Implementation of State Auditor's Recommendations

Audits Released in January 2007 Through December 2008

Special Report to
Assembly Budget Subcommittee #4—State Administration

February 2009 Report 2009-406 A4

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February 24, 2009 2009-406 A4

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

Dear Governor and Legislative Leaders:

The Bureau of State Audits presents its special report for the Assembly Budget Subcommittee No. 4—State Administration. 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 an appendix that identifies monetary benefits 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 2007 through December 2008, that relate to agencies and departments under the purview of the Assembly Budget Subcommittee No. 4—State Administration. 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 Bureau of State Audits' (bureau) 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 2009. 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 2007 through December 2008. Because an audit report and subsequent recommendations may crossover several departments, they may be accounted for on this table more than one time. For instance, in following table the E-Waste Report, 2008-112, is reflected under the Employment Development Department, Department of General Services, and Department of Justice.

	FOLLOW-UP RESPONSE				STATUS OF RECOMMENDATION				
	INITIAL RESPONSE	60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	PAGE NUMBERS
State Administration									
Administrative Office of the Courts									
DNA Identification Fund Report 2007-109				●	1	0	0	0	3
California Exposition and State Fair									
Investigations Report I2007-1 [I2006-0945]				●	1	0	0	0	7
State Board of Chiropractic Examiners									
Chiropractic Board Report 2007-117			●		11	11	0	0	9
Department of Consumer Affairs									
Investigations Report I2008-2 [I2007-1046]	●				0	1	0	0	27
Department of Corporations									
License Applications and Complaints Report 2005-123				●	2	4	1	0	29
Department of Corrections and Rehabilitation									
Investigations Report I2008-1 [I2006-0665]			●		1	0	0	0	37
Sex Offender Placement Report 2007-115			●		1	1	1	0	39
Parole Discharge Report 2008-104		●			0	1	2	0	43
Investigations Report I2008-2 [I2006-0826]	●				0	0	1	0	47

continued on next page . . .

		FOLLOW-UP RESPONSE			STATUS OF RECOMMENDATION				
	INITIAL RESPONSE	60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	PAGE NUMBERS
Employment Development Department									
E-Waste Report 2008-112	●				0	0	2	0	49
Board of Equalization									
Nonprofit Hospitals Report 2007-107				●	1	0	0	0	55
Franchise Tax Board									
Nonprofit Hospitals Report 2007-107				●	1	1	0	0	55
Gambling Commission									
Indian Gaming Report 2006-036				●	0	0	0	1	59
Department of General Services									
CHP Contracting Report 2007-111			●		3	1	0	0	67
E-Waste Report 2008-112	●				0	0	1	0	49
Department of Housing and Community Development									
Housing Bonds Report 2007-037				●	2	1	0	0	75
Department of Insurance									
Executive Life Insurance Report 2005-115.2			●		3	1	0	0	79
Unemployment Insurance Appeals Board									
Unemployment Insurance Report 2008-103	●				0	3	3	0	83
Department of Justice									
E-Waste Report 2008-112	●				0	0	1	0	49
Sex Offender Placement Report 2007-115			●		1	0	0	0	39
Investigations Report I2008-1 [I2007-0728]			●		1	0	0	0	91
Investigations Report I2008-1 [I2007-0958]			●		2	0	0	0	93
DNA Identification Fund Report 2007-109				●	1	0	0	0	3
Medical Board of California									
Physician Diversion Program Report 2006-116R			●		Program discontinued				95
Assessment of Fees Report 2007-038				●	1	0	1	0	99
Prison Health Care Services									
Medical Service Contracting Report 2006-501				●	3	9	0	2	101
Office of Secretary of State									
Poll Workers Training Report 2008-106		●			0	1	0	0	115
State Bar of California									
State Bar Report 2007-030				●	0	3	0	0	125
State Controller									
DNA Identification Fund Report 2007-109				●	1	0	0	0	3
Department of Veterans Affairs									
Yountville Veterans Home Report 2007-121			●		4	2	0	0	131
Victim Compensation and Government Claims Board									
Victim Compensation Program Report 2008-113	●				0	0	10	0	139

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DNA Identification Fund

Improvements Are Needed in Reporting Fund Revenues and Assessing and Distributing DNA Penalties, but Counties and Courts We Reviewed Have Properly Collected Penalties and Transferred Revenues to the State

REPORT NUMBER 2007-109, NOVEMBER 2007

The Department of Justice's, State Controller's Office's, and Administrative Office of the Courts' responses as of November 2008

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to review the implementation of the DNA act—specifically, the collection and management of money in county and state DNA funds. The audit committee noted that since the DNA act became effective, revenues associated with it were significantly lower than expected. Additionally, the Legislative Analyst's Office suggested that the revenue shortfall might be the result of counties not collecting the DNA penalty assessments or receiving only partial payments. Further, information posted on the Department of Justice (Justice) Web site showed that many counties, including five of the 10 largest, did not report collecting any DNA fund money for 2005. Consequently, the audit committee was concerned that the State may not be receiving its fair share of DNA fund money and that counties may not be using the funds as intended.

Finding #1: Reporting of data on county DNA identification funds needs to improve.

The DNA act requires the courts to levy a penalty of $1 for every $10, or fraction thereof, on all fines, penalties, or forfeitures imposed and collected by the courts for all criminal offenses, including violations of the vehicle code but excluding parking violations (initial DNA penalty). The DNA act also requires each county's board of supervisors to submit an Annual County DNA Identification Fund Report (annual report) to Justice and the Legislature detailing collection and expenditure information related to the initial DNA penalty. Further, the DNA act requires Justice to post data from the annual reports on its Web site. In July 2006 the DNA act was amended to levy an additional DNA penalty on all criminal and vehicle violations except parking violations (additional DNA penalty).

However, state law does not require counties to report collections related to the additional DNA penalty. Consequently, the information the counties report to Justice and the Legislature is incomplete and, as a result, the State cannot be fully assured that the counties are assessing and collecting all required DNA penalties. Based on our review of records maintained by the State Controller's Office (state controller), counties transferred to the State about $2.3 million in additional DNA penalties from July 2006, the month the additional penalty became effective, through December 2006, an amount that is not reflected on the Justice Web site. Further, the state controller's records also show that 11 counties did not report transferring any money from the additional DNA penalty to the State for 2006. We contacted each of these counties and were informed by representatives

Audit Highlights . . .

Our review of the implementation of Proposition 69, the DNA Fingerprint, Unsolved Crime, and Innocence Protection Act (DNA act) revealed that:

- *State law does not require counties to report collections related to the additional DNA penalty imposed by the July 2006 amendment to the DNA act; therefore, interested parties would not be able to obtain a complete picture of all the DNA penalty money collected and transferred to the State.*
- *Information available on the Department of Justice's Web site as of June 2007 showed that 22 counties had not transferred any DNA money to the State in 2005 and 24 did not do so in 2006; however, based on the State Controller's Office's records, these counties actually transferred to the State $1.6 million in 2005 and $3.8 million in 2006.*
- *Although there were no significant errors in assessing and distributing DNA penalties at the three counties we reviewed, some weaknesses in the courts' automated case management systems and internal controls resulted in minor errors in the assessment and distribution of DNA penalties.*

of nine of the 11 counties that they combined money they collected from the additional DNA penalty with their collections of the initial DNA penalty rather than identify their collections separately on the documentation sent to the state controller. Moreover, three of the nine counties indicated that they failed to transfer 100 percent of their collections to the State, as required by law. Rather, they only transferred 70 percent, the amount applicable to the initial DNA penalty. Additionally, an official from one county stated that, although the court was assessing and collecting the additional DNA penalty, due to a coding error, the county did not transfer its additional DNA penalty collections to the State until March 2007. Finally, an official from the court in the remaining county acknowledged that it did not begin assessing the additional penalty until September 2007.

Additionally, many counties failed to submit annual reports in 2005 and 2006. In particular, as of June 2007, 22 counties had not submitted the required annual reports to Justice for 2005 and 24 counties had not submitted the reports for 2006. Rather than report that the counties had failed to submit annual reports, the Justice Web site indicated that they had not transferred any DNA fund money to the State. However, based on records from the state controller, all but two counties had transferred certain DNA fund money to the State in 2005, and only one county failed to make the required transfers in 2006. The counties that did not submit annual reports on their 2005 collections actually transferred almost $1.6 million to the State, and the counties that did not submit reports on their 2006 collections transferred almost $3.8 million. Because the Justice Web site shows those counties as not transferring any money to the State, anyone attempting to use the data might erroneously conclude that many counties were not assessing any DNA penalties and that the State was not receiving money it was owed.

We recommended that the Legislature consider revising state law to require that counties include in their annual reports information on the additional DNA penalty established by Chapter 69, Statutes of 2006.

We also recommended that the Administrative Office of the Courts (AOC) contact the courts in the counties that did not report transferring to the State any money or only part of the money for the additional DNA penalty to determine whether they are appropriately assessing the penalty. Additionally we recommended that the state controller contact the auditor-controllers in the counties that did not report transferring to the State any money or only part of the money for the additional DNA penalty to ensure that counties and courts correctly assess, collect, and transfer the money to the State.

Finally, because state law requires Justice to make county-reported data available on its Web site, we recommended that Justice take several steps to ensure that data on county DNA fund activities are accurate. We recommended that Justice annually notify counties that they are statutorily required to submit reports on or before April 1 to the Legislature and to contact each county that does not submit an annual report by the deadline. Additionally, we recommended that Justice establish policies and procedures for posting county data on its Web site and clearly indicate on its Web site any county that failed to submit an annual report.

Legislative Action: Unknown.

AOC's Action: Corrective action taken.

The AOC stated that it is committed to taking immediate, necessary steps to correct issues identified in any audit of the judicial branch. The Administrative Director of the Courts has requested that AOC's internal audit services unit ensure that its audit programs continue to cover the testing of distributions in each of their future audits. However, AOC indicated that with an audit cycle of approximately four years, it is possible that the internal audit services unit may not be able to review implementation of changes in distributions at individual courts in as timely a manner as it would prefer.

Finally, the AOC stated that it provides support to the courts regarding the implementation of new legislation and information about changes in assessments and distributions. This support helps the courts discharge their duties with respect to ensuring that distribution changes are made on an accurate and timely basis.

State Controller's Action: Corrective action taken.

The State Controller indicated that it notified the 11 counties identified as not transferring or improperly transferring additional DNA penalty assessments to the State in April 2008. These counties were directed to the State Controller's Web site containing the July 2006 DNA Penalty Assessment Distribution Guidelines. Personnel contact information for the State Controller was also provided should counties require additional assistance. The State Controller also stated that all counties have remitted assessments to the DNA Identification Fund through November 2008. Finally, the State Controller's Division of Audits stated it will continue to monitor county compliance with the DNA Penalty Assessment Distribution Guidelines through its court audit program.

Justice's Action: Corrective action taken.

In its 60-day response dated February 8, 2008, Justice stated that it would begin sending out form letters every February to all counties reminding them that the report for the previous year was due. Additionally, Justice stated that if a county had not submitted a report by the April 1st due date, a formal reminder letter would be sent on May 1st. Also included in this response, Justice submitted its procedures for posting county DNA fund data on its Web site.

In its one-year response, Justice indicated that it sent a formal reminder letter dated May 1, 2008, to 13 counties that had not yet submitted the required report by the April 1, 2008, due date. However, nine of these counties still did not submit the required report. As a result, according to documents provided with its one-year response, Justice's Web site noted that these counties failed to submit an annual report.

Finding #2: Courts need to improve their methods of ensuring the accuracy of DNA penalty assessments and distributions.

Although we did not discover any significant errors in the transactions we reviewed for the county superior courts of Los Angeles, Orange, and Sacramento, we identified weaknesses in data entry and processing internal controls that could affect many of the DNA penalties processed by all three superior courts. The monetary impact of the errors ranged from 1 cent to $54 per case. While not individually significant, the potential volume of the errors could prove to be material in amount.

For example, the DNA penalty distributions calculated by the case management system used by the Orange County Superior Court (Orange court) resulted in rounding errors affecting 22 of the 40 cases we reviewed. According to an official of the AOC, the case management system the Orange court uses is a precursor to the case management system that the AOC plans to eventually implement statewide. Additionally, based on a report issued by the Judicial Council of California (Judicial Council), California Superior Court criminal case dispositions totaled more than 6.4 million statewide for fiscal year 2005–06. Not every case disposition—the final outcome of a case, such as a case dismissal or criminal sentencing—results in penalty assessments. Nonetheless, the magnitude of the errors will be greatly increased unless the AOC ensures that the cause of the rounding errors in the precursor system is identified and corrected before it implements the new statewide system. Moreover, when an individual was allowed to make installment payments, the Orange court's case management system did not always distribute the payments according to the priority order established by law.

We also identified a data entry error related to a specific type of motor vehicle code offense occurring at one location of the Los Angeles County Superior Court (Los Angeles court). The resulting error appears to have been committed by one court employee and was recurring over at least a 12-month period between 2005 and 2006. Additionally, for three other cases we reviewed involving another Los Angeles court location, the court did not properly assess the DNA penalty for a particular type of misdemeanor offense. Finally, we found that the Sacramento County Superior Court (Sacramento court) erroneously transferred $292,000 to the State for payments received for various vehicle code violations. Because the relevant violations had resulted in the court allowing the offenders to attend traffic school, by law the county should have retained the payments received from the offenders.

We recommended that the AOC work with the Orange court to estimate the total dollar effect of the rounding errors in calculating the penalty assessment distribution to determine whether it will have a significant financial impact on the State. If the AOC determines that the impact will be significant, it should ensure that the Orange court makes the necessary modifications to the distributions calculated by its case management system. Further, as it proceeds with developing the statewide case management system, the AOC should ensure that the system correctly distributes payments to the appropriate funds in accordance with all applicable laws and regulations. The AOC should also ensure that the Orange court reevaluates and makes necessary corrections to the distribution priority order programmed into its case management system. Additionally, the AOC should ensure that the Los Angeles court corrects any manual coding errors and strengthens internal controls over data entry. Finally, the AOC should ensure that the Sacramento court continues its efforts to correct any overpayments made to the state DNA fund.

AOC's Responses:

Orange County's Action: Corrective action taken.

Although the AOC agreed that the 55 percent error rate we found in our sample was too high, it noted that the impact for each case was minimal, ranging from a 9-cent underpayment to a 1-cent overpayment. Nonetheless, the AOC stated that the Superior Court of Orange County implemented a change to its case management system on July 1, 2008, to address the rounding errors made by the system when it calculates the penalty assessment distribution.

The AOC also stated that the court reviewed approximately 750 funds to determine what the appropriate fund distribution should be and make any corrections needed. The distribution priority review was completed on April 8, 2008.

Finally, the AOC stated that the court and AOC personnel have devoted a significant amount of time to the development of the statewide California Court Case Management System (CCMS). Among the CCMS's many advantages, the one most directly affecting the assessment and distribution processes is the use of one statewide distribution table for all courts. This table will be updated after appropriate reviews of statewide legislation and local ordinance changes. The system will also make it easier to monitor and audit distributions.

Los Angeles County's Action: Corrective action taken.

The AOC affirmed that the Superior Court of Los Angeles County has taken steps to ensure that manual coding cashier errors are corrected and that internal controls are strengthened over data entry.

Sacramento County's Action: Corrective action taken.

The AOC stated that the Superior Court of Sacramento County has made all the necessary corrections to processes and database systems to properly capture and distribute penalties going forward. Additionally, in May 2008, the court successfully completed the reversal of all affected fees that caused the erroneous transfer.

California Exposition and State Fair

Investigations of Improper Activities by State Employees, July 2006 Through January 2007

INVESTIGATION I2006-0945 (REPORT I2007-1), MARCH 2007

Investigative Highlight . . .

An official at the California Exposition and State Fair (Cal Expo) violated conflict-of-interest laws when he sold his personal vehicle to Cal Expo.

California Exposition and State Fair's response as of March 2008

We investigated and substantiated an allegation that Official A, a high-ranking officer at the California Exposition and State Fair (Cal Expo), violated conflict-of-interest laws by participating in a state purchasing decision from which he received a personal financial benefit.

Finding: Official A violated state conflict-of-interest laws when he made or directed a governmental decision that authorized Cal Expo to purchase his personal vehicle.

Official A sold his personal vehicle to Cal Expo in July 2005. Because he was involved in the decision to make this purchase while acting in his official capacity and because he derived a personal financial benefit from this transaction, Official A violated the Political Reform Act of 1974 (act) and Section 1090 of the California Government Code (Section 1090).

Under the act, public officials at all levels of state government are prohibited from making, participating in making, or in any way attempting to use their official positions to influence a governmental decision in which they know or have reason to know they have a financial interest. Section 1090 prohibits a public official from participating in the formation of a contract or making a purchasing decision in which he or she has a financial interest.

Although Official A did not sign the initial purchase order authorizing the transaction, he met with Official B and Manager 1 before the purchase to discuss whether Cal Expo should acquire the vehicle. Official A, along with Official B and Manager 1, agreed Cal Expo should purchase the vehicle. Official B, who reports directly to Official A, subsequently approved a purchase order, and Manager 1, who reports directly to Official B, certified that he received the vehicle. Official A subsequently submitted an invoice to Cal Expo for the sale, and Cal Expo paid Official A $5,900 with a check containing Official A's preprinted signature.

More than a year after it purchased the vehicle, Cal Expo became aware that the transaction was potentially a violation of the law and subsequently reversed the transaction by returning the vehicle to Official A and requiring him to pay back the $5,900. However, Cal Expo's actions were not consistent with the remedies available under state law because Cal Expo was entitled to recover the $5,900 it paid for the vehicle and to retain the vehicle itself. By simply returning the vehicle to Official A, Cal Expo did not pursue the remedy that would have provided greater protection of the State's interest.

Cal Expo's Action: Corrective action taken.

In March 2007 Cal Expo reported that it believed invalidating the transaction and returning the vehicle were appropriate remedies. It also believed, because of Official A's record, that formal disciplinary action and criminal prosecution were not warranted. However, Cal Expo shared our concern that this serious ethical breach merited further action. In July 2007 Cal Expo reported that its Board of Directors, management, and supervisory staff had completed an ethics training course. It also reported that at the Board of Directors' meeting in September 2007, it approved a new accounts payable policy, requiring two officials to sign any checks made payable to Cal Expo employees other than for travel reimbursements and prohibiting Cal Expo officials from signing any checks written to themselves.

In March 2008 Cal Expo reported that in keeping with its policy it planned to review the statements of economic interests covering calendar year 2007 for employees required to file, including Official A, to ensure compliance. Cal Expo further reported that it had reviewed its incompatible activities statement with maintenance and event services staff and that it planned to review the statement with all department managers at an upcoming staff meeting.

State Board of Chiropractic Examiners

Board Members Violated State Laws and Procedural Requirements, and Its Enforcement, Licensing, and Continuing Education Programs Need Improvement

REPORT NUMBER 2007-117, MARCH 2008

State Board of Chiropractic Examiners' responses as of September and December 2008

The Joint Legislative Audit Committee (audit committee) directed the Bureau of State Audits to review the State Board of Chiropractic Examiners' (chiropractic board) enforcement, licensing, and continuing education programs; to determine the role of the chiropractic board as defined by state laws and regulations and the board's policies and procedures; and to assess whether board members consistently act within their authority. The audit committee also asked us to analyze the role, function, and use of the chiropractic quality review panels (review panels) and the chiropractic board's compliance with the initiative act requirement to aid attorneys and law enforcement agencies in enforcing the initiative act.

Finding #1: The chiropractic board's lack of understanding resulted in violations of some Bagley-Keene Open Meeting Act requirements.

The Bagley-Keene Open Meeting Act (Bagley-Keene) is the state law that specifies the open meeting requirements for all boards and commissions. Between January 2006 and August 2007 some actions that board members took before and during chiropractic board meetings violated Bagley-Keene requirements. In the most egregious example, board members convened a closed-session meeting on March 1, 2007, at which they fired the former executive officer without providing written notice to her at least 24 hours in advance of the meeting. At the following public session, board members failed to disclose the action they had taken during the closed session as required by Bagley-Keene. In three earlier instances, board members held closed-session meetings to consider another personnel issue without giving the employee the required 24-hour advance written notice of the employee's right to a public hearing. The violations to Bagley-Keene nullified the decisions the board members made in the closed session regarding the former executive officer on March 1, 2007. Using remedies provided in Bagley Keene, the board started the process over by providing proper notice to the former executive officer, holding a public hearing on March 23, 2007, regarding her continued employment with the chiropractic board, and voted to terminate her without cause. These steps fulfilled Bagley-Keene requirements.

Board members also violated Bagley-Keene requirements that allow the board to hold closed sessions in limited circumstances. Although the chiropractic board's December 2006 meeting agenda included a closed-session item for discussion of personnel matters—a topic allowed in closed session—the board's closed session discussion did not include personnel matters and in fact did not meet any of the criteria for a closed session.

Audit Highlights . . .

Our review of the State Board of Chiropractic Examiners' (chiropractic board) enforcement, licensing, and continuing education programs and the role and actions of the chiropractic board members revealed the following:

- *Board members' lack of understanding about state laws related to their responsibilities as board members, including the Bagley-Keene Open Meeting Act, resulted in some violations of state law and other inappropriate actions.*
- *The chiropractic board did not ensure that its designated employees, including board members, complied with the reporting requirements of the Political Reform Act of 1974.*
- *Board members inappropriately delegated responsibility to approve or deny licenses to chiropractic board staff.*
- *The chiropractic board has not developed comprehensive procedures, such as the length of time it should take to process complaints and, as a result, staff do not always process complaints promptly.*
- *The board's weak management of its enforcement program may have contributed to inconsistent treatment of complaints as well as unreasonable delays in processing.*
- *The chiropractic board does not ensure that staff process priority complaints promptly. Of 11 priority complaints we reviewed, staff took from one to three years to process nine of them.*

continued on next page . . .

» *Although the chiropractic board's regulations require that it establish chiropractic quality review panels, it has never complied with its regulation.*

» *The chiropractic board has insufficient control over its licensing and continuing education programs.*

We found other examples of actions that risked violating Bagley Keene. Specifically, for the 13 board meetings held between January 2006 and August 2007, the guest register did not indicate that signing in was voluntary. By not doing so, it is violating Bagley-Keene requirements and is not serving the interests of the general public or the public's ability to monitor and unconditionally participate in the decision-making process. Staff modified the sign-in sheet to indicate that it is voluntary to sign in before attending the meeting and began using the modified sign-in sheet at the 2008 board meetings. In addition, the chiropractic board does not have a mechanism in place to document its compliance with the Bagley-Keene requirement that it provide public notice of chiropractic board meetings at least 10 days in advance. Finally, the minutes of chiropractic board meetings, videotapes, and e-mail correspondence reflect a number of instances when board members disregarded warnings and engaged in communications that could have triggered violations of Bagley-Keene requirements. Although these instances are not violations, they demonstrate that board members disregarded warnings and risked violations.

We recommended that the chiropractic board continue to involve legal counsel in providing instruction and training to board members at each meeting. We also recommended that the chiropractic board continue to retain documentation of the steps it takes to publicly announce its meeting.

Chiropractic Board's Action: Corrective action taken.

According to the chiropractic board, in March 2007 it recognized that board members did not fully understand the requirements of Bagley-Keene and in April 2007 the former chair instructed the acting executive officer to place Bagley-Keene training on the agenda of every board meeting. The chiropractic board's legal counsel provides interactive training at each board meeting, which is documented in the meeting minutes. In addition, to confirm the timely postings of board meeting agendas, the chiropractic board instituted a checklist that is signed by the board member liaison and confirmed by the executive officer. The board member liaison also prints the agenda from the Web site, which includes the posting date.

Finding #2: Board members lack knowledge of the California Administrative Procedure Act.

The California Administrative Procedure Act (administrative procedure act) is the state law that prohibits ex parte communication.[1] If ex parte communication occurs, the board member involved may be required to stop participating in the case and disclose that a communication violation occurred. We found instances where board members invited ex parte communication by referencing a pending accusation and by encouraging licensees to contact the board members

[1] Ex parte communication is direct or indirect communication with a board member, outside the formal hearing process by agency staff or anyone having an interest in a pending licensing or disciplinary matter that affects the rights of individuals who appear before board members, about an issue in the case, without providing notice and an opportunity for all parties to participate in the communication.

if their problems were not addressed by staff.[2] Board members also invited ex parte communications when they inappropriately inserted themselves into the chiropractic board's enforcement process by asking to discuss and receive information from staff about enforcement cases during board meetings. When board members invite ex parte communication, they risk receiving impermissible communications about pending enforcement cases and not being impartial when or if they hear a matter that comes before the board.

Moreover, at the December 2006 meeting, a board member presented a proposal to amend board regulations to improperly give board members the authority to both file accusations and judge their merit. When board members have the option to be involved in filing an accusation, it could threaten the fairness and transparency of a case if it later comes before the board members for formal disciplinary action.

We recommended that the chiropractic board members limit their communications related to board business so they do not engage in ex parte communications or compromise their ability to fulfill their responsibilities in enforcement hearings.

Chiropractic Board's Action: Partial corrective action taken.

In its response to the audit report, the chiropractic board reported that since April 2007, the board members have received extensive training on the requirements of Bagley-Keene and the administrative procedure act. The chiropractic board also reported that board members are committed to conducting themselves in accordance with laws related to ex parte communications and seeking legal advice whenever they have a question. The minutes of the May 2008 board meeting reflect one of the board members asking the board's legal counsel how board members recuse themselves from an agendized item. Based on our review of the chiropractic board's meeting minutes from May, July, and September 2008, the chiropractic board's legal counsel continues to guide and instruct the board members on appropriate actions related to their duties governed by the administrative procedure act. However, the board's response did not address whether any attempts at inappropriate communication have occurred and what the board members did to avert it if, in fact, such communication was attempted.

Finding #3: The chiropractic board did not fully comply with the requirements of the Political Reform Act of 1974.

The Political Reform Act of 1974 (political reform act) is the central conflict-of-interest law governing the conduct of public officials in California. Under the political reform act, the chiropractic board must ensure that board members and designated employees comply with the act's reporting and disclosure requirements. The chiropractic board lacks adequate controls to ensure that its designated employees, including board members, comply with the reporting requirements. Specifically, the chiropractic board did not ensure that all designated employees and board members filed statements of economic interests as required and on time. For example, nine of the 16 employees and board members we reviewed filed their statements of economic interests after the deadline. The political reform act also requires the board to designate one employee as a filing official and give that employee the responsibility of ensuring that the chiropractic board meets the requirements of the political reform act, and state regulation requires the filing official to carry out specific duties. However, the employee whom the chiropractic board designated as its filing official asserted she was unaware of her role and responsibilities. Because the chiropractic board did not implement proper protocols to ensure that the employee it designates as the filing official is notified of his or her appointment and responsibilities, it cannot be sure that it meets all the requirements of the political reform act. Furthermore, because it did not ensure that all designated employees and board members filed statements of economic interests, and that all designated employees and board members filed them correctly or on time, the chiropractic board may be unaware of conflicts of interest.

[2] An accusation is a written statement of charges against a licensee that specifies the laws and regulations allegedly violated.

In addition, some employees appeared to make decisions on behalf of the chiropractic board and the board had not required them to file statements of economic interests. Because the chiropractic board has not established policies and procedures to adequately ensure that only designated employees make critical decisions, or at least review and approve decisions made by employees in nondesignated positions, it cannot ensure that it prevents potential conflicts of interest.

We recommended that the chiropractic board ensure that its filing official is aware of the role and responsibilities of the position and, similarly, promptly inform anyone replacing the filing official. We also recommended that the board establish an effective process for tracking whether all designated employees, including board members, have completed and filed their statements of economic interests on time, thereby identifying potential conflicts of interest. Additionally, we recommended that the chiropractic board periodically review its employees' responsibilities to ensure that all individuals who are in decision-making positions are listed as designated employees in its conflict-of-interest code.

Chiropractic Board's Action: Partial corrective action taken.

The board's executive officer updated the filing officer's duty statement and explained the role, duties, and responsibilities of the position to the employee. According to the chiropractic board, in February 2008, the filing officer attended training provided by the Fair Political Practices Commission on the role of a filing officer. In addition, the chiropractic board established written procedures and a tracking tool to ensure that designated employees, including board members, complete and file their statements of economic interests on time. The written procedures also include a provision for the filing officer to meet with the executive officer annually to review the chiropractic board's conflict-of-interest code to ensure that individuals in decision-making positions are given notification of the filing date. Because the expected time for this meeting had not occurred when the board provided its response, the board has not had the opportunity to document that it has implemented this procedure.

Finding #4: Board members did not always understand other legal requirements.

In the minutes of certain meetings of the chiropractic board and in several communications among board members, the executive officer, and the deputy attorney general, board members attempted actions that were inappropriate. For example, at the June, August, and September 2006 meetings of the chiropractic board, a single personnel matter was on the agenda and discussed during closed session. On November 20, 2006, the board chair responded in an e-mail to a request from a board member for further discussion on the matter. The board chair explained the item had already been discussed at the last meeting and that further action would violate the employee's due process rights as a civil service employee. When board members do not understand the legal requirements of the chiropractic board, they may not always comply with state laws and requirements or serve the best interests of the public.

In October 2007 board members adopted an administrative manual to serve as a guide for board members. The new manual outlines board policies, procedures, and state laws that govern chiropractic board business.

We recommended that the chiropractic board members continue to use their newly adopted administrative manual as guidance for conducting board business and to continue improving their knowledge and understanding of state laws and board procedures.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board stated that it plans to update its administrative manual as needed to address issues as they arise. The chiropractic board provided minutes from its March 2008 board meeting, which indicated the board members voted to update the administrative manual.

Finding #5: Board members inappropriately delegated their responsibility to approve license applications to staff.

Staff reviewed license applications and made decisions to issue licenses without the approval of board members, contrary to the requirements of the Chiropractic Initiative Act of California (initiative act). Additionally, whenever a license applicant did not request a formal hearing to appeal a denial, board members did not review and approve that denial, as the initiative act requires. The initiative act does not contain provisions that allow the chiropractic board to delegate to staff the authority to approve or deny licenses. Because staff rather than board members made final decisions to approve licenses and board members did not review staff-determined denials when applicants did not formally appeal those denials, the chiropractic board did not comply with the initiative act. Our legal counsel has advised us that board members could easily remedy this noncompliance by subsequently ratifying any license approvals and denials granted by staff, thus making those approvals and denials their responsibility.

We recommended that the chiropractic board modify its current process so that board members make final decisions to approve or deny all licenses. Additionally, we recommended that board members ratify all previous license decisions made by staff.

Chiropractic Board's Action: Partial corrective action taken.

In its May 2008 response, the chiropractic board provided meeting minutes showing that the board members voted to ratify license approvals granted by staff since July 1, 2007. Additionally, our review of the board's July and September 2008 meeting minutes found that board members voted to ratify staff approvals of licenses.

In December 2008 the chiropractic board reported that it had established procedures that include the board members ratifying staff denials of applicants who did not request a hearing in response to a denial. The chiropractic board reported that in those instances when an applicant requests a hearing, the board members review and vote on a proposed decision of an administrative law judge. The chiropractic board provided us with a copy of its procedures, dated December 2008, demonstrating the establishment of these procedures. However, as of December 2008, the board had not yet voted to ratify staff denials of licenses.

Finding #6: Board members do not use state e-mail accounts when conducting board business.

As a state agency, the chiropractic board is subject to the Public Records Act (public records act), which requires a state agency to respond to all requests for public records and defines public records as any writing containing information relating to the conduct of the public's business and includes electronic mailings. When the chiropractic board receives a public records request, it must notify the requester within 10 days whether it has records that may be disclosed in response to the request, and the board must provide an estimate as to when it can provide disclosable records. The executive officer told us that the chiropractic board had not considered assigning state e-mail accounts to board members and that this is consistent with all other licensing boards within the Department of Consumer Affairs (Consumer Affairs). However, he agreed that the concept might improve board governance and will be a proposed agenda item for the board's administrative committee. Because board members do not use state e-mail accounts when conducting board business, we question how the chiropractic board can ensure that it fully complies with public records requests and the prompt time frames required to respond to such requests. We also questioned how the chiropractic board ensures the protection of any confidential information board members might have or discuss by e-mail.

We recommended that the chiropractic board consider providing state e-mail accounts to board members to enable them to conduct their chiropractic board business in a secure and confidential environment and make their actions and correspondence accessible when requested in accordance with the public records act.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board voted at its May 2008 board meeting to approve the chiropractic board's implementation of state e-mail accounts for board members effective June 1, 2008. According to the chiropractic board, it initially established e-mail accounts for each of the board members around the beginning of June 2008. However, due to problems with the chiropractic board's transition to a new e-mail system approximately one month later, the chiropractic board has transitioned only board staff to ensure that daily operations were not affected. The chiropractic board plans to train the board members and fully implement this recommendation by January 1, 2009.

Finding #7: Staff could not demonstrate that all board members received copies of Bagley-Keene, attended training required by state law, and received appropriate orientation.

Although state law requires that board members receive copies of Bagley-Keene on their appointment to office, staff were unable to show us that the chiropractic board consistently met that requirement. Staff could demonstrate that only three of the 12 board members who held office during the period we reviewed received a copy of Bagley-Keene within one month of their appointments. The former executive officer also asserted that she maintained a separate file and checklist for each board member that indicated the documents provided to the new appointee, but current staff could not locate those files. Staff retained the board member appointment checklists to document the information they provided to the three most recently appointed board members. Staff also could not always demonstrate that board members attended required ethics training within the prescribed deadline. State law requires board members and designated employees to receive ethics training within six months of assuming office and every two years thereafter. Further, state law requires each state agency to maintain records of ethics training attended by its board members and designated employees for at least five years.

Board members have not attended sexual harassment prevention training as required by state law. Staff were also unable to show that all board members received appropriate orientation within a reasonable time after their appointments to office. Although all but one of the 12 board members who held office during our review period attended orientation, one board member attended the orientation nearly two years after assuming office, and another was in office for four years before attending orientation. Best practices indicate that new board members should receive orientation within one year of assuming office.

Because the chiropractic board does not have policies and procedures for keeping records that board members have received required training or appropriate orientation, it cannot demonstrate its compliance with state laws or that it follows best practices. The executive officer told us that as of October 2007 all new board members will attend the orientation that Consumer Affairs provides within one year of assuming office. If board members do not receive required and appropriate training or receive it late, they are less able to fulfill their responsibilities to the public during their period of service on the board.

We recommended that the chiropractic board ensure that staff retain documentation when they provide a copy of Bagley-Keene to a newly appointed board member. We also recommended that the chiropractic board continue to use the member appointment checklist and establish procedures to periodically record and monitor board member training and to continue to send new board members to the orientation that Consumer Affairs provides.

Chiropractic Board's Action: Partial corrective action taken.

In its response to the audit report, the chiropractic board stated that in approximately March 2007, the board member liaison began maintaining a file that documents when copies of Bagley-Keene are provided to board members. Additionally, in its subsequent responses the chiropractic board provided us with documentation of its board member appointment checklist and stated that it plans to develop written procedures for recording and monitoring board member training by the end of December 2008. The chiropractic board also plans to update its board member

administrative manual to include a list of required training with specific time frames. Finally, the chiropractic board reported that all current board members have completed orientation training and the three newest board members completed the training within the first year of appointment.

Finding #8: Lack of standard procedures and management oversight resulted in slow resolution of many complaints we reviewed.

Because the chiropractic board lacks adequate internal controls over its complaint review process, it cannot ensure that its staff process consumer complaints accurately and promptly. Although the chiropractic board has established some policies and procedures for how it processes complaints, it has not developed benchmarks for the length of time it should take to complete various phases of the complaint review process. Our review of 25 complaints found many instances where the chiropractic board failed to take action on complaints for excessive periods of time in all phases of the complaint process, including the initial opening of the complaint, referring complaints to contracted investigators, obtaining investigation reports, referring complaints to experts, and closing complaints. In addition, management generally did not review the complaints or staff decisions on those complaints to determine whether staff processed them promptly and correctly. When the chiropractic board unreasonably delays processing complaints, it allows chiropractors accused of violating chiropractic laws and regulations—including those accused of what the chiropractic board considers the most egregious violations—to continue practicing longer than necessary without the violations being addressed, potentially exposing the public to further risk. In addition, when the board does not ensure that staff properly document decisions made and actions taken on complaint cases, it is unable to justify the length of time it takes to process complaints.

The initiative act requires the chiropractic board to assist attorneys and law enforcement agencies in enforcing the act's provisions. Although the executive officer told us that all staff are expected to cooperate fully with other law enforcement agencies when called on to assist, the chiropractic board has not established the types of complaints and evidence that should exist before referring cases to law enforcement agencies or attorneys. Because of this and the lack of benchmarks, two of the 25 complaints we reviewed that the chiropractic board referred to the attorney general were 655 and 844 days old, respectively. When the chiropractic board does not promptly refer complaints to the attorney general, it may not enable the attorney general to file viable accusations within reasonable periods of time and thus allows licensees who may pose a threat to the public to continue practicing.

We recommended that the chiropractic board develop procedures to ensure that staff process and resolve complaints as promptly as possible by establishing benchmarks and more-structured policies and procedures specific to each step in its complaint review process. We also recommended that the chiropractic board establish time frames for staff to open a complaint case, complete an initial review, refer the case to an investigator or expert if necessary, and close or otherwise resolve the complaint by implementing informal discipline or referring for formal discipline to ensure that all complaint cases move expeditiously through each phase of the complaint review process. In addition, we recommended that the chiropractic board periodically review the status of all open complaints and investigations and identify and resolve any delays in processing. Finally, we recommended that the chiropractic board strengthen its enforcement policies and procedures to minimize the amount of time it takes staff to process consumer complaints before forwarding them to the attorney general or other law enforcement agency to ensure that it adequately assists attorneys and law enforcement agencies in enforcing the laws relating to the practice of chiropractic.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided copies of its new detailed procedures, dated September 2008, for staff to process and resolve complaints as promptly as possible. The procedures provide guidance for staff on various steps in the complaint process, including complaint intake, complaint analysis, criminal filings, information and fact gathering, complaint closure and recommendations, case referrals, and arrest and conviction cases. Additionally, the procedures establish time frames for

the phases of the complaint review process, including minimizing the amount of time it takes staff to process complaints before forwarding them to the attorney general or other law enforcement agency. Finally, the chiropractic board provided a copy of its new monitoring procedures and responsibilities, dated September 2008, for managers to use to periodically review the status of all open complaints and investigations and to resolve delays in processing. Because of the relative newness of these procedures, it is too early for the board to document the effect of their implementation.

Finding #9: The chiropractic board's enforcement procedures do not provide sufficient guidance to staff processing complaints.

Although the chiropractic board has some good enforcement procedures, it has not established adequate policies and procedures to ensure management oversight of complaint processing and resolution. For instance, it does not ensure that only designated employees make final decisions on cases or that such decisions are reviewed and approved by a designated manager. Without proper policies and procedures, the chiropractic board cannot ensure that staff process complaints in a consistent manner or that it avoids possible conflicts of interest in its complaint review process. Additionally, we found that the chiropractic board issued citations in two cases but failed to report the citations to other states' chiropractic boards and other regulatory agencies as required by its regulations.

The chiropractic board's current policies and procedures also do not provide clear instructions to guide staff about when it is appropriate to open and process a complaint that is internally generated. Staff opened one complaint we reviewed based on a newspaper article asserting that a chiropractor was claiming to hold an advanced degree from an unaccredited school. Despite the apparent minor nature of this internal complaint, staff spent considerable time and effort pursuing it. Nearly four months after opening the case, the executive officer advised staff that because the school was accredited at the time the degree was awarded, this was not a violation of the law and closed the case. Because it has not established clear instructions for staff to follow when considering whether they should open an internal complaint, the chiropractic board's resources are diverted from working on more serious complaints, which is not efficient.

We recommended that the chiropractic board develop policies and procedures requiring that only a manager or a designated employee are allowed to make the final decisions on complaint resolution. We also recommended that the chiropractic board develop procedures to ensure that staff report the issuance of citations to other states' chiropractic boards and regulatory agencies. In addition, we recommended that the chiropractic board develop procedures instructing staff when to open and how to process complaints generated internally.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided copies of new procedures, dated September 2008, requiring managers or designated employees to make the final decisions on complaint resolutions. The procedures also include requirements for staff to report the issuance of citations to other states' chiropractic boards and regulatory agencies. Finally, the procedures instruct staff when to open and how to process complaints generated internally.

Finding #10: The chiropractic board's weak management of its enforcement program may have contributed to inconsistent decisions on similar cases.

The chiropractic board did not adequately supervise enforcement staff and review their decisions on cases. Specifically, many of the 25 cases we reviewed showed no evidence of management review. As a result, we found that staff resolved differently two cases alleging the same violation. However, because the chiropractic board did not clearly document its reasons for resolving each case the way it did, we were unable to determine if the resolutions were reasonable. Staff also did not always process

complaints in accordance with its internal procedures. When management does not ensure that staff process complaints consistently and according to its policies and procedures, it can result in the inefficient use of staff time and the chiropractic board may be unable to later justify decisions it made.

We recommended that the chiropractic board strengthen its existing procedures to provide guidance for staff on how to process and resolve all types of complaints and to ensure appropriate management oversight.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided copies of new procedures, dated September 2008, for staff to follow when processing and resolving consumer complaints regarding licensees. The procedures provide guidance to staff on how to process all types of complaints and also address management oversight of the process. Although the chiropractic board has added a field operations unit to perform investigations, it has not yet provided written procedures for its field operations staff.

Finding #11: The chiropractic board's system for prioritizing consumer complaints is seriously flawed.

The chiropractic board took excessive amounts of time to process the 11 priority complaint cases we reviewed—complaints alleging sexual misconduct, gross negligence or incompetence, use of alcohol or drugs when performing the duties of chiropractic, or insurance fraud. Although the board has identified the types of complaints it considers priority, staff frequently have not labeled such complaints as priority, and the board's system for processing complaints lacks any controls to ensure that staff correctly designate complaints as priority and process them promptly. Consequently, we noted allegations of sexual misconduct or fraud that went unresolved from more than one year to more than three years, potentially leading to repeat offenses and failures by the chiropractic board to protect the public. The chiropractic board's lack of management and supervision of its enforcement staff may also contribute to the staff's failure to consistently give priority to complaints. Failing to properly assign and process priority complaints as quickly as possible undermines the board's ability to protect the public, one of its primary responsibilities.

Moreover, we found some allegations that we believe the board should be categorizing as priority or processing more diligently. For example, the board did not consider allegations of practicing without a license to be a priority. In fact, until May 2007, the chiropractic board considered those allegations to be outside its jurisdiction. Additionally, when the chiropractic board receives a malpractice settlement notification, it simply solicits the patient to file a complaint and if the patient does not file a complaint within the deadline specified, the board closes the case without any further effort to determine if the licensee deviated from the standard of care. When the chiropractic board does not give priority to processing complaints requiring priority attention or process other complaints more diligently, it may be unnecessarily putting the public at risk.

We recommended that the chiropractic board implement tracking methods, such as flagging priority cases during complaint intake, using multiple levels of priority categories, and assigning specific time frames to process those priority categories. We also recommended that the chiropractic board establish procedures that direct board management to monitor the status of open complaints regularly, especially those given priority status, to ensure that they do not remain unresolved longer than necessary.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided a copy of procedures, dated September 2008, for its complaint intake process, which outline multiple levels of priority categories for assigning to complaints received. The procedures also establish specific time frames for processing each priority level. Additionally, the chiropractic board provided a copy of procedures, dated September 2008, for managers establishing responsibility for monitoring the status of all open complaints and ensuring that cases, investigations, and applications are proceeding in an efficient and effective manner. Because of the relative newness of these procedures, it is too early for the board to document the effect of their implementation.

Finding #12: For years the chiropractic board has not adhered to its own regulation to establish chiropractic quality review panels.

Since June 1993 the chiropractic board's regulations have required it to establish review panels throughout California. According to the historical documentation, the board's original intent was to reduce the amount of time between complaint intake and resolution. The chiropractic board planned to refer certain complaints—those alleging minor violations of the initiative act that do not meet the criteria for referral to the attorney general for formal discipline—to a program in which a less formal review and early corrective action could possibly prevent the cases from moving down the path of formal discipline. The board's rule making file shows that over the years, when changes in executive officers and board members occurred, so did priorities and efforts to establish the review panels. The chiropractic board's current executive officer does not believe the review panels are the right solution for the board. In September 2007 he prepared a memo to the chair of the board's enforcement committee recommending that the board repeal the regulation related to the review panels, citing concerns with the cost-effectiveness of review panels, the potential for the review panels to make rulings that are inconsistent with the board's enforcement policies, and the potential for the review panels to be viewed as a peer review system. Moreover, at the November 2007 board meeting, the executive officer noted that the board has considered only the options of using the chiropractic consultant or the review panels for the processing of complaints and that other options need to be considered. We recognize that the issues surrounding the review panels are not simple, but it is clear that the chiropractic board must take some action to remedy its noncompliance with its regulation. In determining what that action might be, we believe the board must consider its complaint review process more broadly. By instituting a stronger system for reviewing and taking action on complaints, the board will be better able to determine what other processes it should add to complement its ability to promptly and appropriately respond to complaints about chiropractors.

We recommended that the chiropractic board carefully consider the intended purpose of the review panels and whether implementing them is the best option to fulfill that intent. If the chiropractic board decides that another option would better accomplish the intended purpose of the review panels, we recommended that it implement the process for revising its regulations.

Chiropractic Board's Action: Corrective action taken.

At its May 2008 meeting, the chiropractic board voted to adopt regulatory language that repeals the regulation that established the chiropractic quality review panels. The chiropractic board has begun the process for making a regulatory change. Specifically, following the board's decision, staff developed and in August 2008, filed the regulation package with the Office of Administrative Law, and noticed the public pursuant to state law applicable to the rulemaking process.

Finding #13: The chiropractic board's recently vacant chiropractic consultant position leaves a gap in its available technical expertise.

The chiropractic consultant position, under the supervision of the executive officer, provided chiropractic expertise to help staff review complaints against and evaluate the professional conduct of licensees who may have violated chiropractic laws and regulations. During our review, we found that the chiropractic board's enforcement process and its staff relied heavily on the chiropractic consultant to complete its reviews and make decisions on complaints and punishment when violations occurred. The chiropractic consultant position has been vacant since August 10, 2007, and the executive officer explained that because of the current budget situation, the chiropractic board is not planning to fill the position. He also said that based on the chiropractic board's initial assessment of the enforcement program and the chiropractic consultant position in particular, it had concerns about the duties and use of the position and did not plan to fill the vacancy until a job analysis was conducted. At the same time, board members expressed concerns about filling the position before instituting a significant change in duties. Instead, the chiropractic board is developing a group of expert consultants or witnesses to bridge the gap in technical expertise. Although we acknowledge the concerns that the executive officer and board members have expressed about the chiropractic consultant position and the way that it was

relied on and used in the past, the chiropractic board can establish processes to limit the autonomy of the position while still gaining invaluable expertise that is readily available to staff rather than having to rely on referrals to outside experts. For example, the chiropractic consultant could be used much like legal counsel to provide opinions to the executive officer, who would remain the final decision maker.

We recommended that the chiropractic board fill its chiropractic consultant position. We also recommended that the chiropractic board require the chiropractic consultant to act only in an advisory capacity and the executive officer to make all final enforcement decisions.

Chiropractic Board's Action: Alternative action taken.

The chiropractic board reported that effective July 1, 2008, the chiropractic consultant position was abolished by operation of law and it does not have plans currently to reestablish the position. The chiropractic board reported that it has the technical resources necessary to investigate quality of care issues and allegations of improper treatment through a network of expert reviewers and expert witnesses. The chiropractic board developed a new expert reviewer and expert witness application to assess qualifications and identify potential conflicts of interest. According to the chiropractic board, it began recruiting candidates in April 2008, and published a manual that provides instructions, guidelines, and expectations that the experts will use to perform their services. The chiropractic board also reported that it conducted mandatory training for all the experts in conjunction with the Office of the Attorney General. The chiropractic board reported that the experts may be called upon to review a complaint prior to the board's initiating an investigation. However, most often the experts will review the evidence at the conclusion of an investigation and render an opinion. The chiropractic board management stated that it makes the final decision on all complaint cases.

Finding #14: The chiropractic board did not adequately control the use of expert witnesses.

Chiropractic board policies and procedures for assigning a complaint case to an expert require the chiropractic consultant to conduct a telephone interview to assess an expert's experience and expertise with the relevant procedure or treatment. This assists the chiropractic board in ensuring that the expert is qualified and has no conflicts or disqualifying criteria such as personal or financial conflicts of interest, complaint history, or insufficient years of practice. Our review of five complaints referred to experts revealed no evidence in the files demonstrating that staff performed telephone interviews before assigning the cases to experts. In addition, the chiropractic board told us that it does not enter into contracts with experts for services. Such contracts would include standard language that informs contracting parties about their responsibilities regarding conflicts of interest. Further, the chiropractic board does not require staff to obtain documentation from experts attesting that they are free of conflicts of interest. Therefore, we could not confirm whether the staff appropriately assigned the cases we reviewed to qualified experts who are free of conflicts of interest.

In addition, experts did not always complete their reviews within 30 days as expected. According to the chiropractic board's procedures, it expects an expert to finish reviewing the assigned case and file a written report within 30 days of assignment. In one case, the expert took more than 200 days to provide a report. Staff told us they perform no follow-up procedures, thus allowing unnecessary delays in the processing of complaints. By not ensuring that its experts adhere to the expected 30-day deadline, the chiropractic board imposes unnecessary delays in its complaint review process and may be putting the public at risk. We also found that the chiropractic board does not evaluate experts' reports as required by its policies and procedures. When the chiropractic board does not perform evaluations and record the results of the experts it uses, staff may improperly assign future cases to an expert who has not provided quality work.

We recommended that the chiropractic board establish policies and procedures requiring its staff to document interviews with experts, including the content of those discussions, to ensure that it refers cases to qualified experts with no conflicts of interest. We also recommended that the chiropractic

board consider entering into formal written contracts for services from experts or require experts to attest in writing that they have no conflicts of interest in cases assigned and strengthen its policies and procedures to ensure that its staff monitor experts on their adherence to the established 30 day deadline for reviewing complaint cases and submitting written reports. Finally, we recommended that the chiropractic board consistently evaluate experts' written reports and thoroughly document the results of the evaluations to ensure that the chiropractic board does not inappropriately refer complaint cases to experts who have not demonstrated quality work in the past.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided a copy of its application for expert witnesses as well as procedures, dated September 2008, for staff to follow when selecting, contacting, and monitoring the expert witnesses. Although the procedures require staff to document their contacts with the experts, the procedures do not require either a contract with or a written statement from the experts attesting that they have no conflict of interest in the cases assigned. The procedures do include steps and time frames for monitoring the progress of the experts. Finally, the chiropractic board established a requirement in its procedures for each expert witness to have an evaluation form completed by the referring board staff analyst after each case is returned. However, the procedures indicate that the chiropractic board has not yet developed the evaluation form.

Finding #15: Lack of documentation makes it difficult to determine the qualifications of chiropractic board staff and investigators.

Although the board's record retention schedule requires it to retain all standard personnel forms for three years after staff leaves employment, the board could not provide current job applications for six of the nine employees we reviewed. For about half of the employees, we were unable to determine whether the staff met the minimum qualifications for their classifications. The executive officer stated that he was unable to explain why the documents are unavailable because he was not employed at the chiropractic board at the time these personnel transactions occurred. For one employee, the chiropractic consultant, we were unable to determine whether the employee met the qualifications. According to the job description, the minimum qualifications for that classification are having a valid license to practice chiropractic and "five years of experience, within the last seven years, in the practice of chiropractic." The chiropractic board contracted with the Department of General Services for personnel functions until September 2006. On her application, the chiropractic consultant stated that she had been a self-employed chiropractor for the previous 17 years. However, when detailing the duties she performed, she stated she had acted as a "consultant to [the] chiropractic community" and had "limited medical-legal consultation." Because the minimum qualifications do not clearly define the phrase practice of chiropractic, we were unable to determine whether the applicant met the minimum qualifications. In contrast, the board requires an expert to have a minimum of three years of experience to be in "active practice" or retired from active practice for no more than two years at the time of appointment. This clearly articulates the requirement for the expert to be actively practicing chiropractic and seeing patients on a regular basis or recently retired from active practice. Because the job description for the chiropractic consultant does not provide this type of clarity, the chiropractic board is unable to ensure that its consultants have the type of qualifications desired.

Moreover, we were unable to determine whether the four investigators with whom the chiropractic board contracted met the minimum qualifications for the position because the board was unable to provide us with documentation to support that it verified bidders' minimum qualifications as required. The board could find only two bids, and the documentation for those did not include any information that would allow us to verify whether each investigator met the minimum qualifications. When the chiropractic board is unable to show that its investigators have the experience necessary to investigate individuals suspected of violating chiropractic law, the board may weaken its ability to defend its disciplinary actions.

We recommended that the chiropractic board retain personnel documentation on all employees according to its record retention policy and to require its contractor for personnel services to comply with the same requirements. Additionally, we recommended that the chiropractic board consider revising the chiropractic consultant position's minimum qualifications to provide additional clarity on the phrase practice of chiropractic, similar to the board's current requirements for experts.

Chiropractic Board's Action: Corrective action taken.

In its response to the audit, the chiropractic board agreed to retain personnel documentation on all employees according to its record retention policy and to require its personnel contractor to comply with the same requirements. Additionally, in a subsequent response, the chiropractic board reported that it established a personnel liaison within its office who maintains copies of job applications and other personnel documentation, pursuant to the record retention policy, for all board staff appointed after February 2008. The chiropractic board reported that its personnel liaison works closely with its personnel contractor to ensure that the contractor maintains original personnel documents pursuant to the record retention policy. The chiropractic board provided copies of personnel documents for new hires and promotions.

As discussed previously, the chiropractic board's chiropractic consultant position was abolished effective July 1, 2008, and the board does not plan to reestablish the position. Instead, the board reported that it obtains technical expertise through a network of expert reviewers and expert witnesses.

Finding #16: The chiropractic board has not established timelines for processing some applications.

When we reviewed a sample of 29 licensing decisions generally completed in fiscal year 2006–07, we found that the chiropractic board has not established policies and procedures in some areas and needs to bolster current policies and procedures in others. Specifically, the board lacks processing timelines for more than half the types of applications and petitions it processes. The chiropractic board processes some types of applications and petitions more promptly than others. For seven of the 10 chiropractic license applications we reviewed, the board failed to adhere to its established timelines for processing licensee applications. In addition, although its procedures outline specific steps for processing an applicant's request for appeal, the board has not established timelines for processing appeals. The chiropractic board has also established timelines for certain phases of processing petitions for reinstatement of a revoked license and petitions for early termination of probation, however, it does not always adhere to them. Finally, the chiropractic board also has not established time frames for processing satellite office certificates, corporation certificates, referral service applications, reciprocal licenses, and applications for restoration after license cancellation and forfeiture. When the chiropractic board does not establish goals and measures for processing applications, appeals, and petitions or work within its established time frames, it cannot measure the overall efficiency and productivity of chiropractic board staff. Additionally, unlicensed applicants are unable to begin practicing chiropractic until the board makes a final decision and notifies them.

We recommended that the chiropractic board establish time frames for all the types of applications and petitions it processes. We also recommended that the chiropractic board establish a tracking system for applications and petitions to analyze where delays are occurring and ensure that applications and petitions are processed promptly. Finally, we recommended that the board establish a time frame for resolving appeals that includes milestones for each phase of the process.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided copies of procedures, dated September 2008, for staff to follow when processing licensing applications and petitions. These procedures also include time frames for processing each phase of a license denial appeal. Additionally, the chiropractic board developed tracking spreadsheets for application and petition processing to analyze where delays are occurring and ensure that applications and petitions are processed promptly. The chiropractic board

anticipated implementing the tracking spreadsheets on October 1, 2008. Because of the relative newness of these procedures, it is too early for the board to document the effect of their implementation.

Finding #17: The chiropractic board approved a reciprocal license despite evidence the applicant was practicing without a license.

For one of the two reciprocal license applications we reviewed that the board approved in fiscal year 2006–07, we question the chiropractic board's decision to grant a reciprocal license without first resolving questions raised by its investigation into a complaint against the individual. Even though the applicant met the minimum licensing requirements, our review of the applicant's file indicated that the chiropractic board had received a complaint in June 2005, before the applicant applied for a reciprocal license, alleging that the applicant was practicing without a chiropractic license. In October 2006, 16 months after receiving the complaint, the chiropractic board referred it to an investigator. Based on his visit to the business location, the investigator concluded that the applicant "is in all probability conducting chiropractic services at [the] location" and recommended that the board subpoena patient records or allow him to conduct an undercover operation. However, the chiropractic board elected to approve the applicant for licensure.

We recommended that the chiropractic board develop specific policies and procedures for staff to follow when the board receives a complaint against an applicant seeking licensure.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided a copy of specific procedures, dated September 2008, for staff to follow when addressing complaints against an applicant seeking licensure.

Finding #18: The chiropractic board lacks documentation to show it verified the status of licenses before approving applications.

State law and board regulations require each shareholder of a chiropractic corporation and each participating member of a referral service to hold a valid chiropractic license. The chiropractic board's procedures require staff to ensure that applicants for corporation and satellite office certificates and referral services hold valid chiropractic licenses. In our review of certificates the chiropractic board approved in fiscal year 2006–07, we found that none of the four satellite office certificate application files and only one of the four corporation certificate application files contained documentation indicating that staff verified the eligibility of the chiropractors' licenses before approving the applications. Licensing staff asserted that they followed the verification process, indicating that they either shredded the documents they reviewed or performed reviews using electronic files. However, to the extent it does not retain documentation, the board cannot demonstrate that it complied with procedures designed to protect consumers.

In addition, we reviewed the most recent referral service application the chiropractic board approved, which was in 2005. The board's documentation did not clearly demonstrate which chiropractors it approved to participate in the referral service. When the chiropractic board does not retain documentation of its efforts to verify licenses of referral service license applicants, it cannot demonstrate that its approval was proper.

We recommended that the chiropractic board implement a standard of required documentation that includes identifying when and who conducted eligibility verifications.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided copies of specific procedures, dated September 2008, which include required documentation identifying when and who conducted eligibility verifications.

Finding #19: The chiropractic board can strengthen its administration of forfeited licenses by improving procedures.

We found one instance where the chiropractic board's inadequate procedures for handling invalid payments from licensees resulted in staff making several errors in processing one of the two applications for license restoration that we reviewed. Specifically, staff did not place the license in forfeiture status and collect penalty payments, and they did not always follow up with the licensee promptly. The initiative act states that the failure, neglect, or refusal of any person holding a license or certificate to pay the annual fee during the time the license remains in force shall, after a period of 60 days from the last day of the month of his or her birth, automatically forfeit the license or certificate, and it shall not be restored except on the written application and payment of a fee equal to twice the annual amount of the renewal fee. However, the chiropractic board's procedures do not provide guidance on how to handle forfeited licenses. As a result of its poor administrative practices, staff inappropriately allowed a license to remain on active status for 447 days longer than it should have and failed to collect $300 in penalty payments.

We recommended that the chiropractic board establish specific procedures for staff to follow when a licensee submits invalid payment with a license renewal. We also recommended that the chiropractic board establish a tracking method to ensure that requests for repayment are sent promptly and all penalties are paid.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided copies of specific procedures, dated September 2008, for staff to follow when a licensee submits an invalid payment when renewing a license. The procedures also include a tracking spreadsheet for staff to document and ensure that requests for repayments are sent promptly.

Finding #20: The chiropractic board did not follow regulations and written policies and procedures in administering its continuing education program.

The chiropractic board's regulations require continuing education providers (providers) to submit applications in which they outline their objectives and commit to conform to the standards specified in the continuing education regulations. Subsequent to the initial approval of a provider, the chiropractic board requires that the provider also seek approval for each course it wishes to offer licensed chiropractors for continuing education. Staff told us in July 2006 the chair of the continuing education committee and the executive officer instructed staff to stop forwarding provider applications to board members for final review. However, because the chiropractic board has not taken formal action to change its regulation, the current process is not in compliance with existing chiropractic board regulations. As a result, the chiropractic board may be challenged for failure to comply with its own regulations. According to our legal counsel, the chiropractic board can remedy this problem by ratifying any provider application approvals granted by staff at a subsequent board meeting, but in the absence of that ratification, the approvals may be subject to challenge.

We also found one instance when a provider did not include five of the required 10 points in the mission statement included in his application, but the chiropractic board ultimately approved the applicant. According to staff, the chiropractic board does not necessarily require all 10 points to be included, even though its regulations indicate that each is required. Because the board's regulations specify what is to be included in a mission statement, we believe staff should uniformly apply that criteria in determining whether the applicant should be approved as a provider.

Further, although the chiropractic board must notify applicants that their provider applications are incomplete within three weeks of receipt, for one of the two incomplete provider applications that it eventually denied, the chiropractic board notified the applicant of the deficiencies 28 days after receiving the application. Chiropractic regulations also state that each provider submitting a completed application will be provided "notification of the board's decision . . . in writing within two weeks following the board meeting." The chiropractic board did not comply with this regulation for six of the 10 approved provider applications we reviewed.

Chiropractic board regulations also require that provider applications include certain documentation to prove the provider has furnished education to licensed health care professionals for the five consecutive years immediately preceding the date of the application. For one of the 10 approved provider applications we reviewed, the chiropractic board could not locate the relevant documentation. When the chiropractic board does not retain documentation indicating providers' eligibility and experience to teach continuing education courses, it is unable to defend its decisions to approve providers.

Finally, the chiropractic board's regulations require each approved provider to furnish the board with a roster of persons completing each course within 60 days of course completion. However, board staff do not always ensure that providers comply with this requirement. When the chiropractic board does not ensure that providers promptly submit attendance logs, it may be unable to corroborate information regarding completion of continuing education requirements for license renewal.

We recommended that the chiropractic board ensure its continuing education program complies with current regulations including requiring board members to ratify staff approvals of providers and ensuring that its process to approve providers conforms to its regulations. We also recommended that the chiropractic board comply with requirements for notifying a provider of board approval within two weeks following a scheduled board meeting and for notifying a provider of application deficiencies within three weeks of receiving the application. In addition, we recommended that the chiropractic board establish a process to track and monitor whether providers submit attendance rosters within 60 days of course completion.

Chiropractic Board's Action: Partial corrective action taken.

Regarding the recommendation of having board members ratify staff approvals of continuing education providers, at the July 2008 board meeting, the executive officer stated that board approval of course providers would be a standing agenda item. The meeting minutes for September 2008 indicate that the board members voted to approve the list of staff-approved continuing education course providers.

The chiropractic board provided a copy of its procedures, dated December 2008, related to our recommendation that it comply with requirements for notifying providers of board member approval within two weeks following a scheduled board meeting and for notifying providers of application deficiencies within three weeks of receiving the application. The chiropractic board reported that it plans to demonstrate compliance with these requirements by retaining copies of the written correspondence beginning in January 2009. Finally, the chiropractic board provided a copy of its procedures, dated September 2008, which include a tracking spreadsheet for documenting the timing of receipt of attendance rosters from continuing education providers.

Finding #21: Some of the chiropractic board's audits do not conclusively show that licensees met their continuing education requirements.

Its regulations require the chiropractic board to conduct random audits of active licensees to verify their compliance with continuing education requirements. The chiropractic board's record retention schedule does not specifically address the retention of licensee audits; it does indicate, however, that the board will retain license files permanently. Because license files include renewal documents, we would expect an audit to become part of a licensee's file. We randomly selected for review 19 licensee audits that staff performed during fiscal year 2006–07. The chiropractic board could not provide

documentation for three of the licensee audits we selected, and for another 10 audits, the board did not retain copies of the top portion of the audit notification letters that informs the licensee about the audit and requests proof of continuing education by a specified date. In two other cases, the chiropractic board inappropriately concluded licensee audits. As a result of the errors made in reviewing the audit results in these cases, staff did not forward the licensees' audit results to the enforcement unit for possible disciplinary action, as they should have. When the chiropractic board does not follow its procedures to verify information it receives from the audited licensees, it fails to adequately ensure that licensees are taking the necessary continuing education courses to practice in California.

We recommended that the chiropractic board establish procedures for maintaining accurate documentation of continuing education audits of licensees. We also recommended that the board establish a mechanism to ensure that all relevant steps are taken before continuing education audits are considered complete.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided a copy of its procedures, dated September 2008, for staff to follow when completing continuing education audits of licensees. Further, the procedures include a tracking spreadsheet for staff to record the completion of relevant steps before considering the audit complete.

Finding #22: The chiropractic board has not established complete procedures for its audits of continuing education courses.

The chiropractic board's regulations allow any board member or board designee to inspect or audit any approved chiropractic course in progress. Course audits are similar to class evaluations and cover topics such as the registration process, appropriateness of subject matter, and evaluation of the instructor's teaching style. Although the board conducts some course audits, we were unable to determine the total number of audits it performed because it does not track such audits. Of the five course audits conducted between February 2005 and June 2007 that we reviewed, only one reported negative results, and the chiropractic board did not follow up on them. Although chiropractic board regulations give it the power to withdraw approval of any continuing education course, staff told us the board has no procedures for responding to a negative course evaluation. As a result, the chiropractic board did not take any corrective action, thus missing an opportunity to improve the continuing education courses available to its licensed chiropractors.

We recommended that the chiropractic board establish a process to track course audits conducted and a procedure for taking corrective action when the course reviewer identifies a deficiency.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided a copy of its procedures, dated September 2008, for staff to record course audits conducted. The procedures also include a process for referring course complaints for further review and action.

Department of Consumer Affairs, Contractors State License Board

Investigations of Improper Activities by State Employees, January 2008 Through June 2008

INVESTIGATION I2007-1046 (REPORT I2008-2), OCTOBER 2008

Contractors State License Board's response as of October 2008

An employee with the Contractors State License Board (board) used a state vehicle for personal reasons and falsified board records to hide her actual activities when she was supposed to be performing field inspections for the board. The State incurred an estimated $1,896 loss due to her personal use of a state vehicle from April 2007 to August 2007.

Investigative Highlight . . .

An employee of the Contractors State License Board (board) used a state vehicle for personal reasons when she was supposed to be performing field inspections for the board, at a loss to the State of $1,896.

Finding: An employee used a state vehicle for purposes unrelated to her state employment and falsified board records to hide her engaging in activities unrelated to her board work during state time.

From April 2007 to August 2007, a board employee drove her assigned state vehicle 1,922 miles more than her job required. Using the standard mileage reimbursement rate applicable to state employees at the time, we estimate that this difference of 1,922 unauthorized miles cost the State $932. In addition, the employee improperly claimed 29 hours of excess travel time for which she received compensation. Based on the employee's salary for that period, we estimate that this travel time, which the employee incorrectly reported, cost the State $872. The employee also drove her state vehicle 189 miles during three days that she was on medical leave, at a cost to the State of $92. Finally, in her daily activity log, the employee regularly misrepresented her physical location and work activities in order to hide that she was apparently engaging in activities not related to her job with the board.

Contractors State License Board's Action: Partial corrective action taken.

The board informed us in October 2008 that it is seeking reimbursement from the employee for the $1,896 loss to the State resulting from the employee's personal use of the state vehicle and compensation for excess travel time. The board previously informed us that it had taken several corrective measures, including issuing the employee a counseling memorandum and a copy of the current departmental policy pertaining to incompatible work activities. The board also terminated the telecommute agreements of the employee and other board employees, and counseled the employee's supervisor to regularly review daily activity logs and other reports prepared by employees for accuracy and completeness.

Department of Corporations

It Needs Stronger Oversight of Its Operations and More Efficient Processing of License Applications and Complaints

REPORT NUMBER 2005-123, JANUARY 2007

Department of Corporations' response as of January 2008

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to review the operations of the Department of Corporations (Corporations) to ensure that it is effectively fulfilling its responsibilities. Generally speaking, we were asked to evaluate Corporations' progress toward meeting the goals and performance measures outlined in its strategic plan as well as its progress toward implementing any changes needed to fulfill its goals effectively. We were also asked to review Corporations' workload studies and fee analyses to determine the extent to which it has implemented any recommendations from these efforts. Furthermore, the audit committee requested that we evaluate Corporations' education and outreach efforts in achieving its goals.

We were also asked to evaluate Corporations' licensing policies and practices to determine if they are efficient, protect consumers, and prevent fraudulent applications from being processed. The audit committee requested that we review a sample of each type of license issued to determine whether the policies are applied consistently and to determine the length of time it takes to issue a license. It also asked that we assess Corporations' policies and practices related to the monitoring of licensees, including the number and frequency of licensee audits that are conducted and the effectiveness of the audits. Finally, we were asked to identify the number of complaints Corporations receives annually and to evaluate its policies and practices for handling complaints, including its process for monitoring the ongoing investigation of complaints, the types of enforcement actions taken, Corporations' ability to enforce actions taken as a result of complaints, and its criteria for deciding to reject a complaint or to turn it over to another enforcement agency.

Finding #1: The fees Corporations collects result in an inequitable distribution of charges among licensees and an excessive fund reserve.

Corporations, which does not receive support from the State's General Fund, supports its operations through revenues earned from fees charged for processing applications for notices, registration certificates, permits, and the initial issuance and renewal of licenses. We found that since 2001, Corporations has not analyzed the licensing and examination fees it charges businesses to determine whether the fees matched its costs of providing the related services. As a result, certain licensees are subsidizing costs for others because Corporations overcharges for some fees and undercharges for others. For example, revenues from securities fees have exceeded the related service costs for six of the last seven fiscal years. The amount of excess revenues from these fees ranged from $750,000 to $9.1 million and totaled $22.2 million during this time. By contrast, the service costs for nine other business activities Corporations regulates have exceeded

Audit Highlights . . .

Our review of the Department of Corporations (Corporations) revealed the following:

- *Corporations' current fee structure results in certain licensees subsidizing the administrative costs for others. For example, revenues from securities fees have exceeded the related service costs by $22.2 million over the last seven years.*
- *Corporations has taken important steps in strategic planning for its operations, however, these efforts are undercut by inaccurate statistical information about its actual performance as reported in its monthly and quarterly performance reports.*
- *Corporations does not always process applications within the time limits set by state law. In fact, for applications submitted between January 2004 and May 2006, the average processing time exceeded the time allowed by law for many of the application types we reviewed.*
- *Although there is no legal requirement dictating the length of time Corporations has to resolve complaints, we found examples of unnecessary delays in a sample of complaints we reviewed.*
- *Corporations has three primary information systems for capturing complaint related data; however, none of them are reliable for determining the number, type, and status of its complaints because the systems contain too many blank fields, duplicate records, and errors.*
- *Corporations did not conduct required examinations of at least 170 licensed escrow offices and 899 licensed finance lenders within its four-year goal.*

the revenues generated from their respective fees by $21 million over the last seven fiscal years. The overcharging of certain licensees has not only covered the undercharges for other services but has also contributed to the buildup of a large reserve in the State Corporations Fund. We anticipate that this reserve will exceed statutory limits at the end of the current fiscal year.

Fees for the licenses processed by Corporations are generally set by statute. Although Corporations has limited authority to set fees below the statutory maximum for businesses that deal with certain securities transactions, offer investment advice, or act as broker-dealers, the only way it can increase fees above the statutory cap is to seek a change in the law.

To strengthen its operational oversight, we recommended that Corporations seek legislative authority allowing it to set fees by regulation. This legislative authority should require that Corporations annually assess its fee rates and establish fees that are reasonably related to its cost of providing the services supported by its fees. Corporations should also factor in the amount of any excess reserves when conducting its annual assessment.

Corporations' Action: Partial corrective action taken.

Corporations submitted a placeholder bill, Assembly Bill 1516, which would have allowed the commissioner to adjust fees to reflect the actual cost of regulatory services for each law and program. However, the Legislature chose to maintain the existing structure outlined in statute.

Corporations currently has statutory authority to make the adjustments necessary to eliminate deficits in some programs and indicated it has done so to the extent possible. For those programs where there is a cap on the assessed fee that limits its ability to make adjustments, Corporations stated it has adjusted the fee to the extent it could to eliminate the deficit in two fiscal years. Additionally, Corporations stated it would annually review its other rates to determine if the fees are sufficient to support program activities. Corporations also stated it would request a fee adjustment from the Legislature for programs that have fees set in statute and have a deficit or surplus. Finally, Corporations has completed its review of the reimbursement rate for examinations performed and the appropriate adjustments have been made.

Finding #2: Corporations has made a good start on its strategic planning but needs better information about its actual performance.

Corporations has taken important steps in strategic planning for its operations, establishing a framework to identify its strengths and weaknesses with the goal of eliminating inefficiencies and increasing productivity through an examination of its current policies and procedures. Corporations' efforts include creating three interrelated documents—a strategic plan, a program-level action plan, and periodic statistical performance reports—designed to establish its goals and measure its effectiveness in meeting those goals. However, the effectiveness of its strategic planning effort is undercut by inaccurate statistical information about its actual performance as well as by the cumbersome methods used to compile the information for the performance reports. We found errors in the manual compilation of three of the 10 performance measures we reviewed. For instance, Corporations reported that the percentage of other securities regulation applications actually processed on time was 96.5 percent, but we calculated it to be 89.5 percent. Although this relatively small difference might not change Corporations' assessment of the need for change in the area, it does illustrate the need for more accurate reporting.

Corporations' systems for collecting its actual performance information are also cause for concern, because of inefficiencies and the potential for errors. Depending on the performance measure, Corporations uses both manual and automated systems to collect the information, and it then manually compiles that information for summary in a performance report. An automated system, with all necessary information accurately reported, would be more efficient and reliable. Currently, the information used to produce the reports comes from a variety of sources, such as forms, data system queries, spreadsheets maintained by team leaders, and other documents that may or may not be

reviewed for accuracy. We found one instance in which staff used informal notes, rather than standard time sheets, to report the time worked on applications. Each month, certain Corporations' staff must generate statistics by performing time-consuming manual calculations and then must input the results into a separate form for the report.

To improve the efficiency and effectiveness of its system for collecting actual performance measure information, we recommended that Corporations do the following:

- Consider assessing the need for new automated data systems or determining whether its current systems are capable of collecting the necessary information.

- Ensure the accuracy and completeness of the information in its automated systems by requiring staff to enter the information and requiring supervisors to review it periodically. For data not currently available in automated format, Corporations should develop stronger procedures to ensure that staff accurately report and supervisors review the information. Corporations should also consider calculating and reporting performance measures quarterly, rather than monthly, until it has a more efficient data collection system.

- To ensure that it has identified all necessary performance measures and appropriately focused its current performance measures, Corporations should continue to assess the reasons for performance deficiencies and add or adjust performance measures as needed.

Corporations' Action: Partial corrective action taken.

Corporations indicated it has met with the Department of Finance (Finance) to discuss the process to obtain or update its automated data systems and has issued a Request for Proposal for a needs assessment and feasibility study. Corporations selected a contractor, and planned to submit the completed feasibility study report to Finance in July 2008.

Corporations indicated it has implemented procedures that require staff to confirm the accuracy of information posted in its automated systems prior to exiting the system. Further, Corporations stated that under its new procedures managers or supervisors will review source documents on a sample basis and ensure that information on the source documents matches information in the electronic file. Managers and supervisors will also review their automated systems monthly for blank fields and request that staff research and complete the data fields with the appropriate information. Further, Corporations indicated that managers will counsel and provide training to employees who consistently make errors when posting information to the automated systems.

Additionally, Corporations stated that it modified its procedures that previously allowed more than one complaint file to be created in the data system for the same complaint. Among other things, these procedures require a supervisor to review the listing of complaints for duplicate files. Additional procedures are also being developed for the review of other data related to complaints. Finally, Corporations stated that its legal counsel will perform a monthly review of the data fields in the Enforcement Case Management System to ensure that all fields are completed and any deficiencies will be discussed with the assigned counsel and the correct information will be posted in the system.

Corporations indicated that the Securities Regulation Division (securities division) has completed an initial review of performance measures to identify deficiencies and determine what caused the deficiencies and develop corrective action plans to meet performance measures. The securities division will also re-evaluate performance measures, baselines and targets for appropriateness, and accuracy. Managers will evaluate and report quarterly to executive staff performance deficiencies and their corrective action plans.

The Financial Services Division (financial division) will review and monitor processing times and compare them with benchmarks on a monthly basis. Further, the financial division will develop corrective measures to address any issues identified and develop new, more appropriate measures that are achievable.

Finding #3: The effectiveness of Corporations' outreach unit is uncertain.

Corporations does not collect enough data or identify sufficient goals to effectively assess its education and outreach efforts. One of Corporations' Education and Outreach Unit's (outreach unit) primary programs is its Seniors Against Investment Fraud (seniors program), which is designed to educate senior citizens about investment fraud and how to protect their finances from predatory schemes. In its budget change proposal for fiscal year 2005–06, Corporations requested $400,000 in ongoing permanent funding for the seniors program (and received $225,000). The proposal identified 12 performance measures intended to aid Corporations in evaluating the achievement of the objectives of the seniors program. However, Corporations does not collect data for four of these measures. For example, when it sought funding for the program in fiscal year 2005–06, Corporations stated that it planned to track the number of seniors program volunteers by geographical area; however, it had not done so as of December 2006. Corporations does not track any data for three other performance measures because, according to the director of the outreach unit, the measures are not clear. Further, although Corporations collects data for eight of the 12 performance measures, it measures its effectiveness for only two—the number of publications disseminated and the number of presentations given—by comparing them to established goals. However, without sufficient data and relevant benchmarks, it is impossible for Corporations to effectively assess its overall performance in protecting senior citizens from investment fraud.

Moreover, Corporations has not developed any formal goals to effectively measure the success of its other primary program—the Troops Against Predatory Scams Investor Education Project (troops program). The troops program was funded by a grant that requires that Corporations collect data and report the results on seven performance metrics. However, Corporations has not established any formal benchmarks to gauge whether or not its efforts are successful. As a result, Corporations cannot assess whether the program is achieving the desired results.

To ensure that the outreach unit can effectively measure its success, we recommended that Corporations ensure that it collects all of the necessary data and establishes reasonable benchmarks.

Corporations' Action: Partial corrective action taken.

According to Corporations, in January 2007, the outreach unit developed a monthly reporting form that will capture the number of Seniors Against Investment Fraud partners and training kits distributed. Corporations also stated that the outreach unit also revised existing performance measures and benchmarks based on relevancy and accuracy. The outreach unit eliminated six of the existing 12 performance measures and replaced them with four new performance measures. Data will be collected monthly and measured against the benchmarks. Conversely, Corporations did not provide any information regarding its efforts to better measure the success of the troops program.

Finding #4: Corporations does not always process applications within the time limits set by state law.

State law requires Corporations to assess the completeness of applications and notify applicants in writing of any deficiencies in the applications within specific time frames, and either issue or reject the application within a specified time period. We found that Corporations does not always process applications within the time limits set by state law. For example, of the 35 applications we reviewed, we noted 10 instances where Corporations did not comply with the statutory time frame for processing applications. Delays could result in entities being unable to conduct business. Delays may also increase the likelihood that businesses will conduct unlicensed financial transactions. However, while Corporations is responsible for the delays in processing some license applications, other factors outside of its control also contribute to lengthy processing times. For instance, license applicants do not always provide the required information when submitting applications. Deficiencies in applications and delays in correcting them create additional work for Corporations' staff and can substantially delay the issuance of licenses. We found that Corporations issued deficiency notices for 32 (91 percent) of the 35 applications we reviewed. Although application requirements can be somewhat daunting, they did

not appear to be overly complex. According to Corporations, these delays generally occurred because of a backlog resulting from a large increase in the number of applications submitted in recent years and some applications requiring a more extensive review.

In addition, Corporations does not have complete data for some of its license applications. We found that the application system data related to corporate securities and franchises contain omissions and inaccuracies, hampering Corporations' ability to compile accurate performance statistics.

To ensure that all applications are reviewed promptly and sufficiently, we recommended that Corporations do the following:

- Continue to monitor the progress of applications through the review and approval process to identify any that have stalled, and investigate the reason for the delay.
- Follow the law in notifying applicants once their applications are complete.
- Follow up with applicants that do not promptly respond to deficiency notices.
- Assess whether it needs additional staff to process applications.
- Maintain all necessary data in its information management systems so that it can effectively calculate the number of days it takes to process applications.

Corporations' Action: Partial corrective action taken.

Corporations stated that it reviewed its procedures for processing applications submitted to its securities division in order to streamline the process to focus on the most critical factors in an application. According to Corporations, this process, along with hiring a retired annuitant, has eliminated the securities division's backlog of applications pending review.

Additionally, Corporations stated that the financial division has revised its procedures for processing applications to include having staff notify supervisors when an application has stalled. The reason for the stall will be determined and corrective action taken. Managers will also review a log or aging schedule to determine if any applications have stalled. These revised procedures will be written and included in an applications procedures manual for the financial division. Further, Corporations indicated that it has developed and will maintain the data necessary to calculate the number of days it takes to process applications.

According to Corporations, it has revised the letter it sends to applicants notifying them that their application has been approved. The revised letter will now include both a reference that the application is complete and has been approved. Corporations also stated that it has developed a tracking mechanism that notifies staff at established intervals that an applicant has not responded to a deficiency notice. Staff will prepare a follow-up letter notifying the applicant that Corporations will close the application if the requested information is not received by a given date. A second notice will be sent if the information is not received and, if no response is provided, Corporations will close the application.

Corporations indicated that it is in the process of identifying the average number of staff needed to handle its normal workload. Corporations will also review the log of outstanding applications to determine if a backlog is developing and, if so, redirect resources if possible, to prevent a further buildup of applications. Additionally, Corporations developed an overall plan to determine if additional resources are needed in various program areas and, if so, request those additional resources in the fiscal year 2008–09 budget process.

Finally, Corporations stated that it has developed policies and procedures for ensuring that all applications received are logged for date of receipt, date approved/license issued, and the number of days for completion. The policies and procedures also require documenting the reasons for any extraordinary issues that delay processing.

Finding #5: Corporations is working to improve its handling of complaints.

Either the securities division or the enforcement division typically handles complaints related to securities regulation. Of the 20 complaints related to securities regulation we reviewed that were closed between May 20, 2005, and July 18, 2006, nine were referred to the securities division. It took the securities division an average of 312 days, ranging from 55 to 531 days, to resolve these nine complaints. The remaining 11 complaints related to securities regulation were referred to the enforcement division and took an average of 170 days to resolve, ranging from 20 days to 383 days.

The time Corporations takes to resolve complaints is contingent on many factors. For instance, the complexity of the case, the availability of staff, and the time it takes for complainants to respond to Corporations' inquiries all may contribute to the length of the process. Moreover, there is no legal requirement dictating the length of time Corporations has to resolve complaints. Thus, we expected the number of days Corporations took to resolve securities regulation complaints to vary depending upon the circumstances of each case. Nonetheless, during our review, we identified four complaints in which unnecessary delays increased the length of the process. For example, the securities division did not begin its investigation of one complaint until 277 days after the complaint was received. In another instance, the enforcement division took 176 days to refer a complaint to the securities division for further action, during which time nothing was done to address the complainant's concerns. Corporations' management could not explain these delays.

Moreover, we reviewed a sample of 20 complaints related to financial services that were closed between November 29, 2004, and August 8, 2006. We found that Corporations took between 35 and 232 days to close these complaints, averaging 106 days. Unlike its process for handling complaints related to securities regulation, Corporations handles financial services complaints by sending letters to licensees requesting them to respond in writing to the complaint allegations within 15 days. Delays can occur if the licensee does not respond within the 15-day time frame. However, we found some instances in which unnecessary delays on Corporations' part increased the length of the process. For example, in four of the 20 complaints we reviewed, Corporations took between 34 and 210 days to send letters to the complainants notifying them that it had begun its review, exceeding its 30-day goal. In two of the four cases, Corporations' staff did not forward the complaints to its financial division for handling for 28 and 38 days, respectively. However, Corporations' staff forwarded the two remaining cases in less than six days.

Corporations has recently modified its procedure for handling complaints. In addition to developing formal policies for rejecting and referring complaints, it has centralized the intake of all complaints by forwarding them to a new complaint team. Corporations believes that this new process will allow it to respond immediately to complaints and prepare each complaint for referral to the appropriate division. Because Corporations initiated this process near the end of our fieldwork, we were unable to test whether it will correct any of the weaknesses we identified. However, it appears that the process contains some good business practices.

To improve the efficiency of its complaint-handling process, we recommended Corporations do the following:

- Develop procedures to track the progress of complaints to ensure that they continue to move through the process without unnecessary delay.

- Monitor its newly established complaint-referral process and develop procedures, if necessary, to decrease the length of time it takes to refer cases to the appropriate division.

Corporations' Action: Corrective action taken.

Corporations stated it established a complaint team in August 2006 that revised the processing of complaints. As a result, Corporations stated that the time to respond to a complaint has been shortened. The complaint team also developed a monthly report that tracks the number of complaints received, the backlog of complaints, responses to complainants, and the average number

of days it takes to process complaints. Additionally, the enforcement division has developed plans and goals that involve completing case investigations and either taking action or closing a case, as appropriate.

Corporations also stated that it will continue to monitor its complaint-referral process to look for additional ways to decrease the time frames for processing complaints. Additionally, an executive staff member will review the complaint-referral procedures and protocols and provide recommendations to the commissioner on how to improve the process.

Finding #6: Information systems containing data regarding complaints are unreliable.

Although it has three information systems for tracking complaint data, Corporations undercuts these efforts by failing to ensure that any of the three systems contain reliable data. Several of the critical data fields in Corporations' Customer Relationship Management (CRM) system and Corporations' Customer Service System (CSS) were often left blank, limiting the usefulness of these systems as management tools. For example, the fields needed to calculate complaint processing times, such as date received, date assigned, and date opened, were blank 9.5 percent, 25 percent, and 68 percent of the time, respectively, for the CRM system. Consequently, these fields cannot be used to determine where a complaint is in the resolution process or to monitor and evaluate complaint-processing times. In addition, we found that the field identifying the specific law a complaint was related to was left blank for more than 24 percent of the 2,876 complaint records in the CSS and for 50 percent of the 2,461 complaint records in the CRM system. Without this information, Corporations cannot determine how many complaints it receives about alleged violations of various laws and cannot effectively identify problem areas or adjust its workforce to handle them.

Moreover, we found several types of data entry errors in Corporations' complaint systems. For example, the CRM system did not reflect the correct status for many of the complaints we reviewed. The status field can be used to indicate the disposition of a particular case, such as closed, in progress, or referred. However, the CRM system listed an incorrect status for 13 of the 20 complaints we reviewed. In each of these cases, the CRM system indicated that the case was still in progress, even though all of them had been closed. Thus, Corporations cannot rely on the system to determine the number of complaints still in progress, completed, or referred to another division. We also found that the CRM system did not reflect the correct date received for eight of the 20 complaints we reviewed. Specifically, the date entered into the CRM system as the date received did not agree with the supporting documentation for four of these complaints, and it was left blank for the others. Similarly, we found data entry errors for the field intended to capture the date a complaint was received in three of the 20 complaints we reviewed in the CSS. In addition, six of the 34 enforcement actions we tested in the Enforcement Case Management System reflected an incorrect date for when the action occurred, limiting the usefulness of the system as a management tool.

To improve the usefulness of its information systems, we recommended that Corporations review its existing complaint records and eliminate duplicates and correct any inaccurate fields. Further, Corporations should maintain accurate and complete data to ensure that the information systems can be used more effectively as management tools.

Corporations' Action: Pending.

Corporations did not fully address our recommendations in its response. Specifically, it noted that the enforcement division is reviewing its case management system to determine how to improve it. Options include more fields of data and creating reports that would capture data to assist management with trends and workload issues. However, its response did not directly address our recommendation to review its existing complaint records and eliminate duplicate records and correct any inaccurate fields.

Finding #7: Corporations failed to perform required examinations of some licensees.

Corporations did not conduct examinations of many of its escrow licensees within the time frames required by law. Additionally, Corporations did not conduct examinations of its licensed finance lenders as frequently as required by its internal policy. Consequently, Corporations' ability to protect consumers against potential fraudulent lending and financing scams was weakened.

The California Financial Code requires Corporations to conduct examinations of licensed escrow offices and mortgage lenders at least once every four years. In addition, although not required by law, Corporations has established a goal for examining every licensed finance lender at least once every four years. However, Corporations did not conduct examinations of many escrow offices and finance lenders within the last four years. Specifically, we found that at least 170 licensed escrow offices and 899 licensed finance lenders—representing 37 percent and 35 percent, respectively, of all such licensees that required examinations—have not had an examination for at least four years. Corporations was more effective with its examinations of mortgage lenders; only two licensed mortgage lenders—less than 2 percent—did not receive the required examination within at least the last four years.

Corporations also lacks clear guidance for conducting examinations and following up on the deficiencies it identifies. For example, it does not have any policies or procedures on the time frames within which examiners must follow up on licensees' responses to deficiencies identified during an examination. In a sample of 20 examinations performed by the financial division, Corporations' examiners identified a total of 112 deficiencies related to 17 of the examinations; the remaining three did not identify any deficiencies. The identified deficiencies included improper charges, unauthorized disbursements from accounts, and altered checks. When we followed up on six of the 17 examinations that identified deficiencies, we found that in four cases the examiners took between 79 days and 187 days to provide a response to the licensees after they had responded to the deficiencies. We expected Corporations to have established response time frames to ensure the prompt resolution of any deficiencies.

We recommended that Corporations develop a plan to conduct examinations of licensees in accordance with state law and its own internal policy. Corporations should also establish clear guidance and response time frames for following up on deficiencies identified in examinations.

Corporations' Action: Corrective action taken.

Corporations stated that it has identified the number of licensees that need to be examined based on statutory requirements or internal policy, as well as determined the average hours per exam. Based on this information, Corporations received additional examiner and enforcement positions in the fiscal year 2007–08 budget and requested additional examiner and enforcement positions in the fiscal year 2008–09 budget. Corporations will continue to evaluate current staffing levels to determine whether sufficient staff exists to perform the required exams. If staffing levels are insufficient after staff redirections from other programs, Corporations will pursue additional staffing through the budget process. Corporations also indicated that it developed procedures and a risk-based process to review enforcement actions taken to determine compliance by licensees, to evaluate the enforcement action, and to identify high-risk candidates for follow-up nonroutine examinations.

Department of Corrections and Rehabilitation

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

INVESTIGATION I2006-0665 (REPORT I2008-1), APRIL 2008

Department of Corrections and Rehabilitation's response as of September 2008

Investigative Highlight . . .

The Department of Corrections and Rehabilitation wasted nearly $11,300 in state funds by leasing unneeded parking spaces and misused state resources by allowing five employees to use them at no charge for their privately owned vehicles.

We investigated and substantiated an allegation that the Department of Corrections and Rehabilitation (Corrections) wasted state funds by leasing unnecessary parking spaces from a private facility. In addition, Corrections mismanaged state resources by failing to properly oversee the parking spaces under its control, and it misused state resources by allowing state employees to park their personal vehicles for free in some of the leased spaces.

Finding: Corrections mismanaged state resources and wasted state funds by leasing more spaces than it needed.

Our review of vehicle parking assignments at a state-owned parking facility under Corrections' control and a nearby parking facility where it leased additional parking spaces revealed that, as of December 31, 2007, Corrections was leasing 26 more parking spaces than it needed for the state-owned vehicles at one of its regional headquarters. Although Corrections may have needed to lease 29 spaces when it first entered into the lease in August 2006, we found it needed only three of the leased spaces for that purpose as of October 1, 2007. As a result of failing to manage the number of parking spaces it needed, Corrections wasted at least $11,277 in state funds from October 1, 2007, through December 31, 2007.

Our investigation found that Corrections had 56 parking spaces under its control as of October 2007. Of those spaces, 27 were state-owned spaces at the regional headquarters building and 29 were leased spaces at a nearby private parking facility. However, as shown in the table on the following page, as of December 31, 2007, Corrections was using only 10 of the 27 state-owned spaces for state-owned vehicles. For the remaining 17 spaces, three were left unused, employees were allowed to park their personal vehicles in seven of the spaces at no cost, and another seven spaces were assigned by Corrections to another state agency. Similarly, we found that Corrections parked state-owned vehicles in only 20 of the 29 leased spaces at the nearby private parking facility. Four of the remaining nine spaces at the private facility were unused and state employees were allowed to park their personal vehicles in five spaces for free. Corrections misused a state resource by allowing state employees to park their personal vehicles in five of the leased spaces.

Table
Status of Parking Spaces Under Corrections' Control as of December 31, 2007

ASSIGNMENT	STATE-OWNED SPACES	LEASED SPACES	TOTALS
State-owned vehicles	10	20	30
Unused	3	4	7
Privately owned vehicles	7	5	12
Other state agency	7	0	7
Totals	**27**	**29**	**56**

Corrections misused state resources by allowing state employees to park privately owned vehicles for free. Our review determined that since at least October 2007, the date of the information provided to us, five employees have parked privately owned vehicles at no cost in private parking facilities leased by the State. In addition, information we obtained suggests that three of these employees have parked privately owned vehicles in the private parking facility since at least January 2006. The information also suggests that Corrections allowed other employees to park privately owned vehicles at the State's expense before October 2007. When asked to clarify when specific individuals began parking privately owned vehicles at either the state-owned or private parking facility, officials at the regional headquarters informed us that the regional headquarters did not maintain records documenting when employees were assigned parking spaces. Further, when asked to explain the criteria used for determining which employees were allowed to obtain free parking for their vehicles, the officials told us that they followed the practice in place before their arrivals, which was to have supervisors assign spaces vacated by departing employees to the new employees hired to replace them. Corrections did not adequately maintain records to document when it began allowing its employees to use the parking spaces for their privately owned vehicles, so we could not quantify the full extent to which state funds were used to provide free employee parking. Nevertheless, Corrections misused state resources by allowing some leased parking spaces to be used for personal purposes.

Corrections' Action: Corrective action taken.

Although Corrections initially reported that it needed to lease five spaces at the private parking facility, it subsequently informed us that it canceled its lease with the private parking facility in April 2008. As a result, Corrections is no longer paying for the 29 parking spaces it had leased in the private facility. Based on the terms of its lease agreement, the cancellation resulted in an annual savings of more than $50,000.

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 and Department of Corrections and Rehabilitation's responses as of October 2008

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

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.*

develop an approach that would allow them to generate such information on an as needed basis. For example, with the assistance 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 proposed.

Assembly Bill 2593 was introduced to require the Department of Social Services to implement some of these recommendations. The bill did not pass during the 2007—08 Regular Session.

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 facilities. Additionally, Justice indicated that it determined a statutory change was not necessary in order for it to share the names and addresses of persons in the sex offender database with Social Services law enforcement officers. Further, Justice noted that it negotiated an interagency agreement with Social Services, whereby Justice will implement certain protocols that will allow Social Services' peace officers to promptly investigate any instance in which the address of a registered sex offender is the same as a licensed facility. According to Justice, the interagency agreement is with Social Services for its final approval and execution.

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 conditions of their licensure. Further, as recommended, Social Services indicated it sponsored an assembly bill 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. Finally, Social Services also noted that it is finalizing an interagency agreement with Justice that will enable periodic automated matches of Justice's sex offender database with addresses of facilities licensed by Social Services.

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.

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 a proposed placement.

Finding #3: The database used by Correction's 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: Pending.

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 it plans to complete this process 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: Partial 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 plans to provide 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 will conduct, 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 Corrections, its Juvenile Division provided refresher training to all field parole agents regarding contact standards for various cases. Corrections also indicated that it plans to provide training to the agents of record in the Juvenile Division to document the contacts and to place the documentation in the field file.

Department of Corrections and Rehabilitation

It Does Not Always Follow Its Policies When Discharging Parolees

REPORT NUMBER 2008-104, AUGUST 2008

Department of Corrections and Rehabilitation's response as of October 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) examine the Department of Corrections and Rehabilitation's (Corrections) adult parole discharge practices. Specifically, the audit committee requested that we review Corrections' discharge policies and protocols and determine whether they comply with applicable laws and regulations. The audit committee also asked us to review Corrections' internal controls over its parole discharge process and determine whether they are sufficient to ensure compliance with Corrections' policies and state law and to identify inappropriate employee conduct. In addition, the audit committee requested that we ascertain whether a sample of parolees were discharged in accordance with staff recommendations and to determine, to the extent possible, the frequency with which parolees received discharges contrary to staff recommendations. Further, the audit committee asked us to assess whether Corrections discharged a sample of parolees in accordance with its policies, protocols, and applicable laws and regulations. The audit committee also requested that we determine whether Corrections took any corrective action as a result of an internal investigation of one of its regions. Finally, the audit committee asked us to review any proposed changes to laws, regulations, policies, and protocols to determine any potential changes in efficiency and effectiveness related to the discharge process and the extent to which those changes might affect the parole administrators' authority.

Finding #1: Corrections failed to adhere consistently to its discharge policies.

Corrections' policies dictate who must complete a discharge review report and who has the final authority to discharge parolees; however, Corrections does not always follow its own policies. With the exception of deported parolees,[1] these policies require that parole agents initiate a discharge review before parolees complete their required period of continuous parole and that the parole agents recommend on a discharge report whether to discharge or retain the parolees. Unit supervisors must read discharge review reports and then decide to discharge parolees or to forward the reports to district administrators. Although in many cases the unit supervisor may discharge parolees, the district administrator or the Board of Parole Hearings (board) must review and discharge certain parolees.

[1] United States Immigration and Customs Enforcement may place a hold on all confirmed illegal immigrants in Corrections' custody. Upon release to parole, these parolees transfer to federal custody pending deportation to their country of origin. Corrections monitors the status of these parolees during the deportation process. We refer to these individuals as deported parolees. Corrections' current policies allow parole staff to use their discretion on whether to prepare discharge review reports for deported parolees.

Audit Highlights . . .

Our review of the Department of Corrections and Rehabilitation's (Corrections) adult parole discharge practices found that:

- *Corrections' data indicate that the responsible parole units did not submit discharge review reports for 4,981, or 9 percent, of the 56,329 parolees discharged between January 1, 2007, and March 31, 2008, and that Corrections lost jurisdiction over these individuals.*
- *District administrators, operating within their authority to exercise judgment, at times discharged parolees despite the parole agents' and unit supervisors' recommendations to retain the parolees without documenting the reasons for their decisions.*
- *Because of errors made by Corrections' Case Records Office, the appropriate authority did not participate in making the decisions to retain or discharge six of the 83 parolees whose discharge reviews we evaluated for compliance with Corrections' policies.*
- *Corrections reported that it has taken immediate corrective measures and has drafted new policies that, if implemented, will govern its parole discharge process.*
- *Changes to state law that became effective January 1, 2008, and proposed revisions to Corrections' policies—if implemented—could increase each district administrator's role and authority in the discharge review process.*

Corrections' data shows that a total of 56,329 parolees were discharged between January 1, 2007, and March 31, 2008. During this 15-month period, Corrections' data indicate that the responsible parole units did not submit discharge review reports for 4,981, or 9 percent, of these parolees and that Corrections lost jurisdiction over these individuals. Nearly half of these cases involved deported parolees for whom Corrections' current policies require only that parole staff prepare formal discharge review reports if staff wish to retain the parolees. The remaining discharged parolees who did not receive discharge review reports were not deported parolees, but the responsible parole units had failed to follow policy and submit the required reports. Consequently, Corrections lost its opportunity to recommend that the board retain these parolees, whose number included 363 individuals originally convicted of violent or serious offenses.

Additionally, our review of a sample of 509 discharges indicated that in 31 instances, district administrators, operating within their authority to exercise judgment, discharged parolees despite the parole agents' and unit supervisors' recommendations to retain the parolees. In 15 of these 31 instances, district administrators did not provide explanations for overruling these recommendations and discharging the parolees. In response to these issues, Corrections reported that it has taken certain immediate corrective measures and has drafted new regulations and a new policy memorandum that, if implemented, will govern its parole discharge process.

To prevent the automatic discharge of parolees, we recommended that Corrections ensure that its staff promptly prepare discharge review reports for all eligible parolees. We further recommended that Corrections finalize and implement the draft regulations and policy memorandum that will detail the policy and procedures governing its parole discharge process. The new policy should require district administrators to document their justifications for discharging parolees against the recommendations of both parole agents and unit supervisors. Finally, the new policy should require that discharge review reports be prepared for deported parolees.

Corrections' Action: Pending.

Corrections reports that is has drafted new regulations and a new policy memo that, when implemented, will govern its parole discharge process. Specifically, Corrections stated that the proposed regulations have been vetted through departmental stakeholders and are now with its Regulations Policy and Management Branch, pending submission to the State's Office of Administrative Law. Corrections also stated that its draft discharge review policy and procedures memorandum is currently undergoing administrative and executive review, and it expects the new policy to be finalized and approved by the end of February 2009. The new policy is intended to clearly define all aspects of the discharge review process, and specifically addresses report preparation and levels of oversight and tracking. For example, the new draft policy memorandum requires district administrators to provide sufficient justification for their decisions to retain or discharge parolees. In addition, the draft policy prohibits deported parolees from discharging by operation of law without a substantive documented review.

Finding #2: Corrections did not always ensure that the appropriate authority participated in discharge decisions.

Under state law, only the board has the authority to retain a parolee. Corrections' discharge policy requires that the board must review each case in which it previously took action to retain a parolee or to revoke or suspend an individual's parole. However, the board is not always involved in the discharge process when it should be. For 83 of the 509 parole discharges that we reviewed, we performed additional testing to determine whether Corrections followed all of its discharge policies. We found that because of errors made by Corrections' Case Records Office, the appropriate authority did not participate in making the decisions to retain or discharge six of these parolees. In four cases the board should have made the final decision to retain or discharge the parolees, but was not given the opportunity. Corrections' staff should have sent the other two cases to district administrators for either a decision to discharge or a recommendation to the board to retain the parolees, but staff did not do so. In all six of these cases, the parolees were discharged. Although Corrections maintains data on actions

taken by the board against offenders' paroles and on the entity that discharged each parolee, which it could use to verify that the board was involved in discharge decisions when required, this data is not always accurate.

In addition, in August 2007 Corrections began requiring its regional administrators, or designees, to audit 10 percent of all discharge review reports submitted each month to district administrators under their supervision. It also began requiring its district administrators to audit 10 percent of the monthly discharge decisions reached by each parole unit under their jurisdiction, excluding those discharge reviews that the parole units initially submitted to the district administrators for disposition. Although Corrections provided information that indicated that between August 2007 and May 2008, it conducted 6,380 discharge audits and noted instances of noncompliance, it was unable to provide us with accurate data on the number of these instances of noncompliance identified through such audits. Finally, these audits occur after staff have already processed the parole discharges and retentions, and therefore the audits would not be effective in preventing inappropriate discharges from occurring.

To ensure that parolees are discharged in accordance with its policies and with state laws, we recommended that Corrections make certain that the appropriate authority makes decisions to discharge or retain parolees. To document more accurately whether its staff completed discharge reports, Corrections should ensure that staff members properly code in its database the reasons for parolees' discharges. Further, to better identify the entities that make final discharge decisions for given cases, we recommended that Corrections establish a more precise method for maintaining information about which entity made the final discharge decisions, such as a new discharge reason code or a new data field that will track this information.

Because we found some discharges that did not comply with Corrections' policies even after Corrections had implemented its protocol requiring that regional and district administrators review 10 percent of the discharge decisions made by subordinates, we also recommended that Corrections consider providing to parole staff and analysts from the Case Records Office additional training on its discharge policies. If, after providing this training, regional and district administrators find that staff are still not following discharge policies, Corrections should consider requiring that the respective administrators perform these reviews before discharge decisions are finalized.

Corrections' Action: Partial corrective action taken.

Corrections reports that in addition to enforcing and reemphasizing existing law and policy, its pending policy memorandum will more clearly define discharge and retain authority and bolster existing discharge review procedures. Corrections also stated that its proposed regulations will provide the clarity that existing law lacks, and will give its pending policy the force of law. Corrections' Case Records Office also redefined the manner in which discharged cases are entered into its database. According to Corrections, all Case Records Office staff have already been trained on the new recording procedures for entering the appropriate discharge reason and code into its database.

Finding #3: Corrections is taking actions to address discharge review reports that were altered inappropriately.

In December 2007 Corrections reported that an internal investigation determined that one of its district administrators discharged parolees after altering discharge review reports prepared by parole agents and unit supervisors who recommended retaining parolees. Corrections subsequently referred the investigation to the State's Office of the Inspector General, which launched an investigation and determined that the district administrator may have used poor judgment but it found no evidence of criminal or administrative misconduct. In addition, Corrections initiated an internal audit to determine whether a sample of parolee discharge decisions comply with state laws and its internal polices.

We recommended that Corrections' new policy prohibit unit supervisors and district administrators from altering discharge review reports prepared by others.

Corrections' Action: Pending.

Corrections' pending discharge policy and procedures memorandum, previously discussed, expressly prohibits unit supervisors and district administrators from altering discharge review reports prepared by others.

Department of Corrections and Rehabilitation

Investigations of Improper Activities by State Employees, January 2008 Through June 2008

INVESTIGATION I2006-0826 (REPORT I2008-2), OCTOBER 2008

Department of Corrections and Rehabilitation's response as of September 2008

The Department of Corrections and Rehabilitation (Corrections) improperly granted nine office technicians increased pay to supervise inmates at its R. J. Donovan Correctional Facility (facility). The office technicians were not entitled to receive this increased pay because they did not supervise the required number of inmates or did not supervise inmates who worked the minimum number of hours required for employees to receive the increased pay. Consequently, between January 1, 2005, and February 29, 2008, Corrections paid these office technicians a total of $16,530 more than they should have received.

Investigative Highlights . . .

The Department of Corrections and Rehabilitation:

» ***Improperly paid its employees $16,530 for inmate supervision that the employees were not entitled to receive.***

» ***Failed to maintain adequate controls and oversight to ensure employees qualified for the increased pay.***

Finding #1: Corrections improperly paid its employees for inmate supervision when they did not qualify for the pay.

From January 2005 through February 2008, Corrections made 239 payments to nine office technicians for inmate supervision; however, for 87 of these payments, Corrections could not demonstrate that the employees satisfied the requirements for earning this compensation. In some instances, employees had not supervised any inmates during a given pay period. In other cases, employees supervised only one inmate during the pay period, or they had supervised at least two inmates as required but the inmates did not collectively work the required number of hours for the employees to qualify for supervision pay. Thus, Corrections paid the employees a total of $16,530 that they were not entitled to receive under the collective bargaining agreement. This amount constitutes 36 percent of the total spent for inmate supervision for the period that we reviewed.

Finding #2: Corrections failed to maintain adequate accounting and administrative controls that would prevent the improper payments.

Our investigation further determined that Corrections paid the nine employees incorrectly because the facility lacked proper controls—including adequate oversight—to ensure that the employees qualified for the increased pay by supervising at least two inmates who collectively worked for 173 hours. For example, according to our examination of inmates' time sheets—and our observation that inmates' time sheets were missing in certain instances—two of the nine employees who received supervision pay for August 2006 did not supervise any inmates during the month. Thus, these employees received the increased pay even in extreme cases in which inmates submitted no time sheets to support the employees earning supervision pay.

Moreover, the number of improper payments may be even higher given what we discovered about the facility's system for recording inmate supervision. Specifically, we found that employees who supervised inmates routinely signed inmates' time sheets regardless of whether the employees or the inmates were present for work.

Our comparison of the inmates' time sheets to the employees' official attendance reports for four months in 2006 identified at least 34 days when employees signed their approval of the work hours that inmates recorded even though the employees were not present at the facility to supervise inmates on those days. For example, time sheets for August 2006 show that four employees certified inmates' work hours during a total of 16 days that these employees' official attendance reports show they did not work. As a result, we are concerned that the facility lacks sufficient controls to ensure the accuracy of the records that justify employees receiving extra pay for supervising inmates. In particular, if these records are inaccurate, we have no assurance that the employees receiving the increased pay have properly earned it.

Corrections' Action: Pending.

Corrections informed us that the findings of our investigation affect several areas of the facility, including personnel, inmate assignments, labor relations, and business services. As a result, it has assigned a team to determine the best approach for addressing our findings. In addition, Corrections stated that it would conduct a review for any statewide issues, and it would initiate recovery for any overpayments to its employees. Finally, Corrections reported that the facility would develop procedures to ensure that it correctly authorizes duties and pay associated with inmate supervision.

Electronic Waste

Some State Agencies Have Discarded Their Electronic Waste Improperly, While State and Local Oversight Is Limited

REPORT NUMBER 2008-112, NOVEMBER 2008

Responses from eight audited state agencies as of November 2008

The Joint Legislative Audit Committee asked the Bureau of State Audits to review state agencies' compliance with laws and regulations governing the recycling and disposal of electronic waste (e-waste). The improper disposal of e-waste in the State may present health problems for its citizens. According to the U.S. Environmental Protection Agency (USEPA), computer monitors and older television picture tubes each contain an average of four pounds of lead and require special handling at the end of their useful lives. The USEPA states that human exposure to lead can present health problems ranging from developmental issues in unborn children to brain and kidney damage in adults. In addition to containing lead, electronic devices can contain other toxic materials such as chromium, cadmium, and mercury. Humans may be exposed to toxic materials from e-waste if its disposal results in the contamination of soil or drinking water.

Finding #1: State agencies appear to have improperly discarded some electronic devices.

In a sample of property survey reports we reviewed, two of the five state agencies in our audit sample—the Department of Motor Vehicles (Motor Vehicles) and the Employment Development Department (Employment Development)—collectively reported discarding 26 electronic devices in the trash. These 26 electronic devices included such items as fax machines, tape recorders, calculators, speakers, and a videocassette recorder that we believe could be considered e-waste. The property survey reports for the other three state agencies in our sample—the California Highway Patrol (CHP), the Department of Transportation (Caltrans), and the Department of Justice (Justice)—do not clearly identify how the agencies disposed of their electronic devices; however, all three indicated that their practices included placing a total of more than 350 of these items in the trash.

State regulations require waste generators to determine whether their waste, including e-waste, is hazardous before disposing of it. However, none of the five state agencies in our sample could demonstrate that they took steps to assess whether their e-waste was hazardous before placing that waste in the trash. Further the California Integrated Waste Management Board (Waste Management Board) has advised consumers, "Unless you are sure [the electronic device] is not hazardous, you should presume [that] these types of devices need to be recycled or disposed of as hazardous waste and that they may not be thrown in the trash."

Audit Highlights . . .

Our review of five state agencies' practices for handling electronic waste (e-waste) revealed that:

- *The Department of Motor Vehicles and the Employment Development Department improperly disposed of electronic devices in the trash between January 2007 and July 2008.*
- *The California Highway Patrol, Department of Transportation, and Department of Justice did not clearly indicate how they disposed of some of their e-waste; however, all indicated that they too have discarded some e-waste in the trash.*
- *The lack of clear communication from oversight agencies, coupled with some state employees' lack of knowledge about e-waste, contributed to these instances of improper disposal.*
- *State agencies do not consistently report the amount of e-waste they divert from municipal landfills. Further, reporting such information on e-waste is not required.*
- *State and local oversight of e-waste generators is infrequent, and their reviews may not always identify instances when state agencies have improperly discarded e-waste.*

To avoid contaminating the environment through the inappropriate discarding of electronic devices, we recommended that state agencies ascertain whether the electronic devices that require disposal can go into the trash. Alternatively, state agencies could treat all electronic devices they wish to discard as universal waste and recycle them.

State Agencies' Actions: Pending.

According to their responses to our audit report, the five state agencies we sampled—CHP, Motor Vehicles, Caltrans, Employment Development, and Justice—indicated that they were taking steps to implement our recommendation. CHP stated that it will establish internal policies and procedures to ensure future compliance with e-waste standards. Motor Vehicles stated that as of August 1, 2008, its property and equipment control unit does not allow any electronic equipment to be disposed of in a landfill; it donates this equipment to public schools or, if in bad condition, disposes of it through a recycler that will properly dispose of the equipment. Caltrans stated that it will issue a memorandum to staff responsible for e-waste disposal, clarifying responsibilities and providing direction on implementation of new electronic disposal procedures to include managing all electronic equipment as if it contains hazardous waste. Employment Development stated that it will evaluate the opportunity to dispose of all its electronic devices as universal waste. Finally, Justice stated that it concurs with the report's recommendations and will continue to dispose of surplus equipment through recycling.

Finding #2: Opportunities exist to efficiently and effectively inform state agencies about the e-waste responsibilities.

Because all five state agencies in our sample had either discarded some of their e-waste in the trash or staff asserted that the agencies had done so, we concluded that some staff members at these agencies may lack sufficient knowledge about how to dispose of this waste properly. We therefore examined what information oversight agencies, such as the Department of Toxic Substances Control (Toxic Substances Control), the Waste Management Board, and the Department of General Services (General Services) provided to state agencies and what steps state agencies took to learn about proper e-waste disposal. Staff members at the five state agencies we reviewed—including those in charge of e-waste disposal, recycling coordinators, and property survey board members who approve e-waste disposal—stated that they had received no information from Toxic Substances Control, the Waste Management Board, or General Services related to the recycling or disposal of e-waste.

Further, based on our review of these three oversight agencies, it appears they have not issued instructions specifically aimed at state agencies describing the process they must follow when disposing of their e-waste. At most, we saw evidence that General Services and the Waste Management Board collaborated to issue guidelines in 2003. These guidelines state: "For all damaged or nonworking electronic equipment, find a recycler who can handle that type of equipment." However, the Waste Management Board indicated that state agencies are not required to adhere to these guidelines; General Services deferred to the Waste Management Board's opinion.

Alternatively, some state agencies we spoke with learned about e-waste requirements through their own research. For example, the recycling coordinator at Justice conducted her own on-line research to identify legally acceptable methods for disposing of e-waste. Through her research of various Web sites at the federal, state, and local government levels, she determined which electronic devices Justice would manage as e-waste and located e-waste collectors who would pick up or allow Justice to drop off its e-waste at no charge.

While Justice's initiative is laudable, we believe that it is neither effective nor efficient to expect staff at all state agencies to identify e-waste requirements on their own. Some state agencies may not be aware that it is illegal to discard certain types of electronic devices in the trash, and it may never occur to them to perform such research before throwing these devices away. Further, having staff at each of the more than 200 state agencies perform the same type of research is duplicative.

The State could use any of at least five approaches to convey to state agencies more efficiently and effectively the agencies' e-waste management responsibilities. One approach would be to have Toxic Substances Control, the Waste Management Board, or General Services, either alone or in collaboration with one or more of the others, directly contact by mail, e-mail, or other method the director or other appropriate official, such as the recycling coordinator or chief information officer, at each state agency conveying how each agency should dispose of its e-waste. Other approaches include:

- Having the Waste Management Board implement a recycling program for electronic devices owned by state agencies.
- Including e-waste as part of the training related to recycling provided by the Waste Management Board.
- Having General Services, Toxic Substances Control, and the Waste Management Board work together to amend applicable sections of the State Administrative Manual that pertain to recycling to specifically include electronic devices.
- Modifying an existing executive order or issuing a new one related to e-waste recycling that incorporates requirements aimed at e-waste disposal.

To help state agencies' efforts to prevent their e-waste from entering landfills, we recommended that Toxic Substances Control, the Waste Management Board, and General Services work together to identify and implement methods that will communicate clearly to state agencies their responsibilities for handling and disposing of e-waste properly and that will inform the agencies about the resources available to assist them.

State Agencies' Actions: Pending.

The three oversight agencies included in our audit concurred with our recommendation and agreed to work collaboratively with each other to implement solutions for ensuring that e-waste from state agencies is managed legally and safely. Further, General Services stated that after consulting with other entities, it will amend applicable sections of the State Administrative Manual to ensure that they clearly require the recycling or disposal of e-waste in accordance with applicable laws, regulations, and policies.

Finding #3: State agencies report inconsistently their data on e-waste diverted from municipal landfills.

Most of the five state agencies in our sample reported diverting e-waste from municipal landfills. Waste diversion includes activities such as source reduction or recycling waste. In 1999 the State enacted legislation requiring state agencies to divert at least 50 percent of their solid waste from landfill disposal by January 1, 2004. State agencies annually describe their status on meeting this goal by submitting reports indicating the tons of various types of waste diverted. A component of the report pertains specifically to e-waste. Between 2004 and 2007, four of the five state agencies in our sample reported diverting a combined total of more than 250 tons of e-waste. The fifth state agency, Caltrans, explained that it reported its e-waste diversion statistics in other categories of its reports that were not specific to e-waste.

Several factors cause us to have concerns about the reliability and accuracy of the amounts that these state agencies reported as diverted e-waste. First, these state agencies were not always consistent in the way they calculated the amount of e-waste to report or in the way they reported it. For example, Employment Development's amount for 2007 include data only from its Northern California warehouse; the amount did not include information from its Southern California warehouse. Also for 2007, the CHP included its diverted e-waste in other categories, while Caltrans did so for all years reported. Further, although instructions call for reporting quantities in tons, for 2007 Justice reported 3,951 e-waste items diverted. Moreover, diversion of e-waste does not count toward compliance with

the solid waste diversion mandate, so state agencies may not include it. The Waste Management Board explained that e-waste is not solid waste, and thus state agencies are not required to report how much they divert from municipal landfills.

The Waste Management Board also allows state agencies to use various methods to calculate the amounts that they report as diverted. For instance, rather than conduct on-site disposal and waste reduction audits to assess waste management practices at every facility, a state agency can estimate its diversion amounts from various sampling methods approved by the Waste Management Board.

If the Legislature believes that state agencies should track more accurately the amounts of e-waste they generate, recycle, and discard, we recommended it consider imposing a requirement that agencies do so.

Legislative Action: Unknown.

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

Finding #4: State agencies' compliance with e-waste requirements receives infrequent assessments that are simply components of other reviews.

A state agency's decision regarding how to dispose of e-waste is subject to review by local entities, such as cities and counties, as well as by General Services. We found that the Sacramento County program agency and General Services perform reviews infrequently, and these reviews may not always identify instances in which state agencies have disposed of e-waste improperly.

Local agencies certified by the California Environmental Protection Agency are given responsibility under state law to implement and enforce the State's hazardous waste laws and regulations, which include requirements pertaining to universal waste. These local agencies, referred to as program agencies, perform periodic inspections of hazardous waste generators. The inspections performed by the program agency for Sacramento County are infrequent and may fail to include certain state agencies that generate e-waste. According to this program agency, which has the responsibility to inspect state agencies within its jurisdiction, its policy is to inspect hazardous waste generators once every three years. For the five state agencies in our sample, we asked the Sacramento County program agency to provide us with the inspection reports that it completed under its hazardous waste generator program. The inspection reports we received were dated between 2005 and 2008. We focused on the hazardous waste generator program because Sacramento County's inspectors evaluate a generator's compliance with the State's universal waste requirements under this program (universal waste is a subset of hazardous waste, and it may include e-waste). In its response to our request, the Sacramento County program agency provided seven inspection reports that covered four of the five state agencies in our sample. The Sacramento County program agency provided three inspection reports for Caltrans, one report for Justice, one for the CHP, and two inspection reports for Motor Vehicles. The program agency did not provide us with an inspection report for Employment Development, indicating that this department is not being regulated under the program agency's hazardous waste generator program. The Sacramento County program agency explained that it targets its inspections specifically toward hazardous waste generators and not generators that have universal waste only, although the program agency will inspect for violations related to universal waste during its inspections. As a result, the Sacramento County program agency may never inspect Employment Development if it generates only universal waste.

The State Administrative Manual establishes a state policy requiring state agencies to obtain General Services' approval before disposing of any state-owned surplus property, which could include obsolete or broken electronic devices. In addition to reviewing and approving these disposal requests, General Services periodically audits state agencies to ensure they are complying with the State Administrative Manual and other requirements. General Services' reviews of state agencies are infrequent and it is unclear whether these reviews would identify state agencies that have inappropriately disposed of their e-waste. According to its audit plan for January 2007 through June 2008, General Services conducts "external compliance audits" of other state agencies to determine whether they comply with requirements that are under the purview of certain divisions or offices within General Services.

One such office is General Services' Office of Surplus Property and Reutilization, which reviews and approves the property survey reports that state agencies must submit before disposing of surplus property. According to its audit plan, General Services' auditors perform reviews to assess whether state agencies completed these reports properly and disposed of the surplus equipment promptly. General Services' audit plan indicates that it audited each of the five state agencies in our sample between 1999 through 2004, and that it plans to perform another review of these agencies within the next seven to eight years.

When General Services does perform its reviews, it is unclear whether General Services would identify instances in which state agencies improperly discarded e-waste by placing it in the trash. General Services' auditors focus on whether state agencies properly complete the property survey reports and not on how the agencies actually dispose of the surplus property. For example, according to its audit procedures, General Services' auditors will review property survey reports to ensure that they contain the proper signatures and that the state agencies disposed of the property "without unreasonable delay." After the end of our fieldwork, General Services revised its audit procedures to ensure that its auditors evaluate how state agencies are disposing of their e-waste. General Services provided us with its final revised audit guide and survey demonstrating that its auditors will now "verify that disposal of e-waste is [sent] to a local recycler/salvage company and not sent to a landfill."

If the Legislature believes that more targeted, frequent, or extensive oversight related to state agencies' recycling and disposal of e-waste is necessary, we recommended that the Legislature consider assigning this responsibility to a specific agency.

Legislative Action: Unknown.

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

Finding #5: Some state agencies use best practices to manage e-waste.

During our review we identified some state agencies that engage in activities that we consider best practices for managing e-waste. These practices went beyond the requirements found in state law and regulations, and they appeared to help ensure that e-waste does not end up in landfills. One best practice we observed was Justice's establishment of very thorough duty requirements for its recycling coordinator. These requirements provide clear guidelines and expectations, listing such duties as providing advice and direction to various managers about recycling requirements, legal mandates, goals, and objectives. The duties also include providing training to department staff regarding their duties and responsibilities as they pertain to recycling. In addition, the recycling coordinator maintains current knowledge of recycling laws and works with the Waste Management Board and other external agencies in meeting state and departmental recycling goals and objectives. Three of the remaining four state agencies in our sample did not have detailed duty statements specifically for their recycling coordinators. These three state agencies—the CHP, Motor Vehicles, and Employment Development—briefly addressed recycling coordination in the duty statement for the respective individual's position. Caltrans, the remaining state agency in our sample, indicated that it did not have a duty statement for its recycling coordinator. The creation of a detailed duty statement similar to the one used by Justice would help state agencies ensure that they comply with mandated recycling requirements, that they maintain and distribute up-to-date information, and that agencies continue to divert e-waste from municipal landfills.

A second best practice we noted was state agencies' use of recycling vendors from General Services' master services agreement. General Services established this agreement to provide state agencies with the opportunity to obtain competitive prices from prequalified contractors that have the expertise to handle their e-waste. For a contractor to be listed on General Services' master services agreement, it must possess three years of experience in providing recycling services to universal waste generators, be registered with Toxic Substances Control as a hazardous waste handler, and ensure that all activities resulting in the disposition of e-waste are consistent with the Electronic Waste Recycling Act of 2003.

The master services agreement also lists recycling vendors by geographic region, allowing state agencies to select vendors that will cover their area. Many recycling vendors under the agreement offer to pick up e-waste at no cost, although most require that state agencies meet minimum weight requirements. Based on a review of their property survey reports, we saw evidence that the CHP, Caltrans, Justice, and Employment Development all used vendors from this agreement to recycle some of their e-waste.

We recommended that state agencies consider implementing the two best practices we identified.

State Agencies' Actions: Pending.

Regarding a thorough duty statement for a recycling coordinator, as we mentioned in our audit report, Justice already follows this best practice. In their responses to our audit report, Motor Vehicles, Caltrans, and Employment Development stated that they would take steps to implement this best practice; CHP thanked us for suggesting it.

Regarding the use of recyclers from the master services agreement, we noted in our audit report that CHP, Caltrans, Justice, and Employment Development all used vendors from the master services agreement. Motor Vehicles stated that in the future, its property and equipment control unit will make an effort to use the master services agreement when disposing of obsolete equipment and that its asset management section will adopt the recommendation and develop guidelines on the use of the master services agreement. Motor Vehicles stated that the guidelines will be disseminated to all divisions by February 2009.

Nonprofit Hospitals

Inconsistent Data Obscure the Economic Value of Their Benefit to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status

REPORT NUMBER 2007-107, DECEMBER 2007

Board of Equalization's, Franchise Tax Board's, and Office of Statewide Health Planning and Development's responses as of December 2008

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to conduct an audit to ascertain whether the activities performed by hospitals that are exempt from paying taxes because of their nonprofit status truly qualify as allowable activities consistent with their exempt purpose. Specifically, the audit committee requested that we determine the roles of the entities involved in determining tax exemptions and the extent of oversight they exercise over nonprofit hospitals to ensure that they comply with requirements for tax exemption and community benefit reporting. It also asked us to examine the financial reports and any community benefit documents prepared during the last five years by a sample of both nonprofit hospitals and hospitals that operate on a for-profit basis and determine the value and type of community benefits and uncompensated care provided. In addition, the audit committee asked us to compare the community benefits provided by nonprofit and for-profit hospitals, and compare the types of care that both types of hospitals provide without receiving compensation (uncompensated care). Further, the audit committee asked us to review the financial information and the claims submitted to the State Board of Equalization (Equalization) or other agencies by nonprofit hospitals to determine whether they meet income requirements to qualify for tax-exempt status and to assess how tax-exempt nonprofit hospitals use excess income, to ensure that the uses are permissible and reasonable in terms of expansion of plant and facilities, additions to operating reserve, and the timing of debt retirement. The audit committee also asked us to determine the most current estimated total annual value of the taxation exemptions of both state corporation income taxes (income taxes) and local property taxes for nonprofit hospitals.

Finally, the audit committee asked us to determine whether the community benefits and uncompensated care provided by nonprofit hospitals meet the requirements for exemption from local property and state income tax. However, although state law outlines the requirements a nonprofit hospital must meet to receive an exemption from paying taxes, it does not specify community benefits and uncompensated-care costs as requirements. Additionally, although state law requires most tax-exempt hospitals to annually submit to the Office of Statewide Health Planning and Development (Health Planning) a community benefits plan (plan), which may include an uncompensated-care element, the law also clearly states that the information included in the plan a nonprofit hospital submits cannot be used to justify its tax-exempt status.

Audit Highlights . . .

Our review of tax-exempt hospitals revealed the following:

- *About 223 of California's 344 hospitals are eligible for income and property tax exemptions because they are organized and operated for nonprofit purposes.*
- *Comparing financial data reported by nonprofit and for-profit hospitals indicated the uncompensated care provided by the two types of hospitals was not significantly different.*
- *Benefits provided to the community, which only nonprofit hospitals are required to report, differentiate nonprofit hospitals from for-profit hospitals, but the categories of services and the associated economic value are not consistently reported among nonprofit hospitals.*
- *The values of tax-exempt buildings and contents owned by nonprofit hospitals are frequently misreported by county assessors.*
- *Lacking more reliable data, we used the reported economic values of community benefits and tax-exempt property to estimate that reported community benefits of $656 million for 2005 were roughly 2.7 times the estimated $242 million in state corporation income taxes and property taxes not collected from nonprofit hospitals.*
- *The Franchise Tax Board, which administers state income tax exemptions, could better use available tools, such as annual filings and audits, to monitor the continuing eligibility of nonprofit hospitals for their tax exemption.*

Finding #1: Lack of specific guidance regarding the content of community benefit plans precludes any meaningful comparison of the plans.

Although state law requires that tax-exempt hospitals submit plans to Health Planning, it does not require Health Planning to review the plans to ensure that hospitals report the same types of data consistently, nor does Health Planning do so. Further, the law provides only limited guidance regarding the content of the plan and does not mandate a uniform reporting standard. Thus, in reviewing the plans that eight tax-exempt hospitals submitted from 2002 through 2006, we found significant variations in the plans that precluded us from performing any meaningful comparison of the economic values the hospitals reported. Although the guidance provided in the law does not require uniform reporting, two hospital associations offer hospitals some guidelines. Additionally, the Internal Revenue Services (IRS) is proposing a new schedule for hospitals to prepare to be included with the informational return that all income-tax-exempt organizations must file. If adopted, the IRS anticipates using the new schedule for the 2008 tax year. The new schedule will require tax-exempt hospitals to report their community benefits and uncompensated-care costs and could influence hospitals to pattern their plans after the schedule's methodologies and format.

We recommended that if the Legislature expects plans to contain comparable and consistent data, it consider enacting statutory requirements that prescribe a mandatory format and methodology for tax-exempt nonprofit hospitals to follow when presenting community benefits in their plans. We also recommended that if the Legislature intends that the exemptions from income and property taxes granted to nonprofit hospitals should be based on hospitals providing a certain level of community benefits, it consider amending state law to include such requirements.

Legislative Action: Legislation proposed.

Assembly Bill 2942 was introduced to require a standardized format and methodology to be used when presenting community benefit information. The bill did not pass during the 2007—08 Regular Session.

Finding #2: Errors in reported property values reduce the reliability of estimated property taxes not paid by tax-exempt hospitals.

We attempted to estimate the amount of property taxes not collected from tax-exempt hospitals, using the values of the buildings and contents owned by tax-exempt hospitals that county assessors submitted on statistical reports to Equalization. Although we found numerous errors in the values that prevented us from ensuring the reliability of our calculation, this methodology resulted in an estimated $184 million in uncollected property taxes in 2005. More specifically, we found errors in the reported values for four of the 12 hospitals we reviewed, representing a total error of about $204 million. The errors for the remaining 211 nonprofit hospitals in the State that are eligible for tax exemption are unknown. Equalization performs surveys of county assessors to determine the adequacy of the procedures and practices they apply in valuing property for the purpose of taxation and for administering property tax exemptions.

To ensure that it provides accurate information regarding the value that is tax exempt, we recommended that Equalization consider including in its surveys of the county tax assessors a process for verifying the accuracy of the values reported on the annual statistical reports submitted by the county assessors.

Equalization's Action: Corrective action taken.

Equalization indicated that its survey of county assessors now includes a review of the exemption values contained in the county assessors' annual statistical reports. It also stated that it uses a survey review worksheet to examine individual exemption claim records for proper classification by the county assessors and to ask questions of assessors personnel on their practices and procedures. Finally, Equalization issued a letter to all county assessors informing them of our finding and that it was incorporating these verification steps into its survey of the county assessors.

Finding #3: Recent legislation affects the Franchise Tax Board's responsibilities for granting income tax exemptions.

We found minor weaknesses in the process the Franchise Tax Board (tax board) used in the past to determine the eligibility of nonprofit hospitals for state income tax exemptions. However, legislation effective January 1, 2008, will allow the tax board to rely on the federal income tax exemptions determined by the IRS. Although it was unable to obtain IRS reports and other information on the federal review process and thus could not gain a full understanding of the method the IRS uses to determine eligibility for tax exemptions, the tax board contended that its research of the IRS web site, publications, and tax law enabled it to conclude that the IRS process is sufficient to ensure proper determination of state exemption status. The tax board also stated that because state and federal laws on tax exemption are essentially identical, the additional audits it plans to perform—made possible by the workload reduction resulting from its use of IRS eligibility determinations—will compensate for any differences in quality between the state and federal review processes. The tax board indicated, however, that until it identifies the actual savings in workload that may occur when the new law is implemented, it cannot evaluate the opportunities for performing audits of nonprofit hospitals or plan for the number or frequency of such audits.

We recommended that, after it identifies the staff resources that are no longer required for reviewing tax exemption applications, the tax board implement its plan to use those resources for performing audits of tax-exempt entities, including hospitals.

Tax Board's Action: Corrective action taken.

The tax board indicated that it has begun to realize staff resource savings from the new exemption application process and is redirecting those resources to perform compliance audits. The tax board also reported that for calendar year 2008 to date, it opened 55 audits and completed 24 compared to this same time last year, when it opened 10 audits and completed four.

Finding #4: The tax board has limited assurance that nonprofit hospitals remain eligible for state income tax exemptions.

The tax board does not use the tools available to it, such as annual filings and audits, to monitor the continuing eligibility of nonprofit hospitals for income tax exemption. According to management staff at the tax board, annual filings, which contain information such as financial data and changes in business activities, offer the tax board's Exempt Organizations Unit (unit) a useful tool for reviewing ongoing compliance with the requirements for maintaining tax-exempt status. However, the unit does not review the information in the annual filings. Management at the tax board stated that the large volume of initial applications for income tax exemptions and limited personnel prevent unit staff from reviewing the annual filings. In the absence of monitoring by the tax board, hospitals exempt from income taxes sometimes submit annual filings that do not contain all the information required by the form or its instructions or information required under the California Code of Regulations (regulations).

Regular auditing is another tool the tax board could use to monitor the tax-exempt status of nonprofit hospitals. However, the tax board does not regularly conduct audits of tax-exempt hospitals, even though, based on data provided by the tax board, the revenues of these hospitals represent 17 percent of the total revenue of all tax-exempt organizations. According to the tax board, an audit can originate when members of the public express concern that a tax-exempt organization may be functioning in a manner requiring revocation of its tax-exempt status. The tax board indicated, however, that it could not identify any complaints that might have prompted audits of tax-exempt hospitals, because it does not maintain a central record of the receipt or disposition of those complaints. Rather, complaints against tax-exempt organizations are stored in the tax board's files and cannot be easily retrieved.

The tax board stated that the revenue information from annual filings entered into its automated record-keeping system could be used to identify income-tax-exempt nonprofit hospitals to be considered for audit. However, because the tax board has not ensured that all tax-exempt nonprofit

hospitals are distinctly identified in its electronic data system, it is unable to efficiently generate a list of the hospitals that might require audits. According to the tax board, creating such a list would necessitate manually reviewing the hard-copy files of the approximately 72,000 tax-exempt organizations operating in the State to determine which are tax-exempt hospitals.

Finally, the tax board told us that the IRS expects to perform an audit within three to five years after each organization receives a federal tax exemption, and it would notify the tax board of any revocations. However, the tax board does not currently coordinate with the IRS to identify audits of California tax-exempt hospitals in a manner that would allow the tax board to adequately rely on IRS audits for assurance of continuing eligibility.

We recommended that the tax board consider developing methodologies to monitor nonprofit hospitals' continuing eligibility for income tax exemption. These methodologies should include the following activities:

- Review the financial and other information from the annual filing submitted by hospitals exempt from income taxes.
- Ensure that the annual filing contains all the information the tax board's regulations specify as necessary for determining eligibility for an income tax exemption.
- Track complaints in a manner that enable the tax board to identify potential trends in noncompliance by income-tax-exempt hospitals and initiate audits of those hospitals.
- Adequately identify tax-exempt hospitals in its automated database, enabling it to use the information in the database to profile those hospitals and identify any potential noncompliance with the law.

The tax board should also gain an understanding of the frequency and depth of IRS audits of tax-exempt hospitals to identify the extent to which it can rely on IRS audits and factor that reliance into its monitoring efforts.

Tax Board's Action: Partial corrective action taken.

The tax board stated that it is developing an audit program to review the annual filings from the hospitals to gain a better understanding of compliance issues and materiality thresholds for ongoing reviews. In addition, the tax board indicated that it is finalizing business requirements for enhancements to its case management system that will provide data collection, modeling, and audit selection capabilities. It plans to implement these enhancements in November 2009. The tax board also reported that it has implemented a new procedure to log all complaints into a computer database that documents the organization name, type, issue, and action taken. Additionally, the tax board stated that it has updated the codes in its business entities accounting system to separately identify tax-exempt hospitals from other types of charitable organizations. Finally, the tax board indicated that a Memorandum of Understanding with the IRS was signed September 2008, authorizing the tax board to receive federal information about exempt organizations including proposed and final revocations, audit adjustments, and reports.

Indian Gaming Special Distribution Fund

Local Governments Do Not Always Use It to Mitigate the Impacts of Casinos, and Its Viability Will Be Adversely Affected by Compact Amendments

REPORT NUMBER 2006-036, JULY 2007

California Gambling Control Commission's and Six County Indian Gaming Local Community Benefit Committees' responses as of September 2008

California Government Code, Section 12717, requires the Bureau of State Audits to conduct an audit every three years regarding the allocation and uses of moneys from the Indian Gaming Special Distribution Fund (distribution fund) by the recipients of the grant money and report its findings to the Legislature and all other appropriate entities. We evaluated the use and administration of distribution fund grants at six counties: Fresno, Placer, Riverside, San Bernardino, San Diego, and Sonoma.

We also compared fiscal year 2005–06 distribution fund contributions to estimated future contributions based on changes in compact provisions in new and amended pending compacts to determine the ability of the distribution fund to continue to fund the programs that depend on it. We then compared estimated contributions to current year expenditures from the distribution fund. Because we are unable to project how fast casinos will expand or forecast the changes to their profitability, we made a conservative estimate based on fiscal year 2005–06 gaming device counts and net win figures.

Finding #1: Local governments did not always use the distribution fund to pay for mitigation projects.

The legislation establishing the distribution fund declares the intent of the Legislature that tribal governments participate in identifying and funding mitigation of the impacts of tribal gaming through the grant process. The legislation also states that the grants are for distribution to local governments impacted by casinos. Finally, the senate floor analysis describes the legislation creating the distribution fund and grant process as establishing "priorities and procedures . . . for the purpose of mitigating impacts from tribal casinos." However, the legislation does not establish a clear requirement that the grants be used only for projects that actually mitigate the impacts from tribal casinos in all instances.

Based on our review of 30 grants, we determined that often a distribution fund grant financed a project that had the potential of offsetting the repercussions of a casino but was mainly used for activities that benefited the county as a whole. In 10 instances, the goods and services purchased with grant money had the potential for use in mitigating casinos' impact, should the need arise. However the main beneficiaries were the counties as a whole. Even though the potential exists that some of the goods or services acquired with these grant funds could be used to mitigate the impact of a casino, it is unclear whether the Legislature intended distribution fund grants to be used in

Audit Highlights . . .

Our review of the allocation and uses of the Indian Gaming Special Distribution Fund (distribution fund) money revealed the following:

- *Local governments did not always use distribution fund money to mitigate casino impacts.*
- *The allocation of distribution fund money in some counties is based, in part, on the number of devices operated by tribes that did not pay into the fund because their compacts require them to negotiate directly with the county to pay for the mitigation of casino impacts. However, these counties continue to receive distribution fund dollars from the State.*
- *In many instances local governments do not use interest earned on unspent distribution fund money for projects related to casino impacts.*
- *Although all benefit committee members are required to file statements of economic interests, in our sample counties, 11 of the 13 tribal members that were required to file failed to do so.*
- *The ratification of compacts in June 2007, along with one that is awaiting ratification, may threaten the future viability of the distribution fund and the programs that depend on it, as they eliminate $92 million in payments to the fund beginning in fiscal year 2007–08. While we estimate that contributions to the State's General Fund would also total at least $174 million, almost $40 million per year could be required to pay for the estimated shortfall in the Revenue Sharing Trust Fund.*

this manner. In other cases grant funds were used for projects totally unrelated to casinos. Specifically, in five instances the money was not used to offset the adverse effects of casinos. Although these and other purchases may be beneficial to the counties, when a distribution fund grant is used for purposes that have little or no relationship to a casino impact, the problems the community experiences because of a casino may not be adequately addressed. The remaining 15 grants we reviewed were used specifically to alleviate casino impacts.

We recommended that the California Gambling Control Commission (gambling commission) seek legislative changes to amend the government code to provide direction to local governments to ensure that they use distribution fund grants only to purchase goods and services that directly mitigate the adverse impacts of casinos on local governments and their citizens.

We also recommended that benefit committees require local governments to submit supporting documentation that clearly demonstrates how proposed projects will mitigate the effects of casinos.

Legislative Action: Legislation enacted.

Chapter 754, Statutes of 2008, amended the California Government Code to, among other things, require benefit committees to select only grant applications that mitigate impacts from casinos on local jurisdictions, and cause any grant for expenditures not related to Indian Gaming to terminate immediately and any money not yet spent to revert to the distribution fund. Chapter 754 also provided $30 million in funding from the distribution fund for grants to local government agencies.

Fresno County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that it adopted new policies and procedures on November 30, 2007, that include codifying more comprehensive descriptions and procedures for the management of funds and for their award and distribution.

Placer County Indian Gaming Benefit Committee's Action: None.

➲ Placer County officials ignored our request to provide 60-day, six-month, and one-year responses to the audit.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee stated that through the application process, applicants must fully describe the casino or gaming impact they propose to mitigate and fully describe how they will use grant funds to mitigate the impact. The benefit committee also stated that, in response to our recommendation, during the next grant award cycle, benefit committee staff will review applications and provide an assessment to the committee on each application's apparent relevance to casino and gaming impacts.

San Bernardino County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that its current grant application process includes the requirement that proposed projects from the grant application contain detailed project descriptions and supporting documentation that clearly demonstrates how proposed projects will mitigate the effects of casinos.

San Diego County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee stated that, since fiscal year 2003–04, its grant application form requires applicants to include a discussion of the impacts on their jurisdiction associated with the particular casino(s) and how the project would be funded. Additionally, the benefit committee stated that, beginning in fiscal year 2006–07, applicants were also required to present their projects at a public meeting so the committee could ask questions about them. The benefit committee also indicated that for the next cycle of grants, the application form would be amended to add a requirement that, if a project proposes in part to mitigate impacts unrelated to casinos, funding for the portion of the project unrelated to the casinos must be found from another source. Finally, applicants will be reminded to fully describe the impacts on their jurisdiction from tribal casinos and explain how their project will mitigate those impacts.

Sonoma County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its 60-day response, the benefit committee stated that it has adopted an application form that requires grant applicants to describe how requested funds will be used to offset the impacts of tribal gaming. The application form requires applicants to provide a complete project description, describe impacts on their jurisdiction associated with the casino and include any data to support the request, and explain how the project will mitigate the impacts.

Finding #2: Compacts ratified since 1999 require tribes to directly fund efforts to mitigate casinos' impacts, but local governments continue to receive distribution fund money.

Post-1999 compacts require tribes to negotiate directly with local governments to pay for local mitigation projects in lieu of paying into the distribution fund. However, based on the allocation methodology established in state law in 2004, two counties where casinos under post-1999 compacts are located received roughly $850,000 in distribution fund money in fiscal year 2005–06. Local governments in those counties received money for projects that, in accordance with the post-1999 compacts, should have been funded directly by the tribes. Consequently, less distribution fund grant money is available to other counties where tribes are not required to provide funding directly to local governments.

We recommended that the gambling commission seek changes to legislation to revise the allocation methodology outlined in the government code so that the allocation to counties is based only on the number of devices operated by tribes that do not negotiate directly with local governments to mitigate casino impacts.

Gambling Commission's Action: None.

The gambling commission states that because it does not have any oversight role related to local mitigation grants and its existing role is purely technical, it declines to seek the recommended legislative changes.

However, our recommendation did not address the gambling commission's oversight role related to local mitigation grants. Rather, it asked the gambling commission to seek a legislative change to the allocation methodology outlined in the California Government Code so that counties that were negotiating directly with Indian tribes to pay for local mitigation projects no longer receive grant funds from the distribution fund because these tribes are not contributing any money to the fund.

Finding #3: Interest that local governments earned on unspent distribution fund money has not always gone toward mitigation projects.

Some local governments have earned interest on distribution funds until the funds are needed for an intended project. In many instances, large amounts of grant money remained unspent for more than a year, and the local governments indicated to us that the interest earned was not always allocated back to the original project or used for similar future projects. In fact, several local governments we spoke to used the interest to pay for general county operational costs. In some cases local governments did not even earn interest, instead depositing the grant funds in accounts that generate no interest.

Our legal counsel advised us that although the law does not specifically require a local government to allocate interest earned on unspent funds to original or future mitigation projects, the government code section cited by local governments states that earned interest may be deposited in their general funds unless otherwise specified by law. The purposes for which distribution fund money may be spent are set forth in the compacts and state law. Accordingly, our counsel advised us that the interest on distribution fund money is subject to the common law rule that unless it is separated by statute from the principal, the interest should be used for the originally intended purpose. Thus, we believe the interest should be used to support mitigation projects. However, several local governments asserted that the government code grants them authority to use interest earned for general purposes. Further, local officials indicated

that a significant number of grants were maintained in accounts that earned no interest. Because the interest on distribution fund money is subject to the common law rule that unless it is separated by statute from the principal, the interest should be used for the originally intended purpose, we believe the interest should be used to support mitigation projects.

We recommended that the gambling commission seek changes to legislation to amend the government code to require that all funds be deposited into interest-bearing accounts, and that any interest earned is used on projects to mitigate casino impacts.

Further, we recommended that benefit committees ensure that local governments spend the interest earned on project funds only on the projects for which the grants were awarded or return the money to the county for allocation to future mitigation projects.

Legislative Action: Legislation enacted.

Chapter 754, Statutes of 2008, amended the California Government Code to require a local government jurisdiction that receives a local mitigation grant to deposit all funds received in an interest-bearing account and use the interest from those funds only for the purpose of mitigating an impact from a casino.

Placer County Indian Gaming Benefit Committee's Action: None.

➔ Placer County officials ignored our request to provide 60-day, six-month, and one-year responses to the audit.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee stated that it sent letters to all mitigation grant recipients clarifying the need to maintain mitigation grant funds in interest-bearing accounts and use the interest earned for casino/gaming mitigation measures.

San Bernardino County Indian Gaming Benefit Committee's Action: Corrective action taken.

San Bernardino County states that it has changed contract language to ensure that interest earned on distribution funds for long-term projects will remain with the project. Material amounts of grant money for long-term projects that remain unspent will be required to be deposited into an interest-bearing account. All interest earned will be allocated back to the original project or used for future mitigation projects.

San Diego County Indian Gaming Benefit Committee's Action: Pending.

In its six-month response, San Diego County officials stated that in the next cycle of grants, the benefit committee would be asked to include a directive to applicants, if state law allows their jurisdictions to do so, to either spend the interest earned on projects that mitigate impacts of tribal casinos or return the money to the county for allocation to future mitigation projects.

Sonoma County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its 60-day response, the benefit committee stated that if state law is amended to require interest earned on unspent grant funds to be used only for mitigation purposes, it will notify all grant recipients of this requirement. As stated above, legislation has since been enacted that requires a local government jurisdiction that receives a local mitigation grant to deposit all funds received in an interest-bearing account and use the interest from those funds only for the purpose of mitigating an impact from a casino.

Finding #4: Grant allocations have generally been properly calculated, but some local governments were not awarded the amounts they were allocated through the Nexus test.

State law requires a county receiving distribution fund money to allocate a portion of its funding to local governments based on the Nexus test criteria described in the text box. In Riverside County, we identified two instances where the Nexus test criteria were not consistently applied. County officials agreed with our assessment and stated that the county would revise its application of the Nexus criteria. Further, Riverside County did not even adhere to its inaccurate Nexus test calculation. We identified several instances where cities in Riverside County were awarded less money than they should have been allocated under the Nexus test.

Nexus Test Criteria

1. The local government jurisdiction borders Indian lands on all sides.
2. The local government partially borders Indian land.
3. The local government maintains the highway, road, or predominant access route to a casino within four miles.
4. All or a portion of the local government is located within four miles of a casino.

We recommended that benefit committees correct the inconsistent application of Nexus test criteria and ensure that local governments receive at least the minimum amounts they are allocated under the government code requirements.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the Riverside County benefit committee stated that it has updated the table identifying the percentages for which local government jurisdictions are eligible for 60 percent nexus grants. Additionally, the benefit committee stated that in an effort to ensure that local governments receive at least the minimum amounts they are allocated under the California Government Code requirements, the 60 percent nexus category of individual tribal casino account balances would be applied to the corrected percentages.

Finding #5: Some grantees were not eligible for funding.

Although state law defines the intended recipients of distribution fund money—cities, counties, and special districts—some benefit committees provided grant money to ineligible entities. In two cases benefit committees awarded grants to school districts, which state law specifically excludes from the definition of special districts. Because the Legislature has identified specific entities and purposes for distribution fund grant money, counties must ensure that they follow the statutory requirements.

We recommended that benefit committees grant distribution fund money only to eligible entities.

Legislative Action: Legislation enacted.

Chapter 754, Statutes of 2008, amended Section 12712 of the California Government Code to specifically exclude city and county school districts and community college districts from the definition of "special district."

Fresno County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that it adopted new policies and procedures on November 30, 2007, that include codifying more comprehensive descriptions and procedures for the management of funds and for their award and distribution.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee provided a listing of the special districts that are eligible to receive distribution grant money. The listing provided did not include any school districts.

Finding #6: Some benefit committee members fail to meet disclosure requirements.

The Political Reform Act of 1974 (political reform act) requires state and local officials and employees with decision-making authority to file statements of economic interests annually and on assuming or leaving a designated position. These statements are intended to identify conflicts of interest that an individual might have. However, the counties we visited could not provide 11 of the 13 statements of economic interests for tribal representatives on the benefit committees for fiscal year 2005–06.

Three of the six counties we visited informed us that the tribal members of their respective benefit committees asserted that they are exempt from the requirements to submit statements. However, the California Fair Political Practices Commission has issued an advice letter regarding this issue stating that any individual serving in a capacity as a member of a public agency, including tribal members of benefit committees, are subject to the provisions of the political reform act. The remaining three counties indicated that they do not know the reasons tribal members did not file the required statements. When designated individuals do not file statements of economic interests, benefit committees may be unaware of conflicts of interest. Further, the benefit committees cannot ensure that members are aware that they should remove themselves from making decisions that may pose conflicts of interest.

We recommend that benefit committees ensure that all benefit committee members follow the political reform act and file the required statements of economic interests, and inform the appropriate agency if they fail to do so.

Fresno County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that it adopted a conflict of interest policy on January 4, 2008, and statements of economic interests have been received from all members.

Placer County Indian Gaming Benefit Committee's Action: None.

➔ Placer County officials ignored our request to provide 60-day, six-month, and one-year responses to the audit.

Riverside County Indian Gaming Benefit Committee's Action: Pending.

In its six-month response, the benefit committee stated that the county is working with tribal members and anticipated resolution of the issue by October 2007.

Riverside County Officials did not provide a one-year response to the audit.

San Bernardino County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that it will continue to inform members of the requirement to file their statements at intervals before and after the deadline, and will notify the appropriate state agency if they do not file within two weeks of the deadline.

San Diego County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee stated that it will remind benefit committee members to submit required statements and will inform the State of any failure by a benefit committee member to do so.

Sonoma County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its 60-day response, the benefit committee stated that it would continue to ask all members to submit required statements of economic interests and will inform the appropriate state agency if they fail to do so.

Finding #7: Many counties did not properly report their use of distribution fund money.

State law requires each county that receives distribution fund grants to submit an annual report by October 1 detailing, among other information, the specific projects funded by the grants and how current-year grant money has been or will be spent. Nevertheless, many counties fail to submit the reports to all required entities, including two of the six counties we visited. In fact, according to the gambling commission and various legislative committees, in 2006 only nine counties reported to all required entities, which include the gambling commission, the chairs of the Senate and Assembly committees on governmental organization, and the chair of the Joint Legislative Budget Committee. Furthermore, six of the 24 counties receiving funds did not report at all.

Additionally, our review found that at least one county did not include all required information in its most recent annual report. The law requires each county to submit an annual report on its current- and prior-year allocations and expenditures for distribution fund grants. However, in fiscal year 2005–06, Riverside County failed to report its current-year grant allocations and only provided expenditures of prior-year grants.

We recommended that benefit committees submit complete annual reports to all required legislative committees and the gambling commission.

Legislative Action: Legislation enacted.

Chapter 754, Statutes of 2008, amended the California Government Code to include language stating that any county that does not provide an annual report shall not be eligible for funding from the distribution fund for the following year.

Placer County Indian Gaming Benefit Committee's Action: None.

Placer County officials ignored our request to provide 60-day, six-month, and one-year responses to the audit.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the Riverside County benefit committee stated that it would provide all required information for grants funded in its annual report.

Sonoma County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its 60-day response, the Sonoma County benefit committee stated that it would submit annual reports to all required legislative committees and the gambling commission by the deadline specified in state statute.

Sonoma County officials declined our request to provide a six-month and one-year response to the audit.

Finding #8: New compact provisions will change the amount of revenues in the distribution and trust funds.

In June 2007 the Legislature ratified one new compact and four of five amendments to existing compacts—the fifth compact amendment was ratified after our audit. From a review of current operating information and compact terms, we estimated that the one new compact and five amendments (pending compacts) to existing compacts would significantly decrease revenues in the distribution fund and, to a lesser extent, increase Revenue Sharing Trust Fund (trust fund) revenues. We conservatively estimated that annual contributions to the trust fund from these compacts would increase by about $6.9 million, while annual contributions to the distribution fund would decrease by $92 million. If the revenue and expenditure levels estimated for fiscal year 2007–08 continue into the future, without additional resources the distribution fund will be unable to meet its obligations by fiscal year 2010–11, approximately four years from now. In addition to the impact on the distribution and

trust funds, we estimated that contributions to the State's General Fund from these compacts would total between $174.3 million and $175.1 million for fiscal year 2007–08. Further, as casino operations expand, General Fund revenues will increase.

Finding #9: Post-1999 and pending compacts and amendments provide revenues to the General Fund.

Between 2003 and 2006, the Legislature ratified five new compacts and amendments to eight others (post-1999 compacts), which provided $128 million in General Fund revenue in fiscal year 2005–06. However, that figure will increase because several casinos operating under post-1999 compacts only recently began operations or will begin operations this year. Overall, we estimated that General Fund revenues for fiscal year 2007–08 from the post-1999 and pending compacts discussed above will total between $304 million and $313.5 million. These amounts represent between 4.3 percent and 4.5 percent of the $7 billion in revenue that Indian gaming in California generated during fiscal year 2004–05. Further, for fiscal year 2007–08, we estimated that trust fund and distribution fund revenue from tribal contributions will total $39.4 million and $47 million, respectively, representing 0.6 percent and 0.7 percent of total fiscal year 2004–05 gambling revenue, respectively.

Finding #10: General Fund revenues may be used for many purposes.

Future General Fund revenue contributions from Indian gaming may be used to help reduce the impact of the $92 million decrease in distribution fund revenue. However, without further clarification in the government code by the Legislature, it is unclear if compact provisions that redirect a portion of their General Fund revenue contributions to the trust fund if there is an insufficient amount in the trust fund to distribute $1.1 million to each eligible tribe take place before or after the government code requirement for the distribution fund to cover any such shortfalls in the trust fund. Furthermore, the General Fund contributions required by the compacts may also be obligated to repay a California Department of Transportation fund that made loans to the General Fund in prior fiscal years. As such, any increase in General Fund revenue from pending compacts may be obligated to repay the Transportation Congestion Relief Fund and thus would not be available for backfill distributions required by the trust fund or for other purposes.

California Highway Patrol

It Followed State Contracting Requirements Inconsistently, Exhibited Weaknesses in Its Conflict-of-Interest Guidelines, and Used a State Resource Imprudently

REPORT NUMBER 2007-111, JANUARY 2008

California Highway Patrol's and the Department of General Services' responses as of November 2008

The Joint Legislative Audit Committee (audit committee) directed the Bureau of State Audits to review the California Highway Patrol's (CHP) purchasing and contracting practices and its use of state resources. Specifically, the audit committee asked us to:

- Review the CHP contracts awarded since January 1, 2004, for helicopters, motorcycles, guns and accessory equipment, patrol car electronics, and counseling services to determine whether the CHP had complied with laws related to purchasing and whether the contracts were cost-beneficial and in the best interest of the State.
- Ascertain whether the State could cancel any noncompetitive purchasing agreements that were not compliant with laws or in the best interest of the State and repurchase goods using competitive bidding.
- Examine relevant internal audits and personnel policy or financial reviews to determine whether the CHP responded to the issues raised and took recommended corrective actions.
- Evaluate the CHP's contracts for specified goods and services and determine whether conflicts of interest existed.
- Identify the CHP's policies and practices for using state equipment, including aircraft, and determine whether the CHP complied with these policies and laws and whether its employees reimbursed the State for any personal use of state property.

Finding #1: The CHP and the Department of General Services (General Services) insufficiently justified awarding a $6.6 million handgun contract.

In early 2006 the CHP submitted documents to General Services to purchase more than 9,700 handguns of a particular make and model. By specifying a particular make and model, the CHP intended to make a sole-brand purchase, which required it to justify why only that make and model would fulfill its needs. However, the CHP did not fully justify the sole-brand purchase. For example, the CHP did not fully explain the handgun's unique features or describe other handguns it had examined and rejected and why. Rather than explain how the specifications and performance factors for this model of handgun were unique, the CHP focused on the projected service life of the previous-model handgun, the CHP's inventory needs, officer safety, the costs for a new weapons system, and the time it would need

Audit Highlights . . .

Our review of the California Highway Patrol's (CHP) purchasing and contracting practices and use of state resources revealed the following:

» *The CHP did not include all the justifications recommended by the State Administrative Manual in its $6.6 million handgun purchase request, nor did it sufficiently justify the cost of its planned $1.8 million patrol car electronics purchase.*

» *The Department of General Services approved the CHP's purchases even though the CHP's purchase documents did not provide all the requisite justifications for limiting competition or for the cost of the product.*

» *Despite the deficiencies in the handgun and patrol car electronics procurements, our legal counsel advised us that those deficiencies did not violate the provisions of law that would make a contract void for failure to comply with competitive bidding requirements.*

» *The CHP has weaknesses in its conflict-of-interest guidelines including not requiring employees who deal with purchasing to make financial interest disclosures, and not consistently following its procedures to annually review its employees' outside employment.*

» *Between 1997 and 2007, the CHP owned and operated a Beechcraft brand King Air airplane (King Air), but could not substantiate that it always granted approval to use the King Air in accordance with its policy, and its decisions to use the King Air were not always prudent.*

to procure a new weapons system.[1] None of these issues describe the new-model handgun's unique performance factors or why the CHP needed those specific performance factors. The CHP's sole-brand justification also did not explain what other handguns it examined and rejected and why. Further, despite its oversight role, General Services approved the CHP's purchase request, although the CHP did not fully justify the exemption from competitive bidding requirements. Because the CHP did not fully justify the handgun purchase, and General Services did not ensure that the purchase was justified, neither can be certain that the purchase was made in the State's best interest.

Moreover, General Services' procurement file for the CHP handgun purchase did not contain sufficient documentation showing how the CHP chose its proposed suppliers or how those suppliers would meet the bid requirements. According to a General Services acquisitions manager, when conducting the CHP's handgun procurement, General Services relied on a list of potential bidders supplied by the CHP and did not verify whether the bidders were factory-authorized distributors. Because it did not adequately document how the CHP chose its proposed suppliers, General Services did not fulfill its oversight role of ensuring that various bidders could compete and that the State received the best possible value.

We recommended that the CHP provide a reasonable and complete justification for purchases in cases where competition is limited, such as sole-brand or noncompetitive bidding purchases. Further, we recommended that it plan its contracting activities to allow adequate time to use the competitive bid process or to prepare the necessary evaluations to support limited-competition purchases. We also recommended that the CHP fully document its process for verifying that potential bidders are able to bid according to the requirements in the bid solicitation document and that General Services verify that the lists of bidders that state agencies supply it reflect potential bidders that are able to bid according to the requirements specified in the bid.

CHP's Action: Corrective action taken.

The CHP told us that is has implemented a new documentation process for its sole-brand purchases requiring authorization through its Administrative Services Division with final approval by the assistant commissioner for staff operations. CHP also noted that it takes the same approach with noncompetitive bid documentation to ensure that its noncompetitive justification documents address all the necessary factors.

The CHP reported that it is verifying potential bidders through General Services' Small Business/ Disabled Veteran Business Enterprise Web site and other on-line searches, and through speaking directly with potential bidders. The CHP updated staffs' desk procedures to reflect the necessary verification.

General Services' Action: Corrective action taken.

General Services told us that verifying the bidder list represents existing procedures and best practices. In January 2008 it issued instructions to acquisitions staff reemphasizing the requirement to verify that potential bidders are able to bid according to bid requirements. Further, General Services held meetings with acquisitions staff during February 2008 to emphasize the importance of verifying potential bidders lists to ensure adequate competition for the requirements specified in the bid. General Services used the CHP's handgun procurement as a case study during those meetings.

Finding #2: The CHP supplied insufficient price justification for spending $1.8 million for TACNET™ systems (TACNET™), and General Services was inconsistent in approving the purchase.

In 2005 the CHP submitted to General Services a $1.8 million purchase estimate for a sole-brand purchase of 170 TACNET™s, which consolidate radio and computer systems in patrol cars to allow for a single point of operation.[2] General Services appropriately denied the CHP's sole-brand request to purchase the TACNET™ when it found a lack of competition among the bidders. The CHP resubmitted

[1] A weapons system comprises the handgun and the ammunition the handgun fires.
[2] TACNET™ stands for tactical network and is a registered trademark of Visteon Corporation.

the procurement as a noncompetitive purchase request but did not include an adequate cost analysis demonstrating that it had determined that the TACNET™'s unit price was fair and reasonable. For example, the CHP stated in its noncompetitive justification that an actual cost comparison was not possible because the TACNET™ was not duplicated elsewhere in the industry. Thus, rather than conducting an actual cost comparison of the TACNET™ with other systems, the CHP compared the cost of the TACNET™ to the cost of separate products that offered at least one of the features of the system. The CHP then concluded that the price for a TACNET™ system was fair and reasonable. The cost analysis is an important part of the contract justification and serves to ensure that state agencies receive a fair and reasonable price in the absence of price competition.

Moreover, General Services did not ensure that the revised procurement documents contained the required analysis. General Services' policy states that it will reject an incomplete noncompetitive justification, but it did not do so in this instance. Also, General Services did not fulfill its procurement oversight role by ensuring that the State received fair and reasonable pricing on a purchase contract in which the marketplace was not invited to compete.We recommended that the CHP provide a complete analysis of how it determines that the offered price is fair and reasonable when it chooses to follow a noncompetitive bid process.

CHP's Action: Corrective action taken.

CHP reported that it has included in its procurement checklist steps for staff to follow in a noncompetitive procurement. These steps include staff documenting their efforts to identify similar goods and providing an evaluation for why the similar goods are unacceptable. Additionally, staff must examine the California State Contracts Register to identify suppliers and document the examination. CHP stated that when it can identify no other suppliers, it will use the information gathered from similar goods to justify the cost of a noncompetitive procurement is fair and reasonable.

Finding #3: The sole-brand procurement method may sometimes allow state agencies to avoid the stricter justification requirements for noncompetitive procurements.

Although state law requires General Services to review state agencies' purchasing programs every three years, General Services cannot specifically screen for sole-brand purchases because data related to these procurements is kept only in the individual department's purchasing files. The justifications and authority needed for a sole-brand purchase are less stringent than those needed for a noncompetitive procurement. For example, state agencies must document more information for a noncompetitive bid, such as why the item's price is appropriate. In addition, state agencies are typically authorized to make sole-brand purchases with higher values than are allowed for noncompetitive purchases. For example, when making a sole-brand purchase of information technology goods and services, the purchase limit is $500,000, but the limit for making a noncompetitive purchase is only $25,000. As a result, the opportunity exists for state agencies to inappropriately use the sole-brand procurement method as a way to limit competition and avoid the more restrictive criteria associated with a noncompetitive bid.

We discussed the need to review sole-brand purchases with General Services, and it agreed that the information necessary to target sole-brand procurements is not currently available. However, General Services told us that it recently added specific steps to its review procedures related to sole-brand purchases and indicated that if it determines that an individual state agency has risk in this area, General Services will include sole-brand purchases in its review.

To ensure that state agencies use the sole-brand procurement method appropriately and not in a manner to avoid the stricter justification requirements for noncompetitive procurements, we recommended that General Services study the results from its review procedures related to sole-brand purchases. Based on the results of its study, General Services should assess the necessity of incorporating specific information on sole-brand purchases into its existing procurement reporting process to evaluate how frequently and widely the sole-brand purchase method is used.

General Services' Action: Partial corrective action taken.

General Services reported that it conducted a survey during July and August 2008 and found that a significant number of state agencies conduct sole-brand procurements. General Services is drafting revisions to the State Contracting Manual to include a requirement for state agencies to justify, document, and report sole-brand procurement requests in the same manner as noncompetitive procurements.

Finding #4: The State does not have sufficient justification to cancel the CHP's handgun or TACNET™ contracts.

The State has several ways that it can end its contractual relationship with a contractor, two of which could be applicable for the contracts we reviewed. The State's standard contract provisions allow the State to terminate a contract for specified reasons, and state law provides that a contract that is formed in violation of law is void. Based on the contractors' performance under the handgun and TACNET™ contracts, our legal counsel has advised us that General Services would not have a basis for relying on the standard contract provisions to cancel these contracts. Moreover, although a broadly worded contract provision permits termination of a state contract when it is in the interest of the State, our legal counsel advised us that it is unlikely that the State could successfully cancel the handgun and TACNET™ contracts on that basis, particularly because the contractors have already provided the goods called for under the contract and have otherwise performed their duties.

In addition, although we identified deficiencies in the procurements of the handguns and TACNET™, our legal counsel advised us that those deficiencies did not violate the provisions of law that would make a contract void for a failure to comply with competitive bidding requirements. The State Administrative Manual, Section 3555, recommends, but does not require, that the statements justifying sole-brand procurements and noncompetitive bids address certain questions, such as what other comparable products were examined and why they were rejected. Because these statements are merely recommended and not legally required, a failure to provide them did not constitute a violation of law that would make these contracts void. Nonetheless, we believe that it is important for state agencies to demonstrate to General Services that they examined other comparable products and to explain why the products were rejected or, if there are no other comparable products, to explain how the state agency reached that conclusion, to ensure that competitive bidding occurs whenever possible.

To ensure that state procurements are competitive whenever possible, we recommended that General Services revise Section 3555 to require that state agencies address all of the factors listed in that section when submitting justification statements supporting their purchase estimates for noncompetitive or sole-brand procurements. In addition, if General Services believes that the law exempting provisions in the State Administrative Manual and the State Contracting Manual related to competitive procurement requires clarification to ensure that the requirements in those publications are regulations with the force and effect of law, General Services should seek legislation making that clarification.

General Services' Action: Corrective action taken.

In March 2008 General Services revised the State Administrative Manual, Section 3555, to require state agencies to fully address all of the factors listed in the section when submitting justification statements supporting a sole-brand purchase estimate. In addition, General Services reported that it issued information to state agencies explaining the need to adequately justify sole-brand procurements and gave staff additional direction for processing such requests internally. Finally, General Services told us that it believed it had sufficient enforcement authority in current statute and that additional clarifying legislation was unnecessary.

Finding #5: The CHP could not demonstrate that all employees complied with the necessary disclosures in its conflict-of-interest policies.

Although the CHP has policies on conflicts of interest, it could not show that it consistently applied those policies. The CHP carries out its conflict-of-interest procedures through employee submission of the following four documents: the Fair Political Practices Commission's (FPPC) Form 700, Statement of Economic Interests (Form 700); the secondary-employment request; the vendor/contractor/consultant business relationships memorandum (business relationships memo); and an inconsistent and incompatible activities statement. The CHP's conflict-of-interest policies and procedures rely heavily on employee disclosure, yet the policies do not encompass all of the individuals involved with its purchasing and contracting process. In addition, the CHP could not demonstrate that all employees required to do so made the necessary disclosures. As a result, neither we nor the CHP is able to fully determine whether potential conflicts of interest exist at the CHP.

For example, the CHP has not designated as Form 700 filers employees in key positions with purchasing responsibility or approval authority, such as the staff in its purchasing services unit, a position within the Office of the Commissioner that has purchasing approval authority, or positions in which employees develop product specifications used as the basis for purchasing necessary goods.

The CHP's secondary-employment policy requires its employees to disclose employment outside of the CHP by submitting a request for approval of secondary employment. The requests and the CHP's reviews give the agency an ongoing opportunity to evaluate whether employees' second jobs create a conflict of interest; however, the CHP does not always adhere to this policy. The CHP also uses a business relationships memo and its inconsistent and incompatible activities statement to inform employees of their conflict-of-interest responsibilities and remind them of the policy surrounding conflicts of interest. Based on our testing, the CHP follows its procedure for having employees sign a statement regarding inconsistent and incompatible activities, but it does not always obtain a signed business relationships memo.

Furthermore, the CHP's draft conflict-of-interest policy does not adequately define the employees and procurements to which the policy applies, nor does the policy address vendor conflicts of interest.

To ensure that it informs employees about and protects itself against potential conflicts of interest, we recommended that the CHP include as designated employees for filing the Form 700, all personnel who help to develop, process, and approve procurements. In addition, we recommended that the CHP ensure that it documents, approves, and reviews secondary-employment requests annually in accordance with its policy. We also recommended that the CHP revise its employee statement regarding conflicts of interest to include employees involved in all stages of a procurement. In addition, the CHP should reexamine its reasons for developing the conflict-of-interest and confidentiality statement for vendors, and ensure that this form meets its needs.

CHP's Action: Partial corrective action taken.

The CHP stated that its major departmental reorganization, finalized in June 2008, invalidated the draft conflict-of-interest code it had submitted to the FPPC. The CHP further noted that its Personnel Management Division has recommenced working on the conflict-of-interest code, including embarking on an extensive analysis and review of positions required to be included in the code that will require notification to be given to collective bargaining units. When submitted to the FPPC, the CHP anticipates its conflict-of-interest code will be approved and implemented by September 2009.

The CHP reported that its Office of Investigations has included in its annual citizens' complaint review an examination of secondary employment requests and that the reviews for 2008 will be complete in December 2008.

In July 2008 the CHP published its policy addressing which procurements require the Conflict of Interest Statement – Employee, and which employees are required to complete the statement.

The CHP updated the Conflict of Interest and Confidentiality Statement for its vendors and included the revised form in its Highway Patrol Manual.

Finding #6: Conflicts of interest caused General Services to declare void two motorcycle contracts.

During 2002 and 2004, General Services formed two statewide contracts with a single motorcycle dealership for CHP to acquire motorcycles for its use. These two contracts generally covered the period from January 2002 to April 2006 and allowed the CHP to purchase motorcycles as needed, for a total amount not to exceed $13.7 million. The CHP purchased motorcycles, obtained warranty services, and exercised a motorcycle buyback provision under these contracts. However, General Services determined that the contracts were entered into in violation of the California Government Code, Section 1090, which prohibits state employees from having a financial interest in contracts they make. Therefore, in June 2005 General Services declared the contracts void.

Although General Services secured a $100,000 monetary settlement from the motorcycle dealer, General Services did not finalize a settlement with the manufacturer, BMW Motorrad USA, a division of BMW of North America, LLC (BMW Corporation), which had provided assurances related to the contracts. The CHP estimates that it has incurred $11.4 million in lost buyback opportunities and motorcycle maintenance costs because General Services declared the two contracts void. This estimate covers the period October 2005 to October 2007 and reflects that the CHP and General Services were not successful in securing another motorcycle contract in 2006. General Services told us in November 2007 that it had reestablished negotiations with BMW Corporation. In its initial response to this audit, General Services disclosed the BMW Corporation had no interest in buying back the existing motorcycles. We are unaware of any other points General Services and BMW Corporation may be negotiating. Therefore, it is unclear if or when a settlement will be reached and what benefits, if any, will be derived from it.

We recommended that General Services continue negotiating with BMW Corporation regarding the canceled contracts for motorcycles to develop a settlement agreement that is in the State's best interest.

General Services' Action: Corrective action taken.

General Services' disclosed that it had concluded in January 2008 its negotiations with BMW Corporation when BMW Corporation informed General Services that it had no interest in initiating a buyback program.

Finding #7: The CHP's broad policies for using its King Air aircraft may have led to some imprudent decisions.

Between 1997 and 2007, the CHP owned and operated an eight-passenger aircraft: a Beechcraft brand model A200 King Air (King Air). The CHP's policies for using the King Air consisted of both an air operations manual that applies to all of the CHP's aircraft and standard operating procedures specific to the King Air. These policies stated that the CHP could use the King Air for missions that supported the agency or for unofficial use, as authorized by the Office of the Commissioner.

Based on our review of the CHP's flight logs from calendar years 2006 and 2007, the purposes of some flights do not seem prudent. For example, the CHP's management used the King Air for two round-trips to destinations in close proximity to Sacramento. Given the State's reimbursement rate at the time of 48.5 cents per mile, the cost to the State of driving to these two locations would have been about $150. Using the CHP's calculation from January 2005 that the King Air's operating cost was $1,528 per hour of flight time, the cost of flying the King Air was at least $1,980 for these two round trips, more than 13 times the cost of driving.

For 14 of the King Air's 69 mission flights during 2006, the purpose of the flight was not aligned well with the CHP's function, as its policy dictates, or for state business. For example, on one occasion, the commissioner's wife accompanied her husband and four of his staff on a round-trip flight between Sacramento and Burbank to attend a function hosted by a nonprofit organization affiliated with the CHP. Although the presence of the commissioner's wife on the flight could be questioned, the commissioner later reimbursed the State $254, the amount of a commercial flight, for his wife's share of the flight. Furthermore, the CHP used the King Air to transport from Portland, Oregon, the family of an officer killed while on duty to that officer's memorial service and the subsequent sentencing hearing of the responsible motorist. Although we understand the CHP's desire to provide support to the officer's grieving family, the CHP's choice to use the King Air for this purpose was not the best use of a State resource. Twelve of the King Air's 69 mission flights during 2006 transported these family members to various destinations, or the flights were required to position the plane to accommodate the family's transportation. Using the CHP's operating cost calculation, the total cost of all the flights we questioned exceeded $24,000 and, other than the reimbursement for the commissioner's wife, the CHP was not reimbursed for these costs.

To ensure that the use of state resources of a discretionary nature for purposes not directly associated with the CHP's law enforcement operations receives approval through the Office of the Commissioner, we recommended that the CHP develop procedures for producing, approving, and retaining written documentation showing approval for these uses.

CHP's Action: Partial corrective action taken.

The CHP told us that it has revised its policy to emphasize usage of state resources for business purposes and that any exceptions must be approved in writing by the Office of the Commissioner. The CHP is planning a meeting with one of its bargaining units and pending that meeting will approve the policy. CHP anticipates issuing the new policy by December 2008.

Department of Housing and Community Development

Awards of Housing Bond Funds Have Been Timely and Complied With the Law, but Monitoring of the Use of Funds Has Been Inconsistent

REPORT NUMBER 2007-037, SEPTEMBER 2007

Department of Housing and Community Development's response as of August 2008

In November 2002 and 2006, California voters passed the Housing and Emergency Shelter Trust Fund acts to provide bonds (housing bonds) for use in financing affordable housing for low- to moderate-income Californians. The Department of Housing and Community Development (department) and the California Housing Finance Agency (Finance Agency) manage the programs funded by the housing bonds.

The California Health and Safety Code, sections 53533 and 53545, requires the Bureau of State Audits to conduct periodic audits of housing bonds activities to ensure that housing bond proceeds are awarded in a manner that is timely and consistent with legal requirements and that awardees use the funds in compliance with the law.

Finding #1: Awards of housing bond funds were timely.

The department and Finance Agency have generally met and sometimes exceeded the goals specified in awards schedules they established in 2002 and 2003 for the 2002 housing bonds. For all complete fiscal years we audited, except fiscal year 2002–03, actual awards exceeded estimated awards.

Finding #2: The department and the Finance Agency generally complied with legal requirements when awarding housing bond funds.

The department and the Finance Agency generally allocated and awarded housing bond funds for the intended programs, to the correct types of sponsors, and for the proper activities. We noted that the Finance Agency's California Homebuyer's Downpayment Assistance Program (Downpayment Assistance Program) and the department's CalHome, Joe Serna Jr. Farmworker Housing (Farmworker Housing Program), and Multifamily Housing programs complied with legal requirements. However, poor file management in the department's Emergency Housing and Assistance Program (Emergency Housing Program) made it impossible for us to verify if the department always assessed applicants' submissions according to criteria for their capability as set forth in program notices. These criteria include minimum standards.

We recommended that the department implement record-keeping procedures for the Emergency Housing Program to ensure that applicants who receive awards have been properly evaluated.

Audit Highlights . . .

Our review revealed that for the Housing and Emergency Shelter Trust Fund Act of 2002:

- *Both the Department of Housing and Community Development (department) and California Housing Finance Agency (Finance Agency) generally awarded funds in a timely manner.*
- *Both the department and Finance Agency generally complied with legal requirements for making awards; however, the department could not provide its rating and ranking tools in some cases for its Emergency Housing and Assistance Program (Emergency Housing Program).*
- *Both the department and Finance Agency generally used appropriate monitoring procedures during the expenditure phase, but the department sometimes overrode controls concerning advance payments for the CalHome Program.*
- *The department does not exert adequate monitoring over the completion phase for two of its programs—Emergency Housing and CalHome.*

Department's Action: Corrective action taken.

By the end of October 2007 the department indicated that it finalized standardized record filing and maintenance procedures for the Emergency Housing Program. In addition, by the end of February 2008, the department says it completed its file review and organization of existing files.

Finding #3: The department and the Finance Agency generally undertake appropriate monitoring procedures during the expenditure phase.

For the expenditure phase (the period from award commitment to final state payment to an awardee), the department and the Finance Agency have processes in place to ensure that awardees exhibit reasonable progress in meeting their goals and are only reimbursed for allowed costs. However, we found that for three of the 18 CalHome awards tested, 17 percent of our sample, sponsors received advances exceeding the 25 percent limit established in their standard agreements. For example, the department approved a 100 percent advance on the last day funds were available for disbursement to one awardee based only on a list of potential home buyers. In these cases, the department overrode what appears to be a reasonable policy to ensure the delivery of services close to the time of payment and to maximize the State's interest earnings. Had the department retained the funds advanced over the 25 percent threshold for the three awards, we estimate it could have earned $42,000 in interest through July 2007 based on the effective yield of the State Treasurer's Office pooled money account.

We recommended that the department consider eliminating its process of overriding restrictions on advances for the CalHome Program.

Department's Action: Corrective action taken.

The department reported that it established clear procedures to guide staff in evaluating circumstances in which an advance above the 25 percent limitation may be appropriate and in documenting justifications received from awardees. In cases where advances are provided, the department stated that staff will evaluate actual performance, as measured by receipt of borrower summaries, at 60-day intervals following the advance.

Finding #4: For two programs, the department does not have adequate monitoring processes for the completion phase.

Of the five programs we reviewed, only Downpayment Assistance, Farmworker Housing, and Multifamily Housing had processes in place to adequately ensure compliance during the completion phase. This phase extends from the final state payment to fulfillment of all contract requirements. However, the CalHome and Emergency Housing programs administered by the department had weak or nonexistent monitoring during the completion phase. Consequently, the department cannot always be certain that sponsors are using bond funds to help intended beneficiaries, such as low- to moderate-income home buyers or homeless individuals.

We found that for 17 of the 18 CalHome Program awards we tested, the department had not verified any of the information provided whether through site visits or by reviewing original documentation, even though the sponsors had received all funds. For the remaining award, the sponsor had not yet received any funds. As a result, the department cannot be certain that sponsors complied with housing bond requirements related to occupants' income limits or their status as first-time home buyers.

Similarly, for the Emergency Housing Program, we found that the department had not performed site visits to verify sponsor activities for any of the awards we tested that were in the completion phase. Moreover, the program manager said that the program has not performed any site visits since 2005 and even then, it did not have formal policies and procedures governing the purpose and documentation

requirements for site visits. Without monitoring processes for verifying compliance, the department cannot ensure that sponsors use funds in accordance with housing bond requirements or that the program benefits the intended populations.

We recommended that the department give high priority to finalizing and implementing monitoring procedures for the CalHome and Emergency Housing programs, which do not currently have such procedures in place. In addition, we recommended that the department review its other housing bond programs that were not specifically evaluated in this initial audit to ensure that monitoring procedures are in place and operating.

Department's Action: Partial corrective action taken.

The department stated that it has finalized the design of its monitoring program of the CalHome program and that on-site reviews by CalHome staff are continuing. In regards to the Emergency Housing Program, the department says that in January 2008, it finalized its monitoring procedures and that on-site monitoring has begun.

The department indicates in-progress monitoring processes and, where appropriate, post completion/long-term monitoring processes are now in place for all bond programs not included in the audit with the exception of the new programs under Proposition 1C that are still in the initial design phase or have recently completed that phase. The department says that in these cases, monitoring program design is under way and that it intends to complete this effort before contracts are executed.

Department of Insurance

Former Executive Life Insurance Company Policyholders Have Incurred Significant Economic Losses, and Distributions of Funds Have Been Inconsistently Monitored and Reported

REPORT NUMBER 2005-115.2, JANUARY 2008

California Insurance Commissioner's, California Department of Insurance's and the Conservation and Liquidation Office's responses as of June 2008

The Joint Legislative Audit Committee (audit committee) directed the Bureau of State Audits to review the California Department of Insurance's (department) management of the Executive Life Insurance Company Estate (ELIC estate) and related litigation. Specific audit objectives included the following:

- Analyze the funds paid into and out of the ELIC estate since April 11, 1991.
- Determine how much money policyholders have received.
- Determine the percentage of policyholders who have received all of the payments they would have received if ELIC had not become insolvent.
- Determine the amount policyholders will receive in the future.
- Determine how the department has used the litigation proceeds that it has received, including payments made to policyholders, the national guaranty organization, and others.
- Determine the percentage of the department's projected $4 billion loss to policyholders that was recovered by litigation including settlements, relating to the ELIC estate, after subtracting amounts distributed to policyholders and the national guaranty organization and others.

Finding #1: The California Insurance Commissioner (commissioner) has not consistently ensured that Aurora National Life Assurance Company (Aurora) complies with ELIC agreements.

The commissioner entered into agreements specifying how ELIC's insurance policies would be transferred to Aurora, how the former ELIC policies would be restructured, and how assets that remained under the commissioner's control and future litigation proceeds that he received would subsequently be distributed to policyholders.

The commissioner, Aurora, and the National Organization of Life and Health Insurance Guaranty Associations (national guaranty organization) are party to the ELIC agreements.

Audit Highlights . . .

» *When the California Insurance Commissioner (commissioner) conserved the Executive Life Insurance Company (ELIC) on April 11, 1991, he reported the company's assets to be $8.8 billion. Later, losses from the liquidation of ELIC investment securities reduced this amount by $1.3 billion. Through December 31, 2006, the remaining $7.5 billion has been increased by investment income, litigation proceeds, and other income, resulting in $10.2 billion in total available assets.*

» *Of the $10.2 billion, the commissioner transferred $6.7 billion to Aurora National Life Assurance Company for use in its role as successor insurer to ELIC and to pay policyholders who did not continue with the company. The commissioner has paid a total of $2.7 billion to policyholders and other beneficiaries of the estate and has used $528 million for administering the ELIC estate.*

» *About $325 million remained in the estate as of December 31, 2006. In 2007 the commissioner transferred $311 million of these remaining funds to Aurora, most of which it reports as disbursed to policyholders and others in October 2007*

» *In August 2005 the department estimated policyholder losses at $936 million, which equates to policyholders recovering 90 percent of their original policy rights.*

continued on next page . . .

» *Including factors not considered by the department, we estimated policyholder economic losses of $3.1 billion as of August 2005, with policyholders recovering 86 percent of their expected ELIC account values.*

» *The commissioner has not consistently monitored, reported on, or accounted for the distribution of the assets of the ELIC estate.*

Key provisions of the ELIC agreements require Aurora to add interest to the funds it receives from the ELIC estate; calculate distributions to policyholders who opted to continue coverage with Aurora (opt-in policyholders) and other ELIC estate beneficiaries, such as the national guaranty organization, according to complex formulas; and determine the amount of ELIC funds that it pays to third-party companies that offset some policyholders' losses.

The commissioner, as trustee of the ELIC estate, has not consistently ensured that Aurora adds the proper amount of interest to the funds it receives from the ELIC estate, or that it accurately calculates the amounts that it distributes to policyholders and others based on provisions in the ELIC agreements. Between September 1993, when Aurora assumed ELIC's policies, and October 2007, one external examination has been conducted, and an internal examination by the commissioner's Conservation and Liquidation Office (CLO) is in the process of being conducted, to verify Aurora's compliance with some of the provisions of the ELIC agreements. However, the commissioner did not monitor other distributions that occurred from 1998 through 2006 for such compliance and therefore cannot provide policyholders and others the same level of assurance that the $225 million Aurora distributed during this period of time was handled in accordance with the ELIC agreements.

To increase assurance that Aurora follows key provisions in the ELIC agreements, we recommend that the commissioner seek the right to review Aurora's future distributions of ELIC estate funds and review those distributions to ensure that it adds the proper amount of interest to the funds, and distributes the funds correctly.

Commissioner's Action: Partial corrective action taken.

A written request, dated February 27, 2008, was sent to Aurora and the national guaranty organization by the CLO. Although there have been numerous discussions with Aurora over the past several months, Aurora has not made a commitment to fulfill CLO's request. Completion of this recommendation will be dependent on Aurora's acceptance to CLO's request and the actual timing of future distributions.

Finding #2: Managers of the ELIC estate have not consistently reported on the disposition of ELIC's assets.

During the period from 1990, before the commissioner conserved ELIC, through 2006, we found that there is a lack of available information on ELIC's operations and the disposition of ELIC's assets. The commissioner has assigned various parties the responsibility of managing the ELIC estate since he conserved ELIC in April 1991. We found that the level of information varied depending on the entity managing the estate or trust at the time. Some of the reports that are either authorized by the insurance code or required by individual trust agreements have not been produced, and audits of the ELIC estate have not been consistently performed. Similarly the extent of audited financial statements available showing the disposition of ELIC's assets, including the receipt and distribution of ELIC funds, is related to which entity was managing the estate. We found that audited financial

statements were not available during the 1991 through 1993 period, and while the ELIC estate was extensively audited during the 1994 through 1996 period, it has not been consistently audited since 1997. Overall, inconsistent reporting has contributed to a lack of information available to former ELIC policyholders and other parties who have an interest in the ELIC estate.

In order to ensure that information is available to policyholders and other parties interested in the disposition of ELIC's assets, we recommended that the commissioner, as soon as practical after the end of each year and upon the termination of any trust, complete a report that includes the assets and liabilities; the amount of all distributions, if any, made to the trust beneficiaries; and all transactions materially affecting the trust and estate.

Commissioner's Action: Corrective action taken.

Summarized financial information along with a brief narrative of the ELIC estate and grantor trusts was posted on the CLO Web site in April 2008.

Finding #3: Managers of the ELIC estate have not consistently audited the estate.

In settling the ELIC estate, the commissioner established a series of trusts to receive and distribute funds to policyholders. Auditing requirements have been met for some of the trusts but not for others. For example, the consolidated audits performed of the ELIC estate from 1997 to 2000 are not comprehensive, and no audits were performed from 2001 to 2004. The purpose of the audits is to ensure that reported financial information is accurate.

By not producing the audits, the commissioner had no way to ensure that ELIC's financial statements were accurate and further reduced the amount of publicly available information on the disposition of the ELIC estate's assets.

In 2006 the CLO's chief financial officer requested the Department of Finance (Finance) to conduct a separate review of the ELIC estate and each of its trusts covering the 2005 and 2006 period. He stated that he plans to continue these reviews yearly until the trusts are closed.

In order to ensure that the financial information reported by the CLO is accurate, we recommended that the commissioner continue the practice of auditing the ELIC estate, and any trusts that remain open, on a periodic basis as implemented by the current chief executive officer in 2006.

Commissioner's Action: Corrective action taken.

Finance reviews for the year ended December 31, 2007, are scheduled to be completed by August 2008.

Finding #4: Inconsistent accounting practices and inconsistent availability of supporting documents hinder a complete accounting of the ELIC estate.

Since ELIC was first conserved in 1991, a variety of methods have been used to account for the estate. For example, from 1991 to 1993, the available financial information is primarily contained in unaudited financial statements prepared by outside contractors and unaudited financial statements included in the annual report to the governor. For the 1994 to 1996 period, audited financial statements exist for the various trusts; however, for the ELIC estate in 1994, only a balance sheet was included in the audit report. Financial reporting was not consistent from 1997 through 2006. For example, in 1998 a $75 million indemnity payment was paid to Aurora pursuant to the rehabilitation plan. While the 1998 ELIC Trust audit reports a $55.5 million expense for its portion of this amount, the CLO's general ledger does not report a $19.5 million expense for the remaining portion that it paid from the ELIC estate. Additionally, the cash-flow statements prepared from 1991 through 1996 were not prepared during the period from 1997 through 2006.

Various trust agreements identify the recipients of ELIC estate distributions as opt-in and opt-out policyholders, Aurora, and the national guaranty association. Although the notes to the financial statements for the 1994 to 1996 period identified the amount of funds paid to opt-in and opt-out policyholders and refer to opt-in and opt-out accounts, the CLO accounting system does not maintain separate accounts to record distributions to these recipients. In addition, it does not maintain separate accounts to record payments made to the national guaranty organization or Aurora. Although there is no specific requirement for structuring the accounting records, maintaining subsidiary accounts that separately track payments to each category of trust recipient would aid the timely reporting of payments to recipients of ELIC estate distributions.

The lack of maintaining separate accounts for tracking the payments made to the four recipients of the trusts may have contributed to the delayed identification of a $90 million posting error to the CLO general ledger distribution account in 1997 and a $62 million posting error to the CLO general ledger distribution account in 2002, which the CLO did not correct until September 2007. Another reason that the distribution account errors may not have been promptly identified during the 1997 through 2006 period is that, although the CLO reconciles its cash account to subsidiary databases for distributions to maintain control of cash, it did not reconcile the distributions reported in its general ledger to the subsidiary databases in order to maintain control for correct financial reporting.

In order to ensure that it accurately records distributions in its primary accounting system, and ensure correct financial reporting, we recommended that the CLO periodically reconcile the distributions reported in its general ledger to its subsidiary databases.

Commissioner's Action: Corrective action taken.

The commissioner stated that the CLO will continue its practice of reconciling distributions to the Trust Administration System subsidiary databases and to the general ledger, and stated that the CLO has reformatted the financial presentation of the ELIC financial statements and has established separate accounts in the ELIC estate general ledger for each future distribution.

California Unemployment Insurance Appeals Board

Its Weak Policies and Practices Could Undermine Employment Opportunity and Lead to the Misuse of State Resources

REPORT NUMBER 2008-103, NOVEMBER 2008

California Unemployment Insurance Appeals Board's response as of November 2008

The California Unemployment Insurance Appeals Board (appeals board) is a quasi-judicial agency created in 1953 to conduct hearings and issue decisions to resolve disputed unemployment and disability determinations and tax-liability assessments made by the Employment Development Department. The appeals board is overseen by a seven-member board or its authorized deputies or agents. The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the appeals board's hiring, procurement, and administrative practices. Specifically, the audit committee asked that we review and evaluate the appeals board's hiring policies to determine whether its policies and procedures comply with applicable laws and regulations. In addition, the audit committee asked us to examine a sample of hires, promotions, and transfers to determine if each one complied with applicable laws, regulations, policies, and procedures.

The audit committee also requested that we determine the prevalence of familial relationships among appeals board employees, to the extent possible. In addition, we were asked to determine whether the appeals board's processes for handling grievances and equal employment opportunity (EEO) complaints are set up in a manner that allows employees to avoid the fear of retaliation. Furthermore, the audit committee asked us to review and evaluate the appeals board's procurement practices for office space, furniture, and other administrative purchases to ensure that they align with applicable laws, regulations, and appeals board policies. Finally, the audit committee asked us to review the appeals board's use of state property such as vehicles and fuel cards and determine whether such use is reasonable and allowable per applicable laws.

Finding #1: Although the appeals board's prehiring process identifies eligible candidates, managers did not consistently document the reasons for their hiring decisions.

We determined that the appeals board's prehiring process generally ensures that individuals it hires, promotes, and transfers are eligible for their positions. However, hiring managers were not always able to consider all of the applicants for a given position because of a freeze on outside hires. In addition, managers did not consistently document each of the steps in the hiring process or their reasons for hiring a particular candidate, making it difficult for an outside party to understand why the appeals board selected particular candidates. For example, there was no evidence that managers conducted interviews for some hires, most notably when hiring two former board members

Audit Highlights . . .

Our review of the California Unemployment Insurance Appeals Board's (appeals board) hiring, procurement, and administrative practices found that:

- *Hiring managers were not always allowed to consider all applicants for a given position because of a freeze on outside hires.*
- *Hiring managers did not consistently document their reason for hiring a particular candidate.*
- *Nearly half of the employees who responded to our survey believed that the appeals board's hiring and promotion practices were compromised by familial relationships or employee favoritism.*
- *The appeals board cannot currently enforce its new nepotism policy on persons who are not currently employed by the appeals board because the new policy should have been submitted to the State's Office of Administrative Law for approval as a regulation.*
- *Employees submitted few equal employment opportunity (EEO) complaints or grievances during roughly the past five years, and 40 percent of employees responding to our survey indicated that they would have some fear of retaliation from their supervisors or upper management if they were to file either EEO complaints or grievances.*

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» *Certain weaknesses in the appeals board's controls over travel expenses prevent it from demonstrating the business purpose of some travel expenses and resulted in some questionable costs that may need to be recovered.*

» *The appeals board expends approximately $5,000 per month for parking spaces, but it has not established any procedures to ensure that these spaces are only used for appropriate purposes.*

as administrative law judges. Consequently, the appeals board is vulnerable to allegations that its hiring decisions are unfair and that employment opportunities are not afforded to all candidates.

To better ensure that its hiring decisions are fair and that employment opportunity is afforded to all eligible candidates, and to minimize employees' perceptions that its practices are compromised by familial relationships or employee favoritism, we recommended that the appeals board do the following:

- Prepare and formally adopt a comprehensive hiring manual that incorporates the State Personnel Board's guidelines and that specifically directs hiring managers to do the following:
  - Conduct and score hiring interviews using a structured interview format and a corresponding rating scale, and benchmark answers that describe the responses that reflect each level of performance on the rating scale.
  - Maintain documentation of each of the steps in the hiring process for at least two years. For example, managers should maintain all applications received from eligible applicants and should preserve notes related to interviews and reference checks.
  - Forward a memo to the appeals board's personnel services unit that documents the results of the hiring process, including the names of the candidates interviewed, the dates of the interviews, the names of the individuals on the interview panel, and the panel's selection, along with an explanation of why that candidate was chosen. After the appeals board approves hiring the selected candidate, the personnel services unit should maintain this memo for a period of two or more years so that it can demonstrate that the hiring process was based on merit and the candidate's fitness for the job.
- Before implementing another soft hiring freeze, the appeals board should carefully consider whether the projected budgetary advantages outweigh the risk that it may not hire the strongest and most qualified candidates during any such freeze.

Appeals Board's Action: Partial corrective action taken.

The appeals board reports that it is already taking measures to ensure that managers and supervisors are familiar with its updated hiring guide that prescribes the use of an interview format, rating scale, and benchmark answers. The guide also instructs that the recruitment file shall be maintained for two years. In addition, the appeals board stated it has created and begun utilizing a request-for-hire form, which requires the hiring office to obtain and document appropriate approvals and to include on the form the following information: the number of applications received for the position; the number of applicants interviewed; whether an official personnel file has been reviewed, references contacted, and if

the employee is related to an appeals board employee; and an explanation of why the proposed hire is the most qualified candidate. The appeals board further asserts that this form will be maintained with the position action package in its personnel services unit for five years.

Furthermore, the appeals board reports that it agrees that before implementing another soft hiring freeze for budget reasons, it should consider whether the projected budgetary advantages outweigh the risk of possibly not hiring the most qualified candidates. The appeals board also agrees that it should present this option to the board members for their consideration since it would have an impact on the budget, and the board members have the responsibility for adopting and approving the budget.

Finding #2: The appeals board has recently sought to establish certain restrictions over the hiring of former board members and relatives.

The appeals board hired a former board member as a full-time permanent administrative law judge in December 2004, apparently without interviewing other qualified applicants. This individual had passed the administrative law judge civil service exam, making him eligible for the position, and we do not doubt that prior board service gave him unique insights into how unemployment insurance cases ought to be decided. However, the appeals board's past practice of hiring board members for civil service jobs could undermine its employees' faith in the civil service selection process.

Notwithstanding, the appeals board recently adopted a policy prohibiting the hiring of a board member into any civil service position at the appeals board for a period of one year from the last day of that individual's term as a board member. We believe this policy would mitigate the potential conflict of interest inherent in hiring board members as civil servants. However, the appeals board cannot currently enforce this policy because, according to our legal counsel, it is actually a regulation that should have been submitted to the State's Office of Administrative Law for approval. Specifically, the Administrative Procedures Act requires a state agency to submit proposed regulations to the Office of Administrative Law for legal review and public comment if the proposed regulation applies to people or entities outside the agency. Generally, regulations that have not been subjected to this process are considered to be "underground regulations" that cannot legally be enforced. Moreover, a person may bring a lawsuit to have a court declare an underground regulation invalid.

We also found that familial relationships among appeals board employees appear to have a negative impact on many employees' perceptions of their workplace. For example, one-fourth of the employees who responded to a survey that we sent to all 639 employees and seven board members working as of April 2008, indicated that their supervisor or manager was related to another appeals board employee, and nearly half of responding employees believed that hiring and promotion practices were compromised by familial relationships or employee favoritism. Moreover, over a third of respondents indicated that familial relationships have a negative effect on supervision, security, or morale and/or created potential conflicts of interest. The appeals board recently adopted a more restrictive nepotism policy specifying that it retains the right to refuse to appoint a person to a position when doing so might create an adverse impact on supervision, security, or morale or involves a potential conflict of interest. However, the appeals board cannot currently legally enforce its new nepotism policy against persons not presently employed by the appeals board because it constitutes an underground regulation.

We recommended that the appeals board rescind its recently adopted, but legally unenforceable, policy that prohibits hiring a board member into any civil service position at the appeals board for a period of one year from the last day of that individual's term as a board member. Likewise, it should not enforce its new nepotism policy against persons not presently employed by the appeals board. Because both of these policies affect persons outside of the organization, the appeals board should submit new versions of these regulations to the Office of Administrative Law for approval.

Appeals Board's Action: Partial corrective action taken.

The appeals board reports that it will immediately explore promulgation of a regulation under the Administrative Procedures Act process to mitigate the potential conflicts of interest inherent in hiring former board members as appeals board civil service employees. In addition, the appeals board stated it would apply its current nepotism policy only to persons employed by the appeals board. Furthermore, the appeals board stated it will immediately address the possibility of promulgating a nepotism regulation that would extend the policy to persons not currently employed by the appeals board.

Finding #3: Many surveyed appeals board employees reported fearing retaliation if they filed EEO complaints or grievances.

The appeals board's EEO complaint process and grievance process are designed to mitigate the threat of retaliation by allowing employees to file or appeal EEO complaints or grievances with designated personnel and outside agencies instead of their direct supervisors. However, appeals board data indicate that employees filed just 14 formal EEO complaints and 10 formal grievances over roughly the last five years. The fact that employees filed few EEO complaints or grievances was confirmed by our survey. Of the employees responding to our survey, only 2 percent indicated that they had ever filed an EEO complaint, with 5 percent indicating that they had ever filed a grievance. In fact, 40 percent of responding employees indicated that they would have some fear of retaliation from their supervisors or upper management if they were to file either an EEO complaint or grievance. The survey also indicated that the degree of fear varied depending on employees' work location, position, and tenure with the organization. Moreover, 11 percent of survey respondents were not aware of the appeals board's EEO policy and 23 percent of respondents indicated that they were not aware of how to file a grievance. Thus, we believe the appeals board could do a better job of informing employees of the grievance process and EEO complaint process and explaining that they both include specific protections from retaliation.

To ensure that employees understand their right to file either an EEO complaint or grievance, and to reduce any associated fear of retaliation, we recommended that the appeals board notify employees annually of its EEO complaint process and grievance process, including the protections from retaliation included in both. For example, the appeals board should remind employees that they could pursue either EEO complaints or grievances with certain outside entities, especially if they believe they may have been retaliated against. The appeals board should also update its employee handbook to better emphasize these processes and procedures, and consider conducting training in this area on a periodic basis.

Appeals Board's Action: Pending.

The appeals board stated that by the end of December 2008, it will update its intranet site and issue a memo to all employees informing them of the EEO complaint process and grievance process. The appeals board asserted it is also exploring additional measures including creating an on-line tutorial regarding EEO complaint and grievance procedures, and protections from retaliation, which would require each employee to "sign-in and out" as verification that he or she completed the tutorial. Finally, the appeals board stated it is in the process of updating its employee handbook concerning EEO procedures, and anticipates it will also be completed by the end of December 2008.

Finding #4: Weak controls over travel expenses have led to the questionable use of state resources.

Although the appeals board has developed travel policies and procedures and included them in a travel manual, its manual does not include some important controls over employee travel expense reimbursements. For example, it does not require supervisors to preapprove an employee's travel plans, nor does it explicitly require supervisors to subsequently review an employee's travel claim to ensure that the travel is in the State's best interest. In addition, the appeals board's travel manual does

not provide guidance to employees on how to establish a headquarters designation. We also found that employees did not always adequately document the business purpose of their travel. Specifically, when we reviewed a sample of 20 travel expense reimbursements from January 2006 to January 2008, we found that supervisors approved each of the underlying travel claims; however, for seven of these payments, totaling $8,942, the supporting documents did not adequately state the business purpose of each trip. In addition, the appeals board's former executive director, who received three of the 20 travel payments in our sample, was reimbursed for travel that did not always appear to be in the State's best interest. We noted eight instances in which the appeals board reimbursed the former executive director for lodging costs that exceeded the State's allowed rates, including one occurrence for which it reimbursed him $259 for the cost of staying one night at the Omni Hotel in San Diego, when the maximum standard rate allowed for this area was $110.

Furthermore, we found that the appeals board may have inappropriately reimbursed the former executive director for expenses that appear to be associated with commuting between his home and headquarters, because the location of his headquarters is in question. The former executive director's three travel payments totaled $6,311, and we found that $2,233, or 35.4 percent, of these costs were for travel between Oakland, the headquarters location he designated on his travel claims and the city in which his residence is located, and Sacramento. In reviewing the former executive director's supporting documents related to these three travel payments, we also noted that the State paid rental car companies approximately $977 for his use of rental cars to travel between Oakland and Sacramento. Although the former executive director designated the Oakland field office as his headquarters on the travel claims we reviewed, his employee history and other forms in his personnel file showed that his position was located in Sacramento County. Since the Department of Personnel Administration (Personnel Administration) regulations generally define headquarters as the place where an employee spends most of his or her workdays or where the employee returns upon completion of a special assignment, and because it appears that Sacramento was the former executive director's proper headquarters designation, we question whether he should have been reimbursed for travel from Oakland to Sacramento.

To ensure that employees are reimbursed only for appropriate and authorized travel expenses, we recommended that the appeals board strengthen its travel policies and procedures by requiring supervisors to preapprove employees' travel plans and to subsequently review their travel expense claims to ensure that all travel is in the State's best interest. In addition, it should update its travel manual to provide guidance to employees on how to properly designate their headquarters location. Furthermore, the appeals board should ensure that employees are reimbursed only for those lodging costs that comply with Personnel Administration's regulations.

Finally, we also recommended that the appeals board review travel-related payments it made to its former executive director from the date of his appointment as executive director/chief administrative law judge in November 2000, to determine whether those payments were reasonable and allowable. To the extent that the appeals board identifies travel reimbursements that do not comply with regulations established by Personnel Administration, it should seek recovery from the former executive director.

Appeals Board's Action: Partial corrective action taken.

The appeals board stated that it updated its travel manual to require employees to obtain prior approval from their supervisor for any travel plans. In fact, the appeals board asserted it has already drafted a new request for travel form for its employees' use. In addition, the appeals board stated that the revised travel manual now explicitly requires supervisors to audit their employees' travel claims to determine the necessity, reasonableness, validity, completeness, and accuracy of the travel expenses. Furthermore, the appeals board asserted that it has updated its travel manual to include guidance to its employees on how to properly designate their headquarters location. The appeals board stated it has already posted its new travel manual on its intranet and asserts that it will also be sending a memo to all of its employees alerting them to the changes to its travel policies and procedures by the end of December 2008.

Finally, the appeals board reports that it intends to ask the Employment Development Department for assistance in reviewing all of the travel-related payments it made to the former executive director from the date of his appointment as executive director/chief administrative law judge in November 2000, to determine whether those payments were reasonable and allowable. The appeals board hopes to complete this review by February 2009, and asserts that to the extent it identifies travel reimbursements that do not comply with Personnel Administration's regulations or that are not in the State's best interest, it will seek recovery from the former executive director.

Finding #5: Although the appeals board appears to comply with state leasing and purchasing requirements, it needs to adopt controls over its paid parking spaces.

The appeals board appears to comply with state leasing and purchasing requirements when it acquires office space, furniture, and equipment. In addition, we found that the appeals board's use of three leased state vehicles and associated fuel cards appears reasonable and allowable. However, during our review of the lease agreements and discussions with the appeals board, we noted that the appeals board pays for parking spaces at various locations. Specifically, the appeals board maintains a total of 35 parking spaces at a cost of approximately $5,000 per month at its offices in Oakland, San Francisco, Los Angeles, Inglewood, and Sacramento. According to the acting executive director, the paid parking spaces were initially intended to accommodate state vehicles, visiting Employment Development Department staff who are attending hearings, and claimants. However, the appeals board leases only three state vehicles, one each for the Sacramento, Orange County, and San Diego field office locations. In addition, the acting executive director is not aware of any appeals board policies or procedures governing the use of these paid parking spaces. Without such controls, the appeals board has little assurance that these paid parking spaces are being used for their intended purposes, and that employees are not inappropriately using them to park their privately owned vehicles at their headquarters.

We recommended that the appeals board develop and implement procedures to ensure that its paid parking spaces are used only for authorized purposes, and that employees are not inappropriately using them to park their privately owned vehicles at their headquarters.

Appeals Board's Action: Pending.

The appeals board stated that it has already begun developing procedures to ensure that its paid parking spaces are only used for authorized purposes in compliance with current regulations. Specifically, the acting executive director met with staff in December 2008 to review the draft paid parking procedures and action plan. In that meeting, she asked staff to make certain changes to the procedures and the action plan, and to return the revised documents to her prior to the January 2009 board meeting, at which time she will present them to the board members for review and discussion.

Finding #6: The appeals board does not adequately account for its information technology and communications equipment (IT equipment).

The appeals board cannot currently account for all of its IT equipment. According to the Employment Development Department's data, the appeals board spent nearly $2 million on such equipment from July 2005 through March 2008. At the request of the acting executive director, the appeals board completed a limited IT equipment survey in February 2008. According to the acting executive director, the survey revealed that the appeals board was unable to determine with certainty the location of some of its IT equipment, including computers, cell phones, and personnel digital assistant devices (PDAs). For example, the survey indicated that the appeals board could not account for 10 of the 61 computers that its asset management records indicated were located at employee residences. These computers are used by appeals board staff, such as administrative law judges and typists, who have the ability to work from their homes when reviewing cases or typing decisions. Because the appeals board does not have

accurate data on the number of computers, cell phones, and PDAs it possesses, it cannot appropriately gauge when it needs to make additional purchases of these items. In addition, the appeals board runs the risk that such IT equipment could be lost, stolen, or misused.

We recommended that the appeals board take steps to resolve the discrepancies between the IT equipment identified in its survey results and its asset management records.

Appeals Board's Action: Pending.

The appeals board stated that by the end of February 2009, responsible employees from its IT and business services units will identify ways to streamline the process for managing IT-related assets, consider shifting responsibility from one unit to the other and explain how this would be done, and develop a timeline for any necessary transition. In addition, the appeals board reported that the statewide physical inventory of all its assets is underway and is scheduled for completion by June 30, 2009. This process includes a reconciliation of the data collected during the physical inventory process. The appeals board asserts that once the physical inventory and reconciliation processes are completed, it will have a thorough and up-to-date accountability of all assets.

Department of Justice

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

INVESTIGATION I2007-0728 (REPORT I2008-1), APRIL 2008

Department of Justice's response as of September 2008

We investigated and substantiated an allegation that the Department of Justice (Justice) absorbed the cost of the salaries and benefits of four employees who were released from work full-time at various times for 12 years to participate in union-related activities based on a series of side letters that it negotiated directly with a bargaining unit. These side letters were not submitted to the Department of Personnel Administration (Personnel Administration), nor were they ratified by the Legislature.

Investigative Highlight . . .

The Department of Justice created inefficiency by entering into a series of side letters that were negotiated directly with a bargaining unit, rather than using the formal approval and ratification process; thus absorbing the salaries and benefits of four employees who were released from work full-time at various times for 12 years to participate in union-related activities at a cost of $2.4 million.

Finding: Justice created inefficiency by entering into side letters with a bargaining unit without Personnel Administration's oversight.

Justice created inefficiency in the collective bargaining process when it entered into a series of side letters with a bargaining unit, without either the appropriate approval or ratification. In particular, we determined that Justice released four employees from their normal work duties on a full-time basis to engage in union activities at various times for more than 12 years at a cost of approximately $2.4 million. This arrangement was based on side letters that never were formally submitted to Personnel Administration, the agency designated by the governor to oversee the collective bargaining process. The side letters also were not ratified by the Legislature. Although we conclude it is unlikely that Justice could recover the cost of providing full-time release for these employees, we nonetheless believe that its actions bypassed controls and deprived Personnel Administration of knowledge of the full range of benefits conferred on the bargaining unit. As a result, Personnel Administration was not able to consider this in the negotiations process.

Justice's Action: Corrective action taken.

Justice reported that two of the employees returned to their assigned full-time duties in May 2008, following the expiration of their release time agreements. The remaining two employees no longer worked for Justice or the State at the time of our report.

Department of Justice

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

INVESTIGATION I2007-0958 (REPORT I2008-1), APRIL 2008

Investigative Highlight . . .

A manager and four subordinate employees at the Department of Justice failed to properly report on their time sheets an estimated 727 hours of leave over a nine-month period in 2006, amounting to almost $18,000 in compensation that was potentially unearned. In addition, the manager failed to adequately monitor his subordinates' absences or time worked.

Department of Justice's response as of September 2008

We asked the Department of Justice (Justice) to assist us with the investigation. We substantiated that a manager and four subordinates at one of Justice's regional offices failed to properly report their absences on their time sheets for several months, in accordance with state regulations and Justice policy. In addition, Justice management failed to ensure the accuracy of their employees' time sheets.

Finding #1: A manager and four subordinates at Justice failed to properly report their absences for several months.

A manager and four subordinates at one of Justice's regional offices failed to properly report their absences for the nine-month period from April through December 2006. Because the employees did not use time sheets to track all their actual time worked, Justice was unable to determine precisely the amount of leave they took. Nevertheless, based on review of other documentation, we estimated that the manager and four subordinates did not account for 727 hours of leave for the nine-month period. As a result, the potential unearned income received by the manager and four subordinates totaled $17,974.

We found that the manager improperly allowed the four subordinates to take informal time off as compensation for unreported overtime they worked either at home or at the office, and failed to ensure that the four subordinates accurately reported their time worked and leave taken. Although the scope of our investigation was limited to the nine-month period in 2006 for which we received documentation about unreported absences, Justice learned that the manager and four subordinates continued to inaccurately report their time worked and absences taken in 2007. Justice began to investigate the 2007 time reporting improprieties before we completed our investigation.

Justice's Action: Corrective action taken.

Justice initially distributed a memorandum in January 2008 to its division chiefs reminding them of their time reporting obligations and policies. In addition, Justice reported in March 2008 that it did not intend to seek adverse actions against the four subordinates. Instead, it decided to counsel the manager and the four subordinate employees about the importance of following Justice's policies regarding proper time reporting requirements and leave use. In July 2008 Justice completed its investigation of the five employees' time reporting and found that the manager and four subordinates continued to inaccurately report their absences in 2007. Although it concluded that as in 2006, the employees failed to follow proper state policy and state regulations, Justice did not quantify the extent of the employees' unreported absences because it had already proceeded to take corrective action for the employees' failure to

observe the proper time-reporting requirements. In concluding its corrective action, Justice provided in August 2008 the subordinate employees with training specifically covering Justice's policies and procedures about leave use and time reporting.

Finding #2: Justice's management failed to ensure the accuracy of their employees' time sheets.

Our investigation determined that the manager never verified the accuracy of his four subordinates' time and did not adequately monitor his subordinates' absences or time worked. In addition, the manager failed to adequately monitor and maintain complete records for the informal leave taken and overtime his subordinates worked to ensure there was conformity between the amount of informal leave they took and the extra time they claimed to have worked. Most important, he ignored the provisions of state regulations that require him to keep complete and accurate time and attendance records for each employee.

The manager's supervisor, who works at Justice's headquarters, did not sufficiently ensure the accuracy of the manager's time sheets. She also neglected her responsibility under Justice policy to provide meaningful oversight of his time reporting and to ensure that the manager properly monitored the time reporting by his subordinates.

Justice's Action: Corrective action taken.

In February 2008 Justice reported that it instructed the manager that he could not grant informal time off to any staff member. Justice also reported that it instructed the manager and his supervisor to ensure that all leave, overtime, and alternate workweek schedules are documented appropriately and they comply with state and Justice policies and procedures. Justice further counseled the manager's supervisor in April 2008 about the need to provide more diligent oversight of her employees. Moreover, Justice documented in the manager's probation report and in a counseling memorandum the manager's failure to follow Justice's policies and procedures for time reporting and leave use. Following this disciplinary action, the manager left Justice in July 2008. Justice subsequently promoted one of the four subordinates to replace him, and in August 2008 it provided the former manager's supervisor and the management's replacement with training specifically covering Justice's policies and procedures about leave use and time reporting.

Medical Board of California's Physician Diversion Program

While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public

REPORT NUMBER 2006-116R, JUNE 2007

State and Consumer Services Agency's response as of December 2007

The Joint Legislative Audit Committee requested the Bureau of State Audits review the effectiveness and efficiency of the Medical Board of California's (medical board) Physician Diversion Program (diversion program). In our review, we found that although the diversion program had made many improvements since the release of the November 2005 report of an independent reviewer, known as the enforcement monitor, there were still some areas in which the program needed to improve in order to adequately protect the public. For instance, although case managers appeared to be contacting participants on a regular basis and participants generally appeared to be attending group meetings and completing the required amount of drug tests, the diversion program did not adequately ensure that it received required monitoring reports from its participants' treatment providers and work-site monitors.

In addition, although the diversion program had reduced the amount of time it takes to admit new participants into the program and begin drug testing, it did not always respond to potential relapses in a timely and adequate manner. Specifically, the diversion program did not always require a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug. Further, of the drug tests scheduled in June and October 2006, 26 percent were not performed as randomly scheduled. Additionally, the diversion program did not have an effective process for reconciling its scheduled drug tests with the actual drug tests performed and did not formally evaluate its collectors, group facilitators, and diversion evaluation committee members to determine whether they were meeting program standards. Finally, the medical board, which is charged with overseeing the diversion program, had not provided consistently effective oversight.

Medical Board's Action: Discontinued the diversion program.

In July 2007 the medical board met and determined that it would allow the diversion program to sunset on June 30, 2008. Due to the termination of the program, the medical board did not address individual audit report recommendations in its responses to the audit. Rather, the medical board described its transition plan, which was approved by the board in November 2007. Key components of the plan are outlined on the following pages:

Audit Highlights . . .

Our review of the Medical Board of California's (medical board) Physician Diversion Program (diversion program) revealed the following:

- *Case managers are contacting participants on a regular basis and participants appear to be attending group meetings and completing drug tests, as required.*
- *The diversion program does not adequately ensure that it receives required monitoring reports from its participants' treatment providers and work-site monitors.*
- *The diversion program has reduced the amount of time it takes to bring new participants into the program and begin drug testing, but the timeliness of testing falls short of its goal.*
- *The diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug, thus putting the public's safety at risk.*
- *Twenty-six percent of drug tests in June and October 2006 were not performed as randomly scheduled.*
- *The diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed needs to be improved.*

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» *The diversion program has not been formally evaluating its collectors, group facilitators, and diversion committee members to determine how well they are meeting program standards.*

» *The medical board has not provided consistently effective oversight of the diversion program.*

Self-referred participants:

- The diversion program will no longer admit new, self-referred physicians into the program.
- Self-referred participants with three years of sobriety will be referred to a Diversion Evaluation Committee (DEC) for a determination of whether the individuals can be deemed to have completed the program.
- On June 30, 2008, self-referred participants with less than three years of sobriety will be sent a letter stating that the diversion program is inoperative and encouraging the physicians to find another monitoring or treatment program.

Board-referred participants:

- The medical board will notify individuals seeking admission into the diversion program in lieu of disciplinary action (board-referred) that the program will be inoperative June 30, 2008, and, at that time the medical board will refer the individuals to the Attorney General's Office and enforcement for further action. Being made fully aware of this condition, participants will be given the choice of entering the program or proceeding through the enforcement process.
- Current, board-referred participants with three years of sobriety will be referred to a DEC for a determination of whether the individuals can be deemed to have completed the program.
- On January 1, 2008, board-referred participants with less than three years of sobriety will be sent a letter stating that the diversion program will be inoperative as of June 30, 2008, and that they must find another program that meets the protocols of the diversion program. In addition, the other program must be willing to report to the Medical Board's chief of enforcement on a regular basis and to immediately notify the board of any positive drug tests.

Board-ordered participants:

- The medical board will no longer approve a stipulation that requires participation in the diversion program as a condition of a disciplinary order or issuance of a probationary license.
- On July 1, 2008, the diversion program condition in all disciplinary orders will become null and void and will no longer be considered a condition of probation. However, individuals will still be required to abstain from drugs and alcohol and must submit to drug testing. Staff will continue to monitor the random drug tests of these individuals.

Out-of-state participants:

Staff will continue to liaison with programs in other states to ensure that out-of-state participants comply with that respective state's program until completion.

Medical Board of California

It Needs to Consider Cutting Its Fees or Issuing a Refund to Reduce the Fund Balance of Its Contingent Fund

REPORT NUMBER 2007-038, OCTOBER 2007

Medical Board of California's response as of November 2008

Section 2435 of the Business and Professions Code (code) directs the Bureau of State Audits to review the Medical Board of California's (medical board) financial status and its projections related to expenses, revenues, and reserves, and to determine the amount of refunds or licensure fee adjustments needed to maintain the reserve legally mandated for the medical board's contingent fund.

The medical board assesses fees for physicians and surgeons (physicians) according to rates and processes established in the code. In 2005, passage of Senate Bill 231 increased physicians' license fees (fees) from a maximum rate of $600 to $790. In addition to establishing the rate, the code also states that the Legislature expects the medical board to maintain a reserve, or fund balance, in its contingent fund equal to approximately two months of operating expenditures.

Finding #1: The medical board does not have the flexibility to adjust fees because they are established in law.

The code requires the medical board to maintain a fund balance that would cover approximately two months of operating expenditures. The code also suggests that if the fund balance becomes excessive, the medical board should take action to reduce the fund balance. However, the code does not provide the medical board the flexibility to adjust fees.

We recommended that the medical board seek a legislative amendment to Section 2435 of the code to include language that allows it the flexibility to adjust physicians' license fees when necessary to maintain its fund balance at or near the mandated level.

Medical Board's Action: Corrective action taken.

In January 2008 Assembly Bill 547 (AB 547) was amended to include language giving the medical board the flexibility to set initial licensing and renewal fees up to a maximum of $790. On September 23, 2008, AB 547 was enrolled; however, the governor vetoed this bill on September 26, 2008. The medical board indicated that it fully supports our recommendation and is considering pursuing legislation again in 2009.

Audit Highlights . . .

Our review of the Medical Board of California's (medical board) financial status and fund balance revealed that:

- *The fund balance of the medical board's contingent fund increased by $6.3 million, to $18.5 million, in fiscal year 2006–07. This represented 4.3 months of reserves, more than 100 percent above the reserve level mandated in the law.*
- *The recent increase in the fund balance resulted from variances between actual and estimated expenditures.*
- *The medical board estimates that its months of reserves will drop to 1.5 months by June 30, 2012, assuming that it spends all of its appropriations in each of the next five fiscal years.*
- *However, based on the medical board's historical experience of overestimating expenditures, we estimate that it will have 3.8 months of reserves by June 30, 2012, unless it issues refunds or decreases license fees for physicians.*

Finding #2: The fund balance of the medical board's contingent fund increased significantly in fiscal year 2006–07, resulting in reserves well above mandated levels.

The medical board's fund balance increased by $6.3 million to $18.5 million in fiscal year 2006–07, which equates to 4.3 months of operating expenditures. The increase was caused mostly by the variance between estimated and actual expenditures in fiscal year 2006–07, primarily related to a planned expansion of medical board programs that was not fully realized in that year.

We believe the fund balance is unlikely to return to the level legally mandated unless fees are reduced or refunded. In particular, while the medical board's estimated revenues consistently approximated actual revenues in the last four fiscal years, the medical board has consistently overestimated expenditures by at least $2 million each year over the same period. Based on the medical board's future revenue and expenditure estimates, adjusted downward by $2 million for the expenditure difference just described, we estimate that the medical board still would have 3.8 months of reserves on June 30, 2012.

We recommended that the medical board consider refunding physicians' license fees or, if successful in gaining the flexibility to adjust its fees through an amendment to existing law, consider temporarily reducing them to ensure that its fund balance does not continue to significantly exceed the level established in law.

Medical Board's Action: Pending.

The medical board said it considered reducing or refunding license fees but instead initiated several other actions that would bring its fund balance into line with mandated levels. These are:

- Seek legislation to increase the mandated two-month reserve to four or six months.
- Seek budget authority to reestablish the Operation Safe Medicine Unit, to expand the Probation Program, and to replace its information technology infrastructure.
- Conduct a study to determine whether seeking an increase in salaries for investigators is warranted.
- Increase spending in fiscal year 2008–09 related to a new telephone system, office relocations, and rent.
- Decrease revenues in fiscal year 2008–09 by eliminating a convenience fee for on-line cashiering.

We note that as of June 30, 2008, the medical board's reserves had grown to $23.9 million or 5.6 months of reserves according to the State Budget Status and Budget Expenditures Status Report provided by the medical board's executive director to the medical board in November 2008.

California Department of Corrections and Rehabilitation

It Needs to Improve Its Processes for Contracting and Paying Medical Service Providers as Well as for Complying With the Political Reform Act and Verifying the Credentials of Contract Medical Service Providers

REPORT NUMBER 2006-501, APRIL 2007

California Prison Health Care Receivership Corporation's[1] response as of June 2008

The state auditor has the authority to audit contracts involving the expenditure of public funds in excess of $10,000 entered into by public entities, at the request of the public entity. The court-appointed receiver requested that the Bureau of State Audits (bureau) conduct an audit of a variety of issues related to existing contracts between the California Department of Corrections and Rehabilitation (Corrections) and certain medical care providers. Specifically, the receiver requested that the bureau review Corrections' processes for procuring medical registry services and its practices involving these services for fiscal year 2005–06 and to determine whether the process is fair and adequate and complies with all applicable laws and regulations, whether the language used in medical registry contracts is adequate and complete and written in the best interests of the State, and whether conflicts of interest exist related to procuring the medical services.

Additionally, the bureau was asked to examine Corrections' medical registry contracts and payment practices for fiscal year 2005–06 and to determine whether contractors comply with the terms and conditions of the contracts, and whether Corrections' accounting and payment practices for contracts comply with laws, regulations, and industry practices. Finally, the bureau was directed to review the medical registry contracts and compare the rates Corrections pays contractors with the amounts the contractors pay their medical care providers, and to determine whether the contractors and medical care providers rendering services in the prisons meet all applicable licensing and certification requirements.

[1] In May 2005, four years after the Plata Davis (Plata) lawsuit was filed, and after meeting regularly with the parties to the Plata settlement, the court conducted hearings to determine if it was necessary to appoint an interim receiver. In February 2006 the court appointed a receiver. The court order making the appointment gave the receiver the authority to "provide leadership and executive management of Corrections' medical health care delivery system with the goal of restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all members of the class action lawsuit as soon as practicable." To achieve those goals, the receiver has the duty to control, oversee, supervise, and direct all administrative, personnel, financial, contractual, legal, and other operational functions of Corrections' medical health care delivery system. In making these recommendations to Corrections, we understand that they would be implemented at the direction of the court-appointed receiver. We do, however, expect that if control and management of Corrections' medical health care delivery system is returned to it, that Corrections would then become responsible for implementing these recommendations.

Audit Highlights . . .

Our review of the California Department of Corrections and Rehabilitation's (Corrections) contracts for medical services revealed the following:

- *Corrections improperly awarded nine of 18 competitively bid contracts with a total maximum amount of more than $385 million.*
- *Corrections did not provide complete justifications for awarding two noncompetitively bid contracts totaling almost $80 million.*
- *Some aspects of Corrections' treatment of some medical providers raises concerns about whether they are, in fact, treated more as employees than independent contractors, which may expose the State to potential liability and penalties.*
- *Only 16 of the 21 contracts we reviewed contained terms that meet the standard of medical care called for in Corrections' regulations.*
- *Many of the contracts we reviewed did not contain terms that Corrections considers standard in medical service contracts to adequately protect the confidentiality, privacy, and handling of inmate medical records under the federal Health Insurance Portability and Accountability Act.*
- *Although all contracts in our sample gave Corrections the ability to inspect and monitor the quality of contractor performance, only five of the 21 contracts imposed a similar obligation on the medical care service providers.*

continued on next page . . .

- *Corrections overpaid registry contractors by $4,050 for five invoices because prisons did not consistently ensure that payment amounts agreed with contract terms.*
- *Corrections failed to ensure that prisons require their consultants to complete statements of economic interests or to document why it was appropriate for them not to do so.*
- *Corrections did not verify the credentials of providers who treat inmates outside of Corrections' facilities because it incorrectly believed these reviews were being conducted by the Department of Health Services.*
- *Of the 22 physicians and nurse practitioners for which we requested credentialing files, Corrections was only able to provide 12. Of these 12, eight were credentialed after they had begun providing services to inmate patients.*

Finding #1: Corrections did not always award contracts according to state policy or its own policy.

Corrections awarded nine of 18 competitively bid contracts incorrectly. Specifically, in awarding these nine contracts, Corrections assigned incorrect hierarchy positions to bidders, primarily because its practice was to apply the small business preference—a 5 percent preference given to small businesses bidding on state contracts—to the bidders' hourly rate rather than the bid price. As a result, for seven contracts Corrections failed to limit the preference to $50,000, as state law and regulations require, and for all nine contracts it gave bidders a larger preference than allowed, causing some bidders to incorrectly receive higher-ranking positions.

Corrections uses a cost threshold to limit the number of contract awards for its registry contracts but it does not have any written policies or procedures for determining the cost thresholds. Additionally, Corrections' solicitation documents did not inform the bidders of its use of a cost threshold or its methodology for calculating the threshold. Further, Corrections did not always apply the cost thresholds properly according to its stated methodology and, as a result, improperly awarded one contract and excluded another bidder from the opportunity to provide services. Finally, we found that Corrections did not always calculate the cost threshold using the methods it described to us and based on our calculations, it improperly awarded contracts. When Corrections does not apply the small business preference or its cost threshold properly, it may be unfairly preventing contractors from providing registry services or selecting contractors who do not meet its criteria.

We recommended that Corrections ensure that staff receive proper training on bidding methods, including the appropriate application of the small business preference, so that bidders are awarded contracts in the correct order. We also recommended that Corrections establish policies and procedures for determining the cost threshold used to limit the number of awards made to registry contractors and implement a quality control process to ensure staff calculate the cost threshold correctly and retain documentation to support their calculations in the contract files. Further, we recommended that Corrections notify potential bidders of its use of a cost threshold to determine the awards to be made and its methodology for calculating the threshold. Finally, we recommended that Corrections implement a quality control process to identify errors in the ranking of bidders before awarding contracts.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver stated that it agrees that staff should receive additional training on bidding methods and its managers are currently providing informal training in the area of bidding and application of small business preferences. Although the Office of the Receiver anticipated developing formal training materials by March 2008, it stated that this process was delayed to May 2008 due to additional time required to enhance the Excel spreadsheet it uses to process calculations and improve its training materials and presentations. Formal training will begin in June 2008.

The Office of the Receiver stated that its Plata Contract Branch has developed and implemented an interim methodology to determine the cost threshold when establishing the number of contract awards. Staff are required to complete spreadsheets that capture and tabulate bid calculations. Staff then consider multiple requirements such as number of bids falling within the criterion, current contract rates and current civil service compensation, if applicable, to determine the number of awards. Staff submit the rate approval packages to managers for review and approval. After manager approval, the rate package is sent to a second level for review and approval.

Regarding our recommendation to implement a quality control process to ensure staff calculate the cost threshold correctly and retain documentation to support their calculations in the contract files, the Office of the Receiver stated that management oversight and review of the spreadsheets that capture and tabulate bid calculations is one of the current quality control processes utilized to ensure accurate calculation of cost threshold and document retention for the bid process. Also, the Office of the Receiver stated that it created a Post Review Unit in the fall of 2007 to address overall quality control issues in contract processes. According to the Office of the Receiver, the Post Review Unit developed its infrastructure, workforce, and initial documentation necessary to perform internal post reviews of individual contract processes with preliminary testing of documentation utilized to review individual contracts commencing in April 2008.

Regarding our recommendation to notify potential bidders of its use of a cost threshold to determine the awards to be made and its methodology for calculating the threshold, the Office of the Receiver stated that it issues a notification of contract awards and the bid matrix it utilized in determining the cost threshold to contractors who submitted bids or contractors requesting copies through the California Public Records Act. However, this information does not reflect the methodology it used for cut-off purposes. The Plata Contract Branch has no immediate plans of providing pre-notification to potential bidders of methodologies used to determine cost thresholds due to the complexity in determining the number of awards to be made which varies by medical specialty.

Finally, the Office of the Receiver stated that it obtained a consultant to provide a review of its current staffing resources and functions in the near future. The Post Review Unit only provides review of a contract after it is fully executed. Therefore, the current quality control process used to identify errors in the ranking of bidders before awarding contracts continues to be addressed through management oversight and review of the spreadsheets staff complete to rank bidders.

Finding #2: Corrections' justifications for awarding two competitively bid contracts were incomplete.

State policy requires a minimum of three competitive bids except in certain circumstances. Corrections did not always retain complete justifications for awarding contracts when receiving fewer than three bids. Specifically, for two of 18 competitively bid contracts, Corrections did not receive three bids and did not justify the reasonableness of the award amounts. Also, although Corrections advertised these two contracts in the California State Contracts Register, it could not demonstrate that it solicited all known potential contractors as state policy requires. Consequently, Corrections was not exempt from complying with state policy requirements for awarding contracts with fewer than three bids.

We recommended that Corrections fully comply with state policy, including justifying and documenting the reasonableness of its contract costs, when it receives fewer than three bids. We also recommended that Corrections retain documentation of its efforts to solicit all known potential contractors when it advertises in the California State Contracts Register.

Corrections' Action: Partial corrective action taken.

According to the Office of the Receiver, it is currently tracking approved rates by discipline using an Excel spreadsheet. A component of the standardized rate package is verification of civil service pay scales and benefits, if applicable; inclusion of rate information from prior or active contracts; and documentation justifying reasonableness of rates and why current providers (for bid services) are unable to provide services. The Office of the Receiver also stated that staff continue to receive informal contract process training, and staff will be receiving formal training commencing in

June 2008 in the bid and contract packaging processes. Documentation including, but not limited to, list of bidders who requested bid packages through the Plata Contract Branch or accessed bid documents via the Department of General Services' Contracts Register will be maintained in the bid or contract files.

Finding #3: Corrections could not justify the prices contained in two noncompetitively bid contracts.

Corrections did not retain justifications for the rates found in two of three noncompetitively bid contracts we reviewed. For one contract, with a maximum amount of almost $79 million, Corrections did not have documentation to support that the rates determined were fair and reasonable. For the second contract, with a maximum amount of $1 million, Corrections obtained approval from the Department of General Services (General Services) using a special category noncompetitively bid exemption request. However, Corrections was unable to produce documentation to support compliance with specific conditions of approval including following the price analysis and methodology requirements of the special category exemption. When Corrections does not justify and document the reasonableness of the contract rates it agrees to pay, in accordance with the methodology approved by General Services, it is unable to demonstrate that the rates are appropriate and reasonable.

We recommended that Corrections fully comply with state policy including justifying and documenting the reasonableness of its contract costs when it chooses to follow a noncompetitive process. We also recommended that Corrections adhere to the price analysis and methodology approved by General Services when using the special category noncompetitively bid request process. For example, it should use Medicare rates as a benchmark for determining the reasonableness of its rates paid to contractors.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver stated it is providing informal training to staff on General Services' Standardized State Contracting process for noncompetitive bid contracts. Additionally, the Office of the Receiver is scheduled to commence formal training in June 2008.

According to the Office of the Receiver, Medicare does not apply to registry contracts, which are typically based on hourly rates. Staff who process noncompetitive bid contracts submit rate approval packages that include documentation pertaining to the reasonableness of rates, market survey, and the reason for the noncompetitive bid contract if outside of a current approved rate package for the same services and geographic area. The Office of the Receiver stated that rates are approved using the Rate Approval Process guidelines it approved in April 2008. The Receiver's consultant submitted a report, dated September 2006, which provided a recommendation to convert exempt medical rates for physician, medical group, and hospitals to a percentage of Medicare. The Office of the Receiver implemented this recommendation and is currently tracking information pertaining to exempt medical rates in an Excel spreadsheet. Additionally, the related documentation on approved rate packages is scanned and stored on shared network drives.

Finding #4: Corrections paid some contractors for services provided before their contracts were approved by General Services.

For four contracts we reviewed, we noted seven instances, totaling almost $20,000, in which registry contractors were performing service at prisons before Corrections obtained General Services' final approval of the contracts. When Corrections does not ensure that it obtains proper approval before allowing contractors to perform services, it exposes the State to potential litigation if General Services does not approve the contract.

We recommended that Corrections ensure that it establishes internal control processes that prevent prisons from allowing contractors to perform services before receiving General Services' approval of the contract.

Corrections' Action: Corrective action taken.

The Office of the Receiver stated that its Plata Contract Branch is striving to ensure contracts are fully executed before services are provided at the institutions. However, adequate medical care must be provided in order to mitigate mortality and morbidity based on various federal court cases.

Finding #5: Some contracts did not contain Corrections' standard contract terms.

Three of 21 contracts in our sample did not contain terms that required Corrections to provide 24 hours notice to a medical registry if services had been scheduled but were not needed for a particular shift. Our legal counsel advised us that the reviewing court would likely find that reasonable notice would be an implied term of the contract. However, litigation can be averted if the parties define what constitutes reasonable notice in the contract.

We recommended that Corrections' medical registry contracts contain express provisions related to the required notice period for cancellation.

Corrections' Action: Corrective action taken.

The Office of the Receiver agrees with this recommendation and stated that it has developed and incorporated standardized contract cancellation language into its renewal or new exempt and bid medical contracts.

Finding #6: Some contracts lack Business Associate Agreements that ensure compliance with federal requirements related to privacy, confidentiality, and transfer of inmate medical records.

Under the Health Insurance Portability and Accountability Act (HIPAA), Corrections may act as a covered entity in the provision of medical care to inmates and the various contractors with whom it does business may act as "business associates." As business associates, those contractors are obligated to follow HIPAA, which imposes various obligations related to the confidentiality and handling of prisoner medical information. HIPAA also requires that a business associate enter a Business Associate Agreement that imposes specific obligations designed to ensure compliance with HIPAA. Only six of 21 contracts we reviewed contained the required Business Associate Agreement.

We recommended that Corrections include Business Associate Agreements in all contracts subject to HIPAA and amend existing contracts to include those agreements.

Corrections' Action: Corrective action taken.

The Office of the Receiver agrees with this recommendation and has developed an exhibit that includes standard language pertaining to HIPAA. The Office of the Receiver stated that its Plata Contract Branch has developed a public-access Web site with anticipation that the HIPAA exhibit and other standard documents attached by reference will be available for public use beginning in September 2008.

Finding #7: Corrections' treatment of its independent contractors raises concerns about whether they are, in fact, employees.

Although all the contracts in our sample contained terms that indicate medical registries act as independent contractors, we surveyed each of the contracting medical registries in our sample to evaluate their relationship with Corrections based on 20 general factors that the U.S. Department of the Treasury, Internal Revenue Service (IRS), uses to determine whether a worker is an employee or an independent contractor. Most of the contractors noted that they are not required to comply with

specific instructions from Corrections on how to perform their services and half noted that they pay their workers directly, rather than having them paid by Corrections, which indicates a level of autonomy associated with that of an independent contractor. Other factors, however, suggest several areas in which Corrections appears to maintain a significant degree of control over the manner and means of performing the work. We noted that the IRS and the courts do not expressly state a single, definitive rule regarding what constitutes an independent contractor. Instead, the courts and the IRS make each decision based on the totality of the circumstances. As such, it is difficult to say whether medical registries would be deemed independent contractors or Corrections' employees.

Potential liability and penalties for misclassification of an employee include substantial taxes, back pay, and reimbursement of expenses. Furthermore, California does not make a distinction between intentional and unintentional misclassification of an employee. Thus, the responsibility for proper conduct and classification of an independent contractor falls upon the employer.

To ensure that there is no uncertainty surrounding the legal status of contract employees, we recommended that Corrections seek expert advice and legal counsel to determine whether its current treatment of certain medical registry service providers is such that those medical registry service providers should be considered employees rather than independent contractors.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver stated that the issue as to whether or not registry employees are employees versus independent contractors is a statewide issue that will be referred to the State Personnel Board. This question has statewide implications and is beyond the scope of the Receiver.

The Office of the Receiver also stated that it is in the process of hiring full-time permanent civil service clinical staff, and there will be, over time, an elimination or significant reduction in Corrections' reliance on registries.

Finding #8: Contract terms related to the standard of care are inconsistent and sometimes ambiguous.

All 21 contracts in our sample contained terms related to the standard of care. However, only 16 contained terms that appear to meet the legally required standard contained in regulation. Even then, the language used to describe the standard of care in these 16 instances varies widely. Despite this variation, we considered all these terms to be essentially the same in that they appeared to call for the legally required standard of care set out in regulation. In four other contracts, the contracts contained terms that appear to have been drafted in an attempt to be consistent with the standard of care set out in regulation, but rather than requiring the contractor to meet that standard, they required the contractor to provide medical care "necessary to prevent death or permanent disability." According to our legal counsel, this language does not meet the minimum standard set out in regulation and appears to establish a potentially lower standard of care. In addition, one contract contained only a requirement that the contractor provide services consistent with scope of practice and did not prescribe a standard that was specific to a prison setting.

We also noted that many of the contracts in our sample contained multiple terms related to the standard of care within the same contract. In some cases, these terms appear to be inconsistent with one another. For example, 14 of 21 contracts contained terms requiring contracting medical care providers to follow the legally required standard in regulation and to follow generally accepted professional standards or national standards. We do not in any way question the value of following generally accepted professional standards or national standards. However, because it is not necessarily clear that Corrections' regulatory standard and the standard of care called for by professional or national standards are the same, this inconsistency may create an ethical dilemma and confusion on the part of medical care providers and may even result in litigation. We also noted a lack of consistency across our sample in terms of the standard of care being required. For example, only seven of 21 contracts required the contractors to meet national standards.

Finally, we found that some contracts contained terms related to the standard of care that were inconsistent with the American Medical Association's (AMA) recommendations. The AMA recommends that a contracting physician not obligate himself or herself to a standard of care that is higher than that required by law. Several contracts we reviewed called for the provider to meet Corrections' standard of care and called for "high quality" or even the "highest level of treatment within the scope of available resources" as the standard of care. Although we do not in any way question the importance of providing high-quality medical care to inmates, drafting contracts containing multiple terms that may suggest differing standards of care creates an ambiguity that may result in uncertainty on the part of the provider, and potential disagreement among the contracting parties, about just what is required under the contract.

We recommended that Corrections' medical registry contracts contain clear and consistent requirements related to the standard of care called for under the contract. At a minimum this standard of care must meet the standard of care needed in order to satisfy Corrections' obligations under the Plata settlement agreement. Also, to ensure that Corrections' contracts contain terms for standard of care that meet its constitutional obligations as well as the standard of care that a practicing physician would provide if adhering to generally accepted ethical norms, Corrections should seek legal counsel and other expert advice to determine whether the standard of care currently prescribed in state regulations allows contracting physicians to provide medical care in a manner that is consistent with the generally accepted standard of care in the medical community. If the standard of care is not consistent with the generally accepted standard of care in the medical community, Corrections should revise its regulatory standard to require that the standard of care called for in the State's prisons is, at a minimum, consistent with medical ethics and with the State's constitutional obligations.

Corrections' Action: Partial corrective action taken.

According to the Office of the Receiver, it will ensure that Corrections' contracts include constitutional levels of care for prisoners, as the Receiver's mandate is to establish constitutional levels of medical care in California's prisons. However, the remainder of the recommendations that involve community standards of care may be more suitable for state consideration after the Receiver's work is completed and authority over Corrections' medical system is returned to the State.

Finding #9: Contract terms should impose clearer obligations for contractors to be insured against civil rights claims.

We found that all the contracts we reviewed called for the recommended level of liability coverage as specified by the State. However, although some of the contracts contained terms requiring the contractor to notify the insurance carrier that the contractor regularly provides services to inmates, it is not clear that this term necessarily would ensure that the contractor was insured against civil rights claims.

We recommended that Corrections require medical registries to submit proof that their insurance company has agreed explicitly to insure them against civil rights claims.

Corrections' Action: None.

According to the Office of the Receiver, no evidence has been provided that this recommendation is based upon specific cases of monetary loss. For example, no evidence has been submitted that the State has experienced losses due to civil rights violations by registry personnel. The Office of the Receiver states that while it agrees that a contract provision requiring an insurance company represent clinical registries concerning civil rights claims may seem desirable in theory, this requirement in practice is not one of the Receiver's top priorities for several reasons, including the following: (1) mandating such a clause may drive up the cost of registry contracts to a degree that is not fiscally justified; (2) private insurance carriers may not offer civil rights coverage because civil rights liability is, under certain circumstances, driven by "deliberate indifference" rather than negligence; and (3) given the existing unconstitutional conditions at many prisons, the insurance

carrier may defend claims against registry staff by cross-complaining against the State because of the situation the registry clinician was placed. Therefore, we do not intend to implement this recommendation at this time.

Finding #10: Although many contracts require Corrections to inspect and monitor performance, few impose obligations on contractors to monitor or assess their quality of service.

All of the contracts in our sample enabled Corrections to inspect and monitor the quality of contractor performance. However, only five contracts imposed a corresponding obligation on the part of medical registries to monitor and assess the quality of their own performance.

We recommended that Corrections require registry contractors to monitor and assess the quality of services they provide under the contract.

Corrections' Action: None.

The Office of the Receiver stated that while it agrees that a contract provision requiring registries to monitor and assess the quality of their services may seem desirable in theory, in practice this requirement is not one of the Receiver's top priorities for several reasons, including the following: (1) mandating such a clause may drive up the cost of registry contracts to a degree that is not fiscally justified, (2) the monitoring and assessing of quality is a Receivership function and should not be delegated to private providers, and (3) there is no guarantee that the registry will perform this task adequately and therefore the Receiver will need to monitor the monitoring by the registry, which may be a fiscally unsound method of ensuring adequate clinical quality by registry staff. The Office of the Receiver also stated that it is in the process of hiring full-time permanent civil service clinical staff, and there will be, over time, an elimination or significant reduction in Corrections' reliance on registries.

Finding #11: Prisons did not always follow Corrections' procedures and contract terms for using registry contractors.

When prisons need to hire a service provider under a medical registry contract, Corrections requires them to follow the hierarchy outlined in the registries' contracts. For 22 of 38 invoices we reviewed that were subject to the hierarchy requirement, prisons did not provide us with sufficient documentation to demonstrate that they followed the hierarchy when obtaining services from registry contractors. When prisons do not consistently document their attempts to contact registry providers in accordance with the hierarchy, they expose the State to potential lawsuits from registry contractors for breach of contract terms and they hinder Corrections' ability to terminate registry contractors for nonperformance.

Also, we found that Corrections' policy allows prisons to send requests for services concurrently to all registries listed in the hierarchy. During our interviews with the 16 contractors in our sample, a few commented that, as a result of this practice, the providers do not respond to the contractors with the lowest bid but instead wait to be called by the contractors with the higher bids because they can receive more money.

We recommended that prison staff consistently follow procedures requiring them to document their efforts to obtain services from registry providers. We also recommended that Corrections reevaluate its policy of allowing prisons to send out service requests concurrently to all registry contractors listed in the hierarchy.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver reiterated the response it provided to us in finding number one to describe the efforts it has taken to ensure prison staff consistently follow procedures requiring them to document their efforts to obtain services from registry providers. Also, related to the recommendation that Corrections reevaluate its policy of allowing prisons to send out service requests concurrently to all registry contractors listed in the hierarchy, the Office of the Receiver stated that using the concurrent process to request services is effective, as once the deadline has passed and requests are received (or not), institutions follow the hierarchy ranking order to request services based on response received.

Finding #12: Prisons sometimes fail to monitor invoices for medical services adequately.

Prisons could not provide sufficient evidence of their verifications that services were performed before they authorized payment for three of 50 invoices we reviewed. Prisons also did not always identify and adjust discrepancies between contract rates and providers' invoice charges resulting in overpayment of $4,050 for five invoices that totaled $458,346. In addition, prisons paid overtime on seven invoices even though contractors did not adhere to the contract provisions for overtime. Further, prisons and regional accounting offices failed to take available discounts or took the wrong discounts for the wrong amounts in 14 instances, and paid contractors late penalty payments in four instances because they failed to pay the invoices in compliance with the California Prompt Payment Act (CPPA).

We recommended that Corrections ensure that prisons verify the services they receive from registry contractors before authorizing payment of invoices and continue to implement the draft of a departmentwide policy reiterating the need for prison medical staff to adhere to proper procedures for verifying registry contractors' hours before authorizing payment.

We also recommended that Corrections ensure that prisons obtain the necessary documentation for the services they were unable to verify or seek reimbursement from the registry contractors for the overpayments identified in this report and establish a quality control process to ensure that prisons pay rates that are consistent with contract terms.

Further, we recommended Corrections ensure that prison staff responsible for authorizing overtime adhere to overtime policies and contract terms. Corrections should also evaluate its prisons and regional accounting offices' processes for paying invoices and identify weaknesses that prevent it from maximizing the discounts taken and complying with the CPPA.

Corrections' Action: Partial corrective action taken.

According to the Office of the Receiver, it directed its invoice processing staff to ensure that all invoices are routed to the proper authorizing personnel for authorization of services before the invoices are sent to accounting for payment. The Office of the Receiver stated that its invoice processing system and processes require separate electronic review and approval steps prior to invoices being routed to accounting for processing of payment.

Regarding our recommendation to continue to implement the draft of a department-wide policy reiterating the need for prison staff to adhere to proper procedures for verifying registry contractors' hours before authorizing payment, the Office of the Receiver referred us to its previous discussion regarding management oversight and review of the spreadsheets that capture and tabulate bid calculations as one of the current quality control processes utilized to ensure accurate calculation of cost threshold and document retention for the bid process. Also, the Office of the Receiver stated that it created a Post Review Unit in the fall of 2007 to address overall quality control issues in contract processes.

The Office of the Receiver also stated that it conducted a review of the overpayments identified in our report and the total reimbursement amount was less than $60 and that collection would likely cost more. However, we disagree with the Office of the Receiver's conclusion that the reimbursement amount was less than $60. In fact, one of the overpayments we identified, Corrections' staff requested reimbursement from the contractor for $160 during our audit. Additionally, our review of invoices indicated that Corrections did not pay invoices according to the contract rates resulting in overpayments to one contractor totaling $3,890. Corrections indicated that it reviewed the invoices and that the contractor either billed according to the contractor or the net errors amounted to small amounts. However, Corrections did not provide us with documentation to support its conclusions that the errors did not exist or were minimal. Therefore, we stand by our original analysis and conclusion that the contractor was overpaid. Further, related to our finding that Corrections paid seven invoices that included overtime even though it could not demonstrate compliance with overtime provisions, the Office of the Receiver stated that six invoices were paid at the appropriate rates. However, as we state in the report, our finding was that the contractors must obtain written approval for overtime from the prison's health care manager, chief medical officer, or designee and must submit a copy of the written approval with the monthly invoice. Our review found that Corrections paid invoices without this documentation.

Related to our recommendation that Corrections establish a quality control process to ensure that prisons pay rates that are consistent with contract terms, the Office of the Receiver stated that the Healthcare Invoice, Data and Provider Services Branch (HIDPSB) has developed and trained invoice processing staff to utilize resources to research contracts and rate agreements in order to ensure invoices are paid in accordance with contract or rate agreements terms and conditions. The Office of the Receiver also stated that it has implemented a two-phased system to ensure all existing and new contracts, contract amendments, and interim rate agreements are readily available for all invoice processing analysts including actively transmitting all rate information electronically to each analyst and placing the same information into labeled folders on the division server for easy access reference. In addition, single points of contract have been identified within the entities producing rate-related documents from which HIDPSB receives that data.

Regarding our recommendation to ensure that prison staff responsible for authorizing overtime adhere to Corrections' overtime polices and contract terms, the Office of the Receiver referred us to its previous discussion regarding management oversight and review of the spreadsheets that capture and tabulate bid calculations as one of the current quality control processes utilized to ensure accurate calculation of cost threshold and document retention for the bid process. Also, the Office of the Receiver stated that it created a Post Review Unit in the fall of 2007 to address overall quality control issues in contract processes.

Finally, related to our recommendation that Corrections evaluate its prisons and regional accounting offices' processes for paying invoices and identify weaknesses that prevent it from maximizing the discounts taken and complying with the CPPA, the Office of the Receiver stated it agrees with the recommendation. Specifically, its new contracting and invoice processing system that was being piloted at four institutions has been expanded to include three more prisons. This expansion will continue and additional prisons will be centralized at headquarters at the rate of approximately two every four weeks, to the extent unforeseen software, hardware, or other delaying barriers are not encountered, until all 33 prisons are centralized. The Office of the Receiver expects that when the system is completed, Corrections will gain efficiencies that will improve the payment time frames and thereby maximize the discounts taken. The Office of the Receiver anticipates completing implementation of the system by June 30, 2009.

Finding #13: Corrections fails to demonstrate that it complies fully with certain political reform act requirements.

Corrections lacks adequate controls to ensure that it complies with the duties and responsibilities outlined in the political reform act for filing officers. Specifically, Corrections could not demonstrate that all employees and consultants required to file statements of economic interests and seek approval before engaging in outside employment did so. We reviewed 124 statements and found

that seven employees did not complete their statements correctly and 78 filed their statements late. Also, we found that 14 employees did not file statements at all. Further, seven of nine prisons did not submit a copy of the statements for their health care consultants or the chief executive officer's written determination that their consultants were not required to comply with disclosure requirements.

We recommended that Corrections establish an effective process for tracking whether its designated employees, including consultants, have filed their statements of economic interests timely. We also recommended that Corrections review the statements of economic interests to ensure their accurate completion and to identify potential conflicts of interests. Further, we recommended that Corrections ensure that the chief executive officer retains his or her written determinations for consultants.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver agrees with the recommendations to establish an effective process for tracking whether its designated employees, including consultants, have filed their statements of economic interests timely, and to review the statements of economic interests to ensure their accurate completion and to identify potential conflicts of interests. According to the Office of the Receiver, it determined that current Corrections' regulations do not specifically cover positions in the California Prison Health Care Services Division. However, it has established an action plan for the 2009 filing period that will entail the development of regulations to cover these positions. The Office of the Receiver also reported that it identified 122 designated positions similar to those that would be designated as subject to filing in accordance with Corrections' regulations and that employees in the designated positions were asked to complete Form 700, Statement of Economic Interests for the 2008 annual filing year. Additionally, the Office of the Receiver completed a database that identifies and tracks established, assuming, and departing designated positions. Furthermore, the Office of the Receiver stated that it has developed an action plan for the 2009 annual filing year that includes the following: (1) working collaboratively with the Fair Political Practices Commission to develop training classes for designated filers to ensure their understanding of the process, law, and filing requirements; (2) enhancing the current tracking database to ensure follow-up activities are conducted timely and add a compliance component to ensure the California Prison Health Care Services Division adheres fully to all applicable laws and regulations; (3) implementing a newly developed personnel management system to establish an alert process for all assuming and departing positions for Form 700 filing purposes; and (4) working closely with the California Prison Health Care Services Division contract unit to identify and track consultants for Form 700 filing purposes and potential conflict-of-interest activities.

Finally, the Office of the Receiver does not agree that registry consultants should be interpreted as "consultants" for purposes of annual conflict of interest disclosure purposes. According to the Office of the Receiver, it requested a legal opinion from Corrections' legal office in October 2007 but has not received a response. Therefore, the Office of the Receiver plans to request a legal opinion from attorneys of the California Prison Health Care Receivership Corporations no later than August 15, 2008.

Finding #14: Corrections' credentialing unit often failed to verify properly the credentials of registry contractors' providers.

The credentialing unit does not verify the status of all providers who treat inmate patients. Specifically, the credentialing unit does not perform database searches for providers who treat inmate patients outside of Corrections' facilities. The credentialing unit also does not perform database searches of providers who it classifies as allied health professionals, such as pharmacists, registered nurses, laboratory technicians, radiological technicians, dietitians, and physical therapists.

In addition, Corrections does not have a departmentwide policy directing the prisons to verify the credentials of these providers, which creates confusion and the risk that providers will not undergo any credentialing before performing services. The credentialing unit also does not perform database searches on all physicians and nurse practitioners who provide services to inmate patients. The credentialing unit performs a search only after the prisons submit a request.

Finally, the credentialing unit's database search method is inefficient. Specifically, providers' credentials are verified each time they move to another prison. According to Corrections' former credentialing coordinator, who is now the manager of the Plata Support Division's Pre-Employment Clearance Unit, based on information provided by the U.S. Department of Health and Human Services, she believed that because each prison has its own formal peer review process to further quality health care, federal law requires Corrections to register them as separate eligible entities for purposes of querying the databases. She also stated that Corrections' management has not formally adopted a written policy regarding her interpretation of federal law. This current process appears unnecessary and a waste of time and money.

We recommended that Corrections require the credentialing unit to verify the credentials of contracted providers who work in non-Corrections' facilities or, at a minimum, verify that these facilities have a rigorous process for verifying the credentials of their providers. Corrections should also establish a policy to define allied health professionals and to identify professionals who will be credentialed by the credentialing unit versus those credentialed by the prisons. We also recommended that Corrections require the credentialing unit to determine whether the credentials of those medical and allied health providers who are performing services at prisons under registry contracts have been verified. If not, the credentialing unit should verify them. Further, we recommended that Corrections ensure that prisons request National Practitioners Data Bank searches from the credentialing unit before allowing providers to perform services. Finally, we recommended that Corrections seek clarification from the U.S. Department of Health and Human Services regarding the criteria for eligible entities and whether or not all prisons can be combined into one eligible entity.

Corrections' Action: Partial corrective action taken.

According to the Office of the Receiver, it agrees with the recommendations and on August 30, 2007, it disseminated a contract provider policy that outlines the policy and procedure regarding what is required to credential contract providers that provide on-site services. The policy also defines allied health providers and details the providers that require credentialing. The Credentialing and Privileging Unit completes a pre-employment review on all designated licensed independent and allied health providers prior to services being started and for each individual institution the provider requests to work. This is done to gain better control and accountability of the providers, verify work performance of the providers, and ensure that providers that have been released from one prison for less than favorable cause are not gaining employment at another prison. The directive to comply with this pre-employment credential verification has been given to the health care management at all 33 institutions as well as regional and headquarters staff. Additionally, a new contract provider policy, also disseminated on August 30, 2007, instructs the Health Care Management and Institutional Personnel officers that they shall not hire any licensed independent provider until a credential verification has been completed and approved by headquarters' Credentialing and Privileging Unit and the medical contracts have had language added requiring a credential approval prior to a contract provider being allowed to provide services to each prison.

The Credentialing and Privileging Unit also compares reports to verify that a credential review and approval was completed for new hires. The Office of the Receiver reports that there are inconsistencies and compliance issues with the process that are being addressed. The Credentials Committee is developing a process and directive memo to health care management identifying the requirement, time frame to comply, and the consequences for failing to comply. The Receiver anticipates the memo to be completed and distributed by June 2008.

Additionally, related to the recommendation to require the credentialing unit to verify the credentials of contracted providers who work in non-Corrections facilities or, at a minimum, verify that these facilities have a rigorous process for verifying the credentials of their providers, the Office of the Receiver stated that the credentials committee has determined that the off-site services in licensed community hospitals will not require an additional credential review by Corrections as the licensed community facility is responsible for the credentialing and privileging activity and competency monitoring. Independent providers are and will be verified and approved by the Credentialing and Privileging Unit or the Credentials Committee prior to receiving a start or hire date commitment.

Finally, related to the recommendations regarding the National Practitioners Data Bank searches, the Office of the Receiver stated that with the establishment of the Corrections formal peer review structure within the Professional Practices Executive Committee, the Credentialing and Privileging Unit centrally using the National Practitioners Data Bank to complete all pre-employment credential activity, and the current implementation of a web-based credentialing IT solution, the issues we raised regarding the National Practitioners Data Bank reporting will be addressed.

County Poll Workers

The Office of the Secretary of State Has Developed Statewide Guidelines, but County Training Programs Need Some Improvement

REPORT NUMBER 2008-106, SEPTEMBER 2008

Office of the Secretary of State and five county registrar offices' responses as of November 2008 (three counties did not provide a 60-day response)

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct an audit of the county registrars' training of poll workers. Specifically, the audit committee requested that we determine the role of the Office of the Secretary of State (office) in providing guidelines or standards to county registrars' offices, including those for the training of poll workers, and whether those guidelines meet the requirements set in law and regulations, are periodically updated, and adhered to by the counties. In addition, the audit committee requested that, for a sample of counties, we identify the methods, format, amount, timing, and frequency of training provided to poll workers, and whether the training complies with the guidelines provided by the office, is assessed for effectiveness, and are adequately updated. Further we were asked to determine how each county trains poll workers to handle complaints, the actions each county takes when receiving complaints, and how each county determines the number of poll workers to assign to each polling place.

Finding #1: The office has provided guidelines for training county poll workers, but lacks a directive to monitor their use by the counties or update the guidelines.

In 2003 the Legislature enacted a law that required the office to establish a task force to recommend uniform guidelines for training poll workers. The guidelines were to include certain topics, such as voters' rights and polling place operations. In 2006, as required by state law, the office published the *Poll Worker Training Guidelines 2006* (training guidelines), which reflects the work of the task force. The document was not intended to take the place of training materials or resources for poll workers; rather, it was to establish a minimum set of requirements that training sessions and materials developed by the counties must meet and to set a standard against which county programs for poll workers should be measured.

The law does not require the training guidelines to be updated, and the office has not done so since issuing them in 2006. Nevertheless, senior management at the office have expressed a desire to update the training guidelines and have acknowledged that to do so, the office would need to convene a task force similar to the one used to develop the original training guidelines.

One subject not covered in the training guidelines is the rights of voters who registered to vote without declaring a political party affiliation (decline-to-state voters). The office's senior management stated that in the February 2008 presidential primary election, many

Audit Highlights . . .

Our review of county elections officials' training of poll workers revealed the following:

- *In 2006 the Office of the Secretary of State (office) adopted poll worker training guidelines (training guidelines), as required by law.*
- *The law does not require the training guidelines to be updated and the office has not done so since issuing the training guidelines in 2006.*
- *The office's senior management asserts that although the law does not direct the office to monitor counties' compliance with the training guidelines, the office does conduct some observations of counties' elections and shares the results of its findings with the counties it observes.*
- *The eight counties we reviewed substantially complied with the content of the training guidelines when training their inspectors, but some counties appeared to only partially train poll workers in certain areas.*
- *Some counties employed noteworthy practices targeted toward providing poll workers with added opportunities to practice what they have learned.*
- *Not all counties required inspectors to attend training or were able to demonstrate they trained all inspectors prior to the February 2008 election.*

continued on next page . . .

» *None of the counties could clearly demonstrate how the information collected from the February 2008 election was summarized and used to update their training for the June 2008 election.*

» *Many of the counties were not able to provide reliable data that described how they resolved voter and poll worker complaints.*

decline-to-state voters were confused about which political parties' candidates they could cast ballots for because only two of California's six qualified political parties had authorized this type of voter to cast ballots in their primaries. In addition, some news agencies reported that poll workers gave unclear instructions to decline-to-state voters and that poll workers were unsure as to how much information they could volunteer to these voters. The office has taken steps to eliminate voter and poll worker confusion, such as emphasizing the rights of decline-to-state voters in its June 2008 Voter Information Guide. In addition to its guidelines, the office has communicated training information through periodic memorandums (memos) to county elections officials, as well as through trainings and informational seminars conducted by the California Association of Clerks and Election Officials (CACEO), an association of county elections officials. The office uses the memos as a means of communicating with county elections officials about election-related topics. Of the more than 650 memos the office issued between April 2006 and April 2008, we found that 11 seemed to have implications for poll worker training.

Although not required to do so, the office performs limited monitoring of the poll worker training conducted by counties. The office's senior management noted that although the law establishes the secretary of state as the chief elections officer it does not direct the office to track whether counties conform to the office's guidelines when training poll workers or to develop regulations or policies surrounding poll worker training. However, the office does perform some monitoring of counties' administration of elections through its Election Day Observation Program (observation program). Created in 2003, the observation program began as a poll monitoring program that focused on preventing issues such as long lines at polling places and the intimidation of voters. Subsequent election reviews have focused on how well counties were complying with federal election requirements. During the February 2008 primary election, the office staff visited 31 counties and afterward shared their observations with each county to help them identify ways to strengthen their respective poll worker training. The office performed a similar review in June 2008, and the office's senior management stated that they plan to perform a review in November 2008 but are uncertain about the 2010 election cycle. According to the deputy director of operations, whether the observation program will continue in 2010 is dependent upon available resources and whether changes in the law require changes in polling place operations that dictate a need to observe how the counties are implementing those changes. Many of the eight counties we reviewed look to other sources of information, rather than the office when updating their training programs. Three of the eight counties we visited told us they do not believe they are required to follow the training guidelines. One county told us that it seldom reviews the training guidelines for current elections because the guidelines have not been updated. Seven of the eight mentioned using the CACEO or the United States Election Assistance Commission (commission) for information to update their poll worker training programs. The Election Administration Research Center (center) at the University of California, Berkeley, is another organization that provides tools to counties for improving their training programs. The center released two reports summarizing its findings from surveys of poll workers that the center administered during the 2006 election cycle.

We recommended that the Legislature consider amending the Elections Code to explicitly direct the office to periodically update its poll worker training guidelines and to monitor county adherence to these standards. In the interim, the office should continue with its plans to update its training guidelines and incorporate new guidance on the proper handling of decline-to-state voters. Finally, to the extent feasible, the office should continue its efforts to monitor county adherence to its guidelines through its observation program.

Legislative Action: Unknown.

There does not appear to be any pending legislation that would require the office to periodically update its poll worker training guidelines.

Office's Action: Partial corrective action taken.

The office reports that it will update its poll worker training guidelines in 2009 and has advised county election officials that it will form a committee in the coming months to revise and expand the guidelines to address additional topics, including decline-to-state voters. In addition, the office stated that it had conducted an observation of selected counties for the November 4, 2008, general election. According to the office, it observed the counties in which it had noted deficiencies during the June 2008 statewide direct primary election. The office reported to us that the counties it observed appeared to have corrected all of the deficiencies that were identified during previous observations and no new issues were noted.

Finding #2: County elections officials generally followed the poll worker training guidelines issued by the office and instructed poll workers on the voting options of decline-to-state voters for the June 2008 election.

The eight counties we reviewed substantially complied with the content of the office's training guidelines when training poll workers, which consist of the inspectors who supervise polling places and the clerks who staff them. However, some counties appeared to only partially train poll workers in certain areas. For example, Fresno County partially trained its inspectors on voters' rights to replace spoiled ballots, but did not train them on voters' rights to report illegal or fraudulent activity. Further, three counties in our sample only partially trained poll workers on cultural competency. Specifically, these three counties trained poll workers to display multilingual materials, but not on how to be respectful of diverse cultures. Additionally, some counties did not use suggested training methods, such as role playing for processing voters' ballots and hands-on training for teaching workers to operate voting machines. However, after encountering problems in the February 2008 primary election with ensuring the rights of decline-to-state voters, the eight counties whose training we observed all discussed the voting options available to these voters prior to the June 2008 election.

To ensure that poll worker training programs conform with the office's guidelines, we recommended that county elections officials review the content of their programs, ensuring their training fully covers topics such as voter complaint procedures, preventing voter intimidation, and issues pertaining to a culturally diverse electorate.

Alameda County's Action: Corrective action taken.

At the time of the audit, Alameda County could not demonstrate that it instructed poll workers to be polite to voters and respectful of diverse cultures. In addition, the audit found that Alameda County didn't employ certain training methods called for under the office's guidelines, such as using role-playing scenarios and asking questions of the audience to reinforce key points.

In its 60-day update to the audit, Alameda County provided evidence that it modified its training presentation to stress the importance of poll workers being polite and respectful to all cultures. In addition, the county indicated that its training sessions for the November 2008 election were interactive and included role-playing scenarios.

Fresno County's Action: Corrective action taken.

At the time of the audit, Fresno County could not demonstrate that it had trained poll workers on voters' rights to report illegal/fraudulent activity, prohibiting the intimidation of voters at the polls, and being polite and respectful of diverse cultures. In addition, the county could not demonstrate that it provided hands-on training on the use of voting equipment or used role-playing scenarios during training.

In its 60-day response to the audit, Fresno County stated that for the November 4, 2008, election it implemented the three training topics we reported were missing from its poll worker training program: voters' rights to report illegal or fraudulent activity, prohibiting the intimidation of voters, and being polite to voters and respectful of diverse cultures.

Kings County's Action: Corrective action taken.

At the time of the audit, Kings County's training program did not train poll workers on being polite and respectful to all cultures. In addition, the county did not offer hands-on practice with voting equipment and did not use role-playing exercises during the training class we observed.

In its 60-day response to the audit, Kings County provided an update on its efforts to implement the audit report's recommendations that included an expanded training presentation on voters' rights, treating voters politely, and respecting cultural diversity.

Los Angeles County's Action: Corrective action taken.

At the time of the audit, Los Angeles County's training program complied with the office's poll worker training guidelines. The audit report's Appendix and Table 2 provide more information on which aspects of poll worker training we reviewed during the audit.

Los Angeles County did not provide a 60-day update on its efforts to implement this recommendation, however, based on its performance during the audit, we believe the county requires no additional action regarding this specific recommendation.

Orange County's Action: Corrective action taken.

At the time of the audit, Orange County's training program complied with the office's poll worker training guidelines. The audit report's Appendix and Table 2 provide more information on which aspects of poll worker training we reviewed during the audit.

Although Orange County provided a 60-day update on its efforts to implement some of the audit report's recommendations, it did not address this specific recommendation. Nevertheless, based on its performance during the audit, we believe the county requires no additional action regarding this specific recommendation.

San Diego County's Action: Pending.

At the time of the audit, San Diego County's training program did not provide poll workers with training on preventing voter intimidation at the polls.

San Diego County did not provide a 60-day update on its efforts to implement the audit report's recommendations. Further, its response to the audit report did not address this specific recommendation.

Santa Clara County's Action: Corrective action taken.

At the time of the audit, Santa Clara's training program complied with the office's poll worker training guidelines. The audit report's Appendix and Table 2 provide more information on which aspects of poll worker training we reviewed during the audit.

Santa Clara County provided a 60-day update on its efforts to implement the audit report's recommendations, reaffirming that it complies with the office's training guidelines. Based on its performance during the audit, we believe the county requires no additional action regarding this specific recommendation.

Solano County's Action: Pending.

At the time of the audit, Solano County's training program did not train poll workers on voters' right to report illegal/fraudulent activity, prohibiting voter intimidation at the polls, and did not offer hands-on training on all of its voting equipment.

Solano County did not provide a 60-day update on its efforts to implement the audit report's recommendations. In its response to the audit, the county disagreed with the report's findings and indicated that it receives very few complaints from voters. The county's response to the audit did not address the lack of hands-on training for some voting equipment.

Finding #3: Some counties exhibited noteworthy practices for training poll workers.

In our review of eight counties, we observed some noteworthy training practices. Most of these practices seemed targeted toward providing poll workers with additional opportunities to practice what they have learned while also being sensitive to their time commitments. For example, we found that some counties offered training at various times and locations and tailored the content to the experience level of the attendees to promote greater training attendance. Others offered on-line training or optional workshops with opportunities for more hands-on training just prior to the election.

Recognizing that these practices may improve poll workers' willingness to attend training and their ability to retain the lessons learned, we recommended that county elections officials consider implementing the following practices:

- Maximize the number of training sessions scheduled for poll workers while also offering the training at multiple locations with different start times to better accommodate poll workers' other time commitments. Also, providing condensed training tailored to experienced poll workers may entice greater attendance, while more extensive training can be reserved for new poll workers.

- Offer poll workers an opportunity to reinforce what they learned in class through the use of on-line supplemental training material. Such an on-line program might include practice quizzes on election day procedures, examples of the election materials to be used, and reference materials provided at training. County elections officials might also consider providing podcasts that emphasize critical aspects of poll worker training.

- Provide optional workshops giving poll workers additional opportunities to practice what they learned and to get hands on experience in the use of election day supplies and voting equipment. County elections officials might consider providing these workshops on the days immediately before an election to maximize poll worker confidence and retention of information.

Alameda County's Action: Partial corrective action taken.

Alameda County's 60-day update indicated that it was evaluating the feasibility of having separate training classes for more experienced workers and new poll workers. The county also indicated that it is considering providing on-line training. For the November 2008 election, Alameda County collected on-line surveys from poll workers who commented on the strengths and weaknesses of the county's training program. The county also reported that it offered poll workers the opportunity for individualized, refresher training for those wanting more exposure to classroom materials and voting machines.

Fresno County's Action: Pending.

Fresno County did not provide a 60-day update on its efforts to implement this recommendation. In its response to the audit, the county indicated that it provides an optional "Lab Day" when poll workers can go through the set up and use of the voting machines. However, as we state in the

report, the county did not offer hands-on training during the training class we observed. The county's initial response to the audit did not include any additional perspective on the other aspects of this recommendation.

Kings County's Action: Pending.

Kings County did not provide a 60-day update on its efforts to implement this recommendation. In its response to the audit, the county did not address the report's recommendations.

Los Angeles County's Action: Pending.

Los Angeles County did not provide a 60-day update on its efforts to implement this recommendation. In its response to the audit, the county did not address this specific recommendation. Nevertheless, our audit report commented on the county's use of on-line training for some of its poll workers.

Orange County's Action: Corrective action taken.

Our audit report recognized Orange County's approach of having different training classes depending on the experience level of individual poll workers. In addition, the audit report recognized the county's use of on-line resources such as podcasts and optional workshops where poll workers can reinforce what they learned in class. In its 60-day update, the county reported that it has continued its prior practices and began training poll workers as early as six weeks before the November 2008 election.

San Diego County's Action: Corrective action taken.

In its 60-day update on its implementation of our recommendations, San Diego reported that it implemented on-line training for its poll workers for the February 5, 2008, Presidential Primary, and 20 percent of its poll workers used the on-line training for both the June 3, 2008, and November 4, 2008, elections. Moreover, our audit report recognized San Diego County's use of optional workshops where poll workers could practice with classroom material and voting machines, reinforcing what they had learned in class. According to San Diego for the February, June, and November 2008 elections, 821, 729, and 729 poll workers, respectively, used the workshops to practice their election-day lessons. Finally, San Diego reports it uses a three-week train-the-trainer program to prepare its trainers to teach poll workers.

Santa Clara County's Action: Pending.

Santa Clara County's 60-day update did not address this specific recommendation. In its initial response to the audit, Santa Clara County disagreed with many aspects of our audit report, however, its response did not address this specific recommendation.

Solano County's Action: Pending.

Solano County did not provide a 60-day update on its efforts to implement the audit report's recommendations. The county indicated that it would be able to provide an update sometime during the first quarter of 2009. In its initial response to the audit, the county expressed its disagreement with many aspects of our audit report, however, its response did not discuss this particular recommendation.

Finding #4: Not all poll workers are required to attend training, and most counties we visited could not provide reliable training data.

Although state law requires that polling place inspectors receive training prior to election day, six of the eight counties we reviewed were unable to provide reliable data to demonstrate that all of their inspectors had been trained before the February 2008 election. Specifically, many counties had difficulty providing us complete and accurate lists of inspectors that received training. As a result, we were unable to evaluate whether all inspectors were trained. Of the two counties that could provide reliable

data, one acknowledged that not all of its inspectors were trained, while the other county was able to provide evidence that all its inspectors received training. As a result, many counties in our sample cannot be certain that all these workers have the knowledge to efficiently administer elections.

We recommended that to better ensure that county elections officials provide knowledgeable inspectors to serve voters, counties should take steps to ensure that all inspectors receive training. Steps that counties might take to achieve this goal include:

- Compiling accurate lists of inspectors who have attended training while informing inspectors who did not go through training that they cannot serve as inspectors.

- Recruiting reserve poll workers who have gone through inspector training to be deployed, as necessary, to polling places where the assigned inspectors did not receive the required training.

Alameda County's Action: Corrective action taken.

In its 60-day update, Alameda County reported that it began using a new software program for the June and November elections. At the time of our audit, we had looked into attendance for the February election since it was the most recent. The county asserts that it now uses this new software to track poll workers by assignment and to record training class attendance. Our audit report recognized that Alameda County tries to recruit reservist poll workers.

Fresno County's Action: Pending.

Fresno County did not provide a 60-day update on its efforts to implement this recommendation. In its initial response to the audit, the county indicated that it strives to train all poll workers (inspectors and clerks) and maintained that it had provided us with a thorough record of those attending class. However, as we reported on page 35 of the audit report, the county did not have training records for the February election and its records for the June 2008 election were incomplete, with six of the 29 trained poll workers in our sample missing from the training lists provided. Fresno County's initial response to the audit did not discuss our recommendation regarding reservist poll workers.

Kings County's Action: Corrective action taken.

Kings County did not provide a 60-day update on its efforts to implement this recommendation. In addition, the county's initial response to the audit did not address this specific recommendation. However, our audit report noted that the county had accurate attendance lists and that all inspectors attended training. As a result, we believe the county requires no additional action regarding this specific recommendation.

Los Angeles County's Action: Corrective action taken.

In its 60-day update on its efforts to implement the audit report's recommendations, Los Angeles reported that it has implemented a process to contact precinct inspectors to remind them to attend training. In its initial response to the audit, the county acknowledged that some inspectors work when they do not attend training, explaining that there are various causes for this phenomenon. To address this issue in the past, the county indicated that it had increased the monetary incentive for attending training and focused on developing written and video materials to ensure that poll workers have reference information to run a polling place "from scratch" on election day. The county's initial response did not address our recommendation regarding the recruitment of reservist poll workers. Nevertheless, we acknowledged in the audit report that the county has a goal of recruiting 400 reservist poll workers. As a result, we believe the county requires no additional action regarding this specific recommendation. In addition, in the audit report we acknowledge that Los Angeles County had reliable data on poll worker training.

Orange County's Action: Pending.

During the audit, we did not attempt to assess the accuracy of Orange County's poll worker attendance data because internal documents indicated that this data was inaccurate. In its response to the audit, the county explained that it understood our decision, but maintained that a further review of training attendance would show that all inspectors attended training prior to the February 2008 election. In its 60-day update to the audit report, the county explained that it has not altered its process and indicated it is "completing [its] accounting of the attendance for poll worker training classes [for] election day and will provide proof of training in subsequent responses." The county's 60-day update indicates that it continues to recruit reservist poll workers, which we had originally acknowledged in the audit report.

San Diego County's Action: Corrective action taken.

San Diego County reported in its 60-day update on its efforts to implement the audit report's recommendations that all precinct, assistant, and touchscreen inspectors are required to attend training before each election. Training for clerks is optional. The county scans bar codes from training sign-in sheets and prints an attended training report to document the total number of poll workers who attend training. San Diego County reports that for the November 4, 2008 election, it trained 7,203 poll workers and 300 reserve poll workers in case some poll workers dropped out before or on election day.

Santa Clara County's Action: Pending.

In its 60-day update, Santa Clara County indicated that it would compile and summarize data to demonstrate that, at a minimum, all inspectors are trained before election day. The county's update indicated that it would begin doing this compilation for the November 4, 2008, election. Santa Clara's update did not discuss our recommendation pertaining to reservist poll workers. However, on page 46 of the audit report we discuss the county's practice of purposefully over-recruiting inspectors.

Solano County's Action: Pending.

Solano County did not provide a 60-day update on its efforts to implement the audit report's recommendations. In its initial response to the audit, the county maintains that all of its inspectors received training and explained they could not have received their polling place supplies had they not attended training. In our rebuttal comment, we noted that the receipts for supplies the county provided did not have dates and could not be matched with the dates the county provided the training. The county's response did not address our recommendation regarding reservist poll workers.

Finding #5: Counties we visited collect data on the effectiveness of poll worker training from various sources, but none could demonstrate how they identified changes needed in poll worker training.

The elections officials from the eight counties we visited told us they use a variety of sources for collecting information to identify needed improvements in their poll worker training programs. These sources included post-training feedback from poll workers, comments from instructors, postelection debriefing reports, analyses of voter complaints, and reviews of questions from poll workers on election day. Seven of the counties were able to provide at least some documentation of the information they collected. However, none could clearly demonstrate how the information collected from the February 2008 election was summarized and used to make changes in their training programs for the June 2008 election. At most, counties were able to provide postelection evaluation reports that described what needed to be changed in their training programs for poll workers, however, these reports did not link their conclusions from the data collected to the proposed changes to be made. As a result, we could not determine whether the counties in our sample effectively used the information they collected to improve their poll worker training.

Under state law, voters have the right to ask poll workers and elections officials questions and register complaints about election procedures and to receive an answer or be directed to an appropriate elections official for an answer. Although most of the counties we reviewed discussed procedures for handling voter complaints in their poll worker training, the emphasis the counties placed on handling complaints varied. In addition, although all eight counties told us they receive complaint calls from voters or poll workers on election day, most counties we visited were unable to provide information on how they resolved voter or poll worker complaints.

To better ensure that training programs for poll workers are effectively evaluated and needed improvements identified, we recommended that county elections officials consider taking steps to track voter complaints and poll worker questions that are received during an election, evaluate whether such comments suggest ways to improve their training programs, and implement those improvements.

Alameda County's Action: Corrective action taken.

In its 60-day update, Alameda County provided examples of voter complaint logs it has developed that will be used in conjunction with its automated data systems to develop a synopsis of the election and identify needed changes to its poll worker training programs. The county reports this recommendation was implemented in time for the November 2008 election. Similarly, the county provided us with an example of its poll worker questionnaire that asks poll workers to discuss whether they believe they were adequately trained for election day.

Fresno County's Action: Pending.

Fresno County did not provide a 60-day update on its efforts to implement this recommendation. In its initial response to the audit, the county did not address this specific recommendation. In the audit report, we noted that the county lacked summarized data on voter complaints and poll worker questions on election day.

Kings County's Action: Pending.

Kings County did not provide a 60-day update on its efforts to implement this recommendation. In its initial response to the audit, the county did not address this specific recommendation. In the audit report, we noted that the county lacked summarized data on voter complaints and poll worker questions on election day.

Los Angeles County's Action: Corrective action taken.

In its 60-day update on its efforts to implement this recommendation, Los Angeles reported that it has fully implemented its on-line survey of the effectiveness of its on-line poll worker training. In addition, for the November 4, 2008 election, the county reports it sought more formal feedback on the effectiveness of poll worker and precinct coordinator classes from the instructors who conduct the classes. Further, in the audit report we recognized that the county has summarized data on voter complaints and poll worker questions on election day. In its initial response to the audit, the county indicated that it is now using a new database that will address all of the areas critiqued by our report.

Orange County's Action: Pending.

In its 60-day response to the audit, Orange County indicates that it will use poll worker surveys (from training class and post-election surveys), as well as other sources to determine the need for enhancements to its poll worker training. In addition, the county indicates that it will consider looking into tracking voter questions and concerns.

San Diego County's Action: Pending.

San Diego County states that the audit report concluded that it was unable to provide documented evidence of summarized data on poll worker questions or concerns on election day. The county stated that it does collect data on poll worker questions or concerns, but uses it to send troubleshooters out to specific precincts to resolve issues rather than to evaluate its poll worker training.

Santa Clara County's Action: Pending.

Santa Clara County's 60-day update indicated that its staff will summarize voter complaints and poll workers questions and compile reports that will highlight potential best practices. The county's response indicated that this process would be in place in time for the November 2008 election.

Solano County's Action: Pending.

Solano County did not provide a 60-day update on its efforts to implement the audit report's recommendations. In its initial response to the audit, the county maintained that the Elections Code does not require the county to keep detailed logs of complaints, questions, or its responses and solutions. In our rebuttal comments on page 106 of the audit report (comment #15), we recognize that counties are not required to document voter complaints and poll worker questions. Nevertheless, as we state in the report, relying on the county's assertions of its practices without corroborating documentary evidence would not provide a sufficient basis for our analysis.

Nevertheless, the county's initial response indicated that it currently is implementing a system to track public calls that may result in summarized data on poll worker and voter concerns.

State Bar of California

With Strategic Planning Not Yet Completed, It Projects General Fund Deficits and Needs Continued Improvement in Program Administration

REPORT NUMBER 2007-030, APRIL 2007

State Bar of California's response as of April 2008

The State Bar of California (State Bar), established by the California State Constitution, is a public corporation with a mission to preserve and protect the justice system. The law requires every person admitted and licensed to practice law in a court in California to be a member unless the individual serves as judge in a court of record. The State Bar's 23-member board of governors (board) establishes policy and guides such functions as licensing attorneys providing programs to promote the professional growth of members of the State Bar.

State law requires the Bureau of State Audits (bureau) to audit the State Bar's operations from January 1, 2006, through December 31, 2006, but does not specify topics the audit should address. For this audit we reviewed the implementation of the State Bar's long-range strategic plan, its financial forecasts of expected revenues and expenditures, its administration of the Legal Services Trust Fund Program (legal services program), and its implementation of the recommendations from our 2005 audit. The 2005 audit assessed how the State Bar monitored its disciplinary case backlog, followed procedures for processing disciplinary cases, prioritized cost recovery efforts, and updated forecasts of revenues and expenditures.

Finding #1: The State Bar has not fully implemented its strategic-planning process.

In 2001 the State Bar's board began developing and implementing a strategic management cycle to guide the State Bar's activities. As part of that process, the board developed the State Bar's long-range strategic plan. As an outgrowth of the board's planning activities, the State Bar's staff engaged in a departmental strategic-planning process intended to enhance operations and build a culture of continuous improvement in the State Bar. Although the board adopted the strategic plan in 2004, the State Bar still has not completed its strategic-planning process. Specifically, the State Bar has not fully developed planning documents for each of its departments that are intended to implement the board's strategic goals and specify the indicators needed to measure departmental performance in meeting those goals. These departmental plans were to include annually updated action plans intended to identify the actions necessary to meet strategic goals and prioritize the allocation of resources.

The State Bar completed the preliminary departmental plans by December 2005. The executive director instructed each of the departments to include all ideas and comments from staff in its operational plans recognizing that the plans would require edit and revision. The State Bar expected to finalize the plans during 2006. However, according to the State Bar's executive director, several

Audit Highlights . . .

Our review revealed that the State Bar of California:

- *Began a strategic planning process in 2001; however, development of many departmental plans and performance measures are incomplete.*
- *Does not prepare annual budgets based on the results of strategic planning, but rather on projected costs for current levels of staff and resources.*
- *Is pursuing an increase in annual membership fees from active members to offset a projected deficit of almost $12 million in its general fund by December 2010.*
- *Continues to await approval of additional authority to collect money related to disciplinary cases, but does not expect the new authority to significantly increase collections in the short term.*
- *Needs to improve administration of its Legal Services Trust Fund Program to ensure that it maximizes revenue from interest on trust accounts attorneys establish and appropriately completes required monitoring activities.*
- *Reduced its backlog of open disciplinary cases to 256 cases, moving closer to its goal of 200 backlogged cases.*
- *Needs to continue improving its processing of disciplinary cases by consistently using checklists and conducting random audits.*

challenges, such as reorganization of several departments and the retirement of three key senior executives, have slowed the revision process. The State Bar currently expects to complete the revisions to the departmental plans by July 2007.

In addition, the State Bar has begun to evaluate its information technology systems and is concerned that they may not be capable of effectively capturing performance measurement data identified in the departmental plans. The State Bar estimates the cost to upgrade its information technology systems will total $3.4 million to $5.8 million per year from 2008 to 2013; however, it has not yet identified a source of funds to pay for these upgrades.

Further, because its strategic-planning efforts are still incomplete, the State Bar has not been able to determine whether it is accomplishing the board's strategic goals and does not currently tie its annual budget to its strategic plan and performance measurement efforts. Rather, the State Bar's budget process focuses primarily on estimating the cost of current staff and other resources using known and anticipated price increases.

To ensure that the strategic plan is fully implemented in an effective and timely manner, we recommended that the State Bar do the following:

- Complete revisions of the departmental plans that will serve to implement the board's strategic goals and ensure that each departmental plan contains meaningful performance indicators that will measure how successfully goals are being met.
- Limit performance measurement to indicators that can be accurately tracked on an ongoing basis and measure desired outcomes.
- Ensure that its departments, during their departmental plan revision process, identify the objectives and performance measures that can be attained, considering existing resource levels and information technology capabilities. In addition, on an ongoing basis the departments should revise their annual action plans to update this information given additional information technology upgrades.
- Take the steps necessary to ensure its information technology systems can capture the required performance measurement data to support the projects needed to accomplish strategic-planning objectives, or devise alternative means of capturing this data such as using an Excel spreadsheet.

State Bar's Action: Partial corrective action taken.

The State Bar completed revisions to the 14 departmental plans as of April 30, 2007, including identifying performance measures, and indicated that, going forward, performance measures and action plans will be revised to reflect changes in organizational structure or priorities and will be utilized in developing annual budget documents.

In addition, as part of the overall review of departmental plans, the State Bar has evaluated the usefulness, validity, and source of data and collection strategies for the performance measures. The State Bar has reviewed all departmental plans to determine whether the measures can be captured with the State Bar's existing technology.

Also, the State Bar has completed business case development for three primary functional areas; admissions, discipline, and courts. The State Bar stated that the final business case, association management, will be completed in the fall of 2008. To facilitate performance measurement, its information technology department continues working to develop reporting tools, in many cases using data from its systems combined with data from other sources for reporting purposes.

Finding #2: The State Bar projects deficits in its general fund.

Because it estimates the fees it will collect from the increased volume of membership will not keep pace with its rising costs, the State Bar forecasts it will face a deficit of nearly $12 million in its general fund by December 31, 2010. The State Bar uses its general fund to account for membership fee payments and revenues it receives that are not related to other fund activities and to account for the expenses for maintaining, operating, and supporting its attorney disciplinary process. The State Bar established its Public Protection Reserve Fund (reserve fund) in 2001 to set aside a portion of its general fund as a buffer in the event of a revenue shortfall, like that which occurred after 1997 when it was unable to obtain timely statutory authority to assess the base annual membership fee that funds its disciplinary function and other operations it pays for from its general fund. However, use of the reserve fund to mitigate the projected general fund deficit will not likely provide a satisfactory solution to the State Bar's projected imbalance between revenues and expenses in its general fund. It estimates that even if it uses the balance of the reserve fund to partially offset the projected deficit in its general fund, the combined balance in the two funds will still result in a deficit of about $6.3 million by December 31, 2010.

The State Bar's authority to assess a base annual membership fee is temporary, and historically the State Bar has needed the Legislature to reaffirm that authority every one to two years. Its current authority expires on January 1, 2008, unless extended before that date. The State Bar noted that to remedy the expected deficit, it is in ongoing discussions with key members of the Legislature to obtain statutory authority to increase the base annual membership fee for active members. The State Bar has determined it will need a $25 increase in the fee to eliminate its projected general fund deficit and provide funding for information technology upgrades. However, as previously discussed, it has not successfully completed its strategic planning process that will allow it to identify the resources it needs to meet its strategic goals and base its budgeting process on these identified resources. This fact could hamper its efforts to justify a fee increase.

In addition, the State Bar does not anticipate that pending approval by the California Supreme Court (supreme court) of procedures to help recover its costs to discipline members or recover payments to members' clients from the Client Security Fund will have an immediate significant impact. This new enhanced collection authority, when implemented, will allow the State Bar to use money judgment authority to attempt to collect costs from disciplined attorneys.

The State Bar is preparing to implement its enhanced collection authority when approved. According to the State Bar's chief financial officer, in anticipation of the supreme court's approval, the State Bar is attempting to organize available information regarding the unpaid amounts. For example, the State Bar is trying to find the most current addresses of debtors and merge that information with other pertinent data, such as case numbers, restitution orders, and amounts owed. In addition, the State Bar is formulating a policy to guide staff in determining which cases will be affected by the rule, and therefore should be pursued, and which cases will be most fruitful in terms of potential collections.

However, the State Bar does not expect that its current collection rate will increase appreciably in the near future. According to the State Bar's assistant chief general counsel, the disciplined attorneys whose debts make up most of the unpaid amount were disbarred or resigned with disciplinary charges pending. He stated these attorneys are generally financially distressed and unable to repay clients or the State Bar at the time of their disbarment or resignation. The chief assistant general counsel further stated that, according to the State Bar's outside counsel, in five to 10 years some of the disciplined attorneys will have sufficient earnings to seek loans and will want to reestablish their credit and disbarred attorneys may want to seek reinstatement to practice law. He noted that credit-reporting agencies would pick up abstracts of judgments that have been recorded in county recorders' offices, but that if the State Bar wanted to directly report the debts, it would need procedures to comply with the federal Fair Credit Reporting Act. The chief assistant general counsel stated that the State Bar is still considering the costs and benefits of reporting judgments to credit-reporting agencies.

To effectively allocate its resources and justify its membership fees we recommended that the State Bar align its budgets with the results of its strategic-planning process.

To ensure that it maximizes collection efforts and its ability to implement the Rules of Court as soon as the supreme court approves procedures allowing their use, we recommended that the State Bar do the following:

- Complete its database and input all available information on the Client Security Fund and disciplinary debtors.
- Implement its proposed policy for pursuing debtors.
- Complete its assessment of the costs and benefits of reporting judgments to credit-reporting agencies.

State Bar's Action: Partial corrective action taken.

The State Bar reports it is continuing its effort to organize and input available information regarding the unpaid amounts into an automated system. The purpose is to merge into a database the most current addresses of debtors, case numbers, restitution orders, amounts owed, and other pertinent data about debtors that is kept separately by different State Bar departments and must be manually collected and organized. After an internal review of current procedures and processes to ensure that judgments filed are accurate and the data has integrity as information moves through the system, the State Bar's information technology department recommended the purchase of a software application and Web-hosted services of a third-party vendor. A contract has been negotiated, but not yet executed.

The California Supreme Court approved the Rule of Court in April 2007. In July 2007 the Board of Governors adopted a pursuit policy for court ordered disciplinary costs and Client Security Fund obligations, which was immediately implemented. The State Bar reported that, as of April 2008, it has filed 169 requests for entry of judgments to enforce assessments ordered in 313 disciplinary matters.

In March 2008 the State Bar completed its interviews of collection agencies currently under contract with the Administrative Office of the Courts and has contracted with the selected vendor to provide debt collection services, which include the reporting of judgments to credit reporting agencies.

The State Bar's 2008 adopted budget has been redesigned to link its budget with its strategic planning process. The proposed budget is aligned with the State Bar's organizational and functional structures as defined by its strategic plan and presents basic workload and performance information in major program areas.

Finding #3: The State Bar needs to improve its legal services program and attorney discipline system.

For grant year 2006–07 the State Bar awarded $26.7 million in grant funds from the legal services program to provide civil legal assistance to indigent Californians. The funds for the program come primarily from interest on trust accounts attorneys establish for certain client funds, state budget appropriations, and an allocation of certain court filing fees. The State Bar does not ensure that all attorneys comply with the law requiring them to remit the interest on these trust accounts to the State Bar to support the legal services program. The State Bar reported that in 2006 it received about $15.8 million from attorneys' trust accounts. However, because about 25 percent of the practicing attorneys in California do not remit interest earned on clients' trust accounts that qualify for the legal services program or report that they do not maintain trust accounts, the State Bar does not know whether it receives all the funds it should to support the legal services program.

The State Bar asks attorneys to report when they open or close trust accounts or no longer handle such client funds; however, it does not investigate nonreporting attorneys to determine whether they should establish trust accounts and remit the interest to the State Bar. According to the State Bar's deputy executive director, the State Bar has no authority to mandate reporting and would need an amendment to the statutes or to the Rules of Court to gain the authority to mandate reporting from its members.

Additionally, the State Bar is responsible for on-site monitoring of grantees to determine whether they comply with the program's requirements. However, it does not always adequately perform or document monitoring reviews of the legal services program grantees. Despite the State Bar's grantee-monitoring visits scheduled for the three-year period from January 1, 2004, through December 31, 2006, 12 grantees did not receive program-monitoring visits, and 51 did not receive fiscal-monitoring visits. Further, the State Bar does not always retain documentation needed to demonstrate that staff have completed all the steps in the monitoring process.

A 2005 bureau report assessed the efforts of the State Bar to address the backlog of disciplinary cases it began accumulating after temporarily losing its statutory authority in 1997 to assess a base annual membership fee. In 2005 the State Bar had 315 backlogged disciplinary cases. As of December 2006 the State Bar had reduced the backlog to 256 with the oldest cases dating back to 2003. This progress moved the State Bar closer to its goal of having no more than 200 backlogged cases.

Our 2005 audit also addressed the State Bar's inability to process disciplinary cases efficiently. In response, the State Bar created checklists to ensure that staff follow significant processing steps and developed random audit procedures to improve its oversight of the processing of disciplinary cases. However, the State Bar has not fully implemented either of these policies. Three of the 30 files we reviewed did not contain properly completed checklists, and the supervising trial counsels who oversee the disciplinary case investigators do not always perform the random audits required by the State Bar's policy.

To ensure that it receives all the trust account interest income available for its legal services program, we recommended that the State Bar consider conducting activities, such as interviewing or surveying a sample of members who do not report whether they have established trust accounts. This would allow the State Bar to determine whether some members are holding clients' funds without establishing trust accounts and remitting the interest to the State Bar. If the State Bar finds that the nonreporting members do, in fact, hold client funds that are nominal in amount or are held for a short period of time, it should seek the authority to enforce compliance reporting.

To properly monitor recipients of grants under its legal services program, the State Bar should ensure that it performs and documents all required monitoring reviews; in addition, it should develop a plan to perform the backlogged fiscal on-site monitoring visits while staying current with its ongoing monitoring requirements.

The State Bar should continue its efforts to reduce its backlog of disciplinary cases to reach its goal of having no more than 200 cases.

The State Bar should ensure that staff use checklists of significant tasks when processing case files and fully implement its 2005 policy directive for random audits of case files by supervising trial counsel.

State Bar's Action: Partial corrective action taken.

The State Bar stated it submitted to the Supreme Court for approval a proposal that would require each attorney to complete and maintain an online registration. If adopted by the Supreme Court, proposed Rule 9.8 requires lawyers to report whether the attorney or the attorney's law firm has established and maintained one or more trust fund accounts required under Business and Professions Code, Section 6211. According to the State Bar, in anticipation of the Supreme Court's

action on this proposal and to facilitate online reporting once it becomes mandatory, the State Bar launched its online reporting feature in April 2008, which will remain voluntary pending the Supreme Court's approval of its proposed requirement.

The State Bar stated that it is coordinating with the Administrative Office of the Courts to survey other grant-making organizations to assist in establishing best practices for planning its monitoring processes. The State Bar's Legal Services Trust Fund Program staff brought program and fiscal monitoring visits current as of December 31, 2007, and is on schedule to complete 2008 monitoring visits by the end of the calendar year.

Moreover, the State Bar's Office of the Chief Trial Counsel modified its department plan in May 2007 to, among other things, establish a revised goal of having no more than 250 open backlog cases at the end of each year, rather than the previous goal of 200 open backlog cases. Given staffing constraints, the State Bar felt that it would be difficult to achieve the revised backlog goal of 250 by the end of 2007 and, in fact, the backlog of open cases was 327 on December 31, 2007.

Lastly, the State Bar's Chief Trial Counsel issued a memorandum to all affected staff reminding them to use the checklists and directs appropriate supervisory personnel to perform random audits on a monthly basis with respect to the open investigation files of investigators assigned to original disciplinary investigations. The memorandum also directs supervisory personnel to adequately document the random audits and to confirm that any necessary corrective action has been taken.

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 April 2008

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 established a plan to guide its recruitment efforts that includes information about the Veterans Home's proposed recruitment strategies, marketing and advertising, and monitoring and follow up. Examples of the proposed recruitment strategies include developing a recruitment calendar, exploring the possibilities for an internship program for dieticians and having students from the Napa Valley College Nursing Program do clinical rotations at the Veterans Home, which are similar to steps the Veterans Home told us it planned to take during our audit. Marketing and advertising activities specified in the plan include purchasing various products to give away at recruiting events and obtaining recruitment brochures from Veterans Affairs. 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 is developing new policies and a new program to reduce overtime among nursing staff that it anticipates implementing by January 2009. For example, Veterans Affairs states the Veterans Home developed a unit-based staffing program designed to improve staffing accountability and decrease overtime in the nursing department. Veterans Affairs

also indicated that the nursing department at the Veterans Home will manage overtime tracking and the Veterans Home's fiscal officer will implement improved cost accounting for overtime. Veterans Affairs did not address our recommendations that the Veterans Home establish a cap on how much overtime nursing staff can work.

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 drafted a Notice of Proposed Rulemaking to eliminate 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 the new process has reduced by 50 percent the number of days from the physical being requested to the examination date.

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 the 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.

According to Veterans Affairs, the Veterans Home inventoried its medical equipment in all service areas and updated the inventory list for bio-medical equipment maintenance and repair. In addition, the Veterans Home states its service area managers are now required to submit an updated equipment list monthly and the medical equipment contractor has implemented changes to improve its record-keeping process. 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. The Veterans Home plans to consider hiring a surveyor to identify areas of noncompliance with the ADA, which is a precursor to developing a plan to achieve compliance.

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.

Victim Compensation and Government Claims Board

It Has Begun Improving the Victim Compensation Program, but More Remains to Be Done

REPORT NUMBER 2008-113, DECEMBER 2008

Victim Compensation and Government Claims Board's response as of November 2008

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to review the Victim Compensation Program (program) to determine the overall structure of victim compensation services and the role of each entity involved, and to assess the effectiveness of the structure and communication among the entities. The audit committee also asked us to review the funding structure for the program and determine any limitations or restrictions. We were also asked to determine the types of expenses made from the Restitution Fund in each of the last four years, including identifying the annual amount used for administering the program and the annual amount reimbursed to victims.

The audit committee requested us to determine and assess the Victim Compensation and Government Claims Board's (board) process of approving or denying applications and bills, including how it communicates its decisions to applicants. Additionally, the audit committee directed us to review a sample of applications and bills that the board received from 2003 through 2007 to determine whether it adhered to proper protocols for the approval process. The audit committee also asked us to review, for the selected sample, the amount of time various steps took. In addition, it asked us to determine whether the board has a backlog of applications and bills awaiting its decision, the extent of the backlog, and any efforts taken to reduce the backlog. Finally, the audit committee directed us to review and assess the board's overall process for outreach to potential victims of violent crimes and whether it considers the demographics of the populations it serves in establishing its outreach program.

Finding #1: Despite a significant decline in program payments, program support costs have increased.

From fiscal years 2001–02 through 2004–05, program compensation payments decreased from $123.9 million to $61.6 million—a 50 percent decline. Compensation payments have increased since fiscal year 2004–05, but not to the level they reached in fiscal year 2001–02. Despite the significant decline in payments, the costs the board incurs to support the program have increased. These costs—ranging from 26 percent to 42 percent annually—account for a significant portion of Restitution Fund disbursements. According to board staff, several factors contribute to the board's program support costs making up such a substantial portion of its total disbursements. One factor is that the board is a stand-alone entity that shares no administrative or overhead costs with other entities. Another factor contributing to the support costs is the level of review that state laws and regulations require board analysts to perform to ensure that they pay only eligible bills. Further,

Audit Highlights . . .

Our review of the Victim Compensation Program (program) at the Victim Compensation and Government Claims Board (board) revealed the following:

- *From fiscal years 2001–02 through 2004–05, program compensation payments decreased from $123.9 million to $61.6 million—a 50 percent decline.*
- *Despite the significant decline in payments, the costs to support the program have increased. These costs make up a significant portion of the Restitution Fund disbursements—ranging from 26 percent to 42 percent annually.*
- *The program did not always process applications and bills as promptly or efficiently as it could have. We noted staff took longer than 180 days to process applications in two instances out of 49 and longer than 90 days to pay bills for 23 of 77 paid bills we examined.*
- *The program's numerous problems with the transition to a new application and bill processing system led to a reported increase in complaints regarding delays in processing applications and bills.*
- *Some payments in the Compensation and Restitution System (CaRES) appeared to be erroneous. Although board staff provided explanations for the payments when we brought the matter to their attention, the fact that they were unaware of these items indicates an absence of controls that would prevent erroneous payments.*

continued on next page . . .

» *The board lacks the necessary system documentation for CaRES.*

» *There are no benchmarks, performance measures, or formal written procedures for workload management.*

» *Despite the board's efforts to increase awareness of the program, several victim witness assistance centers do not think the public is generally aware of program services. Further, the board has not established a comprehensive outreach plan.*

another significant contribution to program support costs is that the board contracts with 21 joint powers (JP) units to aid in reviewing bills and applications.

Although not all the work board analysts perform results in compensation payments, the correlation between compensation payments and program support costs provides an overall measure that is informative because it indicates the board's "return on investment" for the level of costs it incurs. Currently, the board does not have a goal that compares program support costs to compensation payments, nor does the board set other similar goals. Further, to aid its efforts to maximize assistance to victims and their families while maintaining a viable Restitution Fund, it is important for the board to develop a method or calculation to establish an annual target fund balance amount.

We recommended that the board establish a complementary set of goals designed to measure its success in maximizing assistance to victims and their families. These goals should include, but not be limited to, one that focuses on the correlation of compensation payments to program support costs and one that establishes a target fund balance needed to avoid financial shortfalls. Further, as the board monitors the goals it has created, it should ensure its cost structure is not overly inflexible and that it is carrying out its support activities in the most cost-effective manner possible.

Board's Action: Pending.

The board agrees that it should strive to maintain a balance between revenues and expenditures thereby ensuring fund stability to the extent it is within its control. The board also agrees that the program's administrative functions should be as cost-effective as possible given the complexities of the program and the need to provide timely compensation to victims of crimes.

Further, the board plans to focus on the following activities to meet the intent of the audit recommendations:

- Explore the feasibility of establishing goals designed to measure success in maximizing assistance to crime victims and their families.
- Regularly monitor program data and analyze key trends and indicators of both expenditures and revenue and adjust strategies as necessary to maintain fund stability. This includes an ongoing assessment of cash flow and prudent reserves.
- Continually evaluate the cost-effectiveness of administrative activities, those that result in payouts, those that ensure fund stability, and those that advance victim access to the program and to needed services.

- Support and promote funding received from existing revenue sources. This is specifically addressed in the board's action strategy to develop a restitution outreach and training program. Further, the board plans to regularly evaluate the cost-benefit of ongoing revenue-generating programs and activities.
- Manage program resources and costs to maximize the availability of federal grant funds.

Finding #2: The board generally complied with state laws and regulations regarding program eligibility.

State laws and regulations describe the requirements for determining if an applicant is eligible for the program. During the eligibility determination process, board staff determine whether both the crime and the applicant qualify under the program. Staff typically use crime reports to determine if a qualifying crime occurred, but according to state regulations they can consider other evidence. Although in our review of 49 applications we found that the board generally determined the eligibility of applicants appropriately, for one application the board lacked documentation to support the eligibility decision. For an additional application we reviewed, the board incorrectly determined eligibility for a crime that did not occur.

To demonstrate that it makes appropriate eligibility decisions on applications, we recommended that the board ensure that it correctly considers reports from other entities, such as law enforcement, and that it sufficiently documents the basis for its decisions.

Board's Action: Pending.

The board agrees that it should correctly consider reports from other entities and document evidence as a basis for its decisions. The board states that it will continue to emphasize the importance of fully documenting all eligibility decisions and that the board's training activities focus on the need to appropriately document decisions and future training activities will continue this focus.

Finding #3: The program did not always process applications and bills promptly.

State law related to eligibility determinations for the program requires the board to approve or deny applications, based on the recommendation of board staff, within an average of 90 calendar days, and no longer than 180 calendar days after the acceptance date for an individual application. For the 49 applications we reviewed, the board's average processing time was 76 days, which is well within the statutory average. However, the board did not make a determination within 180 days in two instances. We also noted various instances where the board did not demonstrate that it approved or denied the applications as promptly as it could have after receiving the information necessary to make the determination. In addition, state law requires the board to pay certain bills within specific time frames. Our review of 77 paid bills associated with approved applications found that the board's average processing time was 66 days. However, because the board took more than 90 days to pay some bills, it did not always meet statutory time frames.

The board's procedures for following up with outside entities to obtain necessary information to verify applications and bills are not sufficiently detailed and contribute to inconsistencies in staff efforts to obtain the information promptly. Additionally, even when staff initially request information and follow up promptly, some entities delay providing the necessary information. The board told us it is reaching out to some entities to emphasize the importance of providing requested information more promptly.

Our review of the board's practices for communicating with applicants found that the board uses standard letters to notify applicants of decisions. For example, state regulations require the board to notify an applicant if program staff recommend that the board approve an application or bill. The board recently revised its process to notify applicants of eligibility decisions once the board reaches its final decision, rather than when staff recommend the decision, which is not consistent with state regulations.

To improve its processing time for making decisions on applications and for paying bills, we recommended that the board identify the problems leading to delays and take action to resolve them. Further, we recommended that the board develop specific procedures for staff to use when following up with verifying entities and continue its outreach efforts to communicate the importance of responding promptly to its requests for information. Finally, to ensure that it complies with state regulations, we recommended that the board modify its process for when it notifies applicants of decisions or seek regulatory change.

Board's Action: Pending.

The board states that improving processing times for making decisions on applications and paying bills is being addressed as an early action item by the architectural adjustment section of its Compensation and Restitution System (CaRES) Optimization project charter. The specific improvements envisioned include correcting issues with the aging reports that will allow the board to more easily identify applications approaching the maximum processing time limit. Future training and development of staff will also assist in this area. The board also notes that its Pre-Scan Unit, fully operational in July 2008, identifies missing items on newly filed applications, reducing the processing times for all applications.

Further, the board states that its ability to process applications and pay bills in a timely manner is dependent upon the timely submittal of key information from verifying entities. To improve its success at obtaining such information, the board plans to develop a new procedure manual, which will provide specific direction to staff for processing applications and bills in CaRES. The manual will include specific time frames for follow up with nonresponsive verifying entities. Through its statewide provider forums, the board has been communicating to service providers the importance of prompt submittal of requested information to the board so staff can process payment requests in a timely manner. The board also states that it is reaching out to law enforcement during its law enforcement outreach seminars.

The board agrees with our recommendation concerning notification of applicants of the board's recommended decisions, and this change has been incorporated into the proposed regulation package the board will consider at a subsequent board meeting.

Finding #4: The board did not consistently explore alternative coverage of expenses or document its approval process.

Although the board has procedures for staff to follow when verifying whether bills are reimbursable from other sources such as insurance or public assistance, we found that board and JP unit staff were not consistent in their verification efforts. According to state law, the board may reimburse eligible individuals for pecuniary loss, subject to the limitations established by type of benefit. A pecuniary loss is an economic loss or expenses resulting from an injury or death to a victim of crime that has not been and will not be reimbursed from any other source. Because the board does not ensure that its staff and JP unit staff demonstrate that they follow procedures consistently to verify whether bills can be paid from sources other than the program, applicants may be treated inconsistently, and the board may use program funds inappropriately. Further, the board could not always provide documentation to support the formal approval of the applications and bills we reviewed. Because the board did not maintain documentation for the approvals of staff recommendations on applications and bills, it is unable to demonstrate the required approvals and may encounter legal problems if decisions are challenged.

We recommended that the board ensure that staff consistently verify and document their efforts to ensure that there are no other reimbursable sources. We also recommended that the board consistently maintain documentation of its formal approval of applications and bills.

Board's Action: Pending.

The board states that regarding the recommendation to consistently verify and document reimbursement sources, the board will ensure that the training and development classes for processing staff include appropriate emphasis on this matter. Further, the board agrees that it can make improvements in maintaining documentation.

Finding #5: The board does not have written procedures or time frames for processing appeals.

We reviewed five applications that the board denied and the applicant appealed. The board took more than 250 days to resolve four of the applications we reviewed. The fifth was more than a year old and was not yet resolved. According to the board's appeals manager, the process can be lengthy because it takes time to evaluate the appeals and obtain additional information as needed. Further, according to the appeals manager, the board does not have written procedures that govern the appeals process and has not established time frames for processing appeals. Without procedures and time frames, the board cannot ensure that appealed applications and bills are processed in a prompt manner.

To ensure that the board processes appeals of denied applications within a reasonable time, we recommended that it establish written procedures and time frames.

Board's Action: Pending.

The board states that it concurs with our recommendation to develop written procedures and time frames for the appeals process and it plans to develop a new procedures manual that will include this subject.

Finding #6: The board is experiencing problems with the transition to CaRES.

The board began making the transition to CaRES, its new system for processing applications and bills, in late June 2006 and began using CaRES exclusively after June 2008. Although the board expects to gain efficiencies and benefits from the use of the new system, it generally has not developed benchmarks or measured results. We also discovered that the board lacks necessary system documentation for CaRES. Further, the board has experienced numerous problems with the transition. Most troubling was our identification of payments that appeared to be erroneous. Although board staff provided explanations, asserting that the payments were appropriate and the data were flawed, the fact that they were unaware of these items indicates the absence of controls that would prevent such erroneous payments being made. In addition, interviews with representatives from victim witness assistance centers (assistance centers) revealed that the new system has caused an increase in complaints regarding delays in processing applications and bills.

To ensure that the board maximizes its use of CaRES, we recommended that the board develop goals, objectives, and benchmarks related to the functions it carries out under CaRES that will allow it to measure its progress in providing prompt, high-quality service; continue identifying and correcting problems within the system as they arise; address the structural and operational flaws that prevent identification of erroneous information and implement edit checks and other system controls sufficient to identify errors; seek input from and work with relevant parties, such as assistance centers and JP units, to resolve issues with the transition; and develop and maintain system documentation sufficient to allow the board to address modifications and questions about the system more efficiently and effectively.

Board's Action: Pending.

The board states that it is continuing its efforts to maximize its use of CaRES. The board states that it has developed the CaRES Optimization project charter that details activities it will undertake to ensure that CaRES performs all functions efficiently and reliably. Further, the board states that this charter sets forth the goals, objectives, and benchmarks related to the functions the board carries out under CaRES. The board also plans to implement edit checks and other system controls to ensure the identification of data errors. The board notes that it recognizes the importance of continuing to seek input from and work with all relevant stakeholders as it implements necessary improvements to CaRES. In addition, the board states that another key element of the project charter is the development and maintenance of system documentation.

Finding #7: Our analysis of CaRES data revealed that JP units process applications and bills more quickly than the board does.

Based on our review of CaRES, the board's average processing times for applications and bills were considerably longer than that of the JP units collectively. Board staff state that this is partly because assistance centers, which oversee a variety of services to victims, often assist the applicants in completing the applications and obtaining the necessary information before submitting the applications or bills. The average number of days for processing applications from the date the application was accepted was 64 days for the JP units and 80 days for the board. With respect to bills, the average processing time was 57 days for the JP units and 111 days for the board. The board has some tools that encourage applicants to contact the assistance centers. For example, the board developed an informational brochure that provides victims with contact information for their local assistance center. However, the board has opportunities to do more in this area.

To increase the number of applicants who work through assistance centers, we recommended that the board emphasize the advantages of doing so whenever possible.

Board's Action: Pending.

The board states that it will continue to encourage applicants to work directly with the county assistance centers.

Finding #8: The board's current process for managing program workload is informal.

The board has not established benchmarks, performance measures, or any formal written procedures for managing workload related to processing applications and bills. In addition, because the reporting function in CaRES, which would provide aging information, is not working yet, the board is currently relying on ad hoc aging reports that are not reliable. As a result, the board does not have critical information readily available to management to make decisions about managing its workload in the most effective manner.

To ensure that the board effectively manages the program workload and can report useful workload data, we recommended that it do the following: develop written procedures for its management of workload, implement the reporting function in CaRES as soon as possible, and establish benchmarks and performance measures to evaluate whether it is effectively managing its workload.

Board's Action: Pending.

The board states that it recognizes the need to effectively manage workload and that its CaRES Optimization project charter includes the specific task to develop the reporting function and that the data generated will be used to identify and manage workflow. With this reporting capability, the board states that it will be able to develop written workload management procedures and relevant performance measures to evaluate workload management.

Finding #9: The board lacks a comprehensive outreach plan to prioritize its efforts and did not consider demographics and crime statistics in developing its outreach strategies.

The board focused its outreach efforts during fiscal year 2007–08 on increasing awareness of the program among crime victims and the families of victims. Further, the board believes that the best avenue to create awareness of the program is to provide information and outreach materials to first responders—those individuals who generally first come into contact with crime victims or their families after a crime occurs. The board also expands awareness of the program through its key partners—JP units and victim advocates. Despite the variety of outreach efforts conducted by the board, it has not developed a comprehensive outreach plan. Without such a plan, it is unable to demonstrate that it has prioritized its outreach efforts, appropriately focused on those in need of program services, and spent program funds effectively. Further, the board did not consider demographics or crime statistics when developing its outreach efforts and priorities in fiscal year 2007–08 and has not quantified whether there are potential populations that are underserved. Finally, the board's outreach efforts for vulnerable populations—those groups of individuals that are more susceptible to being victims of crime and those less likely to participate in the program—have been limited.

We recommended that the board establish a comprehensive outreach plan that prioritizes its efforts and appropriately focuses on those in need of program services. We recommended, as part of its planning efforts, that the board seek input from key stakeholders such as assistance centers, JP units, and other advocacy groups and associations to gain insight regarding underserved and vulnerable populations. We also recommended that the board consider demographics and crime statistics information when developing outreach strategies.

Board's Action: Pending.

The board agrees that it should establish a comprehensive outreach plan that prioritizes and focuses its efforts on those in need of program services. According to the board, its project charter, entitled Develop a Comprehensive Communication and Outreach Plan, reflects the board's commitment to conduct its outreach efforts pursuant to a written plan which focuses on reaching out to those in need of program services. The plan will identify target audiences, including underserved victim populations; determine communication strategies; develop key messages; and determine appropriate communication tools. The board states that in developing the plan it will seek input from key stakeholders, including first responders, as required by law, and advocacy groups associated with underserved and vulnerable populations. The board further agrees that the plan should consider demographic and crime statistics.

Finding #10: The board is still considering how to measure the effectiveness of its outreach efforts and does not specifically budget for outreach expenses.

The board announced the rollout of its new strategic plan for the years 2008 through 2012 in May 2008. One of the goals in this plan is to increase public awareness of the program by 10 percent by July 2009. However, as of October 2008, management was still considering future outreach efforts and how best to quantitatively measure the success of these efforts. Further, the board is missing an opportunity to track useful information from applicants regarding how they heard about the program. The board collects such information but had not summarized the information to measure outreach effectiveness. We also discovered that the board does not specifically budget for and report actual outreach expenses.

We recommended that the board define the specific procedures to accomplish its action strategies for outreach and establish quantitative measures to evaluate the effectiveness of its outreach efforts. Further, we recommended that the board use information from applicants regarding how they heard about the program as part of its overall efforts to measure outreach effectiveness. We also recommended that the board specifically budget for and report actual outreach expenses.

Board's Action: Pending.

The board states that metrics are being developed that will be incorporated into its Comprehensive Communication and Outreach Plan. Further, it states that these metrics will be used to measure the effectiveness of the outreach strategies. The board states that the measures will include, but not be limited to, applications received by county and by ethnicity; Department of Justice crime statistics by county and to the extent available by ethnicity; awareness surveys of first responders and community organizations; and surveys regarding how applicants learned of the program.

In addition, the board states that it recognizes the importance of budgeting for and reporting outreach expenses and that it is developing an outreach budget for the balance of fiscal year 2008–09. The board states that it will have established a specific budget and expenditure system for its outreach program by fiscal year 2009–10.