Performance Audit of the Commonwealth of Pennsylvania Department of Public Welfare's Community/Hospital Integration Projects Program

For the period July 1, 1997, to June 30, 2002

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August 16, 2005

The Honorable Edward G. Rendell
Governor
Commonwealth of Pennsylvania
225 Main Capitol Building
Harrisburg, Pennsylvania 17120

Dear Governor Rendell:

This report contains the results of the Department of the Auditor General's Performance Audit of the Community/Hospital Integration Projects Program (CHIPP) of the Department of Public Welfare (DPW). This audit was performed in accordance with Section 402 of The Fiscal Code and in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States.

As you are aware, CHIPP is a program to de-institutionalize state mental hospital patients and place them in community-based care settings. Accordingly, this performance audit examined the effectiveness of the program's discharge process and the monitoring of service providers by DPW. We also reviewed controls over the funding of the program.

At the outset, it is important to disclose that my predecessor initiated this audit in July of 2002. While the auditors were engaged in field work, DPW imposed a scope limitation regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prevented a thorough examination of our audit objectives and significantly delayed completion of the audit. Although DPW ultimately agreed that the Department of the Auditor General is entitled to have access to the necessary records and interviews, this untimely resolution also limited our audit conclusions.

In chapter one, we indicate that CHIPP discharges at the four hospitals that we reviewed complied with DPW guidelines. However, we must qualify this finding because of the scope limitation described above.

In chapter two, we found that DPW's incident management is disturbingly weak with regard to CHIPP consumers who are arrested or incarcerated. Specifically, our audit revealed that CHIPP providers did not notify DPW of consumer arrests or incarceration and consumers were not consistently monitored during incarceration. We also determined that DPW has not established a mechanism for notifying CHIPP programs when consumers are released from jail. A series of recommendations to improve incident management are also included in the chapter.

In chapter three, we express concern that DPW did not adequately monitor county CHIPP expenditures. We note that excessive budgetary variances were not submitted for approval in accordance with DPW guidelines. We recommend that DPW require the submission of revised budgets and investigate excessive variances on county income and expenditure reports.

I look forward to continuing to work with you and your administration to make sure that the Community/Hospital Integration Projects Program continues to serve the Commonwealth as intended by the General Assembly. To that end, I intend to follow up within the next 24 months to determine the status of the findings and recommendations contained in this report.

Sincerely,

JACK WAGNER
Auditor General

Performance Audit of the
Commonwealth of Pennsylvania
Department of Public Welfare's
Community/Hospital Integration Projects Program

Conducted by the
Pennsylvania Department of the Auditor General

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Results in Brief

Background

The Community/Hospital Integration Projects Program (CHIPP) is a program operated by the Office of Mental Health and Substance Abuse Services (OMHSAS) of the Department of Public Welfare (DPW).

CHIPP promotes the discharge of persons currently treated in state mental hospitals. The program targets individuals with a long-term history of mental health hospitalization or complex mental health service needs for whom the necessary community supports have previously been unavailable. The program is designed to develop the necessary resources for successful community placement of such persons, including case management services, residential facility placement, and rehabilitation or treatment services.

Additionally, CHIPP is designed to build community capacity for diversionary services to prevent unnecessary future hospitalization for individuals served by the Commonwealth's mental health system.

Audit Scope

The Department of the Auditor General began this performance audit of CHIPP in July 2002. The specific audit objectives consisted of the following:

- Evaluate the effectiveness of the program's discharge process.
- Evaluate the effectiveness of the monitoring of service providers.
- Review controls over the funding of the program.

While engaged in fieldwork, DPW imposed a scope limitation regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prevented a thorough examination of our audit objectives and significantly delayed completion of the audit. Although DPW ultimately agreed that the Department of the Auditor General is entitled to have access to the necessary records

and interviews, this untimely resolution also limited our audit conclusions.

Audit Results

Chapter One: Discharging CHIPP consumers from the hospital to the community

- Our review of the files of 175 consumers discharged from Harrisburg, Mayview, Norristown, and Torrance State Hospitals revealed that the hospitals and associated counties complied with the CHIPP guidelines for discharging consumers into the community.

- Due to impediments associated with DPW's response to HIPAA, the audit team could not evaluate the compliance and/or effectiveness of the discharge processes at Allentown, Clarks Summit, Danville, Warren, and Wernersville State Hospitals.

Chapter Two: Monitoring of residential, rehabilitation and case management services

- We determined that DPW's consumer incident management is disturbingly weak with regard to CHIPP consumers who are arrested or incarcerated. An examination of our audit sample of 43 CHIPP consumers revealed that five of them were arrested on at least nine occasions between July 1, 1997, and June 30, 2002. DPW and associated counties were not informed of six of these nine arrests, involving crimes such as aggravated assault, terroristic threats, and theft. Additionally, DPW and counties did not consistently oversee these CHIPP consumers during their periods of incarceration. Finally, DPW has not established a mechanism for either state or county prisons to inform DPW or the county CHIPP programs of the release of a CHIPP consumer into the community. We recommended that DPW enforce its policies and procedures for incident reporting by reviewing county mental health programs and requiring any necessary changes to ensure that all CHIPP consumer arrests

are reported and investigated. Such actions would increase DPW's capability to monitor the CHIPP consumers, to ensure they get the continuity of care they need, and to decrease potential risk to the public. In addition, we recommended that DPW develop and implement policies and procedures to monitor CHIPP consumers during any times they are incarcerated. Moreover, DPW should ensure that, statewide, such consumers receive the continuity of care for their needs. Finally, we urged DPW to work with the Department of Corrections to develop a formal system of notification of the release of CHIPP consumers from state correctional facilities and to require the counties that receive CHIPP funds to design similar systems of notification with the county prisons.

- As a consequence of DPW's reaction to HIPAA, we were unable to assess the necessity of licensure for some residential facilities. Of the 54 facilities that we toured, 14 were unlicensed. DPW licensure was not required for these 14 facilities because they were apartments or three-person residences. Of the 40 licensed CHIPP residences we toured, we verified that each possessed current certificates of compliance. All the 54 CHIPP residential facilities appeared neat and clean.

- Case management services for 80 CHIPP consumers complied with DPW regulations, policies, and procedures. However, the audited sample was limited by DPW's initial interpretation of HIPAA and was not representative of case management services across the Commonwealth.

- We were unable to assess the adequacy of DPW's oversight of case management independence as a result of DPW's response to HIPAA. However, we do know that the providers of case management services also furnish other mental health treatment, rehabilitation, or support services in several counties of the Commonwealth.

Chapter Three: Monitoring the propriety and reporting of CHIPP expenditures

- Although OMHSAS and the four reviewed counties implemented some measures to ensure the propriety and accuracy of reported CHIPP expenditures, OMHSAS did not follow up on the failure of Fayette County to submit required budget revisions during the fiscal years ended June 30, 2001, and 2002. We recommended that OMHSAS should enforce the CHIPP guidelines that require the submission of revised budgets for excessive variances in individual cost centers. Furthermore, OMHSAS should investigate excessive variances documented on county income and expenditure reports and require counties to adopt any necessary measures to maximize the efficiency of CHIPP spending and minimize any potential misuse of funds.

Introduction and Background

A Brief History of Public Sector Mental Health Initiatives

The subject of this audit report is the Community/Hospital Integration Projects Program (CHIPP) operated by the Pennsylvania Department of Public Welfare (DPW). CHIPP is a program to de-institutionalize state mental hospital patients and place them in community-based care settings.

Public sector initiatives for persons with mental illness have changed radically over the last 50 years from efforts to improve conditions in state mental hospitals, dubbed "the shame of the states"[1] in the 1950s and 1960s, to more recent patient-oriented de-institutionalization initiatives that continue to this day.

The original concept of institutionalization was thought to be a positive step in the continuum of moral and social progress, particularly when viewed in light of the often inhumane practices to which persons with mental illness were subject in the past. As our knowledge of mental illness and its treatment improved in the nineteenth century, states established mental hospitals to care for persons with mental illness.

By the early 1900s, Pennsylvania had established 20 state mental hospitals. The benefits of institutionalization, it was believed, were twofold: mandating the treatment of the illness and keeping patients away from society by confining them to hospitals.[2] However, in 1948, Albert Deutsch published *The Shame of the States*, a book in which he described conditions at a number of mental hospitals he had toured, including the Philadelphia State Hospital for Mental Diseases, known as Byberry. Deutsch wrote the following passage about his experience at Byberry:

> *As I passed through some of Byberry's wards, I was reminded of the pictures of the Nazi concentration camps at Belsen and Buchenwald. I entered buildings swarming*

[1] Albert Deutsch, *The Shame of the States*, Harcourt, Brace, New York, 1948.
[2] Ibid., p.137.

> *with naked humans herded like cattle and treated with less concern, pervaded by a fetid odor so heavy, so nauseating, that the stench seemed to almost have a physical existence of its own.*[3]

Deutsch went on to describe conditions at a number of other state mental hospitals. He wrote of chronic staff and supply shortages, patients who were malnourished and unclothed, patients who were needlessly restrained or exploited as free labor for 12- to 14-hour workdays, and old buildings infested with rats and vermin. He pointed out that severe underfunding, bureaucratic inertia, and poor leadership were consistent problems that caused these institutions to become nothing more than custodial asylums, not the treatment-oriented hospitals as originally conceived.[4] Although Deutsch's intent was to improve the conditions at these facilities, his book no doubt contributed to the de-institutionalization movement which started less than ten years thereafter.[5]

The major thrust toward de-institutionalization occurred in the 1960s with the introduction of Medicare and Medicaid and the growth of Social Security Disability Insurance and Supplemental Security Income. These programs paved the way for the establishment of community-based care and, at the same time, provided a major disincentive for institutional-based care. Beginning in 1965, a significant Medicaid reimbursement policy provision, entitled the "Institution for Mental Diseases (IMD) exclusion,"[6] prohibited Medicaid reimbursements to states for patients who occupied beds in mental hospitals.[7] This exclusion is

[3] Ibid., p. 42.
[4] Ibid., p. 138.
[5] Carol T. Mowbray, Ph.D., *et al*., "Managed Behavioral Health Care in the Public Sector," *Psychiatric Services*, Vol. 53, No. 2, February 2002, p. 158.
[6] Health Care Finance Agency (HCFA), Pub. 45-4, *State Medicaid Manual*, Part 4 - Services, 1988.
[7] The Institution for Mental Diseases exclusion prohibits Medicaid reimbursement for any person between the ages of 21 and 65 who resides in an institution for mental diseases. As defined by regulation, the term *institution for mental diseases* means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. 42 C.F.R. 435.1009 (2004). State and private psychiatric hospitals are considered institutions for mental diseases, as are nursing homes that specialize in caring for the severely mentally ill.

believed to have contributed significantly to the downsizing and closure of state mental hospitals nationally.

Because of these new federal programs, states began to examine the growing burden of mental hospitals on their budgets. In addition, there were medical breakthroughs in the form of new drug therapies intended to manage social behaviors more effectively and provide additional life choices for persons with mental illnesses. Finally, because of dissatisfaction with mental institutions and growing consumerism on the part of patients and families, there was widening public support for de-institutionalization. For these reasons, states began the release of long-term patients into the community.[8]

Pennsylvania joined the de-institutionalization movement with the closure of Hollidaysburg State Hospital in Blair County in 1979. Pennsylvania has closed 11 of 20 state mental hospitals since then and has fewer than 2,500 patients in 9 remaining institutions. These numbers represent a decrease of more than 90 percent since 1955, when there were more than 40,000 patients.

However, as institutions closed and community-based care settings have grown, a concern has emerged that de-institutionalization may lead to other social problems for patients who have serious mental health issues. For example, if such persons fail to comply with their prescribed medical treatment, there is concern that this failure will result in undesired social behaviors, a tendency to drift from one community setting to another, and an increase in crime rates and homelessness. Described as the "institutional circuit," the pattern consists of stays in homeless shelters, jails, or prisons, alternating with short-term psychiatric interventions.[9] Because patients in a community-based environment are not confined to the grounds of an institution, and because there is no corresponding mandate for treatment, it is essential for community-based care to exhibit effective program planning, excellent program accountability, and adequate monitoring of discharged patients.

[8] D. Mechanic, *Mental Health and Social Policy*, 2nd ed., Englewood Cliffs, NJ: Prentice Hall, 1980.
[9] Carol T. Mowbray, Ph.D., *et al.*, "Managed Behavioral Health Care in the Public Sector," *Psychiatric Services*, Vol. 53, No. 2, February 2002, p. 157.

Within this general background, the Pennsylvania Department of the Auditor General examined CHIPP for state fiscal years 1997-98 through 2001-02. The auditors examined the discharge of patients into community-based settings, the community-based services provided by CHIPP, including monitoring and accountability of patients (referred to as CHIPP consumers), and CHIPP expenditures.

Department of Public Welfare—Office of Mental Health and Substance Abuse Services

The CHIPP program is managed by the Office of Mental Health and Substance Abuse Services (OMHSAS) of the Department of Public Welfare (DPW). OMHSAS operates under the following vision statement:

> *Every person with serious mental illness and/or addictive disease, and every child and adolescent who abuses substances and/or has a serious emotional disturbance will have the opportunity for growth, recovery, and inclusion in their community, have access to services and supports of their choice, and enjoy a quality of life that includes family and friends.*

OMHSAS establishes and implements mental health services and programs. In addition, it is responsible for the development of standards and criteria for the provision of quality outcome-oriented behavioral health services. OMHSAS also administers the Commonwealth's funds through several funding streams, including community grant programs, the HealthChoices program,[10] behavioral health services through the Medicaid fee-for-service program, and Commonwealth's nine hospitals and one restoration center for seniors with mental illness.

[10] The HealthChoices program provides mandatory managed health care to Medical Assistance recipients. DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) oversees HealthChoices, which is the largest Medicaid program administered by DPW.

The Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P.S. § 4101 *et seq*., and its implementing regulations at 55 Pa. Code § 5100.1 *et seq*., require county governments to provide community mental health services, including short-term inpatient treatment, partial hospitalization, outpatient care, emergency services, specialized rehabilitation, and residential arrangements. Over the past 30 years, the Commonwealth's public mental health program has changed its emphasis from state mental health hospitals to community mental health services.

The Commonwealth's 67 counties are divided into single or multi-county service units under the direction of a county mental health administrator. A single entry point for services has been established by regulation in each service area.

State Mental Hospitals and Restoration Center

DPW operates nine state hospitals—Allentown, Clarks Summit, Danville, Harrisburg, Mayview, Norristown, Torrance, Warren, and Wernersville—for persons with serious mental illness. These hospitals provide special intensive treatment services for patients who need extended psychiatric inpatient services. The admission of persons committed under the Mental Health Procedures Act, 50 P.S. § 7101 *et seq*., is made through the county mental health program after short-term treatment has been provided in the community.

DPW also operates South Mountain Restoration Center, a nursing home that provides long-term care for older people. South Mountain serves the entire Commonwealth.

Community/Hospital Integration Projects Program

CHIPP promotes the discharge of persons currently treated in state mental hospitals. The program targets individuals with a long-term history of mental health hospitalization or complex mental health service needs for whom the necessary community supports have previously been unavailable. The program is designed to develop the necessary resources for successful community placement of such persons, including case management services, residential facility placement, and rehabilitation or treatment services. Additionally, CHIPP is designed to build community capacity for diversionary services to prevent unnecessary future hospitalization for individuals served by the Commonwealth's mental health system.

Counties that receive CHIPP funds are responsible for creating service systems that support people in the community while also managing state hospital utilization. State hospitals have played a vital role in preparing people for discharge, coordinating with counties during the transition to the community, and assisting counties in managing future hospital use.

The Commonwealth has demonstrated a growing reliance on community-based care rather than institutional care of persons with mental illness. During the fiscal year ended June 30, 1992, according to DPW, approximately 41 percent of all mental health funding was spent on state institutional care, while 59 percent was spent on community-based care. Eleven years later, during the fiscal year ended June 30, 2003, the percentage of the state's total mental health budget spent to support state institutional care had dropped to about 18 percent, while the percentage spent in community treatment, services, and supports had grown to 82 percent. It is the intention of DPW to continue this expansion of CHIPP and the corresponding reduction of state psychiatric hospital beds.

More and more Pennsylvanians with mental illness are being discharged from state hospitals to face the challenges of

community living. Between June 30, 1991, and June 30, 2003, the state psychiatric hospital census declined from 6,611 (of an estimated state total population of 11.9 million in 1991) to just 2,309 (of an estimated total population of 12.3 million in 2003). During the same period, admissions declined from 4,682 to 1,638.

According to DPW, CHIPP funding increased from $6.5 million to just over $164 million between fiscal year 1991-92 and fiscal year 2002-03. Correspondingly, DPW reported that the state hospital budget declined from $498.7 million to $402.9 million in that same period.

The following chart illustrates CHIPP discharges from the nine state mental hospitals between July 1, 1991, and June 30, 2002:[11]

Table 1

State Hospital	Number of CHIPP Discharges
Allentown	196
Clarks Summit	72
Danville	126
Harrisburg	197
Mayview	493
Norristown	610
Torrance	276
Warren	223
Wernersville	44
Total	**2,237**

These same discharges can be broken down by region and county:

Table 2

County	Number of CHIPP Discharges
Southeast Region	
Bucks	28
Chester	72
Delaware	242
Montgomery	140
Philadelphia	128
Total	**610**

[11] The information was obtained from a database used by DPW personnel. The June 30, 2002, end date coincides with the end of the audit scope period.

Table 2, *continued*

Northeast Region	
Berks	39
Bradford/Sullivan	5
Carbon/Monroe/Pike	75
Lackawanna/Susquehanna/Wayne	31
Lehigh	65
Luzerne/Wyoming	28
Northampton	75
Schuylkill	58
Total	**376**
Central Region	
Bedford/Somerset	32
Blair	27
Cambria	28
Centre	13
Clinton/Lycoming	22
Columbia/Montour/Snyder/Union	15
Cumberland/Perry	17
Dauphin	85
Franklin/Fulton	18
Huntingdon/Mifflin/Juniata	12
Lancaster	3
York/Adams	73
Total	**345**
Western Region	
Allegheny	496
Armstrong/Indiana	24
Beaver	16
Butler	24
Cameron/Elk/McKean	49
Clarion	3
Crawford	7
Erie	148
Fayette	41
Lawrence	13
Mercer	12
Venango	4
Washington	21
Westmoreland	48
Total	**906**
Grand Total	**2,237**

Objectives, Scope, and Methodology

Historically, the Department of the Auditor General has conducted performance audits of the nine state mental hospitals and the South Mountain Restoration Center. With the implementation of CHIPP, a significant number of patient beds and funds have been transferred from state mental hospitals to private mental health care providers. Accordingly, it was logical for the Department of the Auditor General to conduct a special performance audit of CHIPP.

The Department of the Auditor General began this performance audit of CHIPP in July 2002. The specific audit objectives consisted of the following:

- Evaluate the effectiveness of the program's discharge process.
- Evaluate the effectiveness of the monitoring of service providers.
- Review controls over the funding of the program.

To accomplish these objectives, we analyzed pertinent regulations, policies, and operating procedures; interviewed appropriate staff of DPW, county mental health programs, and mental health service providers; and reviewed select consumer and financial records of DPW, state hospital, and county mental health program offices. Unless indicated otherwise in the body of this report, the scope of the audit covered the period of July 1, 1997, to June 30, 2002.

Because of DPW's concerns about the privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA),[12] DPW imposed scope limitations that prevented a thorough examination of our audit objectives and significantly delayed the completion of the audit.

The privacy standards of the HIPAA regulations, effective April 14, 2003, were designed to protect the confidentiality of individually identifiable health records. HIPAA established

[12] Public Law 104-191, effective August 21, 1996 (42 U.S.C. § 261 *et seq*.)

safeguards (including criminal and civil sanctions) and restrictions regarding the use and disclosure of these records for certain public responsibilities, such as public health, research, and law enforcement.

DPW's response to the privacy provisions of HIPAA began in March 2003. At that time, DPW denied us access to documents and interviews that were necessary for us to reach conclusions regarding the efficacy of DPW's oversight of CHIPP. The Department of the Auditor General, therefore, entered into negotiations with DPW in an effort to define the Department of the Auditor General as a health oversight agency. This designation would entitle the Department of the Auditor General with access to the records necessary to complete the audit's objectives. However, the issue was not resolved in a timely manner, and we therefore closed audit fieldwork on July 8, 2003.

Although DPW ultimately agreed that the Auditor General is entitled to have access to the necessary records and interviews, this untimely resolution limited the audit conclusions.

The audit scope impairments caused by DPW's response to HIPAA included, but were not limited to, the following:

- DPW prohibited access to records that would have enabled us to evaluate the effectiveness of the discharge processes at five state mental hospitals in the Commonwealth. Refer to Chapter One, Finding I-1.

- We were unable to obtain documentation regarding the deaths of certain CHIPP consumers. This impairment prevented an evaluation of the existence or nature of DPW or county investigations of CHIPP consumer deaths, as well as an assessment of the propriety of any corrective actions to prevent future incidents. Consequently, our inability to evaluate these conditions prevented us from making any conclusions or recommendations.

- We were limited to examining the incident files of only 43 CHIPP consumers in the central and western regions of the Commonwealth, whereas we had planned to review the files of 222 CHIPP consumers across the Commonwealth. Accordingly, this audit report almost certainly understates the number of CHIPP consumer arrests during the period July 1, 1997, to June 30, 2002. Refer to Chapter Two, Finding II-1.

- We were not able to obtain information essential to a comprehensive evaluation of DPW's oversight of incarcerated CHIPP consumers. For example, we were unable to determine whether DPW has established procedures to notify county or state prison officials of the mental health issues or treatment plan of the CHIPP consumer upon intake into a prison facility. Refer to Chapter Two, Finding II-2.

- We were unable to conduct the number and kind of interviews and tests to gauge adequately the necessity of licensure for certain types of residences in which CHIPP consumers are placed. Refer to Chapter Two, Finding II-4.

- We were unable to obtain statistics regarding the turnover of case managers. In addition, we were unable to gather the necessary information to calculate either the crude separation rates or the average or median tenure of the current case manager staff in any of the four regions of the Commonwealth. Accordingly, this impairment prevented us from making any conclusions or recommendations regarding the consistency of CHIPP case management services across the Commonwealth.

- We were restricted to examining only 36 percent of our planned sample of case management records. Thus, our evaluation of the overall effectiveness of

DPW's oversight of case management services was limited. Refer to Chapter Two, Finding II-5.

- We could not test any county's compliance with state regulations designed to reduce the effects of the impaired independence of case managers. Therefore, we could not determine the adequacy of DPW's oversight of case management independence. Refer to Chapter Two, Finding II-6.

The remainder of this report discusses the various findings and recommendations that we were able to develop under DPW's initial limited interpretation of HIPAA requirements. The report contains comments where the scope limitation affected our findings and explains how the limitation shaped or prevented our audit conclusions.

We conducted this audit in accordance with the most recent version of *Government Auditing Standards* issued by the Comptroller General of the United States, and pursuant to the authority of Section 402 of the Fiscal Code, 72 P.S. § 402.

Chapter One:

Discharging CHIPP consumers from the hospital to the community

The CHIPP Discharge Process

The CHIPP discharge process is a vital component of the Commonwealth's mental health system. To ensure that the needs of each CHIPP consumer[13] are met, the discharge evaluation must consider all aspects of continuing care after the patient leaves the hospital setting. Professionals at the state hospitals, county mental health offices, and other appropriate agencies must coordinate community placement and services commensurate with these individual needs.

In March 1999, DPW's OMHSAS issued guidelines to state hospitals and counties regarding the hospital discharge planning process for CHIPP consumers. The guidelines require the discharge assessment to be comprehensive and to include the psychiatric, medical, and psychological needs of each consumer. Face-to-face interviews should be conducted with all patients to identify individual interests and needs. Patients, families, county staff, and the state hospital treatment team and medical director should be involved in these reviews. The discharge assessment must also identify the community support and services necessary to promote increased levels of consumer independence and movement toward less restrictive environments. No patient should be discharged if adequate community services are not in place or if the patient's discharge readiness status has significantly changed since the initiation of the assessment process.

Objectives and Methodology

The objective of this portion of the audit was to evaluate the effectiveness of the discharge process of patients into CHIPP and hospital compliance with the aforementioned guidelines.

In order to accomplish this objective, we performed the following audit procedures:

[13] The DPW refers to individuals as "patients" while institutionalized in a state mental hospital. The DPW designates an individual as a "consumer" once discharged into CHIPP.

- Reviewed the CHIPP guidelines issued by OMHSAS in March 1999

- Reviewed the federal Centers for Medicare & Medicaid Services (CMS) regulations for hospital discharges, as well as the associated guide to surveyors

- Examined the written policy and procedures for patient discharges at the Harrisburg, Mayview, Norristown, and Torrance State Hospitals

- Interviewed personnel involved in the CHIPP discharge processes at the Harrisburg, Mayview, Norristown, and Torrance State Hospitals, including social workers, patient advocates, nurses, and psychiatrists

- Analyzed admission documents, comprehensive mental health assessments, treatment plans, discharge records, and aftercare summaries for 175 CHIPP consumers discharged from the Mayview, Norristown, Harrisburg, and Torrance State Hospitals

Finding I-1: CHIPP discharges at four sampled state hospitals complied with DPW guidelines.

Our review of hospital policies and procedures, interviews of professional staff, and analysis of documents for CHIPP consumers discharged from the Harrisburg, Mayview, Norristown, and Torrance State Hospitals found that the discharge process at each of these four state hospitals complied with CHIPP guidelines. The assessments were both comprehensive and multidisciplinary. Professionals from the psychiatric, psychological, social service, and medical disciplines recorded the treatment and progress toward discharge readiness for each of the 175 consumers for whom documents were reviewed. Discharge forms documented the face-to-face participation of the consumers, as well as the involvement of family members and county staff. The treatment team agreed to the specific recommended placement of each of the consumers in less restrictive community settings. Hospital and county staff coordinated the proposed placements and planned follow-up services to ensure continuity of care in the community.

We did not review any documents associated with the discharge of CHIPP consumers from the Allentown, Clarks Summit, Danville, Warren, and Wernersville State Hospitals. DPW denied access to these documents during the prolonged disagreement with the Department of the Auditor General regarding our authority to review certain documents that may be deemed confidential under HIPAA. While ultimately there was agreement that the Department of the Auditor General does have the right to review such records under HIPAA, the agreement was untimely and did not permit conclusions at the above-referenced hospitals.

Recommendation

- CHIPP discharges at the four hospitals reviewed complied with DPW guidelines. Accordingly, no recommendation is necessary.

Response by the Department of Public Welfare

No recommendation, no response necessary.

Chapter Two:

Monitoring of residential, rehabilitation and case management services

CHIPP Services

CHIPP is designed to integrate persons discharged from state mental hospitals into the community and, as appropriate, to minimize admissions or re-admissions to the hospital. The CHIPP philosophy is to provide an array of community services to persons in the least restrictive setting.

To ensure that the individual needs of each CHIPP consumer are met, community support services are customized in an approved treatment plan. This plan identifies the appropriate residential facility placement, case management services, and treatment or rehabilitation services necessary for each discharged consumer to be successful in the community.

CHIPP residential programs vary from independent living to personal care homes to more restrictive, intensive levels of supervised care in long-term structured facilities. CHIPP rehabilitation services include psychiatric therapy, medication monitoring, vocational assistance, and counseling. Case management services are designed to assist CHIPP consumers in gaining access to community resources and services. Although the available mental health services vary by county, each county must devise a system for the management of consumer incidents or events that jeopardize any CHIPP consumer's health, safety, or rights.

State laws and regulations and DPW policy and procedures provide guidelines for the content, frequency, and record of case management services, the licensing of residential facilities, and the management of any incidents at community facilities.

Case Management

Effective case management is essential for the successful community integration of CHIPP consumers. Case management is designed to ensure that CHIPP consumers gain access to community agencies, services, and staff who provide the support, training, and assistance required for a stable, safe, and healthy life in the community.

DPW regulations,[14] policies, and procedures provide guidelines for the content, frequency, and recording of case management services. Case management services must be provided in accordance with the written consumer-specific treatment plans, which are goal- and outcome-oriented. Case managers must conduct an ongoing review and prepare a written record to document that consumers received and participated in services. Contact with the consumer must be made on a regular basis to determine his or her opinion on progress, satisfaction with the program, and needed revisions to the treatment plan.

Two different levels of case management are (1) intensive case management and (2) resource coordination. For both types, case managers perform similar support activities, including needs assessment, service planning, monitoring of delivery, and problem resolution. However, intensive case management targets CHIPP consumers with more complex needs than consumers who are assigned resource coordination. Accordingly, the required frequency of client contacts is greater for intensive case managers than for resource coordinators.

Intensive case managers must make reasonable attempts to contact assigned adult consumers at least every two weeks. The contact or the attempt to contact must be documented. If contact with the consumer cannot be accomplished, then attempts to locate another member of the family, a relative, or a friend must be documented.[15]

Resource coordinators must contact assigned adult consumers at least once each month. Face-to-face contact with the adult consumer must be made at least every two months. If the resource coordinator cannot establish face-to-face contact with the CHIPP consumer, the attempt to contact must be documented.[16]

[14]55 Pa. Code § 5221 *et seq*.
[15]55 Pa. Code § 5221.31(6).
[16]"Resource Coordination: Implementation," *Mental Health and Substance Abuse Services Bulletin*, Department of Public Welfare, Commonwealth of Pennsylvania, July 30, 1993.

Residential Services

An effective residential support system is fundamental to the successful community integration of CHIPP consumers. The CHIPP residential support system follows a continuum of levels of care from long-term structured residences to community residential rehabilitation sites and personal care homes to non-facility based supports for consumers who live independently in their own apartments. The residential programs provide not only housing, but also varying degrees of personal assistance, such as assistance in meeting nutritional and medication needs, and psychosocial rehabilitation services to develop interpersonal and community living skills.

DPW issues certificates of compliance, or licenses, for most types of residential programs in which CHIPP consumers are placed. The licensing standards are specified in DPW's regulations contained in Title 55 of the Pennsylvania Code. The licensing requirements for community residential rehabilitation facilities are detailed in Chapter 5310 of the regulations, while the standards for personal care homes are identified in Chapter 2620. Chapter 5320 enumerates the licensing requirements for long-term structured residences.

The state licensing standards require that the residential programs provide for resident safety through fire alarm and smoke detection systems, evacuation plans, and fire drills. All licensed residential programs must maintain individualized client charts and service plans that document resident strengths, needs, and residential goals. The licensing standards also address the required staffing patterns, training, and supervision of the residential direct care personnel. Finally, the regulations specify standards for the physical environment of the residences, including mandates that the homes and furnishings be comfortable and clean.

Incident Management

All providers of CHIPP services must ensure the health, safety, and rights of the persons receiving the services. The primary goal of an incident management system is to ensure that responses to incidents adequately address these three requirements for the involved individuals. The development and expansion of community-based services for CHIPP consumers have underscored the necessity for consistent statewide processes for reporting, investigating, and following up on incidents.

The CHIPP guidelines issued by OMHSAS in March 1999 address the county program requirements for incident management as follows:

> *Counties will send copies of major unusual incidents for people placed by CHIPP to the Division of Operations Field Office within 24 hours of the incident being reported. . . . Major incidents are defined according to the MH/MR Bulletin #6000-88-04. Re-hospitalization in a state or private hospital and CHIPP consumers leaving service without notice are also to be considered a major incident for purposes of CHIPP reporting. Major incidents should be considered an opportunity for quality improvement. Corrective action plans for programs, policies or procedures should be established when such a need is identified.*

The aforementioned DPW policy bulletin No. 6000-88-04 and its replacement bulletin No. 00-01-05 indicate that reportable incidents include, but are not limited to, the following:

- Abuse or suspected abuse of a client.[17]
- Death of a client.

[17] The term "client" includes individuals referred to as patients and CHIPP consumers elsewhere in this audit report.

- Suicide attempt by a client.

- Accident or injury requiring treatment beyond first aid.

- Use of the services of a fire department or law enforcement agency, including the circumstances in which an individual is charged with a crime or is the subject of a police investigation which may lead to criminal charges.

Objectives and Methodology

The objectives of this portion of the audit were to assess compliance with the aforementioned guidelines and to evaluate the effectiveness of DPW's monitoring of service providers. In order to accomplish these objectives, we performed the following audit procedures:

- Reviewed state laws, regulations, and state and county policies and procedures regarding CHIPP community services.

- Interviewed county program officials, case management staff, and DPW representatives.

- Examined the treatment plans for 80 CHIPP consumers who received community services in the Southeast, Central, and Western regions between July 1, 1997, and June 30, 2002.

- Analyzed case management service documentation for the 80 consumers for the most recent six months of CHIPP services received.

- Toured 54 CHIPP residential facilities, including long-term structured residences, community residential rehabilitation sites, personal care homes, and three-person residences.

- Inspected the current certificates of compliance for each of the toured facilities for which DPW licensure was required.

- Reviewed the incident reports for 43 CHIPP consumers from the Central and Western regions.

Finding II-1: Five CHIPP consumers were arrested on at least nine occasions during the audit period. CHIPP providers in these cases did not notify DPW and counties about six of the nine arrests.

Our review of documents for 33 CHIPP consumers from the Western region and 10 CHIPP consumers from the Central region, along with interviews of Delaware County CHIPP personnel, found that five consumers were arrested on at least nine occasions during the period of July 1, 1997, to June 30, 2002.[18] The nine arrests are summarized as follows:

- **Consumer No. 1 was arrested three times.** Although the service provider did not report any of the three arrests to the Blair County mental health program office or to DPW, the consumer's case manager did make frequent visits to the consumer during his three incarcerations for theft, open lewdness, assault and harassment. However, after the consumer's release from jail the first time, the Blair County prison did not notify DPW or the Blair County mental health program office of the release. It is unknown whether the Blair County prison informed DPW or the county mental health administrators of this consumer's two subsequent releases from jail.

- **Consumer No. 2 was arrested one time.** The service provider did not notify either the Butler County mental health program office or DPW about this consumer's arrest for aggravated assault and terroristic threats, and the case manager did not contact this consumer during his incarceration. Moreover, the Butler County prison did not notify either DPW or county

[18]The reviewed sample of documents for the 43 consumers is not representative of CHIPP incident management across the Commonwealth. The audit team reviewed the incident reports for the same 33 consumers from the Western region and 10 consumers from the Central region for which case management files were analyzed. (Please refer to Finding II-5 in this chapter.) Due to DPW's response to HIPAA, we could not review any incident files for consumers in the Southeast and Northeast regions or in the following individual counties in the Central and Western regions: Allegheny, Beaver, Cameron/Elk/McKean, Centre, Clinton/Lycoming, Columbia/Montour/Snyder/Union, Crawford, Cumberland/Perry, Erie, Franklin/Fulton, Huntingdon/Mifflin/Juniata, Lancaster, Mercer, Venango, and York/Adams. Information regarding the arrested consumer from Delaware County was obtained during interviews.

mental health administrators when this consumer was released into the community.

- **Consumer No. 3 was arrested twice.** In both cases, the service provider reported the arrests (for aggravated assault) to the Dauphin County mental health program office.

- **Consumer No. 4 was arrested once.** Although the service provider notified the Delaware County mental health program office that this consumer was arrested for arson and reckless endangerment, no member of the CHIPP team visited the consumer during the two-plus years that he served in the Delaware County prison.

- **Consumer No. 5 was arrested twice.** The service provider did not notify either the Fayette County mental health program office or DPW about either of the two arrests for retail theft. CHIPP personnel also did not visit this consumer during the six months he was incarcerated in the Fayette County prison.

The following table provides additional details regarding the nine known arrests:

Table 3

(A) Consumer	(B) County	(C) Crime	(D) Date of Arrest	(E) Incident Report	(F) Place Jailed	(G) Period of Incarceration	(H) CHIPP Contact During Incarceration in County Prison	(I) Notification of Release
#1	Blair	Theft	2/3/99	None	County prison	2/3/99 to 2/17/99	Case manager visit on 2/15/99	No
		Open lewdness	8/27/99	None	County prison	8/27/99 to 11/27/99	Case manager visits on 9/22/99 and 10/12/99	Unknown*
		Aggravated indecent assault; Indecent assault; Harassment	6/15/01	None	County prison	6/15/01 to 9/20/02	20 case manager visits	Unknown*
#2	Butler	Aggravated assault; Terroristic threats	5/13/98	None	County prison	5/13/98 to 6/19/98	Consumer called case manager from prison on 5/14/98. The case manager did not visit the consumer in prison.	Consumer notified the case manager.
#3	Dauphin	Aggravated assault	9/16/02	Yes	County prison	Unknown*	Unknown*	Unknown*
		Aggravated assault	3/26/02	Yes	County prison	Unknown*	Unknown*	Unknown*
#4	Delaware	Arson; Reckless endanger-ment	4/7/00	Yes	County prison	4/7/00 to 7/10/02	None	N/A[19]
#5	Fayette	Retail theft	6/21/01	None	County prison	6/21/01 to 7/12/01	Case manager visit on 7/10/01	Unknown*
		Retail theft	12/28/01	None	County prison	12/28/01 to 5/16/02	None	N/A[20]

** This information was not made available to the audit team.*

[19] On July 10, 2002, this consumer was transferred to the Norristown State Hospital Forensic Unit.
[20] On May 16, 2002, this consumer was transferred to the State Correctional Institution at Pittsburgh.

Overall, for six arrests of CHIPP consumers—involving crimes such as aggravated assault, terroristic threats, and theft—the arrests were not reported to the appropriate county mental health program offices or to DPW. As shown in column E in the above table, there is no evidence that Blair, Butler, or Fayette counties received incident reports for the six arrests from the residential, therapy, or case management providers or that these three counties sent incident reports to DPW's regional office.

DPW policy as cited in the March 1999 CHIPP bulletin (No. 6000-88-04) and its replacement bulletin (No. 00-01-05), as well as the individual policies of both Butler and Fayette Counties, require the service provider to report consumer arrests to the county mental health program office. The CHIPP guidelines issued in March 1999 further require the county mental health program office to send copies of the arrest incident reports to DPW's regional field office within 24 hours of receipt.

When there is a failure to report arrests of CHIPP consumers, both DPW and the county are compromised in their capability to provide effective oversight and to administer the necessary quality of care. If DPW and/or the county mental health program officials are not aware of an arrest, then neither DPW nor the county can investigate the incident and take any necessary consumer-specific or system-wide corrective action. Such corrective actions, for example, could include changing the consumer's medications or changing the frequency of recommended counseling sessions. In addition, when DPW and the counties are notified of cases of incarceration, the program officials can then inform prison officials of the applicable mental health issues, thereby helping to ensure CHIPP consumers' continuity of care.

Finally, when DPW does not effectively manage the issues discussed in the preceding narrative by not taking steps to ensure that arrests and other such incidents are reported and followed up on—the public is put at risk for encountering unsupervised CHIPP consumers upon their release from incarceration.

Recommendation

- DPW should enforce its policies and procedures for incident reporting by reviewing county MH programs and requiring any necessary changes to ensure that all CHIPP consumer arrests are reported and investigated. Such actions would increase DPW's capability to monitor the CHIPP consumers, to ensure they get the continuity of care they need, and to decrease potential risk to the public.

Response by the Department of Public Welfare

CHIPP Guidelines established in 1999 required reporting of significant incidents, including, but not limited to arrests. At the time the guidelines were written, there was no uniform mechanism for this reporting requirement and each county mental health program used its own format for reporting to the OMHSAS Field Offices, usually in the form of a faxed incident report. The guidelines offered no specific guidance to the Field Offices regarding tracking or investigation of incidents reported to them. As a result, each Field Office responded to the receipt of incident reports somewhat differently. Field Office staff followed up with the county mental health program regarding incidents of concern in a variety of ways, including, but not limited to, contact by telephone, on-site visits, consumer interviews, meetings.

OMHSAS is moving toward a performance based contracting initiative with county mental health programs that will monitor specific indicators for people who are discharged from state hospitals as well as people receiving community-based services. In addition, OMHSAS is in the process of developing a Community Incident Management System that will require certain incidents, including arrest and incarceration, be reported for all mental health consumers, not only people participating in the CHIPP initiative. The goal is to implement an automated incident reporting system and a formal incident investigation process.

Consistent with the existing CHIPP guidelines, OMHSAS will communicate to county mental health programs the expectation

that major incidents involving individuals participating in the CHIPP initiative will continue to be reported via a paper (fax) process or via electronic email. OMHSAS will clarify that arrests and incarceration will be considered major incidents. In situations where the incident results in a change in status of the individual (per the CHIPP database definitions, status could change from active to inactive, inpatient in state hospital, incarcerated, or deceased), the information will be entered into the database by the OMHSAS Database Management Unit. OMHSAS Field Office staff will follow up with the county mental health program on all change-of-status incidents to determine if a more formal investigation of the event is indicated, document the results of the contact and submit documentation to the OMHSAS Database Management Unit.

OMHSAS will continue to require updates from counties at least annually on all individuals participating in the CHIPP initiative, on all data fields and enter into the CHIPP database.

Comments by the Department of the Auditor General

The nature of the corrective action plan is appropriate. The development of an automated incident reporting system and a formal incident investigation process is essential to effective incident management. However, DPW does not specify a timetable for completion of the corrective action plan.

Finding II-2: DPW and counties did not consistently monitor CHIPP consumers during incarceration.

DPW and counties did not consistently oversee the reviewed sample of CHIPP consumers during their incarceration. As shown in column H of Table 3, the frequency of CHIPP personnel contact varied significantly for the four CHIPP consumers for whom this information was available.

A CHIPP consumer who set fire to his own apartment was not visited by any member of his CHIPP team (including DPW officials, Delaware County Mental Health program personnel, his case manager, or CHIPP psychiatrist) during the more than two years during which he was incarcerated in the Delaware County jail. Additionally, CHIPP personnel did not visit a consumer convicted of retail theft while he was incarcerated for 149 days in the Fayette County prison. On the other hand, the case manager for a CHIPP consumer in the Blair County program visited his/her client twenty times during the 462 days in which the consumer was incarcerated in the county prison.

DPW's reaction to HIPAA prompted the untimely closure of our audit fieldwork. In an effort to obtain information about DPW's oversight of consumers during incarceration, we submitted relevant questions to a DPW representative on September 17, 2004. In its response dated November 23, 2004, DPW stated that it does not require case managers or other involved support personnel to visit or otherwise contact incarcerated consumers, including by telephone. The response did not indicate whether DPW has developed any procedures to ensure that CHIPP consumers continued to receive their care during incarceration. For example, CHIPP consumers must receive continuing and appropriate mental health care during incarceration to ensure appropriate societal behaviors and to prevent further incidents. However, DPW did not state whether it has established procedures to notify county or state prison officials of the mental health issues or treatment plan of the CHIPP consumer upon intake into the facility.

Recommendation

- DPW should develop and implement policies and procedures to monitor CHIPP consumers during any times they are incarcerated. Moreover, DPW should ensure that, statewide, such consumers receive the continuity of care for their needs.

Response by the Department of Public Welfare

The number of individuals participating in the CHIPP initiative who are incarcerated at any given time is very low. According to a review of the CHIPP database on July 12, 2005, of 2554 individuals named in the database, only 18 were incarcerated (9 in a county jail and 9 in a State Correctional Institution.) It is our belief that most counties do maintain contact with CHIPP consumers when they are incarcerated except in the rare occasion that the individual is sent to a prison at a long distance. Both nationally and locally, there has been an increase in attention to the issue of people with mental illness who become involved in the criminal justice system. Many counties have developed cross-system and interdisciplinary committees and task forces to address this issue.

In recognition of the need to focus attention at the state level, Deputy Secretary Erney has identified a Special Assistant in her office to be the OMHSAS lead on criminal justice issues and to liaison with other systems and stakeholders interested in this issue. DPW/OMHSAS actively supports mental health and criminal justice collaboration and the development of specialized services to divert people from incarceration when possible, ensure treatment is provided when an individual is incarcerated and to plan for the treatment and support services needed when re-entering the community to prevent re-offending.

OMHSAS will continue to reinforce with counties and providers the importance of communication and collaboration with local law enforcement and county correctional systems. Specifically for people participating in the CHIPP initiative, OMHSAS will direct

the county mental health programs to continue with incarcerated individuals to ensure continuity of care.

Comments by the Department of the Auditor General

As noted in its response to Finding II-1, DPW has not yet devised a standardized reporting mechanism for incidents that involve CHIPP consumers. Furthermore, our audit disclosed that CHIPP providers did not report six of nine arrests to the applicable county mental health program office or to DPW. Accordingly, the CHIPP database may understate the absolute number of consumers who were incarcerated on July 12, 2005.

Nonetheless, the importance of the continuity of care for incarcerated CHIPP consumers should not be diminished by a discussion of the number of consumers who were jailed at a single point in time.

Although DPW indicates that most counties "maintain contact with CHIPP consumers when they are incarcerated except in the rare occasion that the individual is sent to a prison at a long distance," the audit did not confirm that assertion. DPW should support provider and county mental health office collaboration with state and county correctional systems by devising formal policies and procedures that specify the nature and frequency of case manager contact with incarcerated consumers. At a minimum, the policy should require notification of the mental health issues or treatment plan of the CHIPP consumer upon intake into the facility.

Finding II-3: DPW has not established a mechanism for notifying CHIPP programs when CHIPP consumers are released from jail.

DPW has not established a mechanism for either state correctional institutions or county jails to inform DPW or the county CHIPP programs when CHIPP consumers are released from jails into communities. For example, as noted in column I of Table 3, the Blair County and Butler County prisons did not inform DPW or the associated county programs of the release of consumers from two incarcerations. Regarding the five other CHIPP consumer releases noted in the table, case managers did not recall or document notification of the releases.

In its November 23, 2004, response, DPW acknowledged that it has not developed a system for notification. DPW indicated that it was "exploring mechanisms to formalize a process" for the Pennsylvania Department of Corrections (DOC) to notify DPW and county mental health administrators "of the release of all inmates on the prison mental health roster and those who have received mental health treatment while in prison."

The absence of a system for notification hinders effective monitoring and the continuity of care of CHIPP consumers. A county program unaware of the release or whereabouts of the CHIPP consumer cannot provide needed CHIPP services. For example, CHIPP consumers jailed for violent crimes such as aggravated assault might not receive mental health treatment that is designed, in part, to prevent such violence and thereby protect the public.

Recommendation

- DPW should work with the DOC to develop a formal system of notification of the release of CHIPP consumers from state correctional facilities. Additionally, DPW should require the counties that receive CHIPP funds to design similar systems of notification with the county prisons.

Response by the Department of Public Welfare

The number of individual participants in the CHIPP initiative who have been sentenced to serve time in the state Department of Corrections (DOC) is very small. OMHSAS has developed a process for DOC to notify OMHSAS of the impending release of people (not limited to CHIPP) who are receiving mental health treatment in the prison and are expected to reach their maximum sentence date. This enables OMHSAS and DOC to work with the county mental health programs to develop aftercare plans.

OMHSAS will review the current database, identify those few DOC inmates who have received CHIPP services and are now inmates in the DOC, and request regular updates on the inmate's treatment and aftercare planning.

Some counties have well established relationships between the county jail and the mental health program. OMHSAS will continue to encourage the development of local communication mechanisms for all people with mental illness who become involved in the criminal justice system, including individuals who may have received CHIPP services.

Comments by the Department of the Auditor General

DPW states that it has developed a process for the Department of Corrections to notify OMHSAS of the impending release of CHIPP consumers from state correctional facilities. We are pleased to note that DPW has completed this process.

On the other hand, DPW maintains that it merely "encourages the development of local communication mechanisms" between the county jail and the mental health program. The response does not specify how this encouragement occurs. DPW's approach may not be sufficiently active or forceful. DPW should **require and assist** the counties that receive CHIPP funds to design systems of notification with the county prisons.

Finding II-4: Toured residential facilities were clean and possessed licenses as required, but licensure is not mandated for all types of residences in which CHIPP consumers live.

We toured 54 CHIPP residential facilities across the Commonwealth. Of those facilities, 40 were required to be licensed by DPW, including long-term structured residences, community residential rehabilitation sites, and personal care homes. The remaining 14 facilities were not required to be licensed by DPW, including three-person residences and independent-living apartments. We found that all 54 of the toured facilities were clean and neat. Furthermore, we found that each of the 40 residences that were required to possess a license did indeed hold a current certificate of compliance.

The above-mentioned three-person residences and apartments with supported housing services did not require DPW licensure. During the tours of these 14 unlicensed facilities, we did not note any obvious deficiencies that licensure would resolve. Nevertheless, the absence of required licensure and the attendant DPW inspections may increase the likelihood that such homes would not meet the standards of consumer care and living conditions that licenses are designed to ensure. However, due to impediments associated with the DPW's response to HIPAA, we could not conduct the number and type of interviews and tests that would allow us to evaluate adequately the necessity of DPW licensure for such residences.

Recommendation

The 54 toured residential facilities were clean. Each of 40 residences required to possess a license held a valid certificate of compliance. Audit scope limitations imposed by DPW prevented our evaluation of the necessity of licensure for the 14 remaining three-person residences and independent–living apartments. Accordingly, no recommendations follow.

Response by the Department of Public Welfare

No recommendation was made and no response is offered. Please note: all facilities required to have licenses had appropriate, current licenses. DPW does not require the licensing of small homes or apartments where individuals live independently or share space with one or two others.

Finding II-5: Case management services for a sample of 80 consumers complied with DPW guidelines, but DPW prevented our access to case management files from several counties.

A review of treatment plans and case management service documentation for 80 CHIPP consumers indicated compliance with DPW regulations, policies, and procedures. Each of these 80 consumers was assigned case management services in accordance with the individualized treatment plan. More specifically, 66 of these 80 consumers were assigned intensive case management, and 14 consumers were assigned resource coordination as indicated in the plans. Furthermore, the case management notes documented that each of the 80 consumers in the audited sample received residential, medical, counseling, and educational services consistent with the specifications of the treatment plan. Finally, the intensive case managers and resource coordinators documented the required frequency of contacts with the 80 CHIPP consumers.

However, due to DPW's response to HIPAA, we were able to examine the case management files for only 80 of 2,237 CHIPP consumers discharged from Commonwealth state mental hospitals between July 1, 1991, and June 30, 2002. We had planned to review the case management files for 222 consumers placed in communities throughout the Commonwealth. The following table details, by region, the size of the CHIPP population, the number of case management files that we had planned to review, and the number of records that we were permitted to review:

Table 4

Region	CHIPP Population	Planned Sample	Number of Reviewed Files
Southeast	610	67	37
Northeast	376	20	0
Central	345	28	10
West	906	107	33
Total	**2,237**	**222**	**80**

The sample of documents for the 80 consumers that we reviewed is not representative of CHIPP case management services across the

Commonwealth. We did not review any case management files for consumers in the Northeast region or in the following individual counties in the other three regions: Allegheny, Beaver, Bucks, Cameron/Elk/McKean, Centre, Chester, Clinton/Lycoming, Columbia/Montour/Snyder/Union, Crawford, Cumberland/Perry, Erie, Franklin/Fulton, Huntingdon/Mifflin/Juniata, Lancaster, Mercer, Venango, and York/Adams. Accordingly, we could assess regulatory and policy compliance only for the case management services provided to the 80 consumers in the audited sample and not the overall effectiveness of DPW's monitoring of case management services.

Recommendation

Case management services for the audited sample of 80 CHIPP consumers complied with DPW regulations, policies, and procedures. The audit scope limitation imposed by DPW prevented our ability to assess the overall effectiveness of DPW's monitoring of case management services statewide. Accordingly, we could not evaluate the overall condition of case management services and have not made any recommendations.

Response by the Department of Public Welfare

No recommendation was made and no response is offered. DPW does wish to state that while access to files was delayed during negotiations related to[HIPAA] implementation, access was not prevented. The decision to close field work was made unilaterally by the Department of the Auditor General.

Comments by the Department of the Auditor General

We disagree with DPW's assertion that access to files was delayed but not prevented. The substantial time that DPW took to analyze the Department of the Auditor General's role as a health oversight agency with regard to HIPAA effectively denied access to the essential information required to fulfill this audit objective.

Finding II-6: Several providers of case management services furnish residential or rehabilitative services also, thereby potentially compromising the quality of services to CHIPP consumers.

The providers of case management services also furnish other mental health treatment, rehabilitation, or support services in the counties of Armstrong, Bedford/Somerset, Blair, Butler, Cumberland/Perry, Dauphin, Indiana, Montgomery, and Philadelphia. Due to impediments associated with DPW's response to HIPAA, we could not perform any tests regarding the independence of case management providers in the Northeast region, or in the following individual counties in the other three regions: Allegheny, Beaver, Cameron/Elk/McKean, Centre, Clinton/Lycoming, Columbia/Montour/Snyder/Union, Crawford, Erie, Franklin/Fulton, Huntingdon/Mifflin/Juniata, Lancaster, Lawrence, Mercer, Venango, Washington, and York/Adams.

The lack of independence between case management and other support services could weaken the quality of services provided to CHIPP consumers. DPW regulations and policies require case managers to assist consumers in locating and obtaining the services specified in their treatment plans, to monitor service delivery, and to resolve service problems. A conflict of interest may increase the likelihood that a case manager will link a consumer to services operated by the provider agency where the case manager is employed even though equal or superior alternatives are available. A conflict of interest may also decrease the likelihood that a case manager will report or resolve deficiencies in residential or rehabilitative services provided by his/her employer.

Section 5221.44 of DPW's regulations, 55 Pa. Code § 5221.44, is designed to mitigate the effects of the impaired independence of case managers, as follows:

> *When an agency that provides intensive case management also provides other mental health treatment, rehabilitation or support services, the responsible county administrator shall ensure that the provider agency:*

(1) Does not restrict the freedom of choice of the consumer, or parent, if the consumer is a child, of needed services and provider agencies when needed services, including case management, are available.

(2) Fully discloses the fact that the agency is or may be performing other direct services, which could be obtained at another agency if the consumer so desires.

(3) Provides each consumer and parent, if the consumer is a child, a listing of mental health treatment, rehabilitation and support services available within a reasonable proximity to the consumer's home where needed services could be obtained and if the consumer or parent, if the consumer is a child, so desires, the case manager assists the consumer or parent in obtaining those services.

(4) Documents that the information in this section has been reviewed and understood by the consumer or parent, if the consumer is a child.

DPW's reaction to HIPAA prompted the closure of audit fieldwork before the audit team could test compliance with Section 5221.44 in any county. In an effort to assess the adequacy of DPW's oversight of case management independence, we submitted questions to a DPW representative on September 17, 2004. On November 23, 2004, DPW provided a written response. When asked whether DPW requires, obtains, or retains documentation from counties or providers that supports their compliance with Section 5221.44 of the regulations, DPW stated that counties "are expected to ensure that program requirements are met by these providers, but are not required to submit specific documentation verifying compliance with freedom of choice requirements." DPW's limited response did not indicate whether DPW has implemented any procedures to ensure county or provider compliance with Section 5221.44. Accordingly, we could not

conclude on the efficacy of DPW oversight, if any, nor recommend any necessary corrective measures.

Recommendation

We could not determine the existence or assess the adequacy of DPW oversight of case management independence due to scope limitations imposed by DPW. Accordingly, because we could not evaluate these conditions, we have not made any recommendations.

Response by the Department of Public Welfare

No recommendation was made and no response is offered. DPW does wish to note that OMHSAS does not require conflict-free case management and the Audit Report presented no evidence to support a concern of compromised quality of service by providers of case management services. While access to files was delayed during the negotiations related to [HIPAA] implementation, access was not prevented.

Comments by the Department of the Auditor General

DPW notes that OMHSAS does not require conflict-free case management. However, concerns regarding the effects of conflicts of interest are implicit to the existence and text of Section 5221.44 of DPW's regulation. This regulation was designed to mitigate the effects of the impaired independence of case managers. The finding merely underscores the fact that some providers of case management services are also providers of therapeutic services. The potential for conflicts is present in this situation.

We would also like to reiterate that access to files was prevented until well after our audit field work had closed.

Chapter Three:

Monitoring the propriety and reporting of CHIPP expenditures

CHIPP Funding Guidelines

Counties compete annually for available CHIPP funds through a proposal process. Each county's MH Plan, submitted to DPW's OMHSAS each September, details previously approved CHIPP programs and proposed services.

CHIPP is designed to promote the community placement of persons currently treated in state mental hospitals and to build community capacity for diversionary services to prevent unnecessary future hospitalization for individuals served by the Commonwealth's MH system. Accordingly, the award of CHIPP funds is related to the county's hospital bed day utilization.[21]

OMHSAS selects the counties to participate in CHIPP and also has the authority to monitor all CHIPP expenditures. Guidelines issued by OMHSAS in March 1999 address the requirements for the initial CHIPP proposal and ongoing financial reporting. According to the guidelines, the initial CHIPP proposal should incorporate a projected budget in which "personnel services, operating expenses, equipment and fixed assets, and the county indirect costs" are grouped by cost center. The proposal should also include a narrative that explains and supports the budget request. Final approval of the CHIPP proposal is documented in a letter of agreement signed by the county administrator, OMHSAS community program manager, and the state hospital's chief executive officer.

The financial reports are designed to document the costs of services for individuals placed into community-based settings by CHIPP and the costs of diversionary and capacity-building services developed for persons served by the community MH system. Counties are required to submit quarterly expenditure reports to OMHSAS during the first implementation year. In the second and third years, counties must submit expenditure reports to OMHSAS semi-annually. These reports should be consistent with the costs reported annually to OMHSAS on the county's Income and Expenditure Report, a summary of the revenue sources and

[21] DPW refers to bed day utilization as a measure of the usage of state hospital beds.

expenditures for all of the county's mental health programs. In the fourth year and beyond, the aggregate CHIPP expenditures are reported to OMHSAS on the annual Income and Expenditure Report. All CHIPP programs are also subject to an audit conducted by DPW's Bureau of Financial Operations.

CHIPP Allocations

CHIPP was established during the state fiscal year ended June 30, 1992. As of June 30, 2002, the program had been allocated $155 million over ten years and had placed more than 2,000 individuals in communities throughout the Commonwealth.

CHIPP Initiatives in Dauphin, Fayette, Luzerne, and Montgomery Counties

Dauphin and Montgomery Counties implemented their first CHIPP initiatives during the state fiscal year ended June 30, 1994. Fayette County implemented its first CHIPP initiative during the fiscal year ended June 30, 1996, while the Luzerne/Wyoming jointure began its CHIPP program in the following fiscal year. During the fiscal years ended June 30, 2002 and 2001, contracts for these four county CHIPP programs totaled $20.3 million and $17.3 million, respectively. Expenditure reports and letters of agreement with the applicable state hospitals indicate that these allocations were used to fund community mental health services, including residential services, housing supports, vocational rehabilitation, and consumer drop-in centers.[22]

[22] A drop-in center is one type of psychosocial rehabilitation program for CHIPP consumers.

The following table summarizes the history of CHIPP funding for the four county programs[23]:

Table 5

County	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Dauphin	$1,105,686	$2,255,599	$2,300,711	$2,620,998	$3,542,912	$4,144,540	$4,144,540	$4,144,540	$4,480,171
Fayette	N/A	N/A	$707,783	$1,209,050	$1,607,233	$1,996,900	$2,155,900	$2,155,900	$2,598,760
Luzerne/ Wyoming	N/A	N/A	N/A	$200,000	$575,200	$750,400	$750,400	$1,387,299	$1,730,400
Montgomery	$1,000,000	$1,020,000	$1,040,400	$1,290,400	$2,669,710	$4,270,020	$6,211,270	$9,629,020	$11,503,895

Note: N/A signifies program not yet in existence.

Objectives and Methodology

The objective for this portion of the audit was to evaluate the sufficiency of controls over CHIPP expenditures. More specifically, we sought to determine whether OMHSAS adequately monitored the propriety and reporting of CHIPP expenditures and to assess the compliance of OMHSAS and the counties with the aforementioned guidelines. In order to accomplish our objective, we reviewed CHIPP funds in Dauphin, Fayette, Luzerne, and Montgomery Counties.

We performed the following audit procedures for the four selected counties:

- Reviewed the CHIPP guidelines issued by OMHSAS in March 1999
- Interviewed financial personnel from the DPW and the county Mental Health/Mental Retardation (MH/MR) programs

[23]The amounts represent the dollar value of CHIPP contracts to various providers.

- Examined the letters of agreement between the four counties and the applicable state hospitals for the CHIPP programs implemented during the fiscal years ended June 30, 2001 and 2002

- Analyzed the county Mental Health Report of Income and Expenditures for the fiscal years ended June 30, 2001 and 2002

- Reviewed the county mental health program budgets for the fiscal years ended June 30, 2001 and 2002

- Reviewed the independent auditors' reports for the fiscal years ended June 30, 2001 and 2002

- Analyzed invoices, contracts, and other supporting documentation for sampled expenditures of $101,300 for Fayette County, $861,000 for Luzerne County, and $1,044,000 for Montgomery County for the fiscal year ended June 30, 2001[24]

- Examined invoices, contracts, and other supporting documentation for sampled expenditures of $965,700 for Dauphin County, $102,300 for Fayette County, $232,500 for Luzerne County, and $631,000 for Montgomery County for the fiscal year ended June 30, 2002

[24] Dauphin County's records were moved to an off-site storage location for the fiscal year ending June 30, 2001. Consequently, we were unable to inspect these documents.

Finding III-1: DPW and four reviewed counties implemented a number of expenditure controls.

OMHSAS and the four reviewed counties implemented a number of measures to ensure the propriety and accuracy of reported CHIPP expenditures. In accordance with the March 1999 guidelines, each of the four counties documented its CHIPP expenditures in budget proposals organized by cost center; in letters of agreement signed by the appropriate hospital, county, and OMHSAS personnel; and in annual Income and Expenditure Reports. Local public accounting firms audited each county program's financial statements annually.

The disbursements in our audit sample were supported by appropriate documentation. The sampled disbursements, which totaled $2.0 million and $1.9 million for the four counties for the fiscal years ended June 30, 2001 and 2002, respectively, were accompanied by properly approved invoices and vouchers. The sampled invoices disclosed that providers were paid according to the terms of the associated contracts. Moreover, the number and nature of services on the provider invoices (e.g., hours of counseling services, days of consumer residential services, etc.) were consistent with the narrative descriptions of the CHIPP programs in the proposals and letters of agreement. Finally, the sampled disbursements agreed with the expenditures detailed on the pertinent County Mental Health Reports of Income and Expenditures.

Recommendation

Expenditure controls appear to have been implemented at DPW and the four counties reviewed. Accordingly, no recommendation is necessary.

Response by the Department of Public Welfare

No recommendation, no response required.

Finding III-2: DPW did not adequately monitor Fayette County's CHIPP expenditures.

OMHSAS did not implement all measures necessary to ensure the propriety and reporting of Fayette County's CHIPP expenditures during the fiscal years ended June 30, 2001 and 2002. More specifically, OMHSAS did not follow up on Fayette County's failure to submit required budget revisions during both years.[25]

OMHSAS failed to enforce the March 1999 CHIPP guidelines, which state that counties must submit revised budgets for DPW approval when proposed changes in cost centers exceed certain limits, as follows:

> *In cost centers of $500,000 or more, any change of 5% or greater must be approved. . .*
>
> *In cost centers less than $500,000, any change of 20% or $25,000, whichever is smaller, must be approved.*

During the fiscal years ended June 30, 2001 and 2002, Fayette County reported actual expenditures for individual cost centers that differed significantly from the corresponding budgeted figures. The following table summarizes these variances by cost center for each fiscal year:

[25] During the fiscal years ended June 30, 2001 and 2002, the size of the variances between the reported and budgeted expenditures for Luzerne and Montgomery Counties did not warrant DPW approval. Although Dauphin County reported actual expenditures that differed significantly from the budgeted figures for the fiscal year ended June 30, 2002, it did not submit a required budget revision. However, Dauphin County did submit a proposal and a letter of agreement for nine new CHIPP projects that year. DPW approved these additional expenditures.

Table 6

Cost Centers	2001-02 Fiscal Year				2000-01 Fiscal Year			
	Budget	Reported	Variance	% Variance *	Budget	Reported	Variance	% Variance *
Administrative Case Management	$ 184,890	$ 284,729	$ (99,839)	**(54)**	$ 140,000	$ 140,000	-	-
Outpatient	30,000	-	30,000	**100**	41,000	-	41,000	**100**
Community Services	547,500	485,451	62,049	11	390,000	455,347	(65,347)	(17)
Partial Hospitalization	-	-	-		15,000	15,000	-	-
Community Employment	-	5,000	(5,000)		-	-	-	-
Vocational Rehabilitation	55,100	55,122	(22)	-	55,000	75,000	(20,000)	**(36)**
Social Rehabilitation	267,900	264,944	2,956	1	240,000	250,000	(10,000)	(4)
Family Support Services	6,500	6,500	-	-	6,500	6,500	-	-
Residential	1,168,961	1,107,269	61,692	**5**	828,936	828,936	-	-
Administration	265,000	349,729	(84,729)	**(32)**	257,000	257,000	-	-
Crisis	50,000	40,000	10,000	**20**	84,347	40,000	44,347	**53**
Housing Supports	130,000	107,017	22,983	18	112,000	112,000	-	-
Psychological Rehabilitation	-	-	-	-	50,000	40,000	10,000	**20**
Total	*$2,705,851*	*$2,705,761*	*90*	-	*$2,219,783*	*$2,219,783*	-	-

Note: CHIPP guidelines require DPW approval of the variances in boldface/shaded type.

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Fayette County did not submit revised budgets for DPW approval during either fiscal year. DPW distributed more than $2 million to Fayette County during each of the two fiscal years without having received revised budgets that documented the justification for the individual cost center variances. Moreover, OMHSAS did not contact personnel in Fayette County to investigate or follow up on the variances detailed on the annual income and expenditure reports.

The CHIPP guidelines are designed, in part, to maximize the efficiency of CHIPP program spending. DPW's failure to investigate and follow up on excessive cost variances may result in the failure to detect and, therefore, correct inefficient or inappropriate CHIPP expenditures.

Recommendations

- OMHSAS should enforce the CHIPP guidelines that require the submission of revised budgets for excessive variances in individual cost centers. Furthermore, OMHSAS should investigate excessive variances documented on county income and expenditure reports and require counties to adopt any necessary measures to maximize the efficiency of CHIPP spending and minimize any potential misuse of funds.

Response by the Department of Public Welfare

As required in the current guidelines related to CHIPP funding, OMHSAS Field Offices have and will continue to request and review revised budgets from the county mental health programs for variances in cost centers. OMHSAS has and will continue to investigate excessive variances on income and expense reports. OMHSAS is committed to continuing to partner with the counties to maximize efficiency of spending.

Comments by the Department of the Auditor General

We disagree with DPW's response that they have and will continue to request and review revised county budgets. Our audit did not support that DPW made any effort to request revised Fayette county budgets in order to review and investigate excessive budget variances.

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