

*An entity shall provide the state coordinating agency with sufficient copies of each audit report to allow submission of a copy to each state agency providing financial assistance to the entity. The state coordinating agency shall determine if auditing standards have been met and shall forward a copy of the audit to the Department of Administration, upon request, and other appropriate state agencies. The state coordinating agency shall coordinate the assignment of the resolution to one state agency, if the exceptions concern more than one state agency. The applicable state agency providing financial assistance to the entity must meet its responsibilities under other law for ensuring compliance with the audit report.*

We recommend that DHSS' internal auditor provide training to ADA staff to ensure that single audits reports are utilized as effective monitoring tools. Further, we recommend ADA's grant administrator consider whether single audits have been received and whether single audit findings have been addressed during each grant award cycle.

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# AUDITOR'S COMMENTS

## Grants may not be the most efficient means of delivering services

As we discussed during the Report Conclusion section of this report, DBH needs a comprehensive plan to ensure treatment and prevention services adequately address the state's needs. The plan should implement the general planning guidance provided by the Advisory Board, the Mental Health Trust Authority, and the Mental Health Board. Further, it should prioritize the state's needs to guide the allocation of DBH's limited funding.

DBH's grant process may not be the most efficient use of resources due to underutilization of services by certain grantees. Utilization is monitored by DBH but is difficult to control through the grant process. We believe that DBH should consider purchasing specific substance abuse services rather than granting funds that may or may not be utilized to the greatest extent possible.

We contacted five other states and asked how services are procured. All five states purchased services -- see a summary of the discussions with other states in Appendix C of this report.

## Guaranteed levels of funding for certain groups is not necessary

At some point in the 1980s, funding for certain drug and alcohol programs was funded directly by the legislature in appropriations separate from ADA's operating budget. According to ADA staff, this change was based on the strong need for substance abuse services for certain populations. It was decided that the native organizations, that serve designated populations, should be exempt from participating in ADA's competitive grant process and be guaranteed a level of funding.

Beginning in 2002, the groups no longer received direct appropriations. Instead, their funding was incorporated into ADA's operating budget. However, the funding levels previously awarded under the direct appropriation structure were maintained. The funding levels for the specific native groups have been, and continue to be, held harmless from reductions to funding. In FY 04, most DBH substance abuse grantees received substantial funding cuts. Funding for the designated native groups was not cut.

A comprehensive plan for the delivery of treatment and prevention services based on the state's overall needs would, by design, address the needs of all populations. Designated funding levels for certain organizations would no longer be necessary.

### Exhibit 11

FY 04 Designated Funding	
Manillaq	\$ 968,550
Norton Sound Health Corp	540,000
Yukon-Kuskokwim Health Corp.	875,186
SE. AK. Regional Health Corp.	331,400
Tanana Chiefs Conference	446,935
Council of Athabascan Tribal Gov.	50,565
	<hr/>
	\$3,212,636

DBH should evaluate possible means of offsetting the cost of certifying and monitoring treatment facilities

During the course of our audit, we found that the certification of treatment facilities consumes a large amount of ADA resources. Travel costs for FY 03 were approximately \$212,000. The certification process requires on-site review of records, discussions with staff and clients, and an inspection of the facility. For large facilities, this process may take multiple ADA health facility surveyors several days. If a facility complies with at least 70% of the certification standards they are generally certified for two years. However, it is not uncommon for an entity to receive limited approval due to their failure to meet the 70% threshold. These entities are reviewed again within a designated time frame, usually six months.

As a way to help provide the resources necessary to properly monitor treatment facilities, ADA may want to consider charging a fee for the certification service. The fees could be structured to include an incentive for those entities that meet a certain percentage of standards. For example, those entities that meet 90% of standards could be charged a nominal fee; those that comply with 80% could be charged a higher fee, and so on. Fees could also serve to offset the additional costs generated by those entities failing to meet the 70% standard. These entities are especially costly because they require continued monitoring by the department. Changes to ADA's statutes would be required to permit the agency to collect fees.

Further, ADA may want to consider extending the certification period for those entities that routinely operate in an exemplary manner. Currently, the certification period is two years. For certain, well-run entities performing on-site reviews every three years may be a more effective use of resources. Mandatory change reporting could be required to ensure ADA was informed of any material changes to the entity's operations.

## APPENDICES

**Appendix A:** This appendix summarizes the results of an ADA grantee survey regarding satisfaction with services provided by ADA. An invitation to participate in the web-based survey was sent to all ADA grantees that were awarded grants during FY 02 or FY 03 except for the suicide prevention grantees. Suicide prevention grantees were excluded because the program is unique. Suicide prevention grantees interact with ADA staff in a different manner than other ADA grantees. Further, suicide prevention funding is a relatively small percentage of grant awards when compared to other programs.

A total of 67 grantees were invited to participate. Of the 67 grantees, 24 responded to the survey – a response rate of 36%. Of the grantees that responded, 18 received treatment grants, 14 received prevention grants, and 4 received ASAP funding. [Note: these numbers will not add up to 24 because grantees can receive more than one type of grant and were asked to select all that apply]. This diversity makes the responses fairly representative of the universe of grantees.

Of the 24 respondents, 7 are small grantees (receiving less than \$100,000 annually), 9 are medium sized (receiving between \$100,000 and \$500,000) and 8 are large grantees (receiving greater than \$500,000). Again, the responses represent a cross-section of ADA grantees.

**Appendix B:** This appendix shows the amounts paid during FY 03 to each of the ADA grant programs. A detail description of each grant program is included.

**Appendix C:** Interviews were conducted with substance abuse program administrators for five state substance abuse programs. This appendix summarizes responses to questions related to needs assessments, treatment models and strategies, procurement of services, management information systems, requirements for licensure of counselors and facilities, standards for licensing facilities, and the extent to which mental health services are integrated with substance abuse services.

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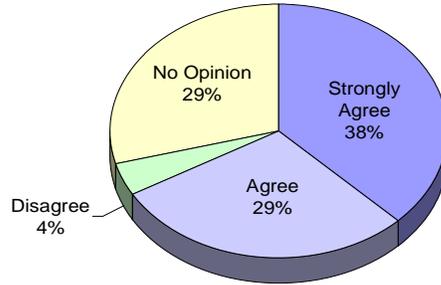
# Appendix A

## Survey Results

Views of survey respondents on the extent to which they agree with positive statements about ADA health facility surveyors.

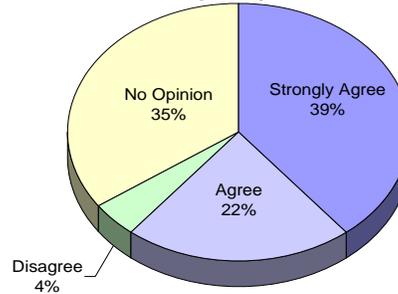
**Surveyors are fair.**

67%	38%	Strongly Agree
	29%	Agree
29%	29%	No Opinion
4%	4%	Disagree
	0%	Strongly Disagree



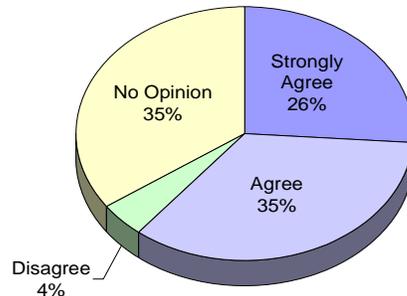
**Surveyors respond to questions quickly.**

61%	39%	Strongly Agree
	22%	Agree
35%	35%	No Opinion
4%	4%	Disagree
	0%	Strongly Disagree



**Surveyors provide reliable information.**

61%	26%	Strongly Agree
	35%	Agree
35%	35%	No Opinion
4%	4%	Disagree
	0%	Strongly Disagree



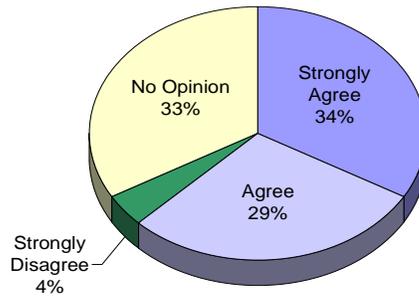
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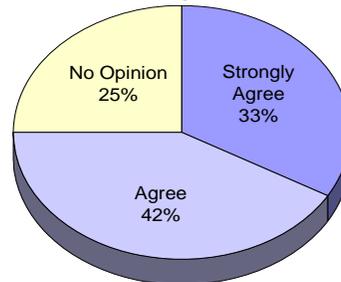
**Surveyors are easy to work with.**

63%	34%	Strongly Agree
	29%	Agree
33%	33%	No Opinion
	0%	Disagree
4%	4%	Strongly Disagree



**Surveyors have the skills necessary to do their job.**

75%	33%	Strongly Agree
	42%	Agree
25%	25%	No Opinion
	0%	Disagree
0%	0%	Strongly Disagree



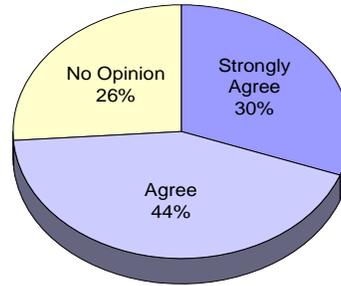
# Appendix A

## Survey Results

Views of survey respondents on the extent to which they agree with positive statements about ADA grant administrators.

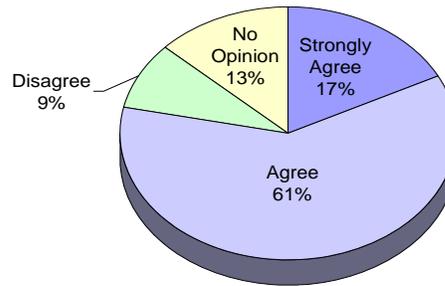
### Grant administrators are objective.

74%	30%	Strongly Agree
	44%	Agree
26%	26%	No Opinion
0%	0%	Disagree
	0%	Strongly Disagree



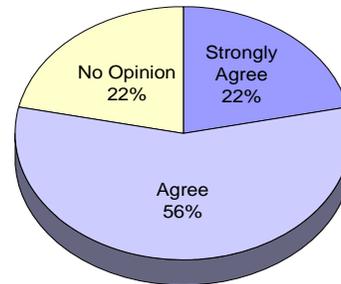
### Grant administrators respond quickly to questions.

78%	17%	Strongly Agree
	61%	Agree
13%	13%	No Opinion
9%	9%	Disagree
	0%	Strongly Disagree



### Grant administrators provide reliable information.

78%	22%	Strongly Agree
	56%	Agree
22%	22%	No Opinion
0%	0%	Disagree
	0%	Strongly Disagree



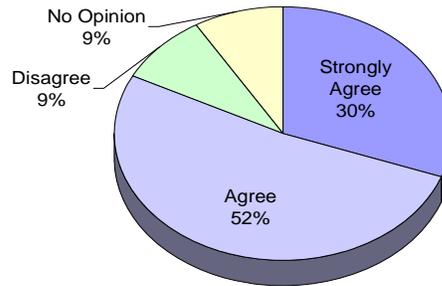
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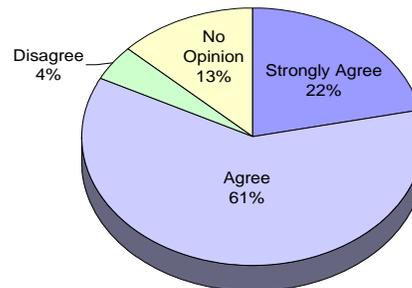
**Grant administrators are easy to work with.**

82%	30%	Strongly Agree
	52%	Agree
9%	9%	No Opinion
	9%	Disagree
9%	0%	Strongly Disagree



**Grant administrators have the skills necessary to do their job.**

83%	22%	Strongly Agree
	61%	Agree
13%	13%	No Opinion
	4%	Disagree
4%	0%	Strongly Disagree



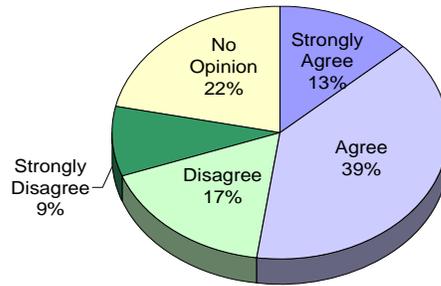
# Appendix A

## Survey Results

Views of survey respondents on the extent to which they agree with positive statements about management including the director and director's staff, prevention program manager, and the treatment program manager.

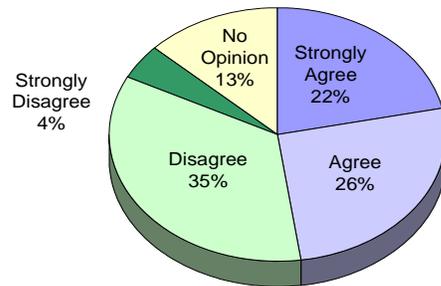
**Management has a well defined mission for the State's alcoholism and drug abuse programs.**

52%	13%	Strongly Agree
	39%	Agree
22%	22%	No Opinion
26%	17%	Disagree
	9%	Strongly Disagree



**Management clearly defines the objectives and priorities of the State's substance abuse programs.**

48%	22%	Strongly Agree
	26%	Agree
13%	13%	No Opinion
39%	35%	Disagree
	4%	Strongly Disagree



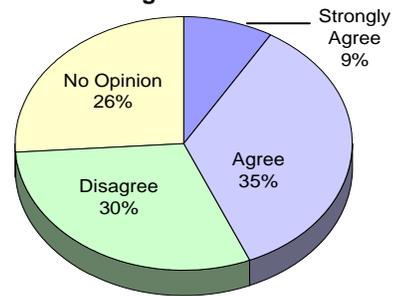
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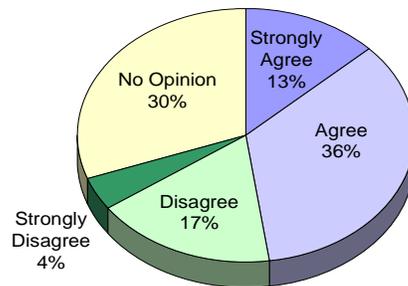
**Management effectively communicates with its grantees.**

44%	9%	Strongly Agree
	35%	Agree
26%	26%	No Opinion
30%	30%	Disagree
	0%	Strongly Disagree



**Management is fair in the awarding of ADA grant funds.**

49%	13%	Strongly Agree
	36%	Agree
30%	30%	No Opinion
21%	17%	Disagree
	4%	Strongly Disagree



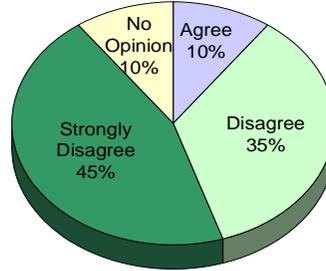
# Appendix A

## Survey Results

Views of survey respondents on the extent to which they agree with positive statements about ADA's Management Information System.

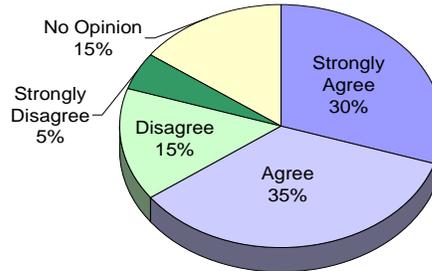
**The MIS system provides information that is helpful in evaluating and/or managing our organization's substance abuse programs.**

10%	0%	Strongly Agree
	10%	Agree
10%	10%	No Opinion
80%	35%	Disagree
	45%	Strongly Disagree



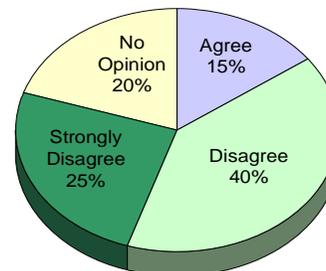
**Our agency regularly enters all required data into the MIS system on a consistent basis.**

65%	30%	Strongly Agree
	35%	Agree
15%	15%	No Opinion
20%	15%	Disagree
	5%	Strongly Disagree



**The MIS system is user-friendly.**

15%	0%	Strongly Agree
	15%	Agree
20%	20%	No Opinion
65%	40%	Disagree
	25%	Strongly Disagree



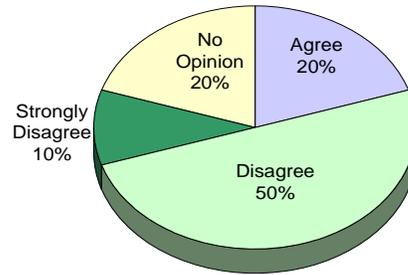
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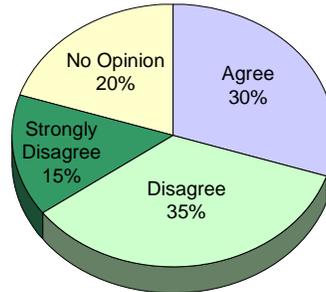
### ADA provides adequate MIS technical support.

20%	0%	Strongly Agree
	20%	Agree
20%	20%	No Opinion
60%	50%	Disagree
	10%	Strongly Disagree



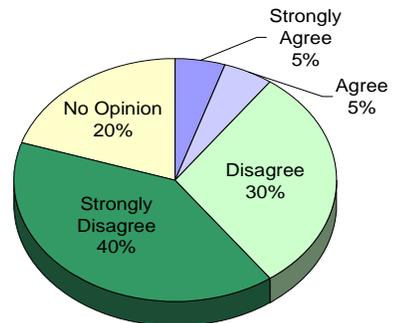
### ADA staff provide adequate MIS training.

30%	0%	Strongly Agree
	30%	Agree
20%	20%	No Opinion
50%	35%	Disagree
	15%	Strongly Disagree



### The MIS system provides accurate data.

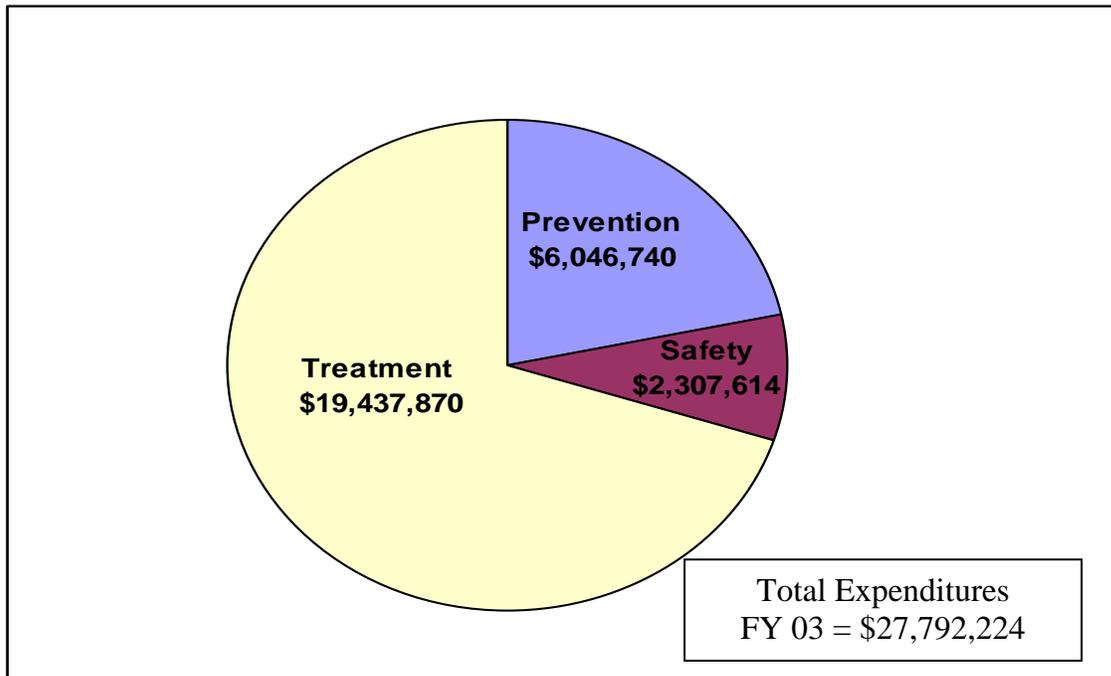
10%	5%	Strongly Agree
	5%	Agree
20%	20%	No Opinion
70%	30%	Disagree
	40%	Strongly Disagree



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## Appendix B

### FY 03 ADA Grant Expenditures by Type of Program



<b>Treatment Programs</b>		<b>Prevention Programs</b>	
Adult Residential and Outpatient Treatment	\$ 9,818,340	SIG	\$ 1,740,029
Designated Grantees	2,712,664	Community Prevention	1,728,704
Women and Children	1,896,073	Innovative Grant	793,460
Dual Diagnosis/Enhanced Detoxification	1,604,681	Team Development Grant	744,057
Youth Residential and Outpatient	1,307,591	Suicide Prevention	664,936
Rural Women with Children	549,060	CAASA	192,718
Therapeutic Courts	537,077	Transitional Housing	<u>182,836</u>
Treatment/Methadone	493,142	<b>Total</b>	<b>\$ 6,046,740</b>
Family Recovery Camps	363,242	<b>Safety Programs</b>	
Domicillary Care	<u>156,000</u>	ASAP	\$ 933,339
<b>Total</b>	<b>\$ 19,437,870</b>	Certification	52,251
		Rural Human Services	1,272,935
		Domestic Violence	<u>49,089</u>
		<b>Total</b>	<b>\$ 2,307,614</b>

## Appendix B

### ADA Grant Programs<sup>1</sup>

**Adult Residential & Outpatient Treatment:** Provide a system of care to adults dependent on alcohol and/or other drugs. Levels of service include: emergency and intermediate residential, outpatient, and aftercare services. Residential should include medical clearance, intake, assessment, and inpatient individualized treatment. Outpatient includes diagnostic and primary treatment designed to address immediate and continuing needs until recovery is possible.

**Alcohol Safety Action Program (ASAP):** Alcohol and substance abuse screening, referral, and monitoring of court imposed education or treatment requirements.

**Certification:** Certification for substance abuse counselors in Alaska. Certifying body is the Alaska Commission for Chemical Dependency Professionals Certification.

**Community Action Against Substance Abuse (CAASA):** Community-based projects proposing sound strategies to change behavior of at risk youth.

**Community Prevention:** Community and statewide efforts targeted at youth to prevent or eliminate alcohol/substance abuse.

**Designated Grantees:** ADA portion of multi-program grants to support activities of regional native health organizations

**Domestic Violence:** Monitoring of court ordered compliance with participation in domestic violence counseling and intervention programs.

**Domiciliary Care:** Emergency services and domiciliary care facility for chronic inebriates in the Fairbanks area.

**Dual Diagnosis:** Non-hospital based enhanced detoxification services for the dually diagnosed.

**Family Recovery Camps:** Culturally relevant substance abuse treatment in a rural camp setting for individuals and their families.

**Innovative Grant:** Promote the development of innovative programs (prevention and intervention) that address fetal alcohol spectrum disorders.

**Methadone Treatment:** Provide short-term (30 day) detoxification using methadone as well as group and individual counseling.

**Rural Human Services:** Provides funds to employ, train and supervise village-based human services workers.

**Rural Women with Children:** Provide treatment services to women of rural communities at risk of losing custody of their children.

**Services for Youth:** Provide a system of care to youth dependent on alcohol or other drugs. Could include either residential and/or outpatient.

**State Incentive Grants (SIG):** Provide comprehensive statewide prevention services targeted at youth aged 10-18.

**Suicide Prevention:** Local projects in small communities to reduce self-destructive behavior and promote community and individual wellness.

**Team Development Grants:** Develop and increase the state's fetal alcohol syndrome diagnostic capacity. Community level screening, diagnosis and service planning.

**Therapeutic Courts:** Treatment services for repeat drunk drivers who lack the ability to pay for treatment. Anchorage & Bethel DWI courts.

**Transitional Housing:** Provide housing to individuals and their families (up to 24 months) as a transitional step between residential treatment and returning home.

**Women and Children:** Provide a gender specific system (continuum) of care to women dependent on alcohol and/or other drugs.

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<sup>1</sup> Descriptions are from DHHS' FY03 Grant Book.

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## Appendix C

### Summary of Interviews Regarding State Substance Abuse Programs

We contacted management staff of five state substance abuse programs. Below is a summary of their responses.

***Does the state conduct a formal statewide needs assessment? If yes, how frequently and by what methods?***

- Idaho            Every three years a regional assessment is done for each of the state's seven regions. Each region has an advisory group made up of key stakeholders. This process results in a regional allocation strategy designed to ensure that small communities get appropriate services.
- Montana        The last statewide assessment was conducted in 1998. A biennial survey of 20,000 school children in the 8<sup>th</sup>-12<sup>th</sup> grades is conducted to understand drug of choice trends and develop youth strategies. A yearly household survey of Indian reservations is also conducted. They rely on the SAMSHA 2001 national assessment; the results of which are available on the SAMSHA website. Also, a county level planning process is conducted every four years.
- Oregon         The state conducts a needs assessment every two years as part of their implementation plan. The development of this plan is tied to the meeting of their legislature and must be approved by that body. Each county participates through a local advisory council made up of various stakeholders.
- South Dakota   A four-year \$4 million assessment project was completed in 2001. Part of the project involved creating a computer program that estimates needed capacity and levels of care in the state by region. This serves as good baseline data and is updated yearly to guide regional and demographic allocation.
- Washington    A formal county level assessment is done every two years. Their MIS allows for constant evaluation and assessment for making strategic decisions

***Does the state take a strong leadership role by endorsing and/or requiring specific treatment models or strategies? How does the state procure services?***

- Idaho            They require that providers use the American Society of Addiction Medicine (ASAM) patient-placement criteria and motivational interviewing and engagement skills developed by the Addiction Technology Transfer Center (ATTC). They require abstinence-based treatment and do not allow "harm reduction" models. Almost all treatment programs follow the "social" model and services are procured through fee for service contracts.

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### Summary of Interviews Regarding State Substance Abuse Programs

- Montana The state does not endorse or require any specific modalities. However, they require that providers use ASAM patient-placement criteria, motivational interviewing techniques and individual based service techniques. The state program approval process requires that programs meet codified administrative rules defining specific standards at the various levels of care. Services are procured through fee for service contracts.
- Oregon The state requires only that the individual programs be safe and are approved by the state. They allow the programs to determine their own methods as long as they are within general state guidelines, contractual requirements, and federal grant requirements.
- South Dakota The states administrative code requires they establish specific levels of care for providers receiving state funds. They require providers to use the ASAM placement criteria and do not prohibit new and unique treatment modalities.
- Washington The State does not require or endorse specific models of treatment. They do require the ASAM placement criteria. Programs must use safe modes of therapy and the state has specific care requirements written into their Admin code.

### ***What type of management information system is used for data collection? What is the extent of training provided to ensure uniformity and usability of subjective clinical data collected?***

- Idaho They currently use a treatment MIS and are building one for prevention. A third-party contractor manages their mainframe (not web-based) system. The state receives only summary data from the contractor. The contractor collects only the minimum federally required data set. This is basic demographic statistical data.
- Montana The state MIS is called ADIS – Alcohol Drug Abuse Information System. ADIS is used to collect basic demographic information. They are currently converting to a web-based system and hope to have this in place within two years. The new system will be more outcomes driven than the current one. They review diagnostic treatment information during yearly on-site reviews to ensure providers are meeting the state reporting requirements.
- Oregon The state has separate systems for treatment and prevention. The treatment system is web-based and individual providers enter their own data. Any errors by providers are followed-up immediately by the state. The CPMS collects demographic data and some performance/outcome data. However, all diagnostic codes are entered onto hard copy forms. These are reviewed by

## Appendix C

### Summary of Interviews Regarding State Substance Abuse Programs

- Oregon (contd.) staff during on-site visits. They are working on converting the prevention MIS to a web-based system.
- South Dakota The state has a mainframe MIS. They are working on converting to a web-based system for both treatment and prevention and have a target date for implementation of June, 2004. They collect mostly demographic information but also some diagnostic information. They have had some difficulty with subjective interpretation of DSM IV patient placement criteria but they provide extensive training and technical support. During yearly on-site reviews a detailed check is made of all clinical records to ensure providers are accurately recording diagnostic information.
- Washington Their MIS is called “TARGET” – Treatment and Report Generation Tool. All providers have the ability to input through the web. Security is furnished through digital certificates. They believe this is the leading system in the country. Billing is done through this system as well as data reporting. The system collects demographic, diagnostic, treatment, outcome, and performance information. The system has a built-in “treatment analyzer” that looks at all the data entered and evaluates what appears to be working and what is not. The system performs monthly diagnostics and they have advisors that provide training so data is input from a uniform perspective.

#### ***Does the state require counselors be certified/licensed? If yes, does the state provide/administer the certification process?***

- Idaho The provider contracts stipulate that all counselors be certified. However, the state does not provide the certification service. The state will accept any certification sponsored or accepted by the International Counselor Reciprocity Consortium (ICRC).
- Montana They require that addiction counselors be licensed. Licensure is granted by the Department of Labor. Applicants must pass a state administered written and oral examination and meet specific experience, education, and continuing education requirements.
- Oregon The state requires that all counselors be certified or working towards being certified. Certification is not state provided They recognize certification from ACCBO – The Addiction Counselor Certification Board of Oregon and from NAADOC - National Association of Alcoholism and Drug Abuse Counselors.

## Appendix C

### Summary of Interviews Regarding State Substance Abuse Programs

South Dakota They require that counselors be certified but the state does not provide this service. They recognize certification through the ICRC – International Counselor Reciprocity Consortium.

Washington The state certifies chemical dependency professionals. Experience and education requirements are written into the Administrative code. NAADOC or IRHC certification will substitute for the experience requirements.

#### *Does the state license/certify facilities? Upon what standards is certification based? Is there a fee?*

Idaho The state requires that all facilities receiving state funds be certified. They developed their own standards drawing on many sources including CARF and JCAHO. The certification period is for a maximum two years. They will judgmentally accept non-state certification depending on the certifying body. The state requirement is waived for CARF or JCAHO certified facilities. They will certify non-contracted providers if requested. They do not charge a fee.

Montana The state must approve all programs and facilities receiving state funds. The approval period is one year. The approval is based on yearly on-site visits. They developed their own standards and the current version has been in place for a number of years. They will waive the state standards for a CARF certified facility but they reserve the right not to waive if the circumstances warrant. They do not charge a fee for the approval.

Oregon The state certifies outpatient programs/facilities. The maximum period is three years. Residential facilities must be licensed. This is a more stringent requirement with a maximum period of two years. The state developed their standards which are reviewed every two years. The most recent major revision occurred 2002. They do not charge a fee.

South Dakota The state does certify facilities. They developed their own standards which have been approved by the legislature. The standards are reviewed and possibly revised every 4-6 years. They were last revised in 1998. They will waive state standards for facilities CARF or JCAHO certified. The cost is \$150. State certification is only required of facilities receiving state money.

## Appendix C

### Summary of Interviews Regarding State Substance Abuse Programs

Washington All facilities that contract with the state must be certified. They have developed their own standards which are written into the administrative code. The certification is for a maximum two years. They charge \$500. However, they may reduce the fee depending on circumstances.

#### *To what extent has the state integrated mental health and substance abuse services?*

Idaho The state is slowly moving towards full integration. The “hang-up” has been ensuring that the substance abuse side gets equal treatment. They have a few dual service integrated contracts but these are pilot projects and only with hospitals.

Montana The Addictive and Mental Disorders division was created in 1995. The division is not totally integrated as the two bureaus operate under separate “chiefs.” The state is working towards creating a service delivery structure where all providers offer co-occurring capable or co-occurring enhanced services. A co-occurring disorder task force has been created which meets every six weeks. They have one integrated contract as a pilot project.

Oregon The state is moving towards integration but it is a work in progress. They currently operate as separate sections under “Mental Health and Addiction Services.”

South Dakota They are slowly working towards integration. Currently, they are working on merging the mental health and substance abuse MIS for dealing with dual diagnosis. They do not, as of yet, plan a full integration. They have one integrated services contract for a program that began four years ago.

Washington They have not combined divisions. They have an interagency crisis response that deals with clients of both divisions. This implements the “no-wrong door” intake policy. The extent of their integration is a co-occurring disorder program. They have no integrated treatment contracts with providers.

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November 19, 2003

Pat Davidson, CPA  
Legislative Auditor  
Division of Legislative Audit  
P.O. 113300  
Juneau, AK 99811-3300

RE: Audit: Control Number 06-30023-03  
Department of Health & Social Services  
Division of Behavioral Health, Selected Issues

Dear Ms. Davidson:

Thank you for allowing my staff and I the opportunity to respond to your recommendations.

Recommendation No. 1

The Division of Behavioral Health's director should create a comprehensive program for prevention and treatment services to guide the delivery of substance abuse services.

The Department concurs. The newly formed Division of Behavioral Health (DBH), comprised of the former Division of Alcoholism and Drug Abuse and the Mental Health portion of the former Division of Mental Health and Developmental Disabilities, has embarked on a process to identify the components of a quality behavioral health system in Alaska. DBH, the Mental Health Trust and the mental health and substance abuse advisory boards are jointly directing this effort. Members of the stakeholder group creating this vision represent provider groups (rural and urban), clients, the tribal health care system, and the educational system and to the extent possible, the populations these individuals represent.

This effort is expected to be completed by January 1, 2004. Simultaneously, an internal effort is underway to create a structure and staffing within the Division that will support the development and enhancement of the behavioral health system as defined by the stakeholder group.

When this process is completed, the vision document created and the new structure will be utilized by DBH to develop a comprehensive program to address the behavioral health needs of Alaskans, including those related to substance abuse. Priorities will be established and continual evaluation will allow for corrections, as necessary, to ensure the best use of resources towards the greatest benefit for the populations/individuals served.

#### Recommendation No. 2

DBH's director should take steps to improve its working relationship with the Advisory Board on Alcoholism and Drug Abuse.

DBH acknowledges the relationship between the Division and the Advisory Board has not always been positive. However, many steps have been taken already to improve the relationship and more are planned. The DBH Director and Associate Director are both new to their current positions, but have in the months since joining the Division worked to enhance the relationship with the Advisory Board. DBH asked the Executive Director to be a partner in steering the efforts of the stakeholder planning process, along with the Mental Health Board ED and the Mental Health Trust ED. Working as equals, the process has been defined, the membership identified and the work begun. Regularly scheduled meetings and frequent informal meetings with the Advisory Board ED have greatly increased the communication and sharing of relevant information between DBH and the Advisory Board. Agreements have been made between both parties to share staff and capacity to accomplish joint endeavors to better serve clients and programs.

The Advisory Board is being asked by DBH to provide input on use of the federal substance abuse prevention and treatment block grant. This input was not sought in the past. Feedback from the Advisory Board ED indicates the relationship between DBH and the Board has improved and DBH has plans for additional work to continue to enhance the relationship.

Recommendation No. 3

DBH's director should take steps to improve the grant award process.

The department agrees with the recommendation to improve the grant award process and acknowledges the errors raised in this audit. In part, the recent changes to grant regulations are helping to move in that direction of improvement and many of the errors occurred in direct conflict with department standards already established. The FY04 grant award cycle was the first in which the recent regulatory changes became effective and our initial efforts to standardize procedures department wide were put to the test. That experience has highlighted areas of process for further improvement, including more standardization in the evaluation process as well as greater centralized oversight of grant procurement activities.

Almost concurrent with the issues raised in the audit; the department recognized that additional steps were necessary to improve grant processes. The department is presently taking a dramatic move toward achieving those objectives and is developing a plan for consolidation of all grant and professional services procurement and administration into a single Section, contained in the Division of Administrative Services. This action is intended to accomplish the following objectives that are pertinent to the Audit Recommendations:

- Improve customer service by establishing a single point of contact for vendors and grantees.
- Promote uniformity and consistency in the application of procurement /grant regulations, policies and procedures.
- Provide continuity of services during employee leave and vacancy.
- Consolidate the administrative expertise in one place to advise Division Directors.
- Eliminate redundant work caused by the segmentation and review process that currently exists.
- Reduce the work hours program staff devotes to administration so these work hours can be refocused on tasks related to their areas of expertise.
- Eliminate duplicate filing systems.
- Facilitate auditing of grants.

***Increases to Grant Amounts:***

The consolidation of grant management will accomplish a greater standardization of the grant award process. By locating the functions centrally, the opportunity to amend grants without appropriate authorization or documentation will be removed. Divisions will not be enabled to provide grant funds outside the structured process.

***PEC scoring methodology:***

Centrally trained and supervised Grant Administrative staff will be charged with coordinating and facilitating both Proposal Evaluation Committees and division staff evaluations; reinforcing a common understanding, execution and appropriate documentation of the processes. Currently there are divergent responsibilities in the job descriptions and expectations for Grants Administrators. Consolidation into a single functional section in the department will enable more oversight of the award process.

***Inequitable treatment of grant applicants:***

Centralized supervision and training, as well as direct oversight of the entire award process should ensure that there is a common methodology for reviewing grant proposals and help to eliminate any opportunity for inequitable treatment of grant applicants.

***Incorrect/unsupported funding recommendations:***

As with divergent understanding of process, or even potential bias, a centrally supervised process should help to eliminate or sharply reduce occasion for errors in scores. The consolidation of the grant award and administration into a single section will offer cross training, more equitable distribution of work load, and backup support for grants administrators that is not possible in their isolated positions spread throughout the individual divisions.

***Missing documentation:***

As stated above, this recent award cycle was the first following changes to the Grant Regulations and the experience with that has highlighted areas of process for further improvement, including more standardization for both the staff evaluation and PEC process and greater centralized oversight of grant procurement activities. The consolidated grant section will also centralize the files for grant award and administration, so that the documentation is kept in a uniform fashion and a single location, more easily available for tracking purposes and review.

The changes described above should result in measurable improvement in the grant award process for Division of Behavioral Health as well as the other divisions in the department. As is evident from the survey results, ADA Grants Administrators are generally perceived, as objective, timely, reliable, helpful and skilled, as we believe are all the Grants Administrators in DHSS. However, the present organizational structure fails to provide them with sufficient resources to guide division directors and division staff through processes that are fully compliant with established standards. The plan for consolidation should provide those resources necessary to correct the errors found in this audit and ensure future errors of this nature are avoided.

Recommendation No. 4

The DHSS Commissioner, in cooperation with the Department of Law, should pursue recoupment of FY03 overpayment to an ADA grantee.

The Department concurs that it should seek repayment of \$273,000 from the Alaska Women's Resource Center. Although the overpayment from Private ProShare program occurred prior to final adoption of regulations, it is the department's position that since the Medicaid State Plan amendment had been adopted that the use of Private ProShare was allowable under state and federal law.

Recommendation No. 5

The DBH director should ensure the new MIS system is designed to address the deficiencies of its current system and collect the information necessary to evaluate the effectiveness of its programs.

The Department concurs. The new MIS system, the Alaska Automated Information Management System (AKAIMS) is designed to improve both the clinical practice at the local level and to increase the ability of the local provider system to identify and better serve the many clients who experience both a substance abuse and a mental health problem. It is also designed to provide both the management information needed to manage programs at the local level and also to provide the information needed to determine at every level of the service delivery system- who is being served, what the costs of those services are, what the system utilization is and most importantly what effect the services delivered are having on the lives of those served.

Providers, DBH staff, clients and a variety of professional MIS folks have been involved at the very detail level, defining exactly what the system needs to do and defining every question being asked to ensure consistency in the data.

Recommendation No. 6

The commissioner of DHSS must implement internal controls over investigating and reporting of potential ethics violations to comply with statutes.

The Department concurs. The Director of Administrative Services in coordination with the former Human Resource manager will be writing clear policies and procedures relating to the DHSS Ethics program. In addition, improved tracking mechanisms have been established in the Commissioner's office to ensure that ethics and other issues are traced and appropriately referred to the DHSS Designated Ethics Supervisor.

Apparently Legislative Audit staff received information related to these ethics violations from DHSS staff who worked for Designated Ethics Supervisor. It is unclear why this staff member did not report these ethics violations to the supervisor or ask to have an investigative file opened. In light of this and the Human Resource Integration, the Commissioner will be re-assessing the delegation of Designated Ethics Supervisor.

Recommendation No. 7

The DBH director should implement policies and procedures to guard against potential ethics violations.

The Department concurs. As outlined in the response to Recommendation No. 6, the department will be implementing revised policies and procedures to govern ethics issues for all DHSS employees. The DBH director will be responsible for implementation of these policies and procedures throughout the entire division.

The Director will work with the Division of Administrative Services to ensure the guidance provided at the Department level regarding actions of employees that must be reported for potential conflict of interest is up to date and readily available. The DBH director will ensure that the Department of Law Ethics handbook guide is available and explained to all DBH employees.

Recommendation No. 8

The DBH director should develop and implement written policies and procedures to ensure compliance with state regulations governing subcontracts of grantees.

The department concurs with this recommendation. However, our intent is to centralize this activity, along with other grant activities for more universal review standards. The regulations are very specific regarding the administrative and financial responsibility for performance and reporting in the event that a grantee subcontracts for goods and services under the grant. They are also specific regarding the requirements for prior approval from the granting agency (division). In an effort to ensure compliance with these requirements, the department currently requires grantees to submit for approval, a copy of their compliant purchasing policy and procedures. This is intended to ensure that subcontracts for both goods and services are procured by a 'reasonably competitive' method.

The planned consolidation of the grant administration function described in our response to Recommendation number 3 should help to ensure a centralized focus on review of all grantee activities. This will include establishing policy and procedures for more stringent review of grantee procurement, in conjunction with the grantee documentation already required, and to ensure that proposed budgets are compliant under 7 AAC 78.180.

Recommendation No. 9

The DBH director should update standards for treatment facilities to reflect current practices and technology.

The Department concurs. The Director is aware of the problems related to having outdated standards in statute and using them to measure the quality of care in treatment programs. Changing the standards will require massive internal changes in terms of the computer programs and other tools used by the field staff doing the certification work.

Also, since it is not clear that the programs or the people they serve would be best served by merely moving to the most recent JACHO standards, the Director will be initiating a study to determine whether JACHO standards are indeed the set of standards that would best serve Alaskans, whether the state should do what most states have done-which is to develop their own standards unique to the state's delivery system- or to look at other national level standards for adoption in Alaska. Funds have been received through a federal grant that will provide the needed resources to ensure that new standards are put in place as soon as possible, but that the standards selected will best serve Alaskans receiving treatment and the providers who deliver that treatment. It is expected getting new standards fully implemented will take 18-36 months.

Recommendation No. 10

We recommend DHSS' internal auditors provide training to DBH program managers and grant administrators to ensure that federal /state single audits of grantees are utilized to the greatest extent possible.

The department concurs with this recommendation. In fact, the department has already begun steps to execute this action. In the recent revision to grant regulations, 7 AAC 78.100 (2) (B) now requires the review of grant applications for a "history of compliance with grant requirements, including a summary of audits and the resolution of audit exceptions." Department wide training for proposal review was offered to grant and program staff this last February and March. Guidelines for staff review included compliance with this regulatory requirement and instructions on how to incorporate this into the review of grant proposals.

As stated above, the centralization of grant administrative activities should provide for a more uniform standard of review. In the plans for grant and contract consolidation, substantial time is earmarked for grant administration training that will include the more effective utilization of audits as monitoring tools.

Pat Davidson, CPA  
Legislative Auditor  
November 19, 2003  
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Auditor's Comments

The auditor has suggested the following points: 1) Grants may not be the most efficient means of delivering services, 2) Guaranteed levels of funding for certain groups is not necessary, and 3) DBH should evaluate possible means of offsetting the cost of certifying and monitoring treatment facilities. In general the Department agrees that these three items are worth reviewing and exploring. DBH is very interested in exploring item #2 to look at more utilization-based models for providing service.

Lastly, I would like to compliment the audit team within Legislative Audit who were responsible for completing the work on this audit in a professional and timely manner. While audits can be difficult, the team on this audit is of the highest caliber and should be complimented for their efforts.

Sincerely,

Joel Gilbertson  
Commissioner