GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

Apr 2003

DEPARTMENT OF HEALTH

ADDICTION PREVENTION RECOVERY ADMINISTRATION

REPORT OF INSPECTION

CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

OIG No. 03-0005HC

APRIL 2003

Inspections and Evaluations Division

Mission Statement

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness and economy in operations and programs. I&E goals are to help ensure compliance with applicable laws, regulations, and policies, to identify accountability, recognize excellence, and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

April 30, 2003

Mr. James A. Buford
Director
Department of Health
825 North Capitol Street, Northeast
Suite 4400
Washington, DC 20002

Dear Mr. Buford:

Enclosed is our final *Report of Inspection of the Addiction Prevention and Recovery Administration*. Your agency's comments on the 20 findings and 29 recommendations by the inspection team are included in the Report.

In accordance with Mayor's Order 2000-105, District agencies are responsible for taking action on all agreed-upon recommendations in this final Report. The Office of the Inspector General (OIG) has established a process to track agency compliance and to facilitate our follow-up inspection activities. Enclosed are *Compliance Forms* on which to record and report to this Office any actions you have taken concerning each outstanding recommendation. These forms will assist you in tracking the completion of actions taken by your staff, and will assist this Office in its inspection follow-up activities. We track agency compliance with all agreed-upon recommendations made in our reports of inspection, and we request that you and your administrators establish response dates on the forms and advise us of those dates so we can enter them on our copies of the *Compliance Forms.*

In some instances, things beyond your control, such as budget decisions, impact on trying to set specific deadlines. In those instances we request that you assign *target dates* based on whatever knowledge and experience you have about a particular issue. Please ensure that the *Compliance Forms* are returned to the OIG by the response date, and that reports of "Agency Action Taken" reflect actual completion, in whole or in part, of a recommended action rather than "planned" action. We will work closely with your designated point of contact throughout the compliance process.

We appreciate the cooperation shown by you and your employees during the inspection and we hope to continue in a cooperative relationship during the upcoming follow-up period.

If you have questions or require assistance in the course of complying with our recommendations, please contact me or Alvin Wright, Jr., Assistant Inspector General for Inspections and Evaluations at (202) 727-5052.

Sincerely,

Charles C. Maddox, Esq.
Inspector General

CCM/AW/JCS/jcs

Enclosure

cc: See Distribution

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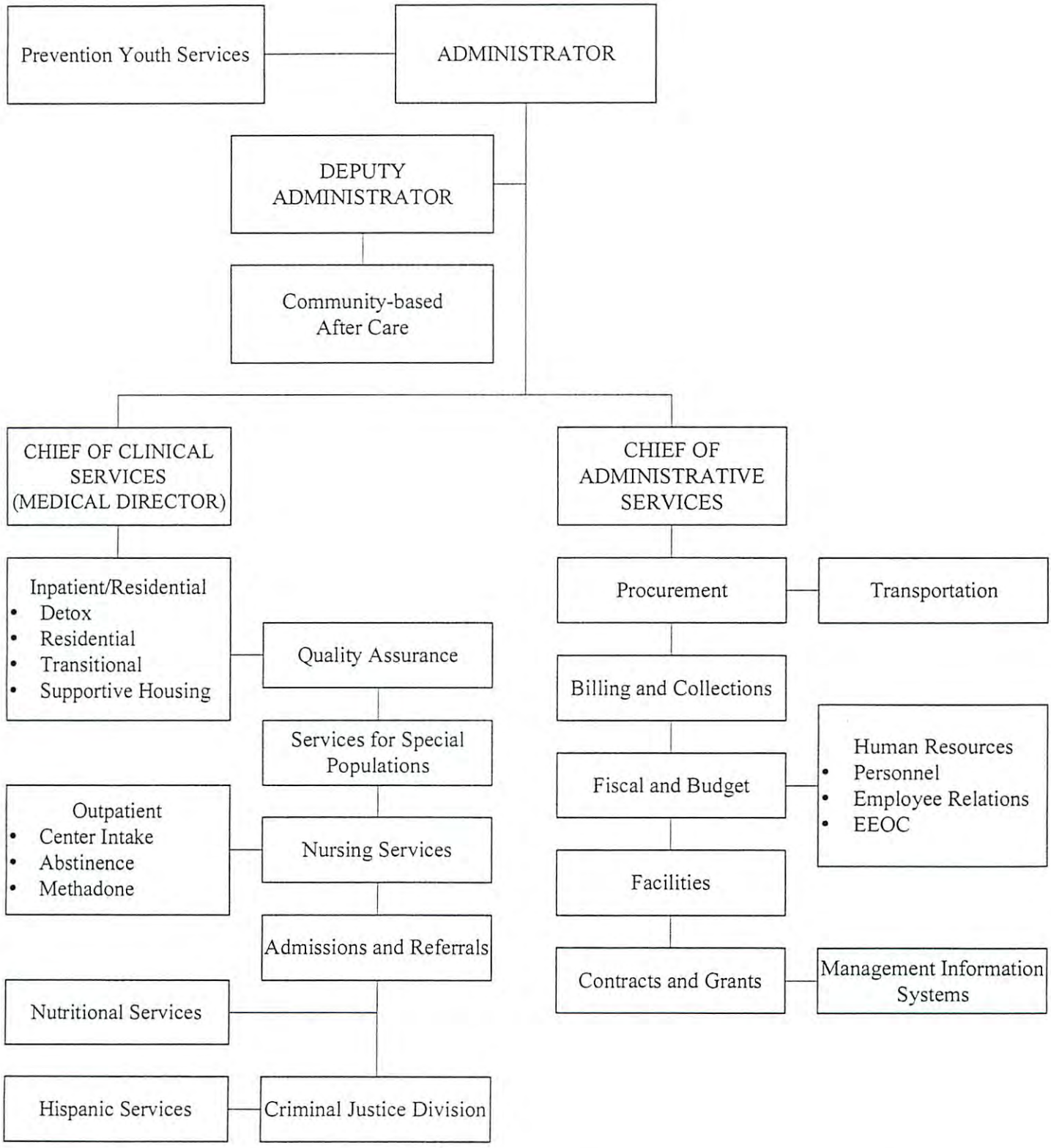
ACRONYMS

APRA	Addiction Prevention and Recovery Administration
ATOD	Alcohol, Tobacco and Other Drugs
CARF	Commission on Accreditation of Rehabilitation Facilities
CDS	Client Data System
CID	Central Intake Division
DHS	D.C. Department of Human Services
DHHS	U.S. Department of Health and Human Services
DOH	Department of Health
D/DOH	Director of Department of Health
FDRA	Food, Drug, and Radiation Protection
MAA	Medical Assistance Administration
OCR	Office of Certification and Regulation
OPYS	Office of Prevention and Youth Services
PBX	Private Branch Exchange
SOAR	System of Accounting and Reporting
TANF	Temporary Assistance for Needy Families

DEPARTMENT OF HEALTH
ADDICTION PREVENTION AND RECOVERY ADMINISTRATION



EXECUTIVE SUMMARY

Background

The Inspections and Evaluations (I&E) team of the Office of the Inspector General (OIG) conducted an inspection of the District of Columbia (District) Department of Health (DOH) Office of Addiction Prevention and Recovery Administration (APRA) between August 2001 and September 2002. The team found significant deficiencies in all inspected areas.

Scope and Methodology

The inspection focused on the following areas:

- APRA's role as the Single State Agency for substance abuse prevention and treatment services;
- the certification process for substance abuse treatment facilities and programs;
- intake, assessment, and referral services;
- detoxification services;
- prevention services; and
- Medicaid reimbursement and patient billing.

The inspection team (team) conducted 13 interviews, toured work areas and facilities, reviewed numerous documents, and directly observed key work processes. Three Management Alert Reports (MAR) were provided to the Director of DOH and the Interim Director of DOH on significant issues found during the course of the inspection. This inspection report contains 20 findings and 29 recommendations, all of which were reviewed and commented upon by DOH senior management prior to publication. The team found APRA management and employees cooperative and responsive throughout the inspection.

Perspective

The DOH monitors how public and private health care services are provided in the District, and sets policies and standards that contribute to the delivery of quality health care services. DOH regulates and manages licenses and permits for health professionals and health care facilities. DOH also administers the District's programs under the Social Security Act Title XIX, including Medicaid and other health care financing initiatives.[1]

The APRA helps keep District residents from becoming dependent on alcohol, tobacco, and other drugs, and helps the persons already addicted return to sobriety and a positive lifestyle. APRA is involved in providing the following services:

[1] Department of Health: "About DOH:" http://dchealth.dc.gov/index.asp.

- aftercare;
- assessments and referrals;
- detoxification services;
- outpatient services;
- prevention services;
- residential services;
- special services for Hispanics;
- special services for persons with HIV/AIDS;
- special services for women with children;
- special services for youth;
- spiritual faith groups; and
- 12-Step Meeting information.

The team found several operational deficiencies that impede the ability of employees to provide these services. Among them are outdated and insufficient communication equipment, outdated computer software and hardware, inadequate funding, inadequate staffing, and a lack of adequate policies and procedures.

Compliance and Follow-Up

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. The I&E Compliance Officer will coordinate with DOH on verifying compliance with the recommendations over an established time period.

FINDINGS, RECOMMENDATIONS, APRA COMMENTS

Certification Process

Substance abuse treatment facilities are operating without certification. The team found that due to a lack of inspection staff, substance abuse treatment facilities are not inspected and certified annually. **Recommendation:** That the Director of DOH (D/DOH) seek funding to adequately staff the APRA's Office of Certification and Regulation (OCR). (Page 22.) **DOH Comments:** Disagreed.

APRA's Response to IG's Recommendation, as Received:

DCMR tit. 29, Chapter 23, Certification Standards for Substance Abuse Treatment Facilities and Programs, were first published as emergency and proposed rules on January 21, 2000. Two more versions were published after incorporating public comments. The last version was published as emergency and proposed rules on September 22, 2000 and became final on November 24, 2000.

This statement should be modified as existing substances abuse treatment facilities are allowed to operate pursuant to 29 DCMR § 2300.6, which states, [*"If an existing facility or program timely files a completed application for initial certification in accordance with this chapter, the facility's or program's continued operation shall not be deemed in violation, if the Department has not rendered a decision on its application".*]

Consequently, any existing substance abuse treatment facility or program that has not filed an application in a timely manner and any new facility or program that commences operation without certification would be in violation of District law.

The Office of Certification and Regulations' (OCR) staffing level remains inadequate to meet the goals and mandates of 29 DCMR, Chapter 24 as noted in this report. However, staffing levels have been increased from three (3) to nine (9) staff members since the time of the Inspector general's review. This allows the unit to survey two programs per month or twenty-four programs per year.

Also, some of the information in your opening statements for this section is inaccurate.

a. *"The District did not issue rules establishing standards for certifying substance abuse treatment facilities and programs until September 2000."*

Response: This statement has a footnote #4 attached to it. The more accurate information for footnote #4 is, "DCMR tit. 29, Chapter 23, Certification Standards for Substance Abuse Treatment Facilities and Programs, were first published as emergency and proposed rules on January 21, 2000. Two more versions were published after incorporating public comments. The last version was published as emergency and proposed rules on September 22, 2000 and became final on November 24, 2000.

b. The following sentence in the same paragraph states, *"Those rules were issued in response to requirements set forth in the in the "Choice in Drug Treatment Act of 2000."*

Response: The correct information is, "Those rules were issued as part of APRA's efforts to establish a Medicaid substance abuse rehabilitation option through a Medicaid state plan amendment, so that additional revenue could be generated to offset local expenditures for treatment services and thereby expand the treatment continuum. Minimum standards of operation and a system for ensuring compliance with those standards were pre-requisite for implementing Medicaid reimbursement authority for substance abuse treatment services, according to the Medical Assistance Administration."

APRA is not imposing fines or penalties for programs that fail to apply for certification. The team found that facilities failing to apply for certification are to be fined or penalized for each day of operation without certification. **Recommendation:** That the chief officer for the Office of Certification and Regulation (CO/OCR) draft a schedule of fines and penalties to be imposed on facilities failing to submit applications for certification. (Page 24.) **DOH Comments:** Disagreed.

APRA's Response to IG's Recommendation, as Received:

It is true that APRA has not imposed civil fines or penalties for substance abuse treatment facilities or programs that fail to apply for certification. APRA still has not issued a schedule of fines and penalties.

APRA, however, does not issue the Certificate of Occupancy for premises occupied by a substance abuse treatment facility; consequently, APRA does not have the authority to revoke the Certificate of Occupancy issued by the Department of Consumer and Regulatory Affairs (DCRA).

APRA does need to establish a schedule of fines and penalties. However, based on the current staffing and the immense responsibilities of the Chief Officer for OCR, APRA needs assistance from the Department of Health (DOH) General Counsel to expedite the drafting of a schedule of fines and penalties as recommended.

APRA needs legal assistance/advice to OCR to ensure that OCR's legal mandates and statutory requirements are met. Other DC government agencies are afforded attorneys who provide legal assistance for the drafting and transmittal of rulemaking for statutory requirements and the scheduling of fines for inclusion in the District's Civil Infractions Program.

APRA is not charging treatment facilities and programs for inspection cost. The team found that due to APRA's failure to draft a schedule of fees, treatment facilities and programs have not been charged for certification inspections as required. **Recommendation:** That the CO/CR establish a fee schedule for the costs of inspection and certification of substance abuse treatment facilities and programs and begin collection of these fees. (Page 26.) **DOH Comments:** Agreed.

APRA is not following enforcement procedures as prescribed under District regulations. The team found APRA has not used any administrative remedies available under District regulations when deficiencies are found in treatment facilities or programs. **Recommendations:** (a) That D/DOH establish polices and procedures to ensure the proper enforcement of administrative actions as set forth in 29 DCMR Chapter 23. (b) That D/DOH establish schedule of fines so that infractions may be issued for non-compliance with standards set forth in 29 DCMR Chapter 23. (c) That D/DOH seek funding for additional staff to provide technical assistance to help facilities become compliant with regulations. (Page 26.) **DOH Comments:** Agreed.

APRA's Response to IG's Recommendation, as Received:

As stated previously, APRA needs legal assistance/advice to OCR to ensure that OCR's legal mandates and statutory requirements are met. Other DC government agencies are afforded attorneys who provide legal assistance for the drafting and transmittal of rulemaking for statutory requirements and the scheduling of fines for inclusion in the District's Civil Infractions Program.

APRA has no system to identify all substance abuse treatment facilities and programs. The team found that APRA is not aware of all substance abuse and treatment facilities operating in the District. As a result it cannot ensure that all facilities are certified. **Recommendation:** That APRA develop a means of identifying all substance abuse treatment facilities and programs operating in the District. (Page 28.) **DOH Comments:** Agreed.

APRA's Response to IG's Recommendation, as Received:

As there is no single source that identifies a listing of all substance abuse providers in the District of Columbia, OCR has compiled a list of substance abuse treatment facilities and programs from numerous databases and other sources, such as; District and federal government agencies, substance abuse treatment provider organizations, local telephone directories and other substances abuse treatment resources.

OCR has developed a database of all substance abuse treatment programs obtained to date. With the continued implementation of the certification process and with OCR's participation in provider training and forums the substance abuse community and OCR will become more aware of each other.

To assist in identifying all substance abuse facilities and programs operating in the District of Columbia, OCR requires a database management system, such as "PERMIT PLUS", which is currently being used by other agencies within DOH.

APRA will work with DCRA to notify APRA/OCR of every Certificate of Occupancy issued to a substance abuse program operator.

Intake, Assessment, and Referral Services

APRA is unable to provide accurate statistics regarding the effectiveness of substance abuse treatment facilities and programs. The team found that, due to ineffective client tracking and reporting on the part of facilities and programs, APRA cannot accurately provide the number of clients receiving treatment, the number of clients who have completed treatment programs, and the success and failure rates for clients at various treatment facilities. **Recommendations:** (a) That D/DOH install an effective management information system that will track patients, services, and success rates within the APRA program. (b) That D/DOH ensure that contract programs and facilities comply with the terms of their contract to provide monthly statistical and narrative reports. (Page 33.) **DOH Comments:** Agreed.

APRA's Response to IG's Recommendation, as Received:

Central Intake Division is responsible for determining level of care and length of stay. Treatment planning occurs at the treatment site to which the patient is admitted. Tracking is part of the continuous quality improvement process and is not a function of the Central Intake Division.

APRA is in agreement that a fully automated Management Information System is necessary to efficiently track clients receiving services from APRA and APRA's providers. However, due to the need to implement the Drug Treatment of Choice Program APRA has expanded its Central Intake Division to include a social work case manager and utilization review nurses who as a part of their authorization and re-authorization functions will manually begin to track clients in treatment.

Providers approved to participate in the Drug Treatment Choice Program must have an approved voucher in order to receive payment for services. The voucher acts as a mechanism to report treatment information and will improve the provider's compliance with statistical and monthly reports now that those reports are linked to payment.

APRA does not have a centralized filing system. The team found that client medical and treatment records are maintained at various treatment facilities and programs throughout the city, and there are no standardized medical and treatment forms for all programs and facilities. APRA does not maintain a central records repository for each client that is current and complete. **Recommendations:** (a) That D/DOH implement an effective centralized patient medical and treatment record system. (b) That D/DOH establish standardized medical and treatment forms to be used for all APRA clients. (c) That D/DOH provide policies and procedures for maintenance of client medical and treatment records. (Page 36.) **DOH Comments:** Agreed.

APRA's Response to IG's Recommendation, as Received:

In preparation for certification with the national accreditation agency, Commission on Accreditation of Rehabilitation Facilities (CARF), APRA completed a full review of its medical record, including all forms. A new medical record was created along with updated forms that met the standards promulgated by CARF for medical record compliance. All new patient records from August 1, 2002 are in the new format. Records prior to that time may still contain old forms. New policies and procedures were also written on the medical record including policies on a new treatment plan and biopsychosocial. Staff was trained in the use of the new forms and assessment tools. CARF accepted the changes in format of the medical record. The recommendation from CARF was to ensure that the changes were dispersed through out all existing records. APRA received full 3-year accreditation from CARF.

The telephone system within the Central Intake Division (CID) is inadequate. The team found that due to a poor operating system, the Mayor's standards for telephone-based customer service are not being met. Calls to CID often go unanswered, and the staff does not have voicemail to effectively retrieve and return phone calls. The IG sent a Management Alert Report (MAR 02-I-006, Appendix 6) to D/DOH citing these problems and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 7. *The team will follow-up on DOH's progress in correcting the problems cited in the MAR.* (Page 37.) **DOH Comments:** Agreed.

APRA's Response to IG's Recommendation, as Received:

A totally new telephone system has been installed on the Detoxification Unit as recommended in Management Alert Report (MAR 02-I-006). Verizon has completed an analysis of the telephone upgrade at 1300 First Street, NE. The new target date for installation and activation is April 2003.

Detoxification Services

The Detoxification Center does not have the capacity to handle the number of persons seeking treatment. The team found that the Detoxification Center operates at capacity and often has to turn away substance abusers requiring treatment.
Recommendation: That D/DOH seek additional funding to increase treatment slots at the Detoxification Center to accommodate the current demand for services. (Page 41.)
DOH Comments: Agreed.

APRA's Response to IG's Recommendation, as Received:

There is an error in the first sentence of this section in that the number of beds in operation on the Detoxification Unit is 80 not 50.

APRA's 80-bed detoxification Center (DETOX) is located at building 12 at the DC General Campus. This facility treats clients suffering from the acute affects of or withdrawal from Alcohol And Other Drugs (ATOD). The patient will stay at the Detox Center until he/she is stabilized and when a follow- up treatment facility has been assigned. The stay at DETOX may vary from 1 to 15 days, however the usual stay is 5 - 7 days.

Patients enter the Center in a variety of ways:

- Brought in by Police
- Brought in by others
- Walked in on their own
- Referred by APRA's Central Intake Division (CID)
- Referred by the District's Criminal Justice Division (CJD)
- Referred by APRA's mobile outreach program (Orion)
- Referred by primary care provider

A prospective client will be given a bed if one is available and if the client qualifies for admission. Unstable patients needing detoxification as well as pregnant women and persons with HIV/AIDS are always accommodated and never turned away. While at the Detox Center the client will be assigned a counselor who will assist in identifying and acquiring a follow up treatment program suitable for the individual patient's needs. The treatment programs are varied but limited in numbers. Some programs are operated under APRA's direction (the Methadone Maintenance Programs, Out patient abstinence clinics, and Aftercare Care); however, all of the residential programs are private providers. The 28-day program, Karreck Hall, referred to on page 21 of the report has not been in operation since the fall of 1999.

If funded, the Detox Center should expand to accommodate 100+ beds. With that capacity the Detox Center should be able to respond to the current demand. Other unstable clients with acute medical or mental health conditions are promptly referred to other hospital-based acute care settings for detoxification.

Physical conditions at the Detoxification Center pose health and safety hazards. The team found possible fire and building code violations, as well as unsanitary conditions, at the Detoxification Center. The IG sent a Management Alert Report (MAR 02-I-008, Appendix 8) to D/DOH citing these problems and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 9. *The team will follow-up on DOH's progress in correcting the problems cited in the MAR.* (Page 43.) **DOH Comments:** Agreed.

APRA's Response to Status of Physical Condition of Detox, as Received:

Additional improvements since response to MAR 02-I-008:

- Dinning room received 11 tables and 44 chairs
- Client washer and dryer was installed
- Personal hygiene supply room for clients was established and stocked
- Linen room was organized and stocked
- A dedicated staff person has been assigned to manage the facility maintenance and supplies
- A program manager with extensive clinical experience has been assigned to the detox unit
- An environmental and safety inspection is conducted weekly by the facility manager
- Detox was inspected and received accreditation by the national organization CARF in January 2002 and June 2002 for detoxification and opioid treatment services.

Prevention Programs

Lack of funds for public service announcements could jeopardize federal funding. The Office of Prevention and Youth Services (OPYS) is responsible for maintaining compliance with a federal law that prohibits the sale of tobacco to minors. OPYS uses monitoring and public service announcements to maintain compliance. The team found that there is no funding available in the current budget for public service announcements (PSAs). By eliminating the use of PSAs, the District runs the risk of failing to comply with federal law and thereby lose between 10 to 40 percent in funds received through the federal Substance Abuse Prevention and Treatment Block Grant allocation. **Recommendation:** That D/DOH provide funding for PSAs to continue informing the public about unlawful tobacco sales to minors. (Page 49.) **DOH Comments:** Disagreed.

APRA's Response to IG's Recommendation, as Received:

Public service announcements are not a requirement of the Synar Amendment. In 1999, the District was not in compliance with the amendment. To rectify this problem, public service announcements were aired. In addition, information dissemination and vendor education was a mechanism to preclude future violations.

Since that time, the District has had two successful compliance checks without public service announcements. The Office of Prevention and Youth Services (OPYS) continues to provide merchant education through information dissemination in English, Spanish and Korean. In addition, a special effort targeting Korean merchants through an Asian Pacific Islander grant is being implemented. Consequently, the lack of funds for public service announcements has not and will not jeopardize federal funding for substance abuse prevention and treatment. Therefore, it is not necessary for DOH to provide funding to support public service announcements about unlawful tobacco sales to minors.

OPYS has no performance measures for prevention programs. The team found that OPYS has no criteria in place to measure the success or failure of prevention programs in regards to the programs' effectiveness in reducing the number of substance abusers. **Recommendation:** That the OPYS program manager establish criteria to measure the effectiveness of prevention programs in reducing the number of substance abusers in the District, and to determine if funding for these programs provides a cost benefit to District stakeholders. (Page 50.) **DOH Comments:** Disagreed.

APRA's Response to IG's Recommendation, as Received:

APRA has required prevention grantees to evaluate their program outcomes, however, there was not a consistent methodology. Beginning FY03, APRA instituted a requirement mandating that all OPYS-funded prevention programs use an APRA evaluation instrument to collect consistent baseline data at program onset and post-data across all prevention programs. This will allow us to determine program outcomes.

In addition, the Substance Abuse and Mental Health Services Administration, USHHS, will be transitioning from Substance Abuse Prevention and Treatment Block Grants to Performance Partnerships. This will require a common set of performance measures across the country that will give both the Federal Government and State Governments data on services delivery outcomes. These Federal requirements are currently under a public comment period.

At the earliest, the Performance Partnerships will become effective in FY 2004 and will gradually replace the current reporting system. Once these requirements are instituted, the District will be able to determine the effectiveness and cost benefit of its funded substance abuse services.

Medicaid Reimbursement

APRA is not effectively determining Medicaid eligibility for clients. The team found Medicaid eligibility reviews are not routinely conducted during the client intake and assessment process. **Recommendation:** That D/DOH ensure Medicaid eligibility reviews are conducted and that clients who appear to qualify for Medicaid are referred to Income Maintenance Administration in accordance with APRA policies and procedures. (Page 55.) **DOH Comments:** Disagreed.

APRA's Response to IG's Recommendation, as Received:

Implementation of the Drug Treatment of Choice Act on October 1, 2002 resulted in an expansion of APRA's central intake services. Staff was re-deployed to the Entitlements section. 80% of the current patients in treatment have been interviewed to determine not only Medicaid eligibility but eligibility for other entitlements and were assessed on a sliding fee scale for self pay responsibility. All new patients from 10/1/02 went through a detailed financial assessment for self pay responsibility. APRA has a direct link to IMA, through the Entitlement Verification Services (EVS). Central Intake has access to the EVS to verify Medicaid numbers at the time of intake. Staff has been trained by IMA to assist clients in completing Medicaid applications. APRA is currently recruiting for a specialist to manage this function.

APRA has no internal controls for its Medicaid billing process. The team found that APRA has no written internal control policies and procedures regarding Medicaid billing and found that APRA has only collected 9% of total claims submitted for Medicaid reimbursement. **Recommendations:** (a) That D/DOH develop written internal control policies and procedures for the Medicaid billing process. (b) That D/DOH develop policies and procedures for investigating denied claims. (Page 56.) **DOH Comments:** Disagreed.

APRA's Response to IG's Recommendation, as Received:

The responsibility for determining the cause of denials does not rest with the billing clerks. Tracking the problem requires coordination between APRAs and MAAs MIS specialists with the APRA billing manager and the Medicaid contractor intermediary.

APRA programs and facilities do not have Medicaid provider numbers. The team found that not all facilities and programs providing services to APRA clients have Medicaid provider numbers. The IG sent a Management Alert Report (MAR 03-I-001, Appendix 10) to D/DOH citing this problem and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 11. *The team will follow-up on DOH's progress in correcting the problems cited in the MAR.* (Page 57.) **DOH Comments:** Agreed.

APRA's Response to IG's Recommendation, as Received:

APRA has submitted application for provider numbers for all APRA operated methadone programs, however, application has not been made for non-methadone facilities because there are no provision to be reimbursed for services to clients other than for physical examinations, which are not provided to non-medicated clients. MAA is awaiting submission and approval of a Medicaid State Plan Amendment for reimbursement under a substance abuse rehabilitation option before approving any new application for provider numbers. At that time, substance abuse providers if qualified can bill for comprehensive services.

APRA does not have the software and training required to submit Medicaid claims. The team found that APRA has not been provided with software and training to submit Medicaid claims to the new Medical Assistance Administration (MAA) contractor. **Recommendation:** That D/DOH take the necessary steps to obtain the needed software and training so that APRA can submit claims for Medicaid reimbursement to MAA. (Page 58.) **DOH Comments:** Agreed.

APRA's Response to IG's Recommendation, as Received:

APRA has begun the process to obtain the needed software and training for ACS. New Medicaid applications were completed and submitted to the Medicaid office. Once the applications have been approved and new provider numbers are issued, new software will be installed and training will be provided. DOH/APRA is in the process of submitting a State plan amendment for a Substance Abuse Rehabilitation Option. Mercer Associates has been contracted by MAA/APRA/DOH to assist in authoring state plan amendment and provide technical assistance and training to APRA staff in MAA regulation and billing.

Patient Billing

APRA does not have a system in place to recover the costs of treatment services. The team found that APRA is not collecting fees from patients who are financially able to pay for treatment services. **Recommendation:** That D/DOH establish a patient billing system and begin assessing and collecting fees as required by municipal regulations. (Page 61.) **DOH Comments:** Disagreed.

APRA's Response to IG's Recommendation, as Received:

There is a billing system with policies and procedures; however, the problem is a lack of staff to screen patients and collect payments from all sites. There are currently only three billing clerks and nine sites.

APRA incorrectly assesses fees for methadone treatments. The team found that APRA is not correctly using the sliding scale published in the DCMR when collecting methadone treatment fees from patients, and that many patients have outstanding balances. Additionally, the team found that APRA might be collecting fees from clients who are Medicaid or Medicare eligible contrary to applicable regulations.

Recommendations: (a) That D/DOH establish policies and procedures directing billing clerks to assess methadone treatment fees in accordance with 22 DCMR Chapter 30. (b) That D/DOH establish policies and procedures for the collection of fees from patients with outstanding balances. (c) That D/DOH direct an audit of the methadone treatment collection process to ascertain if Medicaid or Medicare clients have paid for these services and to establish a mechanism to refund these fees. (Page 62.) **DOH Comments:** Agreed

APRA's Response to IG's Recommendation, as Received:

Policies and procedures are already in effect, which direct billing clerks to assess fees in accordance with said regulations.

Internal controls are inadequate for patient billing and fee collection. The team found that APRA's Patient-Billing Department does not adhere to APRA policies and procedures. The team also found that contractors providing methadone treatment to District residents are establishing their own fees for patient billing. **Recommendations:** (a) That D/DOH ensure that patient billing, fee collection, and reconciliation procedures are being adhered to, and direct an Audit to ensure that all fees are collected and accounted for. (b) That D/DOH establish policies and procedures directing contractors to assess methadone treatment fees in accordance with 22 DCMR Chapter 30. (Page 64.) **DOH Comments:** Disagreed.

APRA's Response to IG's Recommendation, as Received:

- Contractors do remit their fees to APRA on a weekly basis with exception of Whitman Walker who submits their fees once a month.
- Contractors do not send copies of receipts for payments, but they do send a printout of patient's names and payments received. APRA billing clerks determine outstanding balances if any. These printouts are received weekly from contractors with the exception of Whitman Walker, which sends their print out on a monthly basis.
- All Contractors with the exception of Whitman Walker submit the actual money orders submitted by clients to APRA billing clerks, with one exception, Whitman Walker does submit a single check which corresponds with the balances submitted on their print out.
- The DC Treasurer consistently verifies the dollar amount on the Deposit Slip and Soar Revenue Report by submitting a receipt to the billing clerk each week for the previous week's deposit. If discrepancies are found the billing office is notified immediately.
- Billing and collection clerks do have access to these receipts, since they are the ones who actually pick up the receipts from the DC Treasurer .

We agree, however, that APRA needs to conduct an audit of both contractors and APRA run programs on a regular basis.

INTRODUCTION

INTRODUCTION

Background and Perspective

The Inspector General (IG) directed the inspection of DOH in August 2001. Because DOH is such a large agency, major components were inspected separately and reported on in separate reports. OIG inspections comply with standards established by the President's Council on Integrity and Efficiency and pay particular attention to the quality of internal control.[2]

The mission of APRA is to promote and enforce the highest quality regulatory standards for delivery of services related to alcohol, tobacco, and other drug (ATOD) addictions; to prevent ATOD addictions; and to identify, treat, and rehabilitate persons who are addicted.

APRA consists of 188 employees who oversee the delivery of substance abuse prevention and treatment services. APRA directly operates seven programs and contracts with local businesses to provide for additional services (Appendix 2). Local taxes primarily fund APRA's prevention and treatment activities. APRA acquires the remainder of its funding from grants and the federal government. The FY 2001 budget was approximately $23.5 million in locally appropriated dollars and $11 million in grants and federal funding for a total of $34.5 million. In FY 2002, the total budget was approximately $35 million, consisting of $23.4 million in locally appropriated dollars and $11.6 million in grants and federal funding.[3]

Scope and Methodology

The inspection team (team) held an entrance conference with Ivan C.A. Walks, M.D., then-Director, Department of Health, and Chief Health Officer for the District and his senior staff. Walks stated that he welcomed an inspection of APRA and welcomed suggestions from the team for ways to improve the Administration's overall performance and delivery of services to District stakeholders. The inspection was conducted between August 2001 and September 2002. It evaluated the effectiveness of the processes in the operational areas inspected as measured against

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[2] "Internal Control" is synonymous with "management control" and is defined by the General Accounting Office as comprising "the plans, methods, and procedures used to meet missions, goals, and objectives and, in doing so, supports performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud." (*Standards for Internal Control in the Federal Government*, November 1999.)

[3] The team found that APRA has not received any funding for tobacco prevention programs from the State Tobacco Settlement reached in 1999. The U.S. Centers for Disease Control and Prevention (CDC) recommends that the District of Columbia spend between $7.5 million and $14.6 million a year to have an effective, comprehensive tobacco prevention program. D.C. has not allocated any of the $87.2 million received from the Master State Settlement Agreement (MSA) for tobacco prevention programs (under the MSA, state legislatures retained the right to decide how to use its tobacco settlement funds). D.C. ranks last – tied with Michigan, North Carolina and Tennessee – in the funding of tobacco prevention programs (http://tobaccofreekids.org - January 15, 2002). In fact, the District has not allocated any funds received through the MSA for health care expenditures for tobacco-related health issues (Appendix 3).

industry standards, best practices, and federal and District laws and regulations. Also evaluated were the sufficiency of internal controls and resources used by employees to achieve the productivity and quality of work desired by APRA and DOH management.

The team conducted 13 interviews, reviewed numerous documents, directly observed key work processes, and inspected selected work areas and facilities. APRA management and employees were professional, cooperative, and responsive during the inspection.

Compliance and Follow-up

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. A compliance form for each finding with a recommendation that was agreed to will be sent to D/DOH along with this Report of Inspection. The I&E Compliance Officer will coordinate with DOH on verifying compliance with the recommendations over an established time period. In some instances, follow-up inspection activities and additional reports may be required.

Findings and Recommendations:

CERTIFICATION PROCESS

CERTIFICATION PROCESS

Certification of facilities providing substance abuse treatment programs is vital to ensure the health, safety, and welfare of clients receiving treatment. District regulations state that facilities should be inspected and monitored to ensure that:

- they are functioning as a legitimate business;
- they maintain compliance with the District's fire and building code requirements;
- staff are qualified to deliver the services being offered;
- the facility is suitable for food handling if food service is provided;
- the facility is qualified to dispense Methadone;
- the facility is qualified to administer detoxification procedures if they are offering these services; and
- the services provided are effective.

The Certification Division has four employees responsible for the annual inspection and certification of approximately 136 substance abuse treatment centers and programs.

The Drug Abuse, Alcohol Abuse, and Mental Illness Insurance Coverage Act of 1986, D.C. Code §§ 31-3101 to – 3111 (2001), requires the Mayor to certify non-hospital residential facilities and outpatient treatment facilities. D.C. Code § 31-3110 specifically requires the Mayor to issue rules to implement these certifications within 120 days of the February 28, 1987 effective date. No rules were established as required by the Act, and, consequently, no inspections, certifications or monitoring of substance abuse treatment facilities were done.

The Substance Abuse Treatment and Prevention Act of 1989, D.C. Code §§ 44-1201 to – 1210 (2001), again required the Mayor to certify non-hospital residential facilities and outpatient treatment facilities, and to establish rules within 120 days of its effective date of March 15, 1990. Again, however, rules were not established, and no certifications or inspections were conducted.

The District did not issue rules establishing standards for certifying substance abuse treatment facilities and programs until September 2000.[4] Those rules were issued in response to requirements set forth in the in the Choice in Drug Treatment Act of 2000.[5]

[4] DCMR tit. 29, Chapter 23, Certification Standards for Substance Abuse Treatment Facilities and Programs, became effective September 22, 2000. According to 29 DCMR Chapter 23, "[t]he Department of Health (DOH), Addiction Prevention and Recovery Administration (APRA) is responsible for the development and promulgation of rules, regulations and certification standards for prevention and treatment services related to the abuse of alcohol, tobacco and other drugs (ATOD) in the District of Columbia. The Bureau of Food, Drug and Radiation Protection, Environmental Health Administration, within DOH, is responsible for the inspection, monitoring and certification of all substance abuse treatment facilities and programs operating within the District of Columbia."

[5] In November 2000, the D.C. Council enacted the Choice in Drug Treatment Act of 2000. This Act seeks to provide District residents with "access to substance abuse rehabilitation and aftercare plans at the treatment provider of their choice[.]" *See* D.C. Code § 7-3003 (2001).

1. **Facilities providing substance abuse treatment are operate without certification in violation of District law.**

DCMR tit. 29 § 2300.4 states: "[n]o person shall own or operate a substance abuse treatment facility that offers or proposes to offer non-hospital residential, non-hospital detoxification, or outpatient treatment without being certified by the Department."

Additionally, D.C. Code § 31-3106, requires, in part, that:

- each certification issued by the Mayor must state whether the facility is certified as a provider of treatment for drug abuse, mental illness or a combination of the two;
- the facility offer an organized program for the treatment of drug abuse, alcohol abuse, mental illness or any combination of the two; and
- the facility operate under the day-to-day supervision of an individual with demonstrable training and experience in the treatment of drug abuse, alcohol abuse or mental illness.

As of May 7, 2002, APRA has inspected only 15 of 60 facilities submitting applications for certification. Only 2 of these 15 facilities have been approved for certification.

APRA has only three employees conducting inspections and monitoring of substance abuse treatment facilities. Due to the complexity of the inspections, employees can only inspect one facility per month. The team found the completed certification inspections to be comprehensive, professional, and thorough. However, at the rate of one facility per month, it will take APRA approximately 5 years to certify the 60 facilities currently applying for certification.

The chief officer for the Office of Certification and Regulation (CO/OCR) has set a goal of inspecting 1 facility per week and a minimum of 100 facilities during the next fiscal year. She stated that to achieve this goal, at least 20 employees are needed. She stated that an additional 15 employees are needed to ensure that inspectors can give effective technical support to providers in becoming compliant with the new regulations. She further stated that technical assistance is crucial to ensuring that successful standardized, consistent treatment programs are provided by all providers, since facilities have been operating without written standards or guidelines for over 20 years.

Without inspection and monitoring, the District cannot ensure that residents treated in these facilities are receiving effective treatment, and that treatment is done in a healthy and safe environment. For example APRA inspectors have documented facilities failing to:

- monitor clients' compliance and participation in rehabilitation programs;
- conduct criminal background checks on employees;
- conduct drug testing of employees;
- maintain adequate client medical records;
- contact clients after they fail to appear for a scheduled program activity; and
- have proper employee job descriptions.

Recommendation:

That D/DOH seek funding to adequately staff APRA's OCR.

Agree _____ Disagree **X**

APRA's Response to IG's Recommendation, as Received:

This statement should be modified as existing substances abuse treatment facilities are allowed to operate pursuant to 29 DCMR § 2300.6, which states, [*"If an existing facility or program timely files a completed application for initial certification in accordance with this chapter, the facility's or program's continued operation shall not be deemed in violation, if the Department has not rendered a decision on its application"*.]

Consequently, any existing substance abuse treatment facility or program that has not filed an application in a timely manner and any new facility or program that commences operation without certification would be in violation of District law.

The Office of Certification and Regulations' (OCR) staffing level remains inadequate to meet the goals and mandates of 29 DCMR, Chapter 24 as noted in this report. However, staffing levels have been increased from three (3) to nine (9) staff members since the time of the Inspector general's review. This allows the unit to survey two programs per month or twenty-four programs per year.

Also, some of the information in your opening statements for this section is inaccurate.

b. *"The District did not issue rules establishing standards for certifying substance abuse treatment facilities and programs until September 2000."*

Response: This statement has a footnote #4 attached to it. The more accurate information for footnote #4 is, "DCMR tit. 29, Chapter 23, Certification Standards for Substance Abuse Treatment Facilities and Programs, were first published as emergency and proposed rules on January 21, 2000. Two more versions were published after incorporating public comments. The last version was published as emergency and proposed rules on September 22, 2000 and became final on November 24, 2000.

b. The following sentence in the same paragraph states, *"Those rules were issued in response to requirements set forth in the in the "Choice in Drug Treatment Act of 2000."*

Response: The correct information is, "Those rules were issued as part of APRA's efforts to establish a Medicaid substance abuse rehabilitation option through a Medicaid state plan amendment, so that additional revenue could be generated to offset local expenditures for treatment services and thereby expand the treatment continuum. Minimum standards of operation and a system for ensuring compliance with those standards were pre-requisite for implementing Medicaid reimbursement authority for substance abuse treatment services, according to the Medical Assistance Administration."

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

2. <u>APRA does not impose civil fines or penalties for substance abuse treatment facilities or programs that fail to apply for certification</u>.

DCMR tit. 29 § 2300.5 states:

Any existing substance abuse treatment program or facility that is not certified by the department shall submit an application for certification pursuant to this chapter within ninety (90) days of the effective date of this chapter. Failure to file within the specified period may result in civil fines or penalties.

(Emphasis added.)

D.C. Code § 44-1204 (f) (2001) states that the penalty for the operation of a substance abuse treatment facility without the proper certification shall be:

- a civil fine of not less than $100 for each day of operation without certification; and
- revocation of the certificate of occupancy issued by the Department of Consumer and Regulatory Affairs for the premises occupied by the substance abuse treatment facility.

In October 2000, APRA's OCR mailed application packages to 136 substance abuse treatment facilities and programs, informing them of the new certification requirements. The team found that as of May 2002, only 60 of these facilities or

programs had submitted applications for certification.[6] APRA has failed to impose any civil fines required by D.C. Code § 44-1204 (f), and has not revoked the certificates of occupancy of the 76 facilities that failed to comply with the certification requirement.

The CO/OCR stated that no civil fines or penalties have been imposed because APRA has yet to draft a schedule of fines or penalties. Consequently, many facilities operate in violation of District laws without penalty, and revenue from fines, which could be used to support APRA's substance abuse treatment programs, is lost.

Recommendation:

That the CO/OCR draft a schedule of fines and penalties to be imposed on any facilities that operates prior to submitting a completed application for certification.

Agree _____ Disagree **X**

APRA's Response to IG's Recommendation, as Received:

It is true that APRA has not imposed civil fines or penalties for substance abuse treatment facilities or programs that fail to apply for certification. APRA still has not issued a schedule of fines and penalties.

APRA, however, does not issue the Certificate of Occupancy for premises occupied by a substance abuse treatment facility; consequently, APRA does not have the authority to revoke the Certificate of Occupancy issued by the Department of Consumer and Regulatory Affairs (DCRA).

APRA does need to establish a schedule of fines and penalties. However, based on the current staffing and the immense responsibilities of the Chief Officer for OCR, APRA needs assistance from the Department of Health (DOH) General Counsel to expedite the drafting of a schedule of fines and penalties as recommended.

APRA needs legal assistance/advice to OCR to ensure that OCR's legal mandates and statutory requirements are met. Other DC government agencies are afforded attorneys who provide legal assistance for the drafting and transmittal of rulemaking for statutory requirements and the scheduling of fines for inclusion in the District's Civil Infractions Program.

OIG Response: **APRA needs to take the necessary steps to obtain the legal assistance needed to address the condition noted.**

[6] DCMR tit. 29 § 2300.6 states that "[i]f an existing facility or program timely files a completed application for initial certification in accordance with this chapter, the facility's or program's continued operation shall not be deemed in violation, if the Department has not rendered a decision on its application."

3. **APRA does not impose a fee upon treatment facilities and programs seeking certification.**

D.C. Code § 7-3009 (a) requires treatment providers to pay for the cost of their certification. The team found that APRA has not charged any of the 15 facilities that are certified the costs associated with a certification or inspection fee.

The CO/OCR stated that these facilities have not been charged because APRA has not established a fee schedule to be charged for the costs of certification. She stated that APRA is in the process of reviewing fees established by surrounding jurisdictions to determine a fair and reasonable fee schedule, but due to a backlog in inspections, APRA has not been able to establish a fee schedule.

The failure to charge a treatment provider its cost for certification violates D.C. Code § 7-3009 (a) and shifts the burden of APRA's operating expense from treatment providers onto District taxpayers.

Recommendation:

That the CO/OCR establish a fee schedule for the inspection and certification of substance abuse treatment facilities and programs and begin collection of these fees.

Agree ____X____ Disagree _____

4. **APRA does not employ enforcement procedures as prescribed by District regulations.**

DCMR tit. 29, § 2367.2 permits DOH to employ several remedies to penalize substance abuse treatment facilities or programs that violate applicable law. The administrative remedies available to DOH include:

a. summary suspension;
b. suspension;
c. revocations;
d. denial of an application for certification; or
e. civil fines and penalties.

Id.

Although only two facilities inspected by APRA are certified, APRA does not utilize its available administrative remedies to sanction the remaining facilities that have been inspected and are known to be deficient, except to deny their applications for certification. The facilities that have been denied certification, however, continue to

operate and provide substance abuse services. In one particular case, the facility continues to provide services, without penalty, even though APRA denied its corrective action plan three times.[7]

The CO/OCR stated that the division has not applied its available administrative remedies because APRA has not established policies or procedures to implement the administrative actions, and has not published a schedule of fines for non-compliance.

In addition, the chief officer stated that the OCR is attempting to provide technical assistance to the providers to achieve compliance since the facilities were never inspected until rules and regulations were passed in September 2000. Many inspected facilities were unaware of the specific requirements for substance abuse treatment facilities operating in the District. However, due to understaffing, APRA has not been able to effectively provide this technical assistance to facilities found to have deficiencies.

Failing to enforce the administrative remedies set forth in D.C. law and regulations allows substance abuse treatment facilities to provide sub-standard treatment and programs to District residents without penalty.

Recommendations:

a. That D/DOH establish policies and procedures to ensure the proper enforcement of administrative actions set forth in 29 DCMR Chapter 23.

Agree _____X_____ Disagree _____

b. That D/DOH establish a schedule of fines so that infractions may be issued for non-compliance with standards set forth in 29 DCMR Chapter 23.

Agree _____X_____ Disagree _____

c. That D/DOH seek funding for additional staff to provide technical assistance to help facilities become compliant with the regulations.

Agree _____X_____ Disagree _____

[7] This facility's corrective action plan resulting from a May 22-25, 2001 inspection was rejected on November 29, 2001, again on January 8, 2002, and finally on March 21, 2002.

APRA's Response to IG's Recommendation, as Received:

As stated previously, APRA needs legal assistance/advice to OCR to ensure that OCR's legal mandates and statutory requirements are met. Other DC government agencies are afforded attorneys who provide legal assistance for the drafting and transmittal of rulemaking for statutory requirements and the scheduling of fines for inclusion in the District's Civil Infractions Program.

5. **APRA does not possess the ability to identify all substance abuse treatment facilities and programs operating in the District.**

The team requested a list of substance abuse treatment facilities from the OCR to ascertain the number of treatment facilities and programs operating in the District, and to determine if all facilities had applied for certification. The division provided a list of 136 facilities and programs that APRA sent notices to requiring their facility or program to apply for certification. The team, however, through its discussions with employees of other APRA departments, found a number of treatment facilities and programs operating in the District without the OCR's knowledge, thus in violation of 29 DCMR 2300.4.[8]

As a result of APRA's inability to identify all substance abuse treatment facilities and programs operating in the District, it cannot ensure that all such facilities are certified and cannot take remedial action against facilities operating in violation of applicable laws.

Recommendation:

That APRA develop a means of identifying all substance abuse treatment facilities and programs operating in the District.

Agree _____X_____ Disagree _____

APRA's Response to IG's Recommendation, as Received:

As there is no single source that identifies a listing of all substance abuse providers in the District of Columbia, OCR has compiled a list of substance abuse treatment facilities and programs from numerous databases and other sources, such as; District and federal government agencies, substance abuse treatment provider organizations, local telephone directories and other substances abuse treatment resources.

[8] In accordance with 29 DCMR 2300.4, "[n]o person shall own or operate a substance abuse facility … without being certified by the [DOH]."

OCR has developed a database of all substance abuse treatment programs obtained to date. With the continued implementation of the certification process and with OCR's participation in provider training and forums the substance abuse community and OCR will become more aware of each other.

To assist in identifying all substance abuse facilities and programs operating in the District of Columbia, OCR requires a database management system, such as "PERMIT PLUS", which is currently being used by other agencies within DOH.

APRA will work with DCRA to notify APRA/OCR of every Certificate of Occupancy issued to a substance abuse program operator.

Findings and Recommendations:

INTAKE, ASSESSMENT, AND REFERRAL SERVICES

Any resident of the District affected by the abuse of alcohol, tobacco, or other drugs (ATOD) is eligible to receive both inpatient, residential, and outpatient substance abuse treatment services from APRA. To receive these services, residents must first register with APRA's Central Intake Division (CID).

The mission of CID is to facilitate access to substance abuse services for all citizens of the District seeking assistance. CID provides the following patient services:

- an initial assessment by an intake counselor;
- addiction Severity Index;[9]
- complete physical examination;
- diagnosis and development of a treatment plan;
- urine and blood analysis;
- assignment of patients to appropriate treatment sites and to other social service agencies as needed; and
- processing of patients transferred or visiting from other programs.

Upon completion of the assessment, the patient is referred to an appropriate treatment site.

CID also provides the following administrative services:

- data management through its Central Communications Center;
- training opportunities for employees of other social service agencies;
- maintaining a centralized filing system for medical records;
- serving as an information resource for other agencies;
- criminal justice services; and
- processing of information requests.

6. **Due to ineffective client and treatment program tracking and reporting, APRA cannot provide accurate statistics regarding the effectiveness of substance abuse treatment facilities and programs.**

APRA is required to compile the success rates of treatment providers for submission to the City Council (Council) by November 1 of each year. An effective tracking system is essential to assess the effectiveness of all substance abuse treatment programs. The tracking system allows APRA to determine whether:

- clients are receiving appropriate treatment;
- providers are meeting their responsibilities; and
- clients have been successfully treated.

[9] The severity addiction index ratings are interviewers' estimates of a patient's need for additional treatment. The scales rage from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition, and subjective assessment of his treatment needs in a given area.

A legislative finding in the Choice in Drug Treatment Act of 2000 noted that in the first 11 months of FY 1999, APRA served 5,700 clients. No statistics were available, however, regarding whether these individuals had been treated successfully.

a. APRA's Central Communication Center does not have the technology to produce an adequate patient tracking system.

APRA's Central Communications Center is not capable of tracking client information after referring clients for treatment at contracted treatment programs and facilities. APRA's Client Data System (CDS) currently uses an AS400 computer that was purchased in the late 1980's using a grant from the U.S. Department of Health and Human Services (DHHS). Although APRA's certification standards require treatment facilities and programs to have the technology capable of connecting to the CDS, there is no direct access between the APRA record systems and treatment facilities and providers. Consequently, APRA is unable to electronically transmit and retrieve information from treatment facilities and providers.

b. Not all contracted treatment programs and facilities provide the monthly activity reports mandated by CID.

The team also found treatment programs and facilities are not reporting client treatment information to APRA on a consistent basis.

As part of APRA's quality assurance performance standards, program officers must monitor the performance of contracted treatment facilities for the following elements:

a. daily census;
b. number of discharges;
c. type, volume, utilization, cost, and frequency of treatment services provided;
d. number and type of individual and group counseling;
e. number of referrals to outside agencies;
f. completion rates for outpatient care; and
g. concerns, issues, or problems being experienced in the program.

Contracted treatment programs and facilities are required to provide to APRA a monthly activity report at the end of each month of service regarding its progress towards completion of tasks outlined in the program or facilities scope of work. These reports are to consist of both statistical and narrative reports (Appendix 4).

APRA provided the team with Treatment Episode Summaries for fiscal years 2000 and 2001. These reports, however, only show client treatment information from facilities that submit a report, not all facilities. The CID manager stated that, to obtain

data from non-reporting facilities, he would have to visit all treatment facilities and programs and manually extract client treatment information data from their records, and then input this information into APRA's CDS.

As a result of an inadequate management information system and incomplete monthly reporting by treatment programs and facilities, APRA cannot provide accurate statistics regarding:

1. the number of clients receiving treatment;
2. the number of clients who have completed treatment programs; and
3. the success and failure rates for clients at various treatment facilities.

Recommendations:

a. That D/DOH install an effective management information system that will track patients, services, and success rates within the APRA program.

Agree _____X_____ Disagree _____

b. That D/DOH ensure that contracted programs and facilities comply with the terms of their contract to provide monthly statistical and narrative reports.

Agree _____X_____ Disagree _____

APRA's Response to IG's Recommendation, as Received:

Central Intake Division is responsible for determining level of care and length of stay. Treatment planning occurs at the treatment site to which the patient is admitted. Tracking is part of the continuous quality improvement process and is not a function of the Central Intake Division.

APRA is in agreement that a fully automated Management Information System is necessary to efficiently track clients receiving services from APRA and APRA's providers. However, due to the need to implement the Drug Treatment of Choice Program APRA has expanded its Central Intake Division to include a social work case manager and utilization review nurses who as a part of their authorization and re-authorization functions will manually begin to track clients in treatment.

Providers approved to participate in the Drug Treatment Choice Program must have an approved voucher in order to receive payment for services. The voucher acts as a mechanism to report treatment information and will improve the provider's compliance with statistical and monthly reports now that those reports are linked to payment.

7. APRA does not have a centralized filing system for client medical and treatment records.

According to the Commission on Accreditation of Rehabilitation Facilities (CARF),[10] a substance abuse treatment organization should have systems and procedures that provide for monitoring the quality, appropriateness, and utilization of services provided. This monitoring is accomplished mainly through a review of a facility's client records.

In order for a review to be effective, complete and accurate records for each client must be maintained. To be a complete record, CARF provides that a central record must contain information regarding all services received by a client. Records should be organized in a systematic way to ensure that information is readily available. Although duplicate records may be maintained at multiple sites, CARF recommends maintaining a central records repository that is current and complete.

CID does not have a complete, centralized client medical and treatment record system. Each facility providing services to APRA clients maintains a separate partial record for each client, and APRA has no process to transfer records from one facility to another when a patient moves between facilities and programs.

APRA has not provided policies and procedures to facilities regarding client medical and treatment record maintenance. APRA also has not established standardized medical and treatment forms to be used at all facilities for documentation of services provided.

As a result of inadequate policies and procedures and an ineffective patient medical and treatment record system, APRA has found that client records are missing or incomplete. As a result, there is no way to effectively track a client's progress without going to each facility where the client received treatment. CID's record system is further flawed because, even if all of a client's records were collected, the type of information contained in a client's files is not consistent.

Recommendations:

a. That D/DOH implement an effective centralized patient medical and treatment record system that is complete.

Agree ____X____ Disagree _____

[10] CARF is an independent, not-for-profit accrediting body promoting quality, value, and optimal outcomes of services through a consultative accreditation process that centers on enhancing the lives of the persons served. It establishes customer-focused standards to help providers measure and improve the quality, value, and outcomes of their services. CARF has accredited organizations in the areas of Adult Day Services, Assisted Living, Behavioral Health, Employment and Community Services, and Medical Rehabilitation. CARF develops and maintains practical and relevant standards of quality for such programs.

b. That D/DOH establish standardized medical and treatment forms to be used for all APRA clients.

Agree _____ Disagree ____X____

c. That D/DOH provide policies and procedures establishing guidelines for maintenance of client medical and treatment records.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

In preparation for certification with the national accreditation agency, Commission on Accreditation of Rehabilitation Facilities (CARF), APRA completed a full review of its medical record, including all forms. A new medical record was created along with updated forms that met the standards promulgated by CARF for medical record compliance. All new patient records from August 1, 2002 are in the new format. Records prior to that time may still contain old forms. New policies and procedures were also written on the medical record including policies on a new treatment plan and biopsychosocial. Staff was trained in the use of the new forms and assessment tools. CARF accepted the changes in format of the medical record. The recommendation from CARF was to ensure that the changes were dispersed through out all existing records. APRA received full 3-year accreditation from CARF.

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

8. The CID telephone system is inadequate to meet the needs of District residents requiring critically needed services and stakeholders.

The Mayor has established standards for telephone-based customer service that require, among other things, staffing of all main, large, and small service numbers during business hours, specific voicemail box and greeting standards, and the return of telephone calls within 48 hours of receipt (Appendix 5).

The APRA telephone system at CID does not meet these standards. The team found that:

- the main number advertised for the public to obtain critical treatment information is often not answered, or callers receive a busy signal;
- the main number for APRA administrative services, including the medical officer, the quality assurance staff, treatment counselors, and the support staff is often not answered, or callers receive a busy signal; and
- because APRA employees do not have voicemail, callers cannot leave messages and anticipate a response to their calls within 48 hours.

Employees stated that calls to the main number will not roll over to other extensions or to a recorded message. Consequently, if the main number is in use, subsequent callers simply receive a busy signal. In addition, the private branch exchange (PBX) system switchboard does not indicate to the operator when additional calls are received.

Those in need of treatment who cannot easily reach an APRA employee by phone for assistance may forgo treatment altogether. Other District stakeholders are likewise affected, including caseworkers and court system employees who often refer substance abusers to APRA for treatment services and must rely on telephone contact in time-sensitive situations.

The lack of voicemail at the desks of APRA employees prevents compliance with the Mayor's customer service standard requiring that District employees return calls within 48 hours. Many APRA employees must leave their desks to work in other areas of the city and rely on written messages left by coworkers who may happen to answer their telephones. They cannot respond to written messages until they return to the office, which may be days after a call was received. The lack of voicemail, and having to rely on the uncertainty of written messages, severely impacts a substance abuser's ability to receive vital treatment or advice.

The IG sent a Management Alert Report (MAR 02-I-006, Appendix 6) to D/DOH citing these problems and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 7. *The team will follow-up on DOH's progress in correcting the problems cited in the MAR.*

APRA's Response to IG's Recommendation, as Received:

A totally new telephone system has been installed on the Detoxification Unit as recommended in Management Alert Report (MAR 02-I-006). Verizon has completed an analysis of the telephone upgrade at 1300 First Street, NE. The new target date for installation and activation is April 2003.

Findings and Recommendations:

DETOXIFICATION SERVICES

APRA's 50-bed Detoxification Center (Center), which is located on the D.C. General Hospital campus, treats clients requiring medical detoxification from heroin, cocaine, alcohol, and PCP. APRA provides a 24-hour inpatient detoxification program for alcoholics suffering from acute alcohol intoxication or for substance abusers suffering from drug withdrawal. The facility provides services to anyone who has been abusing drugs and alcohol within the last 72 hours. The staff includes a doctor, nurses, treatment counselors, and administrative staff.

Patients enter the center in a variety of ways:

- brought in by police officers or ambulance;
- brought in by others;
- walk in on their own; or
- referred by APRA's CID or the District's Criminal Justice Division (CJD).

The availability of beds at the Center depends on both the number of patients being treated at any given time and the kind of medical problems they have.

The length of stay at the Center depends both on the type of drug usage, the severity of the particular case, and the number of treatment slots available at the time of the patient's arrival. Generally, alcoholics and cocaine users stay for a week to 10 days under medical supervision. Initial treatment and referral discharge plans are drawn up during the stay at the center.

After completing their stay at the Center, clients meet with a counselor for further assessment and referrals for outpatient treatment. Generally, cocaine and alcohol abusers are referred to Karrick Hall located on the grounds of D.C. General Hospital. This facility has a 28-day residential program that offers social detoxification and intensive abstinence support. Other clients are referred to intensive day treatment or, in the case of addicted mothers who have children, to a residential facility that accommodates single-parent families.

Heroin addicts are customarily referred to one of APRA's outpatient methadone maintenance programs and are given an opportunity to gain sobriety, stability, and support before being slowly weaned off methadone.

9. APRA's Detoxification Center does not have the capacity to handle the large volume of District substance abusers requiring treatment.

Five years ago, the Center had the capacity to treat 105 people daily. Due to budget cuts, however, there was a reduction in the number of treatment slots. APRA's budget for detoxification services has remained at approximately the same level for the past 3 fiscal years, and does not permit the addition of treatment slots as needed. The team reviewed census data on drug and alcohol abusers and found that to accommodate all patients requesting services, the Center needs treatment slots for approximately 100

clients per day. Presently, however, the Center can only provide detoxification services to a maximum of 80 people. Because the Center normally operates at capacity, it must turn away 20 or more people who require treatment.

Although the Center maintains a waiting list, the Center's program manager stated that it is critical to treat patients at the point of entry. Many people who have signed up do not return, and the Center's staff cannot locate them when a space becomes available. Therefore, those needing detoxification services do not receive the necessary treatment and may continue to abuse substances by failing to return when a treatment slot becomes available.

Recommendation:

That D/DOH seek additional funding to increase the number of treatment slots available at the Detoxification Center in order to accommodate the current demand for its services.

Agree _____X_____ Disagree _____

APRA's Response to IG's Recommendation, as Received:

There is an error in the first sentence of this section in that the number of beds in operation on the Detoxification Unit is 80 not 50.

APRA's 80-bed detoxification Center (DETOX) is located at building 12 at the DC General Campus. This facility treats clients suffering from the acute affects of or withdrawal from Alcohol And Other Drugs (ATOD). The patient will stay at the Detox Center until he/she is stabilized and when a follow- up treatment facility has been assigned. The stay at DETOX may vary from 1 to 15 days, however the usual stay is 5 - 7 days.

Patients enter the Center in a variety of ways:

- Brought in by Police
- Brought in by others
- Walked in on their own
- Referred by APRA's Central Intake Division (CID)
- Referred by the District's Criminal Justice Division (CJD)
- Referred by APRA's mobile outreach program (Orion)
- Referred by primary care provider

A prospective client will be given a bed if one is available and if the client qualifies for admission. Unstable patients needing detoxification as well as pregnant women and persons with HIV/AIDS are always accommodated and never turned away. While at the Detox Center the client will be assigned a counselor who will assist in identifying and acquiring a follow up treatment program suitable for the individual patient's needs. The treatment programs are varied but limited in numbers. Some programs are operated under APRA's direction (the Methadone Maintenance Programs,

Out patient abstinence clinics, and Aftercare Care); however, all of the residential programs are private providers. The 28-day program, Karreck Hall, referred to on page 21 of the report has not been in operation since the fall of 1999.

If funded, the Detox Center should expand to accommodate 100+ beds. With that capacity the Detox Center should be able to respond to the current demand. Other unstable clients with acute medical or mental health conditions are promptly referred to other hospital-based acute care settings for detoxification.

10. Physical conditions at the Detoxification Center pose health and safety hazards to patients and employees.

DCMR tit. 29, Chapter 23 requires a substance abuse treatment facility or program to maintain a safe environment for its operation and to take reasonable precautions to preserve the safety of persons treated at these locations.

The Center is located in an old building in need of structural, electrical, plumbing, and air-conditioning repairs. The program manager requested that the D.C. Department of Human Services (DHS), which provides facility maintenance services for DOH, make repairs, but was told there is a backlog of such requests at DHS. There is also a year-old request for cleaning and inspection of the air filtration system. While awaiting maintenance on the system, the Center purchased two portable household air filtration systems, but these systems are not adequate to meet the needs of the entire facility. The lack of a well-maintained central system could foster the spread of airborne diseases, and endanger the health of patients and employees.

In addition to maintenance requests, the Center has requested but not received essential office supplies and additional shelving to store medicine, medical records, and food.[11] Employees spend an inordinate amount of time trying to locate patient records and medical supplies because they are stored in boxes rather than in filing cabinets and on shelves. Employees also rummage through trash dumpsters looking for discarded furniture, such as desks and chairs, which creates additional health and safety risks. Currently, the Center has two employees who perform routine cleaning, but as evidenced by the poor conditions found during the inspection, they cannot adequately maintain this 80-bed facility. All of these deficiencies prevent Center employees from carrying out their duties efficiently and effectively, and negatively impact the quality of the District's detoxification program.

[11] An outside contractor provides meals to patients on a daily basis.

The team found the following specific problems:

1. air-conditioning system vents covered with dust and grime;

2. inadequate ventilation and temperature control – portable fans used throughout the facility to maintain comfortable temperatures are also covered with dust and grime;

3. dirty floors throughout the Center, and floors that have not been thoroughly stripped and cleaned in at least a year according to the program manager;

4. exposed, rusting, and leaking pipes;

5. unsanitary food preparation and food service areas;

6. inadequate storage for office supplies, patient records, medical supplies, and food supplies;

7. possible electrical code and fire code violations;

8. standing water in men's restrooms due to poor drainage;

9. lack of ventilation in men's restrooms and mold on the ceiling;

10. lack of shower curtains or partitions in men's shower area and lack of doors for privacy in men's toilet area;

11. cracked tiles throughout the center;

12. walls in need of repair and painting; and

13. evidence of vermin infestation.

In addition, the Center has not been inspected or certified as required by 29 DCMR Chapter 23.

The IG sent a Management Alert Report (MAR 02-I-008, Appendix 8) to D/DOH citing these problems and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 9. *The team will follow-up on DOH's progress in correcting the problems cited in the MAR.*

APRA's Response to Status of Physical Condition of Detox, as Received:

Additional improvements since response to MAR 02-I-008:

- Dinning room received 11 tables and 44 chairs
- Client washer and dryer was installed
- Personal hygiene supply room for clients was established and stocked
- Linen room was organized and stocked
- A dedicated staff person has been assigned to manage the facility maintenance and supplies
- A program manager with extensive clinical experience has been assigned to the detox unit
- An environmental and safety inspection is conducted weekly by the facility manager
- Detox was inspected and received accreditation by the national organization CARF in January 2002 and June 2002 for detoxification and opioid treatment services.

11. The Detoxification Center does not maintain an adequate staff to assist clients who have been discharged after successfully completing their detoxification programs.

DCMR tit. 29 § 2351.4 states that certification standards for substance abuse facilities and programs require facilities or programs to develop patient aftercare plans in order to effectively transition patients into the community after being discharged. The aftercare plan should identify supportive community services or other planned activities designed to sustain therapeutic gains, maintain sobriety, and promote further recovery. The plan should also include procedures for collecting information from patients regarding the outcomes of their care for a minimum period of 4 months after discharge. In the present case, once a patient is discharged from the Detoxification Center, there are no polices and procedures for client follow-up, and due to the lack of trained case managers, there is no additional contact with patients to assess their progress.

Best practices also recommend that case managers be assigned to patients upon discharge to ensure that they have access to all the necessary services and that the services they receive are coordinated. Case managers would also be responsible for client follow-ups and working with patients to promote further recovery. However, the Center does not assign case managers to patients upon their discharge. Clients discharged from the Center meet with treatment counselors who refer them to recovery programs. The program manager for the Center stated that these treatment counselors are not trained social workers and cannot ensure that patients gain access to all the services they may need.

According to the Center's program manger, due to the lack of case managers and effective aftercare treatment plans, there is a high rate of recidivism at the Center.

Recommendation:

That D/DOH establish an effective aftercare program for clients released from the Detoxification Center that includes qualified aftercare case managers.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

Case managers are of paramount importance to assure comprehensive and effective treatment and wrap around services to support the treatment efforts. The stay at the Detox Center, however, is short term. The case managers should be available at the client's major long-term treatment centers or coordinated from and at CID. Certified Addictions Counselors at detox act as the client's case manager and assists the treatment team and the client in appropriate discharge planning.

With regard to the requirement for follow up after discharge, DCMR tit. 29 § 2351.4 specifies that detoxification facilities or programs are exempt.

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

Findings and Recommendations:

PREVENTION PROGRAMS

The mission of APRA's Office of Prevention and Youth Services (OPYS) is to provide effective information and education about the dangers of alcohol, tobacco, and other drugs (ATOD) to District youth, families, and the larger community. To do this, OPYS supports seminars, workshops, training sessions, substance abuse awareness events, and other community outreach programs. OPYS also staffs Project Reachout neighborhood drug prevention centers located in areas of high drug use.

OPYS approaches prevention on three activity levels:

1. **primary prevention**, which focuses on reducing the number of new users, preventing the development of substance abuse-related problems, and strengthening protective factors as a defense against future substance abuse;
2. **secondary prevention**, which emphasizes reducing drug use among ATOD users who are not yet addicted; and
3. **tertiary prevention**, which provides aftercare services for those who have been habitual ATOD users.

OPYS conducts community outreach by sponsoring 10 grants each year. These grants are aimed at community-based providers who carry out neighborhood-oriented drug prevention programs. OPYS also awards a limited number of grants to schools, community-based programs, and agencies that run culturally-sensitive drug prevention programs targeted at high-risk groups, such as Latinos, Asians, senior citizens, and gay/lesbian youth.

12. Lack of funds for public service announcements (PSAs) could jeopardize federal funding for substance abuse and treatment.

OPYS is responsible for maintaining the District's compliance with the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act § 202, 42 U.S.C. § 300X-26 (Supp. #2002) [hereinafter Synar Amendment], a federal law that prohibits the sale and distribution of tobacco to persons under the age of 18. Named after its congressional sponsor Mike Synar, the Synar Amendment requires states to develop laws barring the distribution of tobacco products to minors. The law emphasizes consistent compliance and enforcement, monitoring of retail outlets, and documentation of results. It also requires each state to reduce its violation rate of tobacco sales to minors by 20 percent or less by FY 2002. Federal law stipulates that states failing to comply with the Synar Amendment, as reported in their annual application for federal Substance Abuse Prevention and Treatment Block Grant Allocation, [12] risk losing between 10 and 40 percent of their block grant funds.

The District is currently in compliance with the Synar Amendment. According to the Program Manager for OPYS, consistent monitoring of retail outlets and use of PSAs reinforcing to merchants the unlawfulness of tobacco sales to minors has enabled the

[12] APRA receives federal funding annually through a Substance Abuse Prevention and Treatment Block Grant allocation. This grant is administered by the DHHS.

District to maintain its compliance. She stated, however, that there is no funding in OPYS's current budget for these PSAs. As a result, she fears that the District may not be able to maintain its compliance in the future.

Recommendation:

That D/DOH provide funding for PSAs to continue informing the public about unlawful of tobacco sales to minors.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

Public service announcements are not a requirement of the Synar Amendment. In 1999, the District was not in compliance with the amendment. To rectify this problem, public service announcements were aired. In addition, information dissemination and vendor education was a mechanism to preclude future violations.

Since that time, the District has had two successful compliance checks without public service announcements. The Office of Prevention and Youth Services (OPYS) continues to provide merchant education through information dissemination in English, Spanish and Korean. In addition, a special effort targeting Korean merchants through an Asian Pacific Islander grant is being implemented. Consequently, the lack of funds for public service announcements has not and will not jeopardize federal funding for substance abuse prevention and treatment. Therefore, it is not necessary for DOH to provide funding to support public service announcements about unlawful tobacco sales to minors.

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

13. <u>OPYS does not have performance measures for determining whether prevention programs successfully reduce the number of substance abusers.</u>

OPYS currently monitors all prevention programs for compliance with their stated objectives (i.e., number of persons served, community served, etc.). They do not, however, have criteria in place to measure the success or failure of prevention programs' abilities to effectively reduce the number of substance abusers. The program manager for OPYS stated that she has not established performance measures for prevention programs. Consequently, OPYS cannot provide statistics on the effectiveness of current substance abuse prevention programs, and neither APRA nor stakeholders know if these programs provide a cost benefit.

Recommendation:

That the OPYS program manager establish criteria to measure the effectiveness of prevention programs in reducing the number of substance abusers in the District and determine if funding for these programs are providing a cost benefit to District stakeholders.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

APRA has required prevention grantees to evaluate their program outcomes, however, there was not a consistent methodology. Beginning FY03, APRA instituted a requirement mandating that all OPYS-funded prevention programs use an APRA evaluation instrument to collect consistent baseline data at program onset and post-data across all prevention programs. This will allow us to determine program outcomes.

In addition, the Substance Abuse and Mental Health Services Administration, USHHS, will be transitioning from Substance Abuse Prevention and Treatment Block Grants to Performance Partnerships. This will require a common set of performance measures across the country that will give both the Federal Government and State Governments data on services delivery outcomes. These Federal requirements are currently under a public comment period.

At the earliest, the Performance Partnerships will become effective in FY 2004 and will gradually replace the current reporting system. Once these requirements are instituted, the District will be able to determine the effectiveness and cost benefit of its funded substance abuse services.

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

Findings and Recommendations:

MEDICAID REIMBURSEMENT

Serving as the Single State Agency, APRA has a responsibility to identify all sources of revenue that will support the District's substance abuse treatment and prevention services. This includes billing Medicaid for covered services, billing the Temporary Assistance for Needy Families (TANF)[13] program, and billing and collecting payments from clients who have the ability to pay.

APRA's Patient-Billing Department has four employees. These employees conduct Medicaid reimbursement billing for three APRA facilities, TANF certification and reimbursement, and patient billing and fee collections at APRA-operated Methadone clinics.

The team found the Patient-Billing Department employees to be extremely dedicated. They should be commended for performing duties outside of their position descriptions. They provide counseling to clients and pay special attention to female clients with children. They work overtime hours to ensure that women remain certified so that their families' benefits will remain intact as they attempt to solve their substance abuse problems.

14. APRA is not effectively determining Medicaid eligibility for clients seeking services.

APRA's patient-billing procedures state that, "upon admission to any APRA program, patients are to be interviewed to determine his/her financial status." APRA's website also states that "newly admitted clients who do not have Medicaid but appear to be eligible are to be put on a self-pay status and referred to the nearest D.C. Office of Income Maintenance."[14] Additionally, the website states that "APRA staff will assist clients in the Medicaid application process."

Although previously determined by the Council that many APRA patients are eligible for Medicaid,[15] the team found that Medicaid eligibility reviews are not routinely conducted during the client intake and assessment process. Clients are required to complete a personal financial data form; however, because intake and assessment employees do not routinely review this form to determine clients' Medicaid eligibility, clients are not referred to the Income Maintenance Administration for certification. APRA's failure to assess clients Medicaid eligibility and provide proper assistance in the application process is resulting in the loss of Medicaid dollars, which could be used to treat additional residents needing substance abuse treatment services.

[13] Federal and local welfare funds provided through the Temporary Assistance for Needy Families (TANF) program offer cash benefits and a wide range of services to help in the transition from welfare to work, improve educational levels, and aid in the achievement of self-sufficiency. TANF reimburses APRA for providing substance abuse treatment services to eligible TANF clients.

[14] In order to qualify for Medicaid a patient must complete an application at the D.C. Office of Income Maintenance.

[15] Choice in Drug Treatment Act of 2000, § 2, D.C. Code § 7-3001 (c) (2001).

Recommendation:

That D/DOH ensure Medicaid eligibility reviews are conducted and that clients who appear to qualify for Medicaid are referred to IMA in accordance with APRA policies and procedures.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

Implementation of the Drug Treatment of Choice Act on October 1, 2002 resulted in an expansion of APRA's central intake services. Staff was re-deployed to the Entitlements section. 80% of the current patients in treatment have been interviewed to determine not only Medicaid eligibility but eligibility for other entitlements and were assessed on a sliding fee scale for self pay responsibility. All new patients from 10/1/02 went through a detailed financial assessment for self pay responsibility. APRA has a direct link to IMA, through the Entitlement Verification Services (EVS). Central Intake has access to the EVS to verify Medicaid numbers at the time of intake. Staff has been trained by IMA to assist clients in completing Medicaid applications. APRA is currently recruiting for a specialist to manage this function.

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

15. <u>APRA does not use internal controls for its Medicaid billing process</u>.

APRA submitted a total of $9950 in claims to Medicaid for reimbursement through July of FY 2002. Of this amount, APRA has only been reimbursed $925, which equates to 9% of the total claims submitted. The team found that Medicaid denied most of these claims for one of two reasons:

1. the claim was previously submitted;[16] or
2. the recipient was not eligible on the date of service.

Due to the lack of effective review of denied claims and internal controls, APRA cannot ensure that claims are denied for valid reasons or that fraudulent billing does not occur. To ensure that APRA receives all eligible Medicaid funds, APRA's Medicaid billing process must include policies and procedures for investigating claims that have been denied. APRA should also employ internal controls to determine if contractors providing services to APRA clients, for which they have already been reimbursed by APRA, bill Medicaid for these services to reimburse APRA. Through the implementation of internal control policies and procedures, APRA is more likely to be reimbursed for eligible Medicaid services, thereby reducing its loss of funds needed for additional services and clients.

[16] The statement on the denial of services stated that claims for reimbursement had been previously submitted. These reports did not state if these claims had been paid or who had submitted these claims.

The manager overseeing the Medicaid billing process could not give a reason for this large number of denials. She stated that APRA has no policies or procedures for investigating denied claims.

Recommendations:

a. That D/DOH develop written internal control policies and procedures for the Medicaid billing process.

Agree _____X_____ Disagree _____

b. That D/DOH develop policies and procedures for investigating denied claims.

Agree _____X_____ Disagree _____

APRA's Response to IG's Recommendation, as Received:

Policies and procedures for investigating denied claims are under development.

16. APRA programs and facilities do not have Medicaid provider numbers as required.

To participate in the D.C. Medicaid Program, each substance abuse treatment program or facility must complete an application and be approved by the MAA.[17] After approval, the facility or program is assigned a provider number with which they submit claims to Medicaid for reimbursement.

The team found that not all APRA-run facilities have a Medicaid provider number. The team also found that APRA did not have provider numbers for contractors who provide treatment to APRA patients.

According to the program manager of the Patient-Billing Department, applications have not been filed with MAA for all APRA programs. She further stated that she was unaware that contractors should apply for their own Medicaid provider numbers and that APRA could then bill Medicaid for services provided by these contractors.

The IG sent a Management Alert Report (MAR 03-I-001, Appendix 10) to D/DOH citing these problems and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 11. *The team will follow-up on DOH's progress in correcting the problems cited in the MAR.*

[17] The Medical Assistance Administration (MAA) is responsible for administering Titles XIX and XXI of the Social Security Act, which includes reimbursement to service providers under the Medicaid program.

APRA's Response to IG's Recommendation, as Received:

APRA has submitted an application for provider numbers for all APRA operated methadone programs, however, application has not been made for non-methadone facilities because there are no provision to be reimbursed for services to clients other than for physical examinations, which are not provided to non-medicated clients. MAA is awaiting submission and approval of a Medicaid State Plan Amendment for reimbursement under a substance abuse rehabilitation option before approving any new application for provider numbers. At that time, substance abuse providers if qualified can bill for comprehensive services.

17. APRA does not have the software and training required to submit Medicaid claims to the new MAA contractor.

MAA is responsible for providing reimbursement to service providers submitting claims under the Medicaid program. MAA uses a contractor to track, process, and adjudicate Medicaid claims. Any facility or program submitting a claim for reimbursement must submit their claims to the contractor. Effective July 1, 2002, a new contractor assumed this role. The contractor is to provide software and training to providers who submit claims for Medicaid reimbursement.

However, although the program manager for the Patient-Billing Department requested this software and training from both the contractor and MAA more than 3 months ago, APRA has not been provided with the software or training. As a result, APRA has not been able to submit claims for Medicaid reimbursement since July 2002. This delay in reimbursement caused a backlog in the billing process and is delaying the receipt of reimbursement funds that could be used for treatment services.

Recommendation:

That D/DOH take the necessary steps to obtain the needed software and training from the contractor so that APRA can submit claims for Medicaid reimbursement to MAA.

Agree _____X_____ Disagree _____

APRA's Response to IG's Recommendation, as Received:

APRA has begun the process to obtain the needed software and training for ACS. New Medicaid applications were completed and submitted to the Medicaid office. Once the applications have been approved and new provider numbers are issued, new software will be installed and training will be provided. DOH/APRA is in the process of submitting a State plan amendment for a Substance Abuse Rehabilitation Option. Mercer Associates has been contracted by MAA/APRA/DOH to assist in authoring state plan amendment and provide technical assistance and training to APRA staff in MAA regulation and billing.

Findings and Recommendations:

PATIENT BILLING

18. APRA does not have a system in place to recover the cost of treatment services from patients who are financially able to pay for services.

APRA's public website states, "By District Law, APRA must collect fees in return for services." DCMR tit. 22, § 3026.1 allows for the collection of fees from patients for the costs of:

- admission;
- comprehensive evaluations;
- individual outpatient treatments;
- outpatient group treatments;
- methadone maintenance treatment services;
- laboratory testing;
- inpatient care;
- residential short-term stays;
- residential long-term stays;
- residential stays for pregnant women and children;
- transitional housing;
- vocational aftercare programs; and
- community-based after-care programs.

DCMR tit. 22, § 3026.2 outlines the rates for these services, as well as providing a sliding fee scale for those patients not covered by Medicaid, Medicare, or any other third party insurance, and whose gross family incomes fall within certain ranges.

According to APRA client billing procedures, upon admission to any APRA program, clients are to be interviewed to determine his/her financial status. If a client is not eligible for Medicare, Medicaid, or Temporary Assistance for Needy Families (TANF), his/her financial status is classified as "self-pay," and the sliding scale will determine the appropriate fees.

Currently, the only fees APRA assesses and collects from clients are fees for methadone treatment services. Although the team found that 1,078 clients receiving services from APRA during 2001 were employed at the time of admission, none were assessed any other fees.

The patient billing manager stated APRA does not conduct patient billing for services other than methadone treatment because APRA:

- does not have a mechanism to verify a patient's financial status in order to apply the sliding scale, and therefore employees have been instructed to collect fees only for methadone treatment programs;
- does not have access to patient's tax or social security records in order to identify sources of income;
- does not have written policies or procedures to conduct patient billing and

collection for services other than methadone treatment; and

- does not have the staff, training, or software to conduct effective patient billing.

By failing to have an effective patient billing system, APRA is not fulfilling its role as the Single State Agency in identifying all possible sources of revenue. Consequently, patients may be receiving services at no cost for which they might be able to pay.

Recommendation:

That D/DOH establish a patient billing system and begin assessing and collecting fees as required by municipal regulations.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

There is a billing system with policies and procedures; however, the problem is a lack of staff to screen patients and collect payments from all sites. There are currently only three billing clerks and nine sites.

OIG Response: **APRA management needs to request the appropriate number of staff to address the conditions noted.**

19. APRA's billing and collection clerks do not correctly assess and collect fees for persons classified as "self-pay" who receive methadone treatments.

APRA's patient and billing procedures state that patients classified as "self-pay" are billed for services in accordance with the sliding scale enumerated by 22 DCMR § 3026.1. According to 22 DCMR § 3026.1, fees for methadone maintenance treatment services range between $5 and $15 per day, or $35 to $105 per week, dependent upon a patient's income level. Section 3026.2 states that these fees are not billed to Medicaid or Medicare patients.

APRA's two billing and collection clerks collect these methadone treatment fees for three APRA run treatment facilities on a weekly basis.[18] APRA's billing and collection records indicate that, as of August 12, 2002, $86,925.93 has been collected for FY 2002.

APRA does not have written policies or procedures which address charging fees pursuant to 22 DCMR § 3026.1. APRA has not collected fees for methadone treatment services in accordance with 22 DCMR § 3026.1. The team found that:

[18] These facilities are APRA's Minimal Service Clinic, Women's Services, and Model Treatment Program.

1. Patients are billed a flat $1 per treatment or $7 per week regardless of the patient's income level or Medicaid status. Only TANF patients are granted an automatic waiver for payment of this fee.
2. Patients are required to pay $7 per week to remain in the program regardless of whether they miss any treatments. Credits are granted only if the patient is hospitalized.
3. Some patients have outstanding balances, many extending over one year.

According to the billing clerks, APRA management instructed them to collect $7 per week because this is the amount that has historically been collected. Billing clerks were unaware that Medicaid and Medicare patients are not to be billed, and have been collecting from all clients regardless of their Medicaid or Medicare status in violation of District regulations. Billing clerks also stated that there are no policies for collecting fees from clients who are in arrears. Program managers at the treatment facilities can and do waive these fees at their discretion.

Recommendations:

a. That D/DOH establish policies and procedures directing billing clerks to assess methadone treatment fees in accordance with 22 DCMR § 3026.1.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

Policies and procedures are already in effect, which direct billing clerks to assess fees in accordance with said regulations.

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

b. That D/DOH establish policies and procedures for the collection of fees from patients with outstanding balances.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

There are established polices and procedures for the collection of fees from patients with outstanding balances

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

c. That D/DOH direct an audit of the methadone treatment collection process to ascertain if Medicaid or Medicare clients have paid for these services, and establish a mechanism to refund any fees paid by Medicare or Medicaid clients.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

Currently Medicaid does not reimburse for methadone or other substance abuse treatment services other than complete physical examinations and follow up physical examinations. Therefore, APRA can charge for other services provided. The District of Columbia is currently preparing a State Plan Amendment to establish fees under a substance abuse Medicaid Rehab Option, which may not become effective until June 2003.

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

20. Internal controls are inadequate for patient billing and fee collection for both APRA-run facilities and contracted facilities.

a. APRA's Patient-Billing Department is not adhering to policies and procedures.

APRA's patient billing and fee collection procedures[19] states that:

1. APRA billing and collection staff will be responsible for actual collections of fees for services rendered to APRA patients.[20]
2. Each program manager is to be issued a book(s) of sequentially-numbered receipts from the APRA Office of Billing and Collections.
3. Upon payment, the original receipt shall be given to the client, and a copy of the receipt shall remain in the receipt book.
4. All receipts shall be maintained on file in the Office of Billing and Collections.
5. Payments in the form of a money order will be accepted. No cash or checks are to be accepted under any circumstances.
6. At the conclusion of each collection session, funds will be totaled and copies of the program center Client Payment Report shall be made and distributed to the program manager and the Service Center File, and the original retained by the Office of Billing and Collections.

[19] *Addiction Prevention and Recovery Administration* – Notice Series. Subject: *Patient Billing Procedure, Fee Collectors Procedure*, January 24, 2002.

[20] This procedure appears to conflict with the requirements of contractors providing services to APRA clients. Providers' contracts state that the contractor, not APRA, is responsible for patient billing fee collection.

7. Totals for each day are to be entered in the Patient Methadone Collection Fee Log Book.
8. The Office of Billing and Collection shall collate all receipts into one package with a deposit slip and SOAR Revenue Receipt and hand deliver the collections to the D.C. Department of Treasury.
9. The D.C. Department of Treasury shall verify the dollar amount of the deposit slip and SOAR Revenue Report.
10. All receipts and transmittals shall be maintained on file in the Office of Billing and Collections.

The team found that:

- APRA's patient billing and collection office is only conducting collections at APRA-run facilities.
- Contractors collecting fees from APRA clients are not remitting these fees to APRA on a weekly basis.
- Contractors collecting fees from APRA clients do not send copies of the receipts for payments collected at the same time they remit the funds to APRA. These receipts often arrived 5 months after the funds have been remitted to APRA.
- Contractors do not send the actual money orders for fees collected, but instead send a single check drawn on their own bank accounts.
- The D.C. Treasurer does not consistently verify the dollar amount on the Deposit slip and SOAR Revenue Report by failing to send a copy of the signed SOAR Revenue report to APRA verifying when the deposits have been posted.
- Billing and collection clerks do not have access to SOAR to verify these deposits.

The team found that there are no internal controls to ensure APRA's adherence to its patient billing policies and procedures. Additionally, no audits of patient billing and collection processes conducted by contractors are not performed. APRA's failure to directly collect fees from patients at all facilities or to conduct audits of contractors leaves open the possibility that funds due to APRA are not collected or remitted by contractors.

Additionally, without written verification from the D.C. Treasurer's office reconciling the deposit slips with amounts posted in SOAR, APRA billing clerks cannot ensure that the funds are being deposited into the correct accounts.

Recommendation:

That D/DOH ensure that patient billing and fee collection and reconciliation procedures are being adhered to, and direct an audit of contractors to ensure that all fees collected are accounted for.

Agree _____X_____ Disagree _____

APRA's Response to IG's Recommendation, as Received:

- Contractors do remit their fees to APRA on a weekly basis with exception of Whitman Walker who submits their fees once a month.
- Contractors do not send copies of receipts for payments, but they do send a printout of patient's names and payments received. APRA billing clerks determine outstanding balances if any. These printouts are received weekly from contractors with the exception of Whitman Walker, which sends their print out on a monthly basis.
- All Contractors with the exception of Whitman Walker submit the actual money orders submitted by clients to APRA billing clerks, with one exception, Whitman Walker does submit a single check which corresponds with the balances submitted on their print out.
- The DC Treasurer consistently verifies the dollar amount on the Deposit Slip and Soar Revenue Report by submitting a receipt to the billing clerk each week for the previous week's deposit. If discrepancies are found the billing office is notified immediately.
- Billing and collection clerks do have access to these receipts, since they are the ones who actually pick up the receipts from the DC Treasurer .

We agree, however, that APRA needs to conduct an audit of both contractors and APRA run programs on a regular basis.

b. Contractors providing methadone treatment to District residents are establishing their own fees for patient billing.

Three substance abuse treatment facilities[21] under contract with APRA provide methadone treatments to District residents. For patients categorized as "self-pay," these facilities are required to collect payment and forward collected fees to APRA's Patient-Billing Department. According to the providers' contracts, "self-pay fees shall be consistent with those most recently published in the D.C. Register, including reduced fees for qualified clients as established in the sliding fee scale."

[21] Umoja, Whitman-Walker Clinic, and United Planning Organization/Care Treatment Center (UPO/CTC).

The team found the providers established their own patient fee assessment schedule. Records indicated that fees collected and remitted to APRA do not correspond to the sliding scale figures outlined in the DCMR. Fees ranged from $3 to $20 per session. In total as of August 12, 2002, these facilities have forwarded $117,007.35 for methadone treatment fees to APRA for FY 2002.

APRA's billing and collection clerks stated that program managers at each of these contracted treatment facilities establish their own fee schedule, although there are no APRA policies or procedures or contractual provisions which permit this. Billing clerks further stated they do not provide policies and procedures to contractors outlining the fee amounts to be collected. Their sole responsibility is to process the funds received from the contractors and forward these payments to the D.C. Treasurer's office.

Consequently, APRA patients are being billed for services at amounts higher than allowed under the DCMR, and Medicaid and Medicare patients may be paying for services for which they should not be charged.

Recommendation:

That D/DOH establish policies and procedures directing contractors to assess methadone treatment fees in accordance with 22 DCMR § 3026.1.

Agree _____ Disagree ____X____

APRA's Response to IG's Recommendation, as Received:

There are only two, not three, contract methadone treatment programs and they are Umoja and UPO. Whitman Walker clinic is not a methadone treatment program.

Providers did not establish their own patient fee assessment schedule. The fee schedule was determined by previous APRA administrations. It was determined that the sliding fee scale should be modified to reduce the amount collected; however, it was never re-published.

OIG Response: **Action planned and taken by APRA should adequately address the conditions noted.**

APPENDICES

APPENDICES

Appendix 1:	List of Findings and Recommendations
Appendix 2:	Listing of APRA Facilities and Programs
Appendix 3:	Rankings of State Funding for Tobacco Prevention
Appendix 4:	Statement of Reports and Deliverables
Appendix 5:	Mayor's Customer Service Standards for Telephone
Appendix 6:	Management Alert Report (MAR) 02-I-006 to DOH Interim Director James A. Buford
Appendix 7:	DOH Response to MAR 02-I-006
Appendix 8:	Management Alert Report (MAR) 02-I-008 to DOH Interim Director James A. Buford
Appendix 9:	DOH Response to MAR 02-I-008
Appendix 10:	Management Alert Report (MAR) 03-I-001 to DOH Interim Director James A. Buford
Appendix 11:	DOH Response to MAR 03-I-001

APPENDIX 1

CERTIFICATION PROCESS

1. **Facilities providing substance abuse treatment are operate without certification in violation of District law.**

   Recommendation:

   Due to inadequate inspection staffing levels, facilities providing substance abuse treatment are operating without certification in violation of District law.

2. **APRA does not impose civil fines or penalties for substance abuse treatment facilities or programs that fail to apply for certification.**

   Recommendation:

   That the Chief Officer for Certification and Regulation draft a schedule of fines and penalties to be imposed on any facilities that operates prior to submitting a completed application for certification.

3. **APRA does not impose a fee upon treatment facilities and programs seeking certification.**

   Recommendation:

   That the Chief Officer for Certification and Regulation establish a fee schedule for the inspection and certification of substance abuse treatment facilities and programs and begin collection of these fees.

4. **APRA does not employ enforcement procedures as prescribed by District regulations.**

   Recommendations:

   a. That D/DOH establish policies and procedures to ensure the proper enforcement of administrative actions set forth in 29 DCMR Chapter 23.

   b. That D/DOH establish schedule of fines so that infractions may be issued for non-compliance with standards set forth in 29 DCMR Chapter 23.

   c. That D/DOH seek funding for additional staff to provide technical assistance to help facilities become compliant with the regulations.

5. **APRA does not possess the ability to identify all substance abuse treatment facilities and programs operating in the District of Columbia.**

Recommendation:

That APRA develop a means of identifying all substance abuse treatment facilities and programs operating in the District of Columbia.

INTAKE, ASSESSMENT AND REFERRAL SERVICES

6. **Due to ineffective client and treatment program tracking and reporting, APRA cannot provide accurate statistics regarding the effectiveness of substance abuse treatment facilities and programs.**

a. APRA's Central Communication Center does not have the technology to produce an adequate patient tracking system.

b. Not all contracted treatment programs and facilities provide the monthly activity reports mandated by CID.

Recommendations:

a. That D/DOH install an effective management information system that will track patients, services and success rates within the APRA program.

b. That D/DOH ensure that contracted programs and facilities comply with the terms of their contract to provide monthly statistical and narrative reports.

7. **APRA does not have a centralized filing system for client medical and treatment records.**

Recommendations:

a. That D/DOH implement an effective centralized patient medical and treatment record system that is complete.

b. That D/DOH establish standardized medical and treatment forms to be used for all APRA clients.

c. That D/DOH provide policies and procedures establishing guidelines for maintenance of client medical and treatment records.

8. **The CID telephone system is inadequate to meet the needs of District residents requiring critically needed services and stakeholders.**

The IG sent a Management Alert Report (MAR 02-I-006 Appendix 6) to D/DOH citing these problems and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 7. *The inspection team will follow-up on DOH's progress in correcting the problems cited in the MAR.*

DETOXIFICATION SERVICES

9. **APRA's Detoxification Center does not have the capacity to handle the large volume of District substance abusers requiring treatment.**

Recommendation:

That D/DOH seek additional funding to increase the number of treatment slots available at the Detoxification Center in order to accommodate the current demand for its services.

10. **Physical conditions at the Detoxification Center pose health and safety hazards to patients and employees.**

The IG sent a Management Alert Report (MAR 02-I-008 Appendix 8) to D/DOH citing these problems and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 9. *The inspection team will follow-up on DOH's progress in correcting the problems cited in the MAR.*

11. **The Detoxification Center does not maintain an adequate staff to assist clients who have been discharged after successfully completing their detoxification programs.**

Recommendation:

That D/DOH establish an effective aftercare program for clients released from the Detoxification Center that includes qualified aftercare case managers.

PREVENTION PROGRAMS

12. **Lack of funds for public service announcements could jeopardize federal funding for substance abuse and treatment.**

Recommendation:

That D/DOH provide funding for public service announcements to continue informing the public about unlawful of tobacco sales to minors.

13. **OPYS does not have performance measures for determining whether prevention programs successfully reduce the number of substance abusers.**

Recommendation:

That the OPYS program manager establish criteria to measure the effectiveness of prevention programs in reducing the number of substance abusers in the District and determine if funding for these programs are providing a cost benefit to District stakeholders.

MEDICAID REIMBURSEMENT

14. **APRA is not effectively determining Medicaid eligibility for clients seeking services.**

Recommendation:

That D/DOH ensure Medicaid eligibility reviews are conducted and that clients who appear to qualify for Medicaid are referred to IMA in accordance with APRA policies and procedures.

15. **APRA does not use internal controls for its Medicaid billing process.**

Recommendations:

a. That D/DOH develop written internal control policies and procedures for the Medicaid billing process.

b. That D/DOH develop policies and procedures for investigating denied claims.

16. **APRA programs and facilities do not have Medicaid provider numbers as required.**

The IG sent a Management Alert Report (MAR 03-I-001 Appendix 10) to D/DOH citing these problems and asking to be notified of corrective actions taken. A copy of D/DOH's response to the MAR is at Appendix 11. *The inspection team will follow-up on DOH's progress in correcting the problems cited in the MAR.*

17. **APRA does not have the software and training required to submit Medicaid claims to the new MAA contractor.**

Recommendation:

That D/DOH take the necessary steps to obtain the needed software and training for ACS so that APRA can submit claims for Medicaid reimbursement to MAA.

PATIENT BILLING

18. **APRA does not have a system in place to recover the cost of treatment services from patients who are financially able to pay for services.**

Recommendation:

That D/DOH establish a patient billing system and begin assessing and collecting fees as required by municipal regulations.

19. **APRA's billing and collection clerks do not correctly assess abd collect fees for persons classified as "self-pay" who receive methadone treatments.**

Recommendations:

a. That D/DOH establish policies and procedures directing billing clerks to assess methadone treatment fees in accordance with 22 DCMR § 3026.

b. That D/DOH establish policies and procedures for the collection of fees from patients with outstanding balances.

c. That D/DOH direct an audit of the methadone treatment collection process to ascertain if Medicaid or Medicare clients have paid for these services and establish a mechanism to refund any fees paid by Medicare or Medicaid clients.

20. **Internal controls are inadequate for patient billing and fee collection for both APRA-run facilities and contracted facilities.**

a. ***APRA's patient billing department is not adhering to policies and procedures.***

Recommendation:

That D/DOH ensure that patient billing and fee collection and reconciliation procedures are being adhered to, and direct an audit of contractors to ensure that all fees collected are accounted for.

b. ***Contractors providing methadone treatment to District residents are establishing their own fees for patient billing.***

Recommendations:

a. That D/DOH establish policies and procedures directing contractors to assess methadone treatment fees in accordance with 22 DCMR § 3026.

b. That D/DOH direct an audit of the methadone treatment fees charged by contractors to ascertain if Medicaid or Medicare clients have erroneously paid for services, and establish a mechanism to refund these fees.

APPENDIX 2

APRA DIRECTLY OPERATED PROGRAMS

NAME	WORK PHONE
ADAMS MILLS ABSTINENCE CENTER 1808 Adams Mills Rd., N.W. Washington, DC 20009	
Larry Ricks, Program Manager	202/673-6618
Dalsy Lebron, Supervisory Counselor	202/673-6618
SHAW ABSTINENCE PROGRAM 33 N Street, NE Washington, DC 20002	
Chele Robinson, Program Manager	202/535-1851
AFTERCARE PROGRAM 2146 24TH Place St., NE Washington, DC 20018	
Deborah Ford, RN, Program Manager	202/576-7334
MODEL TREATMENT PROGRAM 1300 First Street, N.E. – 2nd Floor Washington, DC 20002	
Tyrone Patterson, Program Manager	202/772-0664
Mavis Marks, MD - Medical Officer	202/727-0664
Valentine Onwuche, Supervisory Counselor	202/727-0664
Constance Vega, LPN - Acting, Supervisory Nurse	202/727-0664
WOMEN SERVICES 1905 E Street, S.E. Bldg. 13 Washington, DC 20003	
Guity Amirfazli, MD - Medical Officer	202/698-3780
Deloris Champion - Supervisory Counselor	202/698-3773
Gwendolyn Wills, RN - Supervisory Nurse	202/698-3777
CENTRAL INTAKE DIVISION 1300 First Street, N.E. – 2nd Floor Washington, DC 20002	
Fred Chambers, Program Manager	202/727-0668
Elida Yngente, MD - Medical Officer	202/727-0668
Jose Francia - Medical Officer	202/727-0668
DETOX CENTER 1905 E Street, S.E. Bldg. 12 Washington, DC 20003	
Jessie Bally, MD - Medical Officer	202/727-5163
Helen Harrington, Supervisory Nurse	202/727-5163
Grace Jones, Supervisory Nurse	202/727-5163
Pearline Freeman, Supervisory Nurse	202/727-5163
Darelrene Davenport, Supervisory Counselor	202/727-5163

APRA CONTRACTED PROGRAMS

4/30/01

Provider Name	Address	Provider Point of Contact (POC)	APRA Single Point of Contact (SPOC)
Identity	11 Dupont Circle, N.W. Washington, D.C. 20008	Candace Kattar (202) 797-8810	Jeanette Fortune (202) 727-9074
Institute for Behavioral Change and Research	34 O Street, N.W. Washington, D.C. 20001	Howard Mabry (202) 483-1671	Robert Flowers (202) 442-9148
J & E Associates, Inc.	1100 Wayne Avenue, Suite 1200 Silver Spring, MD 20910	Antionette Foster (301) 495-0400	Clarence Stanback (202) 442-9214
La Clinica Del Pueblo	1470 Irving Street, N.W. Washington, D.C. 20010	Gloria Eliot (202) 462-4788	Adrian Dominguez (202) 442-5874
Latin American Youth Center	1419 Columbia Road, N.W. Washington, D.C. 20009	Jose Carlos Vera (202) 483-1140	Robert Flowers (202) 442-9148
Lydia's House	4101 MLK Avenue, S.W. Washington, D.C. 20032	S. Patrice Sheppard (202) 563-7629	Jeanette Fortune (202) 727-9074
Mary's Center for Maternal & Health Care	2333 Ontario Road, N.W. Washington, D.C. 20009	Monica Villarealta (202) 483-8196	Adrian Dominguez (202) 442-5874
McFarland & Associates	2901 Druid Park Drive Baltimore, MD	Edward Morgan (301) 589-0780	Jeanette Fortune (202) 727-9074
Multicultural Career Intern	3145 Hyatt Place, N.W. Washington, D.C. 20005	Robert Winer (202) 673-7314	Jeanette Fortune (202) 727-9074
Neighbors Consejo	1624 Lamont Street, N.W. Washington, D.C. 20010	Najiya Shana (202) 234-6855	Adrian Dominguez (202) 442-5874
Nurture for Life RAP, Inc./SCSN	1949 4th Street, N.E. Washington, D.C. 20002	Ron Clark (202) 462-7500	Colevia Carter (202) 442-9212
OMV Medical	6940 Carroll Avenue Takoma Park, MD	Dr. Denise Bailey (301) 270-9212	Helen Jones (202) 442-9158
Office of Latino Affairs	2000 14th Street, N.W. Washington, D.C. 20009	Dolly Cruz (202) 671-2825	Adrian Dominguez (202) 442-5874
Office of Latino Services	1734 14th Street, N.W. Washington, D.C. 20009	Alex Merati (202) 797-7000	Adrian Dominguez (202) 442-5874

4/30/01

Provider Name	Address	Provider Point of Contact (POC)	APRA Single Point of Contact (SPOC)
Providence Hospital (UMOJA) AFRICAN NAME	1150 Varnum Street, N.E. Washington, D.C. 20003	Dr. Suzanne McNicholas (202) 269-7131	Helen Jones (202) 442-9158
Psychiatric Institute of Washington (Alcohol Detoxification)	4228 Wisconsin Avenue, N.W. Washington, D.C. 20016	Kimberly Thomas (202) 885-5682	Clarence Stanback (202) 442-9214
Psychiatric Institute of Washington (Lambda Ctr.)	4228 Wisconsin Avenue, N.W. Washington, D.C. 20016	Randy Pumphrey (202) 885-5682	Kevin Shipman (202) 442-9216
RAP, Inc.	1949 4th Street, N.E. Washington, D.C. 20002	Kwame Roberts (202) 462-7500	Helen Jones (202) 442-9148
RAP, Inc. (SIG)	1949 4th Street, N.E. Washington, D.C. 20002	Don Freeman (202) 462-7500	Robert Flowers (202) 442-9148
RISE, Inc.	25 Quincy Place, N.E. Washington, D.C.	Howard Newell (202) 832-0492	Jeanelle Fortune (202) 727-9074
Salomon Zelaya Rehabilitation Center	1345 Newton Street, N.W. Washington, D.C. 20010	Pablo Sanchez (202) 745-7719	Adrian Dominguez (202) 442-5874
Salvation Army Harbor Light Center (Beacon Program)	2100 New York Avenue, N.E. Washington, D.C. 20002	Major Douglass Browning (202) 269-6333	Clarence Stanback (202) 442-9214
Trifax Corporation	4121 Minnesota Avenue, N.E. Washington, D.C. 20019	Thelma Noble (202) 388-6000	Clarence Stanback (202) 442-9214
United Planning Organization	410 M Street, S.W. Washington, D.C. 20024	Benjamin Jennings (202) 289-9100	Donna Milliner (202) 442-9162
Unity Healthcare, Inc. (Project Orion)	3020 14th Street, N.W. Washington, D.C. 20009	Michelle Madison (202) 518-6416	Kevin Shipman (202) 442-9216
Vanguard Services Unlimited (Demeter NW)	301 Eye Street, N.W. Washington, D.C. 20008	Marlyn McCants (202) 898-1092	Colevia Carter (202) 442-9212
Vanguard Services Unlimited (Youth Residential)	506 North Pollard Street Arlington, VA 22203	Debra Voltz (703) 841-0660	Helen Jones (202) 442-9158
Whitman Walker Clinic	1407 S Street, N.W. Washington, D.C. 20009	Amy Bullock (202) 939-7656	Kevin Shipman (202) 442-9216

Provider Name	Address	Provider Point of Contact (POC)	APRA Single Point of Contact (SPOC)
WVSA Arts Connection	1100 16th Street, N.W. Washington, D.C. 20036	Desiree Smith (202) 296-9100	Robert Flowers (202) 442-9148
WAVE	526 School Street, S.W. Washington, D.C. 20024	J. Tyler (202) 484-0103	John Murray (202) 727-9074

APPENDIX 3

Rankings of State Funding for Tobacco Prevention

State	Current Annual Tobacco Prevention Funding (FY2003)	CDC's Annual Funding Recommendation ($millions)	Percent of CDC's Minimum Recommendation	Source of Funding	Current Rank	Jan 02 Report Rank
Maine	$15.17 million	11.19 – 25.35	Within CDC Guidelines	MSA	1	3
Minnesota	$36.3 million	28.62 – 74.01	Within CDC Guidelines	State Settlement	2	5
Mississippi	$20 million	18.79 – 46.80	Within CDC Guidelines	State Settlement	3	4
Maryland	$30 million	30.30 – 78.60	99.0%	MSA	4	12
Arkansas	$17.63 million	17.91 – 46.45	98.5%	MSA	5	7
Indiana	$32.5 million	34.78 – 95.80	93.4%	MSA	6	6
Massachusetts	$31.2 million*	35.24 – 92.76	88.5%	MSA & State Excise Tax	7	1
Washington	$26.24 million	33.34 – 89.38	78.7%	MSA & State Excise Tax	8	18
Pennsylvania	$49.75 million	65.57 – 184.76	75.9%	MSA	9	14
New Jersey	$30 million	45.07 – 121.33	66.6%	MSA & State Excise Tax	10	11
Arizona	$18.27 million	27.79 – 71.10	65.7%	State Excise Tax	11	2
Vermont	$5.13 million	7.91 – 15.94	64.9%	MSA	12	10
Alaska	$5 million	8.09 – 16.51	61.8%	MSA	13	28
Colorado	$15 million	24.55 – 63.26	61.1%	MSA	14	19
Delaware	$5 million	8.63 – 18.46	57.9%	MSA	15	13
Virginia	$22.2 million	38.87 – 106.85	57.1%	MSA	16	21
Wisconsin	$15.3 million	31.16 – 82.38	49.1%	MSA	17	20
Florida	$37.48 million	78.38 – 221.26	47.8%	State Settlement	18	29
Hawaii	$4.84 million	10.78 – 23.45	44.9%	MSA	19	27
California	$73.54 million*	165.10 – 442.40	44.5%	State Excise Tax	20	8
Ohio	$27 million	61.74 – 173.68	43.7%	MSA	21	31
New York	$40 million	95.83 – 269.30	43.0%	MSA	22	24
Oregon	$8.75 million	21.13 – 52.84	41.7%	State Excise Tax	23	16
West Virginia	$5.85 million	14.16 – 35.37	41.3%	MSA	24	25
Utah	$6 million	15.23 – 33.38	39.4%	MSA & State Excise Tax	25	26
New Mexico	$5 million	13.71 – 31.95	36.5%	MSA	26	30
Georgia	$15.17 million	42.59 – 114.34	35.6%	MSA	27	22
South Dakota	$2.93 million	8.69 – 18.21	33.7%	MSA	28	34
Rhode Island	$3.3 million	9.89 – 21.91	33.4%	MSA	29	32
Nevada	$4.28 million	13.48 – 32.99	31.7%	MSA	30	33
North Dakota	$2.35 million	8.16 – 16.55	28.8%	MSA	31	35
New Hampshire	$3 million	10.89 – 24.77	27.5%	MSA	32	37
Iowa	$5.08 million	19.35 – 48.71	26.2%	MSA	33	22
Kentucky	$5.5 million*	25.09 – 69.90	21.9%	MSA	34	36
Illinois	$12 million	64.91 – 179.05	18.5%	MSA	35	9
Nebraska	$2 million	13.31 – 31.04	15.0%	MSA	36	17
North Carolina	$6.2 million	42.59 – 118.63	14.6%	MSA	37	51
Wyoming	$900,000	7.38 – 14.40	12.2%	MSA	38	38
Texas	$12.5 million	103.29 – 284.74	12.1%	State Settlement	39	39
Idaho	$1.27 million	11.04 – 24.09	11.5%	MSA	40	40
South Carolina	$2 million	23.91 – 62.01	8.4%	MSA	41	42
Oklahoma	$1.75 million	21.83 – 56.31	8.0%	MSA	42	41

Campaign for Tobacco-Free Kids 7/22/2002

Rankings of State Funding for Tobacco Prevention

State	Current Annual Tobacco Prevention Funding (FY2003)	CDC's Annual Funding Recommendation ($millions)	Percent of CDC's Minimum Recommendation	Source of Funding	Current Rank	Jan 02 Report Rank
Connecticut	$900,000	21.24 – 53.90	4.2%	MSA	43	45
Montana	$380,000	9.36 – 19.68	4.1%	MSA	44	43
Kansas	$500,000	18.05 – 44.69	2.8%	MSA	45	44
Louisiana	$500,000	27.13 – 71.43	1.8%	MSA	46	47
Alabama	$360,000	26.74 – 71.24	1.3%	MSA	47	46
Michigan	$0	54.80 – 154.56	0.0%	MSA	51	51
Missouri	$0	32.77 – 91.36	0.0%	MSA	51	15
Tennessee	$0	32.23 – 89.08	0.0%	MSA	51	51
Washington, DC	$0	7.48 – 14.57	0.0%	MSA	51	51

All funding levels are based on most current allocation of the state's tobacco prevention spending information available.

Master State Settlement Agreement (MSA)

** These states had not yet made spending decisions regarding their tobacco settlement funds at the time of printing; the spending amounts listed represent the most current spending proposal.*

APPENDIX 4

SECTION C

C.10. REPORTS/DELIVERABLES

1. The Contractor shall report unusual incidents by facsimile or telephone to the PO within 24 hours and in writing within 5 days. An unusual incident is an event which affects staff (District employees or Contractor's staff) or clients which is significantly different from the regular routine or established procedures.

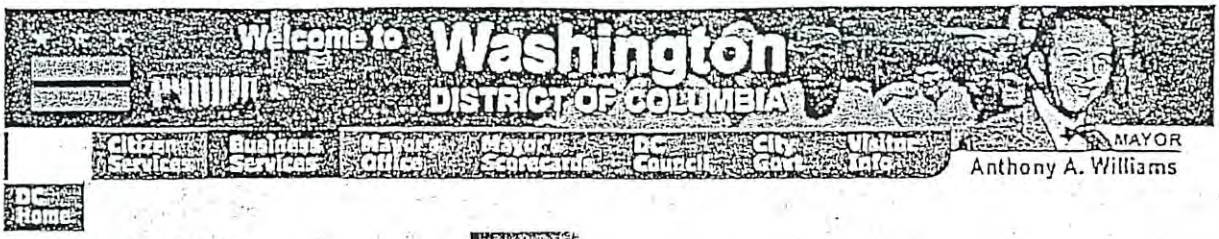
   Examples include but are not limited to: death; injury; unexplained absence of a client from a residence program; physical, sexual, or verbal abuse of a client by staff or other clients; staff negligence; fire, theft, destruction of property, or sudden serious problems in the physical plant; complaints from families or visitors of clients; requests for information from the press, attorneys, or Government officials outside the Department of Human Services; and client behavior requiring attention of staff not usually involved in their care.

2. The Contractor shall submit a monthly activity report to the PO by the 10th day after the end of each month of service regarding its progress towards completion of tasks as delineated in the scope of work. Such reports, which are deliverables, shall consist of both statistical and narrative reports. The statistical report shall be made on a statistical reporting form supplied by the PO. The report shall include the following: (a) total number of persons receiving services during the month; (b) types of services and activities and the number of persons involved in each; (c) total number of admissions to and terminations from service during the month with discharges listed by category; (d) total number of individual and group counseling sessions; (e) average daily census; (f) average length of stay; (g) total number of direct service hours provided by professional staff; (h) racial and ethnic charateristics of patient population; (i) treatment slot utilization rate; (j) number and type of referrals to outside agencies; (k) total number of assessments conducted; (l) total number of individualized treatment plans prepared; (m) total number of direct prevention services provided; (n) total number of payments collected; (o) number of self-pay clients treated; and (p) total number of new admissions of Medicaid eligible clients with subtotals by gender.

   The narrative report shall contain a description of the accomplishments as set forth in the scope of work and shall include the following:

   a. Activities completed during the reporting period;

APPENDIX 5



Mayor's Office

MAYOR'S OFFICE
News Room
Mayor's Cabinet
Mayor's Schedule
Email Outreach
Newsletter

BUDGET AND KEY PRIORITIES
FY 2003 Annual Operating Budget
Customer Service Scorecards
Youth Safety and Juvenile Justice
Safe Passages
Answers, Please!
Clean City
Labor-Management Partnerships

MAYOR'S CORNER
Ask the Mayor
Community Meetings
Issues and Answers
Mayor's Biography
Mayor's Photo
Radio Shows

Grant Funding Alert

Customer Service Standards for Telephone

In order to ensure that the District government is providing the highest level of customer service to each caller, District agencies and offices shall implement the following minimum standards for telephone-based customer service. The overall goal is to staff main and service numbers at all times during business hours.

Agency/department heads are required to comply with these telephone customer service standards to improve the level of customer service within their agency.

- Definition
- District-Wide Customer Service Voicemail Standard
- Receiving and Returning Telephone Calls
- Telephone Etiquette
- Courtesy

Definition

From a customer service perspective, telephone services are operationally defined in four categories: Main numbers, large service numbers, small service numbers and desk numbers.

- Main Numbers - are entry points into the agency/department. Main numbers route calls throughout the organization. (i.e., Department of Health's main number is (202) 442-5999). This number should be staffed at all times during business hours.

- Large Service Numbers - are published numbers that go directly to an agency/department's operational unit that provides a service (i.e., The Office of Fire Code Inspections within the Department of Fire and Emergency Medical Services). This service number should be staffed at all times during business hours.

- Small Service Numbers - are numbers with a constituent volume that does not demand more than one dedicated full-time equivalent employee staffing the number. (i.e., Department of Public Works, Tree Trimming Services). This operation, albeit small, must be structured to provide the same level of high quality service as main and large service number operations. This service number should be staffed at all times during business hours.

  Agencies/Departments have the option to collapse their small service operations into one service number so that it generates sufficient volume to require a full-time equivalent staff person manning the telephone number during business hours.

- **Desk Numbers** - are telephone numbers for agency/department employees. All employees should answer calls professionally and courteously. Desk voicemail should also reflect the same professionalism that would be provided during a direct conversation with a constituent.

Top

District-Wide Customer Service Voicemail Standard

- **Main and Large/Small Service Greetings** - Based upon the requirement that all main numbers are staffed during business hours, the voice mail greeting for all main numbers should be an "after hours" greeting. This greeting should convey the following information:

  - Agency/Department unit
  - Hours of operation
  - What number to dial for immediate assistance
  - Options for caller (e.g., website address, fax number)
  - When calls will be returned (e.g., as soon as possible, when I return)

- **Desk Telephone Standard Greetings** - Every telephone equipped with voice mail should have a standard outgoing greeting that is professional, concise, and conveys relevant and useful information to the caller. Each desk phone should have the following information included within the greeting:

  - Name of employee
  - Title of employee
  - Organizational unit of employee
  - What number to dial for immediate assistance or "0" for operator assistance
  - When calls will be returned (e.g., as soon as possible, when I return)

  Note: The automated greeting option available through the District's voice messaging system does not comply with the standard.

- **Extended Absence Greeting** - Every employee who will be out of the office for more than two business days (annual/sick leave, training, jury duty) should record an extended absence greeting. In addition to the standards in section B, this greeting should outline the expected date of return or all calls should be forwarded to an employee in the office.

- **Returning Phone Calls** - Calls made to all numbers at every level of government should be returned within 48 hours.

- **Voice Mail Boxes** - All employee voice mailboxes should be set-up and ready to accept voice messages. Each voice mailbox should never be full and unable to accept new messages.

Top

Receiving and Returning Telephone Calls

- **Returning Telephone Calls** - Calls made to all numbers at every level of government should be returned within 48 hours of receipt.

- Salutation - State name and agency, and solicit information (i.e., "Thank you for calling agency X this is John Doe. Can I help you?"). At the end of the conversation, thank the person for calling.

- Receiving a Transferred Call

  - All DC employees are expected to take transferred calls from telephone call distribution points (i.e., Mayor's Call Center).
  - The employee should minimize the number of times a caller is transferred to resolve an issue by taking the message and distributing it to the appropriate staff person for resolution. The goal is one transfer per constituent and the transfer should be to another person, not voicemail. If the call is inappropriately transferred to you, take down the caller's information and have the appropriate individual return the telephone call.

- Basic Knowledge

  - All DC employees are expected to have a basic understanding of the primary functions of their agency.
  - The employee should have a basic knowledge of District services (i.e. 311, 911, 727-1000, Answers Please, website address, and main agency numbers).

Top

Telephone Etiquette

In addition to the requirements for salutation, call transfer and basic knowledge (as listed in Section III), each telephone call should be handled with the highest level of customer service by all District employees:

- Answer calls within 3 rings
- Give customers options (i.e., hold, call back, leave a message, try another number)
- Ask to put the caller on hold and wait for the response
- Check back with customer frequently when placed on hold
- Use judgment by handling callers as you would want your call to be handled
- Provide options for resolution
- Facilitate
- Speak as you would like to be spoken to

Top

Courtesy

Each caller to a District agency should be treated with the highest level of customer service by all District employees:

- No speakerphones
- No food or gum while talking with constituent
- No secondary conversations with individuals other than caller while caller is on the phone
- Convey sympathy, professional courtesy and a pleasant attitude
- Provide reference information when transferring calls

- Treat callers as you would want to be treated
- No rudeness
- Do not become confrontational

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APPENDIX 6

LP

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

June 28, 2002

Mr. James A. Buford
Interim Director
Department of Health
825 North Capitol Street, N.E.
Suite 4400
Washington, D.C. 20001

Dear Mr. Buford:

This is a Management Alert Report (02-I-006) to inform you of a significant issue that has come to our attention during our inspection of the Addiction Prevention and Recovery Administration (APRA) of the Department of Health (DOH). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of a District of Columbia government official.

The OIG inspection team has determined that the APRA Central Intake Division, which receives calls from substance abusers seeking treatment and advice, has a dysfunctional telephone system. APRA advertises its phone numbers throughout the city to attract calls from substance abusers who need help. However, problems in the system prevent potential clients and others having business with APRA from getting through to employees for assistance. Administrative offices for other key divisions at the 1300 First Street N.E. location also use this system. The telephone system impairs employees' ability to satisfy two basic requirements of customer service: prompt receipt of and response to contacts regarding advertised services. Consequently, APRA employees cannot efficiently receive and respond to calls from substance abusers or any other District stakeholders, including the OIG.

The Mayor has established standards for telephone-based customer service that require, among other things: staffing of all main, large, and small service numbers during business hours; specific voicemail box and greeting standards; and the return of telephone calls within 48 hours of receipt (see Attachment). The APRA telephone system does not meet all of these standards.

Issues:

The inspection team found that:

- The main number advertised for substance abusers to obtain critical treatment information is often not answered or callers receive a busy signal.

- The main number for APRA administrative services, including the medical officer, the Quality Assurance Staff, treatment counselors, and the Support Staff is often not answered or callers receive a busy signal.
- APRA employees do not have voicemail; therefore callers cannot leave messages and anticipate a response to their calls within 48 hours.

Discussion:

Employees stated that calls to the main number will not roll over to other extensions or to a recorded message. Consequently, if the main number is busy with a caller, subsequent callers simply get a continuous ring or busy signal. In addition, the PBX system switchboard does not indicate to the operator when additional calls are incoming.

The lack of voicemail at the desks of APRA employees prevents compliance with the Mayor's customer service standard requiring that District employees return calls within 48 hours. Employees, many of whom must leave their desks to work in other areas of the city, must rely on written messages left by coworkers who may happen to answer their telephones. Employees cannot respond to written messages until they return to the office, which may be days after a call was received. The impact of employees not having voicemail and having to rely on randomly generated written messages in order to respond to inquiries is that substance abusers who may need urgent treatment or advice cannot leave messages for APRA employees. When this occurs, those in need of treatment who cannot easily reach an APRA employee by phone for assistance are prone to forgo treatment altogether. Other District stakeholders are likewise affected, including case workers and court system employees who often refer substance abusers to APRA for treatment services and must rely on telephone contact in time-sensitive situations.

Recommendation:

That D/DOH take immediate action to ensure that the APRA telephone system will allow employees to respond to all callers promptly and efficiently in line with the Mayor's standards for telephone-based customer service. The system should include voicemail to ensure quick retrieval and return of messages.

Please provide your comments on this report by July 15, 2002. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report to only those personnel who will be directly involved in preparing your response.

Should you have questions or desire a conference prior to preparing your response, please contact [redacted], 202-727-[redacted]

Sincerely,

Charles C. Maddox, Esq.
Inspector General

CCM/LP/jcs

cc: Mr. John A. Koskinen, City Administrator, Office of the City Administrator
Mr. Herbert R. Tillery, Deputy Mayor for Operations

ATTACHMENT

Customer Service Standards for Telephone

Mayor's Office

MAYOR'S OFFICE
News Room
Mayor's Cabinet
Mayor's Schedule
Email Outreach
Newsletter

BUDGET AND KEY PRIORITIES
FY 2003 Proposed Budget
Customer Service Scorecards
Neighborhood Action
Youth Safety and Juvenile Justice
Safe Passages
Answers, Please!
Clean City
Labor-Management Partnerships

MAYOR'S CORNER
Ask the Mayor
Community Meetings
Issues and Answers
Mayor's Biography
Mayor's Photo
Radio Shows

Grant Funding Alert

Customer Service Standards for Telephone

In order to ensure that the District government is providing the highest level of customer service to each caller, District agencies and offices shall implement the following minimum standards for telephone-based customer service. The overall goal is to staff main and service numbers at all times during business hours.

Agency/department heads are required to comply with these telephone customer service standards to improve the level of customer service within their agency.

- Definition
- District-Wide Customer Service Voicemail Standard
- Receiving and Returning Telephone Calls
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- Courtesy

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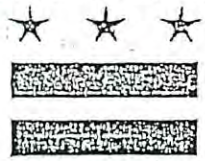
APPENDIX 7

GOVERNMENT OF THE DISTRICT OF COLUMBIA
2002 JUL 16 PM 3:45 DEPARTMENT OF HEALTH



Office of the Director

July 15, 2002

Mr. Charles C. Maddox, Esq.
Inspector General
Office of the Inspector General
717 14th Street, NW
Washington, DC 20005

Dear Mr. Maddox:

This is in response to your Management Alert Report (02-I-006) dated June 28, 2002 regarding inadequacies with the telephone system, which supports the activities of the Central Intake Division and other functional areas within the Addiction Prevention and Recovery Administration (APRA) at the 1300 First Street, NE location. We concur with your findings that the present system inhibits our employees' ability to deliver quality customer service to our clients and other stakeholders. Even though the system has rollover capability, this feature does not function reliably and the analog lines do not support voicemail features. Moreover, the system requires an inordinately high level of repairs and routine maintenance, which translates to frequent service disruptions.

It should be noted that when voicemail was first introduced to the Department of Health, the agency (APRA) made a policy decision to avoid voicemail in patient care areas, thus promoting an immediate human response rather than an artificial voice recording. However, there have been many staff changes, reductions, relocations, and realignments since that time. Consequently, the current system no longer serves the needs of consumers, stakeholders and the functional units housed at 1300 First Street, NE.

We further agree with your recommendation to take immediate action to correct the aforementioned deficiencies and to include voicemail as a feature of the new system. Our goal is to bring APRA into compliance with the Mayor's standards for telephone-based customer service.

We have, therefore, contacted the Office of the Chief Technology Officer (OCTO) to arrange an in depth review of the requirements to convert the phone systems at both 1300 First St, NE and the Detoxification Center to the ISDN format which will support voicemail. A work order has been prepared by OCTO for Verizon to complete this evaluation and provide estimates for system conversion. Our expectation is that the analysis will be completed sometime during the week of 7/15/02. We have targeted system conversion to take place by the end of the fiscal year.

Should you have questions or comments, please contact [redacted] at 202-442[redacted]

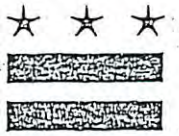
Sincerely,

James A. Buford,
Director

cc: Mr. John A. Koskinen, City Administrator, Office of the City Administrator
Mr. Herbert R. Tillery, Deputy Mayor for Operations
Mr. William Steward, Interim Sr. Deputy Director for Substance Abuse Services

APPENDIX 8

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General



Inspector General

September 25, 2002

Mr. James A. Buford
Acting Director
Department of Health
825 North Capitol Street, N.E.
Suite 4400
Washington, D.C. 20001

Dear Mr. Buford:

This is a Management Alert Report (02-I-008) to inform you of a significant issue that has come to our attention during our inspection of the Addiction Prevention and Recovery Administration (APRA) within the Department of Health (DOH). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of a District of Columbia government official.

The APRA Detoxification Center (Center) located on the D.C. General Hospital campus is a clinical facility that provides medical detoxification from heroin, cocaine, alcohol, and PCP. During an onsite inspection, the OIG inspection team determined that the Center has numerous environmental and safety problems that are not being addressed and require immediate attention. In addition, the inspection team determined that staff activities are hampered by a lack of essential office supplies and storage space.

As a substance abuse treatment facility, the Center must abide by the environmental and safety standards enumerated by 29 DCMR § 2322 for substance abuse treatment facilities. Section 2322 requires, among other things, that such facilities:

- establish and maintain a safe environment and take usual and reasonable precautions to preserve the safety of persons who participate in these facilities;
- meet applicable District fire safety and health requirements;
- maintain a safe, clean environment free of infestation and be in good physical condition;
- provide comfortable ventilation, moisture and temperature control; and
- provide privacy in shower and toilet areas.

Id. Section 2325 further requires that a treatment facility provide food services that comply with the DC Food Code. We found evidence that these standards are not being met.

Issues:

The inspection team found the following specific problems:

1. air-conditioning system vents covered with dust and grime;

2. inadequate ventilation and temperature control – portable fans used throughout facility to maintain comfortable temperatures; however, fans are also covered with dust and grime;

3. dirty floors throughout the Center – floors have not been thoroughly stripped and cleaned in at least a year (according to the program manager);

4. exposed, rusting, and leaking pipes;

5. unsanitary food preparation and food service areas;

6. inadequate storage for office supplies, patient records, medical supplies, and food supplies;

7. possible electrical code and fire code violations;

8. standing water in men's restrooms due to poor drainage;

9. lack of ventilation in men's restrooms and mold on the ceiling;

10. lack of shower curtains or partitions in men's shower area and lack of doors for privacy in men's toilet area;

11. cracked tile throughout the Center;

12. walls in need of repair and painting; and

13. evidence of vermin infestation.

(See photographs, attached.)

In addition, the Center has not been inspected or certified as required by 29 DCMR Chapter 23.

Discussion:

The Center is located in an old building in need of structural, electrical, plumbing, and air-conditioning repairs. The program manager has requested that the Department of Human Services (DHS), which provides facility maintenance services for DOH, make repairs, but was told there is a backlog at DHS. For example, there is also a year-old request for cleaning and inspection of the air filtration system. While awaiting maintenance on the system, the Center purchased two portable household air filtration systems, but these systems are not adequate to meet the needs of the entire facility. The lack of a well-maintained central system could foster the spread of airborne diseases, thereby endangering the health of patients and employees.

In addition to the maintenance requests, the Center has requested, but has not received, either essential supplies or additional shelving to store medicine, medical records, and food.[1] Employees spend an inordinate amount of time trying to locate patient records and medical supplies because they are stored in boxes rather than in filing cabinets and on shelves. Employees also rummage through trash dumpsters looking for discarded furniture, such as desks and chairs, further placing their health and safety at risk. Currently, the Center has two employees who perform routine cleaning, but as evidenced by the poor conditions found during the inspection, they cannot adequately maintain this 80-bed facility. All of these deficiencies prevent Center employees from carrying out their duties efficiently and effectively, and negatively impact the quality of the District's detoxification programs.

Recommendations:

1. That Director of DOH (D/DOH) direct an immediate inspection of the Center to identify any violations of District codes pertaining to health, physical safety, food safety, and building conditions, and ensure that corrective actions are taken as necessary.

2. That D/DOH ensure that sufficient supplies, office furniture, and storage areas are provided for the Center's day-to-day operations.

3. That D/DOH ensure the regular performance of good maintenance and sanitation at the Center that conforms to all applicable District and federal standards.

Please provide your comments to this report by October 4, 2002. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report to only those personnel who will be directly involved in preparing your response.

[1] An outside contractor provides meals to patients on a daily basis.

Should you have questions or desire a conference prior to preparing your response, please contac[redacted], 202-727-[redacted]

Sincerely,

Charles C. Maddox, Esq.
Inspector General

CCM/LP/jcs

Attachments: As stated

cc: Mr. John A. Koskinen, City Administrator, Office of the City Administrator
Ms. Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders

ATTACHMENT

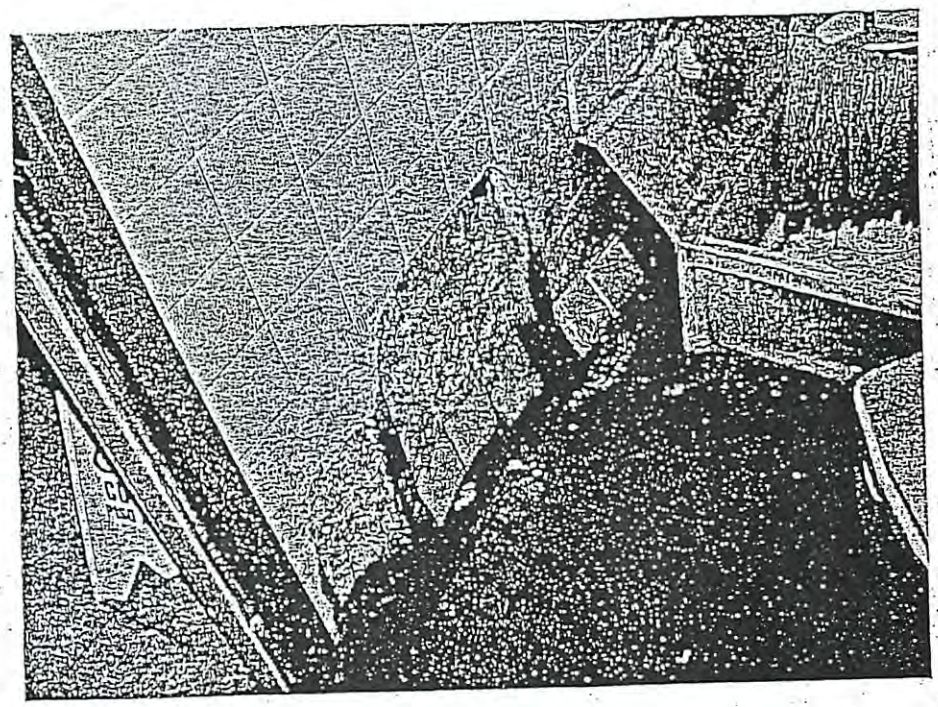


Photo 1: Exposed, rusting, and leaking pipes; broken tiles.

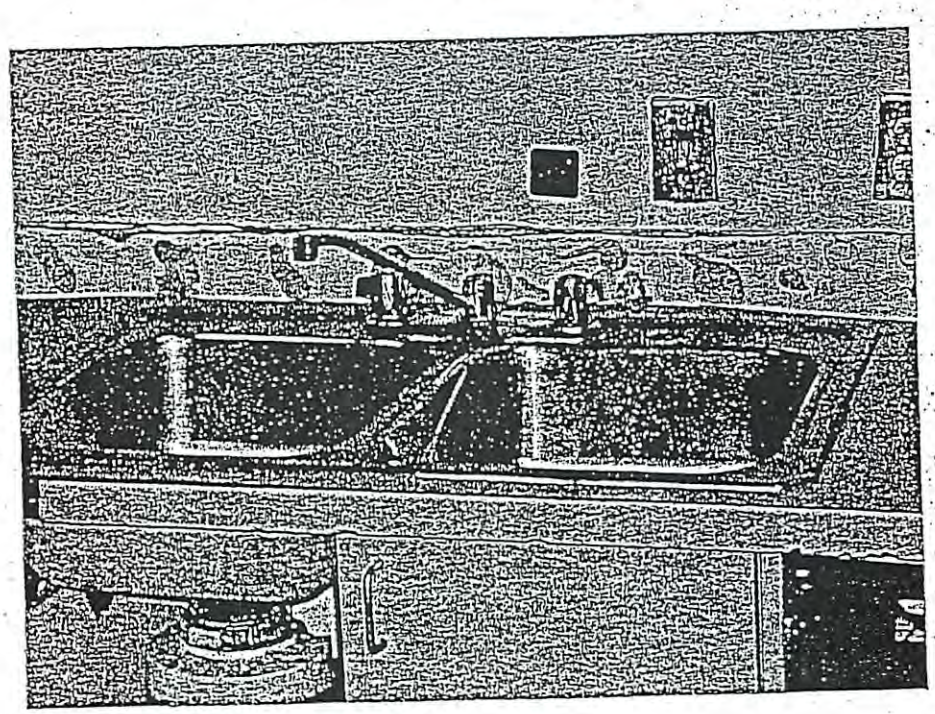


Photo 2: Deteriorating and unsanitary food preparation and service areas.

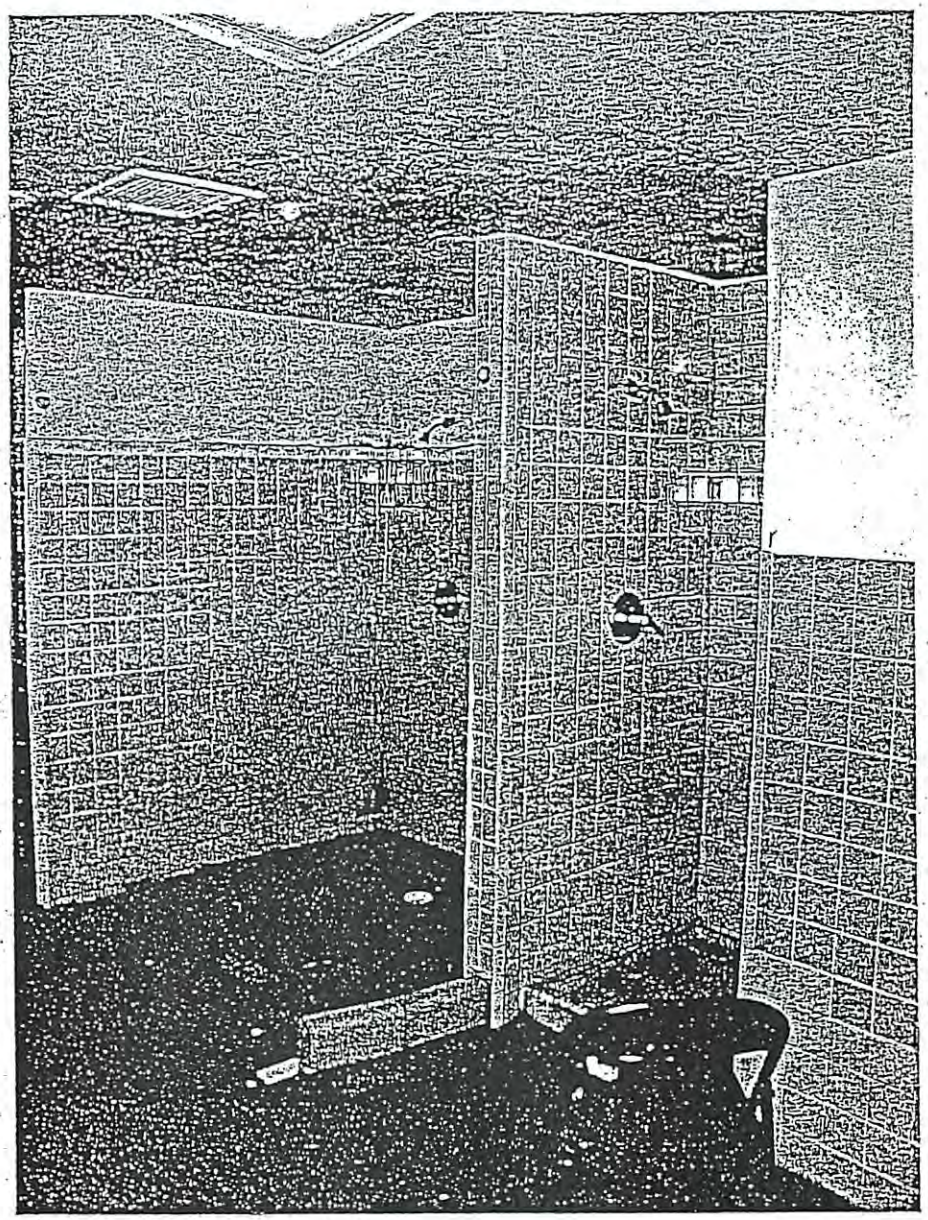


Photo 3: Lack of ventilation in men's restroom facilitates the growth of mold on the ceiling. Standing water due to a lack of proper drainage.

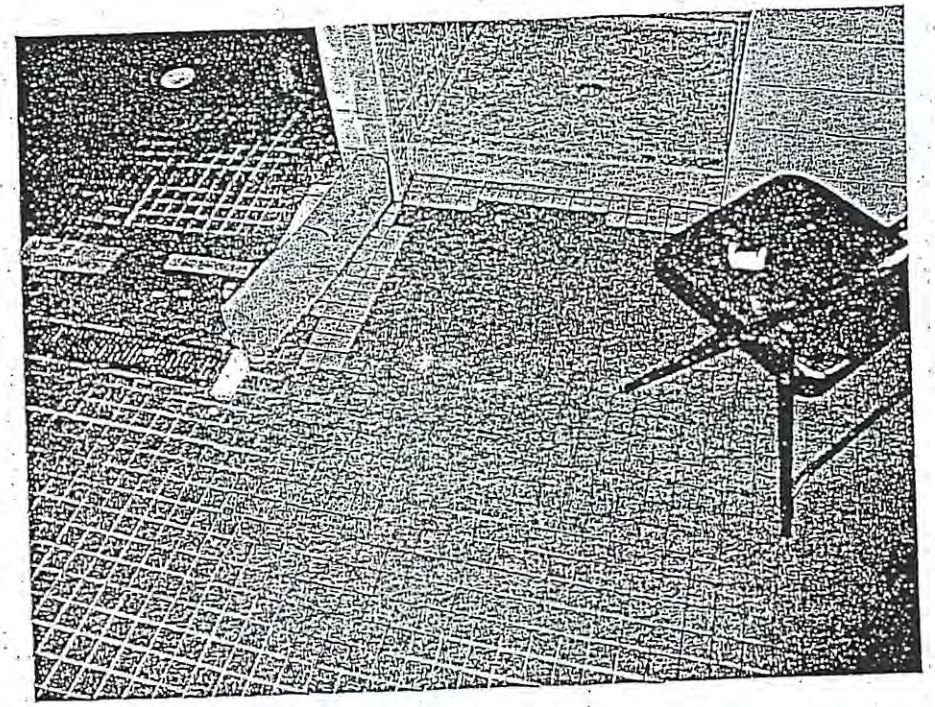


Photo 4: Tripping hazard from improper construction in men's shower area.

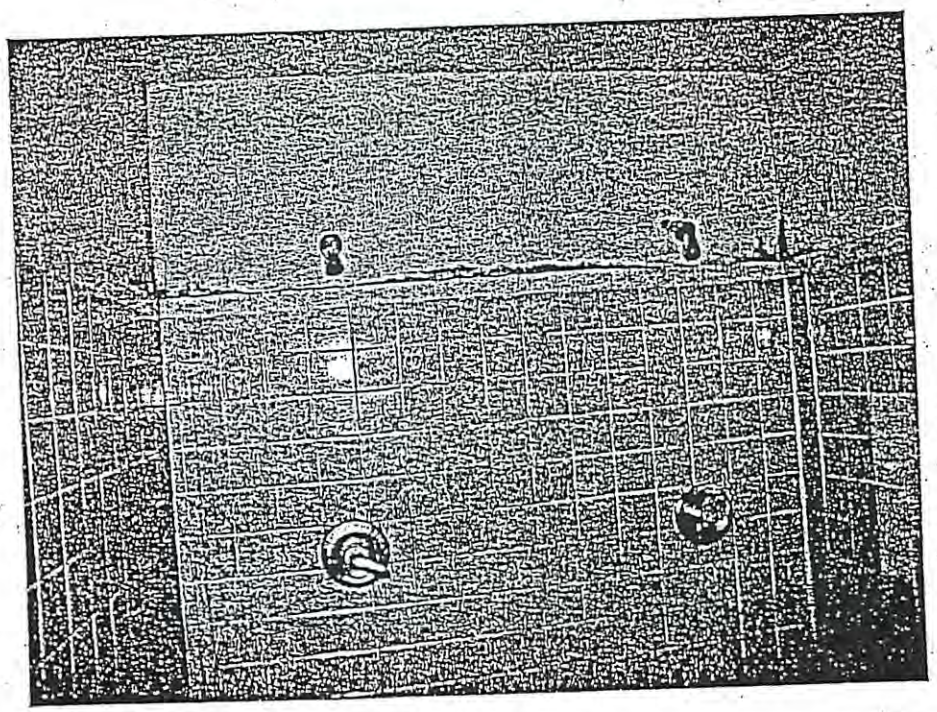


Photo 5: Lack of shower partitions in men's shower area. Cracked and peeling paint.

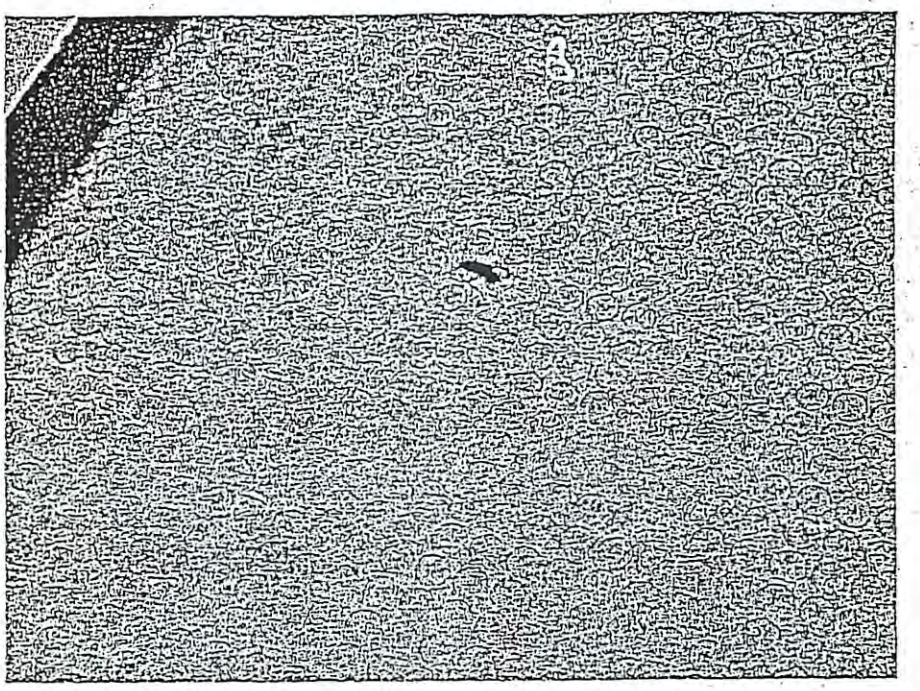


Photo 6: Evidence of vermin infestation.

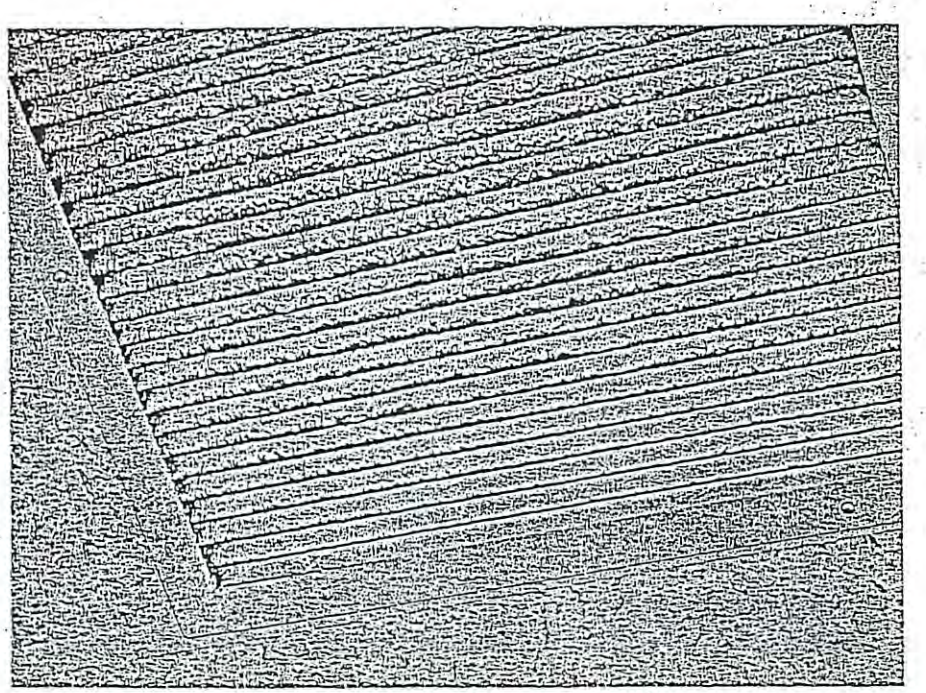


Photo 7: Vents of air-conditioning system covered with dust and grime.

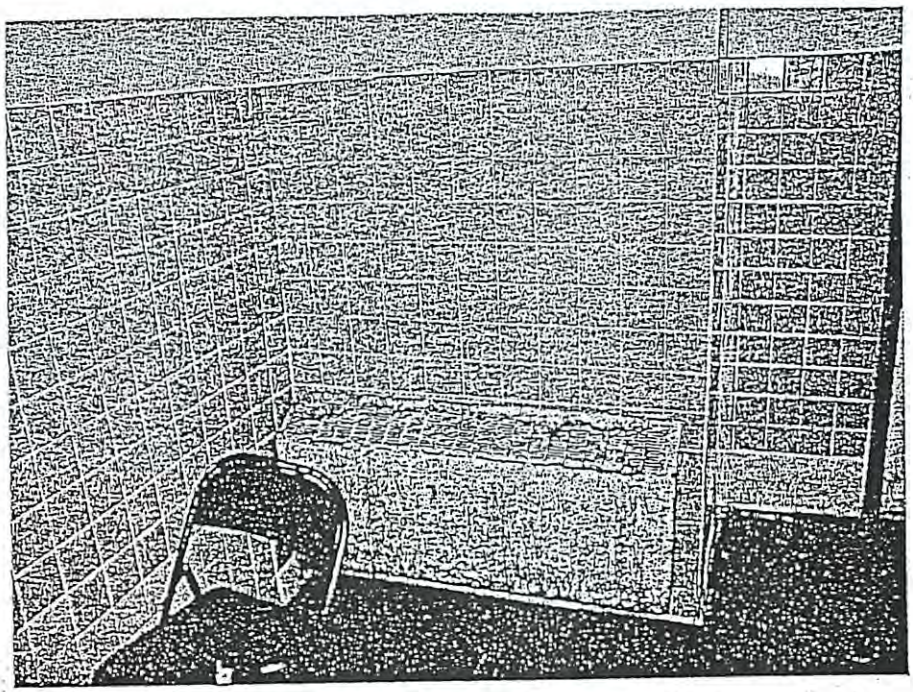


Photo 8: Deteriorated and rusting furnace system in men's shower area.

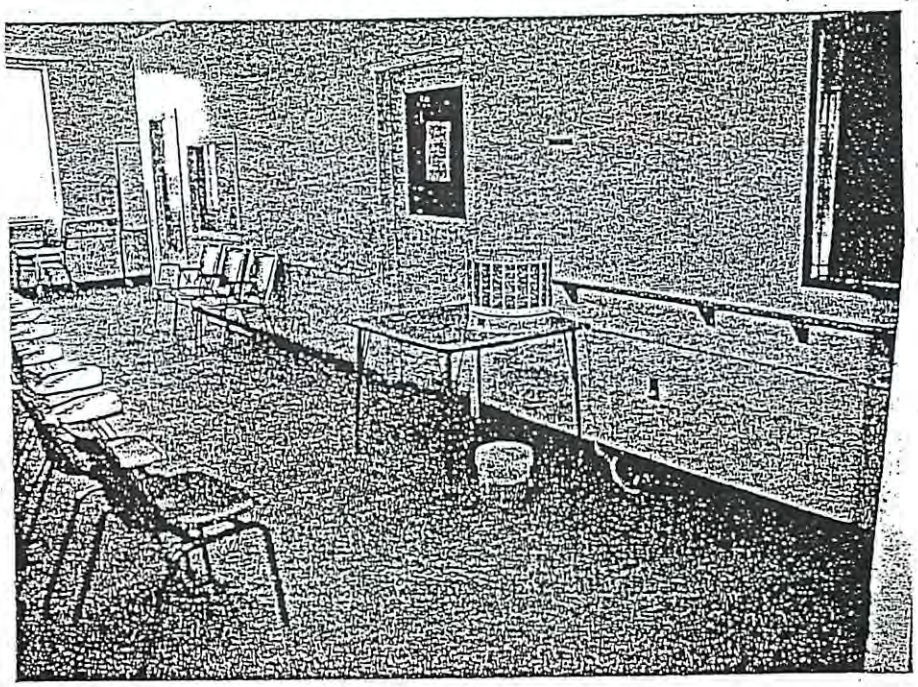


Photo 9: One of two household air filtration systems used for the entire facility.

Photo 10: Storage room for facility office supplies and patient records.

Photo 11: Storage room for facility office supplies and patient records.

APPENDIX 9

GOVERNMENT OF THE DISTRICT OF COLUMBIA

02 OCT 16 AM 11:39

Department of Health

Office of the Director

October 8, 2002

Charles C. Maddox, Esq
Inspector General
Office of the Inspector General
717-14th Street, NW
Washington, DC 20005

ENTERED
926

Dear Mr. Maddox:

This letter responds to your Management Alert report (02-I-008) concerning environmental and safety issues at the Detoxification Center, located on the DC General Hospital campus and operated by the Addiction Prevention and Recovery Administration. The following actions were taken to correct the environmental and safety issues identified in your report.

As noted in the report, the age of the building, with the progressive deterioration to its infrastructure, poses a significant challenge in maintaining this facility in accordance with environmental and clinical standards. It is also noteworthy that funding, which was included in the approved capital budget for the renovation of this facility, was deleted in the last part of FY02 due to budget constraints. This action was taken at a critical juncture after much energy had gone into planning facility upgrades.

Notwithstanding these issues, we take no exception to your findings. We have moved aggressively to address the specific problems cited and to take action on the recommendations. Many of the cited deficiencies have already been corrected. Information on specific action taken and planned is included in the enclosed tables. Steps are being taken to strengthen on-site management of the Detoxification Center in order to maintain an environment conducive to quality patient care and to avoid similar recurrence in the future.

If you have questions concerning our responses, please contact Mr. William Steward, Interim Senior Deputy Director for Substance Abuse Services, at (202) 442-9155.

Sincerely,

James A. Buford
Acting Director

Enclosures:

cc: Mr. John Koskinen, City Administrator, Office of the City Administrator
Ms. Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders

825 N. CAPITOL ST., N.E. • SUITE 4400 • WASHINGTON, D.C. 20002 • (202) 442-5999 • FAX (202) 442-4788

DEPARTMENT OF HEALTH
ADDICTION PREVENTION AND RECOVERY ADMINISTRATION

I. RESOLUTION OF SPECIFIC PROBLEMS:

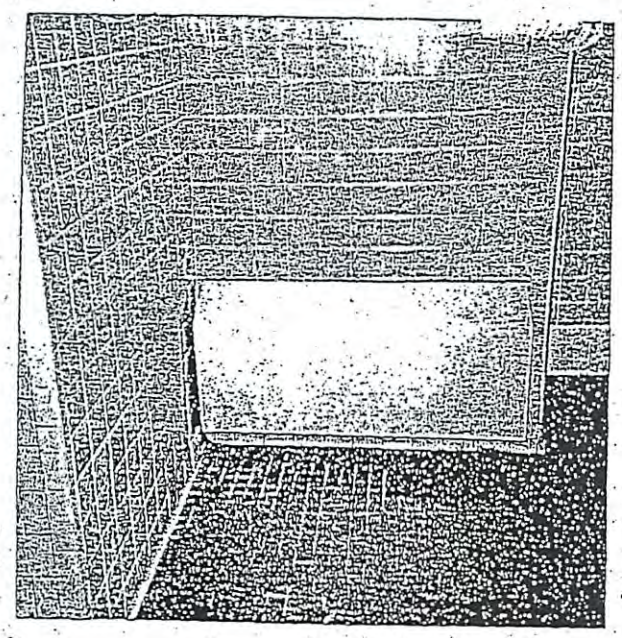
	PROBLEMS	RESOLUTIONS
1.	Air conditioning system vents covered with dust and grime.	All of the vent systems have been thoroughly cleaned and are free from dust and grime. (See attached photographs labeled issue #1)
2.	Inadequate ventilation and temperature control – portable fans used throughout facility to maintain comfortable temperatures; however, fans are also covered with dust and grime.	Dust and grime were removed from all surfaces including fans used to circulate air. Tri-State Co. was retained to vacuum all the HVAC duct system on 10/10/02.
3.	Dirty floors throughout the Center- floor have not been thoroughly stripped and cleaned in the last year	The floors were stripped, cleaned and waxed by contractor service on 10/02/02. The janitorial contract will be a amended within the next sixty days to include a schedule for stripping and waxing floors at least quarterly. (See photograph labeled issue #3)
4.	Exposed, rusting and leaking pipes	Exposed pipes were covered and all leaks repaired. (See photograph labeled issue #4)
5.	Unsanitary food preparation and food service areas	Food is not prepared (cooked) at the site. Food delivery is contracted. However, the kitchen area has been thoroughly cleaned and the contractor has been notified concerning deficiencies. (See photo labeled issue #5)
6.	Inadequate storage for office supplies, patient records, medical supplies and food supplies	There is adequate storage after the storage areas were cleaned out and organized. Skids and shelving were installed to facilitate organization of supplies. (See attached photograph labeled issue #6) In response to recommendation #2, supplies were delivered to the Center on 10/02/02.
7.	Possible electrical code violations	The Fire Marshall was contacted to conduct a review of the Center and determine what actions need to be taken. APRA was advised that the inspection is scheduled for the week of 10/07/02. Appropriate corrective actions will be taken to respond to any deficiencies following the inspection.
8.	Standing water in men's restroom due to poor drainage	Drains were unclogged. A request will be made to DHS to build up the floor to provide a proper slope towards the drain, to be completed no later than 10/31/02.
9.	Lack of ventilation in men's restroom and shower and mold on the ceiling	The men's restroom vents were cleaned and the mold removed from the ceiling and shower stalls. (See attached photograph labeled issue #9)

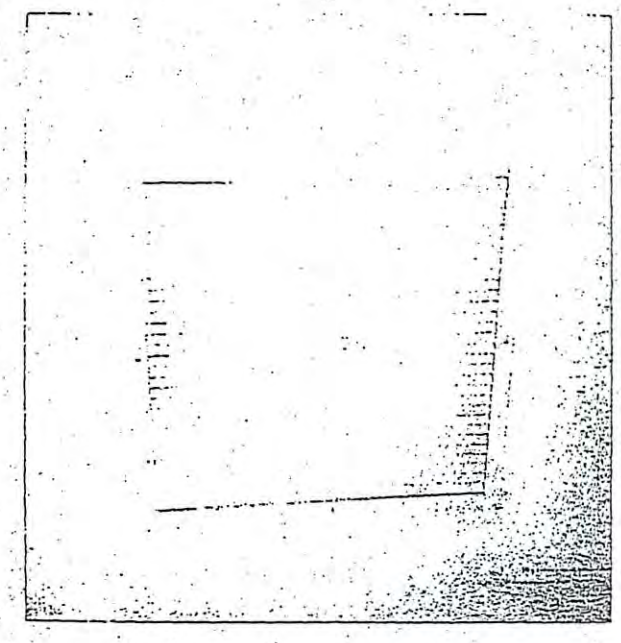
	PROBLEMS	RESOLUTIONS
10.	Lack of shower curtains or partitions in men shower and lack of doors for privacy in men's toilet.	Shower curtains were purchased. Doors to the men's toilet were installed on 10/03/02. (See photograph labeled issues #10)
11.	Cracked tile throughout the Center.	All cracked tile was repaired or replaced.
12.	Walls in need of repair or painting.	Walls were repaired and painted throughout the Center. All cracked tile was repaired or replaced. (See photograph labeled issue #12)
13.	Evidence of vermin infestation.	A pest control contractor inspected and treated the facility on 10/02/02. The contractor will provide routine preventive maintenance quarterly with interim visits on an as needs basis to ensure elimination of vermin infestation.

II. RESPONSE TO RECOMMENDATIONS:

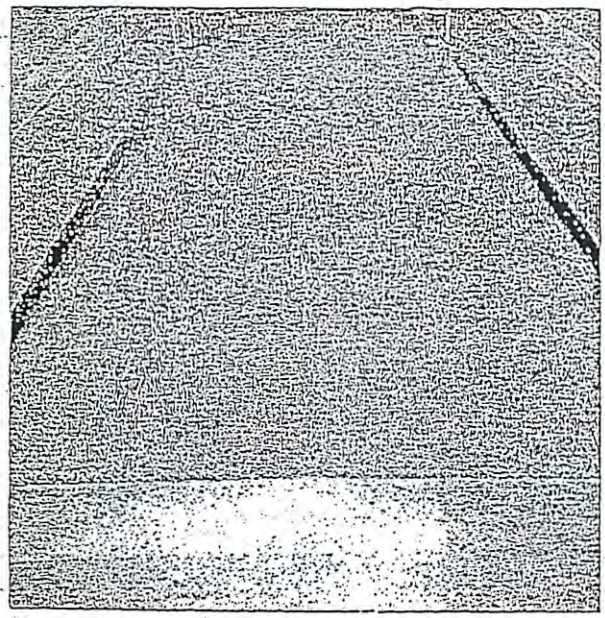
	RECOMMENDATION	ACTION PLAN
1.	That Director of DOH (D/DOH) direct an immediate inspection of the Center to identify any violations of District codes pertaining to health, physical safety, food safety, and building conditions, and ensure that corrective actions are taken as necessary.	The Detoxification Center will be surveyed for compliance with certification standards no later than the end of the first quarter of fiscal year 2003.
2.	That D/DOH ensure that sufficient supplies, office furniture, and storage areas are provided for the Center's day-to-day operations.	See Problem/Resolution #6. Also, actions are underway to determine furniture requirements and prepare purchase orders to satisfy identified needs.
3.	That D/DOH ensure the regular performance of good maintenance and sanitation at the Center that conforms to all applicable District and federal standards.	APRA will review the cited deficiencies with the maintenance contractor and will make modifications to the scope of work as necessary to prevent future deterioration. This task will be accomplished no later than mid-November.

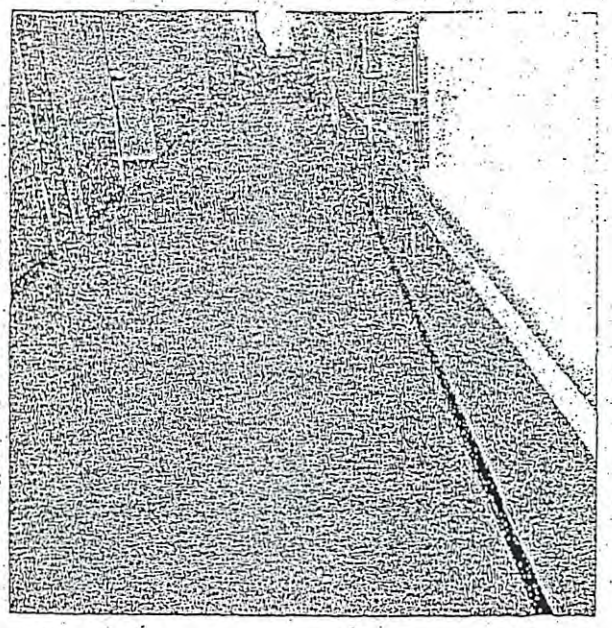
ISSUE NO. 1 (PHOTO REFERENCES #7 AND #8)





ISSUE NO. 3





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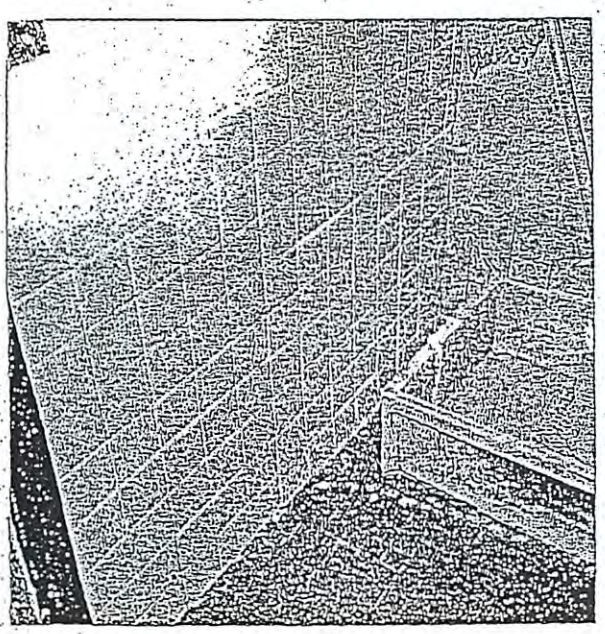

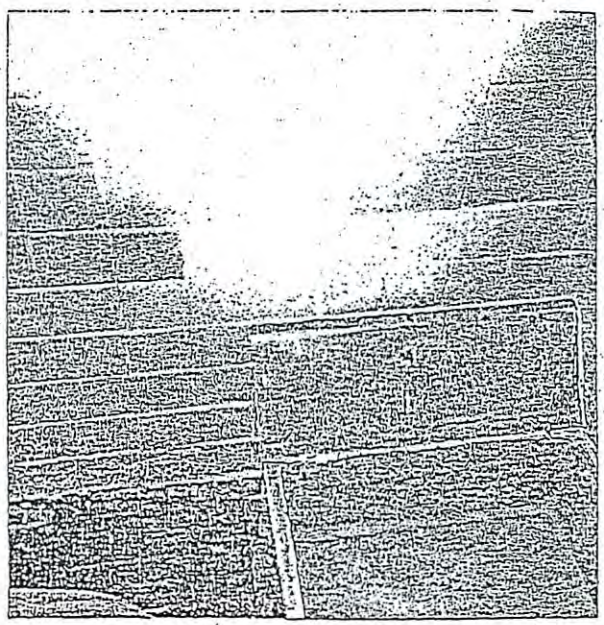

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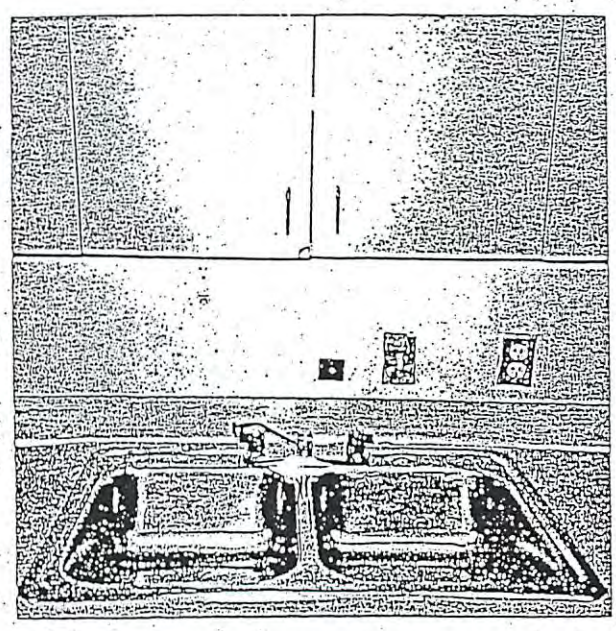
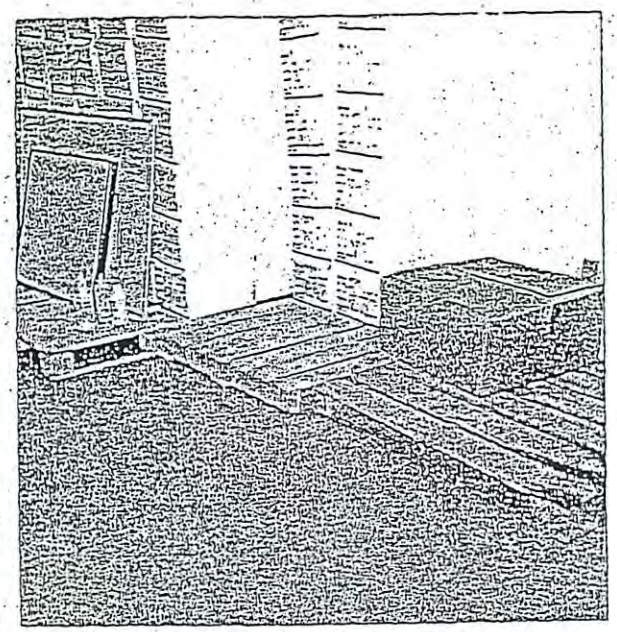
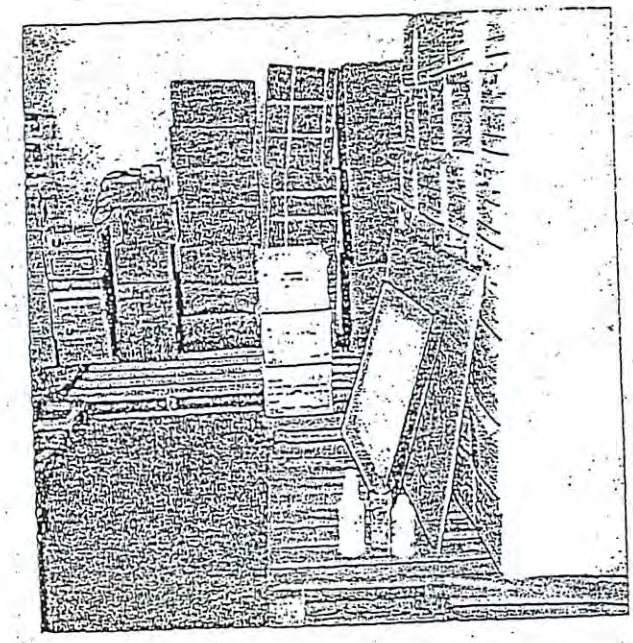
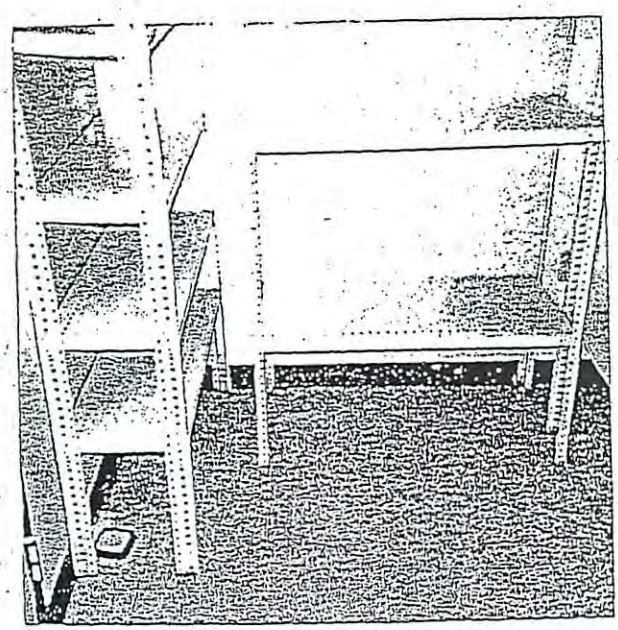
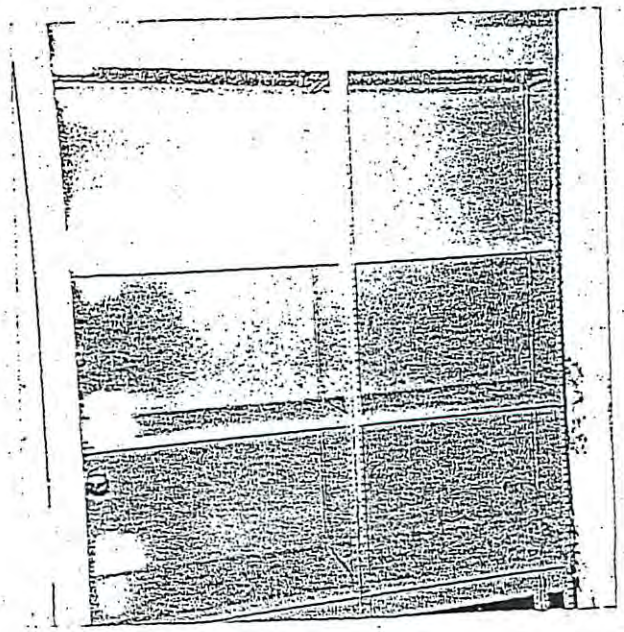


ISSUE NO. 6 (PHOTO REFERENCES #10 AND #11)









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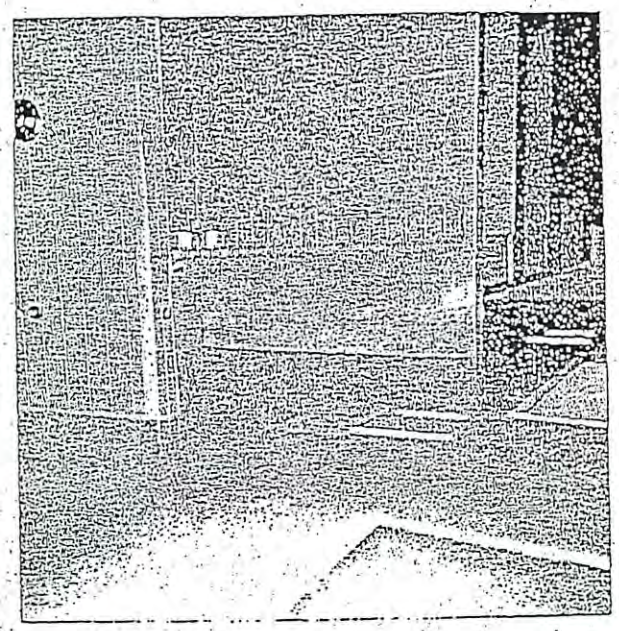

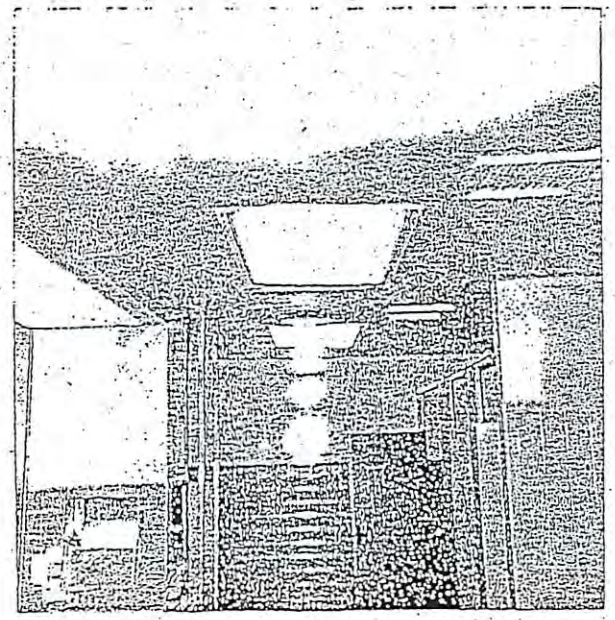

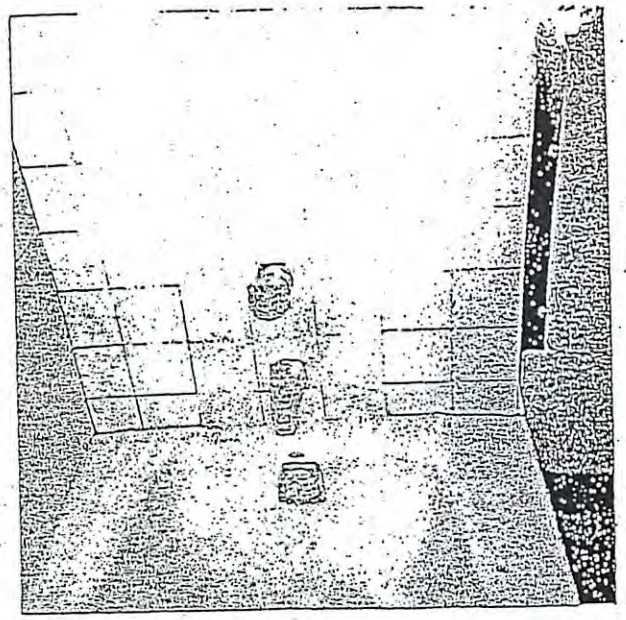

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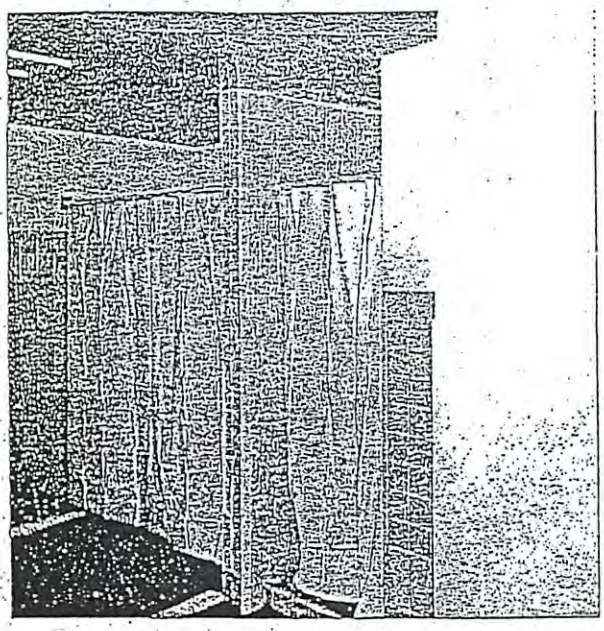

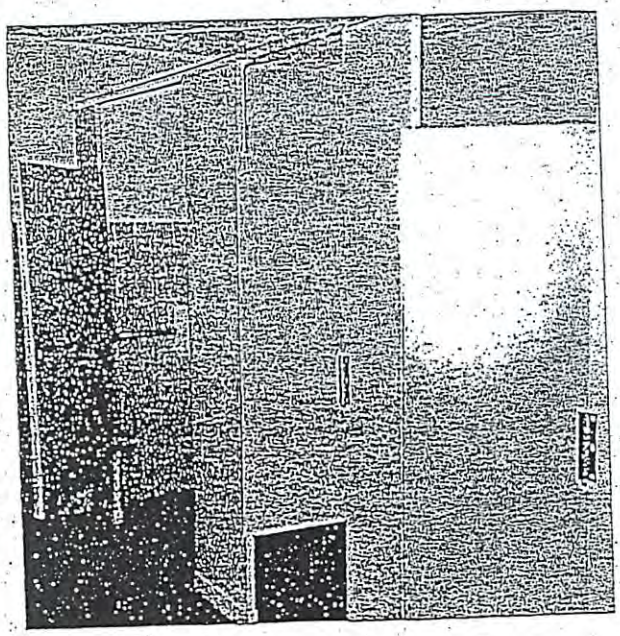

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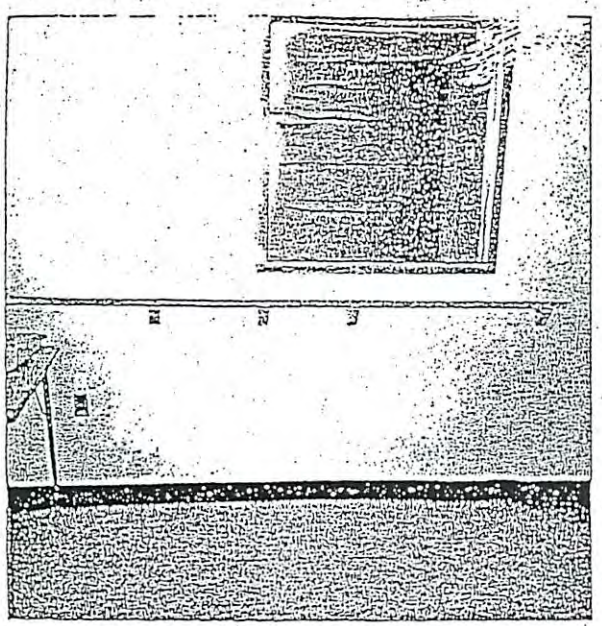

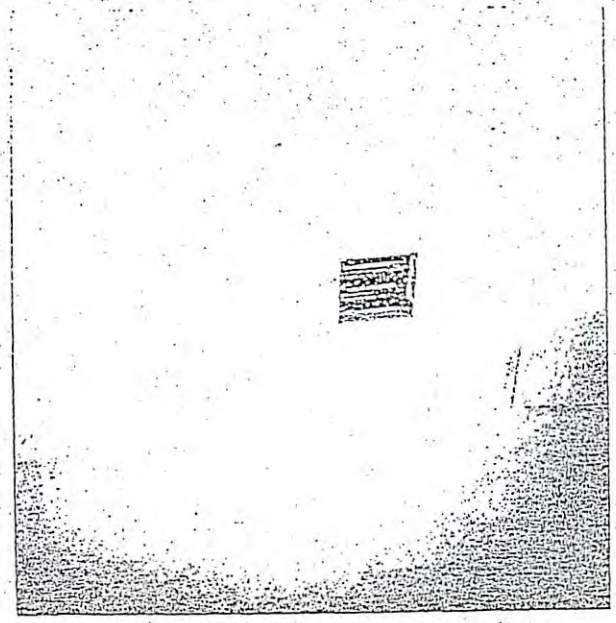

APPENDIX 10

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

October 17, 2002

Mr. James A. Buford
Acting Director
Department of Health
825 North Capitol Street, N.E.
Suite 4400
Washington, D.C. 20001

Dear Mr. Buford:

This is a Management Alert Report (03-I-001) to inform you of a significant issue that has come to our attention during our inspection of the Addiction Prevention and Recovery Administration (APRA) of the Department of Health (DOH). The Office of the Inspector General (OIG) provides these reports when we believe a serious matter requires the immediate attention of a District of Columbia government official.

As the Single State Agency (SSA)[1] responsible for drug abuse services in the District, APRA must identify all sources of revenue that will support the District's substance abuse treatment and prevention services. These services include Medicaid reimbursable services provided to APRA's clients. To qualify for Medicaid reimbursement, each facility or program providing substance abuse treatment is required to submit an application to the Medical Assistance Administration (MAA) within the DOH.[2] Upon approval, the facility or program is assigned a Medicaid provider number, which allows that entity, or APRA on behalf of that entity, to seek reimbursement for covered services from the Medicaid Program. The OIG inspection team has determined that APRA has failed to submit paperwork necessary for 34 of the 37 substance abuse treatment facilities or programs which it operates, or contracts with, to qualify for Medicaid reimbursement. Included in the 34 facilities or programs lacking a Medicaid provider number is the Detoxification Center.[3]

As a result of APRA's failure to obtain Medicaid provider numbers for all treatment facilities and programs, APRA can only request Medicaid reimbursement for services provided at 3 of 37 facilities.

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[1] The Drug Abuse Office and Treatment Act of 1972 provides for a Single State Agency in each State to be responsible for the planning, development, administration, implementation and evaluation of drug abuse services. APRA evolved from the January 1996 reorganization plan developed by the DOH and assumed the responsibilities and functions of the SSA.

[2] MAA serves as the SSA responsible for administering Titles XIX and XXI of the Social Security Act, which establish the Medicaid Program.

[3] APRA operates a Detoxification Center located on the D.C. General Hospital campus. The center handles medical detoxification from heroin, cocaine, alcohol, and PCP.

Recommendations:

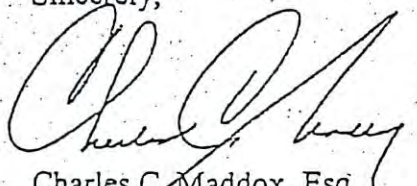
1. That Director, DOH (D/DOH) ensure that APRA management files the appropriate applications to obtain a Medicaid provider number for all its substance abuse treatment facilities and programs.

2. That D/DOH ensure that all contractors are provided with the necessary application forms to obtain valid Medicaid provider numbers.

Please provide your comments to this report by November 1, 2002. Your response should include actions taken or planned, dates for completion of planned actions, and reasons for any disagreement with the concerns and recommendations presented. Please distribute this Management Alert Report to only those personnel who will be directly involved in preparing your response.

Should you have questions or desire a conference prior to preparing your response, please contact [redacted], Director of Planning and Inspections, 202-727-[redacted]

Sincerely,



Charles C. Maddox, Esq.
Inspector General

CCM/LP/jcs

cc: Mr. John A. Koskinen, City Administrator, Office of the City Administrator
Ms. Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders

APPENDIX 11

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Director

November 1, 2002

Charles C. Maddox, Esq.
Inspector General
Office of the Inspector General
717 14th Street, NW
Washington, DC 20005

Re: Management Alert Report (03-I-001)

Dear Mr. Maddox:

This is in response to your letter of October 17, 2002, regarding the Addiction Prevention and Recovery Administration's (APRA) failure to obtain Medicaid provider numbers for APRA-operated and contract substance abuse treatment facilities and programs.

Presently Medicaid does not reimburse for non-physician substance abuse treatment services. In order to expand Medicaid coverage to non-physician substance abuse treatment services the Department of Health (DOH) must request approval from the Center for Medicaid and Medicare Services (CMS) of a Medicaid State Plan Amendment to implement a Substance Abuse Medicaid Rehabilitation Option in the District of Columbia. Over the past year the Medical Assistance Administration (MAA) and APRA have worked with a consultant to complete the requirements for the Rehabilitation Option and the State Plan Amendment for submission to CMS. The target date is January 2003.

MAA currently authorizes reimbursement to APRA for physician services related to physicals and follow-up medical visits at the rates of $75 and $25 respectively. APRA currently bills Medicaid for reimbursement for all Medicaid eligible clients who receive intake and annual physicals, and follow-up medical visits. APRA was reimbursed for physicals and follow-up visits by Medicaid at three of the four existing APRA intake and treatment facilities i.e., Model Treatment, Umoja, and Women Services, which are the three programs with Medicaid provider numbers. The only other APRA intake program, which does not have a Medicaid provider number, is the Detoxification Unit located on the DC General campus. The Detoxification Unit is an 80-bed sub-acute inpatient facility. Federal regulations do not allow Institutes for Mental Diseases (IMD) to qualify for Medicaid reimbursement. They define IMDs to include 24-hour treatment facilities and programs treating addictive disorders with more than 16 beds.

825 N. Capitol Street, N.E. Suite 4400 Washington, D.C. 20002 (202) 442-5999 Fax (202) 442-4788

I assure you, this Department continues to pursue every opportunity for additional revenue to include Medicaid reimbursement for substance abuse treatment services under a Medicaid Substance Abuse Rehabilitation Option. If you have any additional questions or concerns please contact me or [redacted] at 442-[redacted]

Sincerely,

James A. Buford
Acting Director
Department of Health

cc: John A. Koskinen, City Administrator
Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders