PERFORMANCE AUDIT
OF THE

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH BOARD

AN AGENCY UNDER CONTRACT WITH THE
DEPARTMENT OF COMMUNITY HEALTH

June 1999

39-508-98

EXECUTIVE DIGEST

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH BOARD

INTRODUCTION

This report, issued in June 1999, contains the results of our performance audit* of the Washtenaw County Community Mental Health Board, an agency under contract with the Department of Community Health.

AUDIT PURPOSE

This performance audit was conducted as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are conducted on a priority basis related to the potential for improving effectiveness* and efficiency*.

BACKGROUND

The Board was established in 1965 and operates under the provisions of the Mental Health Code, being Sections 330.1001 - 330.2106 of the *Michigan Compiled Laws.*

The Board's mission* is to promote and enhance quality of life; to provide, with dignity and respect, community-based mental health services for individuals in Washtenaw County and their families and supports; and to identify appropriate resources for anyone in need who cannot be directly served.

The Board operates and/or contracts for mental health services including inpatient, outpatient, day program,

* *See glossary on page 36 for definition.*

residential, case management, respite, crisis, and prevention services for mentally ill* (MI) and developmentally disabled* (DD) individuals.

The Board's Access Unit serves as the single entry point for Washtenaw County residents seeking mental health services. The Board is also the designated Substance Abuse Coordinating Agency for both Washtenaw and Livingston Counties, established in accordance with Act 368, P.A. 1978.

Board operations generally are funded by approximately 90% State and federal funds and 10% local funds. Total expenditures for the fiscal year ended September 30, 1998 were approximately $38.5 million. As of September 30, 1998, the Board had 283 full-time equated employees and was serving 3,046 consumers*.

AUDIT OBJECTIVES, CONCLUSIONS, AND NOTEWORTHY ACCOMPLISHMENTS

Audit Objective: To assess the Board's effectiveness and efficiency related to the delivery of services.

Conclusion: The Board was generally effective and efficient in the delivery of services. However, we noted reportable conditions* related to the Board's management information system, person-centered planning*, day program case records, and ability-to-pay determinations (Findings 1 through 4).

Noteworthy Accomplishments: The Board implemented a Program Evaluation and Quality Improvement System which provides a systematic, coordinated mechanism for the ongoing evaluation,

* *See glossary on page 36 for definition.*

assessment, and improvement of services to Board consumers. Quarterly quality improvement reports are submitted to the Board's governing body for review and analysis of aggregate data on consumer satisfaction and service effectiveness and efficiency. Also, in February 1998, the Board received a three-year accreditation from the Rehabilitation Accreditation Commission* (CARF).

Audit Objective: To assess the Board's effectiveness in administering and monitoring contracts with mental health service providers* .

Conclusion: The Board was generally effective in administering and monitoring contracts with mental health service providers. However, we noted reportable conditions related to pharmaceutical contract controls, substance abuse contracts, residential service provider inventories, quarterly maintenance inspections, and residential contract administration (Findings 5 through 9).

AUDIT SCOPE AND METHODOLOGY

Our audit scope was to examine the program and other records of the Washtenaw County Community Mental Health Board. 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.

To accomplish our objectives, we examined Board records and activities for the period October 1, 1995 through November 30, 1998. We interviewed Board and contractual staff; reviewed applicable statutes, rules, policies, and procedures; assessed the effectiveness of

* *See glossary on page 36 for definition.*

applicable areas of the internal control structure*; and analyzed applicable program, financial, and clinical records. Also, we surveyed consumers and referral sources (survey summaries are presented as supplemental information). In addition, we analyzed contracts with mental health service providers and tested compliance with the contracts. Further, we conducted site visits of contract providers and examined provider expenses reported to the Board.

AGENCY RESPONSES

Our audit report includes 9 findings and 11 corresponding recommendations. The Board's preliminary response indicated that it generally agreed with our recommendations and has taken steps to implement them.

* *See glossary on page 36 for definition.*

Mr. Peter Holmes, Chairperson
Board of Directors
and
Ms. Kathleen Reynolds, Executive Director
Washtenaw County Community Mental Health Board
555 Towner Blvd.
Ypsilanti, Michigan
and
Mr. James K. Haveman, Jr., Director
Department of Community Health
Lewis Cass Building
Lansing, Michigan

Dear Mr. Holmes, Ms. Reynolds, and Mr. Haveman:

This is our report on the performance audit of the Washtenaw County Community Mental Health Board, an agency under contract with the Department of Community Health.

This report contains our executive digest; description of agency; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; survey summaries, and charts, presented as supplemental information; 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 Board's written comments and oral discussion subsequent to our audit fieldwork.

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

AUDITOR GENERAL

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Description of Agency

The Washtenaw County Community Mental Health Board was established in 1965 and operates under the provisions of the Mental Health Code, being Sections 330.1001 - 330.2106 of the *Michigan Compiled Laws*. The Board is subject to oversight by the Department of Community Health.

The Board's mission is to promote and enhance quality of life; to provide, with dignity and respect, community-based mental health services for individuals in Washtenaw County and their families and supports; and to identify appropriate resources for anyone in need who cannot be directly served.

The Board's administrative office is located in the City of Ypsilanti. The Board's governing body is composed of 12 members responsible for serving the mental health needs of Washtenaw County residents. The Board operates and/or contracts for mental health services, including inpatient, outpatient, day program, residential, case management, respite, crisis, and prevention services for mentally ill (MI) and developmentally disabled (DD) individuals.

The Board's Access Unit serves as the single entry point for Washtenaw County residents seeking mental health services. Access Unit staff are responsible for responding to consumer requests for mental health services by linking them to the appropriate service providers.

The Board is also the designated Substance Abuse Coordinating Agency (SACA) for both Washtenaw and Livingston Counties, established in accordance with Act 368, P.A. 1978. Primary SACA functions include comprehensive planning, license review, subcontracting for services, and data collection and reporting.

Board operations generally are funded by approximately 90% State and federal funds and 10% local funds. Total expenditures for the fiscal year ended September 30, 1998 were approximately $38.5 million. As of September 30, 1998, the Board had 283 full-time equated employees and was serving 3,046 consumers.

Audit Objectives, Scope, and Methodology and Agency Responses

Audit Objectives

Our performance audit of the Washtenaw County Community Mental Health Board, Department of Community Health, had the following objectives:

1. To assess the Board's effectiveness and efficiency related to the delivery of services.

2. To assess the Board's effectiveness in administering and monitoring contracts with mental health service providers.

Audit Scope

Our audit scope was to examine the program and other records of the Washtenaw County Community Mental Health Board. 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 were conducted from June through November 1998 and included examining Board records and activities for the period October 1, 1995 through November 30, 1998.

To accomplish our first objective, we interviewed Board and contractual staff; reviewed applicable statutes, rules, policies, and procedures; assessed the effectiveness of applicable areas of the internal control structure; and analyzed applicable program, financial, and clinical records. We concentrated on client financial liability determinations, Access Unit activities, waiting lists, case management, and administration of day programs. Also, we surveyed consumers and referral sources to obtain feedback related to satisfaction with the delivery of Board services (survey summaries are presented as supplemental information).

To accomplish our second objective, we obtained an understanding of the Board's internal controls related to contract administration; analyzed contracts with mental health service providers, identified critical elements of the contracts, and tested compliance with the contracts; conducted site visits of contract providers; and examined provider expenses reported to the Board. We concentrated on residential, substance abuse, and pharmaceutical contracts.

Agency Responses

Our audit report includes 9 findings and 11 corresponding recommendations. The Board's preliminary response indicated that it generally agreed with our recommendations and has taken steps to implement them.

The agency preliminary response which follows each recommendation in our report was taken from the Board's written comments and oral discussion subsequent to our audit fieldwork.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

DELIVERY OF SERVICES

COMMENT

Audit Objective: To assess the Washtenaw County Community Mental Health Board's effectiveness and efficiency related to the delivery of services.

Conclusion: The Board was generally effective and efficient in the delivery of services. However, we noted reportable conditions related to the Board's management information system, person-centered planning, day program case records, and ability-to-pay determinations.

Noteworthy Accomplishments: The Board implemented a Program Evaluation and Quality Improvement System which provides a systematic, coordinated mechanism for the ongoing evaluation, assessment, and improvement of services to Board consumers. Quarterly quality improvement reports are submitted to the Board's governing body for review and analysis of aggregate data on consumer satisfaction and service effectiveness and efficiency. Also, in February 1998, the Board received a three-year accreditation from the Rehabilitation Accreditation Commission (CARF).

FINDING

1. Management Information System

The Board needs to improve its internal control structure over its management information system. The Board uses its management information system for planning, monitoring, and evaluating delivery of its services. We reviewed management controls over data and reports used for monitoring and reporting consumer waiting lists, consumer access to services, and other consumer and provider data, such as consumer addresses and contract identifiers for residential service providers and group homes.

Our audit of the Board's management information system disclosed:

a. Board waiting list documentation did not support the number of consumers waiting for services as reported to the Department of Community Health. For example, the Board reported 118 developmentally disabled (DD) consumers waiting for respite services as of October 1, 1997; however, supporting documentation indicated only 45 consumers waiting for respite services.

   Also, the Board did not prioritize consumers' needs when establishing waiting lists for mentally ill (MI) adult and MI child services. The Mental Health Code requires that boards maintain waiting lists for all service needs not met. The priority for service for consumers on the lists shall be based on severity and urgency of need.

b. The Board did not ensure the reliability of the sequencer report used to monitor the Access Unit program. The Board's Access Unit serves as the single entry point for Washtenaw County residents seeking mental health services. Access Unit staff are responsible for responding to consumer requests for mental health services by linking them to the appropriate service providers.

   Our review of the Access Unit program data reports disclosed that the sequencer report totals were underreported in 5 of 6 months reviewed. For 4 of these 5 months, the totals did not include data from the first 10 days of the month.

   The sequencer report, which helps monitor Access Unit staffing levels, summarizes data including the number of incoming and outgoing phone calls and the average length of time for calls. The report also documents the number of abandoned calls, which are instances in which consumers did not have the opportunity to actually speak with Access Unit staff.

   Also, the sequencer report data is included in the Human Services Information System (HSIS) report that discloses program results as part of the quality improvement process. As a result, the integrity of some HSIS reported data for the Access Unit program was questionable.

c. Board data related to consumers and referral sources was not accurate. Our distribution of surveys to 120 consumers and 43 referral sources disclosed that 2 deceased consumers remained in the Board's data base of current consumers and addresses for 17 (14%) consumers and 4 (9%) referral sources were not accurate. Board staff stated that they attempt to maintain current information; however, changes often occur.

d. The Board did not consistently assign reporting unit (RU) numbers, which are used as contract identifiers. The Board assigns RU numbers to residential service providers upon entering into a contract for mental health services. During our review of 10 providers, we encountered difficulty in tracking contracts and obtaining appropriate documentation, such as quarterly inventory and maintenance reports from Board staff. These difficulties resulted, in part, from the fact that the Board at times transferred previous RU numbers to new providers or group homes or added another group home to a current provider RU instead of assigning a unique RU number to the new provider or group home. We were informed by the Board that this sometimes happened in an effort to maintain RUs in a particular sequence to summarize data by consumer population.

   Also, RU numbers were commonly identified by name. The name of the RU was usually the name of the street where the group home was located. Thus, whenever a group home moved from one location to another, the name of the RU changed. The Board informed us that it is discontinuing the practice of naming the RU after the street of location to eliminate some of the confusion.

Because of internal control structure weaknesses over maintenance and utilization of data, our audit disclosed varying management data and reports that were inaccurate or inconsistently utilized. These weaknesses could affect management's ability to plan, monitor, and evaluate delivery of services.

RECOMMENDATION

We recommend that the Board improve its internal control structure over its management information system.

AGENCY PRELIMINARY RESPONSE

The Board generally agrees with the recommendation. The Board has no waiting lists for children's services and only a small, prioritized waiting list for adult MI residential placement (Finding 1.a.). The Board replaced the sequencer identified in Finding 1.b. with a new state-of-the-art phone system linked to a computer that automates data collection. The Board consistently assigns RUs within defined population subgroups to facilitate reporting (Finding 1.d.).

FINDING

2. Person-Centered Planning

The Board did not ensure that all consumers were provided the opportunity to participate in a person-centered planning (PCP) process.

The Mental Health Code established the right for all individuals to have their individual plan of service* (IPS) developed through a PCP process regardless of age, disability, or residential setting. The IPS may include a treatment plan, support plan, or both. Under PCP, the consumer directs the planning process with a focus on what the consumer wants and needs. Professionally trained staff participate in the planning and delivery of treatment and supports. However, the development of the treatment or support plan, including the identification of possible services and professionals, is based upon the expressed needs and desires of the individual. Reviews are completed quarterly to determine the consumer's progress and ensure that services and supports continue to meet the consumer's needs.

Beginning October 1996, all Board IPSs scheduled for annual review or for review upon request of the consumer were to be revised to incorporate PCP principles. Our review of case files, as of October 1998, for 30 consumers (20 MI adult, 6 DD, and 4 MI child) disclosed:

a. Ten (50%) of 20 MI adult case files did not contain an IPS developed through the PCP process.

* *See glossary on page 36 for definition.*

b. Three (15%) of 20 MI adult case files did not contain the most recent quarterly reports. Also, previous quarterly reports were missing from 3 files, 1 of which was also missing the most recent report. Further, our review of an additional 6 MI adult and 6 DD residential consumer case files disclosed that quarterly reports in 3 case files were not completed or were not completed in a timely manner.

The Board acknowledged that the MI adult program was not as advanced in implementing the PCP process as its other programs. However, providing and documenting case management services through the PCP process is essential to ensure that consumers are gaining access to and receiving appropriate medical, social, educational, and other services.

RECOMMENDATION

We recommend that the Board ensure that all consumers are provided the opportunity to participate in the PCP process.

AGENCY PRELIMINARY RESPONSE

The Board agrees with the recommendation and informed us that it has implemented corrective action within adult services to ensure that all persons with mental illness are afforded the opportunity for PCP and that PCP is fully implemented and documented in the records.

FINDING

3. Day Program Case Records

The Board did not routinely maintain current and complete consumer case files at the day program location. Also, day program staff did not regularly participate in PCP meetings for their consumers.

The goal* of the Board's day programs is to empower consumers to live and function as citizens in the community by increasing their vocational and individual independence. Services and supports provided to consumers are specific to

* *See glossary on page 36 for definition.*

individual needs in skill building areas such as communication, motor skills, daily living, personal safety, employment, volunteer work, and social/recreational activities. Each consumer is actively involved in planning and setting his or her goals through the PCP process. Professional disciplines, including an occupational therapist, psychologist, and nurse, as well as other individuals selected by the consumer, may be involved to assess and recommend services. Day program staff provide services in relation to established PCPs and track consumers' progress with daily progress notes.

Our review of case files for 26 day program consumers disclosed:

a. Day program case files for 5 (19%) consumers did not include the current IPSs and assessments. IPSs in case files dated as far back as December 1996.

b. Progress notes in 12 (46%) case files did not address all applicable goals and/or were based on PCP goals that were more than one year old, dating back as far as July 1996.

c. Day program staff did not participate in the PCP meetings for 15 (58%) consumers. We were informed that day program staff were not always invited to the meetings or the meetings were scheduled at times that day program staff were unable to attend. However, our review of the 15 case files where the staff did not attend the meetings disclosed that in 8 cases the day program staff were invited. It is important for day program staff to have an active role in planning consumer treatment because consumers who attend day programs spend such a large percentage of their day at these programs.

To effectively monitor consumers' progress and provide appropriate services, day program staff need access to current and complete consumer records. Working on goals that have already been attained, that are no longer applicable, or that the consumer may be unable to achieve is not productive and may result in frustration for the consumer. Also, IPSs may be more effective if day program staff regularly participate in PCP meetings.

RECOMMENDATIONS

We recommend that the Board maintain current and complete consumer case files at the day program location.

We also recommend that day program staff regularly participate in PCP meetings for their consumers.

AGENCY PRELIMINARY RESPONSE

The Board agrees with the recommendations and informed us that it has been in the process of systematically reducing the on-site day program and moving consumers to community-based services. The Board will ensure that all goals are current and reflect community-based services accurately. The Board will ensure that staff invited to participate in PCP meetings participate in the meetings.

FINDING

4. Ability-to-Pay Determinations

The Board did not obtain or complete in a timely manner income documentation to support some consumer financial liability determinations.

Section 330.1804 of the *Michigan Compiled Laws* requires that consumers receiving services from boards reimburse the boards for the costs of services based on the consumers' ability to pay. Also, Section 330.1818 of the *Michigan Compiled Laws* requires that the consumers' ability-to-pay determinations shall be based on the most recently filed State income tax return or other financial documents. Further, Section 330.1828 of the *Michigan Compiled Laws* requires the financial liability of consumers to be revised annually.

Our review of files for 36 consumers disclosed:

a. Initial financial liability determinations for 4 (11%) consumers and redeterminations for 4 (15%) of 27 consumers were not completed in a timely manner. Delinquencies ranged from three months to over one year.

b. Files for 9 (25%) consumers did not contain evidence of income verification. Board staff informed us that they do not always verify consumer income.

Completion of consumer financial liability determinations in a timely manner and review of appropriate documentation to support determinations help ensure accurate calculations of consumers' financial liability commensurate with the consumers' ability to pay.

RECOMMENDATION

We recommend that the Board obtain or complete in a timely manner income documentation to support all consumer financial liability determinations.

AGENCY PRELIMINARY RESPONSE

The Board agrees with the recommendation and will continue to work to improve its compliance with timely completion of initial financial liability determinations. The Board does accept valid Medicaid cards as proof of financial eligibility. The Board will continue to try to improve its verification of lack of income for indigent consumers.

CONTRACT ADMINISTRATION

COMMENT

Audit Objective: To assess the Board's effectiveness in administering and monitoring contracts with mental health service providers.

Conclusion: The Board was generally effective in administering and monitoring contracts with mental health service providers. However, we noted reportable conditions related to pharmaceutical contract controls, substance abuse contracts, residential service provider inventories, quarterly maintenance inspections, and residential contract administration.

FINDING

5. Pharmaceutical Contract Controls

The Board did not have adequate controls in place to ensure the appropriateness of pharmaceutical contract payments and compliance with medication price contract limits.

The Board contracts with a pharmaceutical company as the primary source for medications and pharmacy services for mental health consumers. The pharmaceutical company, in turn, contracts with a pharmacy that provides these services. For fiscal year 1996-97, the Board expended $720,869 for the pharmaceutical contract.

Our review disclosed the following control weaknesses:

a. The Board did not verify the appropriateness of pharmaceutical contract payments. The Board remits monthly payments to the pharmaceutical company based on monthly invoices. The invoices indicate total amounts for specific medications, including bulk medication purchases and shipping, pharmacy-supplied medications and over-the-counter medications, and returned and destroyed medications, as reported by the pharmacy. However, the Board did not verify the accuracy of specific medication amounts. To help ensure that payments are appropriate, the Board should develop procedures to trace the invoice details related to specific medications to supporting documentation. Board staff informed us that the Board relied on the pharmaceutical company's control system for ensuring the appropriateness of billings.

b. The Board did not monitor medication prices for compliance with its contract. The pharmaceutical contract states that medication prices will not increase more than 20% during an 18-month period. Our review disclosed that the prices for two products increased by more than 20% ranging from $.27 to $.81 per tablet.

Improving the Board's internal control structure is essential to its ability to ensure appropriateness of contract payments and compliance with contract terms.

RECOMMENDATION

We recommend that the Board improve controls to ensure the appropriateness of pharmaceutical contract payments and compliance with medication price contract limits.

AGENCY PRELIMINARY RESPONSE

The Board agrees with the recommendation and informed us that it has implemented computerized authorization and claims payment for indigent medication services to address Finding 5.a. The medical director was aware of the price increase identified in Finding 5.b.; however, the pharmacy contract was not revised to reflect the increase.

FINDING

6. Substance Abuse Contracts

The Board did not have sufficient controls in place or maintain documentation to support that substance abuse contractors provided effective services in accordance with contracts.

The Board has been designated as the Substance Abuse Coordinating Agency (SACA) for Washtenaw and Livingston Counties. In carrying out its responsibilities as SACA, the Board contracts out all substance abuse services through a central referral agency. The Board contracts with approximately 35 different substance abuse providers for both prevention and treatment services throughout the Washtenaw and Livingston County area. For the fiscal year ended September 30, 1997, the Board expended $4.7 million on substance abuse coordination.

Our review of the Board's contract administration and monitoring of the substance abuse contracts for 4 providers and the central referral agency for fiscal year 1997-98 disclosed:

a. The Board did not obtain satisfaction survey results for 4 of the 5 reviewed. Satisfaction surveys are required by contract and are necessary to facilitate feedback to the Board regarding each contractor's program results. We were

informed that the individual responsible for monitoring substance abuse contracts was new to the position and overlooked this requirement.

b. The Board did not obtain a final activity report from 1 of 2 prevention contractors reviewed. The Board requires annual final activity reports indicating specific program results and compliance with the intent of the contract.

c. The Board did not have several required documents for 1 of 5 contracts reviewed, including a request for proposal, scoring guideline, fixed unit rates, equipment inventory, current financial statements, list of board members and minutes, one quarterly report, and site review. These documents were required as part of the initial contracting and subsequent monitoring processes. Maintaining appropriate contract documentation is necessary to ensure the appropriateness and propriety of the contracting process and the extent of services provided. The Board informed us, but could not provide documentation to support, that this contractor was considered a sole source, which would exempt it from having to submit some of these documents.

d. The Board's referral agency did not use the American Society of Addiction Medicine (ASAM) criteria to determine level of care for 4 of 15 cases reviewed. The Center for Substance Abuse, Department of Community Health, requires the use of this criteria to determine the appropriate placement of substance abuse consumers within the continuum of available services.

e. The Board's monitoring of substance abuse contractors could be improved by establishing a mechanism for periodic reporting of program results to ensure that providers are meeting the intent of the contract and accomplishing goals and objectives*. The contract requires the evaluation of both the qualitative and quantitative effectiveness and efficiency of contractors. Also, Coordinating Agency Program Evaluation Guidelines, published by the Department of Community Health, suggest that administration periodically analyze performance. Although the Board received periodic program reports

* *See glossary on page 36 for definition.*

from prevention contractors, it did not receive periodic program reports from treatment contractors.

Improved controls would help ensure effective and efficient use of funds and support the effective delivery of services to substance abuse consumers.

RECOMMENDATION

We recommend that the Board implement sufficient controls and maintain documentation to support that substance abuse contractors provided effective services in accordance with contracts.

AGENCY PRELIMINARY RESPONSE

The Board agrees with the recommendation and informed us that it has implemented a regionwide customer satisfaction survey (Finding 6.a.) and is collecting results quarterly. All prevention subcontractors, but one, submitted their final program reports (Finding 6.b.). The one contract without a request for proposal in Finding 6.c. was for HIV AIDS education and training. This was a sole source contract to the only qualified applicant, our regional HIV AIDS Resource Center. The Board will ensure that the use of the ASAM criteria is clearly documented in all Access Unit case records. The Board does receive periodic reports on treatment programs (Finding 6.e.) through yearly on-site reviews, case record audits, and case-by-case submission of admission and discharge data by each provider.

FINDING

7. Residential Service Provider Inventories

The Board did not ensure that the residential service providers' inventory records were complete and accurate. Also, the Board overpaid one provider $3,159 for its home furnishings.

The Board enters into Type B and Type G contracts with residential service providers. Type B contracts are to provide residential services to individuals in licensed group home settings. Type G contracts are to provide support to individual consumers in their own homes.

Board policy and contracts require that all residential service providers report the acquisition and disposition of furnishings and equipment costing over $300 to the Board. Board policy and the Type B contract further require that providers report inventory activity on a quarterly basis. The Board's contract analyst is responsible for updating each facility's inventory records based on these reports and performing any necessary follow-up when reports are not received.

Our review of 7 Type B and 3 Type G providers disclosed:

a. The 7 Type B providers did not submit 24 (86%) of 28 required quarterly reports to the Board.

b. The Board did not maintain inventory listings for 3 (30%) of the 10 providers. One provider incurred $14,960 in start-up costs in fiscal year 1996-97 for home furnishings, which should have been reported on an inventory listing. Also, the Board overpaid this provider $3,159 for its home furnishings.

c. The Board's inventory listings did not always include an item's value, a serial number, or the purchase date.

We were informed that the contract analyst did not regularly follow up with providers who failed to report.

Furnishings, equipment, or vehicles purchased with Board funds become the property of the Board. Therefore, it is critical that the Board maintain complete and accurate inventory records to ensure that its property is recovered upon termination of a contract.

RECOMMENDATIONS

We recommend that the Board improve controls to ensure the completeness and accuracy of residential service providers' inventory records.

We also recommend that the Board recover the $3,159 overpayment for home furnishings.

AGENCY PRELIMINARY RESPONSE

The Board agrees with the recommendations and informed us that it has implemented new contract monitoring procedures to ensure compliance with provider inventories.

FINDING

8. Quarterly Maintenance Inspections

The Board did not ensure that residential service providers submitted quarterly maintenance and inspection reports.

Board policies and procedures require residential service providers to maintain property and grounds in a safe, attractive condition and to comply with all licensing and certification standards. Also, providers that lease to the Board are required to document their maintenance efforts by submitting a quarterly preventive maintenance report to the Board.

Our review of 7 residential service providers that lease to the Board disclosed that providers did not submit 18 (64%) of 28 fiscal year 1996-97 quarterly maintenance and inspection reports to the Board.

Although the Board completes annual maintenance inspections of each residential facility, periodic reports from the providers help ensure that homes are maintained in a clean, safe manner and facilitate more effective and efficient follow-up.

RECOMMENDATION

We recommend that the Board ensure that residential service providers submit quarterly maintenance and inspection reports.

AGENCY PRELIMINARY RESPONSE

The Board agrees with the recommendation and informed us that it has incorporated reports on the quarterly maintenance inspections into its quality improvement process to ensure compliance.

FINDING

9. Residential Contract Administration

The Board did not have a signed contract in place before receiving services and making payments to one residential service provider.

The Board directly provides and/or contracts for mental health services, including inpatient, outpatient, day program, residential, case management, respite, crisis, and prevention services for MI and DD individuals. For fiscal year 1996-97, the Board had 50 contracts with residential service providers totaling over $12 million.

Our review of 10 residential service providers disclosed that one provider did not have a signed contract in place prior to delivery of services. At the time that the services began, the provider was contracting with the Board for another type of program. Instead of entering into a new contract, the Board made fiscal year 1996-97 payments of $185,447 to the provider on the existing contract. As a result of our audit, the Board obtained a signed contract for fiscal year 1996-97 in September 1998.

To protect the interests of all parties, sound contract administration requires that contracts be executed and contract requirements be verified before commencement of services.

RECOMMENDATION

We recommend that the Board ensure that signed contracts are in place before receiving services and making payments to residential service providers.

AGENCY PRELIMINARY RESPONSE

The Board agrees with the recommendation and will ensure that contracts are in place prior to the initiating service and making payments.

SUPPLEMENTAL INFORMATION

Washtenaw County Community Mental Health Board
Consumer and Guardian Survey Summary

Summary Overview

We sent surveys to 120 consumers or guardians of consumers who were reported as active consumers as of August 1998. Nineteen of the surveys were returned as undeliverable mail. We received 31 responses from the 101 delivered surveys, a response rate of 31%. Our survey was of both adults and children with a mentally ill or developmentally disabled diagnosis.

Following is a copy of the survey that includes the number of responses received for each item. The total number of responses for each item may not agree with the number of responses reported above because some respondents provided more than one response to an item and other respondents did not answer all items.

1. Please indicate the response that best describes who is completing this survey. I am a:

15	Current consumer of the Board
1	Former consumer of the Board
7	Relative of current or former Board consumer
4	Guardian of current or former Board consumer
2	Other

2. Please indicate how long you have been receiving services from Washtenaw County Community Mental Health Board.

2	Less than 6 months
2	Between 6 months and 1 year
4	Between 1 and 3 years
22	More than 3 years

3. Are there any mental health services that you are waiting to receive?

4 Yes 26 No

4. I learned about the Board through:

4	School
6	Doctor
6	Family Independence Agency (formerly Department of Social Services)
5	Family/Friends
1	Court
7	Other

For questions 5 through 16, check the box for the response that best describes your attitude towards the following statements:

	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Not Applicable
5. Following my initial request for services, I was able to begin receiving services within a reasonable amount of time.	7	17	2	1	1	0
6. The mental health services that I received have helped me to better handle my needs.	8	18	0	1	1	2
7. I am satisfied with the amount of services received from the Board.	6	19	1	2	1	1
8. I am satisfied with the type of services received from the Board.	6	18	1	1	2	2
9. I am satisfied with the quality of services received from the Board.	7	19	1	1	1	1
10. Board caregivers were helpful in coordinating my needs with other agencies.	10	11	6	0	1	2
11. Board caregivers considered my preferences and opinions when selecting the program(s) for and provider(s) of my treatment.	9	13	4	1	1	2
12. Board caregivers ensured that my treatment was delivered in accordance with the agreed-upon treatment plan.	8	15	2	1	1	2
13. Board caregivers promptly addressed my complaints and concerns.	5	17	2	1	2	3
14. Board caregivers treated me with dignity and respect.	12	15	0	0	0	2
15. Board caregivers protected my rights to privacy and confidentiality.	12	14	1	0	1	1

	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Not Applicable
16. If you are a former consumer:						
A. The Board and I mutually agreed to discontinue Board services.	0	2	2	0	0	26
B. Board caregivers clearly explained to me the effect of discontinuing Board services.	1	0	2	0	1	26

17. Would you recommend the Board to a close friend with needs similar to your own?

24 Yes 3 No

Washtenaw County Community Mental Health Board
Referral Sources Survey Summary

Summary Overview

We sent surveys to 43 referral sources who had professional interaction with the Board. This included contractors and agencies that also provided mental health services in Washtenaw County. Four of the surveys were returned as undeliverable mail. We received 21 responses from the 39 delivered surveys, a response rate of 54%.

Following is a copy of the survey that includes the number of responses received for each item. The total number of responses for each item may not agree with the number of responses reported above because some respondents provided more than one response to an item and other respondents did not answer all items.

1. Which of the following statements most accurately describes your level of knowledge and interaction with Washtenaw County Community Mental Health Board?

   5 I am very familiar with and have regular contact with the Board.

   8 I am somewhat familiar with and have periodic contact with the Board.

   8 I am unfamiliar with and have little contact with the Board.

2. Which one or more of the following best describes your agency's relationship with the Board?

   17 Contractual provider of services

   1 Contractual purchaser of services

   6 Referral source (to the Board)

   7 Referral source (from the Board)

   0 Other

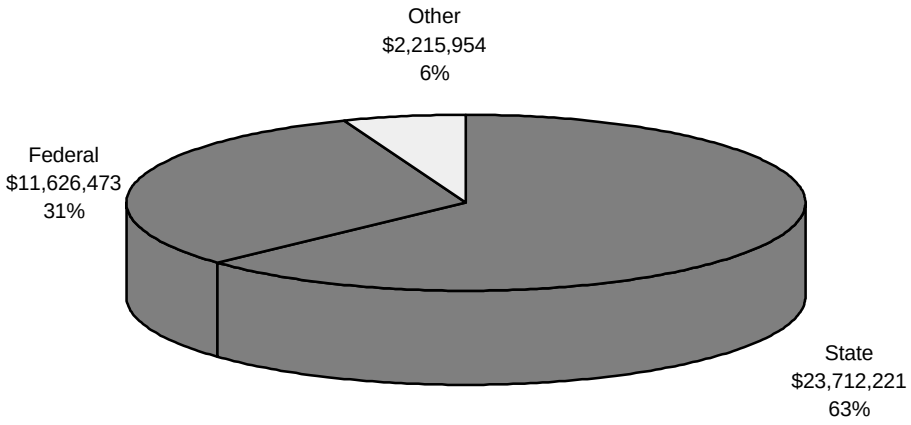
3. How many years has your agency had a working relationship with the Board?

   Responses ranged from less than 1 to over 30 years.

For questions 4 through 9, check the box for the response that best describes your attitude toward the following statements. If your agency does not refer individuals to the Board, please skip questions 4 and 5.

	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Not Applicable
4. The Board responds promptly to referrals and requests for service.	1	6	4	4	0	5
5. The Board helped referred individuals receive service(s) consistent with their needs.	2	9	2	3	0	4
6. The Board provides adequate, meaningful, and timely responses to my agency's requests for technical assistance.	2	6	5	4	1	2
7. The Board's reporting requirements and informational requests are reasonable, pertinent, and unduplicated.	2	6	5	5	1	1
8. The Board surveys our service needs when completing its annual program plan.	2	5	5	5	0	3
9. The Board offers (either directly or through contract) a continuum of services to benefit consumers with all levels of need.	3	10	2	4	1	0

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH BOARD
Revenues
For the Fiscal Year Ended September 30, 1998

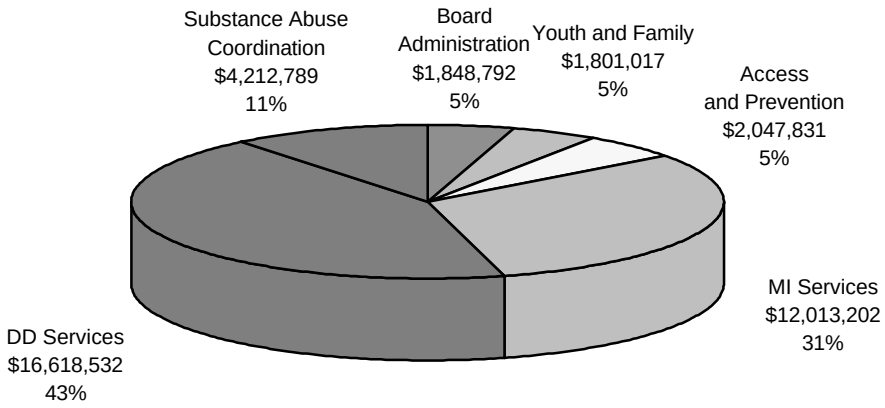


	Amount
State	$ 23,712,221
Federal	11,626,473
Other	2,215,954
Total Revenues	$ 37,554,648

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH BOARD

Expenditures

For the Fiscal Year Ended September 30, 1998

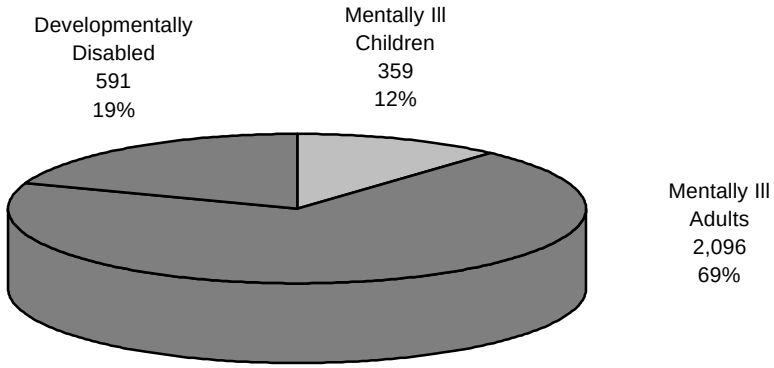


	Amount
Board Administration	$ 1,848,792
Youth and Family	1,801,017
Access and Prevention	2,047,831
MI Services	12,013,202
DD Services	16,618,532
Substance Abuse Coordination	4,212,789
Total Expenditures	$ 38,542,163

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH BOARD

Unduplicated Consumer Headcount

For the Period Ended September 30, 1998



	Headcount
MI - Adult	2,096
MI - Children	359
Developmentally disabled	591
Total	3,046

Glossary of Acronyms and Terms

ASAM	American Society of Addiction Medicine.
consumers	Individuals who are or have received mental health services.
developmentally disabled (DD)	An individual with disabilities that become evident in childhood; are expected to continue indefinitely; constitute a substantial handicap to the affected individual; and are attributed to mental retardation, cerebral palsy, epilepsy, or other neurological conditions.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical for the amount of resources applied or minimizing the amount of resources required to attain a certain level of outputs or outcomes.
goal	The agency's intended outcomes or impacts for a program to accomplish its mission.
HSIS	Human Services Information System.
individual plan of service (IPS)	A written plan of supports and services directed by the individual as required by the Mental Health Code. This plan may include both support and treatment elements.
internal control structure	The management control environment, management information system, and control policies and procedures established by management to provide reasonable assurance that goals are met; resources are used in compliance with laws and regulations; and that valid and

	reliable performance related information is obtained and reported.
mental health service providers	An organization other than the Board that provides, under contract, a service or the facilities for the provision of a service.
mentally ill (MI)	An individual with a substantial disorder of thought or mood which significantly impairs the individual's judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
mission	The agency's main purpose or the reason the agency was established.
objectives	Specific outputs a program seeks to perform and/or inputs a program seeks to apply in its efforts to achieve its goals.
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.
person-centered planning (PCP)	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Rehabilitation Accreditation Commission (CARF)	An organization that serves as the preeminent standards-setting and accrediting body. CARF (formerly known as the Commission on Accreditation of Rehabilitation Facilities) promotes the delivery of quality services to people with disabilities and others in need of rehabilitation.
reportable condition	A matter coming to the auditor's attention that, in his/her judgment, should be communicated because it represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
RU	reporting unit.
SACA	Substance Abuse Coordinating Agency.