CHAPTER 3

The Division needs to improve contracting and data collection systems to ensure accountability

Chapter Summary

Contracts are the Division's primary means of holding stakeholders accountable.

Most of the Division's core functions are performed under contract with not-for-profit community-based providers. Contracts are the primary means of holding those providers, and ultimately the Division, accountable for meeting statutory requirements. As directed by HB 59, the Division has promulgated rules and issued standards for substance abuse services providers; rules allow no-bid contracting but require providers to submit two preliminary documents demonstrating the need for services before the state enters into contracts.

Under current practices, effective services cannot be verified.

The Division's contract requirements do not support its data and information needs for assessing provider performance or monitoring client outcomes. Further, the Division has not required that all documentation be present or complete before finalizing provider contracts. As a result, contract terms do not give the Division the client-based information it needs to guide development of an integrated statewide service system, or to ensure that state funds are used to purchase effective services.

Contracts could strengthen Division assurances of consistent, effective service delivery.

We recommend the Division strengthen its contracting procedures by clearly defining necessary client-level data, and that it modify contract terms to require consistent reporting of this data by providers. In addition, the Division should improve compliance with its own contracting rules by requiring complete contract applications, and should also clearly link providers' application promises to contract performance expectations.

Contracts hold providers and the Division accountable for expenditure of funds

The Division's purpose is to administer a state prevention and treatment system that counters the debilitating effects of alcohol and drug abuse on individuals, families, and communities. It supports this purpose by entering into contracts for services.

Best practices in service contracting demand measurable performance outcomes.

Effective contracts hold vendors accountable for service delivery in terms of both quality and quantity of services; that is, they should be performance (outcome) based. According to both the National State Auditors' Association and the Office of Federal Procurement Policy, performance-based service contracts should include terms, spelled out in detail, that enable staff to monitor and evaluate each contractor's performance objectively. A performance-based contract should be structured around the purpose of the work to be performed. It should:

- Identify the responsibilities of the parties to the contract
- Define deliverables
- Document parameters of what is agreed upon, including:
    - specific measurable deliverables
    - reporting requirements
    - inspection and audit provisions
    - termination provisions
    - incentives and penalties tying payment to performance

An important Division function is managing service contracts

The Division contracts for a wide variety of tasks including research, certification of providers, community substance abuse services, and the operations of juvenile and adult drug courts. It also contracts for developing and maintaining the Wyoming Client Information System (WCIS), a provider service database shared with the Mental Health Division.

Contracting is the main tool used to achieve Division service objectives.

Prevention and treatment service contracts constitute the largest proportion of Division expenditures, 69 percent ($34.2 million), including HB 59 funds. Figure 3.1 indicates the type and number of contracts, and the funds the Division has obligated through contracts, for the current biennium.

Figure 3.1

Division contracts, FY ’05 – ’06

Contract Type	Number	Contracted Amount
Prevention/Treatment services	235	$34,217,120
Consultants/Professional/Admin. Services	175	$15,561,291
All Contracts	**410**	**$49,778,411**

Source: Substance Abuse Division contracts database

We reviewed a sample of Division contracts, which we defined as the letter of intent, the contract application, and the contract document, to determine the extent to which procedures support the Division’s planning, management, and oversight functions (see Appendix H for summary of our contract review methodology). We compared 40 contracts, 24 of which were contracts for treatment services, with Division rule requirements.

Division data and adherence to contract rules need to improve.

We found prevention and treatment service contracting problems stem from two shortcomings. First, the Division has not defined client-level data and outcomes in enough detail to ensure that contractors are providing information essential for evaluation of the quantity or quality of services. Second, the Division is not following its own contract requirements; contracts lack crucial pieces of information that would justify the need for services.

Rules establish the Division’s service contracting process

The Division’s contract process is well-tracked.

The procedure. Generally, a certified provider’s proposal to contract for state-reimbursed services goes to a program coordinator in the Division, who initiates a contract. It passes through several reviews within the Division and the Attorney General’s Office. The signed contract is returned to the provider with an invoice form; the provider uses the form to submit an accounting of its services, although actual monthly payment is structured as a one-twelfth drawdown of the overall contract amount. The Division’s process of reviewing contracts is well-tracked, each phase being verified with participant signatures and dates.

Division contract rules appear to follow best practices.

Form and content. Rules require that the Division's decision to fund a contract be based on the cumulative information contained in a letter of intent and an application. Together with the contract, the information in these documents can give the Division an ongoing means of assessing substance abuse services at a systems, provider, and individual client level (see Appendix I for rules and contract review criteria). According to Division rules and best practices, the information required in these documents should:

- Define a service area
- Demonstrate a particular service is needed
- Demonstrate the contractor has the staff and financial ability to provide that service
- Demonstrate a collaborative relationship with other providers in the service area
- Define the expectations for the provision of that service and the parameters by which success in that provision will be measured

Penalties and incentives should be included in service contracts.

In developing contract requirements, the Division has an opportunity to articulate its expectations regarding the cost, quality, and quantity of services expected in return for state payment. Best practices indicate incentives, both positive and negative, should be formally included in the contract language. Division rules require that contracts include:

- Purpose and intent statement
- Description of services provided
- Data and information required for monitoring and evaluation
- Payment schedule
- Monitoring, evaluation, and audit provisions

Contracts lack provisions to track the effectiveness of client services and generate system information

Based on our contract review, we determined that the Division's contracts tend to focus on sustaining the relationship between the Division and contractors, rather than on defining the expected

Division contracts focus on provider needs, not client outcome measures.

outcomes of purchased services or establishing how those outcomes will be measure and monitored. As a result, the Division knows how much is being spent and by whom, but cannot demonstrate that the funds are effectively targeted at individual client or statewide system needs.

Client outcomes. In interviews, providers highlighted that in the course of substance abuse treatment and recovery, there is near certainty of relapse. Some additional challenges in providing treatment include that the client population tends to be mobile, and that many clients with substance abuse problems also have mental health (co-occurring) diagnoses. These challenges make it imperative that the Division accurately track and count individuals if it is to correctly assess treatment effectiveness. However, due to shortcomings in data requirements and contract language, the Division does not know which individuals are receiving which services or whether those services have contributed to tangible improvements in clients' lives.

Individual client data is essential because substance abusers are mobile and may re-enter treatment numerous times.

Measuring the outcomes of human services can be difficult, but some indicators of improvement after treatment can be reported. Examples of positive and measurable indicators are:

- Elimination or reduction in frequency of substance use
- Reductions in the level and cost of care needed
- Improvement in obtaining or maintaining employment
- Decreased involvement with law enforcement and the courts

Providers that contract with the Division are not, however, required to submit outcome or indicator information.

System development. System development means developing the services that are needed, at the capacity and in the places they are needed. Information the Division collects can be used to determine the level of funding providers are using, but not whether these funds secure appropriate services for more individuals than in the previous year, or whether the services are having positive results. Ensuring that individuals receive the services they need is of particular concern because, during the course of our research, one contractor submitted a report to the Division showing clients were going to inappropriate levels of care: they were being placed

Systems development requires reliable client-based data.

in the facility of the provider that had assessed them, rather than being referred to a provider with more appropriate services, a concern previously articulated in the *Blueprint*.

The Division cannot identify the scope of the state's abuse problems or trends impacting resource needs.

Without client level information, the Division cannot determine current scope of the state's substance abuse problem or identify changes in trends that will affect the resources needed to meet the state's problems, such as changes in the number of recipients, type of services used, or clients' needs/intensity of problems. The Division's information base does little to assist in identifying the volume or location of services needed in different areas of the state, and thus does not support the HB 59 mandate to develop a comprehensive and integrated statewide system of care.

The Division has not defined contract terms that help it carry out oversight

The Division does not currently identify and track individual clients' treatment, progress, and outcomes, primarily because of the limitations of its data system, and also in part because of non-specific contract language about data requirements and service outcomes. Its data gathering is not based on statewide unique identifiers; consequently, the system cannot distinguish individual clients who go to more than one provider, or identify clients who cross agencies to receive substance abuse services. Also, the Division and providers do not agree on the scope of necessary data or on the state's need to access individual client data.

Contract language is general, non-specific to data needs and requirements.

Contract language. In applications as well as contracts, the Division requires providers to submit information according to a standard format. However, it does not require providers submit client-level information under Division-defined terms. Our review of applications showed that references to data are vague, and definitions of client outcomes are lacking. What data the Division gleans from provider applications is provider-level service data or aggregate service hours, rather than individual client-based information or data that can be used to assess system level needs.

Similarly, data requirements in contracts are generic; for example, a standard provision is "All documents, reports,

records, field notes, materials, and data of any kind resulting from performance of this contract are at all times the property of the Agency." This language, although broadly claiming Division ownership of the data, does not specify necessary data elements or client outcomes that Division staff could use for monitoring. Also, although some recent contracts specify tracking clients' Social Security numbers, they do not specifically require providers to submit these numbers to the Division for tracking and oversight purposes.

The Division's data system lets providers determine what data is relevant and in what form to submit it.

Data system. The Division's main client database, generated through the Wyoming Client Information System (WCIS), is the same database used by the Mental Health Division. Despite its name, the system does not track or aid in monitoring individual clients and their receipt of services. It has an individual identification component, but every provider has its own system, procedures, and definitions of what elements to track. Not only do the identifiers differ from one provider to the next, but the system focuses on treatment episodes (from admission to discharge) rather than on individuals. Thus, there is a strong likelihood that clients are counted multiple times if they receive treatment from more than one provider or if they enter and exit the system more than once.

Client admissions do not sufficiently describe the population.

For example, one of the more thorough contract applications we reviewed showed that over a three-year timeframe, the provider had over 4,500 admissions; however, this only represented 1,750 different clients. Although this provider's information may not be representative of all providers in the system, it illustrates the need for individual client identifiers if the Division is to understand and plan realistically for the size of the client population and its treatment needs.

Changes to the Division's data system still leave discretion to the providers.

Some changes to WCIS are being implemented, but we do not believe these changes will be adequate to meet Division needs to track individual client outcomes in the future. One key concern is that, even after system improvements, each provider will still have discretion as to what data elements it will submit. It appears providers will continue to define their own standards for submitting client-based data to the Division.

Providers must submit client-based information to other state health programs.

Client confidentiality. Most providers we interviewed stated they are concerned with allowing access to or use of individual client data by both the Substance Abuse and Mental Health Divisions. Providers already must collect and report individually identified client data, including Social Security numbers, in order to comply with certain state (DFS) and federal (Medicaid; the Substance Abuse and Mental Health Services Administration - SAMHSA) requirements. Consistency in requiring use of the same type of unique client identification numbers would aid the Division in creating precise client counts and evaluating and monitoring client services and outcomes.

The Attorney General has advised that client-based information can be accessed.

Two federal laws, the better-known of which is the Health Information Portability and Accountability Act (HIPAA), allow state health oversight agencies such as the Division to access and use such information. However, some providers have not been forthcoming and others have been inconsistent in reporting clients' Social Security numbers. This problem continues even though the Mental Health Division received an Attorney General's informal opinion in 2002 stating that it could have access to client information otherwise protected by HIPAA.

Recommendation: The Division should define necessary client-level data and outcomes, and structure contract provisions so that data will be reported uniformly.

Federal client level data requirements will go into effect in 2007.

Good data is essential to demonstrate and improve provider, Division, and system-wide performance. In order for the Division to ensure services are both delivered and effective, it must have access to client-specific data. Contract data provisions are where this data can be required for use in planning, making policy decisions, and coordinating resources in accordance with HB 59. The Division needs to clearly define necessary client-level data and outcomes, and then structure contract provisions so this data will be reported consistently. Although SAMHSA will implement client-level reporting requirements by FY '07, the Division should begin now to adapt its contracts.

The Division makes contract decisions without required documents and information

We found that the Division is not taking advantage of the opportunity afforded by contracts to hold providers accountable for the services they promise and the funding they receive. In short, up-to-date information is not readily available for contract decision-making.

Letters of intent. For the 40 contracts we reviewed, we saw only two accompanying letters of intent; for the 24 service contracts, we saw one letter of intent, although this letter did not specify several elements required in rules: a demonstrated need for services, the area to be covered, or that the provider was certified to offer services.

Most contract applications lacked important system needs and monitoring information.

Contract applications. Although many more contracts were accompanied by applications than by letters of intent, few applications were complete. For example, 20 of 21 applications reviewed (95 percent) did not explain why area service needs were currently not being met. In addition, 17 of 21 (81 percent) did not contain descriptions of the provider's financial and data management systems and 18 of 21 (86 percent) did not include a plan for measuring and reporting outcomes.

Moreover, application information regarding needed services typically described the provider's business needs, such as a need for further staff training, rather than emphasizing the needs of the population to be served. Also, when describing provider collaboration and coordination at the local level, applications did not detail collaborative arrangements that would ensure clients are being directed to the most appropriate service provider.

Contracts focus on services utilized, not on the services' effectiveness.

Contracts. Contract provisions were of a pro forma nature: we noted a lack of specificity or substance in many provisions, the absence of which limits the agency's ability to measure the effectiveness of its contractual arrangements. Contracts did not require providers to report the results of services provided, only that they promised to deliver services. For example, language

describing a contract's purpose and objectives would note the Division's goal of a developing a continuum of care, but not require the provider to report its contributions toward meeting that goal.

Also, descriptions of the services to be provided tended to be identical regardless of the provider's size, location, range of services offered, and clientele. Detail was along the lines of "the contractor will provide Outpatient Services." We found no descriptions of performance measures to tie providers' quality or effectiveness of services to payments. Contract performance criteria were at the aggregate level, requiring total contact hours or services used. If providers did not attain 75 percent service utilization, contracts specified they would be penalized only in the last quarter of the fiscal year according to a Division-prescribed formula.

Continued staff turnover makes a seamless application process and comprehensive contract provisions essential

Staff turnover enhances the need for a thorough, consistent contracting process.

In the short time since its inception, the Division has faced challenges from significant staff turnover, rapid growth in staff size, and increases in assigned duties. Many staff and stakeholders said the Division has no reliable institutional knowledge to inform contracting and policy decisions. In several instances, we concluded staff turnover may both contribute to and be the result of inconsistent understandings of staff and Division responsibilities.

Staff familiarity with contract-relevant statutory provisions was mixed.

For example, we heard conflicting interpretations of what is required in service contracts and how the contracting process occurs. W.S. § 35-1-620(a)(i) allows service contracts to be bid or no-bid. However, various staff members provided different opinions on how the process occurs: some referenced the no-bid application process described in the Division's rules, while others said the process requires competitive bidding. In addition, W.S. § 35-1-622(b) limits state funding of community providers to 90 percent of their non-federal cost of operations. Yet there was limited awareness of the funding limitations in statute, which may need to be factored in when applications are reviewed.

Recommendation: The Division should follow its contracting rules by requiring complete applications and linking them to contract terms.

Clear and consistent contract processes and expectations will aid in staff efficiency and improved oversight.

The Division needs to follow its contracting rules by first requiring complete contract applications. It should not enter into contracts with providers until all required documentation and substantive information from the pre-application process have been received. Then, it needs to clearly link contract provisions with the expectations set out in the letters of intent and applications. Once these conditions are met, the Division can do a better job of ensuring the effectiveness of state-funded services. Also, since contract development, monitoring and oversight are the Division's main functions, a seamless process can help new staff transition into and master their jobs, as well as ensure consistency in contract content.

With better information, the Division can refine its service and funding priorities and make demonstrable progress toward building a comprehensive and integrated continuum or care. The Division's present approach to contracting places minimal expectations on providers and may have allowed a sense of entitlement to continued funding to develop, rather than serving as an incentive for providers to deliver high quality, effective substance abuse services.

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