PERFORMANCE AUDIT
OF THE

DIVISION OF CHRONIC DISEASE AND INJURY CONTROL

COMMUNITY PUBLIC HEALTH AGENCY
DEPARTMENT OF COMMUNITY HEALTH

June 2003

39-690-02

Michigan

Office of the Auditor General

REPORT SUMMARY

Performance Audit
Division of Chronic Disease and Injury Control
Community Public Health Agency
Department of Community Health

Report Number:
39-690-02

Released:
June 2003

The Division of Chronic Disease and Injury Control endeavors to promote healthy lifestyle factors in individuals and vulnerable populations and communities to improve the length and quality of life for all Michigan residents through an organized program to reduce risk factors in schools, communities, health care settings, and work sites. The Division focuses its efforts on various chronic diseases and injuries.

Audit Objectives:

1. To assess the Division's effectiveness in administering State injury prevention programs.

2. To assess the Division' s effectiveness in administering programs that help prevent and minimize State chronic disease deaths, illnesses, and costs.

3. To assess the effectiveness and efficiency of the administration of selected Divisionwide activities.

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Audit Conclusions:

1. We concluded that the Division was generally effective in administering State injury prevention programs.

2. We concluded that the Division was generally effective in administering programs that help prevent and minimize State chronic disease deaths, illnesses, and costs.

3. We concluded that the Division was generally effective and efficient in its administration of selected Divisionwide activities.

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Noteworthy Accomplishments:

Using a continuous quality improvement model, Division staff implemented a data evaluation process that was successful in streamlining the overall program reporting process for the Division's Breast and Cervical Cancer Control Program. As a result of these changes, the Division reported that there has been an increased adherence to the Centers for Disease Control and Prevention (CDC) timeliness performance indicators for abnormal breast screenings and for abnormal cervical screenings. Because of this improvement, CDC highlighted the Michigan Quality Improvement Program on its Web site.

In addition, the Division's Diabetes Control Program was recognized by the Assistant Secretary for Health and Human Services, U.S. Department of Health and Human Services, in 2002 for its "Best Practice Initiatives" in diabetes. The Division informed us that the "Best Practice Initiatives" award is given to state programs that demonstrate quality and success in program outcomes.

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Reportable Conditions:

The Division did not seek to continue its injury prevention programming for fire safety and prevention by reapplying for federal funds available through CDC (Finding 1).

The Division did not maintain proper documentation of the use of its SAFE KIDS van, as required by State regulations (Finding 2).

The Division needs to ensure that diabetes self-management education programs are recertified in a timely manner (Finding 3).

The Division could improve the effectiveness of its Diabetes Control Program by enhancing its efforts to ensure the completeness of its diabetes database (Finding 4).

The Division needs to improve its monitoring controls to ensure that contractors are effectively and efficiently fulfilling their programmatic and fiscal obligations (Finding 5).

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Agency Response:

Our audit report contains 5 findings and 5 corresponding recommendations. The Division's preliminary response indicated that, although it agreed with Finding 1, it did not necessarily agree with the recommendation. The Division's preliminary response also indicated that it generally agreed with Findings 2, 3, 4 and parts a., c., and d. of Finding 5 and that it had complied or would comply with the corresponding recommendations. The Division's preliminary response further indicated that it did not agree with part b. of Finding 5.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: www.state.mi.us/audgen/

Michigan Office of the Auditor General
201 N. Washington Square
Lansing, Michigan 48913

Thomas H. McTavish, C.P.A.
Auditor General

James S. Neubecker, C.P.A., C.I.A., D.P.A.
Executive Deputy Auditor General

Scott M. Strong, C.P.A., C.I.A.
Director of Audit Operations

STATE OF MICHIGAN
OFFICE OF THE AUDITOR GENERAL
201 N. WASHINGTON SQUARE
LANSING, MICHIGAN 48913
(517) 334-8050
FAX (517) 334-8079

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

June 6, 2003

Ms. Janet Olszewski, Director
Department of Community Health
Lewis Cass Building
Lansing, Michigan

Dear Ms. Olszewski:

This is our report on the performance audit of the Division of Chronic Disease and Injury Control, Community Public Health Agency, Department of Community Health.

This report contains our report summary; description of agency; audit objectives, scope and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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DIVISION OF CHRONIC DISEASE AND INJURY CONTROL
COMMUNITY PUBLIC HEALTH AGENCY
DEPARTMENT OF COMMUNITY HEALTH

Description of Agency

The Division of Chronic Disease and Injury Control, Community Public Health Agency, Department of Community Health (DCH), endeavors to promote healthy lifestyle factors in individuals and vulnerable populations and communities to improve the length and quality of life for all Michigan residents through an organized program to reduce risk factors in schools, communities, health care settings, and work sites.

Sections 333.5101 - 333.5955 of the *Michigan Compiled Laws* (Article 5 of the Public Health Code) address the prevention and control of diseases and disabilities and are the basis for DCH's efforts to address diseases, including chronic diseases.

The Division focuses its efforts on various chronic diseases and injuries. These chronic diseases include cancer, cardiovascular disease, diabetes, kidney disease, dementia, and osteoporosis. Injuries include those associated with motor vehicle crashes, bicycles, fires, and falls. The Division collaborates with numerous other State, federal, regional, and local entities and individuals to help prevent and control chronic diseases and injuries. Organizationally, the Division consists of the Cancer Prevention and Control Section; Cardiovascular Health and Nutrition Section; Diabetes, Dementia, and Kidney Section; and Injury Prevention Section.

Executive Order No. 2001-9, effective November 6, 2001, reduced funding available to DCH. As a result, effective December 15, 2001, the Cardiovascular Disease Prevention - Worksite and Community Health Promotion Program was eliminated from the Cardiovascular Health and Nutrition Section. In addition, in December 2001, the Violence Prevention Section was merged with the Unintentional Injury Prevention Section because of these same budget cuts, which resulted in a program reduction with only federally funded programs remaining active. These federally funded programs included rape and sexual assault primary prevention programs targeted at junior and senior high school students and a federal Centers for Disease Control and Prevention cooperative agreement for violence against women surveillance.

For fiscal year 2000-01, the Division expended approximately $26.5 million on chronic disease activities, $4.9 million on injury prevention activities, and $3.0 million for administration, for a total expenditure of $34.4 million. As of September 30, 2002, the Division had 42 employees and used contractual service providers to assist in operating its programs.

Audit Objectives, Scope, and Methodology and Agency Responses

Audit Objectives

Our performance audit* of the Division of Chronic Disease and Injury Control, Community Public Health Agency, Department of Community Health (DCH), had the following objectives:

1. To assess the Division's effectiveness* in administering State injury prevention programs.

2. To assess the Division's effectiveness in administering programs that help prevent and minimize State chronic disease deaths, illnesses, and costs.

3. To assess the effectiveness and efficiency* of the administration of selected Divisionwide activities.

Audit Scope

Our audit scope was to examine the program and other records of the Division of Chronic Disease and Injury Control. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances.

Audit Methodology

Our audit procedures, conducted during February through September 2002, included examining records and activities for the period October 1, 2000 through September 30, 2002.

Our methodology included reviewing statutes and appropriations act boilerplate language; gaining an understanding of the mission* of DCH and the Division; and interviewing the Division's employees to determine its goals* and objectives* related to minimizing death, illness, and cost of chronic diseases and injuries. We determined that

** See glossary at end of report for definition.*

the Division used agreements with contractors, nonprofit agencies, and local health departments and conducted numerous programs as it worked to accomplish its goals and objectives.

To accomplish our first and second objectives, we gained an understanding of each of the major types of diseases and injuries sufficient to understand reasonable prevention strategies. We used financial and nonfinancial priority indicators to narrow the focus of our audit scope. We determined whether the Division had systems, controls, procedures, and documentation necessary to make reasonable policy and programmatic decisions. We reviewed and tested the timeliness, accuracy, and relevance of underlying data and information to ensure that policy and programmatic decisions were supported.

To accomplish the third objective, we considered the extent to which Divisionwide activities were controlled, directed, and coordinated in ways to ensure that the Department's mission and the Division's goals and objectives could be effectively and efficiently accomplished. We reviewed selected administrative efforts, such as the accuracy of calculations, contract monitoring, compilation and sharing of best practices, maintenance of adequate policies and procedures, and program evaluation processes.

Agency Responses

Our audit report contains 5 findings and 5 corresponding recommendations. The Division's preliminary response indicated that, although it agreed with Finding 1, it did not necessarily agree with the recommendation. The Division's preliminary response also indicated that it generally agreed with Findings 2, 3, 4 and parts a., c., and d. of Finding 5 and that it had complied or would comply with the corresponding recommendations. The Division's preliminary response further indicated that it did not agree with part b. of Finding 5.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussions subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of Management and Budget Administrative Guide procedure 1280.02 require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the final report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS OF INJURY PREVENTION PROGRAM ACTIVITIES

COMMENT

Audit Objective: To assess the Division of Chronic Disease and Injury Control's effectiveness in administering State injury prevention programs.

Conclusion: We concluded that the Division was generally effective in administering State injury prevention programs. However, we noted reportable conditions* related to fire safety and prevention program activities and the SAFE KIDS van (Findings 1 and 2).

FINDING

1. **Fire Safety and Prevention Program Activities**

   The Division did not seek to continue its injury prevention programming for fire safety and prevention by reapplying for federal funds available through the Centers for Disease Control and Prevention (CDC). Statistics from national and State organizations have demonstrated that fire safety and prevention program activities are effective in reducing fire-related injuries and death and also can result in significant economic savings.

   CDC provides funding for the installation of smoke alarms and for fire safety education to persons living in homes located in high-risk communities through its Prevention of Fire-Related Injuries Grant. CDC's definition of a high-risk community includes those that have fire death rates that are higher than the State and national averages. In addition to the Division, other State and local departments, such as the Fire Marshal Division, Michigan Department of State Police, and local SAFE KIDS coalitions and chapters, provide fire safety education and smoke alarms to high-risk communities.

* *See glossary at end of report for definition.*

The Department of Community Health (DCH) reported in October 2001 that Michigan's death rate because of unintentional fires exceeded the national rate for all except one year between 1990 and 1998 by an average of 7% to 31%. DCH also reported that from 1994 to 1998, Wayne County's average annual rate of death because of unintentional fires was 2.3 deaths per 100,000 residents and that this rate exceeded the Statewide rate of 1.5 per 100,000 residents by 53%. Wayne County's average death rate during this time exceeded the national death rate for this same period (1.36 deaths per 100,000 residents) by 69%.

In 1998, the Division applied for CDC's Prevention of Fire-Related Injuries Grant and received a three-year CDC grant award of $150,585, $156,585, and $158,270 for fiscal years 2000-01, 1999-2000, and 1998-99, respectively. CDC renewed the grant annually based on the Division's program efforts. The Division reported that 8,691 smoke detectors were installed in 3,757 homes during the three-year grant period and estimated that 999,328 citizens in Michigan were reached through various public awareness activities, such as flyers, radio, television, bill boards, etc. However, the Division did not reapply and compete for the grant for the award period beginning in fiscal year 2001-02 and, as a result, will not be eligible to receive a multi-year grant award for fire prevention funding from CDC until fiscal year 2006-07. The Division could not provide documentation of its decision-making process regarding its decision not to reapply for the federal grant.

In addition to Michigan, 13 other states were awarded CDC grant money for fire prevention during fiscal years 1998-99 through 2000-01. Of those 13 states, 12 (92%) applied for and received repeat funding for a five-year period beginning in fiscal year 2001-02. Also, our review of status reports from the Division to CDC indicated that Michigan's Fire Safety and Prevention Program was successful, which resulted in the receipt of the federal funding awards each year. In addition, we noted that the criteria CDC established as a basis for awarding the grants did not change substantially between the two grant award periods. Therefore, we conclude that, if the Division had applied, Michigan likely would have been approved for repeat funding.

According to the U.S. Fire Administration, 80% of fires occur in residences and an average of 4,400 Americans die and another 25,000 are injured annually in fires. Nationally, approximately 3,600 children under the age of 15 are killed or injured in fires each year. Of children aged 14 and under who were killed or injured, 64% of the children killed and 40% of those injured were asleep.

According to CDC, the chances of dying in a residential fire are cut in half when a working smoke detector is present. In addition, the Children's Safety Network Economics and Insurance Resource Center reported that every dollar spent on smoke detectors saves society approximately $55 to $70. Based on this data, the savings to the citizens of Michigan during the three-year grant award period as a result of the Fire Safety and Prevention Program were between approximately $5.7 million and $7.3 million and, if the Division had applied for and received funding for the next five-year grant award period, the potential savings to the citizens of Michigan would have been between $9.6 million and $12.2 million. The Division could not document that it had performed a similar analysis before making its decision to not reapply for the grant award or that it had considered how other programs it was continuing to administer provided comparable or better economic and social benefits to the citizens of Michigan.

RECOMMENDATION

We recommend that the Division seek to continue its injury prevention programming for fire safety and prevention by applying for federal funds available through CDC.

AGENCY PRELIMINARY RESPONSE

The Division agreed that it did not document the rationale for the decision not to re-compete for a CDC fire safety grant, but the Division did not necessarily agree with the recommendation. The Division would like to be able to participate more fully in providing fire safety and prevention programming and will respond to appropriate future grant opportunities to provide resources to address this issue. The decision to compete for federal funding will be based on availability of funds, funding priorities of CDC, and programmatic considerations (e.g., the needs of the State, available internal and external resources to prepare an application and carry out the program, the environmental and political realities in which the program would operate, and past performance and experience).

FINDING

2. SAFE KIDS Van

The Division did not maintain proper documentation of the use of its SAFE KIDS van, as required by State regulations.

The SAFE KIDS Program is dedicated to preventing unintentional childhood injuries in Michigan through implementation of community-based injury prevention programs; dissemination of injury prevention information to children, parents, and caregivers; coordination of training programs for firefighters, educators, law enforcement officers, public health workers, health professionals, emergency care providers, and others; and organizing and staffing of car seat checkup events for the general public. DCH informed us that car seats, smoke alarms, bike helmets, and other types of safety devices have been widely distributed to at-risk families in partnership with a variety of community-based organizations and committed volunteers. The Division informed us that the SAFE KIDS van is used at Statewide community events by program staff and local coalition staff to increase public awareness of the SAFE KIDS Program.

Our review of the Division's controls over the use of this vehicle determined that the Division did not maintain a vehicle travel log for the van that specified the vehicle and driver identification, daily miles driven, or management's assertion that the use of the vehicle was appropriate. In addition, the Division did not adequately document that prior approval was obtained for each use of the van.

Department of Management and Budget (DMB) Administrative Guide procedure 0410.04 requires departments to maintain appropriate documentation to meet Internal Revenue Service regulations for business and personal use of State-provided vehicles. The documentation is to include vehicle and driver identification, daily miles driven, and purposes of the trips. State agencies that use a State-owned vehicle are generally charged for such expenses as mileage, maintenance, insurance, and gasoline.

RECOMMENDATION

We recommend that the Division maintain proper documentation of the use of its SAFE KIDS van, as required by State regulations.

AGENCY PRELIMINARY RESPONSE

The Division agreed that it did not maintain a vehicle travel log for the SAFE KIDS van as required by State regulations and informed us that it has implemented procedures to comply with the recommendation. The Division also informed us that, in September 2002, a vehicle mileage log was added to the van notebook and a written procedure was developed that drivers must follow to complete the

mileage log. The Division further informed us that the mileage log is submitted to Vehicle Services within the Department of Management and Budget on a monthly basis.

EFFECTIVENESS OF CHRONIC DISEASE PROGRAM ACTIVITIES

COMMENT

Background: Executive Order No. 2001-09 reduced the funding available to DCH. As a result, effective December 14, 2001, the Division's Cardiovascular Disease (CVD) Prevention - Worksite and Community Health Promotion (WCHP) Program was eliminated from the Cardiovascular Health and Nutrition Section. The CVD Prevention - WCHP Program funded risk factor screening, behavioral change programs, and awareness efforts through either worksite or community settings and was implemented in all Michigan counties through a network of approximately 200 private vendors and 45 local health jurisdictions.

According to a publication from DCH, CVD is the leading cause of death in Michigan, causing more deaths than the next six leading causes of death combined. In addition to being the leading cause of death, CVD is a significant cause of illness, hospitalization, and disability and places an enormous strain on society. According to DCH, the economic burden of CVD in Michigan is estimated at $6.76 billion annually.

DCH reported that, since 1995, the CVD Prevention - WCHP Program has awarded over 5,000 worksite grants; reached more than 230,000 employed Michigan residents with CVD prevention services; identified 36% of participants screened for CVD risk factors as being at-risk, and subsequently referred them to their physicians for follow-up care; reached over 885,000 Michigan community residents through direct CVD education and awareness services provided through local health jurisdictions; assessed over 250,000 Michigan residents for CVD risk factors; and helped over 80% of risk reduction program participants make positive progress toward improving their goals related to diet, physical activity, weight management, and smoking.

DCH also informed us that CDC featured DCH's CVD Prevention - WCHP Program in a national satellite video conference as an example of a worksite wellness program in

1999 and that the Association of State and Territorial Public Health Promotion and Education awarded the Program the Health Promotion Award of Excellence in 2001.

Audit Objective: To assess the Division's effectiveness in administering programs that help prevent and minimize State chronic disease deaths, illnesses, and costs.

Conclusion: We concluded that the Division was generally effective in administering programs that help prevent and minimize State chronic disease deaths, illnesses, and costs. However, we noted reportable conditions related to the recertification of diabetes self-management education programs (DSMEPs) and the diabetes database (Findings 3 and 4).

Noteworthy Accomplishments: Using a continuous quality improvement model, Division staff implemented a data evaluation process that was successful in streamlining the overall program reporting process for the Division's Breast and Cervical Cancer Control Program (BCCCP). As a result of these changes, the Division reported that there has been an increased adherence to the CDC timeliness performance indicators from 79% during fiscal year 1999-2000 to 92% during fiscal year 2000-01 for abnormal breast screening and from 50% during fiscal year 1999-2000 to 78% during fiscal year 2000-01 for abnormal cervical screenings. The Division informed us that these figures have remained steady during fiscal year 2001-02. CDC's benchmark allows for a 5% error rate of missing or incomplete BCCCP data. The Division reported that BCCCP's error rate had decreased to .8%, relating to 271,718 records that had been subject to review.

The Division informed us that, because of this improvement, CDC highlighted the Michigan Quality Improvement Program on its Web site and that, since then, Michigan's BCCCP has been regarded as a model for this process and Division staff have been contacted by several other states for guidance in assisting them in implementing and revising their own quality improvement programs.

In addition, the Division's Diabetes Control Program was recognized by the Assistant Secretary for Health and Human Services, U.S. Department of Health and Human Services, in 2002 for its "Best Practice Initiatives" in diabetes. The Division informed us that the "Best Practice Initiatives" award is given to state programs that demonstrate quality and success in program outcomes*.

** See glossary at end of report for definition.*

According to the Division, its Diabetes Control Program promotes quality diabetes care, treatment, and self-management education through all its programs and projects. Through the Michigan Diabetes Outreach Network (MDON), Diabetes Care Improvement Project (DCIP), over 165 agencies agreed to provide care, treatment, and self-management education to people with diabetes. The agencies are comprised of outpatient DSMEPs, physician offices, community health centers, home care agencies, and others. To date, there are over 30,000 clients who have provided intake data and 19,000 clients who have provided follow-up data.

The Division also informed us that trends in follow-up data from fiscal year 1995-96 through fiscal year 2000-01 for glycosylated hemoglobin tests*, foot examinations, and microalbuminuria tests* (all done at least once annually) show a significant improvement in the number of persons with diabetes having these tests done. Glycosylated hemoglobin tests increased from 14% in fiscal year 1995-96 to 78% in fiscal year 2000-01. Foot examinations increased from 58% in fiscal year 1995-96 to 77% in fiscal year 2000-01. Microalbuminuria tests, added to the data system in fiscal year 1999-2000, increased from 22% to 28% between fiscal years 1999-2000 and 2000-01.

FINDING

3. Recertification of DSMEPs

The Division needs to ensure that DSMEPs are recertified in a timely manner.

The Division is responsible for certifying that DSMEPs in Michigan are meeting national standards for diabetes self-management education, which are established by the American Diabetes Association. Certification status is granted for a three-year period of time, and certified DSMEPs are accountable for continuous implementation of the national standards throughout the three-year certification period. These national standards require each DSMEP to have documentation of its organizational structure, mission statement, and goals; a written curriculum with criteria for successful learning outcomes, and a continuous quality improvement process to evaluate the effectiveness of the education experience provided and determine opportunities for improvement. The standards are designed to define quality diabetes self-management education that can be implemented in diverse

* *See glossary at end of report for definition.*

settings and will facilitate improvement in health care outcomes. In accordance with Medical Services Administration Hospital Policy No. 00-06, certified DSMEPs are eligible to receive Medicaid reimbursement for services rendered to Medicaid participants.

At the time of our review, we identified 67 DSMEPs certified in Michigan that served approximately 17,000 people with diabetes annually. The certifications for 31 (46%) of the 67 DSMEPs expired during the period October 1, 2000 through August 31, 2002. Our review of the site visit and recertification dates for the 31 DSMEPs determined that 19 (61%) were not recertified prior to their certification expiration dates. The Division performed site visits and recertified the 19 DSMEPs between 8 and 114 days after their three-year certification period had expired.

DSMEPs that are not recertified in a timely manner may not be eligible for Medicaid reimbursement. Therefore, it is critical that the Division recertify DSMEPs in a timely manner to ensure that they maintain their Medicaid eligibility. It is also important that the Division perform timely site visits so that it can ensure that DSMEPs are continuing to deliver quality education and meet the national standards for certification.

RECOMMENDATION

We recommend that the Division ensure that DSMEPs are recertified in a timely manner.

AGENCY PRELIMINARY RESPONSE

The Division agreed that most DSMEPs were not recertified from 8 to 114 days after their three-year certificate expired and has implemented measures to comply with the recommendation. The Division informed us that there were several staff shortages and local program reorganizations that resulted in this circumstance. The Division also informed us that all agencies, except one, received written notice of the extension from the Division prior to the end of the certification period. The Division further informed us that it has taken steps to secure part-time contractual certification staff on an as-needed basis to meet future needs in a timely manner.

FINDING

4. Diabetes Database

The Division could improve the effectiveness of its Diabetes Control Program by enhancing its efforts to ensure the completeness of its diabetes database.

The Division maintains a diabetes database that includes data on persons with diabetes and their care, hospitalizations of persons with a diagnosis of diabetes, and statistics related to diabetes complications. A primary purpose of this database is to facilitate a Diabetes Care Improvement Project (DCIP) according to the American Diabetes Association standards. The information on the database is collected from six Michigan Diabetes Outreach Networks (MDONs) throughout the State, which gather information from certified DSMEPs. DSMEPs that participate in the DCIP sign agreements with MDONs to submit specific demographic and care data for the diabetes clients who receive the DSMEPs' services.

The DCIP includes MDONs collecting, analyzing, and reporting client and agency data on the outcomes of the services provided. According to the Division, a key component of the DCIP is submitting completed data forms to the six MDONs across the State. The Division inputs the information obtained from the MDONs into its diabetes database and provides feedback to the DSMEPs, which they can use for quality improvement purposes.

The Division informed us that it uses the information to help determine the effectiveness of its Diabetes Control Program by measuring such outputs* and outcomes as lipid profiles*, microalbuminuria tests, and eye and foot examinations, which are all important health indicators of diabetics. The Division also uses the database to make Diabetes Control Program decisions, such as advising medical professionals on the types of care to provide clients. In addition, the database is used to provide data on diabetes in Michigan to CDC for use in nationwide statistics.

Our review of the Division's diabetes database disclosed:

a. The Division did not routinely monitor which DSMEPs were participating in the DCIP and submitting the required data, and it did not have a procedure in

* *See glossary at end of report for definition.*

place that required DSMEP participation. As a result, the Division did not receive data from all DSMEPs for inclusion in its diabetes database.

At the time of our review the diabetes database contained data from only 43 (64%) of 67 certified DSMEPs. The Division informed us that a DSMEP's submission of most of the data that is tracked on the diabetes database is voluntary unless a DSMEP has entered into an agreement with an MDON to participate in the DCIP. Of the 24 DSMEPs that did not have data on the diabetes database, the Division informed us that 11 (46%) did not have an agreement with an MDON. The Division could not determine if the remaining 13 (54%) DSMEPs did or did not have agreements with MDONs.

b. The Division did not collect data on diabetes clients age 17 and younger.

Researchers from CDC reported in May 2002 that hospital discharges of children, ages 6 to 17, with type 2 diabetes* nearly doubled from 1979 through 1981 to 1997 through 1999. Consequently, the Division's data collection procedures should specifically address compiling and evaluating data on diabetes clients age 17 and younger in Michigan to help ensure that the Division is making informed programmatic decisions that benefit clients of all ages in Michigan.

c. The Division did not have controls in place to ensure that MDONs were collecting and analyzing client information data pertaining to Medicaid participants from all DSMEPs, and it did not require MDONs to submit this data for inclusion in the diabetes database.

The Division requires all DSMEPs to submit client information forms to MDONs on every Medicaid participant in the DSMEPs and encourages DSMEPs to submit a form on every participant, regardless of payment source. DSMEPs that participate in the DCIP are generally required to include this information as part of the DCIP data forms they submit. As mentioned in part a., there were 24 DSMEPs that did not have any information entered into the diabetes database when, at a minimum, the MDONs should have client

* *See glossary at end of report for definition.*

information form data for all DSMEPs. The information gathered on the client information form provides the opportunity to follow demographic and diabetes diagnosis data.

By ensuring that DSMEPs submit client diabetes information, the Division will be better able to analyze and report on the outcomes of the diabetes services being provided in Michigan, which in turn will help the Division determine if the MDONs and DSMEPs are successfully meeting the care needs of the diabetes clients they treat. In addition, the increased knowledge resulting from an improved database will allow the Division to proceed in a timely manner with needed programs for affected citizens as medical experts develop new disease-related treatment and prevention programs.

RECOMMENDATION

We recommend that the Division improve the effectiveness of its Diabetes Control Program by enhancing its efforts to ensure the completeness of its diabetes database.

AGENCY PRELIMINARY RESPONSE

The Division generally agreed with the recommendation and concurred with the finding that some changes in the diabetes database could enhance its usefulness for program, provider, State, and federal reporting purposes. Nonetheless, the database is largely a voluntary data collection system and the number of providers involved as the system is currently designed will continuously vary throughout the year. To resolve this structural problem, the Division informed us that it has applied for and received additional funds from CDC to design an enhanced evaluation and reporting system based largely on established State and national HEDIS (Health Plan Employer Data and Information Set) measures that can provide statistically valid sample data sets. This revision, which will include DSMEP Medicaid reporting, should be completed within 24 months.

EFFECTIVENESS AND EFFICIENCY OF SELECTED DIVISIONWIDE ACTIVITIES

COMMENT

Audit Objective: To assess the effectiveness and efficiency of the administration of selected Divisionwide activities.

Conclusion: We concluded that the Division was generally effective and efficient in its administration of selected Divisionwide activities. However, we noted a reportable condition related to contractor monitoring (Finding 5).

FINDING

5. Contractor Monitoring

The Division needs to improve its monitoring controls to ensure that contractors are effectively and efficiently fulfilling their programmatic and fiscal obligations.

During fiscal years 2001-02 and 2000-01, the Division contracted for services totaling approximately $18.8 million and $18.0 million, respectively, for its Cancer Prevention and Control Section; Injury Prevention Section; and Diabetes, Dementia, and Kidney Section. The contractors for these services included various local and county health departments, regional SAFE KIDS coordinators, Child Passenger Safety programs, and Rape and Sexual Assault Prevention Education programs throughout the State.

DCH's mission statement specifies that it will strive for the delivery of quality services in a fiscally prudent manner. Monitoring contracts is essential for effective and efficient program administration. Monitoring should include assessments of financial information and programmatic performance information to ensure that contractors are performing according to contractual provisions.

Our review of the Division's efforts to monitor its contracts disclosed:

a. The Division did not receive required progress reports from several contractors and could not document that it had received the reports in a timely manner from several other contractors. Generally, a progress report contains a brief description of local activities of the contractor and a status report on work toward the accomplishment of stated program goals and objectives.

We reviewed 68 contractors' submission of progress reports between October 1, 2000 and April 15, 2002. A total of 202 progress reports were due during this period. Our review disclosed:

Reports Received						
On Time	1 - 5 Days Late	6 - 10 Days Late	11 - 20 Days Late	More Than 20 Days Late	Without Date Stamp	Reports Not Received
96 (48%)	29 (14%)	4 (2%)	5 (2%)	4 (2%)	31 (15%)	33 (16%)

b. The Division did not always ensure that contracts contained specific and measurable project outputs, outcomes, and completion dates.

For example, the Division began planning the Michigan Emergency Department Community Injury Information Network (MEDCIIN) project in fiscal year 1997-98 for the purpose of gathering Statewide data on injuries seen in hospital emergency departments and to provide this data to generate Statewide, as well as regional, estimates of the types and causes of injuries, injury severity, and demographic characteristics of people seen in emergency departments for traumatic injuries. So that the summary data from the hospitals would be statistically valid, the Division developed a sampling methodology that included selecting 23 hospitals from 15 counties. The Division solicited 23 hospitals to voluntarily submit data and began signing letters of agreement with them in fiscal year 1998-99. According to the Division, data collection for this project began in spring 2000, and as of May 16, 2001, all 23 hospitals had signed agreements to submit data.

The Division contracted with the Michigan Public Health Institute (MPHI) to assist in administering this project. The stated objective in the contract indicates that MPHI's Center for Collaborative Research in Health Outcomes and Policy will work with hospitals to collect emergency department data and supplementary assault variables, overcome technical barriers to participation, refine the processes for the surveillance system, and develop a long-term relationship with each hospital. From fiscal year 1998-99 through fiscal year 2001-02, MPHI's contract for this project totaled approximately $1.7 million. As an incentive to submit data and to help offset the associated costs, MPHI subcontracted with each of the 23 hospitals and paid stipends ranging primarily between $3,000 and $6,000 per year. One hospital received a

stipend of $20,000 in fiscal year 2000-01. Between fiscal year 1998-99 and 2000-01, MPHI paid $256,000 in total stipends to the hospitals.

The Division's contract with MPHI contained some general system management objectives, but it did not contain quantified performance objectives relating to the collection of data from the hospitals. As a result, the Division did not have an objective basis by which it could assess the performance of MPHI in fulfilling its related contractual obligations. In addition, neither the letters of agreement between the Division and the participating hospitals nor the contracts between MPHI and the participating hospitals contained time lines or due dates for the submission of the injury and intimate partner violence (IPV) data. At the time of our review, the Division did not yet have statistically valid data because several hospitals had submitted only partial or no data.

The following tables indicate, as reported in Division records, the number of hospitals that had submitted data and the status of the data submitted and the total stipends paid to those hospitals that had submitted only partial or no data as of March 2002:

	Hospitals That Have Submitted		
Category	Full Data	Partial Data	No Data
1999 Injury Data	15	5	3
1999 IPV Data	13	5	5*
2000 Injury Data	18	4	1
2000 IPV Data	17	2	4*
2001 Injury Data	11	8	4
2001 IPV Data	0	9	14

* One hospital has not agreed to submit IPV data in addition to the MEDCIIN data or does not yet have a system in place to collect the IPV data.

Data	Number of Hospitals That Submitted Only Partial or No Data	Total Stipends Paid
1999	9	$ 22,000
2000	5	$ 10,000
2001	23	$127,000

c. The Division did not ensure that contractors providing injury prevention services submitted monthly financial status reports (FSRs) to the Division's contract managers, as required by the contracts. For fiscal year 2000-01, 10 (50%) of the 20 contractors did not submit any of their FSRs to a contract manager and 6 (30%) of the 20 contractors had submitted only some of their FSRs to a contract manager. During fiscal year 2001-02, 11 (32%) of the 34 contractors did not submit any of their FSRs to a contract manager and 4 (12%) of the 34 contractors had submitted only some of their FSRs to a contract manager.

Submission of the FSRs to the contract manager when required would allow the Division to better monitor the efficiency of its contractors throughout the course of the contract year and determine if they are meeting specific program requirements.

For example, we noted in our review of the Prevention of Fire-Related Injuries contracts that 1,759 fewer smoke detectors were purchased and installed over the grant period of fiscal year 1998-99 through fiscal year 2000-01 than were budgeted for by 4 of the 5 contractors. Even though DCH informed us that these contractors should not receive their full contract award amounts if they did not purchase and install the number of smoke alarms they were budgeted for, 3 of the 4 contractors did in fact receive the full amount of their contract awards. One of the contractors had budgeted for 500 smoke detectors and was donated 500 smoke detectors by a local vendor. Progress reports submitted by the contractor indicated that it had installed 461 smoke detectors. There was no budget amendment to retract the related funding they were budgeted for the smoke detectors, and the Division could not provide documentation to indicate that the 500 donated smoke detectors were in addition to the 461 reported to have been installed. According to DCH, the

average cost of a smoke detector was $12. Therefore, the related funding for the budgeted smoke detectors was $6,000.

d. The Division did not ensure that the 4 regional SAFE KIDS contractors had subcontracts with the 43 local SAFE KIDS coalitions and chapters.

The contracts between the Division and the regional SAFE KIDS contractors included budgeted amounts for the existing local SAFE KIDS coalitions and chapters for incentives to establish new local coalitions and chapters and for local community partnership grants. The contract amounts totaled $262,801 and $187,000 for fiscal years 2001-02 and 2000-01, respectively. The contract language between the Division and the regional SAFE KIDS contractors requires that a written subcontract be executed by all affected parties prior to the initiation of any new subcontract activity in part to ensure that the subcontract does not affect the contractors' accountability to DCH for the subcontracted activity. Our review disclosed, and the Division concurred, that no written subcontracts were in place between the regions and their local subcontractors.

Improving its monitoring controls will help the Division to ensure that contractors are meeting the established goals and objectives of its respective programs and that contractors are adhering to contractual provisions and effectively and efficiently administering them.

RECOMMENDATION

We recommend that the Division improve its monitoring controls to ensure that contractors are effectively and efficiently fulfilling their programmatic and fiscal obligations.

AGENCY PRELIMINARY RESPONSE

The Division generally agreed with the recommendation and parts a., c., and d. of the finding but did not agree with part b. of the finding.

Regarding part a. of the finding, the Division informed us that it has developed a standard, electronic procedure for tracking the timely receipt of progress reports starting in fiscal year 2002-03.

Regarding part c. of the finding, the Division generally agreed that the program contract managers should receive copies of FSRs on a monthly basis. The Division will add language to all fiscal year 2003-04 section contracts that will require FSRs to be submitted. The Division will propose to DCH that procedures be established to withhold payments if necessary to encourage compliance.

Regarding part d. of the finding, the Division agreed that the use of a standard subcontract could improve the Division's ability to monitor accomplishment of established goals and objectives of the program and funding allocations. The Division informed us that, during fiscal year 2002-03, the Injury Prevention Section has elected to work with one Statewide contractor who will establish a standard subcontract for all SAFE KIDS coalitions and chapters.

The Division respectfully disagreed with part b. of the finding. The Division considered the performance rate for data submission from the hospitals to be satisfactory. The Division also did not believe that it was possible to establish precise due dates for MEDCIIN data submission for two reasons. First, the parties agreed that the system would be entirely voluntary and, as such, hospitals could only agree to provide their best efforts in participating. Second, the average hospital stipend was approximately $375 per month, which did not cover a hospital's costs to input and report the data. As a result, hospitals were required to invest their own resources to produce the data, and mandatory reporting deadlines would be impossible to enforce.

Glossary of Acronyms and Terms

BCCCP	Breast and Cervical Cancer Control Program.
CDC	Centers for Disease Control and Prevention.
CVD	cardiovascular disease.
DCH	Department of Community Health.
DCIP	Diabetes Care Improvement Project.
DSMEP	diabetes self-management education program.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical with the minimum amount of resources.
FSR	financial status report.
glycosylated hemoglobin test	A test that measures the amount of glucose-bound hemoglobin. As the blood glucose level increases, the proportion of hemoglobin molecules that bind glucose increases with time. The measurement of glycosylated hemoglobin yields important information regarding how well a patient's diabetes is being controlled.
goals	The agency's intended outcomes or impacts for a program to accomplish its mission.
IPV	intimate partner violence.
lipid profile	A blood test that measures total cholesterol levels.
MDON	Michigan Diabetes Outreach Network.

MEDCIIN	Michigan Emergency Department Community Injury Information Network.
microalbuminuria test	A test to detect the presence of small proteins in the urine that can occur in diabetics.
mission	The agency's main purpose or the reason that the agency was established.
MPHI	Michigan Public Health Institute.
objectives	Specific outcomes that a program seeks to achieve its goals.
outcomes	The actual impacts of the program.
outputs	The products or services produced by the program.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
reportable condition	A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
type 2 diabetes	One of the two major types of diabetes; the type in which the beta cells of the pancreas produce insulin, but the body is unable to use it effectively because the cells of the body are resistant to the action of insulin.
WCHP	Worksite and Community Health Promotion.