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Implementation of State Auditor's Recommendations

Audits Released in January 2008 Through December 2009

Special Report to
Assembly Budget Subcommittee #1—Health and Human Services

SPECIAL REPORT

February 2010 Report 2010-406 A1

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February 23, 2010 2010-406 A1

The Governor of California
Members of the Legislature
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

The State Auditor's Office presents its special report for the Assembly Budget Subcommittee No. 1—Health and Human Services. This report summarizes the audits and investigations we issued during the previous two years that are within this subcommittee's purview. This report includes the major findings and recommendations, along with the corrective actions auditees reportedly have taken to implement our recommendations. To facilitate the use of the report, we have included a table that summarizes the status of each agency's implementation efforts based on its most recent response.

This information is also available in a special report that is organized by policy areas that generally correspond to the Assembly and Senate standing committees. This special policy area report includes a table that identifies monetary values that auditees could realize if they implemented our recommendations, and is available on our Web site at www.bsa.ca.gov. Finally, we notify auditees of the release of these special reports.

Our audit efforts bring the greatest returns when the auditee acts upon our findings and recommendations. This report is one vehicle to ensure that the State's policy makers and managers are aware of the status of corrective action agencies and departments report they have taken. Further, we believe the State's budget process is a good opportunity for the Legislature to explore these issues and, to the extent necessary, reinforce the need for corrective action.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Introduction

This report summarizes the major findings and recommendations from audit and investigative reports we issued from January 2008 through December 2009, that relate to agencies and departments under the purview of the Assembly Budget Subcommittee No. 1—Health and Human Services. The purpose of this report is to identify what actions, if any, these auditees have taken in response to our findings and recommendations. We have placed this symbol ➲ in the margin of the auditee action to identify areas of concern or issues that we believe an auditee has not adequately addressed.

For this report, we have relied upon periodic written responses prepared by auditees to determine whether corrective action has been taken. The State Auditor's Office (office) policy requests that the auditee provides a written response to the audit findings and recommendations before the audit report is initially issued publicly. As a follow-up, state law requires the auditee to respond at least three times subsequently: at 60 days, six months, and one year after the public release of the audit report. However, we may request an auditee to provide a response beyond one year or we may initiate a follow-up audit if deemed necessary.

We report all instances of substantiated improper governmental activities resulting from our investigative activities to the cognizant state department for corrective action. These departments are required to report the status of their corrective actions every 30 days until all such actions are complete.

Unless otherwise noted, we have not performed any type of review or validation of the corrective actions reported by the auditees. All corrective actions noted in this report were based on responses received by our office as of January 2010. The table below summarizes the number of recommendations along with the status of each agency's implementation efforts based on its most recent response related to audit reports the office issued from January 2008 through December 2009. Because an audit report and subsequent recommendations may cross over several departments, they may be accounted for on this table more than one time. For instance, the Information Technology Contracting Report, 2009-103, is reflected under the Department of Health Care Services and the Department of Public Health.

Table
Recommendation Status Summary

	FOLLOW-UP RESPONSE				STATUS OF RECOMMENDATION					
	INITIAL RESPONSE	60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	NO FOLLOW-UP RESPONSE	PAGE NUMBERS
Department of Developmental Services										
State Overtime Costs Report 2009-608		●				2	1			3
Department of Health Care Services										
Durable Medical Equipment Report 2007-122				●	1	1		1		11
Information Technology Contracting Report 2009-103		●			2	3	1			15
Department of Mental Health										
State Overtime Costs Report 2009-608		●					3	1		3
Department of Public Health										
Veterans Home-Yountville Report 2007-121				●	1					23
Low-Level Radioactive Waste Report 2007-114				●		3	1	2		31
Clinical Laboratories Report 2007-040				●	1	8				37
Information Technology Contracting Report 2009-103		●			1	3	1			15
Department of Social Services										
Investigations Report I2008-1 [I2006-1040]				●	1					45
Sex Offender Placement Report 2007-115				●	1					47
Safely Surrendered Baby Report 2007-124				●		1	4	1		53

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	FOLLOW-UP RESPONSE				STATUS OF RECOMMENDATION					
	INITIAL RESPONSE	60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	NO FOLLOW-UP RESPONSE	PAGE NUMBERS
Investigations Report I2009-1 [I2007-0962]		●			2					61
CalWORKs & Food Stamps Programs Report 2009-101	●					1	4	1		63

High Risk Update—State Overtime Costs

A Variety of Factors Resulted in Significant Overtime Costs at the Departments of Mental Health and Developmental Services

REPORT NUMBER 2009-608, OCTOBER 2009

Departments of Mental Health and Developmental Services' responses as of December 2009

California Government Code, Section 8546.5, authorizes the Bureau of State Audits (bureau) to establish a process for identifying state agencies or issues that are at high risk for potential waste, fraud, abuse, and mismanagement or that have major challenges associated with their economy, efficiency, or effectiveness. The law also authorizes the bureau to audit any state agency that it identifies as being at high risk and to publish related reports at least once every two years.

In February 2009 the bureau issued a report titled *High Risk: The California State Auditor Has Designated the State Budget as a High-Risk Area* (2008-603). This report concluded that the State's budget condition should be added to the bureau's list of high-risk issues because of the current fiscal crisis and history of ongoing deficits. This current report, which addresses the significant amount of overtime compensation the State pays to its employees, is part of the bureau's continuing efforts to examine issues that will aid decision makers in finding areas of government that can be modified to help improve efficiency and effectiveness.

We focused our initial review of overtime costs on five state entities: the California Highway Patrol, the Department of Forestry and Fire Protection (Cal Fire), the Department of Veterans Affairs, the Department of Mental Health (Mental Health), and the Department of Developmental Services (Developmental Services). From these five entities, we further studied three—Cal Fire, Mental Health, and Developmental Services—because each had numerous individuals in one job classification code earning more than $150,000 in overtime pay, which represented 50 percent of their total earnings during the five fiscal-year period we chose for review. We eventually narrowed our focus to two classifications of jobs—registered nurses-safety classification (nurses) at Napa State Hospital and psychiatric technician assistants at Sonoma Developmental Center—because employees in these classifications at each of the facilities earned a large portion of their total savings in overtime.

Finding #1: Employees working excessive amounts of overtime may compromise health and safety.

The focus on voluntary rather than mandatory overtime at Mental Health and Developmental Services, as required by their respective bargaining unit agreements (agreements), has resulted in a relatively small group of employees working many hours of overtime, while other individuals are working little or no overtime. For example, in

Review Highlights . . .

Our review of the State's overtime costs revealed the following:

- ***Employees at five entities, excluding the Department of Corrections and Rehabilitation, were paid at least $1.3 billion of the more than $2.1 billion in overtime pay during fiscal years 2003–04 through 2007–08.***
- ***Significant amounts of overtime were paid to a relatively small number of individuals in two job classifications at the departments of Mental Health (Mental Health) and Developmental Services (Developmental Services). For instance, in fiscal year 2007–08, at Mental Health's Napa State Hospital (Napa), 19, or 4 percent, of the 489 nurses in the registered nurse– safety classification averaged $78,000 in regular pay and $99,000 in overtime compensation.***
- ***According to various studies, individuals working excessive amounts of overtime may compromise their own and their patients' or consumers' health and safety.***
- ***One reason for the significant amounts of overtime at Napa and Developmental Services' Sonoma Developmental Center (Sonoma) is fluctuations in staffing ratios caused by the need to provide certain patients or consumers with one-on-one care.***

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» ***Pursuant to their respective bargaining unit agreements (agreements), both Mental Health and Developmental Services allowed leave hours to be counted as time worked in calculating overtime. For instance, during our review of overtime at Sonoma, we identified one employee who was paid for 160 hours of overtime in one month, even though that same employee took 167 hours of leave during that same month.***

» ***State law was changed in February 2009 to no longer allow leave to be counted in computing overtime for the two job classifications we tested. However, this same state law indicates that it may be superseded by agreements ratified subsequent to the law's effective date that once again could contain provisions that allow employees' leave time to be counted as time worked in computing overtime.***

fiscal year 2007–08, Mental Health's Napa State Hospital (Napa) paid $9.6 million in overtime wages to its 489 nurses. However, $1.9 million—20 percent of its total overtime costs—was paid to only 19 (4 percent) of these nurses. Similarly, in fiscal year 2007–08, Developmental Services' Sonoma Developmental Center (Sonoma) paid $1.1 million—25 percent of the total overtime paid to psychiatric technician assistants—to only 27 (6 percent) of its 430 psychiatric technician assistants. Sonoma's psychiatric technician assistants were the largest overtime earners at Developmental Services.

Some nurses at Napa and psychiatric technician assistants at Sonoma work substantial amounts of overtime to meet internal staffing requirements, even though the vacancy rates were relatively low for these job classifications at the respective facilities in fiscal year 2007–08. We reviewed the payroll records for 10 nurses at Napa and 10 psychiatric technician assistants at Sonoma who earned significant amounts of overtime pay in fiscal year 2007–08 and found that these individuals worked an average of 36 hours of overtime each week. These hours were usually in addition to the employee's regular 40-hour workweek. In fact, we identified a nurse employed at Napa who earned $733,000, or 66 percent of his total earnings, in overtime during fiscal years 2003–04 through 2007–08. This amounts to about 51 overtime hours each week during the five-year period.

Based on our review, 38 nurses at Napa and 65 psychiatric technician assistants at Sonoma worked, on average, at least 20 hours of overtime each week during fiscal year 2007–08. At the same time, 451 nurses at Napa (92 percent) and 365 psychiatric technician assistants at Sonoma (85 percent) worked fewer than 20 hours of overtime each week, on average. If the overtime had been distributed equally among all nurses and psychiatric technician assistants, they would have worked only six and eight hours of overtime per week on average, respectively. This closely compares with the results of a 2004 National Sample Survey of Registered Nurses conducted by the U.S. Department of Health and Human Services that found that the typical full-time registered nurse works an average of 7.5 hours of overtime each week.

Although nothing came to our attention indicating that the overtime at Napa and Sonoma affected the quality of care provided to patients or consumers, an August 2004 study published in *Health Affairs* entitled "The Working Hours of Hospital Nurses and Patient Safety" suggested that working substantial amounts of overtime could increase the risk of medical errors. For example, the study found that when a nurse worked a shift lasting more than 12.5 hours, the incidence of medical errors tripled. The study also found that the risk of errors increased when a nurse worked more than 40 or 50 hours in a week. Another study published in the *American Journal of Critical Care* entitled "Effects of Critical Care Nurses' Work Hours on Vigilance and Patients' Safety Issues" in 2006 indicated that these results could be applied to nurses and to psychiatric technician assistants. This study also indicated that experience in other industries suggests that accident rates increase when employees work 12 hours or more in a day.

Finally, a 2004 study by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, entitled "Overtime and

Extended Work Shifts: Recent Findings on Illnesses, Injuries, and Health Behaviors" indicated that long hours also can increase the health and safety risks to the employee. Specifically, the report cited many studies in which overtime was associated with poorer perceived general health, more illnesses, increased injury rates, and increased mortality. Injuries and poor performance were particularly noted on long shifts and when employees worked 12-hour shifts combined with working more than 40 hours a week. Thus, nurses and psychiatric technician assistants who work long shifts or more than 40 hours a week could place patients or consumers—and the employees themselves—at greater health and safety risk. Despite the increased risks associated with working long hours, our testing showed that during December 2007 and January 2008, nine of the 10 Napa nurses we reviewed regularly worked 12 or more hours in a day and on average worked more than 34 hours of overtime per week. Similarly, eight of the 10 psychiatric technician assistants we reviewed at Sonoma regularly worked 12 or more hours in a day and on average worked more than 35 hours of overtime per week.

To make certain that patients and consumers are provided with an adequate level of care, and that the health and safety of the employees, patients, and consumers are protected, we recommended that Mental Health and Developmental Services encourage Department of Personnel Administration (Personnel Administration)—which is responsible for negotiating labor agreements with employee bargaining units—to include provisions in future collective agreements to cap the number of voluntary overtime hours an employee can work and/or to require the departments to ensure that overtime hours are distributed more evenly among staff. One solution would be to give volunteers who have worked the least amount of overtime preference over volunteers who already have worked significant amounts of overtime.

Mental Health's Action: Pending.

Mental Health stated it will raise the issue of having staff with the least amount of overtime receive preference over employees who have worked significant amounts of overtime.

Developmental Services' Action: Partial corrective action taken.

Developmental Services states that the decision-making process for staffing and supervision continues to be influenced by the health and safety of consumers and retaining the facilities' certification with the Federal Centers for Medicare and Medicaid Services. However, Developmental Services stated it informed Personnel Administration of the bureau's recommendation and it will work closely with them in future overtime contract negotiations. Also, Sonoma's executive teams have implemented a weekly meeting to review overtime issues, activities, and actions. In addition, Sonoma is using existing and new reports to improve overtime monitoring.

Finding #2: Several factors cause the need for significant amounts of overtime.

The annual authorized positions agreed to by state hospitals, Mental Health, and the Department of Finance (Finance) do not take into account fluctuations in patient needs, resulting in the need for overtime to meet the monthly, weekly, and sometimes daily changes in staffing required to provide proper care to patients. With assistance from its respective facilities, Mental Health determines the number of positions needed for the coming year based on the department's estimated patient needs and population. However, the estimate of positions needed does not take into consideration the need for certain patients to receive more intensive care, such as one-on-one observation. Therefore, mental health hospitals prepare internal staffing ratios in order to meet the fluctuating needs of their patients. These internal staffing ratios are based on the average number of patients each level-of-care staff member will monitor, which then dictates the ratios needed. In some of the residential units at Napa, the internal staffing ratios are double the minimum staffing ratios established by the Department of Public Health (Public Health). Additionally, some of Napa's internal staffing ratios include a fixed number of staff to meet the need for one-on-one observation. However, because the Public Health's annual authorized positions are generally insufficient to meet actual staffing needs, the facilities use overtime to meet their internal staffing ratios for level-of-care staff.

According to the assistant deputy director of Long-Term Care Services at Mental Health, the impact of federal law changes such as the Family Medical Leave Act (family leave), Enhanced Industrial Disability Leave (enhanced leave), and additional negotiated mandatory training and/or educational leave days has led to an overwhelming use of overtime to sustain the required staffing ratios in the state hospitals. When the current relief factor was established, it took into account a change in the number of holidays and the current average use of sick time and educational leave, among other things. All these issues were before implementation of family leave, enhanced leave, and the current consent judgment requirements, leaving a very outdated relief factor that results in overtime to cover for these shortages. As an example, the enhancement plan (the implementation tool for the consent judgment) requires significant hours of training regarding new processes and training to implement a new electronic clinical data tracking system. It also requires computer use and basic computer skills from job classifications that have not historically required these training hours.

As recommended by the deputy director of Public Health's Center for Health Care Quality, and as required by law, staffing for patients in general acute care hospitals is based on the patients' needs. Evaluations performed by trained experts at Napa may determine that patients require a higher level of care than can be provided with the minimum staffing ratios established by Public Health. For example, at Napa, the nurse administrator, the clinical administrator, and the program's management staff determine the level-of-care staffing needs for each residential unit. Based on this assessment of patients' level-of-care needs within these units, Napa develops its internal staffing ratios, which, as previously noted, may exceed the legally mandated minimum staffing requirements. For instance, one program at Napa includes eight residential units with three levels of care: acute psychiatric, skilled nursing, and intermediate care. This program houses individuals with more serious physical or complicated diagnostic conditions and multiple medical as well as psychiatric problems that require a higher level of observation from staff.

Because of recent furloughs and potential layoffs of level-of-care staff, overtime at Mental Health most likely will increase, adding to the State's overtime costs. Our testing was performed for fiscal year 2007–08, a year in which Mental Health had high overtime costs. In December 2008, in an attempt to reduce the State's spending, the governor issued an executive order directing Personnel Administration to implement a furlough plan. This plan required most state employees to take two unpaid days off each month, beginning in February 2009. Moreover, in July 2009, Executive Order S-13-09 was implemented, adding a third unpaid furlough day each month. For facilities such as Napa that provide services 24 hours a day, seven days a week, the employees accrue their unpaid furlough days and use them when feasible. Additionally, Mental Health has required its facilities to provide layoff notices to staff. Napa needs to ensure that an adequate number of licensed individuals are available to meet mandated and/or required internal staffing needs. Napa already relies on overtime to meet fluctuations in staffing ratios, and the impact on staffing levels due to furloughs and layoffs likely will result in additional overtime.

We also found that Napa occasionally overstaffed some of its residential units, having more level-of-care staff on duty than necessary to meet the internal staffing ratio. Specifically, within Program 4, Napa was overstaffed on six of the 10 days we tested during fiscal year 2007-08. According to Napa's central staffing officer, the overstaffing was due to the designated staffing units not accurately reporting patient and staffing needs to the central staffing office. However, based on discussions with Finance's Office of State Audits and Evaluations and the results of its audit of Mental Health's budget dated November 2008, the Legislative Analyst's Office has suggested that an independent consultant evaluate workload distribution, staffing ratios, and overtime at Mental Health. Among other things, Finance's audit concluded that the current staffing model might not reflect the true hospital workload and the hospital may not be using staff efficiently. Although no time frame has been set for its commencement, if the evaluation concludes that current staffing ratios are unwarranted or that staff are not being used efficiently, an updated staffing model that reflects the accurate hospital workload could offset some of the increased overtime costs.

The assistant deputy director of Long-Term Care Services at Mental Health agrees with the Legislative Analyst's Office recommendation to hire an independent consultant to perform a workload staffing study. Mental Health feels the staffing study will allow for changes to the existing ratios to better reflect the reality of staff workload. However, Mental Health would like to hold off on the study until the hospitals have reached and sustained full compliance with the consent judgment, which is expected in November 2011, in order to allow staff to focus their full attention on their compliance efforts.

To ensure that all overtime hours worked are necessary, and to protect the health and safety of its employees and patients, we recommended that Mental Health implement the Legislative Analyst's Office's suggestion of hiring an independent consultant to identify improvements necessary to the current staffing model of Mental Health's hospitals. The staffing levels at Mental Health may need to be adjusted, depending on the outcome of the consultant's evaluation.

Mental Health's Action: Pending.

According to Mental Health, it entered into a consent judgment with the United States Department of Justice under the Civil Rights of Institutionalized Persons Act on May 2, 2006. Since that time, Mental Health has worked diligently to implement new staffing standards included in the agreement. Once fully compliant, Mental Health will consider reevaluating staffing needs by requesting an augmentation to the state hospitals appropriation to fund the study in fiscal year 2011–12.

Finding #3: Agreements allowed leave time taken to count as time worked in calculating overtime payments.

Overtime provisions contained in the agreements for nurses and psychiatric technician assistants, bargaining units 17 and 18, respectively, contributed to the State's substantial overtime costs during fiscal years 2003–04 through 2007–08. Specifically, with the exception of sick leave for psychiatric technician assistants, the overtime provisions for bargaining unit 18 allowed employees to include hours they took as paid leave when computing overtime compensation. A similar provision was included in bargaining unit 17's agreement, but includes sick leave. Thus, for example, a nurse could use eight leave hours, including sick leave, to cover his or her regular shift, work an alternate eight-hour overtime shift during the same day, and ultimately earn pay for 20 hours in the same day (eight hours times the 1.5 overtime pay rate plus eight hours of paid leave). Therefore, staff covered by these agreements were paid at the overtime rate even though they may not actually have worked more than 40 hours during the week or more than eight hours in one day.

A new state law overrides these overtime provisions in current agreements and will reduce the State's overtime costs. California Government Code, Section 19844.1, which became effective in February 2009, provides that periods of paid or unpaid leave shall not be considered as time worked for the purpose of computing overtime compensation, Therefore, employees covered by the agreements for bargaining units 17 and 18 are paid overtime only if their actual hours worked cause them to exceed 40 hours per week or eight hours per day. However, language in Section 19844.1 indicates that agreements ratified after the effective date of the section may contain provisions that require certain entities, including Mental Health and Developmental Services, to again include periods of paid and unpaid leave as time worked in the calculation of overtime.

To ensure that the State is maximizing the use of funds spent on patients and consumers, we recommended that Mental Health and Developmental Services encourage Personnel Administration to resist the inclusion of provisions in agreements that permit any type of leave to be counted as time worked for the purpose of computing overtime compensation.

Mental Health's Action: None.

Mental Health did not directly address the recommendation to encourage Personnel Administration to resist the inclusion of provisions in agreements that permit any type of leave to be counted as time worked for the purpose of computing overtime compensation.

Developmental Services' Action: Pending.

Developmental Services stated it informed Personnel Administration of the bureau's recommendation and it will work closely with them in future overtime contract negotiations.

Finding #4: Weak internal controls allowed over- and underpayments of overtime.

Our testing identified weaknesses in the internal controls at both Napa and Sonoma. Specifically, we found instances in which employees were overpaid or underpaid for overtime worked, instances when timekeeping and attendance records were not completed properly, and instances in which we were unable to locate timekeeping records at Sonoma.

During our review of 10 employees at Napa for December 2007 and January 2008, we found several discrepancies between attendance records and the payroll records. These discrepancies caused several over- and underpayments of overtime made to employees at Napa. Our analysis revealed five such errors in the two months we tested. For example, payroll staff at Napa erroneously omitted from the attendance records used to calculate overtime payments the overtime hours worked by and supported in the timekeeping records, causing over- and underpayments. Napa's human resources manager stated that these types of over- and underpayments were due to clerical error.

Finance identified similar issues at Napa during a review of internal controls conducted from July 2007 through December 2007. Specifically, the report cited inadequate personnel practices that do not provide reasonable assurance that attendance records are accurate and that payroll is proper, especially regarding overtime. As a result of its review, Finance made several recommendations to Mental Health. Among these was that Napa develop adequate timekeeping procedures to ensure that attendance records are adequately prepared, certified, and retained for audits. Although Napa has written timekeeping procedures, they were not always followed. For example, although Napa requires that the shift lead, unit supervisor, and nursing coordinator certify the accuracy of attendance sign-in sheets by signing them, we identified instances in which not all the authorizing signatures were present.

Finance also recommended that Napa improve its overtime reviews and preapprovals and include a second-level review outside the unit of the individual working overtime, and that these reviews be documented adequately in the personnel records. According to Napa's corrective action plan, as of April 1, 2008, overtime must be pre-approved by Napa's Central Staffing Office. However, for the five days we tested after this date, we identified four days when the tested unit did not obtain the required preapproval.

In addition, Napa's unit sign-in sheets and authorizations for extra hours were not always completed properly. For example, we noted instances in which the required authorizations were missing, the reasons for the overtime were not provided, and the number of overtime hours worked was not included. Finally, Finance recommended that Napa conduct random overtime auditing to help reduce fraud and abuse. Mental Health's October 29, 2008, corrective action plan stated that as of April 2008 Napa had conducted random overtime audits. However, Napa's human resources manager contradicted this assertion, stating that it has not performed any random overtime audits because of the combination of furloughs and the current overtime investigations of some employees that are taking significant staffing resources.

We also found several discrepancies at Sonoma between attendance records and the payroll records that caused over- and underpayments during December 2007 and January 2008, for the 10 employees reviewed. Our analysis revealed six such errors in the two months we tested. For example, some of the overpayments at Sonoma occurred because sick leave was counted as time worked for the purpose of calculating overtime payments, even though this practice is prohibited under the terms of the bargaining unit agreement. Sonoma's human resources manager attributed the mistakes to human error because personnel staff must enter information for hundreds of staff members into numerous complicated systems.

Sonoma uses overtime slips as its timekeeping records to approve and support its employees' overtime hours worked. We tested two employees' overtime slips for December 2007 and January 2008. Sonoma was able to locate only 96 of the 100 overtime slips it should have had on file for this period.

To improve internal controls over payroll processing, we recommended that:

- Napa and Sonoma research the overtime over- and underpayments we noted and make whatever payments or collections necessary to compensate their employees accurately for overtime earned.
- Napa and Sonoma review, revise, and follow procedures to ensure that their overtime documentation is completed properly; that timekeeping staff are aware of the overtime provisions of the various laws, regulations, and bargaining unit agreements; and that staff who work overtime are paid the correct amount.
- Mental Health fully implement Finance's recommendations cited in its report on Mental Health's internal controls dated December 2007.

Sonoma's Action: Partial corrective action taken.

According to Sonoma, the following have been implemented related to our recommendations:

- Sonoma worked with Developmental Services headquarters to reconcile the payment errors identified during the bureau's review and submitted the corrections to the State Controller's Office for processing.
- Sonoma has developed an ongoing process to audit the compensation transactions in an effort to avoid payment errors in the future. In addition, it provided training to all its human resources transaction personnel and timekeepers of applicable laws, regulations, contracts, rules, and policies. It also plans to provide training to all its managers and supervisors responsible for approving employees' time.

Napa's Action: Partial corrective action taken.

According to Napa, the following have been implemented related to our recommendations:

- All necessary salary adjustments that were identified during the bureau's review have been made and processed by the State Controller's Office.
- In October and November 2009 it informed its management team to carefully review timekeeping documents since their signatures on these documents indicate they have reviewed and approved the time.

Mental Health's Action: Pending.

Napa stated that, because of its staffs work on two investigations/audits of alleged overtime fraud and the effect of furlough days, it was unable to implement Finance's recommendation that it perform random audits of overtime worked. Napa also stated that, as of November 2009, the two investigations/audits previously mentioned were completed and it would begin conducting the recommended random audits in January 2010. These random audits are intended to reduce the instances of fraud and abuse.

Department of Health Care Services

Although Notified of Changes in Billing Requirements, Providers of Durable Medical Equipment Frequently Overcharged Medi-Cal

REPORT NUMBER 2007-122, JUNE 2008

Department of Health Care Services' response as of December 2009

The Joint Legislative Audit Committee requested the Bureau of State Audits to conduct an audit of the Department of Health Care Services' (Health Care Services) Medi-Cal billing system with particular emphasis on the billing instructions and coding for durable medical equipment (medical equipment).

Although Health Care Services adequately notified medical equipment providers of changes to the reimbursement rates and codes for medical equipment, we noted other findings.

Finding #1: Health Care Services' Allied Health Provider Manual (provider manual) does not include reimbursement guidance for speech-generating devices.

Health Care Services' policies and procedures and the information in its provider manual regarding reimbursement methodologies for medical equipment generally agree with state law and regulations and federal program requirements. However, the provider manual does not contain the methodology for calculating reimbursements for speech-generating devices included in state law.

To better ensure its provider manual represents a comprehensive guide for medical equipment providers, we recommended that Health Care Services include billing procedures for speech-generating devices.

Health Care Services' Action: Corrective action taken.

Health Care Services added the reimbursement methodology for speech-generating devices to its provider manual. According to Health Care Services, it released a provider bulletin in July 2008 informing providers of the change.

Finding #2: Health Care Services has no practical means to effectively monitor and enforce its medical equipment reimbursement rates.

Some providers have overbilled Medi-Cal, and Health Care Services has overpaid providers, for certain wheelchairs and wheelchair accessories with listed Medicare prices. In 2003 Health Care Services implemented new price controls, intended to lessen the opportunity for fraud and abuse. However, as indicated by a small number of limited scope audits that Health Care Services conducted of billings that providers submitted from September 1, 2005, through August 31, 2006, the price controls have not met their intended purpose. During 2007 and 2008 Health Care Services conducted a limited review of 21 providers' billings for wheelchairs and their

Audit Highlights . . .

Our review of the Department of Health Care Services' (Health Care Services) Medi-Cal billing system for durable medical equipment (medical equipment) found that:

- *Health Care Services' policies and procedures regarding reimbursement methodologies for medical equipment generally agree with state laws, regulations, and federal program requirements.*
- *Providers are adequately informed regarding changes in reimbursement methodologies and health care codes.*
- *Because Health Care Services has not identified a practical means to monitor and enforce its billing and reimbursement procedures, price controls enacted in 2003 have not met their intended purpose.*
- *Health Care Services conducted a limited review of providers and found that 21 providers overbilled, and Health Care Services overpaid, about $1.2 million, or 25 percent of the $4.9 million those providers billed.*
- *Although Health Care Services has recovered almost $960,000 of the overpayments, it does not know the extent to which other providers may have also overbilled for medical equipment.*
- *Although Health Care Services intends to use postpayment audits to enforce its price controls for medical equipment, its current auditing efforts do not provide enough coverage of medical equipment reimbursements to effectively ensure providers' compliance with the billing procedures.*

accessories with listed Medicare prices and found that providers overbilled, and Health Care Services overpaid, about $1.2 million, or 25 percent of the $4.9 million those providers billed. In addition, because Health Care Services has not yet reviewed billings for medical equipment without listed Medicare prices, including wheelchairs and wheelchair accessories, it does not know the extent to which providers comply with the price controls and bill using the lowest billing rate option. Furthermore, Health Care Services does not require providers to submit documents that would show they billed at the lowest of the billing options for medical equipment with a listed Medicare price or wheelchairs and wheelchair accessories without a listed Medicare price. According to the chief deputy director, for a billing that a provider submits electronically, Health Care Services has no automated method for auditing the claim to determine the relationship between the billed amount and the invoiced amount.

To maintain control over the cost of reimbursements, we recommended that Health Care Services develop an administratively feasible means of monitoring and enforcing current Medi-Cal billing and reimbursement procedures for medical equipment. If unsuccessful, Health Care Services should consider developing reimbursement caps for medical equipment that are more easily administered.

Health Care Services' Action: None.

➲ Health Care Services believes its current process is administratively sound and balances program flexibility with a cost-effective approach to curtail fraud and maintain access to care for beneficiaries. According to Health Care Services, it processes over $300 million each week in payments and it would be a massive and costly undertaking to review each claim and the associated documentation to determine if the providers are following Medi-Cal's billing and reimbursement procedures. Health Care Services believes post-payment audits is the most reasonable method to monitor and enforce its medical equipment and reimbursement procedures.

Finding #3: Current auditing efforts do not sufficiently cover the medical equipment reimbursements to ensure the providers comply with the billing and reimbursement procedures.

Audits of the Medi-Cal providers performed by Health Care Services in 2007 and 2008 revealed that the providers it reviewed billed for most of the wheelchairs and accessories they supplied at the maximum listed Medicare prices, not the significantly lower amounts the upper billing limit would have produced. According to the chief deputy director, Health Care Services has always intended to use postpayment audits to monitor and enforce its medical equipment billing and reimbursement procedures, including the upper billing limit. However, because medical equipment reimbursements make up a relatively small portion of total Medi-Cal payments—0.8 percent according to the 2006 payment error study Health Care Services conducted—current auditing efforts of total Medi-Cal payments do not provide enough coverage of medical equipment reimbursements to effectively ensure compliance. Moreover, perceiving a high cost and a low potential for benefits from the effort, Health Care Services focused its audits in 2007 and 2008 on medical equipment that represented only 10 of the more than 400 health care codes and reviewed a provider only if it had billed more than $50,000 from September 1, 2005, through August 31, 2006, for only one wheelchair type. However, using that methodology excluded some providers from a monitoring device intended to ensure that they adhere to price controls.

If Health Care Services continues using audits to ensure that providers comply with Medi-Cal billing procedures for medical equipment, including the upper billing limit, we recommended it design and implement a cost-effective approach that adequately addresses the risk of overpayment and ensures all providers are potentially subject to an audit, thereby providing a deterrent to noncompliance.

Health Care Services' Action: Partial corrective action taken.

According to Health Care Services, its Medical Review Branch received the billings of about 30 providers whose payments increased the most in 2008, compared to 2007 and focuses on about 30 procedure codes that were billed by these providers that were deemed at-risk. Its review showed that 17 providers submitted claims in excess of the upper billing limit for these procedures and were reimbursed inappropriate amounts. The overpayment amounts totaled almost $22,000. The Medical Review Branch is still conducting internal meetings to consider the next steps and plans to meet with the Health Care Services' legal office to discuss the findings further. Health Care Services plans to complete its report and make it available in the next few weeks.

Departments of Health Care Services and Public Health

Their Actions Reveal Flaws in the State's Oversight of the California Constitution's Implied Civil Service Mandate and in the Departments' Contracting for Information Technology Services

REPORT NUMBER 2009-103, SEPTEMBER 2009

Responses from the Departments of Health Care Services and Public Health, and the State Personnel Board, as of November 2009

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) examine the use of information technology (IT) consulting and personal services contracts (IT contracts) by the Department of Health Care Services (Health Care Services) and the Department of Public Health (Public Health). The audit committee specifically asked the bureau to review and assess the two departments' policies and procedures for IT contracts to determine whether they are consistent with state law. The audit committee also requested that we identify the number of active IT contracts at each department and—for a sample of these contracts—that we determine whether the departments are complying with California Government Code, Section 19130, and with other applicable laws, rules, and regulations. For the sample of contracts, the committee also requested that we collect various data and perform certain analyses, including determining whether the two departments are enforcing the knowledge-transfer provisions contained in the contracts.

The audit committee also asked us to identify the number, classification, and cost of IT positions budgeted at each department for each of the most recent five fiscal years. In addition, we were to determine the number of vacant IT positions, the turnover rate, and any actions that the departments are taking to recruit and retain state IT employees.

For a sample of contracts under review by the State Personnel Board (board), the audit committee asked us to identify the California Government Code section that the departments are using to justify an exemption from the implied civil service mandate emanating from Article VII of the California Constitution. For the contracts overturned by the board, we were asked to review the two departments' responses and determine whether corrective action was taken. Finally, the audit committee requested that we review and assess any measures that the two departments have taken to reduce the use of IT contracts.

Audit Highlights . . .

Our review of the personal services and consulting contracts for information technology (IT contracts) used by the Department of Health Care Services (Health Care Services) and the Department of Public Health (Public Health) revealed the following:

- *Over the last five years, the State Personnel Board (board) has disapproved 17 of 23 IT contracts challenged by a union.*
- *Many of the board's decisions were moot because the contracts had already expired before the board rendered its decisions.*
- *Of the six IT contracts still active at the time of the board's decisions, only three were terminated because of board disapprovals.*
- *Health Care Services did not comply with state policy regarding the use of blanket positions and was disingenuous with budgetary oversight entities.*
- *Neither Health Care Services nor Public Health has a complete database that allows it to identify active IT contracts and purchase orders.*
- *The departments complied with many, but not all, state procurement requirements.*
- *The departments did not obtain the requisite financial interest statements from half the sampled employees responsible for evaluating contract bids and offers.*

Finding #1: The board disapproved most of the departments' challenged IT contracts, but these decisions had limited impact.

Over the last five years, the board has disapproved 17 IT contracts executed by Health Care Services, Public Health, and their predecessor agency—the Department of Health Services (Health Services).[1] The board disapproved the IT contracts because the departments, upon formal challenges from a union, could not adequately demonstrate the legitimacy of their justifications for contracting under the California Government Code, Section 19130(b), which provides 10 conditions under which state agencies may contract for services rather than use civil servants to perform specified work. These conditions include such circumstances as the agencies needing services that are sufficiently urgent, temporary, or occasional, or the civil service system's lacking the expertise necessary to perform the service.

Although the union prevailed in 17 of its 23 IT contract challenges, many of the board's decisions were moot because the contracts had already expired before the board rendered its decisions. This situation occurred primarily because the union raised challenges late in the terms of the contracts and because the board review process was lengthy. The board's former senior staff counsel stated that if the board disapproves a contract, the department must immediately terminate the contract unless the department obtains from the superior court a stay of enforcement of the board decision. However, as the board's executive officer explained, the board's decisions usually do not state that departments must immediately terminate disapproved contracts, and she is unaware of the historical reasons behind this practice. Of the six IT contracts that were active at the time of the board's decisions, only three were terminated because of board disapprovals. For each of the other three IT contracts, the departments either terminated the contract after a period of time for unrelated reasons or allowed it to expire at the end of its term. We found that one contract was not terminated because the department was unaware of the board's decision and another because of miscommunications between the department's legal services and program office managing the contract. Because the board lacks a mechanism for determining whether state agencies comply with its decisions, the departments experienced no repercussions for failing to terminate these contracts.

Additionally, our legal counsel believes that uncertainties exist about whether or not a contract disapproved by the board is void and about the legal effect of a void contract. However, if a court were to find that the disapproved contract violated public contracting laws, the contractor may not be entitled to any payment for services rendered.[2] Because the legal effect of a board-disapproved contract is uncertain, it may be helpful for the Legislature to clarify when payments to the related contractors must cease and for what periods of service a vendor may receive payments.

To create more substantive results from the reviews conducted by the board under California Government Code, Section 19130(b), we recommended that the Legislature specify that contracts disapproved by the board must be terminated and require state agencies to provide documentation to the board and the applicable unions to demonstrate to the satisfaction of the board the termination of these contracts. We also recommended that the Legislature clarify when state agencies must terminate contracts disapproved by the board, when payments to the contractors must cease, and for what periods of service the contractors are entitled to receive payments.

To provide clarity to state agencies about the results of its decisions under California Government Code, Section 19130(b), we recommended that the board explicitly state at the end of its decisions if and when state agencies must terminate disapproved contracts. Additionally, we recommended that the board obtain documentation from the state agencies demonstrating the terminations of disapproved contracts.

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[1] Only July 1, 2007, Health Services became Health Care Services, and Public Health was established. All contracts disapproved by the board were originally executed by Health Services. However, the management of these contracts was performed by Health Services, Health Care Services, or Public Health.

[2] *Amelco Electric v. City of Thousand Oaks* (2002) 27 Cal. 4th 228, 234, upholding *Miller v. McKinnon* (1942) 20 Cal. 2d 83, 89, and *Zottman v. San Francisco* (1862) 20 Cal. 96, 101, 105-106.

To vet more thoroughly the Section 19130(b) justifications put forward by the departments' contract managers, to ensure the timely communication of board decisions to the contract managers, and to make certain that disapproved contracts have been appropriately terminated, we recommended that legal services in both departments take these actions:

- Review the Section 19130(b) justifications put forward by the contract managers for proposed personal services contracts deemed high risk, such as subsequent contracts for the same or similar services as those in contracts disapproved by the board.
- Notify contract managers of the board's decisions in a timely manner and retain records in the case files showing when and how the notifications were made.
- Require documentation from the contract managers demonstrating the termination of disapproved contracts and retain this documentation in the case files.

Legislative Action: Unknown.

We are not aware of any legislative action at this time.

Board's Action: None.

The board' executive officer stated that the board's legal counsel concluded that the board is unable to implement our recommendations without a statutory amendment.

Health Care Services' Action: Partial corrective action taken.

Health Care Services stated that its legal services is available to review personal services contracts identified by its contract managers as high risk. However, Health Care Services did not specify how its contract managers would identify contracts as high risk. Additionally, although Health Care Services stated that it revised its request-for-offer template to include evaluation criteria as identified in past board decisions, it did not indicate how this assists the contract managers in identifying those contracts they should forward to legal services.

Health Care Services also stated that notifying contract managers of relevant board decisions is in accordance with its current practices and that it would request notifications from program managers of contract terminations related to board-disapproved contracts and document them in the case files.

Public Health's Action: Corrective action taken.

Public Health issued a policy effective November 3, 2009, that requires its program staff to obtain approval from its legal services before entering into personal services contracts. Public Health stated that it has developed procedures to ensure that contract managers receive timely notification of board decisions and to maintain documentation for all notices of contract terminations in legal services' case files.

Finding #2: The departments have entered into subsequent contracts for substantially the same services as those in contracts disapproved by the board.

Although not prohibited by law from doing so, the departments entered into numerous subsequent contracts for the same services as those in the contracts previously disapproved by the board. Specifically, we found that for nine of the 17 contracts disapproved by the board, the departments entered into subsequent contracts for substantially the same services as those in disapproved contracts. In one case, the board disapproved an IT contract for the same service from the same supplier that it had already disapproved in an earlier union challenge. Without some limitation on subsequent same-service contracts, board decisions related to Section 19130(b) of the California Government Code

will often affect only contracts with terms that have expired or will soon expire, and the decisions will not preclude similar contracts from immediately replacing those that the board disapproves. As a result, all the effort and resources spent reviewing challenged IT contracts would seem to be an inefficient use of state resources.

To create more substantive results from the reviews conducted by the board under California Government Code, Section 19130(b), we recommended that the Legislature do the following:

- Prohibit state agencies from entering into subsequent contracts for substantially the same services as specified in contracts under board review without first notifying the board and the applicable unions, allow unions to add these contracts to the board's review of the original contracts, and allow the board to disapprove the subsequent contracts as part of its decision on the original contracts.

- Require state agencies that have contracts disapproved by the board to obtain preapprovals from the board before—in a manner similar to the process that occurs for requests under California Government Code, Section 10130(a)—entering into contracts for substantially the same services. Further, if an agency enters into a contract without the board's preapproval, the Legislature should allow the applicable union to challenge this contract and prohibit the agency from arguing that the contract was justified under Section 19130(a) or (b). Instead, the board should resolve only whether the subsequent contract is for substantially the same service as the disapproved contract.

Legislative Action: Unknown.

We are not aware of any legislative action at this time.

Finding #3: Although it saved the State $1.7 million by replacing IT consultants with state employees, Health Care Services failed to follow budgetary instructions and rules.

Partly in response to the disapproved contracts, the two departments sought to replace IT contractors with state IT employees. For this purpose, in January 2009, the Department of Finance (Finance) approved the creation of an additional 28 IT positions within the information technology services division (IT division) of Health Care Services and 11 IT positions within the IT division of Public Health. Health Care Services began the process of converting IT contractor positions into state positions as early as October 2006, but it did not clearly disclose this effort in its budget change proposal (BCP) requesting additional positions. Specifically, despite language in Health Care Services' January 2009 BCP stating that the 28 requested positions "will replace contractors *currently* providing IT support functions" and that these conversions will occur over three fiscal years, it had already replaced nine contractors, and the termination dates for the contracts associated with these nine contractors had already expired.

Because permanent positions had not yet been approved in the state budget, Health Care Services funded the new employees—who were hired as permanent civil servants—using temporary-help positions authorized in the budget as *blanket positions*, which are positions in the approved budget that an agency may use for short-term or intermittent employment needs when expressing those needs as classified positions has proven impracticable. According to the *State Administrative Manual*, an agency may not use temporary—help positions provided under its blanket authority to fund permanent employees. Although it did not comply with state policy regarding the use of blanket positions and was disingenuous with budgetary oversight entities, we estimate that Health Care Services saved the State more than $1.7 million when it converted IT contracts to IT positions. Public Health stated that it will not be able to replace its IT contracts with state employees until fiscal year 2010–11, which is when it anticipates it will be able to hire and train employees who have the appropriate skill sets to make the transition successful.

To ensure that Finance and relevant legislative budget subcommittees are able to assess its need for additional IT positions, we recommended that Health Care Services prepare BCPs that provide more accurate depictions of the department's existing conditions.

To comply with requirements in the *State Administrative Manual*, we recommended that Health Care Services refrain from funding permanent full-time employees with the State's funding mechanism for temporary-help positions.

Health Care Services' Action: Pending.

Health Care Services stated that it strives to provide clear and precise BCPs and that it would continue to provide training to staff on the preparation of BCPs, based on guidance from Finance, that are accurate and complete. Health Care Services also stated that it is currently in the process of removing all of the individuals identified by the audit out of temporary-help positions and into newly authorized positions.

Finding #4: The two departments cannot readily identify active IT contracts.

Neither Health Care Services nor Public Health has a complete database that allows it to identify active IT contracts and purchase orders. Consequently, the departments cannot readily identify such procurements. The best source of information for the purposes of this audit was the contracts database maintained by the Department of General Services (General Services) and populated with self-reported data from state agencies. However, we found errors in the data reported by Health Care Services and Public Health indicating that the information in General Services' database is incomplete and inaccurate for these departments.

Public Health stated that it is in the process of developing a new database that will identify all contracts that are active and IT-related. The database will include this information for all completed contracts and those in progress. Public Health anticipates implementing its database in October 2009. The chief of its Contracts and Purchasing Support Unit stated that Health Care Services is monitoring the development of Public Health's database, and Health Care Services will consider its options for creating a similar database if the implementation of Public Health's database is successful.

To readily identify active IT and other contracts, we recommended that Public Health continue its efforts to develop and implement a new contract database. Additionally, we recommended that Health Care Services either revise its existing database or develop and implement a new contract database.

To ensure that reporting into General Services' contracts database is accurate and complete, we recommended that both departments establish a review-and-approval process for entering their contract information into the database.

Health Care Services' Action: Partial corrective action taken.

Health Care Services stated that it will complete, by March 2010, its assessment of the feasibility of enhancing its contract database. Health Care Services also stated that it reiterated to staff the importance of entering accurate information into General Services' database, provided additional instruction, and performed spot checks of data entered into the system in August and September 2009. Health Care Services indicated that, because the latter activity resulted in the detection of a few errors, it implemented a new procedure that involves the preparation of a data entry form by supervisory or analytical staff. Further, Health Care Services stated it plans to continue to perform spot checks to ensure the accuracy of the data in General Services' database.

Public Health's Action: Partial corrective action taken.

Public Health stated that it will complete its new contract database by July 2010. Public Health also stated that it established a new procedure for staff to enter information into General Services' database and will have a staff person conduct a review to ensure the procedure is reliable.

Finding #5: The departments generally complied with the procurement requirements that we tested.

The departments complied with many, but not all, state procurement requirements we reviewed. For a sample of 14 contracts, the departments obtained the requisite number of supplier responses, encouraging competition among suppliers. The departments also complied with requirements related to maximum dollar amounts and allowable types of IT personal services, except in one instance. In this instance, Public Health procured some unallowable printer maintenance services under its contract with Visara International (Visara). Visara's master agreement with General Services allows it to provide maintenance on numerous printer types. However, 13 of the 17 printer types listed in Public Health's contract with Visara are not included in General Services' master agreement. Therefore, the prices negotiated between Public Health and Visara for maintenance on these 13 printer types were not subject to the required level of scrutiny that is designed to ensure that Public Health is not paying too much.

To make certain that it procures only maintenance services allowed in the State's master agreement with Visara, we recommended that Public Health either make appropriate changes to its current Visara contract or have General Services and Visara make appropriate changes to Visara's master agreement.

Public Health's Action: Partial corrective action taken.

Public Health stated that it processed an amendment to remove non-covered printers from its Visara contract and is working with General Services to add these printers to its Visara master agreement.

Finding #6: The departments have not provided suppliers with selection criteria.

The *State Contracting Manual* establishes the requirements for departments to follow when conducting supplier comparisons, and it provides a request-for-offer template. The request-for-offer template states that if departments use the best-value method to select suppliers, they should detail their selection criteria and the corresponding points that will be used to determine the winning offer.[3] The best-value method, which is the basis for all California Multiple Award Schedules (CMAS) contracts, refers to the requirements, supplier selection, or other factors used to ensure that state agencies' business needs and goals are met effectively and that the State obtains the greatest value for its money.

Three of the requests for offer associated with the five CMAS contracts we reviewed contained only brief, vague statements regarding how the departments would determine the winning offers. Further, none of the requests for offer for these five contracts included information on the corresponding points. Without specific selection criteria, potential suppliers are left to guess the criteria and their relative importance using what they can glean from the departments' requests for offer.

To promote fairness and to obtain the best value for the State, we recommended that the two departments demonstrate their compliance with General Services' policies and procedures. Specifically, in their requests for offer, they should provide potential suppliers with the criteria and points that they will use to evaluate offers.

[3] The *State Contracting Manual* provides departments with limited discretion regarding policy requirements prefaced by the term "should." It states that such policies are considered good business practices that departments need to follow unless they have good business reasons for deviating from them.

Health Care Services' Actions: Corrective action taken.

Health Care Services indicated that it modified its request-for-offer template to include evaluative criteria that it will use on all CMAS procurements.

Public Health's Action: Pending.

Public Health stated that, by January 2010, it plans to develop and distribute to staff a new form they can use to inform potential suppliers of the criteria it will use to evaluate their offers.

Finding #7: The departments did not obtain some required approvals and conflict-of-interest information for the contracts that we reviewed.

The departments did not always obtain prior approvals from their agency secretary, directors, and—in the case of Public Health, IT division—as required by state procurement rules and departmental policies. In particular, we found that the departments did not obtain the appropriate agency secretary's or director's approvals for three of the seven CMAS and master agreement contracts for which the requirement was applicable. Additionally, despite a policy requiring its IT division to review all IT contracts, we found that Public Health's IT division did not review two of the 14 Public Health contracts we reviewed.

The departments also did not consistently obtain requisite annual financial interest statements from bid or offer evaluators. Health Care Services failed to obtain this statement from one employee and Public Health failed to obtain the financial interest statement from six of its employees. For three of the six employees, Public Health stated that the employees were not in positions designated in the department's conflict-of-interest code as needing to file the financial interest statement. Our review raised questions about whether Public Health's conflict-of-interest code appropriately designated all employees engaged in procurement. We believe that state employees who regularly participate in procurement activities may participate in the making of decisions that could potentially have a material financial effect on their economic interests. To maintain consistency with the Political Reform Act, state agencies should designate such employees in their conflict-of-interest codes. Without the approvals mentioned earlier and these financial interest statements, the departments are circumventing controls designed to provide high-level purchasing oversight and to deter and expose conflicts of interest.

To ensure that each contract receives the levels of approval required in state rules and in their policies and procedures, we recommended that the departments obtain approval by their agency secretary and directors on contracts over specified dollar thresholds. In addition, we recommended that Public Health obtain approval from its IT division on all IT contracts, as specified in departmental policy.

To make certain that it fairly evaluates offers and supplier responses, Public Health should amend its procedures to include provisions to obtain and retain annual financial interest statements from its offer evaluators. Further, both departments should also ensure that they obtain annual financial interest statements from all designated employees. Finally, Public Health should ensure that its conflict-of-interest code is consistent with the requirements of the Political Reform Act.

Health Care Services' Action: Partial corrective action taken.

Health Care Services stated that it would obtain the necessary approvals, as required. Health Care Services did not indicate that any revision of policy or procedure would be necessary. Health Care Services also stated that, during the next period for filing financial interest statements, it would provide specific reminders to staff regarding the disclosure categories related to offer evaluators and it would review each contract to ensure that evaluators have filed statements.

Public Health's Action: Partial corrective action taken.

Public Health stated that it would send out, by December 31, 2009, a bulletin reminding staff of its policy for processing IT procurements, which includes obtaining approvals from the division chief, the legal office, and the IT division's chief.

Effective November 3, 2009, Public Health issued a policy that requires each staff member who participates in the procurement process to file a conflict-of-interest and confidentiality statement it created.

Finding #8: Health Care Services could not always demonstrate fulfillment of contract provisions requiring IT consultants to transfer knowledge to IT employees.

Health Care Services and Public Health did not always include specific contract provisions in their contracts with IT consultants to transmit the consultants' specialized knowledge and expertise (knowledge transfer) to the State's IT employees because these knowledge-transfer provisions were not always applicable. However, when its IT contracts included knowledge-transfer provisions, Public Health was generally able to demonstrate that the department met these provisions, while Health Care Services had difficulty doing so for all three of its contracts in our sample that contained knowledge-transfer provisions.

To verify that its consultants comply with the knowledge-transfer provisions of its IT contracts, and to promote the development of its own IT staff, we recommended that Health Care Services require its contract managers to document the completion of knowledge-transfer activities specified in its IT contracts.

Health Care Services' Action: Corrective action taken.

Health Care Services stated that it would remind all managers and supervisors who are responsible for managing IT contracts to document the completion of knowledge-transfer activities. Health Care Services did not indicate that any revision of policy or procedure would be necessary.

Veterans Home of California at Yountville

It Needs Stronger Planning and Oversight in Key Operational Areas, and Some Processes for Resolving Complaints Need Improvement

REPORT NUMBER 2007-121, APRIL 2008

California Department of Veterans Affairs' response as of December 2008 and California Department of Public Health's response as of June 2009

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct an audit of the Veterans Home of California at Yountville (Veterans Home), with an emphasis on the adequacy of health care and accommodation of members with disabilities. Specifically, the audit committee requested that we determine the roles and responsibilities of the various entities involved in the governance of the Veterans Home, including those responsible for setting guidelines for the care of residents. The audit committee asked that we determine whether any of the entities had evaluated staffing levels for medical personnel, review the Veterans Home staffing ratios, and identify any efforts the Veterans Home had taken to address personnel shortages. Additionally, the audit committee asked us to assess how the Veterans Home manages its medical equipment to ensure that it is up to date and functioning properly and evaluate efforts the Veterans Home has made to ensure that its facilities and services are meeting the accessibility requirements of the Americans with Disabilities Act. Finally, the audit committee asked that we review and assess the policies and procedures for filing, investigating, and taking corrective action on complaints from members and review how the Veterans Home ensures members comply with its code of conduct.

Finding #1: Chronic vacancies have limited the ability of the Veterans Home to serve more veterans.

Our review of the Veterans Home revealed that it has had difficulty filling key health care positions in recent years, especially nursing positions. During fiscal year 2006–07 about 41 percent of all vacant positions at the Veterans Home were nursing positions. As a result, the Veterans Home has been limited in its ability to serve the veterans community and some nursing staff have worked substantial amounts of overtime to meet staffing guidelines for providing care to members living in the skilled nursing and intermediate care facilities. For example, we determined that although the Veterans Home has sufficient budget-authorized nursing staff to fill 435 beds without the need for substantial overtime, because of nursing staff vacancies its census shows that as of December 2007 it had only 357 beds filled. Moreover, 20 members of the nursing staff worked an average of more than 20 hours of overtime each week during the last three months of 2007. Although we did not observe such matters at the Veterans Home, one research study we reviewed concluded that excessive overtime by health care workers can lead to medical errors and negative patient outcomes.

Audit Highlights . . .

Our review of the Veterans Home of California at Yountville (Veterans Home) found that:

- *Chronic shortages in key health care positions, such as nursing, have limited the Veterans Home in serving the veteran community. Some nursing staff have worked substantial amounts of overtime to meet staffing guidelines for providing care to members who live in the skilled nursing and intermediate care facilities.*
- *Despite these staffing shortages, the Veterans Home has not had a coordinated and comprehensive strategy for filling chronic staff vacancies in especially important occupational areas.*
- *Weak oversight of its medical equipment maintenance contract provides the Veterans Home little confidence that the equipment has received regularly scheduled testing and maintenance, thereby risking not having properly functioning equipment available when needed and making inappropriate payments to its medical equipment contractor.*
- *The Veterans Home has not assessed its compliance with Americans with Disabilities Act requirements to ensure people with qualifying disabilities have access to the Veterans Home and its programs and services, or designated a representative to respond to complaints of inaccessibility from members.*

continued on next page . . .

» ***State agencies responsible for investigating and resolving complaints by Veterans Home members regarding the Veterans Home and its programs and services, the Veterans Home, the California Veterans Board, the California Department of Veterans Affairs, and the California Department of Public Health, could improve their practices regarding those responsibilities.***

We also found that the veterans' community has an unmet need for the services of the Veterans Home. In addition to unfilled beds, the Veterans Home maintains a waiting list of veterans seeking admittance. As of January 2008 the Veterans Home had a waiting list of 250 veterans for skilled nursing beds and 220 veterans for intermediate care beds. Although the Veterans Home does not regularly monitor the status of those waiting veterans, the mere existence of the lists indicates a certain level of demand for entry into the home. Further potentially limiting the ability of the Veterans Home to admit veterans into the level of care they need is a regulation stating that less than 75 percent of skilled nursing beds must be occupied before the home can admit members directly to that level of care. The California Department of Veterans Affairs (Veterans Affairs) has suspended that regulation in the past and intends to initiate a regulatory change within six months to grant the administrators the discretion to admit veterans to skilled nursing care while ensuring that existing members have access to skilled nursing beds.

According to the deputy administrator at the Veterans Home (deputy administrator), the home faces two major challenges in recruiting and retaining health care professionals: comparatively low salaries and the high cost of housing in the community. Salaries offered at the Veterans Home are lower than those offered at other state hospitals in the area, primarily because of the salary increases for medical and mental health positions at the California Department of Corrections and Rehabilitation facilities that resulted from recent federal court decisions. The Veterans Home must also contend with statewide shortages in several high-need health care occupations, such as registered nurses.

Despite these staffing shortages, the Veterans Home has not had a coordinated and comprehensive strategy for filling chronic staff vacancies in especially important occupational areas. Instead, individual departments within the Veterans Home have assumed important recruiting functions, without involvement from the home's human resources department. As a result, the Veterans Home has not been as effective as it could be in conducting recruiting efforts such as advertising vacant positions. It also is not as prompt as it could be in processing successful job applicants so they can start working at the Veterans Home, primarily because the home takes too much time to schedule, perform, and obtain the results of the physical examinations applicants must undergo.

To improve recruitment of health care staff, the Veterans Home has moved to centralize recruiting efforts under its human resources department. In an attempt to lessen the time between candidate job acceptances and employment start dates, the Veterans Home has identified a specific doctor and two nurse practitioners to perform physical examinations. According to the deputy administrator, the Veterans Home plans further action, such as improving the process for advertising open positions, extending outreach to nursing schools, and establishing a more effective exit interview process to gain a better understanding of why employees leave. In addition, the Veterans Home is seeking increased housing assistance for its employees.

Further, Veterans Affairs has taken action to raise salaries in several health care occupations at the Veterans Home and has performed some recruitment activities that might benefit the home. Veterans Affairs is also planning to implement a recruiting program that will coordinate the department's recruiting efforts and require the Veterans Home to develop a local recruitment plan that addresses department-wide recruiting goals.

To improve its ability to fill vacancies in key occupations, we recommended that the Veterans Home develop a comprehensive plan for recruitment and retention that establishes goals and strategies for reducing chronic vacancy rates and sets timelines and monitoring activities to keep recruiting efforts on track. To maximize its efforts to recruit for key health care positions, we recommended that the Veterans Home ensure the recruitment efforts of all its departments are coordinated through a centralized position or program. In addition, the Veterans Home should implement the remaining steps it has currently identified to better recruit and retain health care staff.

To prevent its nursing staff from working excessive overtime, we recommended that the Veterans Home consider adopting a formal policy for distributing overtime more evenly among nurses, establishing a cap on how much overtime nursing staff can work, and monitoring overtime usage for compliance with these policies.

If Veterans Affairs is concerned that its ability to serve California veterans is limited by a regulation stating that less than 75 percent of skilled nursing beds must be occupied before it can admit new patients directly to that level of care, we recommended it consider changing or eliminating that regulatory requirement.

To help ensure that newly hired employees at the Veterans Home can start work as soon as possible, we recommended that the Veterans Home monitor its new process for completing preemployment physicals. If the process is not resulting in new employees starting work more quickly, the Veterans Home should consider contracting with a vendor to provide the physicals.

To bolster recruitment efforts at the Veterans Home, we recommended that Veterans Affairs continue to develop its department-wide recruiting plan and oversee the recruiting plan the Veterans Home is implementing to ensure that it meets department-wide goals.

Veterans Home's Action: Partial corrective action taken.

The Veterans Home stated that it has developed a facility recruitment plan and is executing it. It has published an examination plan and is training all service chiefs on the recruitment process and timelines. The Veterans Home further stated it has developed and implemented a recruitment calendar, regularly participates in area career fairs and recruitment events, and conducts exit interviews of staff who resign and evaluate the results. Under the Veterans Home's recruitment strategy, recruitment plans will be monitored on a monthly basis and the annual recruitment plan will be renewed each year in January.

In addition, under the Veterans Affairs' recruitment program, supervision of recruiting efforts is vested at the Veterans homes. Veterans Home administrators designate a recruitment coordinator, ensure managers and supervisors are aware of their recruiting assignments, and monitor recruiting achievements. Veterans Homes' recruitment coordinators are responsible for reporting on the conduct of annual recruitment at their respective home and developing and maintaining rapport with community groups who may serve as a resource for recruitment.

According to Veterans Affairs, the Veterans Home developed a staffing model and policy to reduce excessive overtime among nursing staff that, among other things, considered overtime distribution, an overtime cap, and bargaining unit contracts; Veterans Home staff is reviewing the policy. Veterans Affairs also indicated that the impact of state-mandated furloughs has impeded progress in implementing the new staffing model. Veterans Affairs also indicated that nursing overtime reports are being reviewed by the Veterans Home's fiscal officer.

In response to our recommendation that it consider changing or eliminating the requirement that less than 75 percent of skilled nursing beds must be occupied before the Veterans Home can admit new patients directly to that level of care. Veterans Affairs eliminated the requirement.

According to Veterans Affairs, the Veterans Home is monitoring its hiring process, including a new process for completing preemployment physicals. Veterans Affairs indicated that staffing changes in the ambulatory care clinic have resulted in a 50 percent reduction in the number of days from the physical being requested to the examination being conducted.

Veterans Affairs created a department-wide recruiting program that includes its recruiting mission and goals, as well as information about program coordination, roles and responsibilities, and recruitment techniques and strategies. The recruiting program also establishes a recruitment program officer to coordinate Veterans Affairs' recruitment efforts. Among other things, the recruitment program officer is responsible to assist offices and divisions and the Veterans Homes with focused recruitment, monitoring recruitment costs, preparing reports regarding recruitment goal attainment, and developing Veterans Affairs' annual recruitment plan.

Finding #2: With weak oversight of its medical equipment contract, the Veterans Home cannot ensure that equipment is working properly and payments to its contractor are appropriate.

Our review also revealed that the Veterans Home has weak oversight of its medical equipment contract. From the medical equipment inventory provided to us by the Veterans Home, we tested 31 pieces of equipment and found that one piece of equipment had been entered into the inventory twice, leaving 30 items in our sample. Of those 30 items, six were not in use by the Veterans Home and five new items were not promptly added to the inventory. In addition, for 14 of the 19 remaining items, we could not find evidence that the contractor scheduled or performed the required maintenance within appropriate time frames. Without an accurate inventory and regularly scheduled maintenance of its medical equipment, the Veterans Home risks not having properly functioning equipment readily available when needed. Further, the Veterans Home routinely approves invoices for the contractor responsible for maintaining medical equipment but fails to verify that the contractor has met the requirements of its contract. Consequently, the Veterans Home may be making inappropriate payments to the contractor and, more importantly, it further decreases its assurance that every piece of medical equipment will function properly whenever it is needed to meet a member's health care needs.

To ensure the Veterans Home's medical equipment is maintained as prescribed by the equipments' manufacturers, we recommended that the Veterans Home take the steps necessary to ensure the medical equipment inventory, on which maintenance activities are based, is accurate. In addition, to ensure payments to the maintenance contractor are appropriate, we recommended that the Veterans Home require the contractor to provide records of inspections and maintenance work performed prior to authorizing payments.

Veterans Home's Action: Corrective action taken.

The Veterans Home stated it has completed an inventory update involving the contractor, the nursing service, the property department, and plant operations, the latter of which is the contract monitor. In addition, inventory is now periodically reviewed with service area managers and compared to the revised inventory submitted by the contractor. The Veterans Home also modified its agreement with the contractor to revise the preventive maintenance schedule and reporting requirements. Veterans Affairs indicated that the Veterans Home is also using a new contract billing report to help ensure payments to the contractor are appropriate and has developed a new approach to monitoring the contractor's performance for compliance with the contract.

Finding #3: The Veterans Home does not have a plan to comply with the Americans with Disabilities Act but has made accommodations for members with visual impairments.

The Veterans Home does not have a plan for fully complying with the Americans with Disabilities Act (ADA). Title II of the ADA and federal regulations require state agencies to ensure that people with disabilities are not excluded from services, programs, and activities because buildings are inaccessible. As a first step toward meeting this requirement for program accessibility, all public entities had to conduct self-evaluations of their policies and practices and correct any that were inconsistent with the requirements of Title II. Additionally, any public entity needing to make structural changes to achieve program accessibility had to develop a transition plan. According to its equal employment opportunity/civil rights officer, Veterans Affairs has not performed a self-assessment of the Veterans Home for compliance with the ADA. Consequently, neither Veterans Affairs nor the Veterans Home can develop a plan for achieving full compliance with the ADA. The director of residential programs at the Veterans Home said that when repairs and alterations were made to the infrastructure at the Veterans Home, they were done to ADA design codes in force at the time. Nonetheless, it is not clear to what extent the Veterans Home meets the program accessibility requirements of the ADA.

Federal ADA regulations also require state agencies to develop grievance procedures and identify an employee as the agency's ADA coordinator. According to its director of residential programs, the Veterans Home has not met either of those requirements. However, the Veterans Home has made accommodations in its dining hall for members with visual impairments and provided training to dining hall workers to enable them to better serve members with visual impairments.

To meet the requirements of federal ADA regulations, we recommended that the Veterans Home develop and update as needed a plan that identifies areas of noncompliance and includes the appropriate steps and milestones for achieving full compliance. In addition, we recommended that the Veterans Home develop grievance procedures and identify a specific employee as its ADA coordinator.

Veterans Home's Action: Partial corrective action taken.

According to Veterans Affairs, the Veterans Home assigned an employee as ADA coordinator, and has updated its grievance policy to include handling of grievances related to accessibility. In addition, an ADA survey is being contracted for as part of the Veterans Home's development of a strategic infrastructure plan.

Finding #4: The California Department of Public Health (Public Health) has not always promptly completed its investigations of complaints against the Veterans Home.

Our review of complaints lodged against the Veterans Home, including complaints filed with legislative staff, showed that the responsible agencies handled some complaints appropriately. For example, we reviewed the nine complaints concerning the Veterans Home filed with Public Health between October 2005 and October 2007 and found that in every case Public Health met the requirements to conduct an initial on-site investigation within 24 hours or 10 days of receipt of the complaint, depending on its severity. In addition, Public Health's classification of the severity of each complaint appeared appropriate. However, we noted that Public Health did not complete its investigations for three of the nine complaints within 40 business days, its recommended maximum time frame. For another of the nine complaints, Public Health has yet to make a final determination on whether to issue the Veterans Home a citation, even though the complaint was filed more than one year ago. According to the chief of the state facilities unit in Public Health's licensing and certification program, this complaint was mistakenly dropped from his pending file and not addressed again until it was discussed during our audit.

To promptly resolve complaints it receives against the Veterans Home, we recommended that Public Health monitor its system for processing complaints.

Public Health's Action: Corrective action taken.

Public Health has developed a report from an existing complaint and incident tracking system that will identify complaints needing closure as of 30 days from receipt of the complaint to ensure Public Health is in compliance with its recommended time frame for resolving complaints.

Finding #5: The Veterans Board has not always maintained evidence of complaint resolution.

We also reviewed five complaints submitted to the California Veterans Board (Veterans Board) between June 2006 and December 2007 but were unable to determine whether they were resolved appropriately because neither the Veterans Board nor Veterans Affairs could locate documentation concerning actions they took on the complaints. Although the Veterans Board adopted a policy indicating the types of complaints it will process and those it will direct to Veterans Affairs, it did not specify a time frame for resolving the complaints it will process.

To ensure that all complaints against the Veterans Home submitted to the Veterans Board are properly resolved, we recommended that the Veterans Board specify a time frame for resolving complaints in its new policy for complaint resolution and ensure it implements the policy.

Veterans Board's Action: Corrective action taken.

The Veterans Board revised its policy concerning complaints to specify a time frame for resolving complaints. Under its revised policy, the board chair will respond to the complainant through the board executive officer within 10 business days if the complaint does not require board deliberation and action. If board action is required, the response will be provided within 10 days following the next board meeting. If the board chair deems that the complaint requires more urgent action, a special meeting by teleconference may be convened. If the complaint concerns Veterans Affairs' operations, it will be forwarded to the deputy secretary for resolution. The revised policy calls for Veterans Affairs to provide a response to the complainant with a copy to the board within 10 business days of Veterans Affairs' receipt of the complaint.

Finding #6: Veterans Affairs has generally followed its procedures for tracking complaints.

Veterans Affairs received 11 complaints from members between July 1, 2005, and October 5, 2007. In seven cases Veterans Affairs closely followed its established policies and procedures for resolving complaints. Four complaints were not processed entirely according to Veterans Affairs' policies governing written communication, which is its basic policy for handling written complaints. Specifically, Veterans Affairs did not prepare routing slips for the four complaints; according to the assistant deputy secretary of Veterans Homes, these were clerical errors. A routing slip is intended to identify and record on the official file all staff who contribute to the completion of a written communication, including staff who investigate and those who sign or approve the final product, thereby providing accountability to the complaint resolution process. Although lacking routing slips, the four complaints were addressed within a reasonable period by Veterans Affairs, given full consideration by the responsible parties, and documented according to Veterans Affairs' policies.

To ensure that complaints against the Veterans Home are processed so there is accountability in the complaint resolution process, Veterans Affairs should enforce its policy of using routing slips with complaints.

Veterans Affairs' Action: Corrective action taken.

According to Veterans Affairs, it revised its policy for tracking complaint resolution to ensure closure of complaints with accountability. The revised policy, which requires the use of a routing slip, has been distributed to the relevant staff at Veterans Affairs.

Finding #7: The Veterans Home does not always maintain evidence it resolved issues raised at resident council meetings.

As part of our analysis of complaint-handling procedures, we reviewed documents prepared by Veterans Home staff following resident council meetings. These monthly meetings are held in Holderman Hospital and its intermediate care facility annexes to give members the opportunity to raise issues, concerns, and complaints. According to the supervisor of therapeutic activities, the hospital's therapeutic activities staff facilitate the meetings, and social services staff are responsible for taking meeting minutes. We reviewed the available meeting minutes and memos prepared by the social services staff from May through December 2007 to communicate to Veterans Home departments the issues they needed to address. Our review revealed that 20 complaints were raised in the 2007 resident council meetings and, as of December 2007, the Veterans Home took reasonable steps to resolve 16 and had been unsuccessful in resolving two. We could not determine whether the Veterans Home had resolved the remaining two issues because no resolution was apparent in the minutes of resident council meetings or in the memos. The Veterans Home had communicated the outcomes of its investigations at subsequent resident council meetings for 14 of the 20 issues and had yet to report its findings for six. When complaints lodged by members in resident council meetings are not promptly resolved, or resolutions of the issues are not communicated to members, it can lead to dissatisfaction among the members of the Veterans Home.

To appropriately address complaints raised at resident council meetings, we recommended that the Veterans Home better document such issues, ensure that the relevant department resolves them, and promptly communicates the resolutions to all affected members.

Veterans Home's Action: Corrective action taken.

According to Veterans Affairs, the Veterans Home will record the minutes of all resident council meetings, and complaints and concerns of residents are to be routed to the appropriate supervising registered nurse for resolution. Therapeutic Activities at the Veterans Home is to follow up to ensure all complaints and concerns are addressed and communicated to the residents.

Finding #8: The Veterans Home needs to better document the resolution of code of conduct violations.

When we attempted to assess the process the Veterans Home has established for handling alleged violations of its code of conduct for members, we found that the Veterans Home did not adequately document its processing of the alleged violations. The code of conduct specifies behaviors prohibited by members so as to preserve the tranquility of the Veterans Home and to ensure the rights and independence of each member. Our review of 25 violations alleged to have occurred in 2006 and 2007 found complete documentation in only 11 cases. For all 11 cases with complete documentation, we were able to verify that the Veterans Home followed its policies and procedures. In 12 of the 25 cases we reviewed, the Veterans Home did not maintain sufficient documentation for us to determine whether it followed all its policies and procedures. In the remaining two cases, using the limited documentation available to us, we determined that the Veterans Home did not follow appropriate policies and procedures that required referral of members caught using illegal drugs to the drug treatment program at the Veterans Home. Without maintaining appropriate documentation, executive staff at the Veterans Home cannot be assured that alleged violations of the code of conduct receive consistent and equitable treatment.

To handle alleged violations of the code of conduct consistently and equitably, we recommended that the Veterans Home ensure that staff responsible for investigating the allegations fully document the investigations and their results.

To ensure that members of the Veterans Home receive treatment for drug abuse when necessary, we recommended that staff of the Veterans Home follow its policy to refer members who use illegal drugs to the drug treatment program.

Veterans Home's Action: Corrective action taken.

Veterans Affairs revised the code of conduct policy for clarity and the Veterans Home plans to train all staff who investigate code of conduct violations to improve the quality and consistency of investigations. In addition, the Veterans Home will be monitoring investigations for completeness. Further, the Veterans Home updated and strengthened its polices requiring staff to refer members who use illegal drugs to the appropriate treatment professional or medical provider at the Veterans Home.

Low-Level Radioactive Waste

The State Has Limited Information That Hampers Its Ability to Assess the Need for a Disposal Facility and Must Improve Its Oversight to Better Protect the Public

REPORT NUMBER 2007-114, JUNE 2008

Department of Public Health's response as of July 2009

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) conduct an audit assessing the management and oversight of low-level radioactive waste (low-level waste) by the California Department of Health Services (now the Department of Public Health (department)), the Radiologic Health Branch (branch), and the Southwestern Low-Level Radioactive Waste Commission (Southwestern Commission). Although we reviewed the Southwestern Commission's policies and practices, we did not have recommendations for it and, as a result, we do not mention the Southwestern Commission further in this subcommittee report write-up.

Public concern related to the disposal of low-level waste will likely increase in the near future because entities in California that generate this waste are losing access to one of the two disposal facilities they currently use. In June 2008 the disposal facility in Barnwell, South Carolina, is scheduled to cease accepting low-level waste from generators in many states, including California. Generators of low-level waste will need to consider alternative methods, including long-term or off-site storage, to deal with their most radioactive low-level waste. Unfortunately for decision makers in California, the implications of this pending closure and what it means for the State's public policy are not clear-cut.

Finding #1: The department has not adopted dose-based decommissioning standards.

Decommissioning is a process in which the department concludes that a physical location that formerly contained radiation is sufficiently clean for the public to use it safely and qualifies the location for release from further regulatory control. The department is responsible for approving and overseeing plans to decommission licensed equipment and facilities within its jurisdiction. In 1998 the department began informally applying the U.S. Nuclear Regulatory Commission's (NRC) standard of .025 rems, or 25 millirems (thousandths of a rem) per year (mrem/yr) whenever it decommissioned licensed equipment or facilities under its jurisdiction and terminated such licenses. Applying the new dose-based standard meant that equipment or facilities could be released from further regulatory control as long as the degree of residual radioactivity remaining at the site would not result in more than 25 mrem/yr of exposure to those members of the community who would likely be affected. In October 2001 the department formalized this practice of using the 25 mrem/yr standard by adopting regulations that incorporated by reference the federal standard. These new regulatory standards were controversial; within a matter of months, they were challenged in court. In April 2002 the court found that the new regulatory standard had been adopted without satisfying

Audit Highlights . . .

Our review of the State's approach to managing low level radioactive waste (low-level waste) found the following:

» *In June 2008 generators in California will lose access to one of the two low-level waste disposal facilities that currently accept their waste.*

» *The Department of Public Health (department) has yet to follow a 2002 executive order requiring it to develop dose-based decommissioning standards, resulting in a lack of public transparency and accountability over its actions.*

» *The department's Radiologic Health Branch (branch) cannot demonstrate that its inspections of those that possess radioactive material and radiation-emitting machines are performed timely in accordance with federal and state requirements.*

» *The branch has poorly planned for its resource needs, is unable to justify the magnitude of its 2005 fee increases, and used old and incomplete data when asking for more staff.*

» *More than five years after the effective date of the law, the branch is still unable to provide required information on the amount of low-level waste generated in California.*

the requirements of the Administrative Procedure Act and the California Environmental Quality Act (CEQA). In May the court issued an order directing the department to set aside its approval of the challenged regulations, insofar as the regulation incorporated the 1998 NRC standard.

On September 30, 2002, the former governor issued Executive Order D-62-02 (executive order). Unlike the 2002 court order, which simply directed the department to set aside the challenged regulations, the executive order imposed a direct obligation on the department to adopt regulations that would establish dose-based standards for the decommissioning of low-level waste. The executive order also directed the department to comply with all applicable laws, including CEQA, when it adopted those dose-based standards. When we asked the department to describe the efforts that it had undertaken to adopt such regulations, it told us that it had not done so because of the prohibitive expense and because of the likely opposition it might encounter.

To provide greater public transparency and accountability for its decommissioning practices, we recommended the department begin complying with the Executive Order D-62-02 and formally develop dose-based decommissioning standards. If the department believes that doing so is not feasible, it should ask the governor to rescind this 2002 executive order.

Department's Action: Pending.

The department stated that its administration continues to assess the public health and budgetary pros and cons of various options to implement or rescind Executive Order D-62-02.

Finding #2: The branch lacks sufficiently reliable data to ensure it conducts all required inspections on time.

One of the branch's key oversight activities includes inspecting licensees that use radiation-emitting machines or possess radioactive material, ensuring they do not expose the public to harmful radiation. Although federal guidance and state law define how frequently such inspections should occur, the branch is unable to demonstrate that it promptly performs these inspections. Its data systems contain data that are not sufficiently reliable, and this shortcoming prevents the branch from accurately assessing whether all inspections take place when necessary. For example, in one data system, we noted that the data values in the priority code field were incorrect in two of the 16 sample items for which we were able to obtain documentation. Since this field defines the required inspection interval for a given licensee, errors would result in too frequent or too few inspections being scheduled based on this data. Overall, the branch's lack of sufficiently reliable information appears attributable to its use of data provided by its own information technology staff, who do not fully understand what data they are extracting or why they are extracting it, as well as to the lack of management controls that would help guard against inaccurate data entry. Although the branch recognizes the limitations of its current data systems and has tried to replace them since 1996, it continues to operate in an environment in which it cannot adequately manage its work, thus limiting its ability to protect the public from potential health risks. The branch's data needs are currently included as part of the development of a department-wide data system. It states that the project's first phase, which supports the branch, should be completed in November 2010.

To make certain that the branch uses sufficiently reliable data from its current systems to manage its inspection workload, we recommended the department do the following:

- Improve the accuracy of the branch's data for inspection timeliness and priority level. The branch can do so by comparing existing files to the information recorded in the data systems.

- Improve its internal controls over data entry so that it can maintain accurate data on an ongoing basis. Such controls might include developing a quality assurance process that periodically verifies the contents of licensee files to the data recorded electronically. Other controls might include

formalizing data entry procedures to include managerial review or directing the information technology staff to perform periodic logic checks of the data.

Finally, to ensure that the branch uses sufficiently reliable data from its future data system to manage its inspection workload, the department should develop and maintain adequate documentation related to data storage, retrieval, and maintenance.

Department's Action: Partial corrective action taken.

The department's response provided the following updates on the branch's efforts to address the data quality issues with the three information systems it uses to manage its inspection workload. In the long-term, the department plans to replace these three systems with an Enterprise-wide, On-line Licensing system (EOL). The department stated that it has received administrative and legislative approval for the EOL system and that it expects to award a contract for the new system in July 2011. For its current systems, the department indicated that it either has reviewed or is reviewing the data in two of its systems and has implemented controls to better ensure that changes to the data in all three systems are appropriate. Specifically, the department indicated that it has taken the following steps:

California Mammography Information System (CAMIS)

Instituted additional quality control procedures over data entry into the CAMIS. The branch has limited users' access to the CAMIS, indicating which user groups should have the ability to make changes in the data versus having a "read-only" status. Further, the branch requires that any change to the CAMIS be approved beforehand. The branch provided a "CAMIS Change Request" form that it uses to allow its staff to request specific changes to CAMIS data, to explain the reason for the change, and to document the branch's approval.

Health Application Licensing System (HAL)

- Formed a Quality Assurance Unit (QAU), which is responsible for tracking inspections and ensuring that staff enter inspection-related data into HAL accurately. The department provided documentation showing that it is actively tracking errors found as a result of the QAU process and that the error rate is declining. For example, in the third quarter of 2008, the QAU found errors with 21 inspection files for every 100 files it reviewed. By the third quarter of 2009, this error rate dropped to 15 inspection files per 100 files reviewed.

- Engaged in bi-monthly meetings with the department's Information Technology Services Division, which have helped to resolve problems with certain data fields while identifying other needs that still require evaluation and implementation.

Radioactive Materials System

Conducted a 100 percent quality assurance review to validate inspection data shown in the system. After finding few errors, the branch now performs a quality assurance review for 50 percent of the data entered into the system. The branch indicates it is tracking the data entry error rate and will consider performing more reviews if this rate increases. The branch provided examples of its quality assurance reviews.

Finding #3: The branch cannot demonstrate that the extent of its 2005 fee increase was necessary.

The State's Radiation Control Fund (Control Fund) supports most of the branch's operations, and money in the Control Fund comes from the fees that the branch levies on entities that possess radioactive materials or use radiation-emitting machines, fines and penalties assessed, and interest earned from money in the Control Fund. For each fiscal year from 2000–01 through 2004–05, the ending balance of the Control Fund declined. According to the State Controller's Office, the balance of the Control Fund was $13 million at June 30, 2001, declining to $4.3 million at June 30, 2005. Sparked in part by the declining balance, the branch obtained approval in June 2005 from the State's Office of Administrative Law for changes to the regulations that establish its fees. As a result, some of the branch's fees increased by more than 200 percent over the previous fee levels, while other fees increased by less than 35 percent.

Although it appears that the branch needed to address the declining balance of the Control Fund, the analysis and justification for its higher fees lacked specific quantitative workload and fiscal analyses one would reasonably expect. Lacking such analyses, the branch is unable to sufficiently demonstrate how it calculated the various new fee levels and that its fee increases were reasonably related to the costs of services provided to those that pay them. Additionally, the branch's inability to fix problems with its billing systems, and the resulting uncertainty as to whether it was collecting all the revenue it could have, further calls into question the need for the fee increases in June 2005.

To ensure that the branch can sufficiently demonstrate that the fees it assesses are reasonable, we recommended the department evaluate the branch's current fee structure using analyses that consider fiscal and workload factors. These analyses should establish a reasonable link between fees charged and the branch's actual costs for regulating those that pay the specific fees. Further, the analyses should demonstrate how the branch calculated the specific fees.

Department's Action: None.

The department indicates that the branch has accumulated workload and staffing data and has compared it with the fee schedule it implemented in 2005. According to the department, the data shows that its 2005 fees are appropriate.

➲ We asked the branch to provide its analysis and supporting data for its assertion that its current fees are reasonable. In July 2009 the branch provided various spreadsheets comparing the branch's annual costs and revenue. These spreadsheets did not demonstrate how specific fees were calculated. By not explaining how fees were set, the branch continues to be unable to demonstrate that the specific fees it charges bear a reasonable relationship to the cost of regulating those that pay such fees.

Finding #4: The branch has not determined how many employees it needs to fulfill its federal and state obligations.

The NRC, which periodically evaluates the branch's performance, raised concerns regarding its inadequate staffing in 2004 and again in 2006. In addition, the branch justified its need for fee increases in 2005 by citing increased work backlogs. It obtained the approval for eight health physicists for fiscal year 2006–07 and an additional eight positions for fiscal year 2007–08. As of March 2008 it has filled 13 of its 16 new positions with 12 health physicists and one associate governmental program analyst.

The branch claimed in its fiscal year 2006–07 budget change proposal that the additional staff would allow it to meet all its federal and state mandates. However, we question how it could make such a claim when it used workload analyses that were at least three years old, focused only on the current workload and excluded the backlog, and did not account for the staff needed to meet certain state mandates. Although the department indicated that it had not fully evaluated the branch's staffing needs since the mid-1990s, the branch requested an additional three permanent and two limited-term positions for

health physicists for fiscal year 2008–09. However, the branch's inability to fulfill its goal of reducing backlog and meeting state mandates, at a minimum, raises questions as to whether it understands the staffing levels necessary to successfully accomplish all of its responsibilities.

To make certain that it can identify and address existing work backlogs and comply with all of its federal and state obligations, we recommended the department develop a staffing plan for the branch based on current, reliable data. The plan should involve a reevaluation of the branch's assumptions about workload factors, such as how many inspections an inspector can perform annually. The plan should also include an assessment of all backlogged work and the human resources necessary to eliminate that backlog within a reasonable amount of time, and an assessment of all currently required work and the human resources necessary to accomplish it.

Department's Action: None.

The department's one-year response indicates that its branch has developed and is following a plan to correct and eliminate existing inspection backlogs.

We met with the department on July 9, 2009, to obtain further clarification on its response to this recommendation. Rather than providing a written plan as requested, the department provided management reports indicating that it had planned to conduct roughly 14,000 inspections of x-ray and mammography equipment during fiscal year 2008–09, but as of May 2009 the branch had only conducted 7,400 inspections—roughly 53 percent of their annual workload. The department indicates that it currently has 32 inspectors to complete these inspections, but needs an additional 13 to meet its annual workload for these types of inspections. The branch also projects that it will continue to have overdue inspections of licensees that possess radioactive material. The department provided us with management reports showing more than 40 inspections that were overdue as of early July 2009. For perspective, the branch expects to perform roughly 535 inspections of such licensees annually. The branch explained that it currently has 11 inspectors to perform these reviews, but needs an additional two staff to meet its annual workload.

Finding #5: The branch has not complied with a state law requiring that it report data on low-level waste within California.

More than five years after its September 2002 enactment, the branch still has not implemented requirements that the Legislature added to the Health and Safety Code, at Section 115000.1, which call for reporting on the amount of low-level waste stored in California or exported for disposal. As of April 2008 the branch had not produced the report, nor had it yet implemented the information system needed to generate such a report. In fact, the branch did not initially request the necessary data from licensees until April 2007. Without this information, neither the Legislature nor the branch can accurately assess the need for a disposal facility in California. Further, without this information, the department does not have a documented basis to know how to plan for the closure in June 2008 of one of the two low-level waste disposal facilities that accept such waste from California's generators. State law requires the department to have a contingency plan in the event that an out-of-state disposal facility is closed.

Furthermore, when the branch finally does prepare the report, it may not contain all the information required under law. The provisions place data collection and reporting requirements on the department and allow it to use copies of shipping manifests from generators to provide the necessary information. However, the branch determined that the shipping manifests do not provide information on 12 of the 57 discrete data elements required by the legislation. The department is aware of these deficiencies and has stated the branch will need to revisit the issue with the department's executive management and the legislation's author to ensure that the required information meets the intent of the legislation.

To inform the Legislature when it is likely to receive the information to evaluate the State's need for its own disposal facility, we recommended the department establish and communicate a timeline describing when the report required by Section 115000.1 of the Health and Safety Code will be available. The department should also see that its executive management and the branch discuss with appropriate members of the Legislature as soon as possible the specific information required by state law that it cannot provide. Further, to the extent that the department cannot provide the information required by law, it should seek legislation to amend the law. Finally, when the branch has an understanding of the disposal needs for generators in California based on this data, it should develop an updated low-level waste disposal plan.

Department's Action: Partial corrective action taken.

On October 15, 2009, the department indicated that it has completed a final draft of the report for the Legislature per the requirements of Section 115000.1 of the Health and Safety Code. The report consists of two separate documents, the public report and technical report for the Legislature. The department indicates that both documents are working their way through the department for review and approval.

➔ Further, the department believes it does not need to develop an updated low-level waste disposal plan pursuant to Section 115005 of the Health and Safety Code. On July 20, 2009, the department deputy director provided a copy of the plan that was prepared in 1983. However, the document provided was only a preliminary report that acknowledged that it was the first step toward establishment of a plan for the long range management of low-level radioactive waste. As we state on page 60 of our audit report, the department has no documented basis to know how to plan for the closure in June 2008 of the disposal facility in Barnwell, South Carolina, to low-level waste generated in California.

Finding #6: A complete strategic plan could help the branch operate more effectively.

Although no state law specifically requires the branch to have a strategic plan, its inability to completely address issues concerning inspection data that is not sufficiently reliable, as well as its inability to justify its resource requests, suggest the branch might benefit from improving the limited plan it currently has. According to guidelines published by the Department of Finance, strategic planning is a long-term, future-oriented process of assessment, goal setting, and decision making that maps an explicit path between the present and a vision of the future. The branch currently uses a plan that lacks many essential elements of strategic planning and could benefit from setting priorities that would help it more effectively manage its work. The branch's plan contains some objectives tied to the goals, but they are not specific or measurable, as recommended by the Department of Finance. Without measurable objectives, action plans, performance measures, timelines, and monitoring, it is more difficult for branch management to know whether it is meeting the plan's goals.

To better manage its performance in meeting key strategic objectives, we recommended the branch establish a new strategic plan that contains all essential elements, including performance metrics and goals that the branch believes would be relevant to ensuring its success.

Department's Action: Partial corrective action taken.

The department reports that the branch has hired a contractor to lead the efforts in facilitating the development of the branch's strategic plan. Although the department acknowledges there have been staffing and fiscal limitations, a draft plan was completed in July 2009, with final adoption expected in early fall 2009. The branch provided us with a copy of its draft strategic plan, which includes its core values, vision, as well as various measurable objectives

Department of Public Health

Laboratory Field Services' Lack of Clinical Laboratory Oversight Places the Public at Risk

REPORT NUMBER 2007-040, SEPTEMBER 2008

Laboratory Field Services' response as of September 2009

Chapter 74, Statutes of 2006, required the Bureau of State Audits to review the clinical laboratory oversight programs of the Department of Health Services (now the Department of Public Health and referred to here as the department). Specifically, the law directed us to review the extent and effectiveness of the department's practices and procedures regarding detecting and determining when clinical laboratories are not in compliance with state law and regulations; investigating possible cases of noncompliance, including investigating consumer complaints; and imposing appropriate sanctions on clinical laboratories found noncompliant. The law also specified we review the frequency and extent of the department's use of its existing authority to assess and collect civil fines and refer violators for criminal prosecution and bar their participation from state and federally funded health programs, and its use of any other means available to enforce state law and regulations regarding clinical laboratories. Laboratory Field Services (Laboratory Services) within the department is responsible for licensing, registering, and overseeing clinical laboratories. Specifically, we found:

Finding #1: Laboratory Services is not inspecting laboratories every two years as required.

Laboratory Services is not inspecting clinical laboratories every two years, which is required by state law and is a critical component of the State's intended oversight structure. State law requires Laboratory Services to conduct inspections of licensed clinical laboratories no less than once every two years. According to Laboratory Services, 1,970 licensed laboratories required such inspections in California as of June 2007. Based on the state requirement, we expected to find that Laboratory Services was conducting regular inspections. Although inspections help ensure that laboratories follow appropriate procedures and that personnel have appropriate qualifications, Laboratory Services has not conducted any regular, two-year inspections of clinical laboratories.

Further, state law requires a laboratory located outside California but accepting specimens originating inside the State to have a state license or registration. However, Laboratory Services does not conduct regular, two-year inspections of out-of-state laboratories. According to Laboratory Services, 91 laboratories outside California had California licenses as of June 2007.

We recommended that Laboratory Services perform all its mandated oversight responsibilities for laboratories subject to its jurisdiction operating within and outside California, including inspecting licensed laboratories every two years.

Audit Highlights . . .

Our review of Laboratory Field Services' (Laboratory Services) clinical laboratory oversight activities revealed the following:

- ***It is not inspecting laboratories every two years as state law requires and has no plans to do so unless it receives additional resources.***
- ***Laboratory Services has inconsistently monitored laboratory proficiency testing, and its policies and procedures in that area are inadequate.***
- ***It closed many complaints without taking action, and Laboratory Services' recently revised complaint polices and procedures lack sufficient controls.***
- ***Laboratory Services has sporadically used its authority to impose sanctions against laboratories for violations of law and regulations.***
- ***The chief of Laboratory Services attributes its inability to meet its mandated responsibilities primarily to a lack of resources; it has only been successful in obtaining approval for two recent funding proposals.***
- ***Because it had raised its fees improperly one year and failed to impose two subsequent fee increases the budget act called for, Laboratory Services did not collect more than $1 million in fees from clinical laboratories.***

Department's Action: Partial corrective action taken.

Laboratory Services reported that it has established priorities to assure key program activities are conducted, including inspecting laboratories every two years as required. It told us that it has inspected 160 laboratories not previously inspected on the required two year cycle. In addition, Laboratory Services stated that legislation was being considered to allow Laboratory Services to approve accreditation organizations to conduct some inspections every two years on its behalf after January 2011. This legislation was subsequently enacted as law in October 2009.[1]

Finding #2: Inconsistent monitoring and inadequate policies and procedures weaken Laboratory Services' oversight of proficiency testing.

State law stipulates that laboratories performing tests considered moderately to highly complex must enroll and achieve a certain minimum score in proficiency testing, a process to verify the accuracy and reliability of clinical laboratory tests. It is Laboratory Services' policy to monitor proficiency-testing results. However, we found that it did not identify or take action on some testing failures. Specifically, Laboratory Services had not contacted the laboratories or had not identified all the failed tests in five of the six instances we reviewed. Further, it did not review the proficiency-testing results of laboratories located outside California that are subject to the testing. Because the goal of proficiency testing is to verify the reliability and accuracy of a laboratory test, without adequate monitoring, Laboratory Services cannot ensure that laboratories are reporting accurate results to their customers.

Laboratory Services also did not enforce its policy to verify whether laboratories are enrolled in state-approved proficiency testing. State law requires that laboratories conducing moderate-to-high-complexity tests enroll in a state-approved proficiency-testing program. This is a condition of licensure, but it is also important to verify enrollment on an ongoing basis because proficiency testing is a key method for ensuring that laboratories conduct their tests reliably and accurately.

Finally, Laboratory Services has inadequate policies and procedures regarding proficiency testing. For example, the policies and procedures do not specify timelines for key steps in the proficiency-testing review process, including how frequently Laboratory Services will review proficiency-testing results. Lacking specific timelines, Laboratory Services could apply proficiency-testing requirements inconsistently and create confusion within the regulated community.

We recommended that Laboratory Services perform all its mandated oversight responsibilities for laboratories subject to its jurisdiction operating within and outside California, including monitoring proficiency testing results.

We also recommended that Laboratory Services adopt and implement proficiency-testing policies and procedures for staff to do the following:

- Promptly review laboratories' proficiency-testing results and notify laboratories that fail.
- Follow specific timelines for responding to laboratories' attempts to correct proficiency-testing failures and for sanctioning laboratories that do not comply.
- Monitor the proficiency-testing results of out-of-state laboratories.
- Verify laboratories' enrollment in proficiency testing, and ensure that Laboratory Services receives proficiency-testing scores from all enrolled laboratories.

[1] This legislation, which was enacted as Chapter 201, Statutes of 2009, is the same legislation discussed in findings 5, 6, and 8.

Department's Action: Partial corrective action taken.

Laboratory Services stated that it reviews electronic proficiency test results once each month and since August 2008 has notified 195 laboratories of a first proficiency testing failure within 30 days of reviewing the test data. Further, it received documentation from 99 percent of the laboratories notified. Upon review, Laboratory Services reported that the documentation demonstrated adequate corrective action within the required time frame. Laboratory Services modified its procedures to incorporate federal timelines related to proficiency testing. However, it stated that it was unable to comply with timelines for subsequent failures because the notice to laboratories that is necessary to conduct further enforcement action was under review. Laboratory Services told us that it expects to have approval by fall 2009 of this notice. Laboratory Services also stated that it has determined that the manual method of retrieving out-of-state proficiency test reports does not result in meaningful information and that electronic data cannot be generated; however, an enterprise system that is being planned may accommodate the data. Finally, Laboratory Services noted that it is unable to assure using electronic means that all laboratories are enrolled in proficiency testing appropriate to their specialties.

Finding #3: Laboratory Services is focusing on increasing licensing of California laboratories but not out-of-state laboratories.

Recognizing a problem within its licensing process, in May 2008 Laboratory Services began implementing a plan to identify and license laboratories within California that are subject to licensure but have not applied for or obtained it. However, Laboratory Services has not placed the same priority on identifying and licensing laboratories operating outside the State that receive and analyze specimens originating in the State, even though these laboratories are subject to California law. Laboratory Services plans to continue processing applications for licenses and renewals that out-of-state laboratories submit voluntarily, but it does not plan to perform any additional activities. According to the Laboratory Services chief, insufficient staffing has always prevented Laboratory Services from properly administering the licensing of out-of-state laboratories and pursuing licensed out-of-state laboratories. By not enforcing licensing requirements, Laboratory Services cannot ensure that out-of-state laboratories are performing testing to state standards established to protect California residents.

We recommended that Laboratory Services continue its efforts to license California laboratories that require licensure. Further, it should take steps to license out-of-state laboratories that perform testing on specimens originating in California but are not licensed, as the law requires.

Department's Action: Partial corrective action taken.

Laboratory Services told us that it continues to identify and contact laboratories in California that require licensure. However, it also told us that it had placed on hold its project to identify and license out-of-state laboratories requiring licensure. Laboratory Services stated that it has no full-time civil service staff to perform these duties.

Finding #4: Laboratory Services has struggled to respond to complaints, and its new complaints process lacks sufficient controls.

Laboratory Services has not always dealt systematically with complaints as required. It receives complaints from several sources, including consumers, whistleblowers, various public agencies, and other laboratories. State law mandates that Laboratory Services investigate complaints it receives, but it often closed complaints after little or no investigation. Laboratory Services acknowledges it investigated only a small percentage of the complaints it received and conducted only one major investigation during the three-year period ending December 2007. Moreover, Laboratory Services lacks information to know the total number of complaints it has received, investigated, or closed during a specific period. Although Laboratory Services internally developed a database to capture complaints information, it

did not consistently enter complaints it received into that database or update its complaints data to reflect progress or resolution. Laboratory Services' complaints database lists 313 complaint records for the three-year period between January 2005 and December 2007; however, Laboratory Services has no assurance that number is accurate.

We reviewed 30 complaints Laboratory Services received between January 2005 and December 2007 and later closed. Among the complaints we reviewed, we found 16 that Laboratory Services closed without taking action. Laboratory Services told us it did not have jurisdiction over six of these complaints; however, we did not find evidence that it alerted the complainant to that fact when the complainant was known or that Laboratory Services forwarded the complaint to an entity that had jurisdiction. Of the 10 complaints Laboratory Services closed without action and over which it acknowledged having jurisdiction, we found five complaints that alleged conditions with health and safety implications, raising concerns about Laboratory Services' decision to close them.

The second category of complaints we identified comprised 14 cases in which Laboratory Services took some type of action—for instance, sending a letter, making a telephone call, or referring the allegation to another entity. However, Laboratory Services did not conduct on-site laboratory investigations in response to the allegations related to any of the complaints in this category. Although Laboratory Services' files suggest it took some action in response to all 14, we are particularly concerned that the action Laboratory Services took was inadequate or not timely for three complaints having health and safety implications. For example, two complaints alleged that laboratories made testing errors that resulted in the patients receiving unnecessary medical treatment.

Certain key controls in Laboratory Services' complaint policies and procedures are missing or insufficient. Typically, an entity with a complaints process establishes certain key controls to ensure that staff promptly log, prioritize, track, and handle information they receive. Moreover, controls should exist to make certain that substantiated allegations are corrected. Laboratory Services needs controls such as logging and tracking to be able to account for each complaint it receives and to confirm that each complaint is being addressed. Tracking also gives management necessary estimates of workload. The controls of prioritizing and setting time frames are important for Laboratory Services to address serious complaints first and all complaints promptly. Finally, Laboratory Services' follow-up on corrective action is necessary to ensure that the basis of the complaint is removed or resolved. We did not find these controls in Laboratory Services' complaints policies and procedures.

We recommended that Laboratory Services perform all its mandated oversight responsibilities for laboratories subject to its jurisdiction operating within and outside California, including, but not limited to reviewing and investigating complaints and ensuring necessary resolution.

We also recommended that Laboratory Services establish procedures to ensure that it promptly forwards complaints for which it lacks jurisdiction to the entity having jurisdiction. Further, to strengthen its complaints process, Laboratory Services should identify necessary controls and incorporate them into its complaints policies. The necessary controls include, but are not limited to, receiving, logging, tracking, and prioritizing complaints, as well as ensuring that substantiated allegations are corrected. In addition, Laboratory Services should develop and implement corresponding procedures for each control.

Department's Action: Partial corrective action taken.

Laboratory Services stated that it is continuing its complaint review and prioritization based on high, medium, or low potential risk to public health. It stated that it has received 187 complaints since September 2008, investigated 140, and performed on-site inspections for four complaints. The remaining complaints are waiting resolution or were referred to other agencies. Laboratory Services told us that it is attempting to use in-house information technology to track and categorize complaints but has not yet added necessary fields to the existing licensing database, the Health Applications Licensing system (HAL). Laboratory Services is part of the Enterprise Online Licensing

project, which is expected to replace HAL in 2013. Laboratory Services stated that it lost General Fund resources for its complaints position, but continues to do the work through a special funded position. It did not indicate whether it had developed necessary controls and corresponding procedures.

Finding #5: Laboratory Services has imposed few sanctions in recent years.

Laboratory Services did not always have staff dedicated to its sanctioning efforts from 1999 through 2007. Because it lacks an effective tracking mechanism, Laboratory Services could not identify the total number of and types of sanctions it imposed. Therefore, we had to consider various records to compile a list of imposed sanctions. We focused our review on Laboratory Services' records from 2002 through 2007. Our review of those records revealed that Laboratory Services imposed 23 civil money penalties, terminated five licenses, and directed three plans of corrective action during that six-year period. Most of those sanctions were imposed in 2002 and 2003. Of the seven civil money penalties we reviewed, Laboratory Services could not demonstrate that it collected the penalties from two of the laboratories or imposed the penalty on one laboratory, nor could it substantiate how it calculated the penalties. Our review of two license terminations showed that in both cases Laboratory Services imposed the sanctions after the laboratories failed to apply promptly for new licenses when the directorship changed. Although Laboratory Services enforced both sanctions and required the laboratories to obtain new licenses, it could not provide documentation that it notified a federally funded health program as its policy requires.

We recommended that Laboratory Services perform all its mandated oversight responsibilities for laboratories subject to its jurisdiction operating within and outside California, including sanctioning laboratories as appropriate.

We also recommended that, to strengthen its sanctioning efforts, Laboratory Services maximize its opportunities to impose sanctions, appropriately justify and document the amounts of the civil monetary penalties it imposes, ensure that it always collects the penalties it imposes, follow up to ensure that laboratories take corrective action, and ensure that when it sanctions a laboratory it notifies other appropriate agencies as necessary.

Department's Action: Partial corrective action taken.

Laboratory Services stated that it completed its policy and procedures for enforcement of unsuccessful proficiency testing and continues to follow them for initial instances of proficiency testing failures. As discussed previously, the notice to laboratories that is necessary to conduct further enforcement action is under review. Laboratory Services told us that the amount of a civil money penalty and the calculation for the assessment will be documented in the notice that it sends to a laboratory as well as the laboratory file. It stated that it is in the process of writing formal policies and procedures that explain the current practice of how a civil money penalty assessment is determined. Laboratory Services noted that it collected over $30,000 for four sanctions, but had not developed an electronic mechanism to alert staff about ongoing enforcement actions. It acknowledged that ongoing monitoring will be required. Laboratory Services was awaiting the outcome of legislation that would allow it to work with accreditation organizations for monitoring proficiency testing beginning in 2011. This legislation was subsequently enacted as law in October 2009. Laboratory Services reported that it has established timelines requiring laboratories to take corrective action and to provide it documentation. However, it noted that it lacks the resources necessary to develop or implement policies and procedures for evaluating laboratories' corrective action for appropriateness. Laboratory Services told us that it notifies other appropriate agencies of sanctions including Medi-Cal. It is also meeting quarterly with the Center for Medicare and Medicaid Services (CMS) to improve communication about sanctions.

Finding #6: Laboratory Services believes that limited resources have affected its meeting its mandates.

The Laboratory Services' chief attributes much of its inability to meet its mandated responsibilities to a lack of resources. Laboratory Services has only been successful in obtaining approval for two funding proposals for clinical laboratories in recent years. A funding proposal approved for fiscal year 2005–06 resulted in additional spending authority for two positions intended to help Laboratory Services meet its clinical laboratory oversight responsibilities. A funding proposal approved for fiscal year 2006–07 granted Laboratory Services seven positions designated for clinical laboratory oversight activities.

To gain perspective on Laboratory Services' funding issues, we spoke with the deputy director and assistant deputy director for the Center for Healthcare Quality (Healthcare Quality). On July 1, 2007, the Department of Health Services was split into two departments: The Department of Public Health (department) and the Department of Health Care Services. The department was organized into five centers, which are comparable to divisions; Laboratory Services became part of Healthcare Quality. We asked why the department has not submitted a funding proposal for Laboratory Services since it became a part of the department. We also asked about future funding proposals. According to its assistant deputy director, Healthcare Quality needs to assess Laboratory Services, understand its unique features and issues, and prioritize its needs. The assistant deputy director stated that Healthcare Quality wants to fully understand Laboratory Services' operations and history before determining the steps needed to meet Laboratory Services' mandates and to ensure that public health and safety is protected. The assistant deputy director told us that the analysis could lead Healthcare Quality to consider rightsizing Laboratory Services. The assistant deputy director explained that rightsizing is the process for ensuring that revenues collected will fully meet program expenditures. In doing so, expenditures need to be assessed and projected based on workload mandates and program needs.

We recommended that the department, in conjunction with Laboratory Services, ensure that Laboratory Services has sufficient resources to meet all its oversight responsibilities.

Department's Action: Partial corrective action taken.

Laboratory Services stated that it has completed a workload evaluation and identified the resources necessary to conduct a comprehensive laboratory oversight program. It stated it was awaiting the outcome of legislation that will allow it to recognize accreditation organizations to perform onsite inspections and proficiency testing monitoring for licensed laboratories. This legislation was subsequently enacted as law in October 2009. Further, Laboratory Services reported that it has examined its current processes and will leverage existing resources until additional staff can be acquired. However, despite recruiting efforts in 2008 and 2009, few candidates were identified, and Laboratory Services believes that salary disparity with private industry and state mandated furloughs make it difficult to attract and hire qualified candidates.

Finding #7: Laboratory Services' information technology resources do not support all its needs or supply complete and accurate data.

A lack of complete and accurate management data related to the work it performs also has contributed to Laboratory Services' struggles in meeting its mandated responsibilities. Laboratory Services relies on HAL to support licensing, registration, and renewal functions; however, HAL cannot adequately support Laboratory Services' activities related to complaints and sanctions. For example, HAL does not have sufficient fields to capture complaints Laboratory Services receives. To compensate for that and other data-capturing shortcomings of HAL, Laboratory Services has created several internal databases over the years. However, those databases lack the controls necessary to ensure accurate and complete information. All the internal databases we reviewed contain some illogical, incomplete, or incorrect data and could not be used to track activities effectively or to make sound management decisions.

We recommended that Laboratory Services work with its Information Technology Services Division and other appropriate parties to ensure that its data systems support its needs. If Laboratory Services continues to use its internally developed databases, it should ensure that it develops and implements appropriate system controls.

Department's Action: Partial corrective action taken.

Laboratory Services told us that it is seeking to hire staff with information technology database skills to help improve its internal databases and develop management repots. In addition, Laboratory Services reported that it is participating in the department-wide Enterprise Online Licensing project, which is expected to be complete by 2013. In the interim, existing staff have updated the complaint database tracking system to Access 2003 and developed queries for reports.

Finding #8: Laboratory Services has opportunities to leverage its resources better.

Because it has numerous mandated responsibilities for a finite staff to fulfill, it is important that Laboratory Services demonstrate that it is using its existing resources strategically and maximally. During the audit, we identified several opportunities for Laboratory Services to provide oversight of clinical laboratories by leveraging its resources better, including its license and registration renewal process and the inspections and proficiency-testing reviews its staff currently perform on behalf of the federal government. Further, Laboratory Services has not taken advantage of its authority to approve accreditation organizations or contract some of its inspection and investigation responsibilities.[2] Exploring these ideas and others could help Laboratory Services better meet its mandated responsibilities.

We recommended that, to demonstrate that it has used existing resources strategically and has maximized their utility to the extent possible, Laboratory Services explore opportunities to leverage existing processes and procedures. These opportunities should include, but not be limited to, exercising clinical laboratory oversight when it renews licenses and registrations, developing a process to share state concerns identified during federal inspections, and using accreditation organizations and contracts to divide its responsibilities for inspections every two years.

Department's Action: Partial corrective action taken.

Laboratory Services reports that it is using the California Corporation Board Web site to determine the current corporation status and will not process an application until the corporation is in good standing. In addition, it told us that it reviews 10 percent of personnel licensure status on renewal of laboratory licenses. Further, it verifies with the Medical Board of California a medical director's current license status. Laboratory Services told us that it meets with CMS quarterly to further improve communication and coordination of inspections. As discussed previously, Laboratory Services was awaiting the outcome of legislation to allow accreditation organizations to conduct inspections every two years. This legislation was subsequently enacted as law in October 2009. Laboratory Services reported that it coordinates initial state licensing surveys with surveys its staff conduct on behalf of the federal government and that staff use a checklist to assess some state requirements during periodic laboratory inspections on behalf of the federal government.

Finding #9: Improperly imposed and revised fees led to a substantial revenue loss.

As Laboratory Services pursues additional resources and strives to ensure that it maximizes its use of existing resources, it is important to demonstrate that it has assessed fees appropriately. In three instances since fiscal year 2003–04, Laboratory Services incorrectly adjusted the fees it charged to clinical laboratories, resulting in more than $1 million in lost revenue. According to state law, Laboratory Services must adjust its fees annually by a percentage published in the budget

[2] An accreditation organization is a private, nonprofit organization the federal government has approved to provide laboratory oversight.

act. From fiscal years 2003–04 through 2007–08, the budget acts included two fee increases: an increase of 22.5 percent effective July 1 of fiscal year 2006–07 and an increase of 7.61 percent effective July 1 of fiscal year 2007–08. However, Laboratory Services raised fees by 1.51 percent effective July 1 of fiscal year 2003–04, when it was not authorized to do so, and failed to raise fees effective July 1 of fiscal years 2006–07 and 2007–08, when it should have done so. Laboratory Services relied on an incorrect provision of the budget act in calculating its fees, and we found evidence of communication from the budget section within the department directing Laboratory Services not to raise its fees and citing the wrong provision of the budget act.

We recommended that Laboratory Services work with the department's budget section and other appropriate parties to ensure that it adjusts fees in accordance with the budget act.

Department's Action: Corrective action taken.

Laboratory Services stated that it developed policy and procedures to adjust fees and implemented them after the October 2008 Budget Bill was signed. It told us that it retains documentation of the fee adjustment for each year in its policy and procedure manual. Although the department concluded that it did not have the authority to retroactively adjust fees for previous years, we confirmed that the department adjusted fees in accordance with the budget act for fiscal year 2008–09.

Department of Social Services

Investigations of Improper Activities by State Employees, July 2007 Through December 2007

ALLEGATION I2006-1040 (REPORT I2008-1), APRIL 2008

Investigative Highlight . . .

The Department of Social Services wasted $14,714 in state and federal funds.

Department of Social Services' response as of April 2009

We investigated and substantiated an allegation that the Department of Social Services (Social Services) violated state contracting policy and wasted state and federal funds by paying $14,714 for improper overhead costs.

Finding: Social Services failed to scrutinize invoices and wasted state and federal funds by paying unnecessary overhead costs totaling $14,714.

Social Services wasted state and federal funds when it improperly paid for overhead costs that violated a state policy. According to the policy, state agencies must ensure that overhead fees are reasonable; thus, the agencies may pay overhead charges only on the first $25,000 for each subcontract. However, in seven of the nine contracts we reviewed for conference-planning services from 2004 through 2007, Social Services did not limit payments for overhead costs to the first $25,000 of subcontracts, but instead paid overhead costs on the entire subcontract amounts when the subcontracts exceeded $25,000. As a result, Social Services made $14,714 in improper payments, constituting a waste of state and federal funds. Social Services apparently made these improper payments because it failed to scrutinize invoices and did not monitor these contracts adequately for compliance with state policy. In addition, we found that if Social Services proceeds with four additional contracts for upcoming conferences, it likely will waste an additional $13,000 in state and federal funds.

Social Services' Action: Corrective action taken.

Social Services reported that it revised its standard contract language to cite the state policy that limits the application of overhead charges on subcontracts. In addition, Social Services stated that it planned to develop guidelines that would assist staff in the appropriate application of indirect cost rates and identify subcontracts during contract development. Subsequently, Social Services informed us that the exclusion from its standard contract language of a provision implementing the state policy that limits charges for overhead costs to the first $25,000 of subcontracts was an administrative oversight and that it did not intend to take any disciplinary action against any of its employees. In September 2008 Social Services reported that it had recouped $13,171 in overpayments from the contractor. In addition, Social Services indicated that the remaining $1,543 was not improper because it determined that one of the subcontract line items greater than $25,000 contained in the contractor's invoice was for multiple subcontracts, which were each less than $25,000. Finally, Social Services told us that the contractor had revised its budget detail to facilitate the identification of subcontractors.

Sex Offender Placement

State Laws Are Not Always Clear, and No One Formally Assesses the Impact Sex Offender Placement Has on Local Communities

REPORT NUMBER 2007-115, APRIL 2008

Department of Justice's, Department of Social Services', and Department of Corrections and Rehabilitation's responses as of April 2009

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) examine the State's process for placing sex offenders in residential facilities. Specifically, the audit committee asked that the bureau determine residency options for sex offenders on parole, identify the departments responsible for licensing such facilities, and quantify the number of sex offenders in various facilities. It also requested that the bureau review the departments' policies and procedures for licensing facilities and for identifying, evaluating, placing, and tracking sex offenders in local communities.

Finding #1: State laws for licensing residential facilities contain no specific provision for housing sex offenders.

State laws that govern the licensure of residential facilities do not contain specific rules or prohibitions for housing sex offenders. Two state departments are typically responsible for licensing facilities that could house six or fewer persons, including sex offenders. The Department of Social Services (Social Services) licenses community care residential facilities, and the Department of Alcohol and Drug Programs (Alcohol and Drug) licenses residential alcohol and substance abuse treatment facilities. Neither state laws nor departmental policies require consideration of the criminal background of the clients the licensees plan to serve. Further, these two departments are not required to, nor do they, track whether individuals residing at these facilities are registered sex offenders. Additionally, while the database of the Department of Justice (Justice) contains the addresses of registered sex offenders, it is not currently required to, nor does it, indicate whether or not the address is a licensed facility. We attempted to determine the number of sex offenders residing at licensed facilities by comparing the databases from the two licensing departments containing the addresses of such facilities to Justice's database. Because of the variations of the same address included in the databases maintained by Social Services, Alcohol and Drug, and Justice, we were unable to determine the precise number of facilities that housed sex offenders. Nevertheless, our comparison showed that at least 352 facilities appeared to house a total of 562 sex offenders as of December 13, 2007. We also found 49 instances in which the registered addresses in Justice's database for sex offenders were the same as the official addresses of facilities licensed by Social Services that serve children, such as family day care homes and foster family homes.

We recommended that if the Legislature is interested in identifying all sex offenders living in licensed residential facilities, it require Justice, Social Services, and Alcohol and Drug to coordinate with one another and develop an approach that would allow them to generate such information on an as needed basis. For example, with the assistance

Audit Highlights . . .

Our review of the placement of sex offenders in communities found that:

» ***The Department of Justice's (Justice) database contained more than 59,000 registered sex offenders living in California communities. Of these, 8,000 are supervised and monitored by the Department of Corrections and Rehabilitation (Corrections) until they complete their parole.***

» ***State laws and regulations and departmental policies do not require that licensing departments consider the criminal background of potential clients, including registered sex offenders, that the licensed facilities plan to serve.***

» ***State law does not generally allow sex offenders on parole to reside with other sex offenders in a single family dwelling that is not what it terms a "residential facility;" however, in several instances two or more sex offenders on parole were residing in the same hotel room.***

» ***The registered addresses in Justice's database for 49 sex offenders were the same as the official addresses of facilities licensed by the Department of Social Services that serve children.***

» ***Although state law does not prohibit two or more sex offenders from residing at the same "residential facility," it does not clearly define whether residential facilities include those that do not require a license, such as sober living facilities.***

» ***State law is also unclear whether the residence restriction applies to juvenile sex offenders; we found several instances in which Corrections placed juvenile sex offender parolees at the same location.***

continued on next page . . .

» *Local law enforcement agencies generally told us they have not performed formal assessments of the impact sex offenders have on their resources and communities.*

» *State laws generally do not require the departments or their contractors that place registered sex offenders to consider the impact on local communities when making placement decisions.*

of Social Services and Alcohol and Drug, Justice could assign a unique identifier to each registered address in its database, such as the license number issued by the respective licensing department, which would allow it to track the number of sex offenders living together in licensed facilities.

To ensure that registered adult sex offenders are not residing in licensed facilities that serve children, we also recommended that Justice provide Social Services with the appropriate identifying information to enable Social Services to investigate those instances in which the registered addresses of sex offenders were the same as child care or foster care facilities. Further, if necessary, Justice and Social Services should seek statutory changes that would permit Justice to release identifying information to Social Services so that it can investigate any matches.

Legislative Action: Legislation enacted.

Senate Bill 583 (SB 583) was passed in August 2009, which appears to address our recommendations. Specifically, it requires Justice to record each address at which a registered sex offender resides with a unique identifier that consists of a description of the nature of the dwelling. The description choices include a single family residence, an apartment/condominium, a motel/hotel, or a licensed facility. Further, SB 583 requires Justice to make this information available to Social Services, or any other state agency, when it needs the information for law enforcement purposes. This bill is effective January 1, 2012.

Justice's Action: Corrective action taken.

Justice stated that it has actively worked with Social Services to ensure that registered adult sex offenders are not residing in licensed facilities that serve children. It further stated that it continues to make available to Social Services the appropriate identifying information to enable Social Services to investigate those instances in which the registered addresses of sex offenders were the same as child care or foster care facilities.

Social Services' Action: Corrective action taken.

Social Services stated that it has investigated the 49 instances we identified in our report in which the registered addresses in Justice's database for sex offenders were the same as the official addresses of facilities licensed by Social Services that serve children. Social Services stated that it took appropriate actions to address those that were in violation of the terms and condition of their licensure. Further, as recommended, Social Services indicated it sponsored an assembly bill during the 2007–08 regular session that, among other things, would have provided the explicit authority for Justice to share its registered sex offender database with Social Services; however, the bill did not pass. Although the legislation was not successful, Social Services indicated it has continued to perform comparisons of the addresses of sex offenders listed on Megan's list with those of licensed children's facilities.

Further, Social Services indicated that, in January 2009, it mailed a notice to over 75,000 licensees and 58 counties informing them of the existence of Megan's list, encouraging them to use it periodically as a tool to help protect children in care, and providing them with step by step instructions on how to use the list. Finally, Social Services indicated that SB 583 clarifies that Justice will be required to provide it with identifying information related to the registered address of sex offenders, which Social Services can use for law enforcement purposes.

Finding #2: State law is unclear as to whether more than one adult or juvenile sex offender may reside at certain types of facilities.

State law is not always clear as to whether a sex offender on parole may reside with another sex offender in certain types of facilities. Although most sex offenders may live with other sex offenders, the California Penal Code states that an individual released on parole after being incarcerated in state prison for a sexual offense generally may not reside with another sex offender in a single family dwelling during the period of parole, except in a residential facility. We found several instances in which two or more sex offender parolees were listed as living in the same room of a hotel by reviewing addresses in a database of adult parolees maintained by the Department of Corrections and Rehabilitation (Corrections). Although the law is unclear as to whether a single room within a hotel is considered a single-family dwelling, Corrections has interpreted the law as such; therefore, its policies do not allow a sex offender on parole to reside with another sex offender in the same room within a hotel. When we informed Corrections' staff of this policy violation, they indicated that they plan to review all residences of paroled sex offenders to ensure compliance. Nevertheless, we believe the law is unclear on this matter.

This law also is not clear as to whether a sex offender on parole may reside with another sex offender at a residential facility that does not require a license, such as a sober living facility. We identified several instances in which two or more adult sex offenders on parole were residing at the same sober living facility. It is also unclear whether this restriction applies to juvenile offenders. We found several instances in which Corrections placed more than one juvenile sex offender parolee at the same location, such as a group home, that does not require a license, because it does not believe the residence restriction imposed by this statute applies to juveniles.

We recommended that the Legislature consider amending the law that places limits on the number of paroled sex offenders who may reside at the same single-family dwelling to clearly define a single-family dwelling and a residential facility. Further, we recommended that the Legislature specify whether this statute applies to juvenile sex offenders.

We also recommended that Corrections continue to monitor the addresses of paroled sex offenders to ensure that they are not residing with other sex offenders, including those not on parole, in the same unit of a multifamily dwelling.

Legislative Action: Unknown.

We are not aware of any legislative action at this time.

Corrections' Action: Corrective action taken.

Corrections stated that it completed an audit of all adult sex offender parolees and it continues to monitor any situation of alleged noncompliance with state laws and its policies. It also noted that it issued a policy memorandum to appropriate parole staff to clarify residence restrictions for sex offenders. Further, it requires parole agents in its Juvenile Division to confirm with local law enforcement that no other registered sex offenders are living in the proposed placement.

Finding #3: The database used by Corrections' Juvenile Division to track juvenile parolees is incomplete.

When we attempted to identify the number of juvenile sex offenders residing in licensed and unlicensed facilities by using the database that Correction's Juvenile Division uses to track its juvenile parolees, we found that the database was incomplete. More specifically, the Juvenile Division's database does not identify whether the person is registered as a sex offender. Therefore, to identify the sex offenders who are parolees under the Juvenile Division's supervision, we attempted to use Social Security numbers to identify the sex offenders by comparing the data to Justice's sex offender registry. However, of 2,559 juvenile offenders on active parole contained in the database, 22 percent were missing Social Security numbers and over 6 percent were missing criminal investigation and identification numbers. As a result, we may not have identified all juvenile offenders who were also sex offenders by matching their Social Security numbers or criminal investigation and identification numbers with those in the database from Justice. The Juvenile Division's policies state that Social Security numbers are required for identification and to assist juvenile offenders in obtaining employment and benefits. Moreover, a director in the Juvenile Division told us that the criminal investigation and identification numbers are required in order to conduct warrant and historical checks on a timely basis. According to the director, the division is currently working to ensure that the missing information is entered into its database for all juvenile offenders.

We recommended that Corrections' Juvenile Division update its database to include the Social Security numbers and criminal investigation and identification numbers for all juvenile offenders under its jurisdiction.

Corrections' Action: Corrective action taken.

Corrections noted that it issued a memorandum requiring supervisors to review the Juvenile Division's database to determine which parolees are missing criminal investigation and identification numbers. It indicated that this process was completed by December 30, 2008.

Finding #4: Corrections adequately supervised its sex offender parolees but did not always follow its policies.

Our review of 20 adult and 20 juvenile sex offender parolees found that Corrections' parole agents generally supervised them in accordance with department policies. However, in 15 of the 20 adult cases and one juvenile case, Corrections could not provide evidence that it informed local law enforcement agencies of the impending release of the parolee into their jurisdiction as required by its policies, was late in informing them, or did not inform them of a change in parole release date. Further, in two of the 20 adult cases and one juvenile case, Corrections did not ensure that the parolee registered with local law enforcement within five working days as required. Finally, Corrections did not always monitor juvenile parolees as required by its policies.

We recommended that Corrections ensure that its parole regions provide timely notification of the release of all parolees to the applicable law enforcement agencies and that its parole agents review all registration receipts to make certain that all parolees required to register as sex offenders do so within five working days of moving into a local jurisdiction. We further recommended that the Juvenile Division's parole agents monitor juvenile parolees as required and maintain all documents to support its monitoring efforts.

Corrections' Action: Corrective action taken.

Corrections stated that its Division of Adult Parole Operations issued a policy reiterating registration requirements pursuant to various state laws. Further, it noted that the Division of Adult Parole Operations issued a separate policy directing staff to provide enhanced notification to law enforcement agencies, in addition to that already provided in accordance with laws.

Corrections stated that its Juvenile Division provided training to all support staff to reinforce the policy related to providing timely notification of the release of all parolees to the applicable law enforcement agencies. Further, the director of Juvenile Parole Operations issued a memorandum reminding all parole staff of the notification requirements. Additionally, Corrections indicated that the assistant supervising parole agent within its Juvenile Division conducts, at a minimum, quarterly reviews with the agent of record to verify the registration receipt and the copy of such receipt is in the field file. To ensure that the Juvenile Division's parole agents monitor juvenile parolees as required and maintain all documents to support its monitoring efforts, according to Correction, its Juvenile Division provided refresher training to all field parole agents regarding contact standards for various cases. Corrections also indicated that it provided training to the agents of record in the Juvenile Division to document the contacts and to place the documentation in the field file.

Safely Surrendered Baby Law

Stronger Guidance From the State and Better Information for the Public Could Enhance Its Impact

REPORT NUMBER 2007-124, APRIL 2008

Department of Social Services' response as of April 2009

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review the Department of Social Services' (Social Services) administration of the Safely Surrendered Baby Law (safe-surrender law). The Legislature, responding to a growing number of reports about the deaths of abandoned babies in California, enacted the safe-surrender law, which became effective in January 2001. The law provides a lifesaving alternative to distressed individuals who are unwilling or unable to care for a newborn by allowing a parent or other person having lawful custody of a baby 72 hours old or younger to surrender the baby confidentially and legally to staff at a hospital or other designated safe-surrender site. The audit committee asked us to identify funding sources and review expenditures for the safe-surrender program since 2001 and determine how much has been used for public awareness, printing and distribution of materials, and for personnel. We were also asked to determine how Social Services sets its annual goals, examine its process for determining which outreach and public awareness strategies are the most effective, and identify its plans for future and enhanced outreach to increase the public awareness of the law. In addition, the audit committee asked us to gather information regarding safely surrendered and abandoned babies and determine whether the public outreach efforts appear to be appropriately targeted in light of this information.

Finding #1: The safe-surrender law lacks an administering agency and consistent funding for its implementation.

The safe-surrender law is not as effective as it might be because it does not give state agencies rigorous, ongoing responsibilities for publicizing the law's benefits, and the State has not funded the administration or promotion of a safe-surrender program. Before 2006 the law simply required Social Services, the state agency primarily responsible for implementing the law, to report annually to the Legislature on the law's impact. Since 2006 state agencies have had virtually no legal obligations under the safe-surrender law. Social Services' only involvement is compiling information that counties must submit when their designated sites accept surrendered babies, and since 2002 it has not attempted to obtain funds to further implement and publicize the safe-surrender law. The Legislature did pass two bills that, among other things, would have required Social Services to conduct a media campaign to increase public awareness of the safe-surrender law, but Governor Davis and Governor Schwarzenegger vetoed those bills. Nonetheless, in late 2001, at the request of then-Governor Davis, Social Services used approximately $800,000 from its State Children's Trust Fund (trust fund) and obtained $1 million from the California Children and Families Commission (First 5 California) to conduct a two-phase public awareness campaign.

Audit Highlights . . .

Our review of the State's implementation of the Safely Surrendered Baby Law (safe-surrender law) revealed the following:

- *The safe-surrender law does not impose on any state agency sufficient requirements to publicize its availability, thus potentially reducing the law's effectiveness.*
- *The State's failure to provide consistent funding for promoting the law may further reduce its effectiveness.*
- *The Department of Social Services' (Social Services) initial efforts to publicize the safe-surrender law exceeded its statutory obligations; however, it has not developed any further goals for conducting additional activities.*
- *After the Legislature amended the safe-surrender law to provide greater protection to individuals who surrender a child, Social Services supplied counties with erroneous guidance on managing confidential data on these individuals.*
- *Safe-surrender sites included identifying information on individuals who surrendered babies—a violation of state law—in more than 9 percent of the cases since the amendment took effect.*
- *At least 77 children may not have access later in life to information on their birth parents that they may have a legal right to view because, according to Social Services, counties have incorrectly classified them as surrendered.*

continued on next page . . .

» *Likely as the natural result of the safe-surrender process and the act of abandoning a child, which do not lend themselves to robust data collection, we learned very little about the mothers of surrendered and abandoned babies from our review of the caseworker narratives.*

» *Several counties have developed interesting approaches to increasing public awareness about the safe-surrender law.*

If it would like Social Services or other agencies to promote awareness of the safe-surrender law, we recommend that the Legislature consider amending the law to do the following:

- Specify the agency that should administer a safe-surrender program, with responsibilities that include ongoing outreach and monitoring efforts.
- Require continued annual reporting to the Legislature on the law's impact.
- Consider providing or identifying funding that will support efforts to promote awareness of the law.

To support future efforts related to the safe-surrender law, including continuing outreach and improving the quality of the State's statistics, we recommended that Social Services consider using a portion of existing funds, such as those available in its trust fund, and should consider renewing its partnership with First 5 California, which Social Services can legally use for such efforts.

Legislative Action:

Assembly Bill 1049 of the 2009–10 Regular Legislative Session would have established the Safely-Surrendered Baby Fund to receive voluntary contributions to provide outreach to increase public awareness of the safe-surrender law. However, this bill was vetoed by the governor on October 11, 2009.

Social Services' Action: None.

According to Social Services, it continues to provide funding for outreach related to the safe-surrender law to the extent that funding from the trust fund is available. However, Social Services also noted that it has not been provided with any discretionary funding to assist in implementing the recommendation. As a result, no staff is currently dedicated to outreach efforts. Further, according to Social Services, although it had previously stated that it was considering approaching First 5 California regarding funding for outreach activities, this effort was placed on hold because of the budget agreement to place a measure on the May 19, 2009, ballot to discontinue the State First 5 Commission and redirect state and local Proposition 10 funding for other uses. California's voters ultimately rejected this measure.

Finding #2: Social Services' lack of further plans to publicize the safe-surrender law may limit its effectiveness.

Because the State has not funded a program that would publicize the safe-surrender law and its benefits, Social Services has not actively publicized the law since concluding the mass-media portion of its awareness campaign in December 2003. Further, Social Services presumes that counties are actively promoting the law and that increases in the number of abandoned babies would provide the

necessary warning for it to adjust its practices. However, our audit indicated that Social Services' assumptions about the counties' programs for and its statistics about the safe-surrender law may be incorrect.

Social Services' staff stated that although the department will update its information on the safe-surrender law if it changes, it does not plan to actively promote the law. Moreover, Social Services' administrators do not believe that an official safe-surrender program exists because the Legislature has not created or funded such a program.

We believe that Social Services' decision not to set long-term goals for or actively promote the safe-surrender law will probably limit the law's effectiveness. Indeed, some individuals who are unaware of the law may abandon rather than safely surrender babies born to mothers who may not be able to care for them. In justifying its position, Social Services' management explained that the department has fulfilled all of its legal requirements. In addition, management indicated that counties have ongoing public awareness efforts and that Social Services' statistics do not indicate an "alarming increase" in the number of abandoned babies. Although we agree that state law does not presently require it to take any further action, Social Services' assumption that counties are continuing to market the safe-surrender law is not well founded, and its statistics on abandoned babies are incomplete. For instance, for calendar years 2003 through 2006, Social Services reported a total of five deceased abandoned babies found throughout the State, and it reported no deceased abandoned babies for 2005. Our limited review of other data suggests that the actual number of deceased abandoned babies may be much higher. Specifically, the Inter-Agency Council on Child Abuse and Neglect reported that in Los Angeles County alone, 24 deceased abandoned babies were found during the same four-year period. In addition, a database that the Department of Public Health (Public Health) maintains to monitor the deaths of children and the causes of those deaths contains information on six deceased abandoned infants, found across California in 2005, who we determined were one year old or younger. Additionally, Social Services' position suggesting that it will not conduct additional activities related to the safe-surrender law unless the number of abandoned babies increases significantly is not in keeping with the mission of the Office of Child Abuse Prevention.

We recommended that Social Services work with Public Health and county agencies to gain access to the most accurate and complete statistics on abandoned babies to ensure that it is aware of and can appropriately react to changes in the number of abandoned babies.

Social Services' Action: Partial corrective action taken.

According to Social Services, a safe-surrender law subcommittee continues to meet on a regular basis with representatives from Public Health and county agencies to determine if there are areas to improve the quality of data on safely surrendered babies. Topics discussed at these meetings include the following:

- Analysis of existing data on safely surrendered and abandoned babies extracted from the Child Welfare Services/Case Management System (CWS/CMS).
- Identifying other data sources for abandoned babies.
- Clarifying the feasibility and resources needed to collect additional data on abandoned babies.
- Developing a Memorandum of Understanding in order to share data between Social Services and Public Health.

Finding #3: Safe-surrender sites are violating state law by disclosing confidential information on individuals who surrender babies.

Social Services' guidance on the management of confidential data is contrary to the Legislature's intent for the safe-surrender law and, combined with the safe-surrender sites' violation of the prohibition against providing confidential data to county agencies, may adversely affect one of the safe-surrender law's ultimate goals—the adoption of surrendered infants.

Effective January 2004 the Legislature amended the safe-surrender law to protect personal identifying information contained in the medical questionnaire on persons who surrender babies. In August 2004 Social Services issued an information notice to all counties that gave instructions on entering data about safely surrendered babies into the CWS/CMS. Among other things, the instructions stated that if the parent(s) verbally provided their names, the counties should enter the names into the CWS/CMS because the parent(s) has waived their privilege of confidentiality. Conversely, if a parent reveals their name on the medical background questionnaire, their name should not be entered in the CWS/CMS.

According to our legal counsel, the instructions provided by Social Services appear to contradict state law. Specifically, the safe-surrender law states that any personal identifying information that pertains to a parent or individual who surrenders a child is confidential and shall be redacted from any medical information provided to the county agency. In fact, the law unambiguously prohibits the disclosure of identifying information on the person who surrenders a baby by a safe-surrender site—even to county agencies. Further, we believe that it is unlikely that a parent surrendering a child would know that verbally mentioning her or his name could constitute a waiver of the privilege of confidentiality. Moreover, our legal counsel asserts that the safe-surrender law does not provide that a person verbally providing personal information waives his or her right to confidentiality.

Despite the law's clear prohibition of the disclosure of identifying information by safe-surrender sites, we found that county documents in the CWS/CMS created both before and after Social Services provided this guidance contained personal information on parents of surrendered babies. Our review of caseworker narratives for all 218 babies surrendered since 2001 identified the names, phone numbers, or addresses of individuals who surrendered children in 24 cases, including 16 (9 percent) of the 176 cases occurring since January 2004 when the Legislature strengthened the protection given such information. Each of these cases reflects a violation of the safe-surrender law. Individuals who otherwise would use the safe-surrender law might be discouraged from doing so if they were aware of the frequent violation of one of the safe-surrender law's key features—confidentiality.

We recommended that Social Services clarify the circumstances under which the safe-surrender sites and counties must protect the identifying information on the individual who surrenders an infant. At a minimum, Social Services should revoke its erroneous guidance on the waiver of the privilege of confidentiality by individuals who safely surrender babies.

Social Services' Action: Pending.

According to Social Services, an All-County Information Notice is currently being drafted to disseminate a clear, consistent definition of the safe-surrender law and instructions that will clarify each agency's responsibility to keep the surrendering individual's personal information confidential.

Finding #4: Counties are not correctly classifying babies as either safely surrendered or abandoned, which affects the decision of whether to disclose confidential information.

Based on Social Services own review, many counties are not correctly classifying babies as safely surrendered or abandoned in the CWS/CMS. A misclassification can affect access to confidential data on individuals who have relinquished their children. For example, children improperly classified as safely surrendered may not be allowed access to information on their parents even though they have the legal right to review the information. Although its staff are aware of the possible consequences of such misclassifications, Social Services has made only limited attempts to correct the problem. According to

an official at Social Services, it has not changed the data in the CWS/CMS that department staff believe are misclassified, because Social Services views the data as county property. Moreover, Social Services has not required county agencies to correct such mistakes, because its management believes that the department lacks the authority to do so.

The large number of babies whose cases Social Services believes are misclassified appears to arise, at least in part, because of the misapplication of or confusion over guidelines Social Services issued to the counties. We found that Social Services' own criteria for determining whether cases qualify as safe surrenders have changed over time; however, it has not adequately followed up with the counties to ensure that they correctly apply the current criteria.

Another element prompting Social Services to disagree, for reporting purposes, with the way county agencies classify cases involving surrendered babies centers on the parent's mention of adoption. During our review of cases that it considered to be misclassified as safely surrendered, we noted that Social Services appears not to consider a baby as surrendered if the mother merely mentions that adoption is her ultimate goal for the baby, even if she does not sign the necessary adoption forms. Specifically, since 2001, Social Services has disagreed with the classification of 36 cases that counties deemed to be safe surrenders because the documentation prepared by the counties included some evidence that the parent had mentioned adoption. We agree with Social Services' action in 13 of these instances because the caseworker narratives explicitly state that the mother signed paperwork to voluntarily relinquish her child for adoption. However, for the remaining 23 cases, there was no evidence that a parent completed the paperwork required for adoption. In fact, in some of these 23 cases, there was evidence that the mother may have intended to safely surrender the baby.

Legal access to certain information on parents may be compromised because county agencies have inappropriately labeled some babies as surrendered and mistakenly categorized other babies as abandoned. Social Services has identified at least 77 cases in which babies classified as surrendered should have received another classification. These 77 cases represent more than 26 percent of the surrendered babies reported in the CWS/CMS from January 2001 to December 2007. The misclassifications may limit those children's future access to information about their parents. Moreover, the misclassification of cases as safe surrenders may hinder the potential criminal investigation of individuals who abandon babies.

Additionally, the counties' incorrect labeling of abandoned babies as safe surrenders may have negative effects. We found five instances in which counties classified babies found alone in and around hospitals as safely surrendered, although those cases appear to be examples of unsafe infant abandonment. The classification of such babies as safely surrendered may mean that counties are not pursuing criminal investigations of the individuals who left those babies in unsafe situations.

Social Services' staff have also found cases of infants labeled as abandoned in the CWS/CMS who they believe met the safe-surrender criteria, meaning that the parents of those children may not be given the protection they are entitled to under the safe-surrender law. Based on their review of caseworker narratives for children whom county agencies have coded as abandoned in the CWS/CMS, Social Services' staff have identified two cases that county agencies should have classified as safe surrenders instead of abandonments. Further, we reviewed a sample of narratives for 40 babies one year old or younger who were classified as abandoned in the CWS/CMS and identified one additional case that could have been classified as safely surrendered, given the lack of clarity on the definition. If a county agency codes a baby's case file as abandoned when a parent actually surrendered the baby, and if the county then uses the coding in the CWS/CMS to determine which data it must protect, the child may later be able to inappropriately access the information on his or her family that the parents believed was confidential. Ultimately, depending on how a county agency classifies a child in the CWS/CMS, a child may have more or less access to information on his or her birth parents than the law allows.

We recommended that Social Services clarify the definition of safe surrender, and then disseminate and monitor its use among county and state agencies. Additionally, Social Services should require counties to correct records that Social Services' staff believe are erroneous because counties have misclassified babies as either surrendered or abandoned. Because Social Services does not believe it presently has the authority to do so, Social Services should seek legislation to obtain this authority.

Social Services' Action: Pending.

According to Social Services, it has refined a clear, consistent definition of the safe-surrender law that is currently in the last stages of the approval process. Included in the definition is information specific to hospital births. Social Services indicated that it is also developing definitions for "Abandoned Alive" and "Abandoned Dead". As previously noted, an All-County Information Notice, which will include the new definition of safe surrender, is currently being drafted and will be disseminated to child welfare agencies. Social Services anticipates the notice will be disseminated in July/August 2009. However, in a previous response, Social Services stated that it does not have the authority over safe-surrender sites (i.e. hospitals) or the ability to monitor actions taken by other state agencies or individuals who have direct contact with the surrendering individual and has not sought legislation to obtain this authority.

Social Services also noted that the All-County Information Notice under development would include updated instructions for correctly entering safely surrendered baby information in CWS/CMS to ensure that the entry instructions are adequately communicated to counties. Finally, Social Services stated that its staff is encouraging counties to follow the established data deletion process to make the necessary changes to correct inaccurate data related to surrendered or abandoned babies.

Finding #5: The majority of surrendered babies may not have access to key medical information later in life.

Our review of caseworker narratives for all safely surrendered infants in California found that 72 percent of the babies surrendered since the law's enactment may not have access to vital information on their families' medical histories because of the difficulty that safe-surrender sites have in obtaining this information in medical questionnaires or by some other means. Safe-surrender sites must provide, or make a good faith effort to provide, a medical questionnaire to the individual who surrenders a baby. The individual may complete the medical questionnaire at the time of the surrender, anonymously submit it later in an envelope provided for that purpose, or decline to fill out the form. The low number of completed medical questionnaires and the minimal intake of medical information by other means suggest that many surrendered babies may not benefit from having knowledge of their families' medical histories.

To provide surrendered babies and their health care providers as much information on their medical histories as possible, we recommended that Social Services consider ways to improve the availability of medical information.

Social Services' Action: Pending.

According to Social Services, the safe-surrender subcommittee is currently considering revisions to the medical questionnaire. However, as stated in the six-month response, surrendering parents/individuals are provided anonymity. Therefore, developing methods of obtaining medical information for surrendering infants continues to be a challenge. Revisions to the questionnaire and protocols remain under development with an unknown timeline for completion.

Finding #6: Some counties have developed useful models and materials to raise awareness about the law.

Although county efforts to publicize the safe-surrender law vary, some counties have developed interesting products and employed innovative techniques to implement and publicize the safe-surrender law. Los Angeles County appears to have undertaken the most comprehensive and sustained effort, including forming two task forces to help it achieve better results. For instance, according to a representative from Los Angeles County, as a result of one of the task force's recommendations, the county spent more than $500,000 on an outreach campaign. Other local governments, such as San Joaquin and San Bernardino counties, have also employed novel methods to inform the public about the safe-surrender law, including using nonprofit organizations to spearhead efforts and producing an award-winning short film on the safe-surrender law. These efforts by local entities furnish a valuable service and help to make up for the State's limited involvement in publicizing and further implementing the safe-surrender law.

We recommended that Social Services work with the counties to leverage existing models and tools currently in use in California, such as translated materials and existing middle and high school curricula, to continue raising the public's awareness of the safe-surrender law in the most cost-effective manner.

Social Services' Action: Pending.

According to Social Services, its safely surrendered baby outreach subcommittee, which includes representatives from Public Health, nonprofit agencies, counties, and hospitals, continues to meet to discuss the most effective outreach efforts possible, considering the lack of resources available. Included in the discussion is the possible use of the YouTube Web site for a public awareness clip and teaming with the universities to offer information on their Web sites. However, Social Services noted that it has not been provided with discretionary funding to implement our recommendation. As a result, according to Social Services, it has been challenging to adequately address this issue in the current fiscal climate and no staff is currently dedicated to safely surrender baby outreach efforts.

Regarding middle and high school curricula, Social Services stated that it has no authority to approve and distribute such materials. Therefore, Social Services indicated it would defer to the Department of Education and local school boards to promote their use.

Department of Social Services

Investigations of Improper Activities by State Employees, July 2008 Through December 2008

ALLEGATION I2007-0962 (REPORT I2009-1), APRIL 2009

Department of Social Services' response as of August 2009

The Department of Social Services (Social Services) failed to follow the requirements imposed by state civil service laws when a high ranking official arranged for the selection of a subordinate employee to fill a field analyst position. Social Services further violated state civil service laws by appointing the employee to a field analyst position even though she continued to perform the duties of a lower level analyst. As a result, Social Services paid the employee $6,444 more than what is permitted by the State for the duties she performed.

Investigative Highlight . . .

A high-ranking Department of Social Services (Social Services) official arranged for the selection of a subordinate employee to fill a field analyst position. However, the employee continued to perform the duties of a lower-level analyst, and Social Services paid her $6,444 more than what is permitted for the duties she performed.

Finding #1: The official's actions to reserve a field analyst position for her assistant were improper.

In 2005 the official decided that she wanted to promote her assistant to a higher paying position in Sacramento where they both were headquartered. The official located an unoccupied field analyst position in the San Jose field office she felt would be suitable for her assistant. She then contacted the regional manager at that field office and advised the regional manager that she wanted to reserve the position for her assistant in Sacramento but that she would have another field analyst position transferred to the San Jose office soon to make up for the position she was reserving.

Apparently, Social Services had already begun the recruiting process for the unoccupied field analyst position in San Jose when the official contacted the regional manager and reserved the position. After the official contacted the regional manager, who was on the interview panel for the position, the panelists understood that the position had already been reserved for the official's assistant. Subsequently, the panelists selected the assistant to fill the first position, and then presumably they selected the candidate they considered the best of the other candidates to fill the later position.

We recommended that Social Services take corrective action against the official for her improper actions and provide training to management and other key staff regarding the laws, regulations, and policies governing the hiring process.

Social Services' Action: Corrective action taken.

In April 2009 Social Services informed us that the official had since retired but still worked at its headquarters as a retired annuitant. In May 2009 Social Services informed us that it had hired a replacement for the official, and that it no longer employed her as a retired annuitant. Nevertheless, Social Services stated that it discussed the findings of our investigation with the official along with the personnel policies and procedures that should have been

followed. Social Services also commented that it might hire the official as a retired annuitant in the future, but that she would not be placed in a supervisory position with the authority to hire or promote. In addition, Social Services stated that in its supervisor and manager training classes it would incorporate and emphasize the laws, regulations, and policies governing the hiring process and the need to ensure that employees are performing the duties described in their duty statements. Finally, in a June 2009 memo it reminded all supervisors of these rules.

Finding #2: The official's appointment of her assistant to a field analyst position, when she did not intend for the assistant to perform the duties of that position, was also improper.

After the assistant was selected for the field analyst position, the official directed her formal appointment to this higher paying position. The documentation for the appointment reflected that the assistant would be serving as a field analyst in San Jose. However, after the appointment, the official did not change the assistant's assigned duties but instead directed her to continue performing the same duties that she had performed previously. Moreover, after the appointment, the assistant continued working in Sacramento, even though her assigned position number and Social Services' organizational charts indicated that she was now headquartered in San Jose.

After we inquired about the employee's duties, Social Services reported to us in February 2008 that it had determined the employee was not performing the essential duties of a field analyst as described in the duty statement for the position, such as performing inspections in the field. Social Services then offered the assistant the option of either remaining as a field analyst and performing the duties of that position or transferring into an office analyst position and continuing to perform primarily the same duties she had been assigned as the official's assistant. In June 2008 the employee chose to maintain her current duties and transfer into the office analyst position. The transfer became effective retroactive to May 2008. Regarding the assistant having been assigned a San Jose position number even though she was performing her work in Sacramento, Social Services reported that this resulted from a "poor administrative practice."

We recommended that Social Services seek retroactive cancellation of the assistant's appointment to the field analyst position and seek repayment from the assistant of the $6,444 that it improperly paid her. In addition, we recommended that Social Services take steps to ensure that its position numbers and organization charts accurately reflect where employees are headquartered.

Social Services' Action: Corrective action taken.

In April 2009 Social Services reported that it consulted with the State Personnel Board (Personnel Board). Social Services stated that the Personnel Board determined that the appointment should not be rescinded and the overpayment should not be collected because the employee accepted that appointment in good faith more than one year prior to discovery. However, we still conclude that neither the employee nor Social Services acted in good faith in the appointment since evidence showed that the employee never intended to relocate to San Jose or to perform the primary duties associated with the field analyst position.

In addition, as part of the employee's incorrect classification, Social Services stated that it erred in its salary determination when the employee was appointed as an office analyst in May 2008. It indicated that it would work to collect $1,516 in overpayments made to the employee. In August 2009 Social Services stated that it had begun collecting the overpayment from the employee and that final collection would occur in January 2010.

Finally, in its June 2009 memo, Social Services reminded all supervisors of the need to ensure that the department's position numbers and organization charts accurately reflect where employees are headquartered.

Department of Social Services

For the CalWORKs and Food Stamp Programs, It Lacks Assessments of Cost-Effectiveness and Misses Opportunities to Improve Counties' Antifraud Efforts

REPORT NUMBER 2009-101, NOVEMBER 2009

Department of Social Services' response as of November 2009

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits (bureau) to determine the fraud prevention, detection, investigation, and prosecution structure for the California Work Opportunities and Responsibility to Kids (CalWORKs) and the federal Supplemental Nutrition Assistance Program (food stamp) programs at the state and local levels and the types of early fraud detection or antifraud programs used. Additionally, the audit committee requested that the bureau determine, to the extent possible, the cost-effectiveness of the fraud prevention efforts at the state and county levels, and to review how recovered overpayments are used. Further, we were asked to estimate, to the extent possible, the savings resulting from fraud deterred by counties' antifraud activities and whether early fraud detection programs are more cost-effective than ongoing investigations and prosecutions. Lastly, we were asked to assess the Department of Social Services' (Social Services) justification for continuing to use both the Statewide Fingerprint Imaging System (SFIS) and the Income Eligibility and Verification System (IEVS).

Finding #1: Early fraud programs may not be cost-effective in all counties, but they are generally more cost-effective than ongoing investigations.

Although they have taken some steps, neither the counties nor Social Services have conducted meaningful analyses to determine the cost-effectiveness of counties' efforts to detect and deter fraud in the CalWORKs and food stamp programs. As a result, we developed our own analysis, which indicates that the cost-effectiveness of antifraud efforts varies among the counties. Using a three-month projection of savings, our calculations showed that counties generally realize greater savings per dollar spent on early fraud activities than for ongoing investigations. This difference is due largely to the fact that according to the data that counties report, early fraud activities generally result in a much greater number of denials, discontinuances, and reductions of aid than ongoing investigations produce, and also because early fraud activities cost less. Ongoing investigations generally result in fewer discontinuances or reductions of aid because the main purpose of these investigations is to prove suspected fraud that may have occurred in the past.

Further, the net savings resulting from early fraud activities and ongoing investigations vary widely across the six counties we reviewed. For example, in the three-month projection for the food stamp program, Los Angeles County's early fraud activities yielded only 35 cents for every dollar it spent, while Orange County yielded $1.82 in savings. Our calculations show similar variances among counties for the CalWORKs program. Differences in county practices may partially

Audit Highlights . . .

Our review of the Department of Social Services' (Social Services) oversight of counties' antifraud efforts related to the California Work Opportunities and Responsibility to Kids (CalWORKs) program and the federal Supplemental Nutrition Assistance Program, known as the food stamp program in California, found the following:

- ***Although they have taken some steps, neither the counties nor Social Services has performed any meaningful analyses to determine the cost-effectiveness of their efforts to detect and deter fraud in the CalWORKs or food stamp programs.***
- ***Our analysis of counties' investigative efforts found that, using a three-month projection, the measurable savings resulting from early fraud activities exceed the costs for CalWORKs and approach cost neutrality for the food stamp program, assuming a three-month projection of savings.***
- ***Counties' early fraud efforts are more cost-effective than ongoing investigations.***
- ***Neither Social Services nor the six counties we visited took sufficient steps to ensure the accuracy of the data counties report on their investigation activities.***
- ***Social Services does not ensure that counties consistently follow up on information it provides them that might affect welfare recipients' eligibility.***
- ***Although Social Services asserts that the Statewide Fingerprint Imaging System (SFIS) deters welfare fraud, it has not assessed the cost-effectiveness of SFIS.***

account for variations in the cost-effectiveness of early fraud activities across the counties, to the extent that these practices affect the number of resulting denials, discontinuances, and reductions. For example, the counties that typically generated the highest measurable net savings in 2008—Orange and San Diego—not only accepted a high number of early fraud referrals but also had a high percentage of benefit denials, discontinuances, or reductions compared to their early fraud referrals.

Although neither Social Services nor the counties have performed a comprehensive analysis of the cost-effectiveness of the efforts to combat welfare fraud, some efforts have been made. One of the more promising efforts was the forming of a program integrity steering committee (steering committee) to follow up on the results of a 10-year statistical study on fraud prevention and detection activities in the CalWORKs and food stamp programs, and to identify cost-effective approaches for improving program integrity in both programs. In 2008 the steering committee approved eight recommendations for counties and 10 recommendations for Social Services regarding the most promising approaches it found. Social Services indicated that it is addressing four of the 10 recommendations directed to it and is considering how to address the remaining six.

We recommended that Social Services ensure that all counties consistently gauge the cost-effectiveness of their early fraud activities and ongoing investigation efforts for the CalWORKs and food stamp program by working with the counties to develop a formula to regularly perform a cost-effectiveness analysis using information that the counties currently submit. We also recommended that Social Services determine why some counties' efforts to combat welfare fraud are more cost-effective than others by using the results from the recommended cost-effectiveness analysis and that it seek to replicate the most cost-effective practices among all counties. Finally, we recommended that Social Services continue to address the recommendations of the steering committee and promptly act on the remaining recommendations.

Social Services' Action: Pending.

Social Services indicated that it hopes to soon complete the development of a formula to evaluate the cost-effectiveness of county fraud operations. However, Social Services believes that the focus should be first to ensure the accuracy of the counties' reporting of data before developing a formula for determining the cost-effectiveness of these operations. It will continue to work on these efforts as resources permit. Social Services noted that it has shared with the counties the statewide potential "promising approaches" that were developed by the steering committee but it believes that what might work in one county may not work in another county. Social Services says it is continuing to work on the remaining recommendations of the steering committee.

Finding #2: Social Services does not ensure that counties report accurate data on their welfare fraud investigations.

Neither Social Services nor the six counties we visited have taken sufficient steps to ensure the accuracy of the counties' data in their investigation activity reports. These reports, which counties submit monthly to Social Services, summarize the counties' fraud investigative efforts. We found that the information these counties included on the investigation activity report is not always accurate, supported, or reported consistently. Social Services is aware of problems with the data and has taken some limited steps to clarify the instructions for preparing these reports. However, Social Services has not taken steps to improve the accuracy of the counties' reporting and its procedures for reviewing investigation activity reports are inadequate to detect even the most glaring errors in the data that counties report. For example, although counties reported reducing benefits on a total of nearly 5,000 cases during fiscal year 2007–08 as a result of ongoing investigations, only 41 of those cases were reported by Los Angeles County, a number that seems quite low considering the county spent over $23 million to perform ongoing investigations during 2008 and it represents 30 percent of the State's CalWORKs caseload. In fact, Los Angeles County confirmed to us that it has been inadvertently underreporting the number of cases in this category. Despite the known problems with counties'

reporting, Social Services uses these erroneous investigation activity reports to populate part of a report it submits to the federal government and to prepare reports submitted to internal decision makers and the Legislature.

To ensure the accuracy and consistency of the data counties submit on welfare fraud activities that counties report and that Social Services subsequently reports to other parties, we recommended that Social Services remind counties that they are responsible for reviewing the accuracy and consistency of investigation activity reports submitted, that it perform more diligent reviews of the accuracy of the counties' reports, provide counties with feedback on how to correct and prevent errors that it detects, and continue with its efforts to clarify the instructions for completing the investigation activity reports.

Social Services' Action: Pending.

Social Services noted that it has established a workgroup to clarify the instructions for the investigation activity report, but that the efforts of this workgroup will only continue as resources are available. Once the instructions are revised, Social Services intends to provide technical assistance to the counties on how to complete the report accurately. Social Services further stated that it reviews the investigation activity reports during its county visits and discusses any inaccuracies it finds with county staff.

Finding #3: Social Services does not ensure that counties consistently follow up on welfare fraud matches.

Social Services does not ensure that counties consistently follow up on information it provides them that might affect welfare recipients' eligibility. Federal and state regulations require that Social Services distribute 10 lists of individuals' names that potentially could match certain criteria that would cause the individual's aid amounts to be reduced or make them ineligible for aid (match lists). Most of these lists are in paper form. For six of the 10 match lists, federal regulations mandate that the State must, within 45 days of receiving the match information, notify the welfare recipient of an intended action—a discontinuance of or reduction in benefits—or indicate that no action is required. For the remaining four match lists, there is no mandated time period for review. None of the counties we reviewed consistently followed up on all of the match lists that had to be completed within the 45-day timeline and only one county was consistently completing matches for the four match lists without a time requirement. According to representatives from the five counties we reviewed, the format of some match lists could be improved to make them more efficient to use. For example, all five counties told us that having all match lists in electronic form would allow them to process matches more efficiently. Social Services indicates it has attempted in the past to address counties' concerns with the format of the match lists and is taking steps to provide more lists in electronic form.

Although Social Services has a process in place to monitor the counties' efforts to follow up on match lists, it is missing opportunities to improve their efforts because it does not visit all counties on a regular basis and does not always enforce recommendations from these reviews. Specifically, Social Services has not reviewed 25 of the 58 counties during the three-year period from August 2006 to August 2009, including Los Angeles County, which represents 30 percent of the State's CalWORKs caseload and was last reviewed in 2005. Social Services asserts that it lacks resources to review the counties' efforts on a regular basis.

We recommended that Social Services remind counties of their responsibility under the state regulations to follow up diligently on all match lists and work with counties to determine reasons why poor follow-up exists and address those reasons. We also recommended that Social Services revive its efforts to work with counties to address their concerns about match-list formats. Further, we recommended that Social Services perform reviews of all counties regularly and better enforce the counties' implementation of its recommendations to correct any findings and verify implementation of the corrective action plans required.

Social Services' Action: Pending.

Social Services says it will issue a notice to counties to remind them of their obligation to consistently follow up on match lists, but that it will only consider reviving its efforts to address counties' concerns about match-list formats as resources permit. Additionally, to ensure that it conducts county reviews on a three-year cycle, Social Services indicates that it will redirect staff to perform these reviews.

Finding #4: Social Services has not done a cost-benefit analysis of Statewide Fingerprint Imaging System (SFIS).

Although Social Services asserts that SFIS deters individuals from fraudulently applying for aid in multiple counties, it has not done a cost-benefit analysis of SFIS because it believes there is no way to measure the deterrence effect of the system. When justifying the implementation of SFIS, Social Services did not conduct its own study; instead, it used the estimates from an evaluation Los Angeles County performed in 1997 to project statewide savings that would result from SFIS. However, in a report we issued in 2003, we concluded that Social Services' methodology of projecting statewide savings using Los Angeles County's estimated savings was flawed, especially in its assumption that the incidence of duplicate-aid fraud in Los Angeles County was representative of the incidence of this type of fraud statewide. Although studies that Social Services conducted in 2005 and 2009 concluded that SFIS identifies fraud that other eligibility determination procedures do not, these studies were of limited scope.

The large and ongoing historical backlog of SFIS results awaiting resolution by county staff raises questions of how counties are using SFIS in deterring fraud. As of July 31, 2009, there was a statewide backlog of more than 13,700 cases that were awaiting resolution by county staff for more than 60 days. Moreover, the number of duplicate-aid cases SFIS has detected is fairly low, given its cost. In 2008 Social Services data show that statewide the counties used SFIS to identify 54 cases of duplicate-aid fraud, and they have identified a total of 845 instances of fraud through SFIS since its implementation in 2000. Social Services believes that SFIS does not identify many cases because it deters people from applying for duplicate aid, a benefit that it asserts cannot be measured. We acknowledge that fraud deterrence is difficult to measure. However, because the State is spending approximately $5 million per year to maintain SFIS, Social Services has an obligation to justify whether the continued use of SFIS is cost-beneficial to the State. Further, we noted that Arizona has developed a process to conduct a yearly cost-benefit analysis of its fingerprint imaging system.

Recognizing that the deterrence effect is difficult to measure, we recommended that Social Services develop a method that allows it to gauge the cost-effectiveness of SFIS. Social Services should include in its efforts to measure cost-effectiveness the administrative cost that counties incur for using SFIS. Based on its results, Social Services should determine whether the continued use of SFIS is justified.

Social Services' Action: None.

Social Services asserts that it is impossible to measure the deterrence affect of SFIS, but still contends that it is an effective deterrent of duplicate aid fraud. Further, Social Services believes that a new independent cost-benefit analysis would not be beneficial because it believes that the studies it has conducted, including the original evaluation it performed in 1997, coupled with the information available from other states, justifies the deterrence value of SFIS.

Finding #5: Social Services has not taken the necessary steps to claim its share of $42.1 million in food stamp overpayment collections.

Since December 2003 counties have received $42.1 million in overpayments recovered from food stamp recipients. However, Social Services has been delayed in taking the steps needed to claim its share of these overpayments or to distribute the shares of these funds due to counties and the administering federal agency, the U.S. Department of Agriculture (USDA). Overpayments to food stamp recipients

can result from administrative errors by counties or inadvertent errors or fraud by recipients. Counties collect the overpayments from recipients through various means, including tax refunds intercepted and held by the federal government. For the distribution of overpayments to occur, Social Services must work with the USDA to reconcile tax intercepts and county collections, but it noted that its efforts have been delayed by staff turnover and past errors in counties' collection reports. Social Services' records show that of the $42.1 million balance, $17.2 million would go to the USDA, with the remaining $24.9 million split between Social Services and the counties. The counties we reviewed deposit the cash they collect in their bank accounts and receive the interest earnings on these collections until Social Services claims its and the federal government's share. As a result of the six-year delay in addressing this issue, we estimate that Social Services lost approximately $1.1 million in interest earnings on its share of the funds.

We recommended that Social Services continue to work with the USDA and make its reconciliation of the backlog of overpayments a priority to expedite the distribution of the $42.1 million in food stamp overpayment collections to the appropriate entities. Further, it should develop procedures to ensure that it promptly reconciles future overpayments. Additionally, Social Services should continue to monitor the counties' collection reports to ensure that counties are reporting accurate information.

Social Services' Action: Partial corrective action taken.

Social Services indicated that the USDA reinitiated the reconciliation process in March 2008 and it has been working with the USDA since then to resolve the backlog of overpayments. Further, until this audit, Social Services says it was unaware that counties were earning interest on these collections, but it believes that it has the authority to recoup any interest earnings it lost.

Finding #6: Investigation and prosecution efforts vary by county.

County size, demographics, and county department staffing necessitate different approaches to investigating and prosecuting welfare fraud. Although the counties appear to have similar criteria for investigations, their procedures for conducting investigations and their criteria for prosecution and imposing administrative sanctions vary. For example, the monetary thresholds below which the district attorney generally does not prosecute fraud varied among the counties we visited and were as high as $10,000, depending on the type of offense. These variances may affect the number of cases referred and successfully prosecuted in each county. The data reported by counties statewide show variances in the number of referrals for prosecution of CalWORKs and food stamp fraud and in the outcomes of the prosecutions filed. It is in the best interest of Social Services to track these variances, as well as study the counties' prosecution practices to determine whether other counties could become more effective in their efforts by emulating the successful prosecution practices used elsewhere.

Finally, state regulations require counties to conduct administrative disqualification hearings for CalWORKs and food stamp fraud cases for which the facts do not warrant prosecution or cases that have been referred for prosecution and subsequently declined. However, many counties have stopped using the administrative disqualification hearing process, which Social Services attributes to county investigative staff believing that the administrative disqualification hearing standard of proof is higher than in criminal cases. Social Services told us that it has convened a workgroup with the State's presiding administrative law judge to discuss county concerns and clarify the appropriate application of the administrative hearing process. Social Services plans to issue guidance to counties when the workgroup has completed its efforts.

We recommended that Social Services track how counties determine prosecution thresholds for welfare fraud cases and determine the effects of these thresholds on counties' decisions to investigate potential fraud, with a focus on determining best practices and cost-effective methods. We also recommended that Social Services either ensure that counties follow state regulations regarding the use of administrative disqualification hearings or pursue changing the regulations.

Social Services' Action: Pending.

Social Services did not address our recommendation to review the effect of counties' varying prosecution thresholds. However, Social Services noted that the workgroup it convened is continuing to look at making the administrative hearing process work smoothly, but that the workgroup's efforts will only continue as both state and county resources permit. Additionally, Social Services stated that it is finalizing guidance on counties' responsibilities for both the food stamp and CalWORKs administrative hearing process.