SPECIAL REVIEW 2/25-26/99
MENTAL HEALTH CONSUMERS OF ALASKA

OVERVIEW:

On September 24th, 1998, three consumers of Mental Health Consumers of Alaska, (MHCA), met with Ken Fallon and John Bajowski, DMHDD, regarding complaints they had regarding the management and services provided by MHCA. The complaints were specific, and centered around 4 broad areas; fiscal management and accountability, role of the MHCA Board, consumer concerns about services and operations of MHCA, and quality assurance. The results of that meeting were communicated via e-mail on September 25th, 1998 to Leonard Abel, Ph.D., CMHS Program Administrator, and Karl Brimner, Director, DMHDD. The weekend following the interview with the consumer complainants, a homicide occurred at the MHCA Club House. The subsequent police investigation frustrated further action by the complainants on the recommendations made to them by DMHDD staff to meet with the MHCA Board regarding their complaints.

Subsequently, Dr. Abel received a letter dated January 11th, 1999, signed by 10 consumers of MHCA, in which many of the concerns heard by DMHDD staff in September were reiterated. Upon receipt of the letter, a decision was made to conduct a special review of MHCA, in response to consumer concerns. Dr. Dave Wagner, Director of MHCA was informed of a plan for a review in a letter written to him on February 5th, 1999, along with an accompanying outline of the review.

The review was conducted on February 25th and 26th, 1999. Team members doing the review included consumer representatives, Pat Murphy and Walt Kuhr; Pam Miller, Quality Assurance Section, DMHDD; Robert Wright, Auditing Unit, Division of Medical Assistance (DMA); Ken Fallon and John Bajowski, Regional Coordinator and

SUMMARY OF RECOMMENDATIONS:

Included in this review is the observations and recommendations of each team member to the Mental Health Consumers of Alaska, (MHCA), Board and Management. An oral summary of the recommendations was given to the Board and Management at the exit meeting, following the review, on Friday, February 6th; 1999, in the MHCA offices. The recommendations included but were not limited to the following:

1. It is recommended that the MHCA Board and Management recruit and fill all vacant Board positions to a full board of 11 members. Since MHCA is a statewide organization, it is recommended that applicants be recruited from throughout the State of Alaska, in order to insure representation on the Board from the State as a whole.

2. Once a full Board is recruited and installed, it is recommended that the Board and Management begin a strategic planning activity, to determine the agency's mission and goals in order to be in compliance with the existing By-Laws, which read in Article I, Section 1., under **Purposes** as follows:

   (i) peer support and advocacy for mental health consumers, and
   (ii) education of the general public regarding mental illness.

   Or the board may choose to change the By-Laws to reflect the current practice of providing direct services, a combination of both advocacy and direct service, or some other mental health service.

   It is also the recommendation of the review team that the board review and revise Article III, Section 6, of the By-Laws to insure that a quorum, or majority of Directors be present to elect a qualified person to the Board of Directors. As the By-Laws currently read, a majority is not required, opening the possibility that one Director need only be present to fill a vacancy on the Board.

3. Take every step necessary to make sure that the all meetings of the Board are publicly noticed and in compliance with the State of Alaska open meetings laws. Board and staff need to take the steps necessary to made available minutes of Board Meetings, policies and procedures and grant documents are available to consumers . and the public. Openness, transparency, and inclusion to the decision making of MHCA is vital to restoring credibility and consumer confidence in the organization.

ATTACHMENTS

1. **Alaska Mental Health Board Report – Pat Murphy**
2. **Audit Report, Medicaid Rate Advisory Commission Audit Unit - Robert Wright**
3. **Quality Assurance Report – Pamela Miller**
4. **Employee Interviews - John Bajowski**
5. **Agency Interviews – Ken Fallon**

ALASKA MENTAL HEALTH BOARD

Tony Knowles, Governor
Street
State of Alaska

3071

3079

431 N. Franklin

Juneau, Alaska 99801
Phone: (907) 465-

FAX (907) 465-

M E M O R A N D U M

DATE: April 12, 1999

TO: Ken Fallon, Licensed Clinical Social Worker
Division of Mental Health & Developmental Disabilities
Department of Health and Social Services

FROM: Pat Murphy, Board of Directors
Alaska Mental Health Board

SUBJECT: Report on consumer interviews concerning Mental Health Consumers of Alaska

Introduction

3. February 25, 1999 letter from Scot Wheat to Leonard Abel.
4. January 28, 1999 letter from Patricia Lange to Jeanette Grasto.
5. Amended by-laws of MHCA dated May 10, 1995

Interviews were conducted with three current consumers from MHCA and five complainants regarding the management and services of MHCA:

Conclusion and Recommendations

The following conclusions and recommendations were reached by me:

1. The three (3) consumers from the MHCA who were interviewed were very happy with the services provided by the MHCA. The services were case management and advocacy services which were billed to Medicaid. The services appeared to be needed and well performed.

2. These services were provided in MHCA's role as a provider. Article I, Section 1 of the MHCA by-laws set out certain "classic" advocacy and education purpose which doe not include direct provider services. This conflict or lack of clarity on goals, purpose and mission was one of our findings which needs to be addressed both in the by-laws and practically in day to day activity.

3. Secondly as a finding, there were issues raised about whether MHCA is providing statewide advocacy. MHCA provides mainly direct services in Anchorage. Their response is that they partner with other organizations in statewide conferences, etc. This is a decision for the DMH&DD whether this is sufficient.

4. Our third and final finding relates to the Board of Directors, general openness and inclusiveness, and access to documents and openness to participation. The by-laws (see for example Article III, Section 6) are highly nebulous and procedures for participation are not known. Setting up known by-laws, policies and procedures is important. Setting up goals and procedures for broad based participation will go a long way to solving the "upsets" at issues. This is critical.

Conclusion

I am certain that a statewide organization for consumers is important and we should do

Audit Report

Mental Health Consumers of Alaska, Inc.

Selected Issues & Concerns

February 26, 1999

OBJECTIVES, SCOPE AND METHODOLOGY

At the request of the Division of Mental Health and Developmental Disabilities (DMHDD) we have examined selected financial records and documents of Mental Health Consumers of Alaska, Inc. (the grantee) related to the operation of the Community Mental Health Program as well as the general operation of the agency as a whole. The fieldwork was completed on February 26, 1999 in the grantee's Anchorage office. The objectives, scope and methodology of our review were as follows:

Objectives

The objectives of this review addressed selected issues and concerns developed from the request of the DMHDD. These objectives are summarized as follows:

1. Assess the adequacy of the grantee's accounting system.

2. Evaluate the grantee's internal controls over its financial activities.

3. Investigate the validity of allegations made by consumers of the grantee's Clubhouse Program.

4. Determine whether the grantee complied with applicable laws, regulations and grant provisions governing their fiscal activity.

Scope and Methodology

For the objectives listed above we examined the financial records and documents of the grantee as well as the grant files maintained by the DMHDD for the period July 1, 1998 through December 31, 1998. Due to time constraints on conducting this review and the unavailability of fiscal year 1998 financial records, the detailed testing of cash transactions performed was substantially less than a normal audit would require to evaluate the adequacy of the grantee's system of internal controls. Our review focused mainly on the allegations made by the Clubhouse consumers and a simple review of the adequacy of the agency's accounting system and internal controls. Interviews were also conducted with selected individuals from the grant agency as well as from the granting division.

CONCLUSIONS AND RECOMMENDATIONS

The conclusions of this review are summarized below and organized numerically to correspond to the associated objective listed on page 2 of this report.

Conclusion Number 1 (accounting system)

The accounting system in use at Mental Health Consumers of Alaska, Inc. is adequate to the task of recording the day to day financial transactions of the agency. The accounting function is however, currently being subordinated to the programmatic functions of the agency due to recent office staff turnover. Without an office manager the executive director has been doing the accounting work when his schedule allows time. Although we only reviewed the accounting function, it can be assumed that the programmatic function is likely suffering as well due the executive director spreading his time between two positions. Our review found that the untimely payment of some bills has resulted in finance charges and/or late fees. These costs are unbudgeted, unnecessary and unhealthy to any agency. We recommend that the office manager position be filled as soon as possible and that the accounting activities be brought up to date and maintained daily.

The grantee maintains its accounting system on a designated computer located in the Anchorage office. This computer holds the entire accounting system for MHCA and if something were to happen to the computer, or the building, all the agency financial data would, at best, have to be completely reconstructed or, at worst, be completely lost. To alleviate this risk we suggest that the entire accounting system be backed-up to disk or tape and periodically rotated offsite.

Care should be taken when recording expenditures at the beginning of the fiscal year to assure the proper grant period is charged with the expense. We found that several payments made at the beginning of fiscal year 1999 were for costs actually incurred during the latter part of fiscal year 1998. The date the item was purchased or service was received should be noted and the payment should be coded to the proper period. Not doing so could cause audit adjustments that could ultimately result in the disallowance of costs and the grantee being ordered to refund grant monies.

Mental Health Consumers of Alaska, Inc. does not maintain adequate fixed asset records that comply with grant regulation 7 AAC 78.280(I). The grantee should review its property records and bring them into compliance with the grant regulations before

On December 7, 1998 the grantee paid $5,387 for cleaning services at the Clubhouse following a homicide that occurred there on September 26, 1998. An insurance claim was filed for this expense and the grantee received payment from the insurance company for the total cost less $1,000 deductible, or $4,387. The cleaning company was paid with an agency check and the expense was charged to the state grant. Because the cost to the agency was only the $1,000 deductible, an adjustment to the state grant expense report should be made to reduce the cleaning expense by the amount of the insurance reimbursement. If this is not done the grantee will essentially receive reimbursement twice for the same expense, once from the insurance claim and again from the grant award.

Conclusion Number 2 (internal controls)

Mental Health Consumers of Alaska, Inc. is a small nonprofit organization which does not have the resources available to provide for adequate separation of duties in the accounting function. The same individual (office manager) has been responsible for making deposits, preparing checks, reconciling bank statements, entering transactions in the general ledger system, preparing financial and grant reports and filing supporting documentation. Recently, with the resignation of the office manager, the executive director has been performing these duties. This significant lack of separation of duties leaves the agency at risk for errors and irregularities to occur which could go unnoticed. Resignation of the office manager and inactivity by the Board of Directors in the accounting oversight, has resulted in less separation of duties currently then had existed in the past. It should be noted that of the cash transactions we conducted detailed tests on, we found only procedural errors and no recording errors or instances of missing supporting documentation were noted.

MHCA has in place a few basic fiscal policies that provide inadequate guidance to anyone working with the agency's accounting system. We recommend that the Board of Directors review the current fiscal policies and develop a more comprehensive set of policies that are adequate to the task of safeguarding the assets of the agency as well as provide a guide for current and future employees. We also recommend that the Board of Directors become involved in the fiscal oversight of the agency to provide as much separation of duties as possible. A committee of board members could be assigned to review financial statements on a monthly basis, review, approve and sign supporting documentation for checks written each month, and review or actually perform the bank reconciliations. If the committee decides to perform the bank reconciliations, the bank statements should be delivered to the committee unopened. MHCA should also consider

supporting documentation. Actual receipts for purchases made with credit cards should be reviewed for allowability and reconciled to the monthly statement before payment is made. Travel authorization reports currently in use by MHCA are adequate for the purpose of organizing costs and authorizations for employee travel. However, they are not always being completely filled out, proper approvals are missing, and receipts to verify actual costs are incomplete. All travel reports should include travelers name, destination, departure and return date, transportation costs, per diem rate and/or actual expenses incurred, advance payments, final settlement payment/refund, check numbers, purpose of the trip and proper authorizations. The report should be approved for purpose, estimated cost and advance payments prior to the trip occurring. Upon the travelers return the report should be completed with actual costs. Invoices, ticket stubs, etc. should be attached for verification and approvals should be received for final settlement.

MHCA has not had a state single audit since fiscal year 1996. State Single Audit regulations 2 AAC 45, applicable to fiscal year 1997, requires an entity receiving $150,000 or more of state financial assistance to undergo a single audit and submit it to the coordinating agency (Office of Management and Budget) within on year following the end of the audit period. Consequently, MHCA's fiscal year ended June 30, 1997 State Single Audit was due on June 30, 1998 and is currently eight months overdue. The State Single Audit regulations were revised recently and the threshold triggering an audit was increased to $300,000. Agencies with fiscal years beginning on or after July 1, 1997 and ending on or before June 30, 1998 have the option of following either the new or old regulations for FY 98. Should MHCA elect to follow the new regulations for FY 98, a State Single Audit would not be required as the $300,000 threshold was not met. Department of Health and Social Services grant regulation 7 AAC 78.230(b) however requires a grantee to undergo an audit at least every two years. This audit would be a financial audit only and would not involve the additional compliance and disclosure requirements of a Single Audit. If MHCA elects to undergo a Single Audit of FY 98 an audit under 7 AAC 78.230(b) would not be legally required until FY 2000. If they elect to forgo a Single Audit of FY 98 an audit under 7 AAC 78.230(b) would be required for FY 99. Even though the grant regulations require an audit only every other year, we feel it is prudent financial management and recommend that grant agencies undergo annual audits.

Conclusion Number 3 (allegations)

The two main financial related allegations were concerned with a check written from the Clubhouse computer and board members pre-signing agency checks. We could find no evidence during our review that indicated there was any validity to these allegations.

worded and detailed fiscal policies and procedures manual would assist MHCA employees enormously in learning and understanding the accounting procedures that they are expected to follow.

On August 14, 1997 the Board of Directors authorized an employee wellness program that allowed the expenditure of $5,000 per employee per year for medical/dental related costs as a substitute for health insurance. A review of the expenses charged to this program showed payments to dentists, AFLAC Insurance Company and a variety of athletic and health clubs. Although the charges to this program were relatively small compared to the amount authorized, we were unsure of the Board's intention on how employees could use this money. We recommend that the Board of Directors elaborate on the details of this program in a policy that lists at a minimum the type of expenditures allowed and the tax ramifications to the employees who access this program.

Quality Assurance - File review

Mental Health Consumers of Alaska
Feb. 25-26, 1999

A file review was conducted as a segment of the special site review of Mental Health Consumers of Alaska (MHCA). In order to gather the requested information, a total of 9 mental health (MH) files were reviewed. Five of these were Medicaid files and 4 were not. Prior to the examination of the current status of consumer files at MHCA, the plan of correction (POC) submitted by the director of the agency as a result of the FY 98 QA site visit, was reviewed.

Overall, the files did not indicate that significant changes were made in accordance with the submitted FY 98 POC. Items cited as being out of compliance then, continue to be out of compliance at present. In addition to reviewing files for compliance, they were examined closely to determine the existence and continuation of medical necessity. The term "medical necessity" refers to the clinical process of mental health problem identification and treatment of those identified problems.

The clinical assessment is the document that establishes medical necessity. It can be in the form of an intake, comprehensive, psychological, psychiatric, etc. It needs to be conducted by a Mental Health Professional Clinician (MHPC) as a minimum. The assessment document determines medical necessity by identifying and diagnosing problems in addition to recommending treatment. There were several areas of concern regarding the assessment material in the charts at MHCA. Of the 5 Medicaid charts reviewed, there were 2 different forms used for intake assessments. One was a computer-generated assessment, and the other was a narrative form. The computer generated form needs to include the following components to be in compliance with Medicaid regulations and Division standards: a clear, written summary of problems identified, treatment interventions and modalities recommended, a prognosis statement, and a declaration of eligibility for services (CMI, SEDA).

In one case, the assessment did not differentiate between which problems were MH

be used with clients. There was no evidence apparent in the progress notes that this approach was being utilized when intervening with clients.

This assessment form did include an interim treatment plan. However, the goals listed were global and vague, they did not identify the interventions or the person(s) responsible for the delivery of the service(s).

The narrative intake assessment form needs to support the diagnosis given, provide a clear, written summary of problems identified, and recommend treatment interventions and modalities. While there is a place on the form to check off services recommended, they are left blank. The narrative form needs an interim treatment plan if services are to be provided prior to the completion of the official treatment plan.

Treatment plans and review documents were also computer generated. They appeared to be the same document as the intake assessment, with the title of "Treatment Plan," whether it was the plan or a review document.

The treatment plan needs to be based on the problems identified in the assessment in order to ensure the continuation of medical necessity. When the narrative assessment form was used, medical necessity seemed to be more likely to be "lost."

The stated goals were global and vague, not individualized to meet the specific needs of the consumer. Each goal must be specific in order to become measurable and achievable. Specific interventions, service modalities, persons responsible, frequency and duration are required components of the treatment plan. Goals can only be written for those services that the agency provides. For example, one plan had goals written regarding the responsibilities of the psychiatrist for the delivery of medication to the client. First, the agency does not provide psychiatric services and therefore should not be writing goals for a service over which the agency has no responsibility/accountability for. Second, the goals appeared to be written as if they were for the psychiatrist and not the client. Goals can only be written for those consumers whom your agency is serving. Stated discharge criteria or criteria for the lessening of services did not seem to be related to the goals of treatment.

Treatment plan review documents were not referred to as such, but rather as "Treatment Plans." The information contained in them was different than in the initial treatment plan, appearing to be review material. These documents did address progress in a general

Psychosocial assessments were conducted, although they were not recommended in the assessment material. They were not billed for, but can be reimbursed through Medicaid if they are recommended in the assessment material. They are to be conducted every 6 months for all consumers receiving rehab services and every 3 months for those receiving IRS. The purpose of this document is to identify the client's current level of functioning in various life areas, identify problem areas and recommend service modalities. The psychosocials in the files did identify current levels of functioning. They did not summarize problems or make recommendations for services.

Progress notes appeared to be more "process" oriented than progress oriented. They were all identified as "case management" notes, regardless of what service was being provided. Some notes reviewed may be considered medically necessary. Others would not be, for one of the following reasons: the need for the service was not identified in assessment materials (intake and/or psychosocial); the service modality was not prescribed on the treatment plan; or the note did not describe the reimbursable active intervention that occurred during the documented service episode. Progress notes need to clearly identify the goal being addressed, the intervention being utilized, progress the consumer made toward that goal, and any other clinically relevant information. They should also clearly specify the type of the service delivered (in addition to the code number).

The QA team recently began to review non-Medicaid files to ensure the uniformity of documentation for all MH consumer charts. At MHCA, there was an obvious difference between the charts of non-Medicaid and Medicaid consumers. Four non-Medicaid files were reviewed. One out of the 4 did not have an assessment document. None of the 4 had a treatment plan or review document(s), and 3 out of the 4 had no progress notes.

Areas that continue to be out of compliance according to the submitted POC following the FY 98 QA site review report:

<u>Intake</u>
-Clear written summaries/interventions/treatment recommendations

<u>Treatment Plans</u>
-Goals continue to be global
-No client and/or parent/guardian signature(s)

<u>Treatment Reviews</u>
-Needs to document any updated assessments and recommend new assessments

Areas of Improvement from the FY 98 QA site review:

-Treatment reviews appear to be occurring (need more consistency and awareness of timelines)
-Strengths and resources being addressed (needs to be more consistent)
- DSM diagnosis are present in assessments (needs better support in the narrative form)
-Prognosis statements are being addressed (needs to be more consistent)
-Duration of goals addressed (needs to be more consistent)
-Discharge criteria, lessening of services added to review document (needs to be related to treatment goals)
-Consumer/parent/guardian signed informed consent forms in files

In summary of the file review, several areas have been identified for continued improvement. The agency needs information regarding the establishment and continuation of medical necessity in report writing, eligibility determination, required documentation, education regarding necessary components of each of the required documents, the definitions of the various categories of services and Medicaid billings that are available for reimbursement of delivered services.

Recommendations: As a result of the above stated findings, QA recommended a training session for the staff of MHCA. This session did occur on the date of March 15,1999. The training addressed the previously stated concerns. QA staff will be available for follow up technical assistance (TA) to any of the staff members at MHCA. TA will include the monitoring of chart updates per agreement with the agency director, Dave Wagner. It was agreed upon by the director and QA staff, that the agency will set goals for themselves to update a specified number of charts per month, until all open files meet current Medicaid regulations and Division standards.

Mental Health Consumers of Alaska Site Review

Staff Interviews
February 25, 1999

A special site review of the Mental Health Consumers of Alaska (MHCA) was conducted by a DMHDD initiated team on February 25-26, 1999. Dr. Dave Wagner, Executive Director, MHCA scheduled staff interviews and arranged a meeting space for the site review team. The MHCA is FY99 grant funded for the following positions: Executive Director, 1.0 FTE; Office Manager, 1.0 FTE; Client Support Specialist, 0.5 FTE; Clubhouse, 1.0 FTE; and Contract Services. The following personnel were interviewed: Shannon Huber, Representative Payee; Bill Aube, Director, Daybreak; Polly Beth Odom, Daybreak/Care Coordinator.

The Office Manager position (1.0 FTE) has been vacant since the fall of 1998. The position continues to remain vacant. The Office Manager is responsible for third party billing, bookkeeping, managing the front office, and other duties.

The Client Support Specialist (0.5 FTE) provides representative payee service. MHCA has assumed all representative payee services from Southcentral Counseling Center in addition to serving non-CMHC clients in need of these services. Forty-five (45) individuals are being served with five (5) pending, and plans to serve an additional fifteen (15) people as a result of improved efficiency afforded by a new computer. Client Support services are billed to Medicaid (approximately 30 – 40%) when budgeting assistance is required. The remainder of expense is billed to grant funds. However, no Medicaid billing has occurred since December 1998 for representative payee service due to the Office Manager vacancy. MCHA has a procedure to assure client representative payee service is uninterrupted for up to two weeks should assigned staff be absent. However, there does not appear to be a formal policy & procedure for absences in excess of two weeks duration.

The MHCA entered into and implemented an agreement with Daybreak of Wasilla to provide independent care coordination commencing July 1, 1997. Care coordination services are principally available to clients receiving psychiatric services from private practitioners and physician clinics such as Langdon. This is a sub-population in Anchorage which has historically been under-served and estranged from the public community mental health system. Daybreak charges MHCA $35.00/hour of service.

non-Medicaid reimbursable service is estimated being provided weekly. The MHCA Executive Director provides individual clinical supervision for 1.5 – 2.0 hours weekly.

Observations & Recommendations:

1. All interviewed staff/contractors unequivocally praised the Program Director for his support and understanding their needs as employees/contractors. Similarly, all are concerned the Program Director is being unfairly singled out by a small group of disgruntled consumers.

2. All interviewed staff/contractors are clearly dedicated to and appreciate being part of an agency willing to step up to the plate and find a way to deliver service when a gap(s) is identified.

3. Most interviewees tended in varying degree to view the agency's advocacy mission as primarily focused upon advocating for those consumers who access services from MHCA. The agency's broader statewide advocacy responsibility is not in the fore of staff thinking about the agency.

4. The agency will be well served to formalize representative payee policy & procedures. Furthermore, it is recommended the agency build upon the present back up plan and develop additional contingencies to assure representative payee client need is not disrupted in the event a longer period of coverage becomes necessary.

5. The agency will benefit from filling the vacant Office Manager position

AGENCY INTERVIEWS:

Representatives from three agencies, The Mental Health Association of Alaska, (MHAA); South Central Counseling, (SCC); and the National Alliance for the Mentally Ill, (NAMI); were interviewed. These three agencies have had, and continue to have collateral and cooperative working relationships with Mental Health Consumers of Alaska, (MHCA).

While it is evident from the interviews that all three agencies interviewed value MHCA and the contribution this agency has made in advocating for and supporting mental health consumers in Alaska, it is also their perception that MHCA is an agency in transition. While the agency by laws clearly emphasize advocacy for consumers throughout Alaska, the agency has, in more recent years, entered into a service role as well. From the point of view of some consumers and agencies, MHCA as a service provider has superceded their traditional and historical role in statewide consumer advocacy. At the very least this apparent dual role by MHCA has been confusing to both agencies and consumers alike.

Clearly, MHCA, is providing an alternative to other mental health agencies in the provision of case management and client support services for Anchorage consumers, thus providing Anchorage consumers with consumer choice in their service provider. Also, MHCA, has been most effective and responsive to consumers requiring and needing payee services, which was highlighted as a valued service to both consumers and mental health agencies alike. The club house program operated by MHCA, until the closure of the program by the MHCA board following the homicide in the fall of '98, was generally viewed as a valuable program. Nevertheless, from the agencies interviewed perspective, there appeared to be some confusion by consumers as to their role in clubhouse decision making and operations.

An area of concern identified by the agencies interviewed was board growth and development. Though the by laws of the agency allow up to 11 board members, the board has most recently had only 3 to 5 members on the MHCA board. This small number of board members and the lack of representation on the board by consumers outside of south central Alaska, poses problems for an agency whose purpose is to be a statewide organization, and limiting to the day to day policy development, implementation and management of the agency.

With the exception of the federal grant that is jointly managed by MHCA and