STATE OF LOUISIANA
LEGISLATIVE AUDITOR

Contracted Services for Louisiana's Substance Abuse Program

July 1995

Performance Audit

Daniel G. Kyle, Ph.D., CPA, CFE
Legislative Auditor

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Contracted Services for Louisiana's Substance Abuse Program

July 1995

Performance Audit Division
Office of Legislative Auditor
State of Louisiana

Daniel G. Kyle, Ph.D., CPA, CFE
Legislative Auditor

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OFFICE OF
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July 10, 1995

The Honorable Samuel B. Nunez, Jr.,
President of the Senate
The Honorable John A. Alario, Jr.,
Speaker of the House of Representatives
and
Members of the Legislative Audit Advisory Council

Dear Legislators:

This is our performance audit of the Contracted Services for Louisiana's Substance Abuse Program. The audit was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. In doing this audit, we followed applicable generally accepted government auditing standards.

The report presents our findings, conclusions, and recommendations. Also included as Appendix D are the responses of the Department of Health and Hospitals and the Division of Administration.

Sincerely,

Daniel G. Kyle, CPA, CFE
Legislative Auditor

DGK/jl

[LEGLTR]

Office of Legislative Auditor

Executive Summary

Performance Audit

Contracted Services for Louisiana's Substance Abuse Program

Audit Initiation and Objectives

The Legislative Audit Advisory Council requested us to conduct a performance audit of Louisiana's substance abuse program. The council specifically asked our office to review contracted services for the program. The audit objectives were:

- Determine the process used by the Department of Health and Hospitals to award contracts for providing substance abuse prevention and treatment services.
- Determine the adequacy of the process by which the department assesses the quality and cost effectiveness of the contracted services for the substance abuse program.

Contracting Process

The Office of Alcohol and Drug Abuse (within the Department of Health and Hospitals) did not do a formal, comprehensive statewide assessment of needs for the substance abuse program in fiscal year 1994. Instead, the office primarily used budget requests from its regional offices to assess program needs. The office recently took initiatives to address concerns dealing with statewide needs assessments and planning. The office estimates that Louisiana had as many as 84,422 residents in need of substance abuse treatment services in fiscal year 1994.

In fiscal year 1994, the office selected most of its contract service providers on a non-competitive basis. Of the 241 contracts in fiscal year 1994, only two contracts were awarded through the competitive bid process.

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While the office selected most of its contractors on a non-competitive basis, there is no formal process in place to measure cost effectiveness. Instead, officials from the central office said that they made informal comparisons between public facilities and private hospitals.

All contracts over $10,000 require approval by the Department of Civil Service and the Division of Administration. For fiscal year 1994, the approval process for substance abuse contracts over $10,000 took nearly 14 times longer than for contracts under $10,000.

We identified three factors that contribute to delays in the contract approval process. These factors are the amount of each contract, untimely completion of internal reviews, and timing of the contract cycle. These factors increase the length of the contracting process and can cause delays in services to clients and payments to providers. Contractors can either continue offering services in anticipation of contract approval or stop operating until their contracts are approved and payments begin.

Contract Monitoring

The Office of Alcohol and Drug Abuse did not adequately monitor contracted services in fiscal year 1994. As a result, this could have affected the quality of services offered to an estimated 45,395 people receiving treatment services and 213,935 people receiving prevention services. Furthermore, without adequate monitoring, the state cannot be sure if it received all of the $12.7 million worth of services the contractors were required to provide.

The monitoring of contracted services is not uniform among the regions. In fiscal year 1994, none of the nine regions followed the monitoring schedule established by the central office in Baton Rouge. This lack of uniformity in the monitoring process might have been caused by a lack of communication between the central office in Baton Rouge and the regions. Of the 23 people who monitored treatment and prevention contracts in fiscal year 1994, only three said they interacted with the central office during monitoring.

Monitoring of contracted services was incomplete and lacked documentation. Evidence of only 55 percent of the required reviews could be found. For the reviews that were conducted, more than one-third did not have complete documentation.

The instrument used quarterly by the Office of Alcohol and Drug Abuse to monitor contracted services does not assess whether the contractor is accomplishing the objectives listed in their statement of work. There were no contracts in our sample that had a detailed monitoring of the objectives listed in the contracts using the quarterly monitoring instrument. Also, less than one-third of the objectives in the sampled contracts were included in the monitoring report form used by the office at the end of each year.

Recommendations

1. The Office of Alcohol and Drug Abuse should conduct formal, comprehensive statewide assessments of needs for its substance abuse program on a regular basis. The office should determine the frequency of conducting such assessments based on state and federal laws as well as available resources.
2. In cooperation with the Division of Administration, the Office of Alcohol and Drug Abuse should explore alternative measures to expedite the contract review process.
3. The Office of Alcohol and Drug Abuse should reexamine the contract review process within its own office to ensure that contracts are approved in a timely manner.
4. The Office of Alcohol and Drug Abuse should require regions to follow the prescribed schedule for monitoring contracted services. Furthermore, the office should implement management controls to ensure that the monitoring policy is being uniformly implemented in the regions.
5. The Office of Alcohol and Drug Abuse should ensure that all state facilities and contract service providers are sufficiently monitored by an accountable party.

6. The Office of Alcohol and Drug Abuse should implement formal policies and procedures to ensure that all reviews for contracted treatment facilities and prevention programs are completed and documented.

7. The Office of Alcohol and Drug Abuse should include an evaluation of contract objectives during its monitoring of both treatment facilities and prevention programs. This evaluation should also include an end-of-year assessment of all objectives in the contractor's statement of work.

8. The Office of Alcohol and Drug Abuse should establish procedures to evaluate the cost effectiveness of its contracted services. The evaluation of cost effectiveness should include the following:

    - Contracts should be compared to both state and private programs that provide similar types and level of services.

    - Each contract should be evaluated based on the objectives included in the contract that are achieved. The office should develop outcome measures that will assist in the evaluation of contract objectives.

Agency Responses

The responses from the Department of Health and Hospitals and the Division of Administration are included in Appendix D of this report. The Department of Civil Service was also given the opportunity to respond to our draft report. However, the department chose not to respond.

Chapter One: Introduction

Audit Initiation and Objectives

The Legislative Audit Advisory Council requested us to conduct a performance audit of Louisiana's substance abuse program. The council specifically asked us to review contracted services for the program. In response to the council's request, as well as based on our background research, we focused on the following audit objectives:

- **Determine the process used by the Department of Health and Hospitals to award contracts for providing substance abuse prevention and treatment services.**
- **Determine the adequacy of the process by which the department assesses the quality and cost effectiveness of the contracted services for the substance abuse program.**

Report Conclusions

The Office of Alcohol and Drug Abuse (within the Department of Health and Hospitals) did not do a formal, comprehensive statewide assessment of needs for the substance abuse program in fiscal year 1994. Instead, the office primarily used budget requests from its regional offices to assess program needs. The office recently took initiatives to address concerns regarding statewide needs assessments.

In fiscal year 1994, the office selected most of its contract service providers on a non-competitive basis. The approval of contracts involved multiple reviews, including the review by the Division of Administration for contracts over $10,000. The office did not have a formal process for evaluating cost effectiveness of its contracted services and did not adequately assess whether the contractors were accomplishing all of the objectives in their contracts.

The Office of Alcohol and Drug Abuse did not adequately monitor contracted services in fiscal year 1994. As a result, this could have affected the quality of services offered to an estimated 45,395 people receiving treatment

services and 213,935 people receiving prevention services. Furthermore, without adequate monitoring, the state cannot be sure if it received all of the $12.7 million worth of services the contractors were required to provide.

Monitoring of these services was not uniform among the regions. In fiscal year 1994, none of the nine regions followed the monitoring schedule established by the central office. Regional staff noted a lack of communication between the regions and the central office during the monitoring process. Furthermore, the monitoring was incomplete and lacked documentation. We found evidence for only 55 percent of the required reviews. Of the reviews conducted, more than one-third did not have complete documentation.

Scope and Methodology

This performance audit was conducted under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. We followed applicable generally accepted government auditing standards as promulgated by the Comptroller General of the United States. These standards require that the audit is conducted by independent and qualified staff with due professional care. In addition, the audit team must follow standards dealing with materiality and significance, relying on the work of others, internal quality controls, and report presentation. The standards also require that the auditee is given an opportunity to respond to the audit findings and conclusions.

The audit focused on the economy and efficiency as well as compliance issues dealing with contracted services for the state's substance abuse program. However, it did not evaluate the effectiveness of those services. Furthermore, we did not audit electronic data processing (EDP) controls because the Office of Legislative Auditor's EDP Division is responsible for separately auditing such controls.

The survey phase of the audit began in July 1994 and the fieldwork was completed in January 1995. The audit focused on contracted services provided by the Office of Alcohol and Drug Abuse during fiscal year 1994.

To address the audit objectives, we reviewed in-state and out-of-state reports, journals, and other articles relating to substance abuse programs. We also reviewed relevant state and

federal laws governing Louisiana's substance abuse program. We interviewed state officials of the Department of Health and Hospitals who were responsible for administering the substance abuse program, as well as officials of the Division of Administration and the Department of Civil Service. We also interviewed federal officials representing the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Health Care Finance Authority.

We reviewed and analyzed agency policies and procedures and other documents pertaining to the awarding, renewing, and monitoring of contracts. We visited all ten regional offices of the Office of Alcohol and Drug Abuse. During our visits, we interviewed regional administrators and staff and reviewed all 72 monitoring files for the contracted facilities. A random sample of 31 contract files was selected for detailed analysis regarding the scope of work performed by contract service providers.

Survey of Other States. To obtain information relating to contracted services for substance abuse programs in other states, we sent a questionnaire to the following ten southern states:

Alabama	Arkansas	Florida	Georgia
Kentucky	Mississippi	North Carolina	South Carolina
Tennessee	Texas		

The survey included questions about the administration of contracted substance abuse prevention and treatment services for fiscal year 1994. We analyzed the information from the other states and compared it with Louisiana's substance abuse prevention and treatment program. When necessary, we made follow-up calls to further understand survey responses. A copy of the blank survey can be found in Appendix A.

Program Background

Department of Health and Hospitals Administers The Substance Abuse Program Through Ten Regions

According to information collected by the United States Department of Health and Human Services' Center for Substance Abuse Treatment, it is estimated that nearly one-fifth of the population will experience substance abuse-related problems

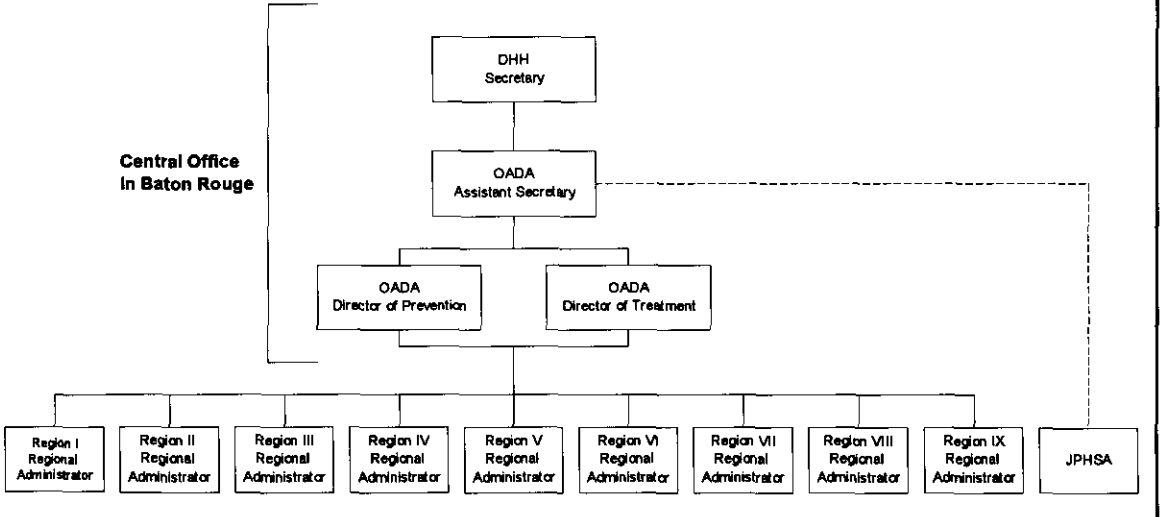
during their lifetimes. An estimated 6.5 to 37.5 million people nationwide are abusing or addicted to alcohol and other drugs. However, only about 300,000 of this number receive some form of treatment (*Treatment for Alcohol and Other Drug Abuse,* Center for Substance Abuse Treatment, Series 11, 1994).

The Office of Alcohol and Drug Abuse (OADA), within the Department of Health and Hospitals (DHH), estimated that Louisiana had as many as 84,422 residents in need of treatment services in fiscal year 1994. Treatment services were provided to 45,395 Louisiana residents in fiscal year 1994. In addition, 213,935 people participated in the office's prevention programs.

The Office of Alcohol and Drug Abuse is responsible for administering the substance abuse program in Louisiana. The program offers treatment services to those afflicted with alcohol and/or drug abuse, as well as prevention services. As shown in Exhibit 1-1, the administration of the program is divided into the central office (located in Baton Rouge) and ten regional offices that cover all 64 parishes.

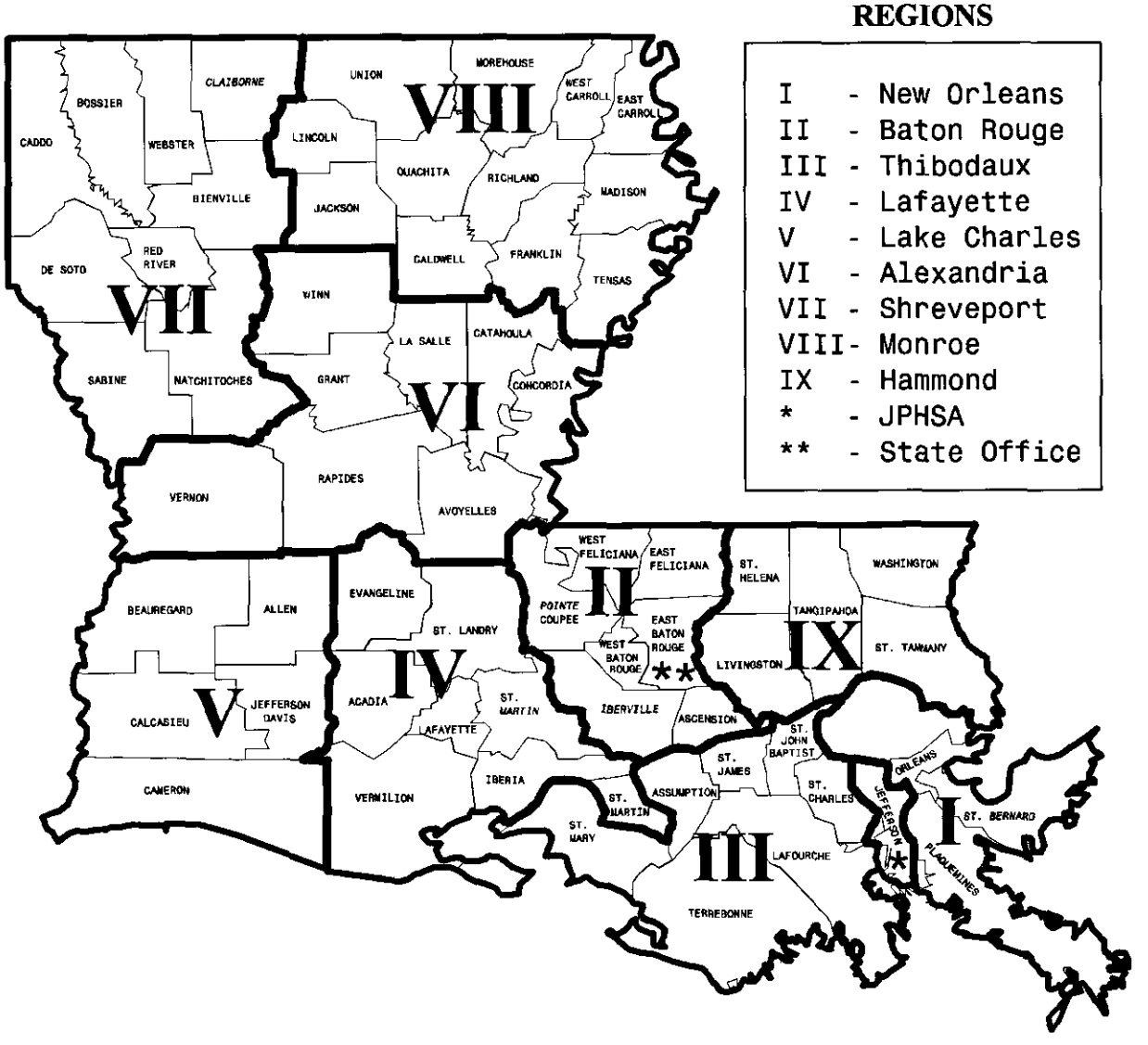
Exhibit 1-1

Office of Alcohol and Drug Abuse
Organizational Chart



Note: Region X is now called JPHSA (Jefferson Parish Human Services Authority).
Source: Prepared by the Legislative Auditor's staff with information provided by the Department of Health and Hospitals.

Exhibit 1-2
Office of Alcohol and Drug Abuse
Administrative Regions
Fiscal Year 1994



Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals.

The responsibility for managing substance abuse services lies with the regional offices. In addition to offering services to their clients, each region is responsible for identifying and addressing the substance abuse prevention and treatment needs of the region and providing oversight of the region's contracted service providers as well as state facilities. The regions are staffed by state employees, most of whom are involved in providing direct services to the clients.

The Jefferson Parish Human Services Authority is responsible for administering Region X. As illustrated in Exhibit 1-2 on page 5, Regions I through IX include the cities of New Orleans, Baton Rouge, Thibodaux, Lafayette, Lake Charles, Alexandria, Shreveport, Monroe, and Hammond. Region X, however, is composed solely of Jefferson Parish and is now referred to as the Jefferson Parish Human Services Authority (JPHSA).

The Jefferson Parish Human Services Authority was created as a special district during the 1989 legislative session by Act 458 to serve as a pilot project for the local control and delivery of health care services. The authority was to expire initially on July 1, 1992, but it has been renewed until July 1, 1998.

In accordance with Louisiana Revised Statute (LSA-R.S.) 28:831, the authority is responsible for the direction, operation, and management of the substance abuse program in Jefferson Parish. The authority and the Department of Health and Hospitals have an administrative agreement which contains the terms of the working relationship between the two. The scope of our audit did not include evaluating the Jefferson Parish Human Services Authority or compare its operations with the Office of Alcohol and Drug Abuse.

Program Funding

More Than Two-Thirds of Program Funds Were From Federal Sources

For fiscal year 1994, total expenditures for the substance abuse program were $30.2 million. Federal sources provided 70.5 percent, or $21.3 million, of these funds. As seen in Exhibit 1-3 on page 7, other means of financing included state general funds, state interagency transfers, and self-generated revenues.

The largest source of federal funding is the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Of the $21.3 million in federal funds in fiscal year 1994, $17.4 million (82.1 percent) was provided by the block grant. The block grant is administered by the Center for Substance Abuse Treatment and is the primary tool used by the federal government to support state substance abuse prevention and treatment programs.

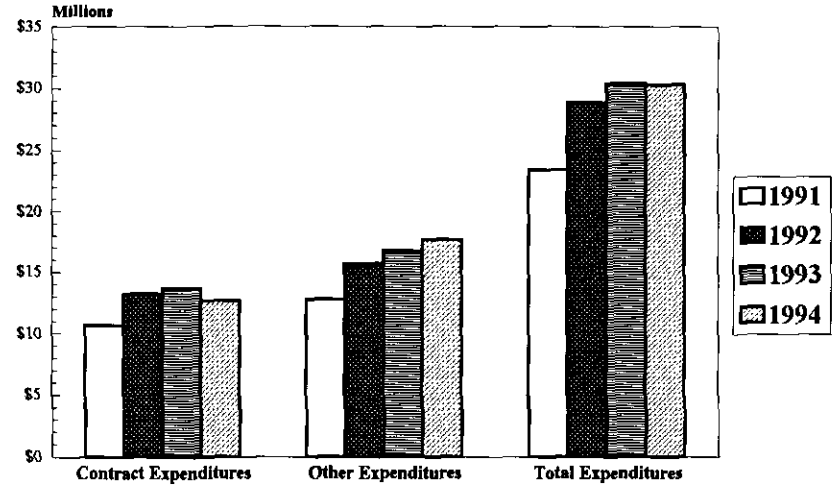
Exhibit 1-3
Means of Financing for the Substance Abuse Program Fiscal Year 1994

Means of Financing	Actual Funds	Percent of Total
Total State Funds	**$8,878,097**	**29.3%**
State General Funds	8,033,201	26.5%
State Funds Through Interagency Transfers	844,896	2.8%
Total Federal Funds	**$21,312,780**	**70.5%**
Federal Funds	18,964,568	62.7%
Federal Funds Through Interagency Transfers	2,348,212	7.8%
Self-Generated Revenues	**$50,001**	**0.2%**
Total	**$30,240,878**	**100.0%**

Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals and the Division of Administration's Financial Accountability Control System (FACS).

Total program expenditures have increased 29.3 percent in the last four fiscal years. As shown in Exhibit 1-4 on page 8, expenditures for the substance abuse program grew from $23.4 million to $30.2 million between fiscal years 1991 and 1994. During the same time period, expenditures for contractual services increased from $10.6 million to $12.7 million, a 19.0 percent increase. Expenditures other than contracted services also increased from $12.8 million to $17.6 million, or 37.9 percent.

Exhibit 1-4
Growth in Expenditures for the Substance Abuse Program
Fiscal Years 1991 Through 1994



Source: Prepared by the Legislative Auditor's staff using budget documents provided by the Department of Health and Hospitals.

While expenditures for the substance abuse program have increased over the past four fiscal years, federal funds, excluding interagency transfers, have stayed almost constant--an increase of only 3.6 percent, from $18.3 million to approximately $19 million. The increase in expenditures has been offset by increases in state general funds and interagency transfers.

Like Louisiana, seven of the ten southern states surveyed received the majority of their funding from federal sources. We surveyed substance abuse programs in ten southern states to learn about their program administration--Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and Texas.

As seen in Exhibit 1-5 on page 9, Alabama and Mississippi were the only surveyed states which received a higher percentage of their funding through federal sources than Louisiana in fiscal year 1994. Florida, Georgia, and North Carolina received more in state funds than they received from federal sources for their substance abuse programs.

Exhibit 1-5
Comparison of Substance Abuse Program Funding for Surveyed Southern States
Fiscal Year 1994

	Federal Funds	State Funds
Alabama	83%	17%
Arkansas	57%	43%
Florida	49%	51%
Georgia	46%	54%
Kentucky	60%	40%
Louisiana	70%	30%
Mississippi	71%*	29%*
North Carolina	44%	56%
South Carolina	61%	39%
Tennessee	65%	35%
Texas	70%	30%

* *Information for Mississippi is estimated.*

Source: Prepared by the Legislative Auditor's staff using information provided by surveyed states.

Program Services

The Program Provides Services Through State-Operated and Contracted Facilities

The service delivery system for the substance abuse program is a mixture of state-operated and contracted community-based programs. These facilities and programs provide services to substance abusing adults, children/youth and their families, and residents of all ages (along with family members) who have the potential to be at-risk of substance abuse. Within the publicly funded facilities, services are extended to individuals who cannot pay or can only pay a small sliding scale fee for services.

The Office of Alcohol and Drug Abuse and federal regulations make a distinction between treatment and primary prevention services. Primary prevention services are directed at individuals who have not been determined to require treatment for substance abuse. The purpose of these services is to reduce the risk of substance abuse.

Federal regulations specify that no less than 20 percent of the Substance Abuse Prevention and Treatment Block Grant shall be expended on primary prevention programs. In addition, regulations require that at least 70 percent of the block grant funds be expended on treatment services (35 percent for alcohol treatment and 35 percent for drug treatment) and no more than 5 percent of the funds be expended on administration. The use of remaining funds is discretionary. Throughout this report "primary prevention services" are referred to as "prevention services."

The prevention and treatment services are categorized as follows:

- **Prevention/Education Program** - promotes the continued freedom from chemical dependency of persons in high risk areas.
- **Inpatient (Residential) Treatment** - provides short-term and long-term residential care facilities.
- **Residential Halfway House Treatment** - provides a structured program tailored to individual needs through residences in halfway houses, three-quarterway houses, and community group homes.
- **Detoxification** - incorporates medical services provided in an acute care hospital setting, and social detoxification provided to individuals for whom supportive supervision is indicated.
- **Outpatient Clinic Services** - offers family or individual counseling, medical treatments, and educational programs to chemically dependent individuals and the high risk populations.
- **Crisis Management** - responds to the acute care needs of substance abusers through a 24-hour hotline.
- **Targeted Case Management** - helps individuals and families improve their level of functioning in society by providing access to necessary medical and social services and entitlement benefits.

The Office of Alcohol and Drug Abuse contracted over half of its substance abuse prevention programs and treatment facilities. For fiscal year 1994, the state operated 59 treatment facilities and contracted with 44 treatment facilities throughout the nine regions and the Jefferson Parish Human Services Authority. In addition to the treatment facilities, the state contracted for 30 primary prevention programs. Exhibit 1-6 below summarizes the number of treatment facilities and prevention programs by region and Appendix B lists names of these facilities. The state also contracted with physicians and other health care professionals to provide services for the state-operated facilities.

Exhibit 1-6

Number of Treatment Facilities and Prevention Programs by Region Fiscal Year 1994

Region Including City or Parish	Number of State Treatment Facilities	Number of Contracted Treatment Facilities	Number of Contracted Prevention Programs	Total Number of Facilities and Programs
Region I - New Orleans	4	8	5	17
Region II - Baton Rouge	3	5	11	19
Region III - Thibodaux	7	4	2	13
Region IV - Lafayette	7	2	1	10
Region V - Lake Charles	3	4	3	10
Region VI - Alexandria	12	6	2	20
Region VII - Shreveport	10	6	0	16
Region VIII - Monroe	4	4	5	13
Region IX - Hammond	6	3	1	10
JPHSA - Jefferson Parish	3	2	0	5
Total	**59**	**44**	**30**	**133**

Source: Prepared by the Legislative Auditor's staff using information provided by Department of Health and Hospitals officials.

Report Organization

The remainder of this report is organized as follows:

- **Chapter Two** describes and evaluates the process of contracting treatment and prevention services for Louisiana's substance abuse program.
- **Chapter Three** discusses the monitoring of contracted services.
- **Appendix A** includes a copy of the survey sent to ten southern states.
- **Appendix B** lists the state operated and contracted facilities for fiscal year 1994.
- **Appendix C** contains a listing of contracts sampled to examine the evaluation of contract objectives.
- **Appendix D** includes the responses from the Department of Health and Hospitals and the Division of Administration. The Department of Civil Service was also given the opportunity to respond to our draft report. However, the department chose not to respond.

Chapter Two: Contract Process

Chapter Conclusions

The Office of Alcohol and Drug Abuse does not do formal, comprehensive statewide assessments of needs for the substance abuse program. Instead, the office primarily uses budget requests from its regional offices to assess program needs. The office has recently taken initiatives in addressing concerns dealing with statewide needs assessments and planning.

The office selects most of its contract service providers on a non-competitive basis. It awarded only two contracts for fiscal year 1994 through a competitive bid process. The selection and approval of contracts involve multiple reviews depending on the contract type. All contracts over $10,000 require approval by the Department of Civil Service and the Division of Administration.

We identified three factors that contribute to delays in the contract approval process. These factors are the amount of each contract, untimely completion of initial reviews by the Office of Alcohol and Drug Abuse, and timing of the contract cycle. These factors increase the length of the contract process and can cause delays in services to clients and payments to contractors.

Lack of Statewide Needs Assessments

Office of Alcohol and Drug Abuse Does Not Conduct Statewide Needs Assessments

The Office of Alcohol and Drug Abuse does not do formal, comprehensive statewide assessments of needs for the substance abuse program. However, program officials said that they assess needs in several ways including state plans, public forums, requests from regional administrators, and submission of annual budgets by regional administrators.

Federal regulations require states to include an assessment of needs, both by locality and by the state in general, when completing an application for the Substance Abuse Prevention and Treatment Block Grant. The assessment should show

incidence and prevalence of alcohol and drug abuse in the state. Because Louisiana did not have such data, the Office of Alcohol and Drug Abuse estimated needs for its substance abuse program for fiscal year 1994 in its block grant application.

The Office of Alcohol and Drug Abuse did not prepare a state plan for fiscal year 1994 or 1995. The last state plan was completed in 1990, which covered three fiscal years (1991-1993). The director of treatment services in the central office said that the three year state plan was an office initiative to aid in budgeting and needs assessments. The office carried forward relevant goals from the 1990 state plan that were not completed during the earlier years to the following years. According to officials in the central office, public forums were used to develop the last state plan. However, only one public forum was held since the last state plan expired. This forum did not cover all areas relating to the substance abuse program--it dealt specifically with women's recovery issues.

The Office of Alcohol and Drug Abuse relied on information from the regions for needs assessments. Officials in the central office said that information on program needs flows from the regions to the central office. The office considered the following information from the regions as assessments of needs for fiscal years 1994 and 1995: annual budget requests, letters requesting new or expanded programs, and letters requesting termination or non-renewal of existing programs. The office compiled, analyzed, and prioritized the requests for new and expanded services for its annual budget request.

Eight of the ten regional administrators said they do needs assessments for their region. However, only one of the eight administrators had documentation of a formal process. The other seven said that they did informal needs assessments.

The office has taken initiatives in addressing concerns dealing with statewide needs assessments and planning. The office recently received a federal grant of $1.24 million to do state demand and needs assessment studies for the alcohol and drug abuse program. The grant was awarded by the Center for Substance Abuse Treatment for the period of October 1994 through September 1997.

Furthermore, the Department of Health and Hospitals has contracted with a consultant to address multiple needs within its various offices. Within the Office of Alcohol and Drug Abuse,

one of the initiatives identified is the development of a three to five year strategic plan. However, program officials did not know when the strategic plan will be completed or implemented.

Recommendation

1. **The Office of Alcohol and Drug Abuse should conduct formal, comprehensive statewide assessments of needs for its substance abuse program on a regular basis. The office should determine the frequency of conducting such assessments based on state and federal laws as well as available resources.**

Overview of Contract Process

Contract Process Consists of Multiple Reviews

The selection of a contract service provider is made within the Office of Alcohol and Drug Abuse. However, each contract must go through multiple reviews. For analysis purposes, we categorized the review process into two groups--initial and subsequent reviews. The initial reviews are completed by the Office of Alcohol and Drug Abuse. The subsequent reviews are completed by the Contract Management Unit of the Department of Health and Hospitals, the Department of Civil Service, and the Division of Administration.

The review process must follow the regulations set forth by the Division of Administration in a March 1991 document titled *Regulations for the Procurement of Personal, Professional, Consulting and Social Services.* Exhibit 2-1 on page 17 outlines the contract review process based on the interviews with officials of these agencies and documents provided by those officials.

Contracts originate at the regional level. According to Office of Alcohol and Drug Abuse officials, regional administrators recommend contractors for new and continued services. The assistant secretary of the office gives the final approval. This was confirmed by eight of the nine regional administrators. Only one regional administrator said the central office makes all of the decisions about who receives a contract without any input from the region. Region X has its own

contracting process because it is administered by the Jefferson Parish Human Services Authority.

The Office of Alcohol and Drug Abuse selects most of its contract service providers on a non-competitive basis. State laws require competitive bids using requests-for-proposals (RFP) for awarding social service contracts over $150,000. Social service contracts include substance abuse treatment facilities and prevention programs. There are exceptions to the competitive bid requirement, including the following:

- contractors who have continuously performed services since November 30, 1985
- contracts with another government entity
- funds designated by the federal government for a particular private or public contractor or political subdivision

Of 241 contracts in fiscal year 1994, there were 14 over $150,000. Of these, only two contracts were awarded using a competitive bid process. The remaining 12 contracts were exempt from the competitive bid process because of the reasons listed above.

For new contracts that do not require competitive bidding, notification of the need for service providers is given through several means, such as word of mouth, responses to the inquiries by interested providers, and calls by regional managers to providers they already know about. Of the contractors notified by regional managers, many are ongoing providers who have a track record with the Office of Alcohol and Drug Abuse.

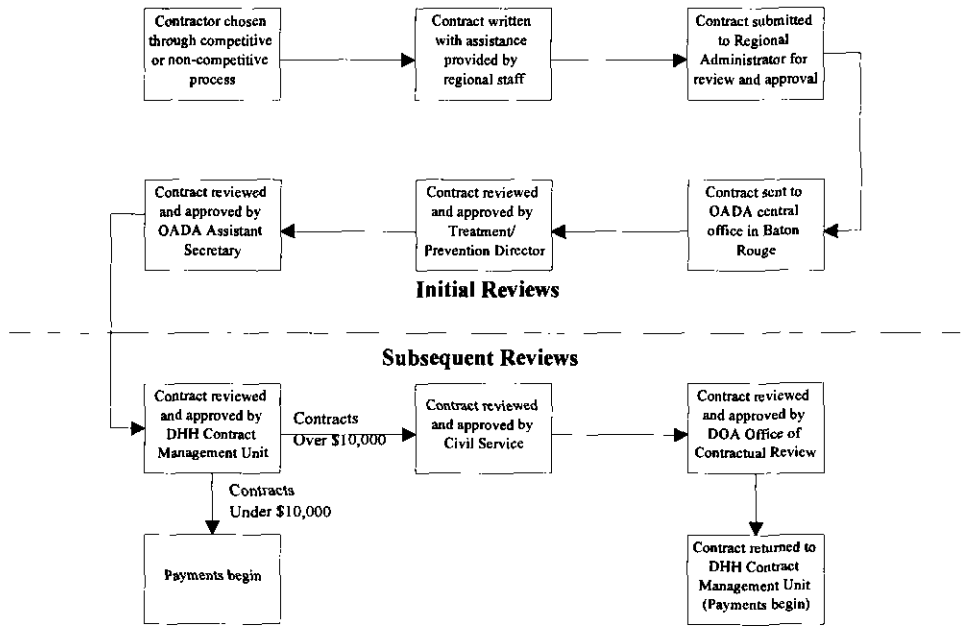
Regional and central office staff complete programmatic review of all contracts before they are sent for subsequent reviews. Regional staff provide assistance to the prospective contractor in preparing the contract. The staff also provides assistance to existing service providers whose contracts are due for renewal. After the regional administrator has reviewed and approved the contract, it is then forwarded to the central office in Baton Rouge.

Central office staff identify anything that may be unusual or may need further verification regarding funding, scope of work, staffing, salaries, and compliance with federal requirements. The directors of treatment and prevention services also review each contract for their respective programs. They either

approve the contracts or send them back to the regions for corrections and re-submission. According to officials in the central office, the assistant secretary makes the final determination about each contract. All approved contracts are then sent to the Contract Management Unit of the Department of Health and Hospitals.

The Contract Management Unit reviews all contracts for the Department of Health and Hospitals. It has authority to grant final approval for contracts up to $10,000. According to its administrator, the Contract Management Unit reviews contracts for technical correctness but not for programmatic problems relating to the substance abuse program. The Contract Management System. Approved contracts over $10,000 are sent to the Department of Civil Service for further review.

Exhibit 2-1
Office of Alcohol and Drug Abuse Contracting Process



Note: If at any stage of the process a contract is not approved, it is sent back to the appropriate officials for modifications.

Source: Prepared by the Legislative Auditor's staff with information provided by the Department of Health and Hospitals, the Division of Administration, and the Department of Civil Service.

The Department of Civil Service reviews contracts to determine if the same services can be provided by state employees. According to the Civil Service official responsible for reviewing contracts for the Office of Alcohol and Drug Abuse, the determination is made by examining the description of duties in each contract. If a state employee is available to perform the same service, the contract is disapproved. Otherwise, the contract is approved and sent to the Division of Administration through the Contract Management Unit.

The Office of Contractual Review within the Division of Administration reviews contracts for compliance with state laws and regulations. According to the director of the Office of Contractual Review, the division also makes sure that the amount of contracts are reasonable for stated services. However, the division does not get involved in programmatic decisions. The division assigns an identification number to all approved contracts and sends them back to their respective state agencies. Department of Health and Hospitals contractors can receive payments after their contracts have been approved and entered into the Contract Management System.

Delays in Contracting Process

Factors Affecting the Timely Approval of Contracts

We identified three factors that contribute to delays in the contract approval process. These factors are the amount of each contract, untimely completion of the initial reviews by the Office of Alcohol and Drug Abuse, and timing of the contract cycle. These factors increase the length of the contract process and can cause delays in services to clients and payments to contractors. Contractors can either continue offering services in anticipation of contract approval or stop operating until their contracts are approved and payments begin.

Additional reviews increase the length of the contracting process for contracts over $10,000. Contracts over $10,000 took nearly 14 times longer to complete the subsequent reviews than contracts under $10,000. As mentioned earlier, the review process for contracts under $10,000 ends with the Contract Management Unit of the Department of Health and Hospitals. Contracts over $10,000 require additional review by

the Department of Civil Service and the Division of Administration. We reviewed the time it took to receive final approval for all contracts of the Office of Alcohol and Drug Abuse for fiscal year 1994. Of the 241 contracts reviewed, 139 contracts were over $10,000.

Contracts valued at $10,000 or less took an average of almost five calendar days to complete the subsequent reviews. On the other hand, contracts over $10,000 took an average of nearly 69 calendar days to complete the subsequent reviews. Contracts over $10,000 spent an average of over 11 calendar days at the Contract Management Unit and the Department of Civil Service and an average of over 57 calendar days at the Division of Administration.

Timely approval of contracts depended on when the initial reviews were completed by the Office of Alcohol and Drug Abuse. The Office of Alcohol and Drug Abuse's contract cycle follows the state fiscal year, from July 1 to June 30. Of the 241 contracts in fiscal year 1994, 184 contracts had July 1 as their starting date. For analysis purposes, we concentrated on these 184 contracts.

Exhibit 2-2
Subsequent Reviews of Contracts Beginning July 1, 1993

	Number of Contracts	Number of Contracts Beginning July 1	Contracts Submitted for Subsequent Reviews After July 1	Contracts Submitted for Subsequent Reviews Before July 1	Contracts Received Final Approval Before July 1
Contracts Up to $10,000	102	72	16	56	56
Contracts Over $10,000	139	112	21	91	56
Total	**241**	**184**	**37**	**147**	**112**

Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals and the Division of Administration.

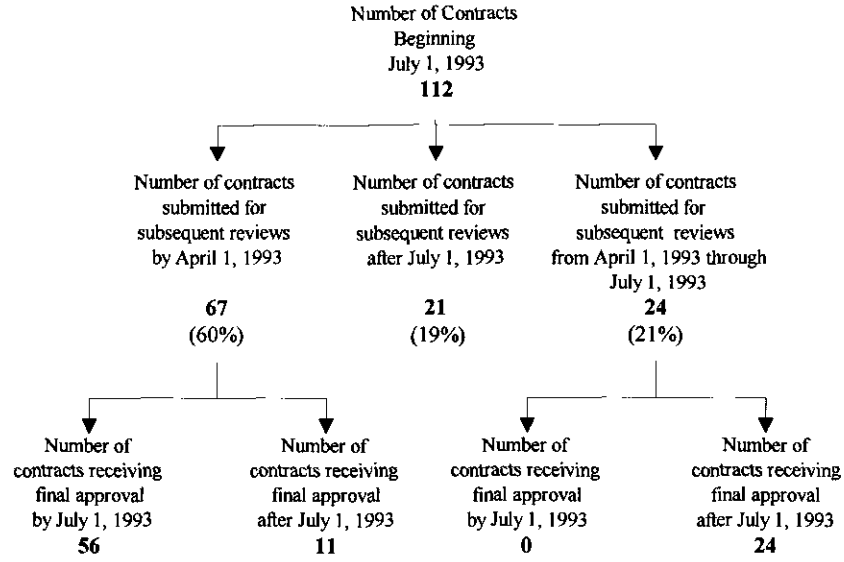
As shown in Exhibit 2-2, the office submitted 37 of the 184 contracts (20 percent) for subsequent reviews after the scheduled starting date of July 1. All contracts up to $10,000 that were submitted for subsequent reviews before their starting date of July 1 were approved on time. However, not all

contracts over $10,000 that were submitted before the starting date were approved on time.

To determine a time frame within which contracts should be submitted by the Office of Alcohol and Drug Abuse for subsequent reviews, we analyzed the timing for the completion of initial and subsequent reviews of contracts over $10,000 which began July 1, 1993. We found that none of the 24 substance abuse contracts completing initial reviews between April 13 and June 30, 1993, were approved before the contract starting date of July 1.

As shown in Exhibit 2-3, the Office of Alcohol and Drug Abuse completed its initial reviews for 67 out of the 112 contracts before April 13. Of these 67 contracts, 56 contracts (84 percent) were approved by the Division of Administration before July 1. The remaining 11 contracts (16 percent) were approved after the contracts were scheduled to begin.

Exhibit 2-3
Timely Submission and Final Approval of Contracts Over $10,000, Which Were to Begin July 1, 1993



Source: Prepared by the Legislative Auditor's staff with information provided by the Department of Health and Hospitals.

Most state contracts begin at the start of the state fiscal year, causing a backlog in the review process. The Division of Administration requires state agencies to submit their contracts to the division for review before the starting date of the contract. According to the director of the Office of Contractual Review at the Division of Administration, the division reviews approximately 7,000 contracts a year for various state agencies with only two staff and a director. Most of these contracts start on July 1, the start of the state fiscal year. The director told us that they need to receive the contracts no later than April, preferably February or March, if they are to be approved before July 1. This is because the average turn around time for the contract review at the division is about six weeks. Therefore, the closer to July 1 a contract is turned in to the division for review, the longer it will take to receive approval.

While the Office of Alcohol and Drug Abuse recognizes the importance of timely submission of contracts, the earliest that any contract completed initial reviews and was sent to the Contract Management Unit for subsequent reviews was March 24, 1993. The timely submission of contracts requires regional administrators to forward their contracts to the central office for further review as early as February. However, this may not give them sufficient time to adequately evaluate the existing contracts. For example, contracts that are being renewed must be written before monitoring of the existing contract is completed, causing difficulties in updating the scope of work of the contracts.

Suggestions by the Division of Administration may help decrease the contract review time. Because of the large number of contracts starting July 1, the director of the Office of Contractual Review within the Division of Administration suggested that the Office of Alcohol and Drug Abuse may want to stagger the starting dates of its contracts. This will allow the office to submit some of its contracts during the division's down time. As a result, the amount of time it takes for contracts to be approved may be reduced.

The division took nearly twice as much time to review Office of Alcohol and Drug Abuse contracts during its busy time period than during down time. It took an average of 72 calendar days to complete the review for contracts that the division received between March and June of 1993. On the other hand, the division took an average of 37 calendar days to review those contracts that it received between July 1993 and February 1994.

The director of the Office of Contractual Review also recommended that state agencies enter into more multi-year contracts for ongoing services. Multi-year contracts for professional, personal, consulting, or social services may be entered into for periods of up to three years. Because the Division of Administration reviews multi-year contracts only the first year, this could reduce the total number of contracts it must review each year.

Recommendations

1. **In cooperation with the Division of Administration, the Office of Alcohol and Drug Abuse should explore alternative measures to expedite the contract review process.**
2. **The Office of Alcohol and Drug Abuse should reexamine the contract review process within its own office to ensure that contracts are approved in a timely manner.**

Comparison With Other Southern States

Most Southern States Surveyed Contract Services For Their Substance Abuse Programs

Like Louisiana, half of the states surveyed have a combination of state-operated and state-contracted service delivery systems for their substance abuse programs. We surveyed substance abuse programs in ten southern states to learn about their program administration--Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and Texas.

Eight of these ten states' substance abuse programs contract for both treatment and prevention services. The remaining two states, Georgia and North Carolina, do not contract. Georgia currently does not contract for services because the state is under a legislative mandate to modify its program. North Carolina provides all of its services through state-operated facilities.

Of the eight states that contracted services for their substance abuse program, only South Carolina and Texas used the competitive bid process when awarding contracts in fiscal year 1994. Texas used the competitive bid process to award nearly all of its contracts. As shown in Exhibit 2-4, Louisiana awarded only two contracts using competitive bids.

Exhibit 2-4
Number and Amount of Contracts
Awarded Using Competitive Bids
Fiscal Year 1994

State	Number of Contracts	Amount of Contracts	Number of Contracts Awarded Using Competitive Bids	Amount of Contracts Awarded Using Competitive Bids	Percent of Contract Amount Awarded Using Competitive Bids
Louisiana	241	$12,655,273	2	$905,839	7.1%
South Carolina	300*	$20,000,000*	45*	$300,000	1.5%
Texas	500	$103,800,000	500*	$103,800,000*	100%*

* Approximate figures.

Source: Prepared by the Legislative Auditor's staff with information provided by the Department of Health and Hospitals and completed surveys from the other states.

Chapter Three: Contract Monitoring

Chapter Conclusions

The Office of Alcohol and Drug Abuse did not adequately monitor contracted services in fiscal year 1994. As a result, this could have affected the quality of services offered to an estimated 45,395 people receiving treatment services and 213,935 people receiving prevention services. Furthermore, without adequate monitoring, the state cannot be sure if it received all of the $12.7 million worth of services the contractors were required to provide.

Regional offices lacked uniformity in the monitoring of contracted services for the substance abuse program. There were no regions that followed the monitoring schedule established by the central office in Baton Rouge. This lack of uniformity may be caused by a breakdown in communication between the regions and the central office.

Monitoring of contracted services was incomplete and lacked documentation. We found evidence for only 55 percent of the required reviews. For the reviews that were conducted, less than two-thirds had complete documentation.

The instrument used quarterly by the office to monitor contracted services does not assess whether contractors are accomplishing the objectives stated in their contracts. Less than one-third of the objectives in 31 sampled contracts were included in the end-of-year monitoring report form used by the office to determine if contract objectives were accomplished.

Even though most of the contractors for the substance abuse program are selected on a non-competitive basis, the office does not have a formal method of evaluating cost effectiveness of its contracts.

Monitoring Process

Contracts Are Required to Be Monitored at Least Quarterly

The contracts procedure manual of the Office of Alcohol and Drug Abuse states that the monitoring of contractual programs is designed to ensure that providers are adequately performing their work and are in compliance with contract stipulations. Monitoring activities also help determine if contractors are in need of technical assistance. To accomplish these goals, the regional office staff must conduct site visits to provider facilities at least once a quarter and prepare a written monitoring report.

To meet the monitoring requirement, the Office of Alcohol and Drug Abuse has developed a quarterly monitoring instrument that is used during site visits. The monitoring instrument is divided into six separate modules:

1. Organization and Management
2. Facility and Maintenance
3. Treatment (It is divided into two sections--Overview and Record Review.)
4. Methadone Treatment (This module was not used because Louisiana did not have any Methadone treatment programs in fiscal year 1994.)
5. Prevention (It is divided into two sections--Overview and Record Review. However, the director of the prevention services told us that the office does not require regions to complete the record review section.)
6. Financial Management

A copy of the quarterly monitoring report should be submitted to the provider with any contract deficiencies indicated as well as a time frame for corrective action. Based on the monitoring report, regional staff is responsible for providing technical assistance to the provider if needed and ensuring that deficiencies are corrected within a reasonable time.

A summary called "Report of Review Finding" should also be prepared as part of each quarterly monitoring report. Documentation of any corrective actions, program assistance needs, and timetables for improvement should be included in the summary. Copies of the completed summaries should be

provided to the regional administrator, the contractor, and the central office in Baton Rouge. In addition to the quarterly montoring reports, regional staff should prepare an end-of-year summary called a "DHH Montoring Report Form" and forward that summary to the central office.

Policies and procedures of the Office of Alcohol and Drug Abuse require the central office staff to review and approve the corrective measures recommended by the regions and assist in follow-up action. If the recommendations concern licensing or contract deficiencies, regional staff should make follow-up site visits to check compliance within two weeks of the time set for remedial action.

For problems which require more than 30 days to solve, the provider must prepare and submit a plan of corrective action to the regional staff within two weeks of receipt of the monitoring report. The plan must indicate target dates for solutions to the problems and persons responsible for carrying out the remedial action. Regional staff should make on-site visits at the mid and final points of the time approved for corrective action to determine progress and final compliance.

Lack of Oversight by Central Office

Contract Monitoring Among the Regions Lacked Uniformity

According to Office of Alcohol and Drug Abuse officials, treatment and prevention monitors should follow the monitoring schedule found in the office's 1991 Monitoring and Review Guide. The guide does not give a specific time each module of the monitoring instrument should be completed. Instead, it gives the number of times each module should be completed as shown in Exhibit 3-1 on page 28. For contracts effective during the entire fiscal year, a total of eight reviews should be completed for each contracted treatment facility and five reviews should be completed for each prevention program.

All regions, except Region X (the Jefferson Parish Human Services Authority), should follow the monitoring review guide schedule. Because Region X was responsible for its own contract monitoring during fiscal year 1994, we did not include it in our analysis.

Exhibit 3-1
Monitoring Schedule for Treatment and Prevention Contracts

Type of Module	Number of Reviews per Fiscal Year for Treatment Contracts	Number of Reviews per Fiscal Year for Prevention Contracts
Organization and Management	1	1
Facility and Maintenance	2	2
Treatment (Overview)	1	Not applicable
Treatment (Record Reviews)	3	Not applicable
Prevention (Overview)	Not applicable	1
Financial Management	1	1
Total Number of Reviews	**8**	**5**

Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals.

None of the regions followed the central office monitoring schedule in fiscal year 1994. All nine regions had different monitoring schedules for their treatment and prevention contracts. Based on the central office monitoring schedule, none of the substance abuse contracts were monitored completely in fiscal year 1994. Of the 72 contracts monitored in the nine regions during fiscal year 1994, 30 were for prevention programs and 42 were for treatment facilities.

We did a detailed analysis of the monitoring files of these contracts and found that 60 (83.3 percent) were monitored partially and 12 (16.7 percent) were not monitored at all. For a contract to be monitored completely, all modules of the monitoring instrument should be completed as specified in the Monitoring and Review Guide.

As shown in Exhibit 3-2 on page 29, the review requirement for the Organization and Management module was completed for only 58 percent of the contracts as required by the central office's Monitoring and Review Guide. The other modules met the review requirements for an even smaller percent of contracts.

Exhibit 3-2
Contracts Meeting or Exceeding
Monitoring Schedule Requirements
Fiscal Year 1994

Modules of the Monitoring Instrument Required to Be Completed	Number (Percent) of Contracts: Meeting or Exceeding Review Requirement	Number (Percent) of Contracts: Not Meeting Review Requirement	Total Number of Contracts
Organization and Management	42 (58%)	30 (42%)	72
Facility and Maintenance	10 (14%)	62 (86%)	72
Treatment (Overview)	21 (50%)	21 (50%)	42
Treatment (Record Review)	11 (26%)	31 (74%)	42
Prevention (Overview)	13 (43%)	17 (57%)	30
Financial Management	14 (19%)	58 (81%)	72

Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals.

Furthermore, the completion of each module of the monitoring instrument varied among regions. As shown in Exhibit 3-3 on page 30, each region had at least one module with no contracts meeting the review requirements.

Monitors in Region IV (Lafayette) sometimes substituted quality assurance reviews in place of the quarterly monitoring instrument. Among the nine regions, we found one region that substituted quality assurance reviews for the quarterly monitoring instrument in fiscal year 1994. Both quality assurance review and the monitoring instruments are required to be completed quarterly. The quality assurance review is designed to serve as an internal evaluation of the appropriateness of service delivery based on licensing standards. The quality assurance review has no role in the contracting process (selection, renewal, and awarding of contracts), according to an Office of Alcohol and Drug Abuse official. Furthermore, neither written policies nor officials in the central office indicated that quality assurance review can be substituted for the quarterly monitoring instrument.

Exhibit 3-3
Modules With No Contracts Meeting Review Requirement by Region - Fiscal Year 1994

Region	Organization/ Management	Facility and Maintenance	Treatment Overview	Treatment Record Review	Prevention Overview	Financial Management
I		X		X		
II		X	X	X		X
III			X			X
IV		X	X	X		X
V				X		
VI	X	X	X		X	X
VII		X				X
VIII		X		X		
IX		X		X	X	
Total	**1**	**7**	**4**	**6**	**2**	**5**

X - No contracts meeting review requirements.
Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals.

Contract providers in Region VI (Alexandria) monitored each other's contracts. Two contract providers in Region VI were assigned monitoring duties in each of the four quarters of fiscal year 1994 and the first quarter of fiscal year 1995. During this time, these contractors monitored both state and contracted facilities. There was one quarter when the two contract providers monitored each other's facility. One of the providers also monitored the other provider during two additional quarters.

Currently, contractors are not required under their contracts to perform monitoring functions and therefore cannot be held accountable for not meeting monitoring duties. The Office of Alcohol and Drug Abuse is ultimately responsible for ensuring through monitoring that contractors are meeting their contract obligations. Hence, the quarterly monitoring should be done by individuals who are independent of the contractors being monitored and are accountable for their monitoring functions.

This lack of uniformity in the monitoring process might have been caused by a lack of communication between the central office in Baton Rouge and the regions. Of the 23 people who monitored treatment and prevention contracts in

fiscal year 1994, only three said that they had interaction with the central office during monitoring. This was also evident in the fact that none of the regions followed the central office's monitoring schedule. Although summaries for completed quarterly monitoring were sent to the central office, we found no evidence that the officials in the central office were aware of this lack of uniformity.

Recommendations

1. **The Office of Alcohol and Drug Abuse should require regions to follow its schedule for monitoring contracted services. Furthermore, the office should implement management controls to ensure the monitoring policy is being uniformly implemented in the regions.**
2. **The Office of Alcohol and Drug Abuse should ensure that all state facilities and contract service providers are sufficiently monitored by an accountable party.**

Incomplete Monitoring

Reviews Conducted in Regions Lacked Documentation

As mentioned earlier, there should be eight reviews done for treatment contracts and five for prevention. Using these figures as a guide, we estimated the number of reviews each contract should have had for fiscal year 1994. Of the 72 contracts, 13 began after the start of the fiscal year or were terminated early. The reviews for these contracts were adjusted based on the number of quarters the contracts actually operated. Based on the guidelines mentioned above, the 72 contracts should have had approximately 437 reviews. We found evidence of only 242 reviews (55 percent) in the regions, as seen in Exhibit 3-4 on page 32.

While some regions have close to or more than the number of reviews that should have been conducted, this does not mean that the correct modules were used. As mentioned earlier, each region had at least one module with no contracts meeting the

review requirements. Regions may have conducted more than the required number of reviews for one module and less than the required reviews for another module.

Exhibit 3-4
Percent of Reviews Conducted
Fiscal Year 1994

Region	Number of Contracts	Approximate Number of Reviews That Should Have Been Conducted	Total Number of Reviews Conducted	Percent of Reviews Conducted
I	13	82	34	42%
II	16	77	7	9%
III	6	42	35	83%
IV	3	18	7	39%
V	7	37	39	105%
VI	8	58	37	64%
VII	6	40	29	73%
VIII	9	54	41	76%
IX	4	29	13	45%
Total	**72**	**437**	**242**	**55%**

Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals.

Less than two-thirds of the reviews conducted had documentation. When a quarterly review is completed, a summary of the review is made and a copy is sent to the central office in Baton Rouge. The completed monitoring instrument is kept at the regions along with the original summary. Of the 242 quarterly reviews conducted, 154 (64 percent) had documentation in the regions of a completed quarterly review instrument and a summary. Documentation of a completed summary but no documentation of a completed quarterly monitoring instrument occurred for 74 (31 percent) of the reviews. The remaining 14 reviews (6 percent) had documentation of a completed quarterly monitoring instrument but no documentation of a completed summary.

Documentation varied among regions, as can be seen in Exhibit 3-5. The number of reviews conducted (as shown in Exhibit 3-4) should be viewed in conjunction with the amount of documentation for each review. Regions may perform well in one of the categories but may lack in the other. For example, Region V (Lake Charles) had 105 percent of the reviews for fiscal year 1994 conducted but had documentation of both the summary and instrument for only 5 percent of these reviews. On the other hand, Region III (Thibodaux) had 83 percent of the reviews conducted and had documentation of the summary and instrument for all of the reviews.

Exhibit 3-5
Documentation of Monitoring
Fiscal Year 1994

Region	Number of Reviews Conducted	Number of Reviews with Documentation of Summary but No Completed Instrument	Number of Reviews with Documentation of Completed Instrument but No Summary	Number of Reviews with Documentation of Completed Instrument and Summary	Percent of Reviews with Documentation of Completed Instrument and Summary
I	34	23	5	6	18%
II	7	0	6	1	14%
III	35	0	0	35	100%
IV	7	2	0	5	71%
V	39	37	0	2	5%
VI	37	5	0	32	87%
VII	29	3	0	26	90%
VIII	41	1	2	38	93%
IX	13	3	1	9	69%
Total	**242**	**74**	**14**	**154**	**64%**

Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals.

Two regions had time periods when no monitoring was done during fiscal year 1994 because of vacant positions, according to officials in the regions. The treatment and prevention monitor in Region I (New Orleans) was transferred to another position in April 1994. However, another monitor was not assigned to the region until September 1994. Only one

review was done in Region I during the fourth quarter of fiscal year 1994. Treatment and prevention contracts were not monitored quarterly in Region VIII (Monroe) from July 1993 to December 1993 because of a vacant position.

Recommendation

1. **The Office of Alcohol and Drug Abuse should implement formal policies and procedures to ensure that all reviews for contracted treatment facilities and prevention programs are completed and documented.**

Inadequate Evaluation of Contract Objectives

The Monitoring Instrument Does Not Evaluate Compliance With Statement of Work

The amount that contractors are paid depends on what is included in their statement of work. Therefore, it is important that the statement of work is evaluated during monitoring. Each Office of Alcohol and Drug Abuse contract contains a statement of work, usually presented as a list of objectives or tasks, which should specify in detailed terms the services and products to be provided. At the end of each year, DHH Monitoring Report Forms should be completed for each contract provider to determine if contract objectives or tasks were accomplished.

Of the 72 contracted treatment facilities and prevention programs in the nine regions for fiscal year 1994, we took a random sample of 31 contracts (43 percent) to determine if all objectives of the contracts were included in the monitoring report forms. We also reviewed the quarterly monitoring instruments for these 31 contracts.

Only one-third of the objectives from the contracts were included in the monitoring report forms. There were a total of 315 objectives found in the statements of work for the 31 sampled contracts. As shown in Exhibit 3-6 on page 35, only 103 of the 315 objectives (33 percent) were included in the monitoring report forms. Region III (Thibodaux) was the only

region to include all of the objectives from the contracts in the monitoring report forms. Without analyzing each objective in a contract, it is not possible to determine if the state received all of the services the contractor was required to provide.

Exhibit 3-6
Percent of Contract Objectives Reviewed
Fiscal Year 1994

Region	Number of Contract Objectives	Number of Contract Objectives Listed in Monitoring Report Form	Percent of Contract Objectives Listed in Monitoring Report Form
I	55	7	13%
II	58	19	33%
III	31	31	100%
IV	25	4	16%
V	42	12	29%
VI	21	0	0%
VII	19	7	37%
VIII	50	20	40%
IX	14	3	21%
Total	315	103	33%

Source: Prepared by the Legislative Auditor's staff using information provided by the Department of Health and Hospitals.

No evidence was found to support the assessment of contract objectives listed in the monitoring report forms. According to an official in the central office, the quarterly monitoring instruments are used to complete the monitoring report forms. However, after examining the quarterly monitoring instrument, we determined that it does not analyze contract objectives.

Several regional administrators also agreed that the quarterly monitoring alone is not enough to evaluate a contractor's compliance with their contract objectives. One administrator said that the quarterly monitoring looks at everything except if the contractor is accomplishing what is supposed to be done. Another said that monitors must do work in addition to the quarterly monitoring instrument if the contract objectives are to be evaluated.

For the 31 sampled contracts, we found only three which had the contract objectives analyzed during the quarterly monitoring. While the three contracts had a combined 31 objectives, only one from each contract was examined. The examination of these objectives was done as a supplement to one of the quarterly monitoring modules.

The only detailed review of the contract objectives was found in the monthly monitoring of prevention contracts. In addition to the quarterly monitoring, the Office of Alcohol and Drug Abuse began monthly monitoring for prevention contracts in fiscal year 1995. Monthly monitoring is not required for treatment contracts.

Three of the nine regions implemented monthly monitoring earlier than required. Of the three, Region III (Thibodaux) and Region IX (Hammond) included a detailed examination of the contract objectives as part of the monthly review. Each of the two prevention contracts sampled in these regions had a detailed review of its contract objectives completed for fiscal year 1994.

Recommendation

1. **The Office of Alcohol and Drug Abuse should include an evaluation of contract objectives during its monitoring of both treatment facilities and prevention programs. This evaluation should also include an end-of-year assessment of all objectives in the contractor's statement of work.**

Lack of Adequate Auditing Controls

Department Did Not Ensure Contractors Were Audited or Audit Findings Were Followed-Up

According to federal requirements, subrecipients receiving $25,000 or more in federal funds in a single year must have an audit. A subrecipient is any person or government department, agency or establishment that receives federal financial assistance to carry out or administer a program. Such audits shall be conducted by an independent certified public accountant or the Legislative Auditor of the State of Louisiana. In addition, the

Department of Health and Hospitals requires that corporations receiving $50,000 or more in state funds for one or more cost-reimbursment contracts must have a financial and compliance audit. The audits must be performed in accordance with *Government Auditing Standards*.

For fiscal year 1994, financial and compliance auditors with the Legislative Auditor's Office had a finding relating to monitoring of audit reports by the Department of Health and Hospitals. The auditors found that the department did not have adequate controls to ensure that all contractors were audited in accordance with *Government Auditing Standards*. In their review they noted that established procedures had not consistently been followed to ensure that all audit reports were received and reviewed.

Furthermore, the Legislative Auditor could not determine that the department had adequately addressed audit findings, including disallowed costs, internal control comments, and noncompliance with laws and regulations. The department had not ensured that qualified employees were responsible for reviewing audit reports for compliance with *Government Auditing Standards* and federal requirements.

The Department of Health and Hospitals concurred with these findings and recommendations. The department is currently in the process of developing an Audit Tracking, Monitoring and Resolution System. Without completed policies and procedures, it is not possible to determine if the new process will correct the deficiencies noted in the financial and compliance audit findings.

Monitoring Process in Other Southern States

Texas and Tennessee Included Outcome Measures As Part of Their Monitoring Process

Most southern states surveyed used monitoring techniques similar to Louisiana. Like Louisiana, most of these states used site visits, independent audits, and information submitted by providers to monitor their contracted programs. Exhibit 3-7 on page 38 lists the different methods used by the various southern states to monitor their contracts.

At least two of the surveyed states have taken the initiative in including outcome measures in their monitoring process. Texas and Tennessee are incorporating outcome measures into the service provider's contracts. Outcome measures report the results or impact of a program as well as why a program exists. These are different than output measures, which report the number of units produced or number of services provided by a program.

Exhibit 3-7
Methods Used by the Southern States to Monitor Contracted Services for Substance Abuse Programs
Fiscal Year 1994

State	Site Visits	Survey of Clients	Survey of Service Providers	Independent Audits	Information Submitted by Provider	Outcome Measures
Alabama	X			X	X	
Arkansas	X		X	X		
Florida				X	X	
Kentucky	X			X		
Louisiana	**X**			**X**	**X**	
Mississippi	X			X		
South Carolina	X			X	X	
Tennessee	X	X		X	X	X
Texas	X			X	X	X

Note: X = Yes, the method was used by the state.
Georgia and North Carolina are not included in this exhibit because they did not contract for services.

Source: *Prepared by the Legislative Auditor's staff using information provided by* the Department of Health and Hospitals and completed surveys from the other states.

The Texas Commission on Alcohol and Drug Abuse began using outcome measures in fiscal year 1994. Specific performance outcomes for detoxification, residential, outpatient, and outpatient-methadone treatment providers were developed and included in the contracts. However, an October 1994 audit titled "Contract Monitoring of Purchased Services" by the Office of the State Auditor in Texas found no specific consequences for contractors' failing to achieve the established results.

According to its officials, the Tennessee Bureau of Alcohol and Drug Abuse Services began developing outcome measures for prevention programs in 1990. Measures for treatment were developed two years later in 1993. A list of accomplishments, or outcome measures, is developed individually for each contract. Quarterly reviews are then performed to ensure that accomplishments are coinciding with the amount of funding the contractor is receiving.

Informal Evaluation of Cost Effectiveness

Contractors Are Paid on Per Diem or Cost Reimbursement Basis

According to the assistant secretary, the Office of Alcohol and Drug Abuse does not currently have a sophisticated way to measure cost effectiveness. Instead, the officials make informal comparisons between public facilities and private hospitals.

For fiscal year 1994, the average cost per person for treatment services was $580.46--45,395 people received treatment services at a total cost of $26.35 million. For the same period, the average cost per person for prevention services was $13.42--213,935 people participated in prevention programs costing $2.87 million. In addition, $1.02 million was spent for administrative purposes for both types of services.

Contractors for treatment facilities and prevention programs receive payments for services by either the per diem or cost reimbursement method. The per diem method pays contractors a fixed rate for a specific unit of service, such as a patient bed per day. The cost reimbursement method pays for actual costs incurred in the performance of the contract.

Per diem rates are set by the Department of Health and Hospitals' Office of the Secretary, Bureau of Health Services Financing. According to a bureau official, the bureau uses a model to set per diem rates, which builds on the rates from previous years. In spite of the model, the bureau has not made any changes to per diem rates in the last five years for the Office of Alcohol and Drug Abuse.

According to the assistant secretary, the Office of Alcohol and Drug Abuse has a good idea of how much a cost reimbursement contract should cost based on the number of clients the program intends to serve. For example, licensing

requirements for treatment contracts dictate how many staff a service provider must have and the cost of supplies is based on state purchasing requirements.

As mentioned earlier in the report, most contracts are chosen on a non-competitive basis. While per diem contracts have a fixed cost, the amount of a cost reimbursement contract must be negotiated. Therefore, it is imperative that cost reimbursement contracts are evaluated for cost effectiveness by comparing them with both public and private facilities offering similar services.

Recommendation

1. **The Office of Alcohol and Drug Abuse should establish procedures to evaluate the cost effectiveness of its contracted services. The evaluation of cost effectiveness should include the following:**
    - ***Contracts should be compared to both state and private programs which provide similar types and level of services.***
    - **Each contract should be evaluated based on the objectives included in the contract that are achieved. The office may want to consider developing outcome measures that will assist in the evaluation of contract objectives.**

Appendix A

Survey Instrument of Other Southern States

STATE OF LOUISIANA - OFFICE OF LEGISLATIVE AUDITOR
Survey of Alcohol and Drug Abuse Programs in Other States

Agency Name: _____

Person Completing Survey: _____

Title: _____ Phone: ( ) _____

Address: _____

1. Does the alcohol and drug abuse program provide both prevention and treatment services?
   ( ) Yes ( ) No. If no, do you provide: ( ) Prevention Services or ( ) Treatment Services
   Which state agency provides the other type of services? _____

2. How many clients received services from the alcohol and drug abuse program in fiscal year 1993-94?
   Total number _____ [Prevention _____ Treatment _____ Other _____]

3. Budget information for the state's alcohol and drug abuse program for fiscal year 1993-94:
   (a) Actual expenditures: $ _____
   (b) Source of funding: federal _____% State _____% Other _____%
   (c) Types and amounts of federal funds received: _____

4. Do you contract for alcohol/drug abuse treatment or prevention services (such as professional services or treatment facilities)? ( ) Yes ( ) No. **If no, please explain why and skip all remaining questions.**

   _____
   _____
   _____
   _____

5. Which of the following types of services are contracted for the alcohol and drug abuse program?
   ( ) Prevention/Intervention ( ) Crisis Management ( ) Detoxification
   ( ) Outpatient Treatment ( ) Inpatient Treatment ( ) Case Management
   ( ) Residential/Half-way House ( ) Other, please explain _____

6. (a) Does your program use a competitive bid process to award contracts? ( ) Yes ( ) No
   (b) If yes, what are the main criteria for using competitive bids (e.g., dollar value, first time contracts only, contracts for certain types of services, etc.)?

   _____
   _____
   _____
   _____

(c) Please list any exceptions to those criteria listed on page 1.

_____

_____

7. For the alcohol and drug abuse program, fiscal year 1993-94:
   (a) All contracted services: Total number of contracts _____ $ _____
   (b) Contracts awarded using a competitive bid process: Number _____ $_____

8. Which of the following methods do you use to monitor contract service providers' **compliance** with contractual agreements? Please list the frequency of each method used.
   ( ) site visits _____ ( ) survey of clients _____( ) survey of service providers_____
   ( ) audits by independent audit firms ____( ) self reporting by service providers _____
   ( ) other, please explain _____

9. How do you evaluate the **scope of work** as stated in the contract?

_____

_____

_____

_____

_____

10. How do you evaluate the **quality** of contracted services for the alcohol and drug abuse program?

_____

_____

_____

_____

_____

11. How do you assess the **cost effectiveness** of contracted services for the alcohol and drug abuse program?

_____

_____

_____

_____

_____

****

Thank You For Your Response. Please return this survey by October 21, 1994 to:

Rakesh Mohan, Senior Performance Auditor; Louisiana Office of Legislative Auditor
Post Office Box 94397; Baton Rouge, Louisiana 70804-9397
Phone: (504) 339-3836 or FAX (504) 342-3716

Appendix B

Listing of State Operated and Contracted Facilities

Listing of State Operated Facilities for Fiscal Year 1994

Region I (New Orleans)

1. New Orleans Alcohol and Drug Abuse Center
2. St. Bernard Alcohol and Drug Abuse Center
3. New Orleans Adolescent Hospital (NOAH)
4. Plaquemine Alcohol and Drug Abuse Center

Region II (Baton Rouge)

1. Baton Rouge Alcohol and Drug Abuse Center
2. Greenwell Springs Hospital
3. H. J. "Blue" Walters Substance Abuse (Pre-Release)

Region III (Thibodaux)

1. Terrebonne Alcohol and Drug Abuse Center
2. River Parishes Alcohol and Drug Abuse Center
3. Lutcher Outreach
4. Hahnville Jail
5. Thibodaux Alcohol and Drug Abuse Center
6. Galliano Outreach
7. St. Mary Alcohol and Drug Abuse Center

Region IV (Lafayette)

1. Lafayette Alcohol and Drug Abuse Center
2. Crowley Alcohol and Drug Abuse Center
3. Eunice Outreach
4. Opelousas Alcohol and Drug Abuse Center
5. New Iberia Alcohol and Drug Abuse Center
6. Ville Platte Alcohol and Drug Abuse Center
7. First Step Detox, Lafayette

Region V (Lake Charles)

1. Lake Charles Alcohol and Drug Abuse Center
2. Region V Alcohol and Drug Abuse Center
3. Joseph R. Briscoe Treatment Center

Region VI (Alexandria)

1. Alexandria/Pineville Alcohol and Drug Abuse Center
2. Cheneyville Outreach
3. Vernon Alcohol and Drug Abuse Center
4. DeRidder Alcohol and Drug Abuse Center
5. Concordia Alcohol and Drug Abuse Center
6. LaSalle Alcohol and Drug Abuse Center
7. Catahoula Alcohol and Drug Abuse Center
8. Grant Alcohol and Drug Abuse Center
9. Avoyelles Alcohol and Drug Abuse Center
10. Oakdale Outreach
11. Bunkie Outreach
12. Red River Treatment Center

Region VII (Shreveport)

1. Northwest Regional Alcohol and Drug Abuse Center
2. Coushatta Outreach
3. Wilkinson Terrace Drug Free Center
4. Mansfield Outreach
5. Minden Outreach
6. STEPS Detox Outreach
7. Vivian Outreach
8. Natchitoches Alcohol and Drug Abuse Center
9. Many Outreach
10. Pines Treatment Center

Region VIII (Monroe)

1. Monroe Alcohol and Drug Abuse Clinic
2. Bastrop Alcohol and Drug Abuse Center
3. Ruston Alcohol and Drug Abuse Center
4. Southern Oaks Addiction Recovery

Region IX (Hammond)

1. Northlake Alcohol and Drug Abuse Center
2. Slidell Alcohol and Drug Abuse Center
3. Hammond Alcohol and Drug Abuse Center
4. Washington Parish Alcohol and Drug Abuse Center
5. Fountainbleau Treatment Center
6. ADU

Region X (Jefferson Parish)

1. Jefferson Alcohol and Drug Abuse Center
2. West Bank Alcohol and Drug Abuse Center
3. Kenner Alcohol and Drug Abuse Center

Listing of Contracted Facilities for Fiscal Year 1994

Region I (New Orleans)

1. Desire Narcotic Rehabilitation Center
2. Odyssey House of Louisiana, Inc.
3. Bridge House Corporation
4. Grace House of New Orleans, Inc.
5. Human Services Foundation (Foundation House)
6. Jefferson Community Housing Development Foundation
7. Kingsley House
8. Mayor's Substance Abuse Indigent Bed Program
9. Velocity Foundation, Inc.
10. Central City Economic Opportunity Corporation
11. Dr. Murphy McCaleb Education Fund, Inc.
12. New Orleans Education Talent Search
13. Health Systems Management, Inc.

Region II (Baton Rouge)

1. LAEL, Inc.
2. Ascension Parish Police Jury
3. Bonne Santè Center
4. Baton Rouge Area Alcohol and Drug Center, Inc. (Detoxification)
5. O'Brien House
6. Southern University
7. Shiloh Missionary Baptist Church (Project Lifeline)
8. Baton Rouge City Court
9. Beech Grove Baptist Church
10. We Care Foundation, Inc.
11. Evening Star Baptist Church
12. Louis Jetson Foundation, Inc.
13. The People's Rehabilitation and Recovery
14. BREC
15. Governor's Office of Women's Services
16. Serenity 67

Region III (Thibodaux)

1. Assisi Bridge House
2. Assisi Bridge House Phase 4
3. Fairview Treatment Center (St. Mary Parish Council)
4. Terrebonne Detoxification Center
5. Alcohol and Drug Abuse Council for South Louisiana
6. Bayou Council on Alcoholism

Region IV (Lafayette)

1. Gatehouse Foundation, Inc.
2. St. Francis Foundation, Inc.
3. Helping Hands, Inc., of Lafayette

Region V (Lake Charles)

1. Family and Youth Counseling Agency
2. Jeff Davis Chemical Health, Inc. (Intensive Outpatient)
3. Allen Parish Outreach Clinic
4. Calcasieu Community Detoxification Center
5. Grand Avenue Substance Abuse Prevention and Education Program (City of DeQuincy)
6. Sacred Heart of Jesus Roman Catholic Church
7. Immaculate Heart of Mary Church (Outreach Center)

Region VI (Alexandria)

1. Cenla Chemical Dependency Council, Inc. (Phase II)
2. Washington St. Hope Center
3. Cenla Alcohol and Drug Abuse Advisory Council (Bridgehouse)
4. Cenla Alcohol and Drug Abuse Advisory Council (Rainbow Detox)
5. Washington Street Hope Center (Hamilton House)
6. Louisiana Black Alcoholism Council, Inc.
7. Bethel AME Church (Project Success)
8. Nazarene Missionary Baptist Church (Project Rescue)

Region VII (Shreveport)

1. Council on Alcohol and Drug Abuse of Northwest Louisiana (Buckhalter)
2. Council on Alcohol and Drug Abuse of Northwest Louisiana (Caddo-Bossier Center)
3. Council on Alcohol and Drug Abuse of Northwest Louisiana (Winnfield Clinic)
4. Council on Alcohol and Drug Abuse of Northwest Louisiana (TASC Program)
5. Council on Alcohol and Drug Abuse of Northwest Louisiana (Adolescent Center)
6. Volunteers of America (MADRE)

Region VIII (Monroe)

1. Columbia Addiction Recovery Resources
2. Delta Recovery Center
3. Northeast Louisiana Substance Abuse Center, Inc.
4. 4 Runners Community Action Program (Serenity House)
5. New Way Center
6. New Day Life Foundation, Inc.
7. Northeast Louisiana University
8. Sixth Judicial District Attorney
9. Fourth Judicial District Attorney's Office

Region IX (Hammond)

1. Unity Halfway House of Bogalusa, Inc.
2. Seven Acres Substance Abuse Center
3. Louisiana Recovery Advocacy, Inc.
4. PRIDE of St. Tammany, Inc.

Region X (Jefferson Parish)

1. Family House
2. Bridge House

Appendix C

Sample of Contracts Taken to Examine Contract Objectives

Appendix C: Sample of Contracts Taken to Examine Contract Objectives

	Treatment or Prevention?	Objectives listed in contract	Objectives from the contract that were in the DHH Monitoring Report Form	Percent of objectives in contract that are in the DHH Monitoring Report Form
Region 1 - New Orleans				
Central City Economic Opportunity Corporation	P	20	2	10.0%
Health Systems Management Inc.	P	18	2	11.1%
Desire Narcotics Rehabilitation Center, Inc.	T	3	1	33.3%
Jefferson Community Housing Development Foundation	T	6	1	16.7%
Odyssey House Louisiana, Inc.	T	8	1	12.5%
Total		**55**	**7**	**12.7%**
Region II - Baton Rouge				
Serenity 67	P	6	2	33.3%
We Care Foundation, Inc.	P	14	5	35.7%
Recreation and Park Commission (BREC)	P	7	2	28.6%
Baton Rouge City Court	P	8	4	50.0%
O'Brien House	T	14	4	28.6%
Bonne Sante'	T	9	2	22.2%
Total		**58**	**19**	**32.8%**
Region III - Thibodaux				
Alcohol & Drug Abuse Council for South Louisiana	P	17	17	100.0%
Terrebonne Detox Center	T	6	6	100.0%
Assisi Bridge House -Phase 4	T	8	8	100.0%
Total		**31**	**31**	**100.0%**
Region IV - Lafayette				
Helping Hands of Lafayette	P	7	0	0.0%
St. Francis Foundation	T	18	4	22.2%
Total		**25**	**4**	**16.0%**
Region V - Lake Charles				
Immaculate Heart of Mary Catholic Church	P	14	4	28.6%
Calcasieu Community Detox Center	T	17	5	29.4%
Allen Parish Outreach (Jeff Davis Chemical Health)	T	11	3	27.3%
Total		**42**	**12**	**28.6%**

	Treatment or Prevention?	Objectives listed in contract	Objectives from the contract that were in the DHH Monitoring Report Form	Percent of objectives in contract that are in the DHH Monitoring Report Form
Region VI - Alexandria				
Bethel African Methodist Episcopal Church	P	5	0	0.0%
Hamilton House (Washington Street Hope Center)	T	8	0	0.0%
Cenla Chemical Dependency Council, Inc.	T	8	0	0.0%
Total		**21**	**0**	**0.0%**
Region VII - Shreveport				
Winnfield Clinic (Council on ADA of Northwest Louisiana)	T	6	2	33.3%
Volunteers of America (MADRE)	T	13	5	38.5%
Total		**19**	**7**	**36.8%**
Region VIII - Monroe				
Sixth Judicial District Attorney's Adolescent Program	P	8	5	62.5%
Northeast Louisiana University	P	15	5	33.3%
Delta Community Action Association	T	14	5	35.7%
Four Runners Community Action Program	T	13	5	38.5%
Total		**50**	**20**	**40.0%**
Region IX - Hammond				
PRIDE of St. Tammany, Inc.	P	6	0	0.0%
Unity Halfway House	T	5	2	40.0%
Grace Place (LA Recovery Advocacy, Inc.)	T	3	1	33.3%
Total		**14**	**3**	**21.4%**

Appendix D

Agency Responses

Response of

Department of
Health and Hospitals

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Edwin W. Edwards
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

Rose V. Forrest
SECRETARY

June 19, 1995

Dr. Daniel G. Kyle
Office of Legislative Auditor
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804-9397

RE: Office of Alcohol and Drug Abuse Comments to the Contracts Performance Audit

Dear Dr. Kyle:

As per your request of June 8, 1995, attached is our written response to the contract performance audit on the contracted services for Louisiana's Office of Substance Abuse Programs.

If you need additional information, please do not hesitate to contact me.

Sincerely,

For Rose Forrest
Secretary DHH

Attachment

c: Joseph Williams, Jr.
Charles Castille

OFFICE OF ALCOHOL AND DRUG ABUSE
COMMENTS TO THE CONTRACTS PERFORMANCE AUDIT
CONDUCTED BY THE OFFICE OF LEGISLATIVE AUDITOR

The following comments/responses are being submitted for your consideration prior to the completion of your final audit report for the Office of Alcohol and Drug Abuse.

I. PREVENTION SERVICES

CHAPTER THREE: CONTRACT MONITORING

Pg. 23, ¶ 1, Sentences 1 and 2, lines 1-4 and numbers 1-6:

The Division of Prevention Services shall begin working with the Licensing Department to revise the Licensing Standards for Prevention due to the fact that the federal government no longer includes intervention in prevention. This will be done along with the revision of the Monitoring Guide for the Office of Alcohol and Drug Abuse.

Pg. 23, ¶ 2, Sentence 1, lines 1,2 and 3:

All site visits will be documented and a copy of the report will be sent to each provider and to the state office of Alcohol and Drug Abuse. The original site visit report will be maintained in the regional file. Along with the site visit report a corrective action plan, with dates of completion, will be required for any deficiencies found in regards to the contracts.

Pg. 24, ¶ 2, Sentences 1 and 2, lines 1-5:

The Division of Prevention Services will begin revising the DHH Monitoring Guide to accurately reflect Primary Prevention as it relates to the contracts.

Pg. 25, ¶ 2, Sentences 1 and 2, lines 1-4 and pg. 27, ¶ 3, sentences 2 and 3, lines 3-7:

Prevention contracts will be monitored on a quarterly basis beginning July 1, 1995 by the Program Specialists assigned to state office. They will each be responsible for five regions in the state and the corresponding prevention contracts.

CHAPTER THREE: CONTRACT MONITORING (INCOMPLETE MONITORING)

Pgs. 28-30, ¶ 1-5:

The Regional Prevention staff will be responsible for monitoring the prevention contracts monthly in regards to the scope of work. There will be a general documentation form devised by this office, and all visits will be noted in

writing as to compliance/non compliance with the contractor's scope of work.

REPORT CONCLUSIONS:

These are a few of the suggestions that we have at this time to correct the deficiencies that have been noted in the area of Prevention Monitoring. I would also like to note a few areas in the report that we feel are important.

Through monitoring our office has closed down two of the contracts reviewed, Immaculate Heart of Mary (Region 5) and Helping Hands of Lafayette (Region 4), and we have changed the contractor of Delta Haven (Region 2) in the past year.

The division implemented the monthly site visits to review the scope of work due to the fact that the objectives in the contracts varied to the extent that we would have to create a monitoring device for each contract. By doing this we are able to address the issues in the scope of work that may not be addressed in the monitoring visit.

II. TREATMENT SERVICES

EXECUTIVE SUMMARY

RECOMMENDATIONS:

1. **The Office should conduct . . . The Office should determine the frequency of conducting . . . .**

   COMMENT:

   While there is no formal statewide needs assessment, the Office of Alcohol and Drug Abuse is in compliance with the Federal Block Grant requirements for estimation of needs by utilizing an algorithm method. A comprehensive statewide needs assessment requires extensive manpower as well as financial resources thus, its frequency may be limited and/or determined by the availability of such resources.

2. **In cooperation with the Division of Administration . . .**

   COMMENT:

   If feasible, this strategy could prove to be mutually beneficial to both Agencies.

3. **bullet 2, line 3, The Office should develop outcome measures . . .**

   COMMENT:

   As a word of caution, please note, outcome evaluation should not be the only performance indicator taken into consideration, due to the difficulties inherent in measuring the effectiveness of substance abuse treatment.

CHAPTER TWO: CONTRACT PROCESS

RECOMMENDATIONS

1. **pg. 14, The Office of Alcohol and Drug Abuse should conduct . . . .**

COMMENT:

Same as Executive Summary, Recommendation # 1.

2. **pg. 21, The Office of Alcohol and Drug Abuse should re-examine the contract review process . . .**

COMMENT:

It is the intent of this Office to review and revise this process.

CHAPTER THREE: CONTRACT MONITORING

RECOMMENDATIONS:

1. **and 2, pg. 27;**

. . . the Office should implement management controls to ensure that monitoring is being uniformly implemented in all of the regions.

2. **. . . all state facilities and contract providers are sufficiently monitored by an accountable party.**

and 1. pg. 30

1. **. . . should implement formal policies and procedures to ensure that all reviews for contracted treatment facilities and prevention programs are completed and documented.**

COMMENT:

OADA will re-evaluate and revise existing policies and procedures in the overall monitoring process as well as assign Central and/or DHH Regional Office staff to conduct monitoring visits. Steps will be taken to assure compliance with prescribed monitoring schedules and appropriate documentation requirements. (See attached draft of DHH policy on monitoring, formative and summative evaluations of DHH contracted programs and services.)

bullet 1, pg. 36 Contracts should be compared to both state and private programs . . . .

COMMENT:

This would be an ideal methodology, but implementation will require a coordination/sharing of data between state and private programs and therefore will involve logistical problems. To date, the private sector has been reluctant to share their data with this Office. Confidentiality, as it relates to Federal Law 42 CFR, and its implication on the disclosure/re-disclosure of alcohol and drug abuse patient information is an additional area of concern. Furthermore, to my knowledge, private sector providers of substance abuse services are not required or mandated by any law or statute that requires them to share information with us.

REPORT CONCLUSIONS:

In general, the report appears to be a comprehensive document in its scope. After reviewing the recommendations, we feel many of them are in fact congruent with the direction/course of action the Office is intending to undertake.

D R A F T

TABLE OF CONTENTS
MONITORING, FORMATIVE AND SUMMATIVE EVALUATIONS OF DHH CONTRACTED PROGRAMS AND SERVICES

Revised June 12, 1995

POLICIES AND PROCEDURES
FOR THE
MONITORING, FORMATIVE AND SUMMATIVE EVALUATIONS
OF DHH CONTRACTED PROGRAMS AND SERVICES

(Rev. June 12, 1995)

I. Purpose

The purpose of this policy/procedure document is to establish a mechanism which provides for the conduct of regularly scheduled reviews and evaluations of the performance of contracts and/or grant agreements funded in whole or part by state and/or federal appropriations or allocations. State and federal appropriations include grants, contracts, contractor/cooperative agreements, loans, and/or loan guarantees in which the Department of Health and Hospitals serves either as fiscal agent or has fiduciary responsibility for the expending of such funds appropriated.

II. Applicability

The policies and procedures contained herein apply to all public and private providers of contracted health and health related services whose funding sources are grants, contracts, provider/cooperative agreements, loans, and/or loan guarantees in which the Department of Health and Hospitals serves either as fiscal agent or has fiduciary responsibility for the expending of such funds.

Note: This procedure does not apply to state 24-hour facilities except as it relates to summative evaluation and in those areas specifically designated by the respective Assistant Secretary and/or Bureau Chief.

III. Definitions

A. "Contracts" within the context of this document, refer to all letters of agreement, grants, cooperative agreements, loans, loan guarantees or other documents executed between DHH and individuals or firms representing the utilization of personnel external to the department for the provision/implementation of D.H.H. initiatives .

B. "DHH Regional Administrative Office" is that office established to provide administrative support services to regional program offices and bureaus within a specific geographic territory.

C. "Formative Evaluation" is defined as a review conducted during the course of an on-going contract designed to

determine the need for contract modifications. Consideration is given to determining if objectives, policies, and mandates are followed. Formative evaluations also focus attention on the effectiveness of the management and delivery system, the validity of program content, and the pertinence of program purposes.

D. "Monitoring" is defined as the review of program processes to which the contract applies, verification of compliance with terms of the contract and ascertaining the need for and provision of technical assistance in the execution of the terms of the contract. The process ranges from periodic checks of compliance with policies and regulations, to re-examination of contracts and services to determine whether the needs that the contract is designed to address still exist.

E. Regional Program Office/Bureau is the organizational entity delegated responsibility and authority by either the Secretary, Assistant Secretary, or Division/Bureau Chief, for the implementation of DHH programs and services within a specific geographic territory.

F. "Summative Evaluation" is defined as a process initiated by the Secretary of the Department of Health and Hospitals which seeks to ascertain the contracted program's overall effectiveness in meeting DHH. goals. Of concern is the review of the product through the use of needs assessments, demand and support assessments, cost-benefit analysis, cost-effectiveness analysis, and or studies which explore program "side effects", intended and unintended. Such evaluations will also address contract continuation and/or expansion.

IV. Summative, Formative, and Monitoring Processes/Procedures

A. Summative Evaluations

The Office of the Secretary is ultimately held accountable for all programs and services offered by the Department. This accountability is inclusive of contractual and direct delivery of service provision arrangements.

Programs and services may often find their conception within programmatic offices, but issues of accountability and ensuring an appropriate congruence between program design and organizational vision remains within the managerial domain of the Secretary. The Division of Program Support, within the Office of

the Secretary will have primary responsibility for the performance of summative evaluations.

1. The Division of Program Support (DPS) shall develop criteria and establish procedures for the selection of contracted programs and services earmarked for summative evaluations. The DHH Secretary will have final authority in determining whether a contracted program or service is evaluated. DPS will conduct studies of specific contracted initiatives to:

    a. Determine results and analyze the extent to which predetermined goals and objectives set by the respective Bureaus and/or Program Offices have been accomplished;

    b. Provide additional information for decision making concerning the continuation, expansion, or reduction of an initiative;

    c. Review methods for improving practices and procedures; and discuss possible positive or negative side effects of the initiative.

2. Additional functions of DPS, working with the respective Bureau Chiefs and/or Assistant Secretaries will include:

    a. Provide consultation and technical assistance at the State, regional and local levels in contract development to ensure the inclusion within DHH contracts of a fully realized scope of work, including tasks to be accomplished; measurable objectives; adequate description of data requirements; and specific deliverables.

    b. Assist in establishing operational procedures for monitoring contracts and conducting formative evaluations at the appropriate levels, including the development of a management information system, evaluation design, and subsequent analysis, and

submission of appropriate progress and final reports.

c. Establish and coordinate a Statewide evaluation committee composed of representatives from regional program and administrative offices along with State level personnel, for exchange of information (including problems and solutions) and *coordination of an overall evaluation effort.*

3. The following activities to advance the development, implementation and maintenance of a DHH contract monitoring and evaluation system may be performed by DPS in coordination with the respective Bureau Chief and/or Assistant Secretary:

a. Make recommendation as to whether existing or future information systems reflecting contracted DHH programs and services, provides sufficient information to establish a framework for meeting management needs.

b. Conduct and/or participate with regional personnel in special studies. Determine the *program components and operations requiring* study, select the appropriate techniques for gathering data, and collect, analyze and present the information in the most useful way to management.

c. Assure process/procedural integrity of those evaluations *in which sanctions are proposed.*

d. Establish/maintain files and prepare Statewide summary reports based on monitoring/evaluation reports submitted by each regional program and DHH Regional Administrative office.

e. Provide technical assistance to field units and cooperate with agency staff in planning,

implementing and monitoring special projects and contracts.

f. Perform demographic analyses of the population within each DHH region, utilizing U.S. Census statistics and other publicly available data, and distribute such reports to regional program and administrative offices for their use in the monitoring/evaluation process.

g. Promote management use of available data in the monitoring/evaluation process through consultation with and the provision of technical assistance to personnel in regional program offices and DHH Regional Administrative offices.

4. A copy of completed evaluations, findings and recommendations will be forwarded to the Secretary, Deputy Secretary of DHH, and the respective Bureau Chief and/or Assistant Secretary.

B. Formative Evaluations

It is a primary role of the DHH Regional Administrative office to provide leadership and direction to regional program office staff and contractual service providers. Additionally, such offices interpret funding decisions, departmental policy, and priorities set by Bureaus and/or Program Offices for programs operating within their jurisdiction.

The formative system of evaluating contracts is a means of assuring that contract deliverables are consistent with program design as specified by various program offices.

1. The policies and procedures contained herein for the conduct of the monitoring and formative evaluation of contracted programs and services will minimally seek to determine the presence of three major variables within programs or services delivered under a contractual agreement: internal

controls, contract compliance, and evidence of results by a contractor. Certain evaluation parameters, but not all, follow.

a. Internal controls that indicate the presence of methods and procedures to ensure that: resource use is consistent with laws, regulations, and policies; resources are safeguarded against waste, loss, and misuse; and, reliable data are obtained, maintained, and fairly disclosed in reports.

b. Reporting compliance is derived from a record of the timely submission of requested reports which contain data representing a clear and convincing relationship between the purposes for which funds were awarded or appropriated, and initiatives or services provided which reflect the expending of such funds.

c. Evidence of results which documents that the organization provided the services in accordance with the terms of the contract.

2. DHH Regional Administrative offices will conduct formative evaluations of the services delivered under health or health related contract(s), grant(s), or agreement(s).

At a minimum, a fiscal review of procedures/process will be done to ensure that:

a. Resources identified for specific objectives are spent accordingly.

b. Fiscal records/accounting procedures are kept in a manner to provide an audit trail of expenditures.

c. Program/fiscal procedures and processes meet the intent of standards and/or contracts.

d. Program/fiscal procedures and processes meet federal and state laws and regulations.

3. Upon completion of the formative evaluation:

   a. Preliminary findings will be discussed with the contractor and the Regional program office prior to distribution of a final report.

   b. A copy of the completed evaluation, findings, and recommendations will be sent by the DHH Regional Administrative office to the following: Region Program office; CEO of the organization providing services; Chairperson of the Board of Directors of the organization providing services; Office of the Secretary, Division of Program Support, Assistant Secretary, Deputy Secretary, and the Bureau of Internal Audit.

      Any adverse findings that may result in a recommendation to suspend and/or terminate a contract, agreement, and/or condition of participation will be reported to the Secretary, Deputy Secretary, Undersecretary, and the appropriate Assistant Secretary immediately prior to the distribution of formal recommended action.

   c. Specific attention will be given to determine if contractor(s) notified regional program offices of life threatening incident(s) immediately but not later than 24 hours after they became aware of the incident(s).

3. The DHH Regional Administrative Office will ensure that each contract has a statement stating if an audit is due, the type of audit due and the audit's due date.

4. The DHH Regional Administrative Office will assure that all contractors are advised of the independent audit requirements.

   a. The DHH Regional Administrative Office will review all existing health and health related contracts, grants, and/or agreements to

determine if an independent audit is necessary.

b. Advise contracting agencies of the audit requirement and that copies of the independent audit shall be forwarded to the *Undersecretary, Office of Management and* Finance (OMF) prior to or on the due date.

c. A statement advising contracting entities that in the event corrective action is warranted, a Board of Director's approved plan of correction for each finding is to be forwarded to the appropriate DHH Regional Administrative office. The plan of correction is to ensure that corrective action has been implemented within six months (unless a shorter time-line has been established by the respective Bureau and/or Program Office) of the issuance of the audit report.

d. In the event that the requirement for an independent audit and a method to provide correction for deficiencies are not incorporated within existing contracts, conditions of participation, and/or agreements, DHH regional administrative fiscal staff will work with the respective program office, if appropriate, to either amend or provide an addendum to the contracts, conditions of participation and/or agreements to ensure that these are included.

4. DHH Regional Administrative Offices will receive copies of all independent audits from the OMF.

a. The contractor will submit a plan of correction to the DHH Regional Administrator for review by both the Regional Program office and the DHH Regional Administrative office.

b. DHH Regional Administrative and Regional Program offices will consult with the OMF and/or the Bureau of Internal Audit, as

necessary, regarding the appropriateness of response and the plan of correction.

c. Upon completion of review at the regional level, a plan of correction will be forwarded to the appropriate Assistant Secretary and/or Bureau Chief. The DHH Regional Administrative office will notify the Undersecretary/Office of Management and Finance when the audit finding(s) has been resolved, or if finding(s) cannot be resolved, their reasons why the finding(s) cannot be resolved.

d. Follow-up to ensure compliance with plans of correction will be done as needed by the appropriate DHH Regional Administrative office.

e. Audit Tracking Reports will be prepared by the Undersecretary/Office of Management and Finance (see DHH policy on Audit Report Monitoring) and forwarded to appropriate department, bureau or division. Reports include:

(1). Audit Not Received: 30 days after Audit Due Date. Report sent to Contract Monitoring and Regional Administrator.

(2). Audit Received:

(a). 3 months after Audit Received. Notification of resolutions not received. Letter to Contract Monitoring and Regional Administrator.

(b). 6 months after Audit Received. Notification of resolutions not received. Letter to Contract Monitoring and Regional Administrator.

(3). Semi-Annual Report. A report will be sent to the Secretary or designee indicating the contracts which audits were not received and the contracts that stills have unresolved findings.

C. Monitoring

Direct interface between the contractor and DHH staff usually occurs at the regional program offices. At this level, monitoring activities are designed to establish routine assessments of contract progress as well as compliance with terms of contract. This progress reporting is undertaken as a means of ascertaining the need for technical assistance, ensuring program integrity, and determining whether or not service adjustments are necessary in order to attain the department's goal(s). Monitoring results will therefore determine either the existence of enhanced service opportunities, verification of adequate/appropriate service delivery, or a recommendation to delete the initiative or terminate the particular contractor. Routine monitoring is necessary for the authorization of on-going payment to the contract provider. The entity responsible for authorizing such payments would normally be responsible for the monitoring component.

1. Changes in Contract Formats

a. The Secretary, through the Office of Contracts Management, will establish deadlines each year for changes in contract formats to be used for the next fiscal year.

b. Any changes recommended after the date set by the Secretary will not be implemented until the following fiscal year unless specifically directed by the Secretary.

2. Contract Provisions

a. Each contract, e.g. service agreement, interagency agreement, grant agreement, and/or other documents affecting the delivery of health and health related services, shall

contain sufficient quantitative measures to ensure that the service delivery system can be subjected to an evaluation.

b. Contracts must contain the following measurable elements:

(1). For each goal, an objective that is quantifiable;

(2). For each objective, an activity or series of activities which cumulatively, represent the efforts to effect the results/outcomes necessary to accomplish the objective(s);

(3). For the program objectives, identify funds allocated toward this effort when feasible;

c. For each subsequent expenditure category, maintenance of support documentation serving as verification that such funds were expended for the purposes stated; and,

d. Provisions for the acceptance of other support documentation representing evidence of the success of the initiative funded.

3. The contracting program Office will develop a schedule for and monitor specific health or health related contracts, grants, and agreements. Such contracts and direct service delivery agreements will be monitored on a routine basis but not less than bi-annually. The frequency of routine monitoring will be stipulated in the contract, grant, and/or agreement by the program office.

4. Copies of the results of monitoring by Regional Program Offices will be forwarded to the DHH Regional Administrative Office to be used in the formative evaluation process.

5. In the event that a contractor fails to comply with corrective recommendations, adverse action may be

taken. In cases where a contractor has violated state or federal law, violations will be reported to state and regional program offices.

V. Sanctions

Non-compliance in the expending of funds awarded in accordance with contractual or other formal written agreements, may result in one or more of the sanctions listed. However, the provisions of this policy do not create a right of appeal of sanctions imposed unless otherwise provided by law. The Regional Administrator may recommend any one or more of these actions to the Secretary or designee for approval. Sanctions include:

A. Withholding a percentage of payments remaining;

B. Suspending all remaining payments due the organization;

C. A request for reimbursement to D.H.H. of funds related to non-compliance issues; or,

D. Discontinue utilizing the organization as a contractor of the specified services under question.

E. Other action as deemed appropriate.

VI. Effective Date

This policy/procedures is effective _____. All previous policies/procedures regarding this subject are hereby rescinded.

Response of

Division of Administration

State of Louisiana
DIVISION OF ADMINISTRATION
OFFICE OF THE COMMISSIONER

EDWIN W. EDWARDS
GOVERNOR

RAYMOND J. LABORDE
COMMISSIONER OF ADMINISTRATION

May 10, 1995

Dr. Dan Kyle, CPA
Legislative Auditor
State Of Louisiana
1600 North Third Street
Post Office Box 94397
Baton Rouge, La. 70804-9397

Dear Dr. Kyle:

The Division of Administration has reviewed the draft copy of the performance audit report on contracted services for La.'s Substance Abuse Program and as it relates to the Office of Contractual Review within the Divison of Administration, we agree with the auditor's findings and recommendations.

Sincerely,

Raymond J. Laborde
Commissioner of Administration

RJL/SHS/cg

c: Susan H. Smith
Director
Office of Contractual Review