Alcohol & Drug Treatment

Need for a managed system

June 1993

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MULTNOMAH COUNTY OREGON

MEMORANDUM

DATE: June 8, 1993

TO: H.C. Miggins, Acting Multnomah County Chair
Dan Saltzman, Commissioner, District 1
Gary Hansen, Commissioner, District 2
Tanya Collier, Commissioner, District 3
Sharron Kelley, Commissioner, District 4

SUBJECT: Audit of Alcohol and Drug Treatment in Multnomah County

Nearly twenty years ago Multnomah County Commissioners decided to contract with non-profit organizations to provide alcohol and drug treatment services to the community. The attached audit was included in the FY92-93 Audit Schedule, and is the first performance audit conducted by this office of these services. Like other audits, this report is a challenge to improve, and it is also a recognition of the importance of these services to the community.

We have discussed these findings and recommendations with representatives of the County, the contractors, Multnomah Council on Chemical Dependency, and the State. Written responses are the last section of this report.

We would appreciate receiving a written status report from the County Chair, or a designee, in six months indicating what further progress has been made regarding the recommendations identified in this report. This response should be circulated to the Commissioners.

We appreciate the cooperation and assistance provided to us by the personnel in the County Mental Health, Youth, and Family Services Division; the contractors; the State Office of Alcohol and Drug Abuse Programs; and the County's Information Services Division and Department of Community Corrections.

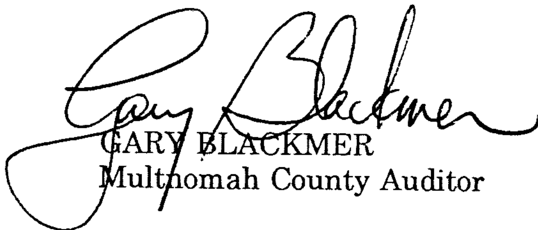

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Table of Contents

Summary i

Background

- Audit Scope 1
- Multnomah County alcohol and drug treatment 1
- Description of contracted services 2
- The Client Process Management System (CPMS) 4
- Financing the Treatment System 4
- Funding trends affecting service delivery 7
- Clients admitted to treatment 8
- Trends in admissions 9
- Methodology 10

Chapter One - Improve management of the treatment system

- Treatment system goals 13
- More planning needed 13
- Contracting for services 14
- Improvements needed in contractor monitoring 15
- CPMS information not used effectively 18
- Reimbursement system lacks accountability 18
- Need for more corrective action 19
- Allocation of County A&D resources 20
- Recommendations 22

Chapter Two - Treatment system improvements can reduce costs and increase client recovery rates

- Measuring client success 23
- Overall County performance meets State standards 25
- Outcomes vary by client group 26
- Some treatments appear to be more cost-effective than others 27
- Completion rates vary among contractors 28
- Costs vary among contractors 30
- County A&D should manage the continuum of care 31
- Lack of coordination reduces effectiveness 32
- Many clients do not move through the continuum of care 33
- Many clients drop out of treatment 35
- Client referrals 35
- Potential for dual enrollment in methadone programs 36
- Recommendations 37

Chapter Three - Reimbursement system needs improvement
Funding treatment services 38
Reimbursement system lacks accountability 39
Over-reported outpatient services 40
Service overlap of County A&D and Community Corrections 42
Medicaid-funded services 43
Causes for service overlap 44
Reimbursement of CODA's methadone services 45
Medicaid billings are reducing other services 46
Recommendations 47

Appendix A - Program Profiles 49
Appendix B - Assessing data reliability 53
Appendix C - Bibliography 55

Responses to the Audit
Hank Miggins, Acting Multnomah County Chair 58
Gary Nakao, Gary Smith, Norma Jaeger, Department of Social Services 59
Patrick A. Vanzo, MCCD Chairman 65
Portland Area Alcohol & Drug Managers Association 66
Susan Dreyer, Transition Projects, Inc. 67
Ann S. Uhler, Kevin McDonald, CODA 68
Linda P. Tyon, Treatment Alternatives to Street Crime 70
Ed Blackburn, Central City Concern 71
M. Tamara Holden, Department of Community Corrections 72

SUMMARY

This report covers our audit of Multnomah County's alcohol and drug treatment system for adults. In general, greater accountability is needed to ensure that contracted services are meeting the community's needs. A better reimbursement system, increased monitoring efforts, and more coordination of contracted services could increase client recovery rates and reduce costs. Responses to this audit are included in the back of the report.

The impact of alcohol and drug abuse on our community is immense. Multnomah County spent an estimated $60 million last year for health, justice, and social services to address problems related to alcohol and drug abuse. The Multnomah County Alcohol and Drug Office (County A&D) administers about $6.4 million of Federal, State, and County funds to provide treatment to adults with substance abuse problems. Adult treatment services are provided by 20 agencies under contract with County A&D. A manager and two staff are directly responsible for adult treatment contracts. Other administrative staff in the County provide assistance in financial monitoring and contract bidding. A variety of services are offered by the contractors including residential, outpatient, detoxification, and methadone treatment.

More can be done to manage the alcohol and drug treatment system in Multnomah County. There are opportunities for County A&D to improve treatment services and reduce costs with additional efforts in monitoring contractors, improving the reimbursement system, coordinating contractor activities, and taking corrective actions. Administrative weaknesses that are built into the treatment system make these efforts particularly important for maintaining accountability.

Need for better reimbursement and monitoring systems

Because the County contracts with other organizations to provide alcohol and drug treatment services, it has less direct oversight and control of the quantity and quality of services provided. The current reimbursement system established by the State Office of Alcohol and Drug Abuse Programs (the State) further weakens the County A&D's ability to hold contractors accountable for services. State guidelines and County agreements with contractors have not sufficiently linked reimbursements to the quantity and quality of services that County A&D should expect.

Without clearly defined expectations for the quantity and quality of treatment services to be provided, it is difficult to determine whether contractors are effectively meeting the community's needs. For example, contractors are reimbursed for "slots" of services. An

outpatient slot is only defined as one client contact in a month, with no other requirements such as the duration of treatment or the amount of individual versus group counseling. The advantage of the State's slot-based system for reimbursing contractors is that it minimizes paperwork and provides a more predictable cash flow for contractors.

Accountability is particularly important in this contracting situation where there is some evidence that the quality of services may be adversely affected by a shortage of funds. We found relatively high turnover rates for counselors, which may reduce the effectiveness of client/counselor rapport and lower treatment success rates.

Monitoring contracted services is an important management function to ensure the best return on public expenditures. Both the State and County A&D perform some monitoring, however we found that the County's monitoring efforts are limited. County A&D has not verified that clients received services, or the quality of those services. Staff efforts currently spent on other activities could be re-allocated to monitor contractors.

County A&D could further increase accountability by considering information on contractor costs and their treatment effectiveness when it reviews proposals for treatment services. According to one indicator, some of the more costly treatment programs were less successful than their lower-cost alternatives. One of the largest contractors cost the County four times more than the others to successfully treat a client in a residential setting. The variation in success rates did not appear to be a result of differences in client characteristics. Contractors noted that some of the variation could be a result of their inconsistent reporting of information into the State's Client Process Monitoring System (CPMS).

CPMS tracks the number and type of clients served and provides measures of effectiveness. Contractors frequently complained that CPMS fails to meet their needs. We found that client data reported to the State was accurately entered in CPMS, but the reports produced by the system are not always timely or clearly understood by personnel from the State, County, or contractors. The State provides regular training on CPMS data gathering, but the data has not been monitored or tested to ensure consistency among contractors. Increased review of CPMS data would also identify areas needing improvement.

When we analyzed the quantity of services provided by the largest contractors in FY91-92 it appeared that six contractors were serving the number of clients required in their contracts. However, four contractors were reimbursed an estimated $118,000 annually for discharged, duplicated, or inactive clients. Two contractors were reimbursed for clients by County A&D as well as Multnomah County Community Corrections, which also purchases treatment services from contractors. The service overlap could be as high as

$110,000 although a Community Corrections manager stated that some overlap was acceptable. We also found three contractors where services for the same client were being paid for by slot and Medicaid funds. They were reimbursed a total of approximately $99,000 per year. State administrative rules, procedures, and directives on Medicaid billing are not consistent on the appropriateness of these reimbursements.

Medicaid reimbursements also affect slot funding on a system-wide level. When billings for Medicaid services exceeded State allocations, County A&D reduced other types of treatment services. Methadone services generated 73% of the Medicaid billings in FY91-92 but outpatient services suffered the largest reductions. We examined methadone financing for one contractor and found that reimbursements significantly exceeded costs. In compliance with statutes, the contractor used the excess funds to subsidize other treatment services.

Need for increased coordination

County A&D has succeeded in developing a treatment system which provides a variety of treatment services. The treatment literature indicates that different clients need different treatment methods. To ensure that clients receive the most cost-effective treatment, County A&D needs to better coordinate the efforts of the large number of contractors which are providing services in a decentralized manner. The client most often selects the contractor for treatment services, which may not necessarily provide the most cost-effective service for the client's individual needs. The majority of contractors currently have no consistent screening and referral system to insure that clients are receiving the most appropriate and least costly treatment. Only one contractor is using standardized screening and referral methods to assure that clients consistently receive appropriate treatment.

It may be possible to further improve the recovery process for some clients with increased efforts by County A&D to evaluate and coordinate the services of the treatment contractors. Clients are not always moving through the stages of treatment, from the more intensive residential programs to the "aftercare" which sustains recovery over the long term. Treatment professionals state that the recovery process for some individuals may not be a simple progression through the stages of treatment and often includes relapses. However, the County A&D has not tracked client movements or evaluated performance data of contractors to identify areas which could be improved.

Multnomah County has a treatment system which appears responsive to most of the racial and cultural characteristics of the community. This is a result of planning efforts which have generally focussed on special-needs clients such as pregnant women and culturally-diverse populations. However, more can also be done to plan for and evaluate

the overall treatment system. Planning efforts have not investigated available information on the usage, costs, or success rates of different types of treatments.

Without adequate planning or monitoring efforts, County A&D is seldom in a position to take appropriate action when problems are detected. For example, we found little evidence that County A&D corrected or determined possible causes for contractors which had treatment success rates that were lower than others. Although County A&D is dependent on its contractors, it may not adequately respond to signs that some contractors are financially troubled, delaying actions until the solvency of the organization is in jeopardy.

Easily obtainable information may provide County A&D with additional indicators of contractor performance and reliability. Indicators such as turnover of contractor executive directors, low cash reserves, and achievement of contract goals could be used to identify contractor problems. These indicators could detect problems earlier, allow County A&D to prioritize limited monitoring resources where they are most needed, and better coordinate fiscal and program monitoring. When problems are identified, more intensive monitoring could occur. County A&D provides some technical assistance, but earlier intervention with the contractor and its board of directors could reduce the risk of interrupted or deteriorated services.

Recommendations

We recommend that County A&D place an increased emphasis on managing the alcohol and drug treatment system. Additional efforts should be made in planning and coordinating the services provided by contractors. County A&D should work with the State to develop a reimbursement system that provides greater accountability. County A&D should better monitor treatment data and make efforts to improve the movement of clients through the treatment continuum. County A&D should also monitor indicators of contractor problems and work with the contractor and its board of directors to resolve those problems.

BACKGROUND

Audit Scope

The purpose of the audit was to determine whether opportunities exist to improve the provision of adult services in the publicly-funded alcohol and drug treatment system; whether treatment efforts are cost-effective and contribute to recovery; and determine the impact of funding practices on the level and quality of services.

The audit scope did not include prevention, treatment services for youth, sobering services, Regional Drug Initiative activities, DUII services, or services funded through direct state contract. Although we reviewed the number of alcohol and drug clients funded by Multnomah County Community Corrections, the audit scope excluded comparative evaluation of their treatment services. We generally excluded contractors which are certified by the County to receive Medicaid reimbursements but do not receive State funding.

Multnomah County alcohol and drug treatment

The abuse of alcohol and drugs has grown to become a visible and costly public problem. Every level of government is seeking solutions, including prevention, treatment, and more aggressive law enforcement efforts. A recent study conducted by a Multnomah County task force estimates that about $60 million of County spending is related to alcohol and drug abuse. The largest costs are borne by the criminal justice system, social services programs, and health services. Individuals, families, and all of society are profoundly affected by this problem in ways that cannot be measured.

The County has been involved, either directly or contractually, in the delivery of alcohol and drug treatment services since the mid-1960s. State legislation enacted in 1973 shaped the direction of the County's alcohol and drug treatment program by mandating that addicted persons receive treatment regardless of their ability to pay. The purpose of the legislation was to increase the ability of those recovering from substance abuse to lead productive lives and to reduce their continued reliance on treatment. Statutes were enacted to encourage local planning and the development of a publicly funded system in each County for prevention and treatment services.

As illustrated in the chart below, the County's Alcohol and Drug Program (County A&D) is one of five units within the Mental Health, Youth and Family Services Division of the

Social Services Department. There are four components of the program: Operations, Contracted Services, Driving Under the Influence of Intoxicants (DUII) Evaluation and the Regional Drug Initiative. Operations is responsible for the management of contracted services and planning for the treatment system. A program manager and two program development specialists manage adult treatment services. Additional personnel in Operations provide technical support, prevention, and planning functions. Personnel at the Division level also assist in fiscal monitoring and the contracting process for treatment programs.

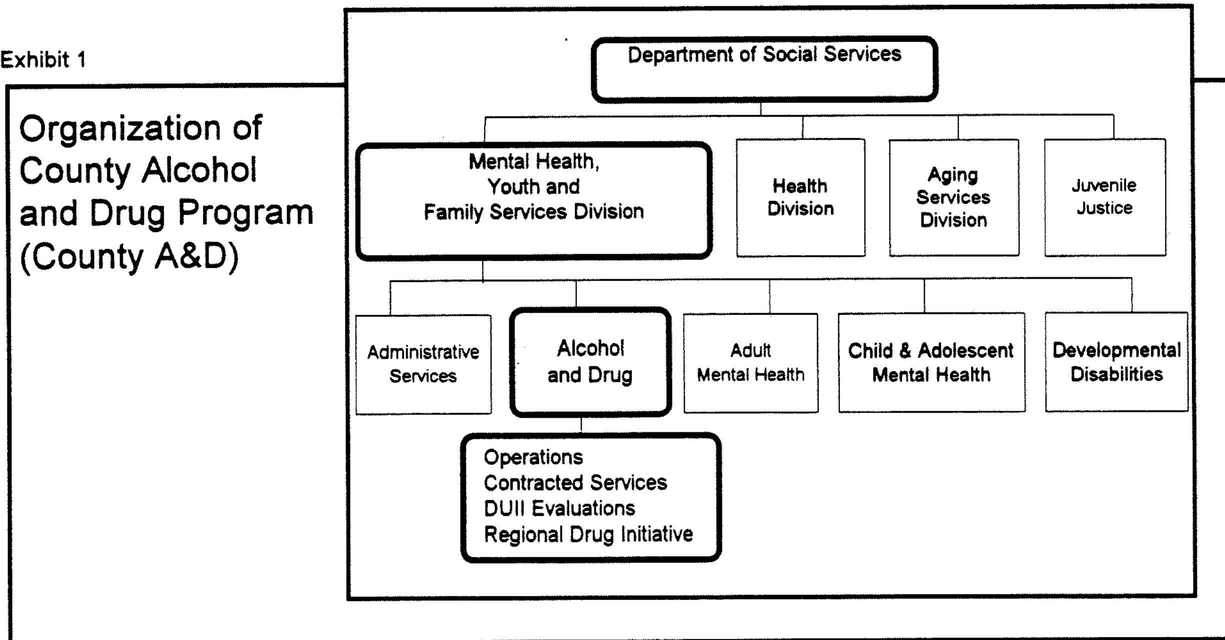


Exhibit 1

Organization of County Alcohol and Drug Program (County A&D)

Description of contracted services

Although some counties provide a mix of direct and contracted services, County A&D contracts for all its adult alcohol and drug services. County A&D currently contracts with a total of 20 agencies, the majority of which have provided these services for over 10 years. These contractors provide a variety of adult treatment services including Detoxification, Residential, Community Intensive Residential Treatment (CIRT), Methadone Maintenance, and Outpatient services. Below are definitions of these treatment services and the major contractors providing each type of service:

Detoxification Non-hospital residential alcohol and drug detoxification for persons acutely intoxicated or addicted. Clients receive medical supervision through the withdrawal episode to stabilize them for treatment or referral. Hooper Detoxification Center, operated by Central City Concern, is the only agency contracting to provide this service.

Residential

Structured residential setting for persons who are chemically dependent and in need of 24-hour supervision, alcohol and drug treatment and care.

Major Contractors:
- Addictions Recovery Association (ARA)
- Comprehensive Options for Drug Abusers (CODA)
- DePaul Treatment Centers (DePaul)
- Harmony House
- Native American Rehabilitation Association of the Northwest (NARA)
- Salvation Army Harbor Light Center (Harbor Light)

Community Intensive Residential Treatment (CIRT)

Highly structured 24-hour residential alcohol and drug treatment seven days per week for persons who need the most intense level of residential alcohol and drug treatment. Requires more hours of therapy, supervision and structured activities than non-intensive residential. DePaul is the only contractor providing this service.

Outpatient

Non-residential alcohol or drug assessment and treatment to persons who do not need 24-hour supervision for effective treatment of their alcohol or other drug abuse problem.

Major Contractors:
- Alcohol Safety Action Program (ASAP)
- Comprehensive Options for Drug Abusers (CODA)
- Counseling Intervention Programs (CIP)
- DePaul Treatment Centers (DePaul)
- Native American Rehabilitation Association of the Northwest (NARA)
- Project for Community Recovery (PCR)
- TASC of Oregon (TASC)
- Transition Projects, Inc. (TPI)

Methadone Maintenance

Non-residential assessment and treatment for persons with opiate (such as heroin) dependency. Clients receive daily dosages of the synthetic opiate, methadone, and rehabilitative counseling.

Major Contractors:
- Comprehensive Options for Drug Abusers (CODA)
- Allied Health Services for Drug Recovery (Allied)

There are differences in the characteristics of clients served by the contractors. For example, ARA serves pregnant women and women with young children exclusively. ASAP, DePaul, Hooper, and Harbor Light, TASC and Transition Projects serve mainly male clients, while Harmony House serves men exclusively. The typical client at ASAP, CIP, CODA, Harbor Light, Harmony House, and Hooper is Caucasian. NARA and PCR admit primarily Native Americans and African Americans, respectively. Harmony House and Hooper serve clients who are older (38-39 years) than average while ARA, ASAP, CODA and TASC typically serve younger clients (28-31 years). Most of the clients at ASAP and TASC are criminal justice referrals. Other demographic differences among the contractor clients are described in Appendix A.

The Client Process Management System (CPMS)

The primary source of information on clients served in Multnomah County's alcohol and drug treatment system is the State's Client Process Management System (CPMS). The CPMS system is operated by the State Mental Health and Developmental Disabilities Division (MHDDD). It was designed to meet the planning and management needs of both the State mental health, and alcohol and drug treatment systems.

CPMS is a centralized, mainframe-based system that was developed in the early 1970's. Contractors submit paper forms to the State with information on all clients receiving treatment, including demographics, service dates, and pre- and post- measures of treatment success. Data entry and report generation are handled centrally in Salem. MHDDD produces reports on utilization, client demographics, and program performance, on a regular basis. Utilization and performance reports are used by the State to monitor contract compliance on the number of clients served and program performance indicators.

Financing the treatment system

The financing of the alcohol and drug treatment system influences the services that are delivered through County A&D in at least three fundamental ways: by funding certain services and not others, by prioritizing service for certain categories of clients, and by setting minimum standards for the treatment that a client will receive.

Public expenditures for alcohol and drug treatment services for adults in Multnomah County were approximately $6.4 million in FY91-92. This amount excludes other alcohol and drug expenditures for prevention, youth, and sobering services which are outside the scope of this audit. The sources of these funds are displayed in Exhibit 2.

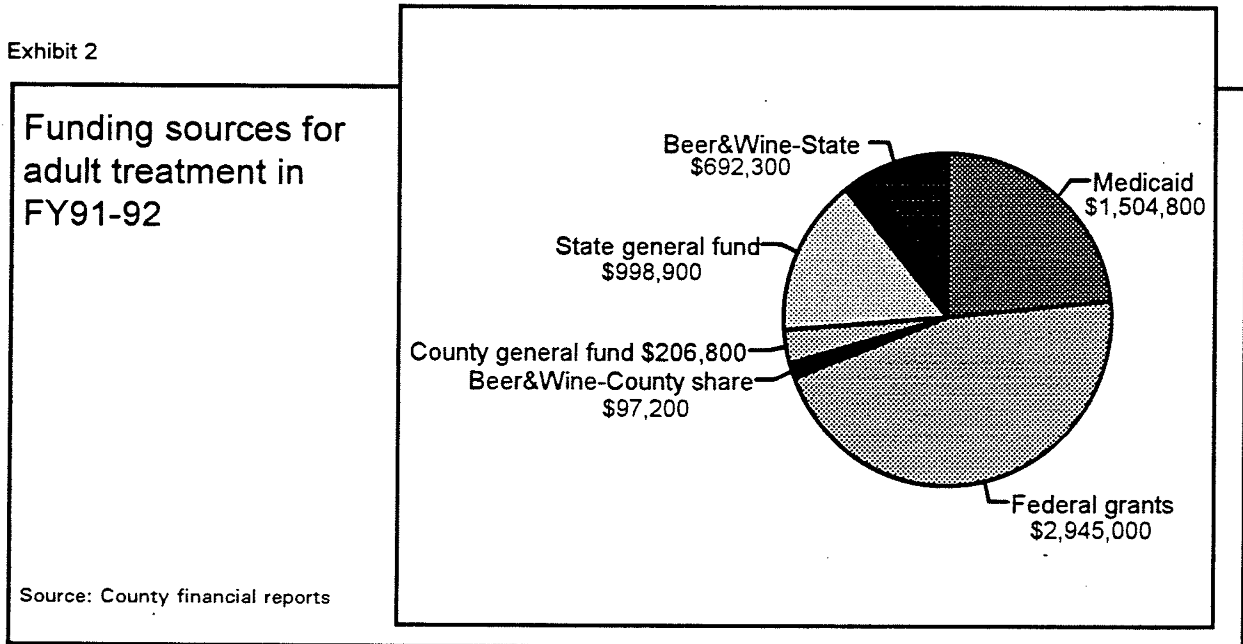
Roughly 72% of the funds supporting alcohol and drug treatment services for adults in Multnomah County are revenues which are administered by the State Office of Alcohol

and Drug Programs (the State) and allocated to County A&D in a biennial agreement. These funds include Federal block grant funds, a portion of beer and wine taxes, and state general funds. The State is responsible for configuring services to meet various restrictions of these funding sources.

Medicaid funds are the second largest percentage of adult treatment funding. In FY91-92, approximately 63% of Medicaid expenditures were paid with Federal funds with the other 37% "matched" with State funds.

Exhibit 2

Funding sources for adult treatment in FY91-92



Source: County financial reports

Discretionary spending of County A&D

County A&D receives a total of approximately $450,000 in beer and wine tax revenues per year which it has the discretion to use on alcohol and drug abuse prevention, early intervention and treatment services. County A&D used $97,200 of these funds to increase reimbursement rates for adult treatment. The remainder of these funds ($352,800) were spent on sobering services to manage public inebriates.

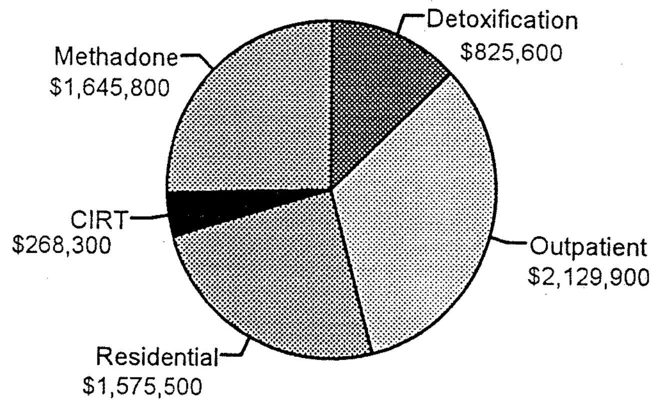
In addition, Multnomah County appropriated approximately $941,500 in County General Funds for alcohol and drug services in FY91-92. Of this amount, $206,807 was spent on adult treatment. The remaining amount was spent on sobering ($307,900), youth ($316,800), and other ($110,000) services.

Spending by type of treatment

The pie chart in Exhibit 3 illustrates the FY91-92 public expenditures for alcohol and drug treatment for adults by type of treatment.

Exhibit 3

Spending by type of adult treatment in FY91-92



Source: County financial reports

Payment mechanisms

Treatment services in County A&D are financed primarily through two different mechanisms. The primary payment mechanism is the State's "slot" system. Under this system, County A&D purchases treatment slots from its contractors. The number of purchased slots is established by contract and each contractor receives a monthly payment of one-twelfth of its slot allotment. For detoxification, CIRT, and residential services, one slot represents 365 days of treatment service. For alcohol and drug outpatient and methadone services one slot represents 12 months of client service which requires a minimum of one face-to-face contact per month in either individual or group type sessions.

Slot rates are set by the State and are not intended to cover the full cost of services. Other revenue sources such as the County A&D's discretionary beer and wine funds, contractor charitable contributions and client fees also contribute to the costs of alcohol and drug services. Slot rates have been annually adjusted for inflation. Rates for drug services are significantly higher than for alcohol services.

The second funding mechanism for adult treatment services in Multnomah County is Medicaid which operates on a fee-for-service basis. Within Federal guidelines, the State defines eligible categories of clients who are entitled to receive methadone and alcohol and drug outpatient services funded by Medicaid. Contractors bill the State Office of Medical Assistance Programs for specific services delivered to eligible clients, at rates set by the State. County A&D recommends providers to the State for Medicaid certification and maintains contracts with certified providers. Currently, all 14 of the

contractors receiving slot funding for outpatient and methadone services are Medicaid-certified. In addition, four contractors are Medicaid-certified, but do not receive slot funding.

Funding trends affecting service delivery

There has been a steady increase over the last five fiscal years in the level of Medicaid funds supporting adult treatment services in Multnomah County. Medicaid expenditures on adult treatment services were $280,500 in FY87-88 and were $1,504,800 in FY91-92. Approximately 70% of the increase from FY87-88 to FY91-92 is attributable to the increase in Medicaid billings for methadone services.

County A&D has shifted targeted funds from alcohol services to drug services, for both residential and outpatient services. Exhibit 4 below shows the shift in alcohol to drug services.

Exhibit 4

Alcohol and drug services: FY87-88 and FY91-92

	FY87-88			FY91-92		
	Alcohol	Drug	Total	Alcohol	Drug	Total
Residential						
% of Funds	61%	39%	100%	40%	60%	100%
# of Slots	97	43	140	78	85	163
Outpatient						
% of Funds	61%	39%	100%	42%	57%	100%
# of slots	598	279	877	436	388	824

Source: County financial reports and agency contracts

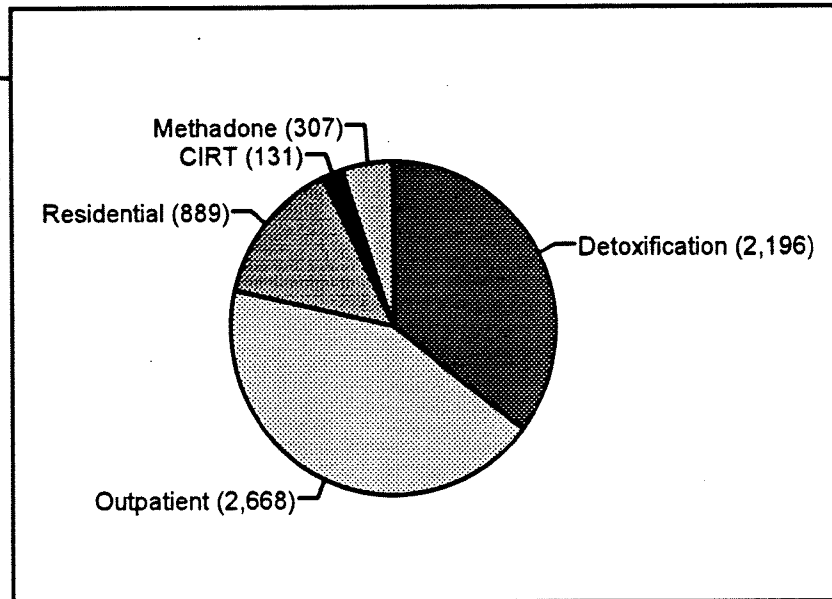
Over this period County A&D has made it a priority to increase service capacity for women and has converted "generic" slots to slots designated for women. In FY87-88 County A&D designated 88 treatment slots for women. In FY91-92, designated slots for women's treatment had increased by 111%, to 186. Much of this increase was due to expansions in the residential slots for pregnant women.

Clients admitted to treatment in FY91-92

A total of 4,915 clients were admitted at least once during FY91-92 to one of Multnomah County's adult treatment programs. These clients accounted for a total of 6,191 admissions, with some clients admitted more than once. Total admissions by type of treatment are summarized in Exhibit 5. Admissions to outpatient treatment and detoxification accounted for more than three-quarters of total admissions.

Exhibit 5

Admissions by type of treatment, FY91-92



Source: CPMS data for County

Two-thirds of the clients admitted to treatment in FY91-92 were men. The population of clients admitted to treatment was reflected in the cultural diversity of Multnomah County including Caucasian (66%), African Americans (20%), Native Americans (8%), and Hispanics (6%). The average age of clients admitted in FY91-92 was 34 years of age. The majority (58%) of clients had a high school degree. More than three-fourths (77%) were unemployed at admission. The most frequent marital status for clients admitted to alcohol and drug treatment was "never married" (44%), followed by "divorced or separated" (36%).

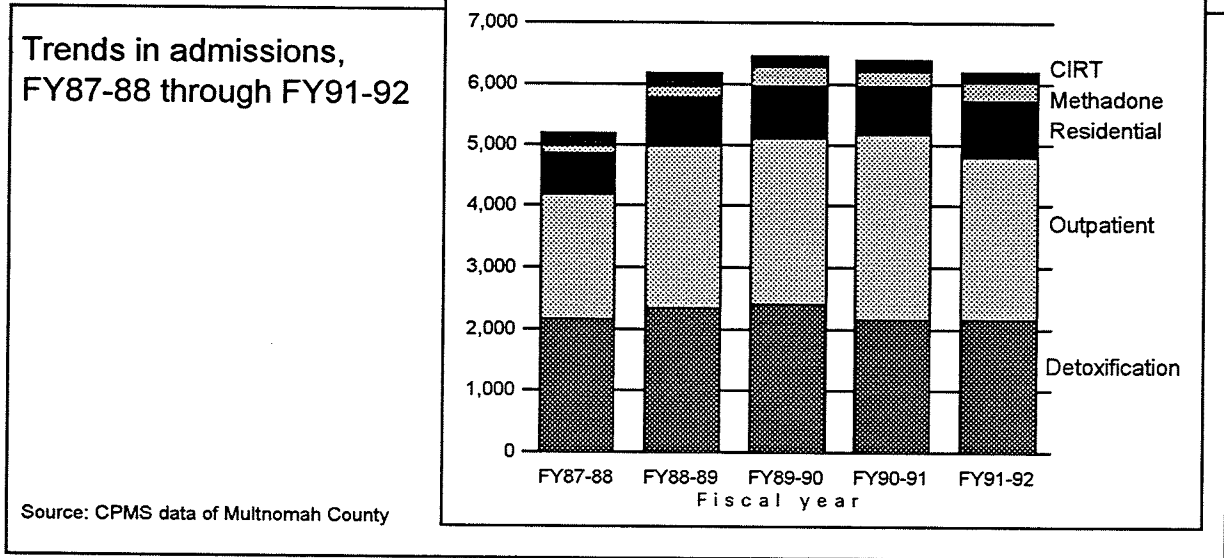
Alcohol was the primary substance abused for slightly less than half (47%) of all client admissions, followed by cocaine (19%), heroin (14%), and marijuana (9%). Just over half of all client admissions (51%) were multiple substance users who regularly use alcohol and one or more drug. Among the primary alcohol users, 68% were assessed at admission as chronic alcoholics. Among the primary drug users, 43% reported using drugs more than three times daily.

Trends in admissions

Trends in total admissions by type of treatment are presented below in Exhibit 6.

Exhibit 6

Trends in admissions, FY87-88 through FY91-92



Source: CPMS data of Multnomah County

Over the last five fiscal years total annual admissions to adult treatment programs increased by 19%. Admissions peaked in FY89-90 at 6,445 and have declined over the last two fiscal years, driven largely by declines in admissions to outpatient programs. Admissions to the CIRT program have been consistent over the last five-year period, while admissions to residential programs generally experienced steady increases over four of the last five fiscal years. Admissions to publicly-funded methadone programs have shown the largest relative increase (83%). Even with this increase, these clients made up only 5% of total adult treatment admissions in the last fiscal year.

The relative number of women in alcohol and drug treatment has increased very gradually over the past five years. Women accounted for the highest percentage of admissions to methadone programs in FY91-92 (56%). They were least represented in admissions to detoxification where they made up 20% of admissions in that year.

Minority client admissions over the last five fiscal years increased by 54%, compared to a 15% increase in non-minority clients. During the same period the number of minority designated slots increased by only 3%. Increases in minority admissions have not been consistent across all race/ethnic groups. For example, the number of Native Americans admitted to County A&D programs has decreased over the last two fiscal years.

Another notable trend is the steady decline in clients who primarily abuse alcohol, from 60% of all admissions in FY87-88 to 47% in FY91-92. During this period, primary drug users increased from 1,546 in FY87-88 to 2,587 in FY91-92. Increases have been greatest in the number of clients using marijuana or cocaine as their primary drug of choice. Admissions of clients who primarily use heroin declined in the past two years although admissions in FY91-92 are still 36% higher than five years ago.

There have been steady and significant increases in the proportions of clients using multiple substances. These increases are consistent with the national literature and anecdotal reports of County contractors who indicate that the resulting population is more costly and difficult to treat. The percentage admitted for alcohol-abuse-only has declined from 43% to 26% over the last five fiscal years, while the percentage admitted for problems with alcohol and one or more drugs has increased from 35% to 51%. Not only are clients using multiple drugs, they are also using drugs with increasing frequency. For example, in FY87-88 only 20% of clients with a primary drug problem reported using a drug more than three times daily. In FY91-92 about 43% reported this level of drug use.

There have been several significant shifts in the referrals that are reported upon admission to alcohol and drug treatment in Multnomah County. Fewer clients are referring themselves to treatment over the last three years, however, self-referrals remain the most common referral source in each year. Criminal justice referrals reported at admission, including referrals from courts and corrections, have risen steadily from 843 in FY87-88 to 1,538 in FY91-92. They accounted for one-quarter of total client referrals in FY91-92. While referrals from the Children's Services Division have increased, referrals from other State Department of Human Resources agencies have declined. Reported referrals at admission from outpatient programs to other treatment types show increases, while referrals from residential and detox programs have seen significant declines over the last two fiscal years.

Methodology

We interviewed managers and staff from County A&D, the Department of Social Services, the State Office of Alcohol and Drug Abuse Programs, and the Federal Department of Health and Human Services. Agency directors and counselors of several contractors were also interviewed. We reviewed budget documents, related audit reports, the County's Biennial Plans for Alcohol and Drug Abuse services, and the State's Alcohol and Drug Abuse plan for FY91-92.

State laws and administrative rules relating to drug and alcohol funding and services were also reviewed. We reviewed professional literature on contracting, treatment costs and effectiveness of alcohol and drug programs. A selected bibliography is listed in Appendix B. We attended several monthly meetings of the County's planning body, the Multnomah Council on Chemical Dependency (MCCD), and the State's Alcohol and Drug Management Issues Group.

We obtained and analyzed computerized client enrollment records extracted from the State's Client Process Management Information System (CPMS). Data files obtained contained approximately 31,000 records on clients enrolled in an alcohol or drug treatment program for adults in Multnomah County between July 1, 1987 and June 30, 1992. This database was used to describe trends in clients served, assess utilization, calculate unit costs and client outcome measures, conduct multi-variate analyses of client outcomes, and analyze client treatment experiences and utilization patterns across the five-year period. Client files were reviewed at three outpatient programs to verify enrollment data in the State's CPMS system. We reviewed the State's quality control procedures used to identify and correct errors in data submitted and entered. We also obtained computerized client records on all clients in FY91-92 from the internal data systems of three of the largest contractors (ASAP, CODA and DePaul). These files were matched against our CPMS data to assess data reliability. We describe in the report the reliability of the records as they related to our findings.

We distributed a survey to selected contracting agencies to collect comparative program information on staffing, costs, and treatment policies and procedures. We used financial reports sent by contractors to the County and developed some assurances that cost information was accurate by verifying financial data to County records and to the contractor's audited financial statements. In some cases, where noted in the report, reliable financial information was not available from contractors.

CPMS data was used to estimate utilization levels for all outpatient and methadone services, taking into account the number of Medicaid eligible clients. For these programs we also matched Medicaid billing records obtained from the State Office of Medical Assistance and Community Corrections automated files with CPMS client enrollment records.

We obtained program information on alcohol and drug treatment programs in the following counties nationally: Baltimore County, Maryland; Hennepin County, Minnesota; King County, Washington; Milwaukee County, Wisconsin; and

Sacramento County, California. We also obtained program information from Clackamas, Jackson, Lane, Marion, and Washington Counties in Oregon.

This audit was conducted in accordance with generally accepted government auditing standards, except for the new requirement for periodic external quality control review. This office will have its new procedures reviewed by the National Association of Local Government Auditors for compliance with audit standards in 1993.

CHAPTER ONE

Improve management of the treatment system

Treatment system goals

Oregon statutes set forth several goals for State-funded alcohol and drug treatment systems. Treatment should be offered in the least costly and most efficient setting. A variety of treatment services should be offered, recognizing that no single approach may be suitable to every person. The treatment system should allow persons recovering from alcohol and drug abuse to lead productive lives and to reduce their reliance on treatment.

At the County level the Division of Mental Health, Youth and Family Services sets goals for units within the Division. Programs should anticipate, plan, and advocate for service needs; provide and assure provision of quality service; select the most qualified contractors and assure accountability through effective contract management and monitoring.

More planning needed

One management responsibility of County A&D is to ensure the planning for necessary services and how they should be delivered. The Board of Commissioners must approve any plan that is developed.

County A&D staff works with the Multnomah Council on Chemical Dependency (MCCD) to plan County treatment services. Voluntary MCCD members are appointed by the County Board of Commissioners and serve in an advisory capacity on all alcohol and drug issues. MCCD also meets a statutory requirement that the County utilize a local planning committee to identify the needs of the community and any gaps in service, and to set service priorities. MCCD recommendations are included in a biennial implementation plan required by the State.

We reviewed the minutes of MCCD meetings and other documents from County A&D to determine the scope of planning in the County. In the past three years MCCD has twice decided to assess the overall effectiveness of the alcohol and drug treatment system. In both cases, the MCCD set agendas for future meetings that would guide the planning process. In reviewing minutes subsequent to those decisions, it appeared that the MCCD agendas were not followed. Work was not completed to relate findings on community

needs to the types of services that should be provided in the County, how much should be provided of each type, or which programs are most cost-effective. MCCD is currently modifying its purpose and its structure which may allow it to address broader issues in the future.

In 1991, the County A&D manager proposed that the County develop an integrated and coordinated treatment delivery system. The proposal stated that system effectiveness could only be improved if there was feedback from the evaluation of outcomes. This proposal also included a recommendation that the County should be responsible for actively ensuring the appropriateness of service delivery, specifying outcome expectations and monitoring the levels of service delivery. Program staff and management indicated that this proposal has never been implemented.

The County A&D manager has initiated several successful planning processes which have resulted in added services for culturally diverse populations and women. However, planning to date has not addressed the effectiveness of contractors in meeting the system-wide goals of the community. Most documents we reviewed, whether completed by County A&D or MCCD, only addressed additions to the existing services provided by contractors, or to specialty populations. These documents did not evaluate the effectiveness of existing services.

We found examples of other counties which do utilize a comprehensive planning process to address system-wide questions and regularly review the existing system of service delivery. Marion County developed a three-year plan, which exceeded the State planning requirement. This plan took a broad look at the service system and set goals for the County. Marion County also utilizes its planning committee members to set the criteria for selecting its contractors.

Contracting for services

The goals for the treatment system should be reflected in the type and amount of service that the County provides through its contracts. Contractor selection, therefore, should be based upon the variety of services that are needed in the population, relative contractor costs, the range of programs that will be most conducive to client recovery, and the prior performance history of the contractors.

During the contract selection process, contractors describe their intake and placement procedures and the service that will be delivered. Decisions to select contractors are made by an evaluation committee. The evaluation committee is told the maximum amount of points that a contractor can receive for each category of information it has supplied to the County. The criteria used to evaluate the contractor's proposal are based upon the judgment of the individual committee members who are selected for their

expertise in the type of treatment under bid. Data such as a contractor's past performance or costs are not used in the selection process.

County A&D has no contract specifications for what might be acceptable or unsatisfactory proposals. The requests for proposals do not specify what treatment is appropriate for specific client types or the level of service that should be delivered. County A&D relies on the clinical expertise of the contractors to determine appropriate services. One drawback of such an approach is that County A&D has only a limited ability to coordinate or direct the level of service and who will be served in the treatment system.

Specifications for human services contracts can be difficult to develop, but contracting literature states that specifications are more critical in contracting situations where there is little or no competition. Although County A&D has attempted to make the contracting process competitive, there is little competition among organizations. County A&D solicits competitive proposals to provide treatment services at least every five years, but receives few proposals. We found only three cases of apparent competition among contractors. As a result, many of the current contractors have provided treatment services for County A&D for over 10 years. Organizations that provide the treatment for private pay clients have not bid for County contracts throughout the years.

Without a competitive market, treatment dollars cannot be easily redirected to another contractor when problems arise. If County A&D has to terminate a contract, treatment services for clients are likely to be interrupted until another organization can be found to provide the services. In these circumstances, County A&D often finds itself dependent on a particular contractor to provide services. In many cases contractors are also dependent upon the County to pay for a major part of their operations.

This situation is common in social services contracting. Other jurisdictions also have a limited amount of competition, specialized services, and use a mix of public and private money to increase system resources. According to contracting literature, this type of contracting environment calls for a "partnership approach" to contracting. In contrast, a "market approach" is characterized by a fully funded service and an adequate number of organizations to create a competitive environment. Without competition to foster quality service, the use of other mechanisms become more important, such as specifying services and monitoring contractor efforts.

Improvements needed in contractor monitoring

Monitoring contracted programs is an important management function to assure that quality services are delivered and that public funds are used in the most effective manner possible. The agreement between the State and County recognizes a joint responsibility for monitoring service performance but holds County A&D responsible for monitoring

services provided by its contractors to ensure that the services conform to State standards.

Monitoring by the State is accomplished through several mechanisms. On-site reviews are completed every two years to assure compliance with administrative rules. Performance indicators developed by the State are reported. An accounting of how many clients a program serves is tracked. The State requires corrective action by a contractor if a there is a lack of compliance with administrative rules or the program has served fewer than the number required by the State for three consecutive months.

While contractors are required to achieve a set number out of the total performance standards (for example, 5 out of 9), until recently no action was taken if standards were not acheived. The State currently requires an action plan from the contractor when performance is not adequate and will remove funding after three months of below adequate performance.

County A&D performs two types of monitoring of contractors. Program monitoring is performed by County A&D staff. Fiscal monitoring is performed by the administrative unit of the Mental Health, Youth and Family Services Division.

We found that County A&D performs a narrow scope of program monitoring, duplicating some State activities and performing other activities in a minimal way. County A&D does not systematically and uniformly monitor the types of clients served or contractor performance. County A&D monitors contractor performance in less formal ways. The County A&D manager stated that issues are raised in their contacts with referral sources and during general discussions with contractors. When these problems are identified, County A&D staff work with the contractor to ensure that they are resolved.

County A&D program monitoring consists of assisting the State in completing biennial site reviews of contractors, tracking problems identified in the reviews, and providing the State with reports on contractor compliance with the review recommendations. County A&D also reviews the reliability of information about Medicaid-funded services. However, County A&D has not regularly validated the number of clients served and relies on contractors to report accurately. In response to this audit County A&D began verifying the number of clients served by each contractor.

County A&D developed a form that could improve monitoring results if it were used consistently. This form identifies 12 monitoring areas, including monthly utilization rates, client complaints, performance indicators, and financial and contract compliance problems. Prior to FY91-92 County A&D had monitored many of the 12 areas in the form, although not consistently. In FY91-92 the monitoring forms indicated that

contractor activities, performance indicators, client demographics, and many other indicators were no longer being monitored.

Because of delays in receiving information from the State, County A&D has historically required contractors to submit a report on the number of clients served each month, which duplicates the State's CPMS reporting process. County A&D discontinued this requirement for a year when they believed that they could rely on State generated reports to determine whether utilization requirements had been met. County A&D again implemented direct reporting when the State was unable to provide CPMS reports in a timely manner. Although these efforts were necessary to provide County A&D with timely information, it represents inefficient use of resources and an additional reporting burden to contractors. As a result of this audit the State is modifying its procedures in an effort to produce more timely reports.

The level of fiscal monitoring performed by the County Division of Mental Health, Youth, and Family Services is more uniform and systematic than the program monitoring done by County A&D. A variety of financial reports are collected including monthly contractor expenditure reports as well as quarterly reports that compare actual to budgeted expenditures. Audited financial statements are collected and analyzed. On-site visits of contracted agencies are generally conducted annually and result in a written report to the contractor's executive director and chairman of the board of directors.

However, fiscal monitoring is not fully integrated with program monitoring or used as effectively as it could be. While County A&D staff may be aware that these contract and financial compliance reviews are completed, information is not routinely incorporated into program monitoring activities. As a result, the fiscal information of the contractors is not linked to the quality of service that is provided.

Rather than monitoring all contractors at a detailed level, County A&D staff resources can be selectively allocated. All contractors can be monitored for key administrative, fiscal, and program indicators. These indicators could serve as an early warning system to identify contractors who may require more detailed monitoring. Some indicators could be: age of the organization or contracted service; the degree to which the contractor relies upon State and County funds; counselor turnover rates; recent turnover of the executive or fiscal director; low fund balances; whether the contractor is regularly achieving utilization levels and performance indicators; and, whether the contractor received an adverse comments from external financial auditors. Several of these indicators are already gathered by the Mental Health, Youth, and Family Services Division. When several indicators of a contractor show problems, County A&D could increase monitoring of the quality and quantity of services provided by that contractor.

CPMS information not used effectively

Management has a responsibility to gather the best information possible and to use it in planning, contracting, and monitoring program effectiveness. Currently, the most comprehensive source of information on clients in the treatment system is the State's Client Process Management System (CPMS).

County A&D and contractors all agree that lack of control over the content and timeliness of data reports is a major problem. Reports on the numbers of clients served in a program and quarterly reports on client characteristics may not be received until three months following the ending date of the report. County A&D receives a large quantity of information from the State on the clients that contractors are serving, but must manually compile statistics that report on the system as a whole. Additional reports or special information requests require extensive programming and compete with other requests for information by State mental health managers and providers.

County A&D stresses that their ability to review and utilize CPMS data would be enhanced if they had direct access to the database from their own office. We found that County A&D has been authorized direct access to CPMS data. Despite some initial concerns about the confidentiality of client records, the State approved County A&D's request for data access in the summer of 1991. At that time County A&D had purchased a computer, installed necessary software and trained one of their staff in accessing the database. The system was never actually used because the responsible staff person left and the position has never been replaced.

County A&D could use CPMS information as a means to systematically review contractor performance both over time and comparatively to other contractors. It would provide County A&D with an objective basis to examine both system and contractor outcomes. Further, by holding contractors accountable with data, the importance and likelihood of accurate data reporting is improved. Chapter Two analyzes one CPMS performance measure and provides examples of some issues and indicators that could be tracked to improve the treatment system in Multnomah County.

Reimbursement system lacks accountability

Management has the responsiblity to ensure that resources are used consistent with laws, regulations, and policies and that they are safeguarded against misuse and waste. Management's ability to maintain accountability is largely dependent upon the design of its funding mechanisms.

The treatment system in Multnomah County is largely financed by State slot funds, Federal Medicaid funds, County Department of Community Corrections funds, and other contractor sources such as client fees and charitable contributions. The Federal, State,

and County reimbursement systems each have their own procedures and regulations. The Medicaid reimbursement system is an entitlement system and is based upon the payment of fees for specific services that a client receives. The slot funding system was designed by the State and, like Medicaid, any modifications to the system are outside the direct control of County management. The County receives State funds which are paid to a contractor for serving a specific number of clients at any point in time. Community Corrections operates a reimbursement system based upon a minimum number of clients to be served and a maximum length of client service.

The design of the slot system and the commingling of Federal, State, County, and contractor dollars makes it difficult for County A&D to determine whether funds are used to meet the goals of the treatment system. For example, a contractor only needs to see a client one time in a month to be reimbursed for an outpatient slot. The level or quality of that service remains undefined. According to the agreement between the County and the State, County A&D cannot require additional performance standards from contractors unless they are negotiated with the contractors and approved by the State. In addition, when contractors receive multiple sources of funding it becomes difficult to distinguish the services contracted by each source to ensure there is a full return on spending. Chapter Three of this audit analyzes this issue in more detail.

Need for more corrective action

Management principles and Division policy require that the County know what it wants to accomplish, checks to see if progress is made, and adjusts when lack of accomplishment is detected. However, the gaps we found in planning, contract monitoring, and use of CPMS information reduce the likelihood that corrective action will be successful. County A&D has not developed clear and specific expectations for the contractors or the treatment system and has not assessed the progress of contractors toward goals. Without these management functions in place, the quality and availability of treatment in Multnomah County can decline, and costs can increase.

County A&D relies upon more than 20 contractors to provide treatment services in the community. The large number makes it difficult to adequately monitor and effectively intervene when problems are detected. Some of the more difficult problems, often caused by administrative or fiscal weaknesses, can also require large amounts of staff time. Further, there is currently an informal policy in the County to avoid direct involvement in the management issues of contractors. According to County Counsel, the County increases its risk of legal liability if it becomes too involved in the day-to-day operations of contractors.

During the course of our audit we found evidence of intervention strategies in place that, if strengthened, could improve the current contracting system. County A&D has

provided some technical assistance to contractors. For example, County A&D provides assistance with Medicaid regulations and reporting and assists programs when specific problems, such as under-utilization, have been identified. However, technical assistance for financial and administrative problems could be provided when monitoring indicates that these problems are threatening the quality of services.

When there are indications of persistent problems with contractors, County A&D could call upon the resources of the contractor's board of directors to assist in resolving the concern. Each contractor has a board of directors which establishes policy and provides oversight for the non-profit organization. Board members have knowledge of the organization and the authority to develop a set of specific measures to address problems. This approach could allow them to take a more active role. County A&D provides written reports to a contractor's board after a review for fiscal and contract compliance. It has also contacted the board when problems have been identified, but these efforts have not been consistent or formalized to date.

Allocation of County A&D staff resources

According to the County A&D Manager, about 50% of staff time is allocated to "core" activities which she defined as managing the RFP process, contract development and amendment, on-site review and monitoring, performance monitoring, and biennial planning. Core activities are clearly linked to the statutory goals of the County A&D program. In fact, these activities are very close to the Division's statement of how the mission is to be accomplished.

The remainder of staff time is spent on "programmatic" activities. These activities include participation in several contractor networks dealing with special populations such as youth, cultural diversity, women, and the homeless which are intended to bring increased effectiveness to the system. County staff also organize quarterly training for contractor staff, and participate in task forces, committees, and advisory groups. Staff work collaboratively with different groups to achieve new program development or enhancement.

The balance of staff efforts between programmatic and core activities should relate to the needs in the treatment system. Core activities are fundamental to agency goals and are a foremost concern. When services are being provided in an efficient and effective manner, more staff time can be devoted to enhancing services through programmatic efforts. Programmatic activities are also an important element in a treatment system, addressing special needs and opportunities for improvement. However, core activities appear to be a higher priority for the allocation of staff time.

In FY91-92 County A&D reduced its efforts in the core area by eliminating a position responsible for data analysis and on-site review. These responsibilities were eliminated to create a supervisory position in another program. The County A&D manager explained that a supervisor was needed for the case management program for persons convicted of driving under the influence of intoxicants, and other direct client evaluation and service referrals.

RECOMMENDATIONS

The Multnomah County alcohol and drug treatment system can be improved through increased management by County A&D. Additional emphasis and efforts are needed in planning services, selecting contractors, monitoring contractor performance, and responding to identified problems.

To better allocate limited staff resources, County A&D should:

- Consider allocating more of current staff resources to the core functions of managing the contracting process, on-site review and monitoring of contractors, and biennial planning.

- Better coordinate program monitoring with the fiscal monitoring performed by administrative staff in the Mental Health, Youth, and Family Services Division.

- Further develop and monitor key fiscal and program indicators which could serve as an early warning system of possible contractor problems.

- Provide earlier, more intensive technical assistance to resolve identified problems that endanger the quality of contracted alcohol and drug services. When problems persist or worsen, County A&D should call upon contractors' boards of directors for assistance.

- Work with the State to better define their roles and responsibilities in monitoring contracted services and intervening when problems are identified.

To ensure that the alcohol and drug treatment system provides appropriate and cost-effective services to Multnomah County clients, County A&D should:

- Work with the Multnomah Council on Chemical Dependency to develop a comprehensive plan for Multnomah County. The plan should utilize available information such as treatment cost, usage, and success data to recommend the most appropriate mix of services.

- Modify the contracting process to incorporate the needs identified in the comprehensive plan and the relative costs and performance of contractors.

CHAPTER TWO

Treatment system improvements can reduce costs and increase client recovery rates

Measuring client success

The State currently monitors 13 performance indicators that measure client outcomes. These indicators are typically used in research evaluations of treatment effectiveness. Original development of program performance indicators and standards was a collaborative effort between the State and contractors. Contractors report performance indicator data to the State which calculates quarterly performance rates for each contractor and for each type of treatment delivered. Contractors are required to meet minimum standards for more than half of the indicators in order to be considered in compliance.

To illustrate how County A&D might assess the effectiveness of its alcohol and drug treatment programs, we analyzed one of these performance indicators: the percentage of County clients successfully completing treatment. We used a database extracted from the State's CPMS system for this analysis. In order to be reported as a treatment success under the CPMS system, a client must have completed the program, been drug-free for 30 days prior to discharge, and achieved at least two-thirds of treatment goals.

We selected this measure because many of the other performance indicators relating to arrests, employment, and educational advancement rely on client reporting or other agency records, and may not be as reliable. The contractors are in a good position to accurately assess whether a client completed treatment. Further, research indicates that treatment completion is correlated with post-discharge outcomes. In 1987, the State contracted with the Research Triangle Institute (RTI) to conduct a longitudinal study of clients treated in 17 programs statewide. The study found that several client benefits were enhanced by treatment completion.

Use of treatment completion as an indicator of client success does have some limitations. Measures of client success over a longer tracking period would provide a better means to evaluate program effectiveness. Neither the State nor the County have conducted post-discharge evaluations since the RTI study. Long-term measures are more costly to obtain but could be collected on a sample basis in the future to provide stronger evaluation data.

In its recent evaluation of the State's treatment system, the National Center for Substance Abuse Treatment also recommends that post-treatment follow-up research be conducted more regularly.

Successful completion rates are affected by the clients who are included in the evaluation. For example, the County's Community Corrections program excludes from its calculations clients who fail to engage in treatment. The State's methodology for calculating successful completion rates excludes clients terminated for "neutral" reasons, including those who were inappropriate for further treatment.[1] Our completion rates were calculated using the State's methodology since it is the contract performance standard which contractors are currently required to meet.

To assess the accuracy of the CPMS database used to measure contractor performance in the audit, we reviewed the State's quality-control procedures for data entry and compared our CPMS data to automated client data for FY91-92 from three of the largest contractors, ASAP, CODA, and DePaul. We found that the State MHDDD uses a variety of automated edits to minimize entry of erroneous data. We found high levels of client match between CPMS and the agency databases we analyzed, ranging from 93% to 98%. We also found 5% or less disagreement on demographic and termination data between the CPMS database and the contractor databases. A more detailed discussion of our assessment of the CPMS system is attached as Appendix B.

Although contractors are responsible for submitting accurate and complete CPMS data to the State, they cited a number of shortcomings of the CPMS system including unreliable utilization and performance reports, design errors, and inconsistent reporting among contractors. Apparent discrepancies between CPMS reports and contractors' internal data reports may have resulted from confusion about how CPMS summary reports are generated. For example, we found that CPMS report labels did not adequately distinguish whether reports were based on newly admitted clients or all clients served. The system design error cited by the contractors is that CPMS tracks only one referral although some clients receive multiple referrals.

Contractors also cited inconsistencies in reporting when clients are enrolled on CPMS and in reporting client outcomes. Although standards for CPMS reporting are described in the State's training materials and contractors receive technical assistance from the MHDDD Data Processing User Support Unit, enhanced training efforts could improve reporting consistency by the large number of contractors who support the CPMS system.

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[1]The following categories of termination are excluded: clients who moved, were inappropriate for further treatment, could not get to the facility, could not come in during treatment hours, were deceased, were terminated due to program cuts, or were terminated due to physical or mental illness.

Overall County performance meets State standards

Our analysis of the CPMS data indicates that successful completion rates in the County's residential alcohol and drug programs have generally met or exceeded the State standards for this indicator over the last five years. In contrast, completion rates in the Community Intensive Residential Treatment (CIRT) program, and in the outpatient alcohol and drug programs have been inconsistent. Completion rates in the CIRT program failed to meet the State standard in four of the five years examined. This program met the standard in FY91-92. Completion rates in outpatient alcohol programs have declined and failed to meet standards in the last two fiscal years. Completion rates in outpatient drug programs were below State standard in the first two years but exceeded the State standard in the last three fiscal years. Although the County rate for outpatient drug programs fell below the statewide average for FY91-92, completion rates for all other types of treatment were at or above the statewide average.

Completion rates for alcohol programs in Multnomah County are higher than those for drug programs. This is consistent with studies in other communities which conclude that drug abusers are generally more difficult to treat than alcohol abusers. These rates for the past five fiscal years and State standards for each of the major types of treatment are presented below in Exhibit 7.

Exhibit 7

Percent of clients successfully terminated

Type of Treatment	State Standard	87-88	88-89	89-90	90-91	91-92	Statewide Average 91-92
Residential/ Alcohol	55%	59%	65%	67%	66%	75%	64%
Residential/ Drug	30%	36%	32%	30%	53%	54%	54%
CIRT	60%	55%	56%	43%	57%	72%	71%
Outpatient/ Alcohol	50%	53%	58%	53%	45%	43%	38%
Outpatient/ Drug	30%	22%	25%	33%	34%	34%	39%

Source: Calculated from CPMS data. Averages from State.

The County's overall successful completion rate was 46% during FY91-92 for all treatment programs, excluding detox and methadone maintenance. This rate falls within the range of completion rates in other jurisdictions we contacted which monitor treatment

completion. For example, current treatment completion rates in Baltimore County, Maryland and Hennepin County, Minnesota were 42% and 50%, respectively.

The contractors would like to see the State standards re-examined. Although the County has generally met the standard for the indicator we analyzed, the State standards were arrived at by consensus between the State and contractors in the mid-70's and have not been adjusted since then to take into account changing client populations. Nor have the standards been validated through research on long-term outcomes.

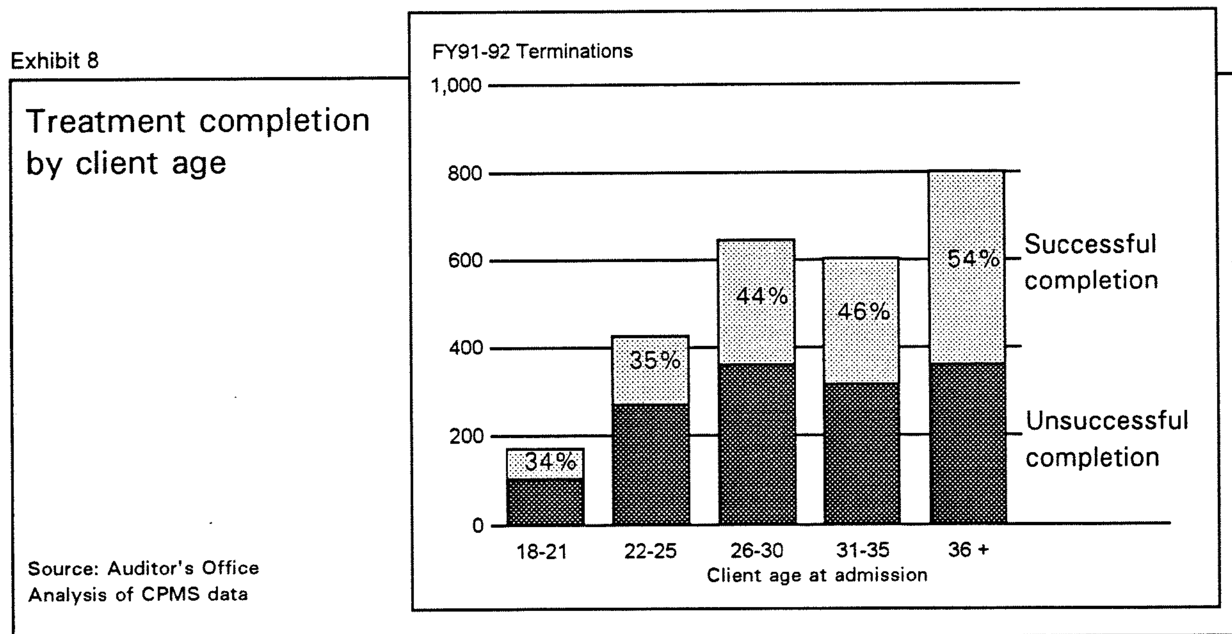
Outcomes vary by client group

County A&D has not attempted to evaluate whether programs designed to meet the special needs of client populations such as women, and young adult addicts and alcoholics, have shown improvement in completion rates. We found significant variations of success among these populations which may have implications for treatment.

The most significant differences in outcomes surfaced in our analysis by age of client. Across each of the treatment types, the rates of successfully completing treatment and being substance-free at termination increased significantly with age. Exhibit 8 below shows the overall completion rates for different aged clients in FY91-92.

Exhibit 8

Treatment completion by client age



Source: Auditor's Office Analysis of CPMS data

In general, we found that women were slightly less likely than men to successfully complete treatment and to be substance-free at discharge for most treatment types. The exception was that women were more likely than men to successfully complete CIRT

programs. We found no consistent differences in treatment success of minority and non-minority clients.

Some treatments appear to be more cost-effective than others

Our analysis of currently available CPMS data and expenditure data reported by the contractors suggests that treatment success is not always related to treatment costs. That is, the types of treatment with higher successful completion rates may not be more costly than those that are less successful. County A&D and most contractors have not attempted to calculate the current cost of treatment services in Multnomah County. The table below compares client outcome measures for each type of treatment for FY91-92 with our estimates of costs per client admitted to treatment and costs per client successfully completed.

Costs were calculated based on contractor-reported expenditure data and audited financial statements when available. Costs for alcohol versus drug outpatient treatment could not be segregated reliably. Costs include revenues from all sources including slot funds, Medicaid reimbursements, grants, client fees, and charitable donations. Costs do not include in-kind contributions or volunteer labor. Unit costs were estimated based on CPMS data on client service.

Exhibit 9

Outcomes and costs by type of treatment FY91-92

Cost per admission: Expenditures for FY91-92 divided by number of clients admitted.

Cost per completion: Expenditures for FY91-92 divided by clients successfully terminated

Type of Treatment	Successful Completion Rate	Cost per Admission	Cost per Completion
Residential/ Alcohol	75%	$2,356	$3,050
CIRT	72%	$3,423	$6,315
Residential/ Drug	54%	$4,246	$8,796
Outpatient/ Alcohol and Drug	37%	$970	$3,733

Source: Contractor financial reports and CPMS data

When gauged by their cost per client successfully terminated, the County's CIRT program appears less costly than its residential drug programs. Although their success rates are

significantly lower, outpatient programs appear to be relatively more cost-effective than CIRT or residential drug programs, given the number of clients who complete treatment successfully.

Although the more costly residential and CIRT treatment is needed by some clients, County A&D has not attempted to evaluate the current mix of treatment capacity relative to client needs and costs. Furthermore, there is no mechanism in the current system to insure that residential treatment is utilized for the clients for whom it is most appropriate and most likely to be successful.

Another issue related to the cost-effectiveness of residential treatment and unexamined by County A&D is the variability in length of treatment. Length of treatment in residential programs is largely determined by the contractors. During FY91-92 the average stay in treatment for the County's publicly-funded residential programs was 10.5 weeks.

Research findings on the correlation between residential treatment duration and outcomes have been mixed. Positive correlations between treatment length and favorable short-term outcomes have been reported in many of the early studies on the effectiveness of alcohol and drug treatment. The Manager of State A&D believes that length of stay is one of the best predictors of treatment success, based on these early studies, evaluations of treatment programs in Oregon prisons, and selected case histories of Oregon clients. However, such studies fail to take into account pre-treatment differences between clients. More recent controlled studies in which clients are randomly assigned to residential treatments of different lengths have found no differences in outcomes related to treatment duration. Shorter treatment duration could increase the number of clients served in the limited slots of the residential programs.

Completion rates vary among contractors

We found that successful completion rates for FY91-92 varied significantly among contractors providing the same service. Some of the measured differences in contractor outcomes could be because they serve different types of clients. Our analysis of FY91-92 admissions did show that the clients served by different contractors varied on demographics, income level, type and severity of substance abused, and community support available.

We conducted multivariate analyses to determine whether differences in the characteristics of clients served could account for differences in client outcomes by contractor. We estimated separate equations for CIRT, residential drug, residential alcohol, outpatient drug, and outpatient alcohol programs, to hold constant the effects of gender, race/ethnicity, age, employment, education, intravenous drug use, and the number of prior treatment episodes. Even after controlling for these differences in client

characteristics and length of treatment, most differences between contractor success rates remained statistically significant. Overall, the amount of variation in outcomes that could be explained by these client characteristics tracked on the CPMS system was relatively low, less than 5%. Inconsistent reporting practices among the contractors may contribute to some of the variances. There may also be other client variables that are not tracked on CPMS which could explain some of the variation in outcomes.

Successful completion rates for the County's residential and outpatient programs are presented in Exhibit 10 below. The exhibit also includes the average number of contracted treatment slots for each contractor during FY 91-92.

Exhibit 10

Completion success rates by contractor in FY91-92

Type of Treatment	Contractor	Completion Rate	Number Discharged*	Slots
Residential Alcohol	Harbor Light	89%	122	13
	DePaul	85%	40	24
	Harmony House	76%	49	11
	NARA	65%	150	26
	ARA	48%	21	7
Residential Drug	Harmony House	79%	14	3
	Harbor Light	69%	49	2
	DePaul	66%	71	7
	ARA	60%	164	35
	CODA	31%	122	34
	NARA	20%	5	8
Outpatient Alcohol	DePaul	68%	44	37
	ASAP	52%	145	61
	TPI	44%	81	120
	TASC	43%	40	26
	CIP	42%	128	20
	PCR	41%	32	99
	NARA	35%	95	72
	CODA	25%	65	4
Outpatient Drug	DePaul	62%	50	21
	ASAP	53%	202	75
	TASC	43%	171	50
	PCR	36%	89	80
	TPI	35%	54	36
	NARA	32%	44	16
	CIP	32%	90	11
	CODA	21%	516	121

*Total clients successfully or unsuccessfully treated. Excludes clients discharged for "neutral" reasons.

Source: County contracts and CPMS data.

Among the residential alcohol programs, Harbor Light, DePaul, and Harmony House had completion rates more than double those at ARA, which treats pregnant women and women with children. Harmony House had the highest completion rate of the residential drug programs. Completion rates at NARA and CODA were considerably lower than those at other residential drug programs. Among the outpatient programs, DePaul and ASAP had the highest completion rates. CODA's outcomes in outpatient services again fell significantly below those of most other contractors providing these services. The Executive Director of CODA indicated that they regularly enroll outpatient clients after assessment but before the first treatment. The Director said that completion rates without the clients who fail to return for treatment would be about 45% for alcohol and 41% for drug outpatient clients.

Costs vary among contractors

In addition to finding wide variations in treatment outcomes by contractor, we also found variations in treatment costs among different contractors. Our estimates of FY91-92 costs per client admitted, costs per bed-day, and cost per successful completion are presented below. Exhibit 11 provides an illustration of how the relative cost-effectiveness of the County's contractors might be assessed.

Exhibit 11

Residential contractor costs in FY91-92

	Cost per Admission	Cost per Bed-Day	Cost per Completion
Average Residential Program	$3,459	$40	$ 5,731
Alcohol			
ARA	$3,258	$32	$ 9,775
DePaul	$3,526	$32	$ 3,940
Harmony House	$2,680	$33	$ 3,405
Harbor Light	$1,860	$24	$ 2,276
Drug			
CODA	$5,871	$64	$21,577
ARA	$3,556	$36	$5,548
DePaul	$2,787	$32	$5,277
Harmony House	$2,440	$31	$3,105

Source: CPMS data and contractor data on expenditures.

Note: Costs for Harbor Light combine alcohol and drug sevices. Costs for NARA could not be calculated because of unreliable financial data.
Cost per admission: Expenditures for FY91-92 divided by number of clients admitted.
Cost per bed-day: Expenditures for FY91-92 divided by the total days of client service.
Cost per completion: Expenditures for FY91-92 divided by total number of clients successfully terminated.

Based on currently available cost and service data on residential programs, treatment costs estimated for Harbor Light and Harmony House were the lowest, while those for CODA and ARA were the highest. The average length of stay was similar among the contractors and did not explain the significant cost differences. The one contractor that had significantly higher treatment costs in its residential program, CODA, had client outcomes that were significantly lower than those in other programs. As a result, the cost per successfully completed clients at CODA's residential drug programs is roughly four times ($21,577) the comparable costs at the other residential programs ($2,000-$6,000). The Executive Director of CODA attributes these high costs to a length of stay which is about 20% longer than at other programs and to a higher level of service at one of their two facilities. Residential services at Harbor Light, Harmony House, and DePaul appear to be the most cost-effective.

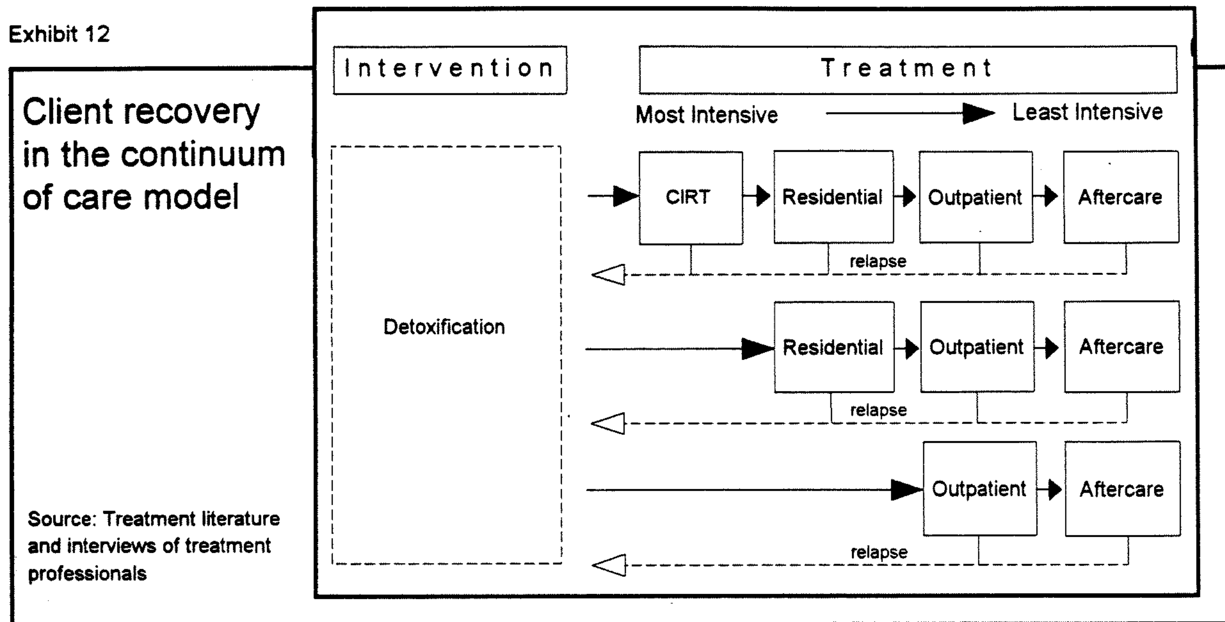
County A&D should manage the continuum of care

Evaluation research strongly indicates that alcohol and drug treatment can effectively reduce substance abuse and that the benefits of treatment often spill over into other areas of clients' lives with positive effects on physical health, psychological well-being, employment, and criminality. More than 600 treatment outcome studies are summarized in a 1990 report prepared for Congress by the National Institute of Medicine. The report focused primarily on alcohol treatment but conclusions are generally applicable to drug treatment as well.

The prominent conclusion of the report was that no single treatment approach is effective for all clients and that a range of treatment alternatives which comprise a "continuum of care" should be widely available. The exhibit on the following page illustrates a model of an effective continuum of treatment services. Under this model, all clients may not enter the continuum at the same point, but most will not complete the recovery process without the benefit of each successive type of treatment. For example, it is unlikely that an episode in residential treatment will sustain recovery without the benefits of outpatient services. Following outpatient treatment, most clients will require aftercare services often provided through 12-step programs in the community such as Alcoholics Anonymous or Narcotics Anonymous.

Exhibit 12

Client recovery in the continuum of care model



Source: Treatment literature and interviews of treatment professionals

Detoxification programs are the first element of the continuum and the point of intervention for many clients. After stabilization, clients should be referred to the most appropriate level of treatment. Because of the ongoing risk of relapse, detox programs may also serve to re-stabilize clients as they move through the rest of the treatment continuum.

Lack of coordination reduces effectiveness

Multnomah County has made it a priority to maintain the mix of services generally included in a continuum of care. But lack of coordination among the decentralized network of contract services reduces the continuity of care and may hinder the recovery process for clients.

We reviewed written intake, assessment, and referral policies and procedures for each of the contractors. With the exception of DePaul, all of the contractors rely on the subjective, clinical judgment of their counselors on a case-by-case basis to make these decisions. DePaul utilizes nationally-validated quantitative assessment tools, and a placement matrix developed in-house. In addition, we found only one example of a formal policy relating to communication among contractors which are treating or have treated the same clients. The Homeless Alcohol and Drug Intervention Network (HADIN) brings together on a regular basis contractors who treat the transient population.

In FY91-92 self-referral was the most frequent type of referral in the County. In these cases, the client selected the contractor. In effect, many clients were also selecting their own treatment type because most contractors do not offer the full continuum of

treatments. Contractors and County A&D staff emphasized the value of client choice in a system in which many clients participate in treatment voluntarily. They also acknowledged that clients are not always adequately informed about the range of services in the County.

In the absence of County placement or referral standards, contractors have complete discretion about whether a client is appropriate for treatment, which type of treatment is most appropriate to client needs, whether a less costly treatment may be equally successful, and whether the client should be referred to another contractor. The lack of client admission, continued care, and discharge standards, and the lack of case management across contractors, reduce the likelihood that clients will successfully engage in the treatment continuum, complete the recovery process, and reduce their reliance on the publicly funded treatment system.

Many clients do not move through the continuum of care

Our analysis of client treatment experiences over the last five years indicated that some clients receive a disproportionate amount of services. This is consistent with the generally accepted theory that the recovery process may include multiple treatments and periods of relapse. However, the decentralized network of contracted services cannot necessarily ensure that the most effective intervention will occur upon relapse and that the client will progress in the recovery process in the most efficient manner. We found that many clients repeat treatment and detoxification and seemingly fail to progress through the treatment system.

To gain an understanding of how clients are served within the alcohol and drug treatment system, we separated clients into two groups: those that had received services once, and repeat clients that had received services more than once in the five year period. Over two-thirds (12,600) of the clients we studied had received services only once of which 77% had been out of the treatment system for over a year. Most of the services (75%) that were delivered to these clients were for treatment rather than detoxification.

Of the repeat clients, 3,080 received services twice while the remaining 2,370 clients received from 3 to 17 services in the five year period. None of the repeat clients had been out of the system for more than a year. The service that was delivered to repeat clients was almost evenly divided between treatment and detoxification. Detoxification accounted for 47% of the services that were provided to repeat clients.

We analyzed client service patterns to determine whether clients were moving through the continuum of care. We found a high re-entry into detoxification instead of entry into treatment. For example, detoxification is the first experience in the continuum for 45%

of the repeat clients. Over one-half re-entered detoxification and one-third of those re-entered detoxification a third time. Clients with three consecutive detoxification episodes accounted for 9% of repeat clients. At the extreme, we found one client who had enrolled in detoxification 14 consecutive times in the past five years without entering treatment. On the average, clients who re-entered detoxification did so 8 months after leaving the first time.

The manager of the detoxification program states that the program also has purposes in addition to intervention or as a gateway to treatment. For some clients, detoxification services are offered for humanitarian reasons with the knowledge that serious illness might occur if the person was not admitted. The manager also pointed out that this type of admission was also beneficial for the community as a less expensive alternative to the hospital, emergency services, or jail.

Our examination of service patterns also showed repeated use of treatment services. For example, over one-third of the repeat clients first received treatment in an outpatient program. Of those clients, 54% re-entered outpatient treatment for a second time and 19% repeated outpatient treatment three times. Clients with three consecutive outpatient treatment episodes accounted for 4% of repeat clients. The average amount of time between repeated outpatient treatment episodes was 9 months.

Clients who receive more than one service are a costly part of the treatment system. We calculated total treatment expenditures for all repeat and all single service clients. We found that from FY87-88 to FY91-92 over one-half of the total public expenditure for treatment was used by repeat clients. Repeat clients tend to utilize the more costly resources such as CIRT and residential treatment services and a large portion of detoxification resources. Exhibit 13 below shows these costs.

Exhibit 13

Five-year public expenditures for alcohol and drug services, FY87-88 through FY91-92

Service	Total Expenditure Single Service	Total Expenditure Multiple Services
Outpatient Alcohol	$2,614,900	$1,727,200
Residential Alcohol	1,242,500	1,774,900
CIRT	141,100	1,197,100
Outpatient Drug	2,350,400	1,981,300
Residential Drug	1,236,900	1,838,600
Methadone Maintenance	2,244,900	1,649,700
Treatment Subtotal	$9,830,700	$10,168,800
Detoxification	$1,232,400	$3,113,400
Service Total	$11,063,100	$13,282,200

Source: CPMS data and County financial information.

This disproportionate use of treatment capacity is not unexpected or unnecessary. Clients may need to repeat treatment or utilize several types of treatment during recovery. However, without County oversight and planning there is no assurance that resources are used as efficiently and effectively as possible. The State of Washington has attempted to develop such assurances by setting limits on client treatment. Clients in need of publicly funded services are assessed in local screening centers and authorized to receive up to 30 days of intensive inpatient services, followed by up to 90 days in a recovery home, and up to 90 days of outpatient treatment. Certain clients may be authorized for up to 180 days of long-term residential services. State law limits the total public treatment service to 180 days per client over a two-year period.

Many clients drop out of treatment

A large number of clients in several programs dropped out of treatment programs shortly after they were enrolled. Close to one quarter (23%) of the clients terminated in FY91-92 from DePaul's CIRT program had been in treatment for less than two weeks. Among the clients terminated from all other residential programs, 14% were terminated after less than two weeks in treatment. Rates of early terminations at CODA (23%) and NARA (20%) were relatively high compared to other residential programs. One-third (33%) of the clients terminated from the County's outpatient programs in FY91-92 had been in treatment for less than one month. Rates of early termination of outpatient clients were particularly high at TPI (41%) and at CODA (40%).

Early termination can occur for a number of reasons. Clients may not believe that they have a substance abuse problem and may not be ready to engage in the recovery process. They may be enrolled inappropriately along the treatment continuum given their individual needs. Unsuccessful completion of a treatment program may also be an indicator of ineffective methods, which can increase overall costs of the treatment system. County A&D has not investigated the causes for high dropout rates. Research suggests that each of these problems could be reduced through the use of clinical assessment and admission, continued stay, and discharge standards.

Client referrals

Clients may fail to move through the continuum because of contractor failure to refer clients to the next type of treatment or because referrals are not always successful. Clients may not follow through with referrals or treatment may not be available. The CPMS client termination data indicates that the majority of clients who successfully completed treatment in FY91-92 were referred to a less restrictive form of treatment along the continuum. For example, among those discharged from detoxification, 75% were referred to treatment. Among those discharged from CIRT, 68% were referred to residential treatment and 27% to outpatient or a 12-step program. Among those

successfully terminated from residential programs, 81% were referred to outpatient or to a 12-step program. Among those discharged from outpatient programs, 60% were referred to a 12-step program. Actual referrals along the continuum may be higher than these number suggest, because contractors can report only one referral onto CPMS when more than one referral may have been made.

Referrals from methadone were not as consistent. Approximately half of those successfully terminated from methadone programs were not referred at all; only 20% were referred to drug-free outpatient programs.

We identified several contractors who failed to refer a disproportionately high percentage of successful clients when compared to other contractors providing the same service. For example, two-thirds (66%) of the methadone clients terminated from CODA left without a referral. Among the outpatient programs, TPI and PCR failed to refer 36% and 22% of their successfully discharged clients, respectively.

We noted earlier that our analysis of client service patterns over the last five years indicates that referrals are not successful in many cases. For example, only 28% of the clients who received service twice subsequently entered the type of treatment referred to at discharge. Inadequacies in the referral process were also highlighted by the Research Triangle Institute in their evaluation of Oregon's alcohol and drug treatment system.

Potential for dual enrollment in methadone programs

Without a central registry of methadone clients, contractors cannot determine whether their clients are also enrolled in other publicly-funded methadone programs in Multnomah County. During methadone treatment, a client receives medically-approved dosages of the drug methadone. Methadone is also a valuable commodity in the illegal drug trade. Therefore, it is important that the amount of methadone given to a client be controlled to prevent over dosage or the drug's diversion for illicit use.

We examined client records for the past five fiscal years to determine if clients had ever been enrolled in two different methadone treatment programs at the same time. By matching names and unique identifiers, we found that four clients had been enrolled over the same time period in different methadone programs. However, according to information received from the two contractors, the clients had not been receiving two dosages of methadone at the same time. We were unable to check clients who might have been deceptive and used multiple names or identifiers to receive multiple doses of methadone.

RECOMMENDATIONS

Improvements can be made to Multnomah County's alcohol and drug treatment system to increase client recovery rates and reduce costs. Additional efforts are needed to monitor contractor performance measures and costs, coordinate contractor activities, and manage client movement in the continuum of care.

To ensure that the most cost-effective mix of services is being provided, County A&D should:

- Analyze information on its contracted services, such as client profiles, length of stay, types of services delivered, outcomes, and treatment costs. This information should be evaluated in the context of the County's comprehensive treatment system plan.

To maximize the benefits for all users of the CPMS data system, County A&D should:

- Work with the State and contractors to ensure consistent reporting of client and performance information into the CPMS system. Activities could include increased training, clarification of definitions in manuals, and increased monitoring of client files and CPMS records.

- Work with the State to convene a group of contractors, representatives from other counties, and State data processing staff to discuss system improvements, such as report content and timeliness, performance indicators and standards, and automated links between contractors and the CPMS system to reduce data-entry efforts.

To improve movement of clients through the treatment continuum, County A&D should:

- Consider methods which better coordinate contractor activities. Alternatives include contractor use of on-line access to CPMS data to identify treatment histories of clients; use of limits on treatments for clients; standardized placement, continued stay, and discharge criteria for use by contractors; improved procedures to facilitate effective referrals; or development of a centalized intake and case management unit.

CHAPTER THREE

Reimbursement system needs improvement

Funding treatment services

Managers from the State, County, and the contractor organizations have all indicated that alcohol and drug services for adults are not adequately funded. While the State contributes the largest share of funding, according to the State A&D Manager the amount is not intended to cover all of treatment costs. Contractors are also expected to obtain revenues from other sources such as county general fund allocations, fees from clients, client insurance, grants, or charitable contributions. However, there are no specific guidelines or requirements established for the share of costs that should be raised by the contractor, or contributed by the County or State. Some of the County's discretionary funds have been spent on adult treatment but most are allocated to sobering and youth programs.

We examined contractor revenues to determine the degree that they rely upon other sources to supplement the cost of treatment services. Typically, treatment contractors rely on State, County, and Medicaid funds for 65% to 85% of their costs. Methadone appeared to be the only service which generated revenues that were substantially higher than costs. Contractors state that their treatment costs are dependent on how much additional funds they can generate to supplement State and County amounts.

When contractors cannot obtain sufficient funds from these other funding sources they have to cut the costs of their services to avoid operating deficits. We looked at counselor salaries, counselor turnover rates, size of counseling groups, the ratio of group counseling time to individual counseling time, and the client's average length of stay. We found indications of cost and service reductions in these areas which could adversely affect the quality of alcohol and drug treatment in Multnomah County.

The largest portion of contractor costs are for personnel. On average, we estimate that labor accounts for 67% of detoxification, CIRT, and residential costs, and 74% of outpatient costs. Salary ranges for entry level counselors varied among contractors from $11,400 to $21,900 and from $13,300 to $25,200 for more experienced counselors. Benefits as a percentage of labor costs ranged from 15% to 29% and averaged 21%. One

executive director stated that counselors are dedicated to providing quality services regardless of salaries and benefit levels.

These salary rates may have contributed to the low experience levels we found when counselors were initially hired, although a high percentage of counselors had 4-year college or graduate degrees. A director acknowledged that there is a small pool of counselors to hire from and that once trained, counselors often leave for better paying jobs in the for-profit sector. Although they varied by contractor, we found counselor turnover rates were generally high, averaging 34% in FY91-92. Research indicates that service quality decreases when there is not a steady relationship between the client and counselor.

High turnover may also be caused by heavy workloads. In outpatient treatment, contractors had ratios as low as one counselor for 25 clients while other contractors had ratios as high as one counselor for every 42 clients. Large client workloads can diminish the rapport between the client and counselor, and reduce the quality of treatment services.

Contractors may make up funding shortages by increasing the size of group counseling sessions. We found that the average outpatient group size varied from four clients per group at DePaul to 30 clients per group at PCR. Larger group sizes can also increase Medicaid revenues where clients are billed at the same rate regardless of group size. Additionally, contractors can schedule clients for more group counseling activities relative to individual treatment.

Contractors can also vary the length of stay of clients. Without limits on the maximum amount that will be paid per client or on the duration of time a client can stay in treatment, a contractor can keep clients longer than clinically necessary. Alternately, by rapidly turning over clients in outpatient slots a contractor could maintain reimbursements while decreasing service levels.

Reimbursement system lacks accountability

Contractors may reduce the quality and quantity of services due to funding shortages, but there is no clear standard to determine whether the services are provided at an acceptable level. Specifications for services are not adequately set forth in the agreements with contractors. Reimbursements are based upon utilization of "slots" which are described as a capacity to provide service, rather than a description of services provided. An outpatient slot only requires one client contact in a month to qualify a contractor for reimbursement. The advantages of the slot reimbursement system are administrative ease, more timely reimbursements to contractors, and a more constant source of funding for contractors.

Because slots are not linked to specific services it becomes more difficult to distinguish the services provided by contractors who receive funding from multiple sources. Contractors are encouraged to seek additional sources of funding, but they have not always been given clear guidelines by the State or County on what is allowable. In some cases the additional funds were intended to purchase additional services. It is difficult to maintain accountability without clear funding guidelines, effective monitoring activities, or a reimbursement system that adequately defines services. Lack of accountability contributed to the conditions described in the remainder of this chapter.

State and County A&D managers, as well as contractors, expressed some dissatisfaction with the current reimbursement system. The State manager noted that any change would require approval from the MHDDD, which might be difficult.

Over-reported outpatient services

Six of the 10 contractors we reviewed appeared to be accurately reporting their services to the State's CPMS system, however we found that four contractors in Multnomah County had been over-reporting their outpatient services. This CPMS data is used by the State to monitor the actual number of clients served to insure that contractors are treating the number of clients for which they are funded. We estimate that actual outpatient services provided by these four contractors between January and June 1992 were approximately 36% of reported levels. These contractors reported service levels at 111% to 452% of their contracted slot capacity while actual utilization ranged from 81% to 97% of their contracted capacity.

Contractors must submit CPMS forms upon enrolling or terminating a client from treatment. The State produces a monthly listing of clients receiving outpatient services and requires contractors to verify that all clients on the list received treatment in that month. The State also reviews monthly utilization reports and notifies County A&D and the contractor when underutilized services are identified. County A&D is responsible for working with the contractor to resolve the problem. If utilization rates fall below the required 100% for more than three consecutive months the State and County A&D can reduce that contractor's outpatient slots.

We estimate that these four contractors received approximately $118,600 for over-reported clients in FY91-92. Reported utilization levels are compared in Exhibit 14 to our estimates of the actual average number of clients served and our estimated costs of over-reported services.

Exhibit 14

Over-reported outpatient services

Outpatient Program	Estimate of average clients served per month	Contracted Slots	CPMS reported clients served	Annual cost of unused slots
NARA	71	88	246	$24,885
PCR	151	177	196	$49,474
TASC	107	126*	180	$37,000
TPI	151	156	705	$7,241
Total				$118,600

*Includes services contracted by Community Corrections

Source: Auditor's estimates of costs, analysis of State Utilization Reports, and County contracts

Over-reporting clients on CPMS resulted from simultaneously enrolling clients in more than one treatment service element, or failing to terminate discharged clients.

In 12 of the contractors analyzed in our audit, we identified a total of 235 CPMS records indicating a client was simultaneously enrolled in more than one treatment service at the same contractor. For example, Client Y might be enrolled over the same period in both alcohol and drug outpatient treatments by Contractor X. Approximately three-quarters of these duplicate enrollments occurred in two outpatient contractors: PCR and TPI. These duplicate records inflated client utilization levels by as much as 50% to 60%.

To identify whether discharged clients were counted towards CPMS utilization, we analyzed CPMS data for all outpatient contractors. We found that NARA, PCR, TASC, and TPI had some clients enrolled in treatment for exceptionally long periods.

We sampled case files with long treatment periods at NARA, PCR, and TASC to verify when clients were discharged from treatment, whether a CPMS termination form was in the file, and whether the clients received treatment in each of six months between January and June of 1992. Our file reviews indicated that most of the clients in our samples had been discharged from treatment prior to January 1, 1992 and did not receive treatment services during the January-June 1992 period.

We did not review case files at TPI because of the extensive fieldwork which would have been necessary to determine actual levels of client service. Contractor staff had not been routinely enrolling or terminating clients on the State's CPMS system for much of FY91-92. TPI's Clinical Director agreed with our finding that most of the clients enrolled on CPMS as of July 1, 1992 should have been previously terminated. According to the TPI's Clinical Director, corrected enrollment records for June through September of 1992 indicate fewer clients were served than their contract required during this period.

We found several factors that contributed to over-reporting of client services by contractors. The Clinical Director at TPI attributed the problem to staff turnover and a change in County requirements for reporting utilization. At NARA many of the over-reported clients involved State prison inmates who did not have case files and who may have only been seen once in January 1991.

Lack of adequate monitoring by County A&D and the State enabled the over-reporting of client services to continue. On-site review practices by the State and County A&D did not include verification of CPMS reporting accuracy. In addition, staff at two of the contractors explained that State and Federal agencies allowed contractor staff to select the sample of cases for review. Allowing contractors to select the sample can reduce the validity and reliability of a case review.

The CPMS computer system has few automated data checks to determine whether clients are enrolled in multiple programs. Computerized checks such as exception reports could also reveal clients enrolled for unusually long treatment periods. In about half the sampled cases we reviewed, we found a CPMS termination form in the case file although the information was not reflected on the CPMS computer system. One possible cause of this discrepancy is client information reported at enrollment may not exactly match the information reported at discharge, which prevents termination on the CPMS system.

During our audit some efforts were made to correct these problems. State and County A&D staff are currently verifying utilization counts for all contractors in Multnomah County. The State has indicated that contractors will no longer select sample cases in on-site reviews. TPI began correcting and updating their CPMS records.

Service Overlap of County A&D and Community Corrections

County A&D and the County Department of Community Corrections both contract for adult treatment services with CODA, DePaul, ASAP, and TASC. We analyzed client enrollment records from Community Corrections and CPMS for FY91-92. We compared the number of unduplicated clients to the combined minimum service requirements for each agency's contract in order to identify whether services for the same clients were

being paid for by both County A&D and Community Corrections. We found service overlap at CODA and TASC, but not at DePaul and ASAP.

Nearly all of CODA's clients paid for by Community Corrections were also being counted toward County A&D slots. Using minimum services requirements of both contracts, Community Corrections and County A&D contracted for a combined total of 14,497 bed days at CODA but received only 12,419 bed-days, resulting in a 2,078 bed-day service overlap in FY91-92. Using the average rate per bed-day, the cost of service overlap was approximately $73,600. The Executive Director of CODA indicated that overlap may be about half this amount because they did not report children of clients in their residential programs,who are reimbursable. A Community Correction's manager states that some overlap in CODA's services has been allowed because the combined resources of County A&D and Community Corrections increases both the quality and quantity of treatment services in the community.

We also found service overlap in TASC's outpatient services. Community Corrections and County A&D separately contracted for a combined total of 126 slots. Due to the combined effects of service overlap and over-reporting clients on CPMS, TASC averaged 84% of the minimum utilization requirement in FY91-92. The $37,000 cost was discussed in the previous section. Community Corrections considers its contracted services at TASC to be in addition to those of County A&D services. Staff from County A&D and Community Corrections jointly conducted a review of TASC's outpatient services and found that under-utilization was not currently a problem.

Medicaid-funded services

Contractors are authorized to bill Medicaid on a fee-for-service basis for outpatient treatment delivered to Medicaid-eligible clients. Medicaid-eligible clients are generally low-income pregnant women or single parents and their children. In addition, CODA is authorized to bill Medicaid for methadone treatments.

Until relatively recently, Medicaid funds and State slot funds were to be used to serve two distinct client populations. Oregon Administrative Rules and the *Community Mental Health Financial Procedures Manual* prepared by the State Mental Health Division note that slot funding can not be used for clients who are Medicaid-eligible. In addition, the State's Intergovernmental Agreement with Multnomah County and the County's agreements with contractors also stated that the number of clients to be served through the use of Medicaid funds were in addition to the clients to be served through the use of contracted slot funds.

This language was deleted from the Intergovernmental Agreement for the FY91-93 biennium, after the manager of the State Office of Alcohol and Drug Abuse Programs

decided that the requirement was unenforceable. The State manager communicated to contractors that it was acceptable to bill Medicaid for clients filling slots as long as two conditions were met: total revenue from Medicaid and other revenue sources should not exceed total contractor expenses, and private insurance for a particular client should be deducted from the amount billed to Medicaid.

In order to clarify whether service overlap between Medicaid and outpatient slot services would violate Federal Medicaid regulations, we contacted auditors with the Regional Health Care Finance Administration (HCFA) and the Department of Human Services Inspector General's Office in Seattle. HCFA staff viewed the practice as a violation of regulations in the *Community Mental Health Financial Procedures Manual*, but neither agency could decide whether the practice complied with Federal regulations.

We matched records from the CPMS client database to Medicaid billing records for the six month period of January to June 1992 and found Medicaid and slot service overlap at CODA's methadone program and outpatient programs at NARA and PCR. Because of limited information on Medicaid clients on CPMS, our test would not necessarily detect service overlap among all the contractors.

During FY91-92, CODA received funds for 260 slots in its methadone program and billed an average of 69 clients to Medicaid each month. The total average number of clients served monthly was 290. Separating Medicaid services from slot-based services, CODA's slot utilization rate averaged 85% over the six month period examined. We estimate that the contractor received approximately $83,640 per year in slot funds for clients whose services were also billed to Medicaid.

We also identified some degree of Medicaid service overlap at outpatient programs at NARA and PCR. Because both contractors were identified by our analysis as under-utilized, all clients billed to Medicaid would have also been filling slots. Medicaid and slot service overlap at both NARA and PCR averaged approximately 9 clients per month. These agencies each received an estimated $15,300 in FY91-92 toward the cost of serving clients also billed to Medicaid.

Causes for service overlap

The State Alcohol and Drug manager said that the State has not been concerned about tracking utilization by funding source because the slot rate is not intended to cover the full costs of the services. Contractors are expected to supplement slot money from other funding sources. At the County level, even though utilization requirements appear in separate agency contracts, neither County A&D nor Community Corrections have obtained information that would allow them to separate clients by funding agency.

The CPMS database is not designed to separate County A&D contracted services from Community Corrections or Medicaid services. When slot utilization is computed by CPMS for County A&D, it includes Community Corrections and Medicaid services. Community Corrections tracking records also include clients counted towards County A&D slot utilization.

Reimbursement of CODA's methadone services

As noted earlier in the chapter, contractors rely upon a number of funding sources to cover their costs. For most types of treatments, contractor revenues closely matched the cost of their services. Although State, County, and contractor managers generally view the treatment system as not adequately funded, in one case we found contractor revenues that were substantially more than service costs. In FY91-92 CODA's methadone revenues from the combination of slot funds, Medicaid, and client fees exceeded treatment costs by approximately $263,100 as shown in Exhibit 15 below. There are no prohibitions against contractors generating excess revenues. CODA used these excess funds, in compliance with the intergovernmental agreement, to help cover the costs of its residential drug services. Approximately $83,640 of this excess was due to an overlap of slot and Medicaid services as indicated in the previous section.

Exhibit 15

Revenues and expenses for CODA methadone services

State Revenue	$541,917
Medicaid Revenue	$227,836
Client Fees	$394,384
Other	$ 609
Total Revenue	$1,164,746
Total Expenses	$901,638
Revenues over expenses	$263,108

Source: CODA financial reports

Outside the $83,640 service overlap, we could not identify which funding source caused the remaining $179,468 in excess revenues. Oregon statutes and administrative rules require contractors to charge fees to clients that are based on the cost of the services

adjusted for the ability of clients to pay. We could not determine whether CODA's client fees exceeded the cost of services. We found that in accordance with regulations, CODA, like other contractors, used sliding fee schedules to adjust amounts charged to clients based on their ability to pay. However, only one contractor, DePaul, had estimated the costs of their services in order to compute client fees.

We also did not have adequate information to determine whether Medicaid reimbursements for methadone exceeded the cost of services. State regulations limit billings for Medicaid clients to the lesser of the cost of services or Medicaid rates. Finally, we could not determine whether the excess revenues came from the remaining funding source, State revenues, because the methadone treatment slot is not adequately defined. We did not examine the revenues or costs of the other methadone services in Multnomah County who do not receive slot funds.

Medicaid billings are reducing other services

Multnomah County's alcohol and drug treatment system is also adversely affected by Medicaid funding problems. For a number of years Multnomah County's Medicaid billings for alcohol and drug treatment have exceeded the amount allocated by the State. In earlier years, the State covered the shortage in Multnomah County with Medicaid surpluses from other counties who had underspent their Medicaid allocations. However, in the last two biennia State slot funds for outpatient and methadone services were reduced in Multnomah County to pay the Medicaid shortage. In the two biennia of FY89-91 and FY91-93 slot funding for clients who were not Medicaid eligible was reduced by $120,000 and $341,000 respectively.

Contractors who received both State slot funds and Medicaid funds had to cut back services when they lost some of their revenues to cover the Medicaid shortage. Contractors who only received Medicaid funds were unaffected. This policy creates significant funding uncertainties for contractors who receive State slot funds. It is also more difficult for County A&D to match treatment resources to community needs. Resources were shifted from clients who have no insurance to those who are eligible for Medicaid, generally low-income single parents and pregnant women.

Methadone services grew at the expense of alcohol and drug outpatient services. In FY91-92, 73% of the Medicaid shortage was generated by methadone services while 27% was generated by outpatient services. However, 84% of the Medicaid shortage was paid for with reductions in outpatient services and 16% with reductions in CODA's methadone services. Only contractors who both received slot funds and Medicaid funds were affected. Contractors who received only Medicaid funds did not have to reduce services to help cover the Medicaid shortages, even though they generated 62% of the shortage in FY91-92.

RECOMMENDATIONS

Improvements to the alcohol and drug reimbursement system can make Multnomah County's alcohol and drug treatment system more accountable and manageable. Additional efforts are needed to develop a better funding mechanism and to increase monitoring of contractor services and costs.

To implement a more accountable reimbursement system that better links scarce resources to services provided by contractors, County A&D should:

- Work with the State and contractors to develop an alternative funding mechanism. Whether a fee-for-service or other model, the funding mechanism should better define service expectations.
- Distinguish County A&D services from Community Corrections and Medicaid services to determine whether County A&D contract requirements are being met. County A&D should request that the State obtain a written opinion from Federal authorities on the appropriateness of current Medicaid billing practices identified in our audit.
- Work with the State to periodically review treatment costs and reimbursement rates to evaluate the funding system. In conjuction with reviewing the appropriatness of State and County reimbursement rates, County A&D should regularly review contractor estimates of their service costs as the basis for setting client fee schedules and ensuring Medicaid rates paid for contracted outpatient and methadone services do not exceed estimated service costs.

To better manage the treatment system and to reduce funding uncertainties for contractors, County A&D, the State and contractors should identify alternative solutions to deal with Medicaid match shortages.

To better monitor the number of clients served by contractors, County A&D should:

- Use CPMS data to identify duplicated, discharged, or inactive clients in a timely manner.
- Verify the number of clients served as part of its regular monitoring procedures.

- Request the State to use CPMS edit checks to detect duplicate clients and regularly generate automated exception reports on clients in treatment for long periods.

- Consider developing a multi-part CPMS form which ensures consistency of key client information on both the enrollment and the termination forms.

APPENDIX A

PROGRAM PROFILES: Clients Admitted FY 1991-92

Client Characteristics	ALL PROGRAMS	ALLIED	ARA*	ASAP	HOOPER	PCR	CIP
		Methadone	Residential	Outpatient	Detoxification	Outpatient	Outpatient
Average Age	34.4	37.5	27.5	31.4	37.5	35.9	31.2
Women (%)	34%	67%	99%	36%	21%	44%	42%
Minority (%)	35%	32%	45%	19%	32%	78%	9%
HS Grads (%)	59%	49%	40%	57%	68%	62%	52%
No Income (%)	54%	6%	68%	23%	72%	35%	23%
Monthly Income (Mean)	$306	$364	$137	$523	$152	$555	$537
Clients Unemployed (%)	79%	94%	99%	54%	93%	70%	48%
Income Source is Welfare (%)	12%	86%	35%	22%	NA	24%	22%
Medicaid Eligible (%)	13%	97%	50%	19%	0%	26%	24%
Living Alone (%)	36%	25%	15%	14%	55%	16%	12%
Married/Cohabiting (%)	16%	17%	6%	33%	7%	15%	28%
One or More Arrests (%)	55%	41%	68%	63%	NA	51%	62%
One or More DUII (%)	17%	7%	6%	21%	NA	7%	22%
Alcohol Primary (%)	48%	0%	18%	42%	70%	30%	58%
% of A.P. Chronic Alcoholic	72%	--	53%	9%	94%	30%	9%
Most Frequent Primary Drug	Cocaine	Heroin	Cocaine	Marij./Hash	Cocaine	Cocaine	Amphetamines
% of D.P-IV Users	44%	90%	42%	27%	60%	24%	30%
% of D.P.-Use 3+ per Day	42%	39%	69%	24%	90%	14%	5%
Average Age at First Use	17.7	20.9	18.1	17.4	16.8	19.9	16.4
Primary Sources of Referrals	Self (33%) Corrections (25%)	Oth. Meth. (90%)	Corr. (29%) CSD (18%)	Corr. (65%) Self (11%)	Self (65%) Outpat. (7%)	Corr. (35%) Self (24%)	Corr. (52%) CSD (22%)
Primary Referral Targets FY91-2 Successful Completions	AA/NA (34%) Resid. /CIRT (29%)	Outpat. (20%) None (20%)	Outpat. (60%)	AA/NA (78%) Corr. (8%)	Resid. (48%) Outpat. (27%)	AA/NA (64%) None (22%)	Corr. (37%) AA/NA (29%)

*Excludes minor-aged children

PROGRAM PROFILES: Clients Admitted FY 1991-92 continued

Client Characteristics	CODA			DEPAUL			HARMONY
	Residential	Outpatient	Methadone	CIRT	Residential	Outpatient	Residential
Average Age	30.0	31.1	36.3	33.2	34.8	33.4	39.0
Women (%)	48%	49%	47%	27%	32%	62%	0%
Minority (%)	20%	24%	18%	29%	50%	31%	20%
HS Grads (%)	59%	63%	74%	72%	73%	71%	64%
No Income (%)	65%	33%	34%	88%	67%	36%	80%
Monthly Income (Mean)	$201	$537	$446	$39	$114	$407	$142
Clients Unemployed (%)	82%	59%	69%	100%	98%	64%	90%
Income Source is Welfare (%)	9%	16%	15%	8%	22%	20%	0%
Medicaid Eligible (%)	15%	23%	23%	5%	20%	21%	0%
Living Alone (%)	10%	18%	21%	40%	61%	36%	25%
Married/Cohabiting (%)	17%	33%	43%	6%	5%	14%	16%
One or More Arrests (%)	76%	56%	44%	58%	64%	50%	53%
One or More DUII (%)	22%	11%	13%	34%	25%	32%	34%
Alcohol Primary (%)	0%	0%	13%	35%	30%	36%	77%
% of A.P. Chronic Alcoholic	NA	NA	2%	80%	79%	64%	98%
Most Frequent Primary Drug	Cocaine	Cocaine	Heroin	Cocaine	Cocaine	Cocaine	Mixed
% of D.P-IV Users	52%	35%	88%	41%	36%	43%	64%
% of D.P.-Use 3+ per Day	26%	24%	23%	81%	73%	59%	100%
Average Age at First Use	20.4	19.2	21.7	17.2	18.9	18.1	14.9
Primary Sources of Referrals	Corr. (57%)	Corr. (49%) CSD (30%)	Self (32%) Family (21%)	Corr. (31%) Detox (17%)	Res/CIRT (48%) Outpat. (34%)	Res/CIRT(37%) Corr. (18%)	Detox (39%) Self (26%)
Primary Referral Targets FY91-2 Successful Completions	AA/NA (39%) Res/CIRT (37%	AA/NA (76%) None (13%)	None (66%) Outpat. (23%)	Res/CIRT (68%) AA/NA (14%)	Outpat. (85%)	AA/NA (79%)	Outpat. (60%) AA/NA (27%)

PROGRAM PROFILES: Clients Admitted FY 1991-92 continued

Client Characteristics	NARA		HARBOR	TASC	TRANSITION
	Residential	Outpatient	Residential	Outpatient	Outpatient
Average Age	31.7	32.3	35.8	31.1	34.9
Women (%)	54%	43%	21%	26%	12%
Minority (%)	96%	83%	27%	32%	67%
HS Grads (%)	47%	61%	51%	44%	34%
No Income (%)	30%	30%	100%	30%	89%
Monthly Income (Mean)	$427	$347	NA	$503	$38
Clients Unemployed (%)	77%	79%	99%	49%	98%
Income Source is Welfare (%)	24%	19%	0%	13%	3%
Medicaid Eligible (%)	7%	13%	0%	12%	2%
Living Alone (%)	26%	21%	100%	12%	47%
Married/Cohabiting (%)	22%	17%	8%	22%	13%
One or More Arrests (%)	54%	57%	NA	71%	39%
One or More DUII (%)	38%	26%	NA	8%	8%
Alcohol Primary (%)	95%	69%	71%	19%	73%
% of A.P. Chronic Alcoholic	94%	49%	100%	3%	63%
Most Frequent Primary Drug	Mixed	Mixed	Cocaine	Cocaine	Cocaine
% of D.P-IV Users	33%	63%	30%	27%	6%
% of D.P.-Use 3+ per Day	78%	46%	100%	2%	61%
Average Age at First Use	14.0	14.4	16.8	19.9	17.2
Primary Sources of Referrals	Outpat. (61%)	Self (33%) Corr. (23%)	Self (100%)	Corr. (89%) CSD (9%)	Self (38%) Corr. (13%)
Primary Referral Targets FY91-2 Successful Completions	Outpat. (60%) AA/NA (36%)	AA/NA (38%) None (30%)	AA/NA (96%)	Corr. (62%) AA/NA (31%)	AA/NA (60%) None (36%)

APPENDIX B

Assessing CPMS Data Reliability

In order to assess the accuracy of the CPMS database used to measure contractor performance in the audit, we reviewed the State's quality-control procedures. We found that the State Mental Health and Developmental Disabilities Division (MHDDD) uses a variety of automated edits to minimize entry of erroneous data. Data processing staff have regular contact with treatment providers to correct errors as they are identified. Until errors have been corrected by the contractors, the client record on CPMS will not be updated. The disadvantage of these controls is that resolution of errors is cumbersome and the CPMS database used to generate reports is not always up to date.

We checked the accuracy of CPMS data used for analysis in this audit by comparing it to automated client data for FY91-92 from three of the largest County A&D contractors, ASAP, CODA and DePaul. CODA's clients matched CPMS clients 97% of the time, and DePaul's matched 98%. For ASAP, we found that 93% of the clients in our CPMS database matched their database. Some of the discrepancy between databases on ASAP clients appears to be due to differences in how fiscal year files were defined. Our CPMS file was based upon the date the client was last seen while the ASAP file was based upon the date that the termination form was completed. Termination forms at ASAP were completed up to 8 months after the client was last seen.

In addition to validating the number of clients included in the CPMS database we checked the accuracy of selected client information used in the audit. For matched clients, we compared, when possible, demographic variables including gender, ethnicity, and birth date, as well as the performance variable, type of termination. We found 5% or less disagreement on these variables between the CPMS database and the contractor databases.

Although contractors are responsible for submitting accurate and complete CPMS data to the State, they cited a number of shortcomings of the CPMS system. These included unreliable utilization and performance reports, inconsistent reporting among contractors, design errors, and the need for additional data.

Several contractors noted discrepancies between CPMS reports and their own agency data. These apparent discrepancies may have resulted from confusion about how CPMS summary reports are generated. For example, we found that CPMS report labels did not adequately distinguish whether reports were based on newly admitted clients or all clients served. In this case only the computer programmer at the State's MHDDD understood the actual contents of the reports. We did not review the State's computer programs used to generate CPMS reports because we did not rely upon the reported information in the audit.

Contractors cited reporting inconsistencies which could affect the reliability of calculated performance indicators. For example, we were told that some contractors enroll clients on CPMS at initial assessment, while others wait until clients return for treatment. Some clients may fail to enter treatment after the assessment. If the contractor regularly reports clients at assessment, a lower rate of successful completion could result. Contractors also stated that there is some subjectivity used in assessing client performance at termination. Although standards for CPMS reporting are described in the State's training materials and contractors receive technical assistance from the MHDDD Data Processing User Support Unit, enhanced training efforts could improve reporting consistency by the large number of contractors who support the CPMS system.

The system design error cited by the contractors is that CPMS does not currently track multiple referrals. Although clients may receive multiple referrals, for example, to Alcoholics Anonymous (AA) and an outpatient program, only one can be reported. This limitation is particularly problematic for contractors providing residential and CIRT services which are required to meet two mutually exclusive performance standards relating to referrals. They must refer a certain percentage of clients to treatment services and a certain percentage to self-help programs, such as AA.

Finally, two contractors indicated that they would like to see additional CPMS data collected, including service data, prior treatment history, clinically-based measures of addiction, and measures of physical well-being.

In spite of their frustrations with CPMS, several contractors maintain their own automated systems with most of the same data elements on the current CPMS system. Duplicate entry of the same CPMS data by contractors and MHDDD is inefficient and could be eliminated if contractors could submit required data in automated form.

APPENDIX C

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Responses to the Audit

MULTNOMAH COUNTY OREGON

COUNTY CHAIR'S OFFICE
Hank Miggins, Acting Chair
1120 S.W. 5th, Room 1410
Portland, Oregon 97204
Phone (503) 248-3308

June 2, 1993

Gary Blackmer, Auditor
1021 S.W. 4th, Room 136
Portland, Oregon 97204

Dear Mr. Blackmer:

Thank you for your very thorough audit report on Multnomah County's Alcohol and Drug Treatment System. I appreciate the efforts you and your staff put into this report.

I have directed the department managers to give this audit, and the concerns for a "managed system," a high priority.

I have reviewed the attached comments from the Departments of Social Services and Community Corrections. I support these efforts and will monitor them with the expectation of reporting the status to you and the Board within six months.

Sincerely,

Hank Miggins
Multnomah County Chair

HCM:mrm
0291G

AN EQUAL OPPORTUNITY EMPLOYER

MULTNOMAH COUNTY OREGON

DEPARTMENT OF SOCIAL SERVICES
MENTAL HEALTH, YOUTH AND FAMILY SERVICES DIVISION
ADMINISTRATIVE OFFICES
426 S.W. STARK ST., 6TH FLOOR
PORTLAND, OREGON 97204
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BOARD OF COUNTY COMMISSIONERS
GLADYS McCOY • CHAIR OF THE BOARD
DAN SALTZMAN • DISTRICT 1 COMMISSIONER
GARY HANSEN • DISTRICT 2 COMMISSIONER
TANYA COLLIER • DISTRICT 3 COMMISSIONER
SHARRON KELLEY • DISTRICT 4 COMMISSIONER

MEMORANDUM

TO: Hank Miggins, Acting Chair

VIA: Gary Nakao

FROM: Gary Smith
Norma Jaeger

DATE: June 1, 1993

SUBJECT: Response to Alcohol and Drug Treatment System Audit

Attached you will find the Mental Health, Youth and Family Services Division's response to the above referenced audit. In general, we concur with the audit's recommendations. Where we have disagreements, these are noted in the body of the response.

The recommendations of the audit, if implemented, will have significant implications on everyone involved with the County's alcohol and drug system. For the most part, these implications can be positive. However, it must be pointed out that increasing the level of accountability in this system will carry with it a price. The "price" can take different forms: increased costs associated with County monitoring; increased costs to contractors to provide required information; more formal and structured cost finding, payment and contractor selection processes; less "freedom of choice" for consumers and contractors. However, these are the legitimate prices of doing business in an atmosphere of limited resources, the need to set priorities, and the public's right to accountability for publicly funded services. We would welcome the opportunity to discuss these implications with you and the rest of the Board of County Commissioners in the near future.

This audit offers us the opportunity to review our alcohol and drug treatment system in detail. We appreciate the County Auditor and his staff's willingness to fairly and objectively review our current practices.

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GWS/mas

[0183B]

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MENTAL HEALTH, YOUTH AND FAMILY SERVICES DIVISION RESPONSE TO AUDIT OF THE MULTNOMAH COUNTY ALCOHOL AND DRUG TREATMENT SYSTEM CONDUCTED BY MULTNOMAH COUNTY AUDITOR

SUMMARY

In general, we commend the extensive scope and detail of the audit and agree with the majority of findings and recommendations. The Multnomah County Alcohol and Drug Program will establish a detailed plan for addressing the recommendations. We will involve the Multnomah Council on Chemical Dependency, Portland Area Alcohol and Drug Managers Association and the State Alcohol and Drug Program to address or implement all recommendations. We appreciate the persistence, responsiveness and commitment shown by the staff of the Multnomah County Auditor in attempting to identify the significant issues and provide thoughtful and well reasoned recommendations for improvement in this important human service area.

OVERVIEW

We commend the audit as having noted a number of strengths and positive findings about the alcohol and drug treatment system in Multnomah County:

- The County has been successful in developing and maintaining a continuum of services to meet differing client service needs.
- Despite acknowledged inadequacies in financial support, services achieve successful treatment completion rates well within the range found nationally.
- The program has successfully met the challenge of planning and developing services to meet the special and diverse needs of members of minority groups and women, including pregnant women and women with small children.
- The program has actively responded to the increased recognition of the links between alcohol/drug abuse and criminal behavior and is significantly addressing the needs of corrections clients.
- Analysis of five years of client data indicated that overall the County programs have met or exceeded State performance standards.
- The County and its providers have successfully expanded services to increase federal financial support through the Medicaid program, thus increasing services available in the community and improving access to very low income persons.

AREAS OF DISAGREEMENT

We do have some areas of disagreement with some findings in the report.

1. The audit recognizes some but not all County monitoring activities. There is extensive, problem oriented interaction with contractors around issues of program performance. However, such problems and issues are more commonly identified in the course of our regular contact with these programs rather than through structured site visits. We may have failed to be clear about this activity when discussing our monitoring activities. We will develop a more detailed process for documenting this type of monitoring activity.

2. While the audit identifies problems which are correlated with inadequate funding, it stops short of a conclusion about the adequacy of the current level of State funding of treatment slots. We believe that the audit could be clearer and stronger in addressing the inadequate funding of services. The audit does point out the lack of accountability resulting from current State policy requiring contractors to seek multiple sources of funding to make ends meet. We agree that this leads to inadequate accountability. We do not agree that increased monitoring is the solution. Policy change is necessary to adequately fund basic services. Such policy could retain incentives for programs to enhance service quality through fund-raising.

3. The audit compares various programs and presents conclusions about their treatment costs and treatment outcomes. This section of the report is a valuable example of analyses using available CPMS data. However, we are concerned that relevant differences among these programs have not been adequately analyzed and therefore the comparisons may be misleading when viewed as conclusions. Before action could be taken from such comparison additional analysis is needed. We accept the recommendation for more evaluation of programs using such analysis.

4. The audit is focused upon the management of the adult treatment system. We agree that managing the adult treatment system is an important component our overall mission. We believe that other responsibilities of the County Alcohol and Drug Program are also important. These areas include managing services for children and adolescents, providing support and leadership in public education and prevention, and providing central evaluation and referral for the DUII treatment system. Since these areas were not examined in the audit, the direct recommendation to reallocate staff efforts requires thorough further analysis before implementation. We do take seriously the recommendations to increase efforts in the identified areas.

RECOMMENDATIONS AND COUNTY RESPONSES

Better allocation of staff resources and increased system management

To assure that staff resources are used effectively to address priority program needs we will undertake the following actions:

- analyze and prioritize staff time allocation;
- set up a more coordinated monitoring system, including better linkage of fiscal, administrative and programmatic monitoring;

- develop a set of key program indicators to identify programs in need of intensive monitoring. We find this to be one of the most helpful recommendations to balance available resources and necessary activities;

- examine our capacity to provide earlier technical assistance when agencies are having problems;

- improve our communications and involvement with contractor Boards of Directors to utilize their skills and other resources in strengthening programs; and

- develop a memorandum of agreement with the State defining mutual roles and responsibilities in monitoring provider performance and intervening with deficient performance.

Develop a comprehensive plan for alcohol and drug services using available data on treatment cost, usage and success data to determine the most appropriate services to be offered and modify the contract process to incorporate the needs identified in the plan.

We agree with the need for a comprehensive plan for services based upon better data and we will:

- work with the Multnomah Council on Chemical Dependency to develop such a comprehensive alcohol and drug services plan;

- incorporate all appropriate data and community input to describe the most appropriate mix of services and allocation of available resources. Such a plan will guide service contracts for the 1994-95 fiscal year; and

- assure that provider selection and resulting contracts for services will reflect the comprehensive plan and appropriate information about provider cost and performance

Ensure that the most cost-effective mix of services is being provided.

To address this issue we will:

- explore means to directly access CPMS data, compile relevant data elements, analyze such data and integrate it into planning, monitoring and contract development;

- work with the State and providers to improve the accuracy, timeliness and consistency of data reported from Multnomah County to the CPMS system. We are applying for funding to establish a centralized management information system which would integrate CPMS data and other data elements to better support many management and monitoring functions, including client tracking, referral and service management functions; and

- work with the appropriate State agency, other counties and providers to further refine the CPMS system. We have received assurances from the State of its willingness to engage in such a process.

Better monitor the number of clients served by contractors.

We will request CPMS exception reports to identify duplicate enrollments and clients enrolled for excessive periods. We will continue direct client record verification that clients are actively receiving services. As indicated in the report, the County Alcohol and Drug Office, with assistance from the State and the Department of Community Corrections, has completed total census audits of all outpatient providers to verify reported utilization levels. We will conduct similar audits of the residential programs to establish a baseline to carry out continued validation monitoring. While we found problems in timely CPMS reporting, we only found two providers with resulting minimal underutilization.

We will ask the State to consider a multiple part CPMS form to assure consistent enrollment and termination information. This simple yet insightful recommendation is very helpful.

Improve movement of clients through the treatment continuum.

We have long advocated for the need for more direct management of client movement into and among services in the treatment system, as well as tracking client participation in treatment. We will pursue the following activities in response to this recommendation:

- address with our Contractors ways of improving client continuity of care, and;
- develop a Federal proposal which, if funded, would provide for a central intake function to be operated by the County and a system management council made up of providers and County to better assure proper movement of clients to and through appropriate levels of service.

Implement a more accountable reimbursement system linking scarce resources to services presented by contractors.

We have presented a proposal to the State Alcohol and Drug Program Office to enable Multnomah County to pilot a fee-for-service reimbursement system which would tie reimbursement directly to units of service provided to clients. This approach, which would have provider support as well, would allow us to address the issues of multiple funding of services, give us better data on service volume actually delivered to clients, and allow for accurate monitoring of demand for services matched to supply of services. This approach is also included in the previously mentioned federal grant proposal.

We will coordinate with Community Corrections to better manage joint funding of alcohol and drug services. However, unless there is a change in the policy of requiring providers to seek added local funding for State alcohol and drug funded services, we must be cautious in how we restrict provider revenues from other County sources.

With respect to requesting that the State seek a written opinion about the policy of Medicaid billing, we believe this to be properly a State decision. We do not plan to intervene in this issue with the State. If we are given approval for reimbursing on a fee-for-service basis this will become a moot point as all reimbursement sources would become separate, as we agree they should be.

We will work with the State to review treatment costs and reimbursement rates and review contractor estimates of service costs. Certainly, if slots are no longer the means of funding services there will be a need for a systematic and consistent method of cost finding and rate setting. However, we believe such activity is not particularly relevant or useful if the slot funding approach remains, since reimbursement is not tied to costs. Should our federal proposal be funded, cost finding and rate setting would be an integral part of the system. This function will require resources beyond those currently available to our program.

Identify alternative solutions to deal with the Medicaid match shortages.

We have long advocated that the State recognize the shortfalls in available Medicaid allocations and seek additional State matching funds to increase the available allocation. Additional State matching funds, or identifying allowable local match, are the only currently available remedies to the existing problem of having to surrender State funded slots to meet the need for Medicaid matching funds.

We are, however, assessing whether the County can reduce Medicaid expenditures through instituting a "managed care" system relative to Medicaid funded services delivered by our performing providers. Such a system would only be a cost control measure if the current level of reimbursement is resulting from providing more services than are clinically necessary. We do not have any data to suggest that this is the case. In addition, we would have to obtain additional resources to undertake such a function.

In conclusion, we will be developing a plan to implement the audit recommendations. We believe that the changes proposed will strengthen both the system of alcohol and drug services and the accountability and effective management of the system.

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May 28, 1993

Mr. Gary Blackmer, County Auditor
Multnomah County
1021 SW 4th Avenue, Room #136
Portland, Oregon 97204

Dear Mr. Blackmer:

The purpose of this letter is to provide the response for the Multnomah Council on Chemical Dependency (MCCD) to the Final Draft of "Alcohol and Drug Treatment: Need for a Managed System". After many hours of discussion, a thorough review of the original, working draft and detailed feedback to your office prior to the issuance of the Final Draft, we feel you have compiled a document that is remarkably fair, generally accurate and most timely. As with any such effort, we can point to items here or there in the document and offer alternative views. However, that is not the point or intent of this letter. Rather, we choose to accept your report and will use it as a tool for those parts of the system that the MCCD can affect.

We do want to take this opportunity to comment on selected points raised in your report. Those are: systems design, data management, and services financing.

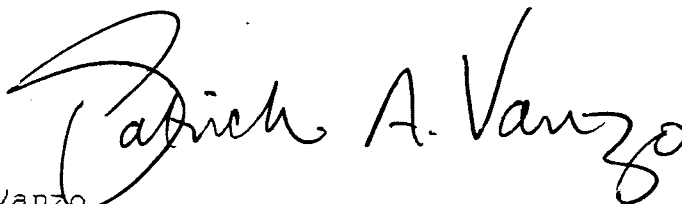
Providers were able to recount numerous examples of how the state-county services management process lacks clarity and precision. The result of this, from a provider's perspective, is a process that carries with it significant potential for double-jeopardy in some arenas and virtually no review/monitoring in others. Seemingly, the major players -- state, county, and providers -- have never reached agreement on the scope of their shared work. Until this situation is dealt with effectively and thoroughly, we will not have a system of care, but rather the confusion, blaming and disjointedness we currently experience.

The potential for "bad" data to enter the CPMS system and contaminate the various reports seems quite high. Varying interpretations, conflicting advice, lack of attention to detail, inability to receive reports in a timely manner, inability to edit/correct data errors, lack of multiple entry alternatives in favor of forced choice options, and long-standing distrust all combine in such a way as to make providers, and many on the MCCD, very wary about the generalizations that anyone can draw from this flawed database.

The financing of care in the county managed system seems to be unhinged, for the most part, from the actual costs of care. The state-county-provider partnership needs to be structured in such a way as to establish true costs. Subsequently, reimbursements need to be provided which are proportionally greater than the fractional slot reimbursement currently provided.

Thanks for taking the time to hear our concerns over the last several months and for giving us numerous opportunities for input. Your process, front to back, has certainly been an open one from the MCCD's point of view.

Sincerely,



Patrick A. Vanzo
MCCD Chairman

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JUN 01 1993
Multnomah County Auditor

MEMORANDUM

TO: Gary Blackmer, County Auditor

FROM: Portland Area Alcohol and Drug Managers Association (PAADMA)

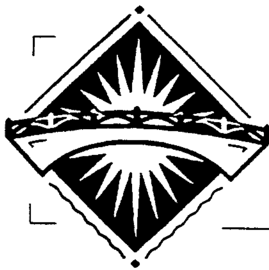
SUBJECT: Audit Report on Multnomah County's Alcohol and Drug Treatment System

PAADMA represents the majority of contracted alcohol/drug treatment providers in the Portland area. When initially approached regarding this audit, our members committed to active participation in the effort. We have spent many hours, individually and collectively, studying the audit report. The following represents the consensus of PAADMA's review:

1) We concur with the report's recommendations for improved planning, monitoring, and evaluation. Consistent with these functions, we support the concept of performance-based contracting. Given the lack of documented reliability and validity of the CPMS, we recommend that this data system be replaced or significantly revised prior to any further decision - making based upon it.

2) PAADMA believes that there was inadequate attention in the audit to the issue of funding for treatment. We appreciate the audit's acknowledgment of our underfunded status. There was, however, no consideration or analysis of comparable costs of privately-funded non-profit programs or of publicly-funded programs in other regions. In other words, no cost analysis or cost-benefit analysis was conducted outside of Multnomah County's contracted providers. Such an analysis would have been valuable in understanding the parameters of the concept of "under-funding" and perhaps in clarifying some of the audit findings.

In summary, it is our position that inadequate funding is a primary factor in every negative audit finding reported and that greater attention to this issue would have enhanced the potential utility of the audit recommendations. As indicated, however, we generally support the recommendations and request that a reliable and valid data system be developed to serve as a foundation for effective performance-based contracting.



Transition Projects, Inc.

Formerly Burnside Projects, Inc.

1211 SW Main Street
Portland, Oregon 97205
503-222-9362
FAX: 503-274-7633

Gary Blackmer, Auditor
Multnomah County
1021 SW 4th Avenue, Room 138
Portland, Oregon 97204

June 2, 1993

To Gary Blackmer,

We are writing this letter to respond to you regarding the recent Multnomah County Audit Report that has been distributed. We regard the report as having been a useful document to us and to the treatment providers in the county. Many good conversations have resulted from the report and I think that the agencies have all used it to enhance their programs. Transition Projects has used this as a stimulus to evaluate programs and processes at tne agency and corrections have been made. The PAADMA group has been more mutually supportive and positive to eachother and the process has been beneficial. We feel better able to provide the services needed to poor and low income clients as result of some program adjustments.

We would like to address some of the specific problems outlined in the audit as they apply to our agency and to tell you of our remedial process. First, we have closed the 705 open clients and our CPMS list is now reflective of the actual number of clients that we are treating in the program. Second, we are not aware of any duplicate clients and again our open client list is accurate to the clients we are seeing.

We would like to recognize the openness that you and your staff displayed as we jointly critiqued the language and approach of the first draft of the audit. We all deserve credit for trying to better the system of treatment and we think that the second draft reflects a more balanced and appropriate reflection of treatment in the county.

Sincerely, Susan Dreyer, Clinical Director

Susan Dreyer, Clinical Director

Night & Day Shelter
Alcohol & Drug-Free Housing
Clean-Up Center
Corrections Counseling
Alcohol & Drug Treatment
Women's Programs
Hispanic Services
Crisis Intervention Services
Mental Health Services
Employment Counseling & Job Placement
Public Education
A United Way Agency

Programs in substance abuse and mental health treatment

Mr. Gary Blackmer, Multnomah County Auditor

CODA's Board of Directors recognizes its obligation to spend public funds wisely. The cost of services to the low or no-income families it serves and the amount of revenue necessary to provide the services are reviewed at every Board meeting, and the Board Treasurer meets regularly with the Finance Director to review expenditures and recommend changes that may create greater efficiencies. The Board agrees with the County Auditor's recommendations to improve the system, particularly with the low levels of funding.

CODA's costs for residential services are higher than other public funded programs due to the longer length of treatment, the inclusion of children's services, higher lease costs and a more intense level of service than required by administrative rules. However, these costs are low compared to residential services provided by private, proprietary companies. During last year, one such program in the local area went out of business because of a lack of funds; their charges were just over $100 per day. The fact that CODA's residential services and other publicly funded programs can provide services and stay in business is a tribute to how frugally the public funds are being spent.

CODA disagrees with the assumption used that the residential components are comparable from financial cost analysis, client demographic and treatment outcomes. Furthermore, the assumption that length of treatment is inconsequential directly contradicts the findings of the Multnomah County Community Corrections research done by Stephen Kapsach, Ph. D., of Reed College in January 1992. This study of CODA'S Alpha House clients, paid for by Multnomah County, showed that,

> **"Length of stay is clearly related to the rates of rearrest: those who stay longer in treatment tend to do better in avoiding trouble later. These results are consistent with the gist of the literature and should be apparent in data on length of stay as it relates to measures of drug use and social adjustment."**

CODA has two residential programs with distinct differences in the amount of services provided and treatment goals expected. Alpha House provides a CIRT level of services for a three to six month length of stay. The clients are men and women with children who are younger and have more criminal history than any other residential program.

New Directions is a transitional residential service that provides

Outpatient Services 306 N.E. Twentieth Avenue • Portland, OR 97232 239-8400
Administration 210 N.E. Twentieth Avenue • Portland, OR 97232 239-8400

supportive services to men and women with children who have completed a primary treatment service like Alpha House and are ready to begin work, enroll in school or establish themselves in the community as primary caretaker of their children. Both programs have significantly longer treatment episodes than other residential programs and both have "family treatment models" which demand a higher staffing level and greater expertise. Both facilities have paid night staff who monitor clients at night, which is not required at adults-only facilities.

Audit's length of stay for all residential programs - 10.2 weeks
CODA's Alpha House length of stay 13.14 weeks
CODA's New Directions length of stay 12.28 weeks

The data system (CPMS) that was used for the analysis by the auditor does not separate out the two programs. Consequently, the costs for both programs were added together, which inaccurately demonstrates the cost of treatment.

Finally, treatment goals become more complex in longer programs. New behaviors measured in the shorter programs that do not include families, are simpler and easier to measure. As these behaviors are practiced, other treatment goals are initiated. An example that illustrates this difference is the 52% abstinence rate at termination, compared to the 31% completion rate.

There is no current standardized measurement of treatment goals that could evaluate programs reliably. The "cost-benefit" method of comparing programs on a "per successful outcome" basis dilutes treatment goals and renders them useless, clinically and discounts the benefits to clients (and their families) who have not attained all their treatment goals.

The "cost-benefit" analysis may be accurate for measuring short-term "snap shots" of treatment outcomes, but is unreliable as a measurement tool for the effectiveness for longer-term substance abuse treatment. Long term family treatment reduces criminal recidivism, health care costs, and family disintegration.

In summary, CODA continues to look for operational efficiencies, however, the length and types of treatment, the populations served, age, criminal involvement and severity of drug use increases the overall costs per completion. **A family treatment model seems costly in the short term, but saves both lives and money in the long term.**

Ann S. Uhler
Executive Director

Kevin McDonald
CODA Board Chair

1733 N.E. 7th Avenue
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(503) 281-0037

TREATMENT ALTERNATIVES TO STREET CRIME

EXECUTIVE DIRECTOR
Linda P. Tyon

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June 1, 1993

Gary Blackmer
Multnomah County Auditor
1021 SW 4th Avenue, Rm. 136
Portland, Oregon 97204

Dear Mr. Blackmer,

This letter is the written response, as requested, to the final draft of the audit report on Multnomah County's alcohol and drug treatment system.

In general, we find this draft a much improved document. However, there were a couple of areas of concern. On page 42 of the report you indicate a "service overlap" between alcohol and drug treatment slots and CCA treatment slots was found. You also, in fairness, state that since your review County A/D and Community Corrections conducted a review and found no current underutilization. Please note that the County offices conducted a census audit of <u>all</u> open files reported for a month. This audit required three persons one full and one-half days of review. In the case of your office I am presuming that since your staff were on site less than one-half day, that a sample of files were reviewed and a percentage was applied to calculate the underutilization. This may have resulted in a less than accurate estimate of utilization.

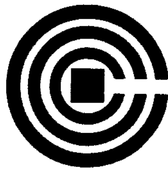
Additionally, I would have preferred that a stronger emphasis be placed on the under-funding of the system in general. In the first draft you reported the relative cost effectiveness of outpatient services which showed TASC as the second most cost effective of the contractors. No mention of this was made in the final draft.

Thank you for the opportunity to respond. We at TASC appreciate your willingness to listen and respond to our concerns.

Sincerely,

Linda P. Tyon
Executive Director

TASC of Oregon, Inc. Serving the Local Community Since 1977



CENTRAL CITY CONCERN

Solutions To Homelessness & Chemical Dependency

June 2, 1993

Administrative Office
709 N.W. Everett
Portland, Oregon 97209-3517
(503) 294-1681
FAX (503) 294-4321

Portland Addictions Acupuncture Center
727 N.E. 24th
Portland, Oregon 97232
(503) 239-0888

Hooper Center / CHIERS
20 N.E. Martin Luther King, Jr. Blvd.
Portland, Oregon 97232
(503) 238-2067

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Gary Blackmer
County Auditor
1021 SW 4th Avenue Room 136
Portland, OR 97204

Dear Gary,

The following are my comments regarding specific sections of the Alcohol and Drug Treatment Audit.

Page 4 first paragraph:

"The typical client at ... and Hooper is Caucasian."

This statement results in a false characterization of the population served by Hooper and other programs. The fact is is that minorities make up 32% of the Hooper clients which is a higher representation than the actual proportion of the minority population in Multnomah County. The typical client is not caucasian. Caucasians are not typicial of minority clients. A more accurate statement would be:

"Caucasians represent the majority of clients at....and Hooper. Minorities are represented as clients at a higher level than the percentage of the minority population of Multnomah County."

Page 10, bottom of third paragraph:

"... referrals from residential and detox programs ... have seen significant declines..."

CPMS data in regards to referrals admitted seems to be highly unreliable. Futhermore, the information presented in the audit results in a false characterization because it doest not include admissions to the Portland Acupuncture Addictions Center, which admits about 250 Hooper referrals a year, or programs not funded by Multnomah County.

cc: Richard Harris

MULTNOMAH COUNTY OREGON

DEPARTMENT OF COMMUNITY CORRECTIONS
421 S.W. 5TH, SUITE 600
PORTLAND, OREGON 97204
(503) 248-3701
FAX (503) 248-5376

GLADYS McCOY
COUNTY CHAIR

MEMORANDUM

TO: Gary Blackmer, County Auditor

FROM: M. Tamara Holden, Director
Department of Community Corrections

SUBJECT: Audit Report on A&D Treatment System

DATE: May 27, 1993

Thank you for the opportunity to review and comment on your audit of Multnomah County's A&D treatment system. I appreciate the effort that went into the report and the recommendations offered by your staff. Although you made it clear that the scope of your study was limited to the Department of Social Services/Alcohol and Drug Program, our Department, as a provider of contracted A&D treatment, will benefit from your analysis.

I. Department of Community Corrections Contract Management

DCC develops and contracts for correctional treatment services to meet the needs of our clients, our supervising probation/parole officers, and other criminal justice agencies. Your working draft emphasized the importance of client - program matching, contract monitoring, and evaluation. I would like to summarize our progress in those areas because your report did not address DCC's management of substance abuse services.

A. Client - Program Matching

Because DCC is responsible for supervising and case managing the clients it refers to treatment, the appropriateness of the referrals is important to us. Our Diagnostic Center provides central intake services and is the locus of client assessment in a number of areas, including substance abuse, mental health, sex offender issues, and subsistence needs. We have assigned three Alcohol & Drug Evaluation Specialists to do thorough assessments of drug involved offenders using a standardized instrument, the Addiction Severity Index. Assessment reports guide referral decisions to help assure that our contract resources are used as effectively as possible.

AN EQUAL OPPORTUNITY EMPLOYER

B. Program Monitoring

Our monitoring effort includes the following components:

1. Performance Objectives

Quantified objectives are included in each contract and contractor performance is monitored against those objectives monthly.

2. Database

Client intake and exit forms are sent to us monthly for entry in our database. Intake forms include demographic and social history information. Exit forms include data on treatment outcomes and units of service provided. The database allows us to assess program outputs and treatment outcomes for specific sub-populations. Unlike CPMS, this database is locally managed and immediately accessible for analysis.

3. Performance Reports

Staff produce a monthly spreadsheet detailing the performance of our contract programs. Data includes numbers served, number of drop-outs, types of termination, length of stay, and payments made. These reports are shared with contractors to help us resolve reporting and performance discrepancies.

4. Quality Assurance

Our QA is based on a written set of standards that emphasizes good case management and criteria of importance to probation/parole officers. We also expect our contractors to meet State licensing requirements promulgated by the Office of Alcohol and Drug Abuse Programs.

5. Site Reviews

DCC staff visit our contract programs <u>quarterly</u> to inspect files, discuss problems, and assess progress in meeting our performance and case management objectives.

6. Technical Assistance

DCC staff regularly assist contractors with their management information systems, case file management, training, and compliance with State and DCC program standards.

7. Monthly Contract Services Meeting

The DCC Contract Services Committee meets <u>monthly</u> to discuss program development and inter-agency issues, and to resolve operational problems. The Committee consists of representatives of all of our contract agencies and a cross section of DCC staff (including managers, probation/parole officers, and program specialists).

C. Program Evaluation

We evaluate our programs for a variety of reasons, all of which are based on the premise that evaluation is a tool and a process for improving our decision making and service delivery. Evaluation helps us to :

- Assure accountability and compliance with funding and performance criteria;
- Promote the concept of stewardship, assuring that public funds are spent wisely;
- Identify implementation and operational problems and provide technical assistance as needed;
- Quantify and measure program outputs and outcomes to determine if objectives and goals are being met; and
- Suggest new strategies for meeting identified needs.

1. Process/Performance Evaluation

For several years, DCC site reviews, summary statistics, and informal feedback from staff have helped us identify problems and determine whether a program is meeting our needs. Process concerns include agency case flow, referral mechanisms, record management, interagency communication, curriculum content and scheduling, units of service provided, appropriateness of program for minority populations, case planning, staff training and supervision, and discharge planning. Performance criteria (specified in our contracts) include numbers served, drop out rate, and termination type (successful, unsuccessful, administrative). Our Annual Report includes a statistical summary of each program's performance, measured against its contract objectives. Beginning in May of this year, we will be implementing two additional evaluation components to help round out our ability to assess program performance: client exit surveys and probation/ parole officer surveys.

2. Impact Evaluations

Our plan for impact evaluations includes internal studies and outside evaluators. The evaluation of one of our residential contract programs by the Reed College Public Policy Workshop was completed in 1992. That project was designed to provide an impact analysis <u>and</u> educate our Community Corrections Advisory Committee about program evaluation. Our intent was to make Committee members knowledgeable consumers of evaluation information. We are presently working with several nationally respected authorities on correctional treatment programs who have obtained federal funding to evaluate many of our contract programs. Our involvement with federally funded outside evaluators is a very cost effective way for us to benefit from program evaluations. The following studies are in progress:

- RAND Corporation study of four outpatient treatment programs;
- The Urban Institute/BOTEC Analysis evaluation of our drug testing program;
- National Council on Crime and Delinquency evaluations of our VOA Women's Residential Treatment programs (and other correctional treatment programs in Oregon); and
- Northwest Professional Consortium evaluation of our ADAPT program serving pregnant, addicted women.

The following studies have been proposed for federal funding:

- American University evaluation of our drug diversion program; and
- National Development and Research Institutes evaluation of our gender-specific treatment for women.

Beginning in 1993-94, our internal impact evaluations will compare groups that complete or drop out of treatment. We will do follow-up analysis at 6 and 12 months after program termination, comparing the groups on the basis of recidivism, substance abuse, and employment status (three generally accepted indicators of program impact). Such studies are becoming less staff intensive as DCC progresses toward completion of an M.I.S./automated case file system that links users with case management, criminal history, and court databases. At present, three of our seven field offices are piloting the system.

II. Dual Reimbursement Systems

As you learned in the course of your research, two of the four agencies that contract with both DSS and DCC to provide A&D treatment use the same clients to support claims for reimbursement under both contracts. There are several perspectives on this issue. It is always our intention when contracting for services that we expand the availability of treatment in the community. The agencies in question might point out that even if an overlap of service exists, they still provided 85% of the service that would be expected if there were no overlap (per your data). If 90% or 95% performance is considered acceptable, how egregious a situation do we have with 85% performance? If the County can only offer minimal reimbursement rates for service, are the agencies not doing an admirable job of responding to our needs within our budgets?

Regarding our contract with CODA for detoxification and residential treatment, I think it is important to fully appreciate what we purchase from that agency. We developed, and put out for bid, a model for residential treatment that significantly exceeds the minimum standards promulgated by the State Office of Alcohol and Drug Programs. We feel that our program does a better job of meeting the needs of our target population and we are willing to pay for that level of service (we developed the residential treatment funded by the Corrections Levy with the same premise). CODA has used our funding to supplement its other revenue and make our program model available to clients served under the DSS contract. In effect, both DCC and DSS benefit from an expansion of service capacity and an enhanced level of service. It should also be noted that the success rate for our clients in CODA's residential program (Alpha House) was 54% in 1990-91 and 61% in 1991-92. This performance is significantly higher than that reported in your working draft, though that may be at least partly due the fact that clients who drop out before completing 5 days in treatment are considered as having failed to engage in treatment, rather than as program failures.

Regarding our contract with TASC, your analysis led you to conclude that the County was getting less service than it paid for. I'm not sure that is true today. On April 19, DCC and DSS staff did a special audit of TASC to determine if our contracts were being under-utilized (as suggested in your Final Draft). Staff found that DSS slot usage and DCC exit information were being accurately reported and that utilization is not currently a problem.

Problems in the collection and reporting of CPMS data, as well as our inability to access and operate on the data, led us to develop our own client tracking system for Community Corrections contract services.

If, indeed, there is a service overlap problem which is adversely impacting the cost effectiveness of contract treatment services, we will work with DSS to remedy and monitor the situation. We may want to include the following language in future RFPs:

> Clients served under the contract awarded to the successful proposer may not be used to support a claim for reïmbursement for similar services under any other Multnomah County contracts.

If some agencies can segregate clients for billing to DSS and DCC, we could reasonably expect all agencies to do so. Administratively, that would be a cleaner process and it need not result in significantly fewer clients being served. However, we need to be very sure about the nature and extent of the problem, as well as its impact on the services received by clients.

Thank you very much for the opportunity to comment on your audit report. I hope you find my feedback helpful.

c: Hank Miggins
Cary Harkaway
Michael Haines
Michael King
Judith Duncan
Horace Howard
Jim Rood
Wayne Salvo
Teresa Carroll
Susan Kaeser