CALIFORNIA STATE AUDITOR

Bureau of State Audits

Implementation of State Auditor's Recommendations

Audits Released in January 2008 Through December 2009

Special Report to
Senate Budget and Fiscal Review Subcommittee #4—State Administration, General Government, Judicial and Veterans Affairs

SPECIAL REPORT

February 2010 Report 2010-406 S4

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February 23, 2010 2010-406 S4

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

Dear Governor and Legislative Leaders:

The State Auditor's Office presents its special report for the Senate Budget and Fiscal Review Subcommittee No. 4—State Administration, General Government, Judicial and Veterans Affairs. This report summarizes the audits and investigations we issued during the previous two years that are within this subcommittee's purview. This report includes the major findings and recommendations, along with the corrective actions auditees reportedly have taken to implement our recommendations. To facilitate the use of the report, we have included a table that summarizes the status of each agency's implementation efforts based on its most recent response.

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

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

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Introduction

This report summarizes the major findings and recommendations from audit and investigative reports we issued from January 2008 through December 2009, that relate to agencies and departments under the purview of the Senate Budget and Fiscal Review Subcommittee No. 4—State Administration, General Government, Judicial and Veterans Affairs. The purpose of this report is to identify what actions, if any, these auditees have taken in response to our findings and recommendations. We have placed this symbol ➲ in the margin of the auditee action to identify areas of concern or issues that we believe an auditee has not adequately addressed.

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

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

Unless otherwise noted, we have not performed any type of review or validation of the corrective actions reported by the auditees. All corrective actions noted in this report were based on responses received by our office as of January 2010. The table below summarizes the number of recommendations along with the status of each agency's implementation efforts based on its most recent response related to audit reports the office issued from January 2008 through December 2009. Because an audit report and subsequent recommendations may cross over several departments, they may be accounted for on this table more than one time. For instance, in following table the State Mandates Report, 2009-501, is reflected under Commission on State Mandates, Department of Finance, and the State Controller.

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	FOLLOW-UP RESPONSE				STATUS OF RECOMMENDATION					
	INITIAL RESPONSE	60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	NO FOLLOW-UP RESPONSE	PAGE NUMBERS
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Investigations Report I2008-0805		●				1				7
Board of Chiropractic Examiners										
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Commission on State Mandates										
State Mandates Report 2009-501		●				1	2			27
Contractors State License Board										
Investigations Report I2008-2 [I2007-1046]				●		1				31
Department of Corrections and Rehabilitation										
Investigations Report I2008-1 [I2006-0665]				●	1					33
Sex Offender Placement Report 2007-115				●	3					35
Parole Discharge Report 2008-104				●	2	1				41
Investigations Report I2008-2 [I2006-0826]				●		1				45
Investigations Report I2008-0805		●			1					7
Investigations Report I2009-1 [I2007-0891]			●			1				47

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	FOLLOW-UP RESPONSE				STATUS OF RECOMMENDATION					
	INITIAL RESPONSE	60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	NO FOLLOW-UP RESPONSE	PAGE NUMBERS
Operations and Cost Management Report 2009-107.1		●				2	3			49
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California Prison Health Care Services

It Lacks Accurate Data and Does Not Always Comply With State and Court-Ordered Requirements When Acquiring Information Technology Goods and Services

REPORT NUMBER 2008-501, JANUARY 2009

California Prison Health Care Services' response as of August 2009

State law gives the Bureau of State Audits (bureau) 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 current court-appointed receiver requested that the bureau conduct an audit of contracts for information technology (IT) goods and services initiated by California Prison Health Care Services (Prison Health Services) for the improvement of prison medical health care services.

Finding #1: Prison Health Services does not have accurate data for contracts it initiates.

Prison Health Services does not have sufficiently reliable data to allow it to identify all contracts it initiates, including IT contracts, and related information. When entering into contracts through the state contracting process, Prison Health Services typically performs all necessary work to identify the preferred vendor for its IT contracts. The contracting office of the Department of Corrections and Rehabilitation (Corrections) executes the contract with the preferred vendor, and its accounting office is responsible for making payments on these contracts. While Corrections maintains two databases that contain various information related to contracts, including those initiated by Prison Health Services and approved through the state contracting process, these databases often contain inaccurate and incomplete data. Prison Health Services noted that its staff use reports generated from these databases to identify the number of contracts it initiates and to assess appropriate future staffing levels to support its operational efforts internally instead of relying on Corrections. Its chief information officer stated that Prison Health Services was in the process of implementing a new enterprise-wide business information system that would house future contract information and would have appropriate controls to limit inaccurate data. Corrections noted that data related to some existing contracts has been migrated to the new system from the existing contracts database. Therefore, even though Prison Health Services intends to limit inaccurate data, the new system may already contain inaccurate or incomplete data.

We recommended that Prison Health Services ascertain that the internal controls over the data entered into the new enterprise-wide business information system work as intended. We further recommended that for contract-related data that has already been migrated from old databases to the new system, Prison Health Services needs to ensure the accuracy of key fields such as the ones for contract amount, service type, and the data fields that identify contracts initiated by Prison Health Services by comparing the data stored in its new database to existing hard-copy files.

Audit Highlights . . .

Our review of California Prison Health Care Services' (Prison Health Services) contracts for information technology (IT) goods and services revealed the following:

- ***Prison Health Services does not have reliable data to identify all IT contracts it initiates—current databases contain inaccurate or incomplete data.***
- ***The new enterprise-wide business information system may already contain inaccurate or incomplete data, migrated from the old databases.***
- ***Eight of 21 contracts we reviewed lacked required certifications justifying the purchase and four service contracts did not have evidence of compliance with all bidding and contract award requirements.***
- ***Prison Health Services has not complied with all provisions of the federal court's order when using alternative contracting methods—two contracts did not contain justification for an expedited formal bid method.***

Prison Health Services' Action: Corrective action taken.

Prison Health Services stated that it has implemented the processes required to ensure complete and accurate contract information. It has also established one certified trainer and two certified power users to ensure the new enterprise-wide system is used to its highest potential. Further, according to Prison Health Services, to ensure that complete and accurate IT contract information has been migrated to the new enterprise-wide system, it has established various internal controls such as comparing the hard-copy contracts to an internal tracking log in the enterprise-wide system and reviewing key fields in the new enterprise-wide system upon receiving a copy of an executed agreement.

Finding #2: Prison Health Services does not consistently follow state contracting requirements to purchase information technology goods and services.

Prison Health Services failed to consistently adhere to state contracting requirements, including Corrections' and its own internal policies, when entering into contracts for IT goods and services. State laws and regulations outline the process that Corrections must follow when making such purchases. Because the receiver acts in place of the secretary of Corrections for all matters related to providing medical care to adult inmates, Prison Health Services must adhere to the same contracting requirements as Corrections, except to the extent that the federal court has waived those requirements. Our review of 21 contract agreements related to IT goods and services executed between January 1, 2007, and June 30, 2008, found that Prison Health Services did not have required documentation to justify the purchases for eight contracts, failed to ensure the contractor agreed to the various required provisions for one contract, and could not demonstrate it complied with appropriate bidding and bid evaluation requirements for four contracts. Prison Health Services' failure to comply with these requirements could be attributed to its lack of adequate controls to ensure that appropriate individuals reviewed these contracts.

We recommended that Prison Health Services ensure that all responsible staff are aware of and follow processing and documentation requirements, including evidencing the review and approval of contracts.

Prison Health Services' Action: Corrective action taken.

Prison Health Services stated that it has developed policies, procedures, guides, checklists, and flowcharts related to proper processing, execution, and documentation of service agreements and made them available to all staff involved with contract practices. In addition, its policies require that contracts are routed through various internal stakeholders to ensure compliance. According to Prison Health Services, it provides training to its staff on the processing of all purchase and service agreements on a continuous basis.

Finding #3: Prison Health Services cannot be assured that it met all court-ordered provisions related to alternative contractng methods.

Although Prison Health Services uses the alternative contracting methods authorized by the federal court that established the receivership, it has not fully complied with all provisions of the court's order for using such methods. To better fulfill Prison Health Services' mission to raise the quality of inmate medical care, the court approved the receiver's request to use streamlined alternative contracting methods in lieu of the state contracting process. The court outlined specific requirements that are to be met when applying any one of the three alternative methods and affirmed that the underlying principles of accountability and transparency called for in state contracting law should be maintained. However, Prison Health Services has not developed internal policies and procedures to ensure the appropriate implementation of the court-approved alternative contracting methods. We found that Prison Health Services did not comply with the explicit requirements imposed by the court in executing five of six IT-related contracts approved since January 1, 2007, that used

alternative contracting methods. In addition, Prison Health Services cannot support that it reported all required information to the court because of weak internal controls and poor record keeping and retention practices.

We recommended that Prison Health Services develop policies to support its use of alternative contracting methods. These policies should include a requirement that Prison Health Services develop clear and specific criteria and guidelines for determining when the waiver authority should be used and how the requirements of the waiver are to be met and documented. Further, Prison Health Services should clearly identify the value of all contracts it executes and ensure that all contracting documents are maintained in a central location. We also recommended that Prison Health Services develop a system of tracking all contracts executed under alternative contracting methods and retain all bids it receives for each contract. To better track its contracts, Prison Health Services should assign a sequential contract number or other unique identifier to each contract executed using alternative contracting methods.

Prison Health Services' Action: Corrective action taken.

Prison Health Services has developed a policy that outlines when the waiver authority may be used for entering into new contracts. The policy includes identifying which distinct project efforts such contracts may support and provides specific guidance on obtaining approval for using alternative contracting methods. The procedure includes specific criteria for the selection of contractors using one of the three processes authorized by the federal court. It also contains a checklist for ensuring that certain requirements are met and guidance for the retention of appropriate documentation in a centralized contract file, including all solicitations and bids. Prison Health Services stated that it has distributed the policy and procedure to management and staff and it has provided related training.

Prison Health Services noted that all contracts processed using standard state contracting procedures clearly identify the value of the agreement by the use of standard forms. It has instructed staff to ensure that contracts developed without the use of standard forms contain all pertinent information found on the standard forms. Further, Prison Health Services noted that it identifies the value of all executed contracts by the establishment of an internal tracking log that identifies key data elements for each executed agreement.

Prison Health Services maintains a log for tracking key data elements, such as funding amount and vendor name, for each executed contract using the alternative methods. In addition, Prison Health Services maintains a tracking log of the type of agreement to be executed, services to be solicited, bidders list for solicitation purposes, bidder responses, and awarded vendor information. Further, solicitation and bids for acquisitions using alternative contracting methods are centrally housed. Prison Health Services also noted that it assigns a unique identifier to contracts executed using the alternative methods.

California Prison Health Care Services

Improper Contracting Decisions and Poor Internal Controls

INVESTIGATION I2008-0805, JANUARY 2009

California Prison Health Care Services' and Department of Corrections and Rehabilitation's responses as of May 2009

When California Prison Health Care Services (Prison Health Services) discovered that some of its information technology (IT) acquisitions had been made with a single vendor in 2007 and 2008 without complying with either the state contracting process or the alternative contracting processes established by a federal court, it requested that we investigate the matter.

Finding: Prison Health Services acquired $26.7 million in IT goods and services in a noncompetitive manner from November 2007 through April 2008.

We found that staff at Prison Health Services ignored state contracting laws, as well as the alternative contracting requirements, when it acquired $26.7 million in IT goods and services in a noncompetitive manner from November 2007 through April 2008. Specifically, Prison Health Services used 49 purchase orders to acquire $23.8 million worth of IT goods from a single vendor when it should have sought competitive bids. It also contracted with the same vendor to provide $2.9 million in IT services again without using a competitive process. Further, staff at the Department of Corrections and Rehabilitation (Corrections) helped to execute the purchase orders for Prison Health Services after initially questioning the propriety of the process used. Consequently, the State cannot be certain that Prison Health Services spent $26.7 million in public funds prudently or that it received the best value for the money spent.

To ensure consistent application of proper contracting procedures for acquiring IT goods and services, we recommended that Prison Health Services do the following:

- Require employees with procurement and contracting responsibilities to attend training at regular intervals regarding state contracting processes.
- Formally communicate to purchasing and contracting staff at Prison Health Services and Corrections the meaning of the federal court's waiver order and the correct procedures that must be followed to use the alternative contracting processes approved by the court.
- Develop and document contracting procedures for staff to follow when acquiring IT goods and services under existing state processes.
- Develop and document the contracting procedures for staff to follow when acquiring IT goods and services under each of the alternative contracting processes approved by the federal court.

Investigative Highlights . . .

California Prison Health Care Services' (Prison Health Services) staff violated legal requirements and bypassed internal controls by noncompetitively acquiring $26.7 million in information technology (IT) goods and services. Specifically, Prison Health Services:

» *Used 49 purchase orders to acquire $23.8 million of IT goods from a single vendor without inviting competitive bids.*

» *Contracted with the same vendor to provide $2.9 million in IT services without using a competitive process.*

Staff at the Department of Corrections and Rehabilitation ultimately executed purchase orders after initially questioning the propriety of the process used.

- Specify in writing who at Prison Health Services has authority to sign contracts and purchase orders under the state and alternative contracting processes, and distribute this information to employees who have responsibilities regarding procurement.

- Establish internal procedures to ensure there is documentation of approval from the receiver or his designee to make an acquisition under each of the alternative contracting processes.

- Ensure that prior to staff selecting a method for acquiring an IT good or service, the proposed acquisition is reviewed by an appropriate staff member to evaluate whether the method of acquisition is proper.

- Ensure that when contracts and purchase orders are being processed by staff at either Prison Health Services or Corrections for IT goods and services, an appropriate staff member will evaluate the proposed acquisition to determine whether it is proper and has the authority to halt the acquisition until any suspected impropriety has been resolved.

To ensure that the State follows applicable contracting laws, Corrections should establish a protocol for communicating with Prison Health Services' executive management when it becomes aware of any potential violations of state contracting laws.

Prison Health Services' Action: Partial correction action taken.

Prison Health Services reported that it has obtained approval from the Department of General Services to use a noncompetitively bid contract to continue to use the vendor that is the subject of this report. It also reported that it adopted a formal policy governing the use of the federal court's waiver of state contracting laws. Further, Prison Health Services notified us in May 2009 that it developed a training policy for staff with purchasing responsibilities. In addition, it developed procedures for staff to follow when acquiring IT goods and services under state processes as well as under contracting processes approved by the federal court. Further, it established a policy to ensure that authority to sign purchasing documents is limited to authorized individuals.

Corrections' Action: Corrective action taken.

Corrections reported that its managers will continue to review contract documentation and abort any transactions that violate applicable contracting requirements.

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' response as of April 2009

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.

In its 60-day response, the chiropractic board reported that 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: 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. In its one-year response, the chiropractic board reported an instance when a board member appropriately identified a potential conflict with an enforcement action before the board and appropriately recused himself from the activity.

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.

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.

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

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: Corrective action taken.

In its six-month response, the chiropractic board reported that 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. In its one-year response, the chiropractic board reported that in December 2008, the executive officer reviewed the duties of all employees in decision-making positions to ensure those individuals file the necessary conflict-of-interest forms. He found that the chiropractic board needed to amend its conflict-of-interest code to include some new positions added and to delete the chiropractic consultant position because it has been eliminated. The chiropractic board reported that it has advised the Fair Political Practices Commission of the needed amendments.

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.

In its original response to the report, the chiropractic board stated that it plans to update its administrative manual as needed to address issues as they arise. The chiropractic board subsequently 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: Corrective action taken.

In its 60-day response, the chiropractic board provided meeting minutes showing that the board members voted to ratify license approvals granted by staff since July 1, 2007. 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. In its one-year response, the chiropractic board provided its January 2009 public board meeting minutes demonstrating that the board members have begun ratifying staff denials of licenses of those applicants that did not request a hearing.

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: Corrective action taken.

In its 60-day response, the chiropractic board reported that the board voted at its May 2008 board meeting to approve the 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 initially transitioned only board staff to ensure that daily operations were not affected. The chiropractic board reported that as of March 2, 2009, all board members have fully operational state e-mail accounts.

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: 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 one-year response, the chiropractic board provided us with documentation of its use of the board member appointment checklist. The chiropractic board also provided its written procedures, dated December 2008, for recording and monitoring board member training.

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: Corrective action taken.

In its six-month response, the chiropractic board provided copies of 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 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. In April 2009 the

chiropractic board reported that its compliance unit staff submit monthly status reports to the compliance unit manager who is responsible for ensuring complaints are processed timely and for removing obstacles that bog down the complaint investigation process. The chiropractic board also reported that it has reduced the average complaint processing time from 416 days for fiscal year 2007–08 to 390 days for the period July 1, 2008, through January 31, 2009.

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.

In its six-month response, 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.

In its six-month response, the chiropractic board provided copies of 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. The chiropractic board has added a field operations unit to perform investigations. In April 2009 the chiropractic board provided documentation demonstrating that it is developing processes and written procedures for guiding its field operations unit when conducting investigations, inspecting chiropractic clinics, and performing probation monitoring. The chiropractic board anticipates completing the procedures by September 2009.

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.

In its six-month response, 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 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. In its one-year response, the chiropractic board reported that on a monthly basis, the compliance analysts must report the status of all urgent cases to their manager. Additionally, the chiropractic board reported that in September 2009, it plans to begin conducting internal audits of various completed files to determine if time frames are being met. The compliance unit will be audited first and the chiropractic board expects to have audit results by November 2009.

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.

In its 60-day response, the chiropractic board reported that at its May 2008 meeting, the board voted to adopt regulatory language that repeals the regulation that established the chiropractic quality review panels. 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. In April 2009 the chiropractic board provided a copy of the Office of Administrative Law's Notice of Approval of Regulatory Action repealing the chiropractic quality review panels effective April 2, 2009.

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.

In December 2008 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 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: Corrective action taken.

In its six-month response, 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. The procedures do include steps and time frames for monitoring the progress of the experts.

As of April 2009 the chiropractic board reported that as a result of improvements, the average time from when a case is assigned to an expert to receipt of the report was reduced from 58 days for fiscal year 2007–08 to 27 days for the period July 1, 2008, through January 31, 2009. Additionally, the board reported that since July 1, 2008, 76 percent of cases assigned were completed and returned from experts within 30 days of assignment. Finally, the chiropractic board reported that beginning May 1, 2009, its compliance unit will begin conducting written evaluations of its expert reviewers/witnesses. Evaluations will be reviewed on a quarterly basis to determine if an expert should be removed from the program. Also, effective May 1, 2009, the chiropractic board began to implement a more comprehensive evaluation that evaluates the quality of the report. The chiropractic board also expects to measure quality, processing time, and cost of each report by July 1, 2009.

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.

In its six-month response, 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 applications, petitions, and 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. In its one-year response, the chiropractic board reported that it tracks all applications received on the spreadsheets, which are updated by staff. The chiropractic board also reported that the licensing manager uses this information to monitor workload and that many of the delays in processing are the result of incomplete packages received from the applicant or petitioner. Further, the chiropractic board reported that in September 2009, it plans to begin conducting internal audits of various completed files to determine if time frames are being met. The compliance unit will be audited first and the chiropractic board expects to have audit results by November 2009.

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.

In its six-month response, 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.

In its six-month response, 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.

In its six-month response, 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.

In its six-month response, 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. Also, 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. Finally, the chiropractic board reported that in September 2009, it plans to begin conducting internal audits of various completed files to determine if time frames are being met. The compliance unit will be audited first and the chiropractic board expects to have audit results by November 2009.

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.

In its six-month response, 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.

In its six-month response, 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.

State Mandates

Operational and Structural Changes Have Yielded Limited Improvements in Expediting Processes and in Controlling Costs and Liabilities

REPORT NUMBER 2009-501, OCTOBER 2009

Commission on State Mandates' and Department of Finance's responses as of November 2009; State Controller's Office response as of December 2009

The California Constitution requires that whenever the Legislature or any state agency mandates a new program or higher level of service for a local entity, the State is required to provide funding to reimburse the associated costs, with certain exceptions. The Commission on State Mandates (Commission), the State Controller's Office (Controller), the Department of Finance (Finance), and local entities are the key participants in California's state mandate process. The Bureau of State Audits (bureau) examined the state mandates process under its authority to conduct both follow-up audits and those addressing areas of high risk. To follow up on our prior audits, we reviewed the status of the Commission's work backlogs and assessed how processing times had changed over the years. We also reviewed the Controller's efforts for using audits to identify and resolve problems in state mandate claims. Further, we evaluated how the State's mandate liability had changed from June 2004 to June 2008. Finally, we assessed the effect of recent structural changes on the state mandate process and summarized possible ways to accomplish the process more effectively.

Finding #1: The Commission still has lengthy processing times and large backlogs.

A test claim from a local entity begins the process for the Commission to determine whether a mandate exists. Although the Commission's test claim backlog dropped from 132 in December 2003 to 81 in June 2009, 61 test claims filed before December 2003 are still pending. In addition, between fiscal years 2003–04 and 2008–09, the Commission did not complete the entire process for any test claims within the time frame established in state law and regulations. In fact, during this period, the Commission's average elapsed time for completing the process was more than six years, and between fiscal years 2006–07 and 2008–09, the average time increased to more than eight years. Both the test claim backlog and the delays in processing create significant burdens on the State and on local entities. At the state level, these conditions keep the Legislature from knowing the true costs of mandates for years; as a result, the Legislature does not have the information it needs to take any necessary action. Additionally, as the years pass, claims build, adding to the State's growing liability.

In addition, the Commission has not addressed many incorrect reduction claims, which local entities file if they believe the Controller has improperly reduced their claims through a desk review or field audit. The Commission has only completed a limited number of these claims, and consequently its backlog grew from 77 in December 2003 to 146 in June 2009. The Commission's inability to resolve these claims

Audit Highlights . . .

Our review of state mandate determination and payment processes found that:

- ***The Commission on State Mandates (Commission) still has a large backlog of test claims, including many claims from 2003 or earlier.***
- ***The Commission's backlog of incorrect reduction claims has significantly increased and creates uncertainty about what constitutes a proper claim.***
- ***The high level of audit adjustments for some mandates indicates that the State could save money if the State Controller's Office filled 10 vacant audit positions.***
- ***The State's liability for state mandates has grown to $2.6 billion in June 2008, largely because of insufficient funding.***
- ***Recent reforms that could relieve the Commission of some of its workload have rarely been used.***
- ***A number of state and local entities have proposed mandate reforms that merit further discussion.***

leaves local entities uncertain about what qualifies as reimbursable costs. Conversely, the Commission has processed most requests for amendments to state mandate guidelines, completing 61 of 70 requested amendments between January 2004 and June 2009. Nevertheless, it did not address an amendment submitted by the Controller in April 2006 that requests the incorporation of standardized language into the guidelines for 49 mandates determined before 2003. Commission staff said that pending litigation caused them to suspend work on the boilerplate request. Although the court's February 2009 decision is on appeal, Commission staff have scheduled 24 mandates for review in 2009 and 25 for review in early 2010.

We recommended that the Commission work with Finance to seek additional resources to reduce its backlog, including test claims and incorrect reduction claims. We also recommended that the Commission implement its work plan to address the Controller's amendment.

Commission's Action: Partial corrective action taken.

In October 2009 the Commission adopted a plan to implement the bureau's recommendations. The plan includes continuing discussions with Finance regarding the Commission's staffing needs and the preparation of a budget change proposal for fiscal year 2011–12, contingent upon Finance authorizing such submittals. Related to the Controller's amendment request, the Commission says it adopted amendments for three programs and issued draft staff analyses for 21 programs.

Finding #2: The Controller appropriately oversees mandate claims, but vacant audit positions, if filled, could further ensure that mandate reimbursements are appropriate.

The Controller uses a risk-based system for selecting the state mandate claims for reimbursement that it will audit, has improved its process by auditing claims earlier than in the past, has sought guideline amendments to resolve identified claims issues, and has undertaken outreach activities to inform local entities about audit issues. Nevertheless, continuing high reduction rates, reflecting large audit adjustments for some mandates, indicate that filling vacant audit positions and giving a high priority to mandate audits could save money for the State. The Controller has reduced 47 percent of the cumulative dollars it has field-audited for all mandate audits initiated since fiscal year 2003–04, cutting about $334 million in claims. Audit efforts were greatly aided by a 175 percent increase in audit staff positions in the Controller's Mandated Cost Audits Bureau (from 12 to 33) in fiscal year 2003–04. However, the Controller was not able to take as much advantage of an additional increase of 10 staff positions two years later, and has had 10 or more authorized field-audit positions unfilled since fiscal year 2005–06. Given the substantial amounts involved, filling these positions to maximize audits of mandate claims is important to better ensure that the State makes only appropriate reimbursements.

We recommended that to ensure it can meet its responsibilities, including a heightened focus on audits of state mandates, the Controller work with Finance to obtain sufficient resources and increase its efforts to fill vacant positions in its Mandated Cost Audits Bureau.

Controller's Action: Partial corrective action taken.

The Controller reported that continued budget reductions have caused it to increase the number of vacant auditor positions to 13. The Controller also said, however, that it has been working closely with Finance to restore funding for these positions.

Finding #3: New mandate processes have been rarely used, and the State has done little to publicize these alternative processes.

New processes intended to relieve the Commission of some of its work have rarely been used. One of these options allows Finance and the local entity that submitted the test claim to notify the Commission of their intent to pursue the jointly developed reasonable reimbursement methodology process (joint process), within 30 days of the Commission's recognition of a new mandate. In this process, Finance

and the local entity join to create a formula for reimbursement rather than basing it on detailed actual costs. Although Commission participation is not eliminated, the joint process greatly reduces the Commission's workload related to establishing a mandate's guidelines and adopting a statewide cost estimate. As of August 2009, the joint process had only been implemented once, and the legislatively determined mandate process, another new process, had not generated any new mandates. Additionally, the Commission can work with Finance, local entities, and others to develop a reimbursement formula for a mandate (Commission process) instead of adopting guidelines for claiming actual costs in the traditional way. Between 2005 and 2008, the Commission had to assure that reimbursement formulas following the Commission process considered the costs of 50 percent of all potential local entities, a standard Commission staff said was difficult to meet. Since the elimination of the 50 percent criterion, the Commission process has been used twice as of August 2009. One factor that may be contributing to the lack of success of the new and revised processes is the State's limited efforts to communicate them to local entities. In particular, we noted that as of July 2009 neither Finance nor the Commission had provided information on their Web sites publicizing the existence of the alternative processes.

We recommended that the Commission add additional information in its semiannual report to inform the Legislature about the status of mandates being developed under joint and Commission processes, including delays that may be occurring. We also recommended that the Commission and Finance inform local entities about alternative processes by making information about them readily available on their Web sites.

Commission's Action: Pending.

In October 2009 the Commission adopted a plan to implement the bureau's recommendations in fall 2009. The plan includes adding information on the status of mandates following alternative processes in the Commission's next report to the Legislature and developing information on alternative processes for the Commission's Web site.

Finance's Action: Corrective action taken.

To provide information regarding reimbursable state mandates, including the processes for seeking a mandate determination, Finance added links on its Web site to the Commission's and Controller's Web sites.

Finding #4: A recent court case overturned revised test claim decisions.

In March 2009 a state court of appeal held that the Legislature's direction to the Commission to reconsider cases that were already final violates the separation of powers doctrine. The court stated that it did not imply that there is no way to obtain reconsideration of a Commission decision when the law has changed, but that the process for declaring reconsideration was beyond the scope of its opinion. In April 2009 an Assembly Budget Subcommittee recognized the importance of reforming the reconsideration process and, according to Commission staff, directed Finance, the Legislative Analyst, and Commission and legislative staff to form a working group to develop legislation to establish a mandate reconsideration process consistent with the court decision. Until a new reconsideration process is established, mandate guidelines may not reflect statutory or other relevant changes. Thus, the State could pay for mandate activities that are no longer required.

We recommended that the Commission continue its efforts to work with the legislative subcommittee and other relevant parties to establish a reconsideration process that will allow mandates to undergo revision when appropriate.

Commission's Action: Pending.

In October 2009 the Commission adopted a plan to implement the bureau's recommendation. The plan includes developing draft language and a legislative proposal, and submitting them to the Governor's Office.

Finding #5: Participants in the mandate process have proposed reforms that merit consideration.

The mandate process suffers from various problems that have motivated stakeholders to contemplate numerous reform proposals. Some improvements have been made, but other suggestions for reform have not. Given ongoing problems and significant costs, the State could benefit from taking a second look at structural reforms proposed in recent years related to pre-mandate and post-mandate processes and other issues. Proposals include creating a mandate cost review committee composed of state and local representatives to review bills while in the legislative process, converting mandated activities to funding sources such as block grants or categorical programs administered by state agencies, and recasting the membership of the Commission to include more local entity appointees.

We recommended that the Legislature, in conjunction with relevant state agencies and local entities, ensure the further discussion of reforms.

Legislative Action: Unknown.

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

Department of Consumer Affairs, Contractors State License Board

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

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

Contractors State License Board's response as of October 2009

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.

Board's Action: Partial corrective action taken.

At the time of our report, the board informed us that it gave the employee a counseling memorandum and a copy of the current departmental policy pertaining to incompatible work activities. The board subsequently informed the employee that she owed the State $1,896. The employee filed an appeal of the board's attempt to collect $1,896, particularly regarding her inappropriate use of a state vehicle while on medical leave. She later submitted a letter to Department of Consumer Affairs (Consumer Affairs) disputing the board's position that she received an overpayment. Consumer Affairs concluded in March 2009 that $94 of the $1,896 owed to the State for misuse of her state vehicle was appropriate. Therefore, Consumer Affairs determined that the employee must reimburse the State $1,802 for her state vehicle misuse. In April 2009 Consumer Affairs notified the employee to make payment arrangements for the $1,802 she owed the State. However, as of October 2009, the employee had not paid back any of the money she owed. Consequently, Consumer Affairs intends to garnish the employee's wages.

Department of Corrections and Rehabilitation

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

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

Department of Corrections and Rehabilitation's response as of April 2009

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.

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.

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

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

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

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

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

Audit Highlights . . .

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

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

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

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

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

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

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

continued on next page . . .

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

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

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

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

Legislative Action: Legislation enacted.

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

Justice's Action: Corrective action taken.

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

Social Services' Action: Corrective action taken.

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

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

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

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

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

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

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

Legislative Action: Unknown.

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

Corrections' Action: Corrective action taken.

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

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

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

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

Corrections' Action: Corrective action taken.

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

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

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

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

Corrections' Action: Corrective action taken.

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

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

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 August 2009

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits 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

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.*

[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.

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.

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: Partial corrective action taken.

Corrections finalized and implemented a new policy memorandum, which defines all aspects of its parole discharge review process. For example, the new policy details the discharge review reporting process and the associated time frames. In addition, it requires district administrators to document sufficient justification for their decisions to retain or discharge parolees. Furthermore, the new policy prohibits deported parolees from discharging by operation of law without a substantive documented review. According to Corrections, it has not yet finalized its related regulations due to recent legislation that may impact the scope of such regulations and the parameters by which its Division of Adult Parole Operations operates.

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: Corrective action taken.

Corrections new policy memorandum clearly delineates discharge and retain authority. In addition, Corrections reports that its Case Records Office redefined the manner in which discharged cases are entered into its database. According to Corrections, Case Records Office staff have also been trained on 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: Corrective action taken.

Corrections' new 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

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

Department of Corrections and Rehabilitation's response as of November 2009

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: Partial corrective action taken.

Corrections informed us that it initiated payment recovery from the nine office technicians. However, Corrections stated that it was unable to recoup $1,900 of the $16,530 we identified because the overpayments occurred more than three years before it initiated recovery. In addition, because Corrections used the incorrect period for overpayment recovery when it initiated efforts, it also failed to collect $3,230 to which the State was entitled for improper payments made from September through December 2005. As a result, in March 2009 Corrections indicated that it had set up accounts receivable totaling $11,400 for the employees. Subsequently, it notified us that one of the office technicians provided it with documentation showing she met the criteria for one of the months we identified in our report. Based on our review of the documents, the office technician was entitled to $190 for that month. Thus, Corrections reduced its overpayment recovery efforts to $11,210. However, it had only recovered $2,090 as of May 2009. Further, Corrections reported in September 2009 that it suspended its collection efforts pending an interpretation by the Department of Personnel Administration (Personnel Administration) of the rules related to supervising inmates. It received Personnel Administration's interpretation in October 2009. As of November 2009 Corrections had not informed us how Personnel Administration's interpretation affected its overpayment recovery efforts.

Department of Corrections and Rehabilitation and Department of General Services

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

ALLEGATION I2007-0891 (REPORT I2009-1), APRIL 2009

Department of Corrections and Rehabilitation's and Department of General Services' responses as of September 2009

The Department of Corrections and Rehabilitation (Corrections) and the Department of General Services (General Services) wasted $580,000 in state funds by continuing to lease 5,900 square feet of office space that Corrections left unoccupied for more than four years. Delays and inefficient conduct by both state agencies contributed to the waste of state funds.

Investigative Highlight . . .

Because of multiple delays and inefficient conduct, the Department of Corrections and Rehabilitation (Corrections) wasted $580,000 in state funds from January 2005 through June 2008, and the Department of General Services has taken more than four years to complete Corrections' request for office space.

Finding #1: Corrections failed to adequately describe its need for space and to promptly fulfill its responsibilities in the leasing process.

Over the four-year period that Corrections was seeking office space, it failed to give General Services an accurate description of its space needs and to promptly provide required information and approvals that were necessary to facilitate the lease process. Its failures contributed to General Services' delays in meeting Corrections' space needs and caused Corrections to waste state funds.

We recommended that Corrections require its employees to confirm leasing needs before submitting a request to General Services to ensure that accurate information is communicated, and to promptly review and approve required lease information to facilitate the process. In addition, we recommended that Corrections obtain training from General Services about the leasing process and General Services' expectations of Corrections' staff in charge of requesting leasing services.

Corrections' Action: Partial corrective action taken.

Corrections informed us that it moved into the office space in May 2009. Corrections indicated subsequently that it initiated several improvements to its leasing procedures and lease project management. In particular, Corrections reported that it is refining its lease project processes to include conducting field reviews of its leased space. In addition, it stated that it has completed a business plan to standardize leasing processes, ensure quality assurance, and strengthen lease inventory records management. Further, in September 2009 Corrections completed a lease process flow diagram, and its remaining leasing staff attended training conducted by General Services about its leasing process. Finally, it planned to complete development of its formal project tracking system and implement other lease management activities, including a lease issue escalation log, by December 2009.

Finding #2: General Services failed to properly exercise its project management responsibilities.

General Services was slow to act on Corrections' request for a reduction of its leased space, and it allowed the negotiation of a new lease to drag on for an unreasonable amount of time while the State continued to pay for unused space. Furthermore, its leasing actions failed to ensure that Corrections' request was efficiently processed without wasting state funds and time.

We recommended that General Services establish reasonable processing and completion timelines for lease activities. We also recommended General Services strengthen its oversight role to prevent state agencies from unnecessarily using leased space when state-owned space is available and to create guidelines for leasing representatives. Finally, we recommended that General Services develop a procedure to evaluate all costs incurred in the processing of a request, including any rent paid on unoccupied space, to ensure that it makes cost-effective decisions when considering the feasibility of a space request.

General Services' Action: Corrective action taken.

In May 2009 General Services confirmed Corrections' occupancy of the office space. In addition, General Services updated its timelines for its lease activities to extend to 36 months from 24 months the maximum time to complete leasing projects. Furthermore, General Services stated that the addition of 15 space planning staff has allowed for a more manageable distribution of its workload to improve the efficiency of planning activities and for timely resolution of critical issues associated with lease projects. It also provided us with its two new policies that, effective May 1, 2009, established procedures for its staff in resolving lease project disputes and in monitoring lease project progress. In addition, to strengthen its enforcement over using state-owned space, General Services indicated that it established policies and practices requiring it to address conflicts with state agencies regarding the use of available state-owned space. Finally, in August 2009 General Services provided us with a policy that, effective June 1, 2009, established its initial processing of lease requests as not to exceed 18 days.

California Department of Corrections and Rehabilitation

It Fails to Track and Use Data That Would Allow It to More Effectively Monitor and Manage Its Operations

REPORT NUMBER 2009-107.1, SEPTEMBER 2009

California Department of Corrections and Rehabilitation's and California Prison Health Care Services' responses as of November 2009

The Joint Legislative Audit Committee requested that the Bureau of State Audits evaluate the effect of California's rapidly increasing prison population on the state budget. We were asked to focus on specific areas of the Department of Corrections and Rehabilitation's (Corrections) operations to provide the Legislature and the public with information necessary to make informed decisions. Specifically, we were asked to do the following:

- Review the current cost to house inmates; stratify the costs by their security level, age, gender, or any other relevant category tracked by Corrections; and determine the reasons for any significant cost variations among such levels and categories.
- Determine the number of inmates Corrections has sent to other states and calculate the State's cost and impact on Corrections' budget.
- Analyze Corrections' budget to determine the amounts allocated to vocational training, rehabilitation, and education programs.
- For a sample of institutions offering vocational training, rehabilitation, and education programs, review Corrections' system for determining the number of instructors and custody staff needed for inmates to participate in these programs. If such staffing is inadequate, determine if any inmates have been denied access to these programs.
- To the extent possible, determine the costs for incarceration under the three strikes law. At a minimum, determine the incarceration cost for each of the following three scenarios:
  - The third strike was not a serious and violent felony.
  - One or more of the strikes was committed as a juvenile.
  - Multiple strikes were committed during one criminal offense.
- Calculate annual overtime pay since 2002 for Corrections' employees, including correctional officers and custody staff, and investigate the reasons for significant fluctuations.

Audit Highlights . . .

Our review of California's increasing prison cost as a proportion of the state budget and the California Department of Corrections and Rehabilitation's (Corrections) operations revealed the following:

» ***While Corrections' expenditures have increased by almost 32 percent in the last three years, the inmate population has decreased by 1 percent during the same period.***

» ***Corrections' ability to determine the influence that factors such as overcrowding, vacant positions, escalating overtime costs, and aging inmates have on the cost of operations is limited because of a lack of information.***

» ***The cost of housing an inmate out of state in fiscal year 2007–08 was less per inmate than the amount Corrections spent to house inmates in some of its institutions.***

» ***Overtime is so prevalent that of the almost 28,000 correctional officers paid in fiscal year 2007–08, more than 8,400 earned pay in excess of the top pay rate for officers two ranks above a correctional officer.***

» ***Over the next 14 years, the difference between providing new correctional officers with enhanced retirement benefits as opposed to the retirement benefits many other state workers receive, will cost the State an additional $1 billion.***

continued on next page . . .

» *Nearly 25 percent of the inmate population is incarcerated under the three strikes law. We estimated that the increase in sentence length due to the three strikes law will cost the State an additional $19.2 billion over the duration of the incarceration of this population.*

» *Although Corrections' budget for academic and vocational programs totaled more than $208 million for fiscal year 2008–09, it is unable to assess the success of its programs.*

» *California Prison Health Care Services' ability to transition to using telemedicine is impeded by a manual scheduling system and limited technology.*

- Review the number of vacant positions during the last five years and determine whether they affect the annual overtime costs and whether filling vacancies would save Corrections money.

- Determine the extent to which Corrections currently uses and plans to use telemedicine. Further, determine if by using telemedicine Corrections is reducing inmate medical and custody costs and the cost to transport and guard inmates outside the prison environment.

In a subsequent report we plan to provide additional information on several of the subjects we were asked to review, including the size and additional costs of specific portions of the population of inmates sentenced under the three strikes law. We also plan to provide additional information on medical specialty visits similar to the types of consultations that California Prison Health Care Services (Health Care Services) is currently providing through its use of telemedicine and their associated costs. Finally, we plan to provide additional information related to vacant positions.

Finding #1: Corrections cannot determine the impact of inmate characteristics on incarceration costs.

Although Corrections spent more than $8 billion in fiscal year 2007–08 to incarcerate inmates in various security levels at its 33 institutions, it did not track costs by individual inmate or by specific inmate populations such as security level or age. While Corrections' accounting records identify cost categories at each institution related to inmate housing, health care, and program costs, Corrections does not specifically track the costs of institution characteristics such as the physical design or the presence of specialized units that increase costs, and therefore its ability to compare the costs to operate one institution versus another is limited. At the time of our audit, Corrections was in the process of developing a new automated solution that will allow for statewide data analysis, according to the chief of its Program Support Unit, and may be used to analyze various characteristics related to the operation of an institution. According to the project advisor, the new system will replace the assignment and scheduling systems currently used by the institutions and was initially scheduled to be implemented by June 2009 but has been delayed after testing revealed that the system was not complete and fully ready.

We recommended that in order to help it assess the effect of policy changes and manage operations in a cost-effective manner, Corrections should ensure that its new data system will address its current lack of data available for statewide analysis, specifically data related to identifying the custody staffing cost by inmate characteristics such as security level, age, and custody designations. We further recommended that if the implementation of this new system continues to be delayed or if Corrections determines that the new system will not effectively replace the current assignment and scheduling systems used by the institutions, it should improve its existing data related to custody staffing levels and use the data to identify the related costs of various inmate populations.

Corrections' Action: Pending.

In its 60-day response, Corrections stated that to meet the requirements of the recommendation, it will need to fully implement its new Business Information System, a phase of the new Strategic Offender Management System, and a statistical analysis package with an external reporting component to analyze the data from the new systems. Currently, it expects the Business Information System to be fully deployed by June 2010, and expects the Strategic Offender Management System to be fully deployed by June 2012. Despite the somewhat lengthy time frame for the deployment of these new systems, Corrections indicates that it does not intend to develop a method to utilize existing information as it would be duplicative of the other information systems. However, until Corrections has finished implementing its new data systems and performed this suggested analysis, we are unable to assess their success in addressing this recommendation.

Finding #2: Corrections' overtime costs for custody staff have increased significantly over the last five years.

Corrections spent $431 million on overtime for custody staff in fiscal year 2007–08, and these overtime costs have risen significantly over the last five years. This increase in overtime costs was caused by various factors including salary increases, vacant positions, and the need for additional guarding for increased medical care required by the receiver. However, the cost to recruit and train new correctional officers, combined with the significant increases in the cost of benefits in recent years has made hiring a new correctional officer slightly more expensive than paying overtime to those currently employed by Corrections. Some of the increase in overtime costs may also be related to the way in which hours worked were classified in the past. Corrections' implemented labor agreement allowed leave credit to be counted as time worked when calculating the amount of overtime an officer earns. For example, a correctional officer could hypothetically take 40 hours of leave during his or her regularly scheduled work period, then work an eight-hour shift in a previously unscheduled period and be paid for the eight hours at the overtime rate. In February 2009 state law was added specifying the way in which overtime is calculated, removing leave of any kind from being considered in determining the total hours worked and thus when overtime hours commence. However, state law leaves open the possibility for future labor agreements to override these provisions.

A state law effective August 2003 requires Corrections to establish a standardized overtime limit for correctional officers, not to exceed 80 hours each month. However, the law also indicates that the State is not relieved of any obligation under a memorandum of understanding relating to hours of work, overtime, or alternative work schedules. The current implemented labor agreement for correctional officers dated September 2007 allows them to exceed the 80-hour overtime limit in certain circumstances. Additionally, a Corrections' policy memorandum dated February 2008 requires each institution to track and immediately report all instances in which the 80-hour overtime limit is exceeded and states that the institution is responsible for limiting the instances in which the 80-hour overtime limit has been or will be exceeded to operational needs or emergencies. During the course of our analysis of the overtime hours worked by correctional officers, we found errors in the overtime data. Specifically, we found that personnel specialists at some institutions improperly keyed retroactive overtime salary adjustments as new overtime payments. Although we have no reason to believe they were not paid the proper amounts, by coding the adjustments improperly, Corrections' payroll data misrepresented the nature of the overtime worked, inadvertently inflating the number of overtime hours it indicated correctional officers had worked, and deflating the average hourly amount it indicated that they received for working those hours. After removing these adjustments, we determined that over 4,700 correctional officers were each paid for more than 80 hours of overtime in at least one month during fiscal year 2007–08. Employees working such a high number of overtime hours causes concern regarding the safety of officers, supervisors, and inmates.

To ensure that the State is maximizing the use of funds spent on incarcerating inmates, we recommended that Corrections communicate to the Department of Personnel Administration the cost of allowing any type of leave to be counted as time worked for the purposes of computing overtime compensation. Additionally, in an effort to more closely align its operations with state law, make

certain that inmates are provided with an adequate level of supervision, and protect the health and safety of employees; we also recommended that Corrections encourage the Department of Personnel Administration to not agree to provisions in bargaining unit agreements that permit any type of leave to be counted as time worked for the purpose of computing overtime compensation.

We also recommended that Corrections encourage the Department of Personnel Administration to negotiate a reduction in the amount of voluntary overtime a correctional officer is allowed to work in future collective bargaining unit agreements in order to reduce the likelihood that involuntary overtime will cause them to work more than 80 hours of overtime in total during a month. Further, we recommended that Corrections should better ensure that it prevents the instances in which correctional officers work beyond the voluntary overtime limit in a pay period.

Finally, to ensure that overtime hours are accurately reported, we recommended that Corrections provide training to its personnel specialists to ensure they properly classify retroactive overtime salary adjustments according to the *Payroll Procedures Manual*.

Corrections' Action: Partial corrective action taken.

In its 60-day response, Corrections stated that it will partner with the Department of Personnel Administration on an ongoing basis to ensure the department's intent of not exceeding the current provisions, and that it is committed to future memorandums of understanding that require an employee to physically work more than 40 hours in a pay period/work week. However, Corrections did not address the portion of our recommendation regarding communicating the cost of allowing any type of leave to be counted as time worked. We are concerned that without stakeholders understanding the cost component, they may not fully understand the impact when negotiating future memorandums of understanding.

In addition, Corrections also stated that in future negotiations, its office of labor relations will recommend to stakeholders that a memo be sent to the Department of Personnel Administration recommending a reduction in the work period overtime cap to 60 hours, in an attempt to ensure that the Corrections stays within the 80 hour limit.

Finally, Corrections stated that it will provide direction to institution personnel offices via a memorandum regarding the proper procedure for coding salary adjustments and that it intended to circulate this memo by December 2009. Additionally, Corrections planned to provide reminders and supplemental training during a monthly conference call scheduled to occur in December 2009 as well as a Personnel Information Bulletin, distributed via e-mail during the same time period.

Finding #3: Although Corrections budgeted more than $200 million for academic and vocational inmate programs in fiscal year 2008–09, it lacks a staffing plan based on inmate needs.

In reviewing the adequacy of staffing for Corrections' education and vocational programs, we found that it does not have a current staffing plan based on inmate needs. According to the acting superintendent of the Office of Correctional Education (acting superintendent), Corrections does not have a staffing plan for allocating teachers and instructors based on inmates needs. Instead, she indicated that teacher and instructor positions are initially allocated in the institution's activation package when the institution is first opened. She stated that an institution can augment their staffing plans through a budget change proposal, when an institution changes missions, or because of overcrowding. When we asked Corrections why it has not developed a staffing plan based on inmate needs, the acting superintendent stated that Corrections recognizes that the current staffing packages for rehabilitative programs are not based on inmate needs and the need for change has become apparent as Corrections has begun to deactivate gymnasiums and other nontraditional beds and has lost teachers and other program staff due to these reductions.

We recommended that Corrections develop a staffing plan that allocates teacher and instructor positions at each institution based on the program needs of its inmate population to ensure that it is addressing the program needs of its inmate population in the most cost-effective manner.

Corrections' Action: Pending.

In its 60-day response, Corrections stated that as a result of significant budget reductions, it is revising the way in which it provides educational services. As part of these changes, Corrections is developing a plan that allocates educational staff based on the target population of each institution using assessments of the risk of recidivism, criminogenic need, including adult basic education test scores, and the length of time left to serve. Further, Corrections states that it will work with the administration and Legislature to develop an ongoing process to tie education funding to inmate need, pending funding availability.

Finding #4: Corrections does not currently track individual inmate participation in education programs and therefore cannot assess program effectiveness or compliance with state law.

During our review of Corrections' administration of its education and vocational programs, we found that while Corrections collects aggregate data, such as the total number of inmates participating in a program and the total number of inmates who successfully complete a program, it does not maintain data for individual inmate's participation in education programs once the inmate leaves the institution. As a result, Corrections cannot demonstrate whether or not inmates have been denied access to programs. When inmates are assigned to a program that is full, they are placed on a waiting list, and while awaiting placement they are usually placed in a work assignment. Corrections told us that it does not maintain historical waiting list or program assignment data. It also stated that it maintains data on program assignments as long as an inmate remains at an institution, but that once an inmate leaves the institution—by being paroled or transferred to another institution, for example—the program participation data are not kept. Therefore, Corrections cannot determine the length of time inmates are on a waiting list for a program, whether inmates are paroled before being assigned to a program, whether inmates are assigned to the programs their assessments indicated they should attend, or the length of time inmates are in programs. Additionally, because Corrections does not maintain historical waiting list and program assignment data for individual inmates, it does not have sufficient data to determine whether it has made literacy programs available to at least 60 percent of eligible inmates in the state prison system, in compliance with state law.

Finally, we found that Corrections' policy regarding education programs is outdated and does not align with state laws regarding prison literacy. State law requires Corrections to implement literacy programs in every state prison designed to ensure that upon parole, inmates are able to achieve a ninth-grade reading level and to make these programs available to at least 60 percent of eligible inmates. Corrections' policy states that the warden is responsible for ensuring that inmates who are reading below the sixth-grade reading level are assigned to adult basic education and that the warden shall make every effort to assign 15 percent of the inmate population to academic education. Despite the differences between Corrections' policy and state law, it appears that Corrections' programs are more closely aligned with state law. Nevertheless, because Corrections has not updated its policy regarding adult education programs since 1993, staff may not be clear on the relevant requirements that should be met.

We recommended that Corrections track, maintain, and use historical program assignment and waiting list data by inmate to allow it to determine its compliance with state law and the efficacy of its programs in reducing recidivism. We also recommended that Corrections update its adult education program policies to ensure that staff are aware of the relevant requirements that should be met related to prison literacy.

Corrections' Action: Pending.

In its 60-day response, Corrections stated that it is in the process of developing a number of items that will address this issue, including phases of the Strategic Offender Management System, a risk assessment tool, and a statistical analysis tool. Corrections expects completion of the risk assessment and statistical analysis tools by June 2010 and expects the relevant portions of the Strategic Offender Management System will be deployed at the institutions in June 2012. However, until this system is implemented, we are unable to assess Corrections' success in addressing this recommendation.

In addition, Corrections stated that it will review all policies and procedures to ensure they are up to date and address Penal Code 2053.1, which relates to prison literacy. However, Corrections did not provide a time frame for this task and indicates that resources for updating policies and regulations are dependent upon funding availability.

Finding #5: Health Care Services has limited information regarding the cost-effectiveness of telemedicine consultations.

In 2006 a federal court appointed a receiver to provide leadership and executive management over the California prison medical health care system. The receiver uses the name Health Care Services to describe the organization he oversees. Health Care Services currently uses telemedicine—two-way video conferencing between an inmate and a health care provider—to furnish some medical specialty care to inmates housed in the adult institutions run by Corrections. Although Health Care Services has expanded the use of telemedicine in the last three years, according to the federal receiver's *Turnaround Plan of Action* and the *Telemedicine Project Charter*, insufficient telemedicine infrastructure exists to support the plan to vastly expand the telemedicine program.

The use of telemedicine reduces the costs to transport and guard inmates who otherwise may need to be taken out of the institution to visit medical specialty care providers. However, Health Care Services has gathered only limited data related to the cost savings of using telemedicine. Also, Health Care Services has limited information available regarding the effectiveness of telemedicine use. The expansion of telemedicine is in its early stages and although the receiver planned to transition additional medical care to telemedicine, progress in doing so has been impeded by a manual scheduling system and limited technology. Without systemwide improvements, it is unlikely that significant amounts of additional care could be provided via this delivery method. A 2008 review of the telemedicine program, which Health Care Services contracted with a consultant to provide, indentified numerous shortcomings and recommended significant revisions to program management policies, existing hardware and technology, and related human resources.

We recommended that Health Care Services review the effectiveness of telemedicine consultations to better understand how to use telemedicine to minimize costs. In addition, we recommended that Health Care Services perform a more comprehensive comparison between the cost of using telemedicine and the cost of traditional consultations, beyond the guarding and transportation costs, so that it can make informed decisions regarding the cost-effectiveness of using telemedicine. We further recommended Health Care Services increase the use of the telemedicine system by continuing to move forward on its initiative to expand the use of telemedicine in Corrections' institutions, implement the recommendations that it has adopted from the consultant's review of telemedicine capabilities, and maintain a focus on developing and improving its computer systems to increase the efficiency of using telemedicine.

Health Care Services' Action: Partial corrective action taken.

In its 60-day response, Health Care Services stated that it is currently carrying out a project to increase telemedicine in selected institutions that will provide it with information on how to better use telemedicine. Specifically, Health Care Services stated that the project will evaluate the need for additional services and identify and address needed resources and existing barriers. However, it did not provide us with information on how this initiative will address its understanding of the effectiveness of telemedicine consultations or provide information on how to use telemedicine to minimize costs. Health Care Services also indicated that it will be performing an analysis on telemedicine costs, and that a discussion with management regarding the analysis will be scheduled soon. It did not indicate what cost aspects the analysis would address but estimated that it would complete this analysis by June 2010.

Health Care Services also indicated that it will continue to implement the recommendations from the consultant's review of its telemedicine capabilities and expects to complete its efforts by March 1, 2011. Also, Health Care Services stated that its efforts to implement an interim scheduling system, which it expects to be completed by the end of February 2010, has been incrementally expanded and improved, but did not provide any specifics regarding what it has accomplished in this area. Finally, it stated that it is continuing in its efforts to implement a Health Care Scheduling System, which it expects to complete by December 2011, and that the Scheduling System team is working to incorporate telemedicine requirements into phases of the project scheduled to be deployed after the summer of 2010.

Department of Corrections and Rehabilitation

Its Poor Internal Controls Allowed Facilities to Overpay Employees for Inmate Supervision

REPORT NUMBER I2009-0702, NOVEMBER 2009

Department of Corrections and Rehabilitation's response as of December 2009

Many of the Department of Corrections and Rehabilitation's (Corrections) employees receive extra pay called a pay differential for supervising inmates who perform the work that a civil servant would typically perform. To receive the pay differential, the employees must supervise at least two inmates who collectively work at least 173 hours. We examined Corrections' payments for inmate supervision to 153 employees at six correctional facilities using a random sample of payments made from March 2008 through February 2009.

Finding #1: Corrections overpaid employees for inmate supervision and failed to collect overpayments it previously made.

Our investigation concluded that Corrections had overpaid 23 of the employees we reviewed a total of $34,512. The overpayments to the individual employees ranged from $380 to $3,900. Based on our sample, we estimated that Corrections may have overpaid its employees as much as $588,376 statewide during the 12-month period we reviewed. In addition, we found that for the most part Corrections had not initiated collection efforts to recover the improper payments it had identified after we reported on an investigation at another correctional facility in October 2008.

We recommended that Corrections initiate accounts receivable for the employees identified as receiving improper payments and begin collection efforts for these accounts.

Corrections' Action: Pending.

In October 2009 Corrections inferred that we applied the requirements for receiving the pay differential too strictly and supplied some information it received from the Department of Personnel Administration (Personnel Administration). However, we concluded that much of the information from Personnel Administration did not impinge on our investigation. In addition, we disagreed with a Personnel Administration opinion that inmates did not necessarily need to work the required number of hours for the employees to qualify for the pay differential.

Corrections also reported that it planned to establish a task force of key staff to fully review the information received from Personnel Administration. It commented that once the task force completes the assigned responsibilities, it will recover the funds it improperly paid to its employees.

Investigative Highlights . . .

Our investigation of inmate supervision payments made by the Department of Corrections and Rehabilitation (Corrections) revealed the following:

- *Corrections overpaid 23 employees a total of $34,512 over a 12-month period at five of the six correctional facilities we visited.*
- *Based on our sample, Corrections may have improperly paid as much as $588,376 to its employees statewide during the same 12-month period.*
- *Corrections failed to implement sufficient controls to ensure that employees who received inmate supervision pay met the requirements.*
- *Except in a few instances, Corrections had not initiated collection efforts to recover improper payments it identified subsequent to our initial investigation.*

In December 2009 Corrections reported that the task force planned to complete its proposed actions by March 2010. It also noted that some grievances had been filed about establishing accounts receivable and that the grievances were put on hold pending the outcome of task force's actions and direction from its legal staff.

Finding #2: Corrections lacked sufficient controls to ensure that only employees satisfying the inmate supervision requirements received the pay differential.

Five of the six facilities we visited had few or no policies in place during the period we reviewed to ensure that employees receiving the pay differential for supervising inmates met the necessary requirements each month. The remaining facility had implemented a policy requiring employees to submit inmate time sheets along with their own time sheets each month. However, the policy did not apply to all employees who received the pay differential. In addition, we noted weaknesses in document retention at the facilities in our review and found that many employees' personnel files did not contain certain required documents related to inmate supervision.

We recommended that employees at all of its facilities submit copies of the supervised inmates' time sheets to their personnel offices each month along with their own time sheets so personnel staff can use these documents to verify each employee's eligibility to receive the pay differential. We also recommended that Corrections take steps to develop clearer requirements that specifically define what constitutes "regular" supervision of inmates. Finally, we recommended that Corrections provide adequate training and instruction to its employees who supervise inmates and the personnel staff reviewing time sheets regarding the requirements for receiving the pay differential and proper documentation.

Corrections' Action: Pending.

In December 2009 Corrections reported that its task force planned to establish necessary guidelines and internal controls by March 2010.

Department of Finance

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

ALLEGATION I2008-0633 (REPORT I2009-1), APRIL 2009

Investigative Highlight . . .

The Department of Finance saved a vacant position by transferring an employee from one position to another.

Department of Finance's response as of April 2009

Our investigation revealed a sequence of events indicating that the Department of Finance (Finance) improperly kept a vacant position from elimination; thus, it circumvented a state law intended to abolish long-vacant positions.

Finding: Finance circumvented state law and improperly prevented a vacant position from being abolished.

During the seven month period from June 2006 through January 2007, three Finance employees occupied one position at various times. However, this position was not filled by anyone for a full five-month period from July through November 2006. Had the position remained unfilled through December 31, 2006, it would have been deemed vacant according to California Government Code, Section 12439, and therefore would have been abolished. However, based on our review of employment records from the State Controller's Office (Controller), Finance manually keyed Employee B's transfer into this position on December 21, 2006, and made it effective December 1, 2006. Finance then transferred Employee B to another unit on January 17, 2007. Employee B informed us that he requested the transfer to another unit in January 2007, but he was not aware he had been transferred to the vacant position in December 2006. Finance appointed another employee, Employee C, to the vacant position on January 18, 2007. When Finance manually keyed in Employee B's transfer into this position effective December 1, 2006, for a period of 49 days, it prevented the position from being abolished by the Controller. As a result, Finance circumvented state law governing the abolishment of vacant positions.

To ensure the laws governing vacant positions are followed, we recommended that Finance transfer employees from one position to another only when there is a justified business need.

Finance's Action: Corrective action taken.

Finance issued a memoranda to its executive management and its chief of human resources to stress the importance of strict compliance with the law governing vacant positions and to require that any circumvention of this law be reported to its management. Finally, Finance issued a counseling memorandum to the manager who directed staff to move an employee in order to save the vacant position.

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 January 2009

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 do the following:

- 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

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.*

safety, the costs for a new weapons system, and the time it would need 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.

[1] A weapons system comprises the handgun and the ammunition the handgun fires.

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 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.

[2] TACNET™ stands for tactical network and is a registered trademark of Visteon Corporation.

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.

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 March 2010.

The CHP reported that its Office of Investigations has included in its annual citizens' complaint review an examination of secondary employment requests.

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: 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. CHP stated that it published General Order 0.9, Use of State Owned Equipment and Resources, in November 2008.

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 December 2009

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: Partial corrective action taken.

According to their one-year responses to our audit report, four of the five state agencies we sampled have implemented our recommendation. The four state agencies are CHP, Motor Vehicles, Caltrans, and Employment Development. CHP stated that it developed an e-waste disposition process and updated desk procedures and a standard operating procedure. These procedures include indicating whether any e-waste items were disposed of in accordance with CHP's e-waste program and defining all electronic devices as universal waste that require disposal only by authorized e-waste recyclers. Motor Vehicles stated that as of August 1, 2008, it does not allow any electronic equipment to be disposed of in a landfill. It also stated that it donates operable equipment to public schools and equipment in poor condition is disposed of through an approved recycler or an e-waste event that will properly dispose of the electronic equipment. Caltrans stated that it established a recycling program and, as part of this program, all electronic waste will be treated as universal waste and recycled. Employment Development stated that all staff responsible for the disposition of surplus items have been trained on the proper disposition of electronic equipment and e-waste. It also stated that it identified and is using an accredited e-waste recycler.

The fifth state agency—Justice—stated that it continues to educate staff regarding the proper disposal of all waste and surplus items, including e-waste. It also stated that it is still in the process of revising its property control manual that will further emphasize the proper disposal and documentation of all assets. Justice indicated that conflicting priorities and staff shortages have delayed completion of this manual until February 2010.

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: Corrective action taken.

The three oversight agencies included in our audit—General Services, Toxic Substances Control, and the Waste Management Board—stated that they have worked collaboratively to implement solutions for ensuring that e-waste from state agencies is managed legally and safely. General Services stated that the three entities emphasized the need for proper e-waste management to department directors and jointly provided training about recycling and e-waste disposal to approximately 200 state employees. Further, General Services stated that after receiving input from the other two entities, it amended the State Administrative Manual to clearly require state entities to dispose of irreparable and unusable e-waste using the services of an authorized recycler. The California Environmental Protection Agency also stated that Toxic Substances Control and the Waste Management Board coordinated with General Services to create an informational poster about e-waste for mounting by state agencies in locations where e-waste items may be handled and disposed of by staff.

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: Corrective action taken.

Regarding a thorough duty statement for a recycling coordinator, we mentioned in our audit report that Justice already follows this best practice. In their follow-up responses to our audit report, the other four entities—CHP, Motor Vehicles, Caltrans, and Employment Development—stated that they had created or updated the duty statements for their recycling coordinators or updated other comparable documents such as desk procedures and standard operating procedures.

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. In its follow-up response to our audit report, Motor Vehicles stated that it had developed guidelines on the use of the DGS master service agreement for e-waste disposal and procedures for handling e-waste.

Children's Hospital Program

Procedures for Awarding Grants Are Adequate, but Some Improvement Is Needed in Managing Grants and Complying With the Governor's Bond Accountability Program

REPORT NUMBER 2009-042, MAY 2009

California Health Facilities Financing Authority's response as of November 2009

The Children's Hospital Bond Act of 2004 (2004 act) established the Children's Hospital Program (program) and authorized the State to sell $750 million in general obligation bonds to fund it. The purpose of the program is to improve the health and welfare of California's critically ill children by funding capital improvement projects for qualifying children's hospitals. The California Health Facilities Financing Authority (authority) is authorized by the 2004 act to award grants for the purpose of funding eligible projects. The 2004 act also states that the Bureau of State Audits may conduct periodic audits to ensure that the authority awards bond proceeds in a timely fashion and in a manner consistent with the requirements of the 2004 act, and that grantees of bond proceeds are using funds in compliance with applicable provisions.

Finding #1: The authority does not always ensure that it receives interest earned on advances of program funds to grantees.

The authority's regulations state that children's hospitals not within the University of California (UC) system may receive advances of program funds, and the authority is required to recover any interest earned on these advanced funds by reducing subsequent disbursements. However, the authority does not always comply with this requirement. For example, we noted that the authority did not recover interest from two hospitals, totaling more than $34,000, even though the two hospitals reported the interest earnings to the authority. According to the authority's program manager, the authority should be recovering such earned interest, and it plans to do so by reducing future grant disbursements to the two hospitals by the amount of the interest earnings.

In addition, although the authority's grant agreements with children's hospitals require that the grantees establish separate bank accounts or subaccounts for grant funds and provide to the authority copies of all statements for these accounts, the authority has not ensured that hospital grantees not in the UC system submit all bank statements. Periodic collection of these bank statements would assist the authority in identifying interest that may have been earned, allowing it to credit this interest against future disbursements or to collect the interest from the hospitals.

Finally, the authority's current regulations do not require that grantees deposit advanced grant funds in an interest-bearing account, although some grantees have done so. Given the amount of bond proceeds

Audit Highlights . . .

Our review of the administration and use of bond proceeds from the Children's Hospital Bond Act of 2004 (2004 act) revealed the following:

- ***The 2004 act's restrictive requirements limit the number of hospitals that can use the funds.***
- ***The California Health Facilities Financing Authority (authority) did not always recover interest earnings on funds paid to the hospitals in advance of actual expenditures—we identified more than $34,000 of interest due to the State.***
- ***The authority's regulations do not require grantees that are not in the University of California system to deposit fund advances in interest bearing accounts.***
- ***The authority has not finalized and implemented procedures to close out program grants.***
- ***Although the authority desires to voluntarily comply with the governor's 2007 executive order regarding accountability for bond proceeds, it is uncertain of its timeline to do so.***

earmarked for hospitals not in the UC system, the potential interest earnings on funds advanced to grantees may be significant. According to the program manager, he knows of no legal prohibition against such a requirement and intends to seek an opinion from the program's staff counsel.

We recommended that the authority verify that it has the legal authority to require grantees that are not in the UC system to deposit grant funds paid in advance of project expenditures in an interest bearing account and, if it has such authority, require that grantees earn interest on grant funds. In addition, the authority should develop and implement procedures to ensure that it promptly identifies and collects interest earned on those advances.

Authority's Action: Partial corrective action taken.

According to the authority, its legal counsel advised that there are no legal impediments to requiring hospitals not in the UC system to establish interest bearing accounts. As such, the authority indicated it formed a working group, which has met, to determine how best to implement this recommendation. The authority decided it is not going to pursue regulations at this time, but is now advising grantees to establish interest-earning accounts. However, the authority indicated that it has internally agreed to remain flexible in this area in that, to the extent a grantee demonstrates extenuating circumstance to justify the use of noninterest bearing accounts, it will consider their position on a case-by-case basis.

The authority also indicated that currently it has procedures in place to identify and collect interest earned on advances, but takes note of our recommendation to ensure these tasks are performed as promptly as possible. It reiterates that prior to the final disbursement for a grant award, the authority's staff will review bank statements for the dedicated account and direct the grantee to remit interest generated by grant disbursements for that award. We are concerned with the authority's response, because it made these same statements in its response at the time we published our report in May 2009; however, as we indicated in our report, the authority's procedures were not effective to ensure that it collects all bank statements and promptly collects interest earnings on advances of grant funds.

Finding #2: The authority has not promptly and effectively closed out grants for completed projects.

The authority has not yet finalized and implemented procedures to close out program grants. Although it has received some documentation from grantees regarding project completion, it does not ensure that all required information is received and has not determined all the steps it needs to perform to close out grants after projects are completed. The authority's regulations contain requirements for completed projects that include items such as a certification that the project is complete and documentation clearly showing that grant awards do not exceed the cost of the project. The authority has developed a checklist to use in gathering and evaluating information regarding completed projects. However, the authority does not always promptly complete the checklist. In addition, the checklists showed no evidence of review by program management. One of the items not completed on the checklist was whether the grantee provided a final report referred to as the Completion Certificate and Final Report. The authority requires grantees to submit this report to document, under penalty of perjury, the uses of funds expended on the project; estimated total cost of the project; interest earned on advanced grant funds; whether the hospital received a notice of completion for the project; the results of the project and the performance measures used; and any follow-up implementation actions such as equipment, staffing, or licensing. At the time of our fieldwork, March 2009, the authority still had not received a Completion Certificate and Final Report from two hospitals even though their projects had completion dates of October 2007 and September 2008.

Finally, according to the program manager, the authority may need to take additional steps to achieve final closeout of the grants for completed projects, however, the authority has not yet identified the additional steps it would need to take to officially close out an award.

We recommended that to ensure that the authority meets the objectives contained in the program regulations for the completion of grant-funded projects, including obtaining certification that projects are completed and grants do not exceed project costs, it should take the steps necessary to ensure that it promptly executes its project completion checklist, determines any additional steps it needs to perform to close out grants, and finalizes and implements the necessary steps to ensure that grant closeout procedures are followed.

Authority's Action: Partial corrective action taken.

The authority indicates that it believes it is and has taken all reasonable steps necessary to verify completion of a project and to close out grants. However, it stated that to further enhance its closeout procedures, in addition to the use of a project completion checklist, the authority has developed and implemented a standard letter to grantees, as well as a standard memorandum-to-file, to be written upon the completion of the requirements for each grant award in order to memorialize the finality of a grant award and that all grant requirements have been met. Again, we are concerned with the authority's response because, although it indicates it enhanced its close-out procedures, it does not address whether it is now promptly completing its project completion checklist.

Finding #3: The authority is uncertain of its timeline to voluntarily implement the governor's bond accountability program.

Although the authority is not required to comply with the governor's January 2007 executive order regarding accountability for bond proceeds, according to the program manager, the authority desires to voluntarily comply with the bond accountability standards and is working with the Department of Finance (Finance) to implement the executive order. We believe that the information required by the executive order regarding the use of the bond proceeds will benefit interested members of the public. However, the authority's program manager indicated that he is uncertain whether the authority has sufficient staff time available to ensure compliance in the near future. He stated that even though the authority plans to hire one additional staff member, a considerable amount of time and effort will be needed to address existing program needs, as well as to implement the additional funding for the children's hospital program authorized by the voters in November 2008.

We recommended that since the authority has decided it desires to comply with the governor's executive order to provide accountability for the use of bond proceeds, it should develop and submit to Finance an accountability plan for its administration of the program bonds. In addition, it should take the necessary steps to periodically update Finance's bond accountability Web site to provide public access to information regarding its use of the bond proceeds.

Authority's Action: Partial corrective action taken.

According to the authority, it has submitted a proposed bond accountability plan to Finance for its review and, currently, the authority is waiting for a response from Finance. Additionally, the authority stated that it will work to periodically update Finance's bond accountability Web site with information regarding the use of bond proceeds.

Department of Housing and Community Development

Housing Bond Funds Generally Have Been Awarded Promptly and in Compliance With Law, but Monitoring Continues to Need Improvement

REPORT NUMBER 2009-037, NOVEMBER 2009

Department of Housing and Community Development's and California Housing Finance Agency's responses as of November 2009

In 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 (HCD) and the California Housing Finance Agency (Finance Agency) primarily award, disburse, and monitor the housing bond funds received by various programs.

The California Health and Safety Code requires the Bureau of State Audits (bureau) to conduct periodic audits of housing bond activities to ensure that proceeds are awarded in a manner that is timely and consistent with legal requirements and that recipients use the funds in compliance with the law.

Finding #1: HCD and the Finance Agency generally undertake appropriate monitoring procedures during the disbursement phase.

For disbursement of housing bond awards, both agencies generally have processes in place to ensure that recipients meet legal requirements. However, HCD did not always follow its procedures when issuing advances to sponsors receiving CalHome Program bond funds. For example, it has continued to advance funds to recipients at amounts greater than the limit set in their standard agreements, a practice that we previously reported in September 2007 during our initial audit of these bond programs. In response to that audit, HCD implemented procedures that establish criteria for issuing advances constituting more than 25 percent of the total award. However, HCD did not follow these procedures for two of the 10 recipients we tested that received advances exceeding the limit. Establishing limits on the amounts advanced to recipients helps ensure that projects are, in fact, progressing before all funds are disbursed, and it also allows the State to maximize interest earnings.

In addition, HCD did not always ensure that recipients submitted quarterly status reports for its CalHome Program, as required in its CalHome regulations. HCD uses these reports, in part, to assess the performance of program activities. Also, the Finance Agency did not always ensure that its sponsors, comprising local entities qualified to construct or manage housing developments, had a regulatory agreement in place. These agreements provide assurance that developments being built using funds from the Residential Development Loan Program remain affordable to low- and moderate-income households.

Audit Highlights . . .

Our review revealed the following for the Housing and Emergency Shelter Trust Fund acts of 2002 and 2006:

- *As of December 2008 the Department of Housing and Community Development (HCD) and the California Housing Finance Agency (Finance Agency) had awarded nearly all the November 2002 bond funds.*
- *Although both HCD and the Finance Agency awarded housing bond funds authorized in November 2006 for eight of 10 programs in a timely fashion, HCD has not yet issued any awards for the remaining two programs.*
- *Both HCD and the Finance Agency have established and generally adhered to policies intended to ensure that only eligible applicants receive awards.*
- *For disbursement of the housing bond awards, both agencies generally have processes in place to ensure that recipients meet legal requirements; however, as we reported in September 2007, HCD continues to advance funds to recipients at amounts greater than the established limit for its CalHome Program.*
- *Because of state budget difficulties, HCD restricted travel, beginning in July 2008, for performing on-site monitoring visits. Thus, it has not met the goals it established for conducting such visits for its Emergency Housing, CalHome, and Supportive Housing programs.*

We recommended that HCD follow its procedures on restrictions of bond fund advances that exceed 25 percent of the total award under the CalHome Program. In addition, HCD should ensure that it receives and reviews required status reports from recipients of funds under its CalHome Program. We also recommended that the Finance Agency obtain signed copies of recorded regulatory agreements before disbursing funds to its recipients of the Residential Development Loan Program.

HCD's Action: Corrective action taken.

HCD explained that CalHome Program's ability to grant an advance in excess of 25 percent under special circumstances is important to mitigate risks to participants (occupants) who might otherwise lose an opportunity to own and occupy a home. Therefore, it developed and implemented a procedure for granting advances in excess of 25 percent to recipients of its CalHome Program that requires the following: substantiation from the recipient, addition of the request to the tracking report, and review and approval by the manager. The request is then documented, processed, and filed in the recipient's file. HCD believes that this procedure ensures that the appropriate controls are in place. Further, HCD asserted that the two instances of noncompliance identified by the bureau were traced back to two staff members who no longer work for HCD. To ensure that subsequent infractions of the procedure do not occur, HCD indicated it has reissued the procedure to all CalHome Program staff members.

Further, according to HCD, status reports from recipients of its CalHome Program are due 30 days after the end of every quarter. It indicated that as contractors receive an award, they are added to a quarterly report tracking log. According to HCD, staff previously kept their own log; however, that log will now be centralized. If reports are late, HCD stated that its staff will call or email the contractor and note on the log who called, who the contact was, the date called, and the result. It also indicated that the log will be reviewed periodically by the manager and follow-ups will be performed as necessary.

Finance Agency's Action: Partial corrective action taken.

Finance Agency agrees this is an important safeguard that should be implemented. According to the Finance Agency, it has already contacted all awardees requesting this documentation and amended its monitoring procedures to include requiring a copy of the recorded regulatory agreement prior to any future funding disbursements. The Finance Agency added that the majority of the files are now complete, and it expects full compliance from the remaining participants shortly. It also indicated that it suspended any further funding disbursement to localities that have not submitted a copy of a recorded regulatory agreement until they comply with this requirement.

Finding #2: HCD needs to improve its efforts to monitor during the completion phase.

We reviewed the completion phase monitoring for three programs: the CalHome Program, the Emergency Housing and Assistance Program (Emergency Housing Program), and the Multifamily Housing Program-Supportive Housing Program (Supportive Housing Program). All three had processes in place that should assist in ensuring compliance during the completion phase. In fact, HCD has improved its processes for the CalHome and Emergency Housing programs, which our 2007 audit identified as having weak or nonexistent monitoring during the completion phase. Both programs now have monitoring procedures in place to ensure that sponsors are using bond funds to help their intended populations. However, because of state budget difficulties, HCD restricted the amount of travel for performing on-site visits beginning in July 2008; thus, it has not met the goals it established for conducting on-site visits for these three programs. In fact, HCD did not perform any on-site monitoring reviews for its Supportive Housing and CalHome programs during fiscal year 2008–09.

However, HCD did perform on-site monitoring for its Emergency Housing Program, focusing on those sponsors it considered a higher risk. We believe focusing review efforts on the higher-risk sponsors for the Emergency Housing Program is a reasonable approach that HCD should consider adopting for the other two programs. By not monitoring at least the higher-risk sponsors, HCD cannot ensure that

sponsors use funds in accordance with housing bond requirements or that the programs are benefiting the intended populations. Moreover, for the on-site visits HCD performed for its CalHome Program prior to fiscal year 2008–09, it did not always communicate its findings and concerns to the sponsors in a timely manner or ensure that sponsors provided appropriate responses. As a result, HCD cannot ensure that sponsors take timely and appropriate corrective action.

We recommended that when practical, HCD should adopt a risk-based, on-site monitoring approach for its CalHome and Supportive Housing programs similar to the monitoring methodology used for the Emergency Housing Program. In addition, HCD should ensure it promptly communicates concerns and findings identified during on-site visits conducted for its CalHome Program and ensure that recipients provide a timely response to the concerns and findings.

HCD's Action: Partial corrective action taken.

HCD stated that it has adopted a risk-based, on-site monitoring approach for its CalHome and Supportive Housing programs similar to the monitoring methodology used for the Emergency Housing Program. It indicated that it has also re-examined and re-communicated its travel expenditure policy to support field visits to conduct site monitoring.

In addition, HCD concurs that it is important to communicate concerns and findings identified during on-site visits to the contractors. HCD explained that there has been a longstanding documented process for such communication, which includes that such letters are required to be prepared by CalHome Program staff within a defined time frame. However, according to HCD, during a change in management, it inadvertently did not approve or did not send these letters to the contractors. HCD stated that the current manager is developing a centralized tracking log for the site monitoring that will include the name of the recipient (contractor) and dates of the following: site visit and completion, letter of findings, and clearance of findings. It also asserted that the original documentation will be stored in the contractor's file. Finally, HCD indicated that the tracking log will be completed by October 31, 2009, and will ensure that, in the event of any future management changes, the process will be followed.

Finding #3: HCD has not yet completed its verification of data transferred to a new system.

HCD continues to lack sufficient internal controls over its information technology system. Specifically, we noted during our September 2007 audit that HCD did not ensure the accuracy and completeness of the data converted into its Consolidated Automated Program Enterprise System (CAPES), which it uses to administer and manage various housing programs. In August 2008 HCD indicated that it expected all converted data would be validated and, where necessary, corrected by April 2009. However, as of September 2009, HCD still had not completed the data validation process, and it indicated that it does not expect to do so until March 2010.

We recommended that HCD complete its review of the accuracy of the data transferred to CAPES and ensure that its clean-up efforts are thoroughly documented and retained for future reference.

HCD's Action: Pending.

HCD concurs with the necessity to complete its review of the accuracy of the data transferred to CAPES. Due to time and staffing constraints, it indicated that it was not possible to check all data prior to the conversion process, as would have been ideal. Subsequently, HCD stated it developed a comprehensive clean-up plan that not only encompassed the converted data mentioned in the previous report, but also the data entered into CAPES after the May 2007 implementation. However, it also indicated that the continuing staffing limitations as a result of the State's fiscal situation has impeded HCD's efforts to complete the entire clean-up process prior to this audit by the bureau. Finally, HCD plans to finish the clean up of the CAPES data by March 2010, and ensure that thorough documentation of the clean-up efforts will be available at the next periodic visit by the bureau.

Finding #4: Certain programs funded by Proposition 1C are not subject to periodic audits by the bureau.

The Housing and Emergency Shelter Trust Fund Act of 2006 (Proposition 1C) currently does not require the bureau to conduct periodic audits of the Transit-Oriented Development Implementation Program; the Regional Planning, Housing, and Infill Incentive Account; and the Housing Urban-Suburban-and-Rural Parks Account, which constitute $1.35 billion, or 47 percent of the Proposition 1C funds. For the bureau to perform periodic audits of these three programs, a change in the statute is necessary.

We recommended that if the Legislature believes that the bureau should perform periodic reviews of the bond programs not currently included in the audit requirements under Proposition 1C, it should propose legislation to require the bureau to do so.

Legislative Action: Unknown.

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

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 January 2009

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: Corrective action taken.

The CLO sent a written request seeking the right to review future distributions to Aurora and the national guaranty organization on February 27, 2008. Although discussions with Aurora continue, Aurora has not made a commitment to fulfill the CLO's request. There have been no subsequent distributions for the CLO to review. Future distributions, if any, are dependent on the outcome of pending litigation.

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.

The CLO has placed summarized financial information along with a brief narrative of the ELIC estate and grantor trusts for the year ended December 31, 2007, and December 31, 2008, on its Web site. The CLO will continue to update this information after the end of each year.

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's reviews for the year ended December 31, 2007, and December 31, 2008, have been completed and are available on the CLO's Web site. The CLO will continue the practice of having Finance auditors review the ELIC estate and grantor trusts.

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.

Department of Justice

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

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

Department of Justice's response as of April 2009

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

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

Department of Justice's response as of April 2009

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.

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.

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.

Department of Justice

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

ALLEGATION I2007-1024 (REPORT I2009-1), APRIL 2009

Department of Justice's response as of September 2009

A Department of Justice (Justice) regional office employee failed to properly report her time worked and leave taken from June through August 2007. In addition, she claimed travel expenses that she did not incur during the same period. Further, the employee's manager did not ensure that the employee accurately reported her time and travel expenses. Consequently, Justice paid the employee $648 in unearned compensation and reimbursed her $497 for travel expenses not incurred.

Investigative Highlight . . .

An employee's time sheets did not reflect overtime worked. She was later absent from work for 136 hours—or 17 days—these absences were not reflected on her time sheets.

Finding #1: The employee failed to properly account for overtime worked and absences taken, and claimed travel expenses she did not incur. In addition, Justice's management failed to ensure that the employee properly reported her time, attendance, and travel expenses.

Our investigation determined that the employee failed to properly account for 77 hours of overtime she worked in June and July 2007. Had the employee properly accounted for the 77 hours of overtime on her time sheets, she would have earned 116 hours of compensated time off. In addition, she failed to properly account for 136 hours—or 17 days—of absences she took in July and August 2007. The employee acknowledged that she was absent on the 17 days and that she did not charge her leave balances for the absences because she used the informal time off to account for the uncompensated overtime she worked in June and early July 2007. However, the employee's 136 hours of absences exceeded the 116 hours of uncompensated overtime by 20 hours. Therefore, by taking more time off than she actually earned in hours of uncompensated overtime, Justice essentially paid the employee $648 in estimated compensation she did not earn for the excess 20 hours of leave she failed to charge against her leave balances.

At the same time the employee worked the unrecorded overtime in June and early July 2007, she claimed reimbursement for more travel expenses than she actually incurred. Specifically, the employee overstated her mileage by 62 miles on each of 19 days she drove her personal vehicle to an off-site location to conduct her work. Because she claimed more mileage than she actually traveled in violation of state regulations, Justice overpaid her $497 for travel expenses she did not incur.

We recommended that Justice properly modify the employee's leave balances to reflect the 116 hours of overtime that she earned in June and July 2007. We further recommended that Justice charge to the employee's leave balances the 136 hours for her absences on 17 days in July and August 2007, thus eliminating the need to seek reimbursement of unearned compensation. Finally, we recommended that it seek reimbursement from the employee for the compensation she did not earn and the travel expenses she did not incur.

Justice's Action: Partial corrective action taken.

Justice reported in July 2009 that the employee revised her time sheets to account for all of the hours of overtime she worked and nearly all the hours she was absent; however, the remaining unaccounted hours are pending Justice review. It also established a payment schedule to collect from the employee the overpayment of travel expenses.

Finding #2: Justice's management failed to ensure that the employee properly reported her time, attendance, and travel expenses.

Justice's management in the regional office did not ensure that the employee properly reported the time she worked and the absences she took, and it similarly failed to ensure that the employee properly reported her travel expenses. In particular, the employee's manager allowed her to disregard time-reporting requirements prescribed in state regulations and Justice's policies. Further, managers at the regional office engaged in administrative practices that failed to effectively ensure the accuracy of her time sheets, in violation of state laws and regulations, and her manager failed to scrutinize the appropriateness of her travel claim reimbursements.

We recommended that Justice prohibit the regional office employees and managers from engaging in informal timekeeping arrangements, require them to use time sheets and its overtime request form, and provide training to these employees regarding the proper time-reporting and travel claim requirements.

Justice's Action: Partial corrective action taken.

Justice reported in June 2009 that it issued a memorandum to the regional office employees, as well as legal staff at other Justice regional offices in the division, reminding them of the proper time-reporting policies and procedures that it previously discussed at meetings with these employees. It also informed us that it issued a memorandum of instruction to the employee and her manager about their failure to follow time-reporting and travel expense claim policies and procedures. Finally, in September 2009 Justice reported that it provided travel expense claim policy training to the subject and other regional office employees, and indicated that it is preparing to provide these regional office employees with formal training regarding proper time reporting.

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 six county registrar offices' responses as of December 2009 (two counties did not provide a one-year 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 decline-to-state voters were confused about which political parties'

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.*

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.

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

Office's Action: Corrective action taken.

The office reports that it is finalizing its updated poll worker training guidelines and intends to provide an opportunity to all counties, individuals, and organizations with extensive elections expertise to comment on the final draft standards. The office stated that the updated standards expand upon previous guidelines and incorporate information from lessons learned in past elections and changes in the Elections Code. The office provided its draft training guidelines and we verified that it contained instructions explaining how to process votes from declined-to-state voters. The office anticipates that the updated guidelines will be completed in time for use during the November 2010 general election.

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.

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.

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 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. As a result, we believe no additional action is required regarding this 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. As a result, we believe the county requires no additional action regarding this recommendation.

San Diego County's Action: Corrective action taken.

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 indicates that it has added language to its poll worker training manual to emphasize the prevention of voter intimidation.

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. As a result, we believe no additional action is required regarding this recommendation.

Solano County's Action: None.

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 one-year 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: Corrective action taken.

Alameda County indicated that it met with various software companies in January and February 2009 and reviewed their online poll worker training. However, Alameda concluded that the cost for the software was exorbitant and thus cost-prohibitive. Alameda County also considered having tailored training for new versus experienced poll workers, but concluded that it would be too time-intensive for its staff to schedule these trainings.

Fresno County's Action: Corrective action taken.

Fresno County indicated that it has implemented a hands-on training program for poll workers focusing on the proper use of voting machines. Looking ahead to the 2010 statewide elections, Fresno intends to implement an online poll worker refresher course, provide optional workshops one week prior to the election, and implement a program whereby experienced poll workers will attend a condensed class.

Kings County's Action: None.

Kings County did not provide a one-year 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: Corrective action taken.

Los Angeles County reported it is engaged in continuous improvement in its use of online poll worker training. It stated that it anticipates using the online system to specifically address poll worker needs related to decline-to-state voters in the June 2010 primary election.

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. As a result, we believe no additional corrective action is required in response to this recommendation.

San Diego County's Action: Corrective action taken.

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. As a result, we believe no additional corrective action is required in response to this recommendation.

Santa Clara County's Action: None.

Santa Clara County's one-year 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: None.

Solano County did not provide a one-year update on its efforts to implement the audit report's recommendations. 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.

Alameda County reported that it began using a new software program for the June and November 2008 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: None.

Fresno County did not provide an 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.

Our audit report noted that the county had accurate attendance lists and that all inspectors attended training. As a result, we believe no additional action is required regarding this recommendation.

Los Angeles County's Action: Corrective action taken.

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 no additional action is required regarding this recommendation. In addition, in the audit report we acknowledge that Los Angeles County had reliable data on poll worker training.

Orange County's Action: Corrective action taken.

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 one-year update response, Orange County stated every poll worker for the county has been receiving a class slip in the mail prior to attending training. The slip is signed by the trainer and used to confirm training in the county's database and as a receipt for payroll. In addition, the county stated that about one week prior to the election, administrative staff contact untrained inspectors and

either reschedule them for training or determine the need for a replacement. Orange County also stated it is working on a pass system in which poll workers will carry a pass, much like one would have with their gym or grocery store membership, that would be scanned at various stages of the poll worker process, such as attendance at training.

San Diego County's Action: Corrective action taken.

San Diego County reported 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: Corrective action taken.

Santa Clara County reported that in 2008 it implemented a report in its Election Information Management System that allows it to list election officers and pertinent personal information, including whether the officers attended training. Santa Clara provided a sample report for the May 19, 2009, statewide special election.

Solano County's Action: None.

➲ Solano County did not provide an update on its efforts to implement the audit report's recommendations. In its initial response to the audit, the county maintained that all of its inspectors received training and explained they could not have received their polling place supplies had they not attended training. However, 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.

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 reported that for the 2010 statewide elections, it will survey all poll workers after conducting training classes to get their feedback on the trainers, class materials, content, and other pertinent information.

Kings County's Action: None.

Kings County did not provide an update on its efforts to implement this recommendation. In its initial response to the audit, the county did not address this recommendation. In the 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.

Los Angeles County reported that it has implemented a new complaint-tracking system called AskEd. Los Angeles County plans to use complaint data from the prior elections, beginning with the November 2008 election, to identify poll worker training needs for the 2010 statewide elections.

Orange County's Action: Corrective action taken.

Orange County reported that it has surveyed its poll workers extensively and used their comments and suggestions to improve poll worker training, poll site operations, and overall voter satisfaction. In addition, Orange County stated it conducts surveys of voters that call to ensure it provides outstanding customer service, and surveyed its poll sites when voting systems are delivered and after the election to get an overall sense of how the election went. Orange County provided a copy of its survey report for the May 2009 special statewide election.

San Diego County's Action: None.

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. San Diego County did not provide an update on any efforts regarding this recommendation.

Santa Clara County's Action: Corrective action taken.

Santa Clara County reported that it evaluates the effectiveness of its poll worker training using paper-based surveys of poll workers, electronic-based evaluations of online training by poll workers, and post-election debriefings by county elections staff. It provided examples of a summary of best practices developed from feedback by training instructors and county elections staff. In addition, Santa Clara County provided examples of summaries compiled by county elections staff of voter complaints and questions or concerns from poll workers regarding election day activities.

Solano County's Action: None.

Solano County disagreed with many aspects of the audit report and did not provide an update regarding its efforts to address this recommendation.

STATE BAR OF CALIFORNIA

It Can Do More to Manage Its Disciplinary System and Probation Processes Effectively and to Control Costs

REPORT NUMBER 2009-030, JULY 2009

State Bar of California's response as of September 2009

The California Business and Professions Code requires the State Bar of California (State Bar) to contract with the Bureau of State Audits to audit the State Bar's operations every two years, but it does not specify topics that the audit should address. For this audit, we focused on and reviewed the State Bar's disciplinary system. To determine the efficiency and effectiveness of this system, we examined the State Bar's discipline costs, the method by which the State Bar accounts for its discipline expenses, the outcomes of cases, the length of time that the State Bar takes to process cases, and the recovery of discipline expenses. We also evaluated the State Bar's attorney probation system and its audit and review unit. Further, we reviewed the State Bar's progress in addressing recommendations from reviews of its operations and the circumstances surrounding an alleged embezzlement by a former State Bar employee. Finally, we reviewed the status of the State Bar's implementation of recommendations made in our 2007 audit titled *State Bar of California: With Strategic Planning Not Yet Completed, It Projects General Fund Deficits and Needs Continued Improvement in Program Administration*. This report summarizes our assessment of the State Bar's strategic planning efforts, projected General Fund deficit, legal services trust fund, and certain aspects of the attorney disciplinary system.

Finding #1: The State Bar does not account for discipline costs so that it can measure efficiency.

The State Bar does not track the costs of the disciplinary system according to its various functions and therefore cannot be certain that it is using its resources as efficiently as possible, nor can it determine whether policy changes affect the costs of the disciplinary functions. The State Bar's total costs for its attorney disciplinary system have risen from $40 million in 2004 to $52 million in 2008, or 30 percent over five years. This upsurge in expenses has outpaced both inflation and the growth in the State Bar's active membership, and it does not match the changes in caseload size in most stages of the system for disciplining attorneys who violate professional standards. Although the State Bar accounts for the expenses for the intake and the State Bar Court functions separately, it combines expenses of other functions such as investigations, trials, and audit and review. Consequently, the State Bar could not readily differentiate the cost of its investigation and trial functions.

Additionally, we found that the State Bar's offices in San Francisco and Los Angeles do not track their disciplinary expenses in the same manner, which further contributes to the difficulty of identifying actual expenses by function. Therefore, not only is the State Bar unable to separately track and monitor what it spends on key aspects of its disciplinary system, such as investigations and trials, it cannot

Audit Highlights . . .

Our audit of the State Bar of California revealed the following:

- *The costs of its disciplinary system have escalated by $12 million from 2004 to 2008, while the number of disciplinary inquiries opened has declined.*
- *It cannot measure its efficiency or identify where to reduce costs because it does not track expenses by key disciplinary function.*
- *Its offices in San Francisco and Los Angeles calculate discipline costs differently.*
- *Because of the methodology it uses to calculate the average time it spends to close investigations, it reported a decrease of 11 days from 2004 to 2007 when the average investigation time has actually increased by 34 days.*
- *Relatively simple changes to its billing procedures would probably yield additional revenue that could offset some of its increased discipline costs.*
- *Its probation office's workload has increased from 791 cases in 2004 to 867 cases in 2008, yet the number of probation deputies was only recently increased by one.*
- *It discovered an alleged embezzlement of nearly $676,000 by a former employee and is taking measures to strengthen its internal controls.*
- *It still needs to fully implement recommendations made in a consultant's report, in the periodic audits conducted by its internal audit and review unit, and in our prior audit.*

even make meaningful comparisons between the two offices because it has no consistent method of accounting for its operations. This fact inhibits the State Bar's ability to identify specific reasons for cost increases, and if warranted, to take appropriate actions to contain them.

Because the State Bar does not track costs separately for each of its key functions within the disciplinary system, it cannot measure the cost impact of policy changes. In 2005 the California Supreme Court criticized the State Bar for failing to bring all possible charges against an attorney who was ultimately disbarred and for failing to follow its internal guidelines that delineate the appropriate actions that the State Bar must take against attorneys who have repeatedly violated professional or legal standards. The former chief trial counsel provided guidance to staff to ensure consistency in applying sanction standards and to take cases to trial if they warrant more severe discipline than the respondent is willing to accept in a stipulation. Before this policy shift, according to the former chief trial counsel, the State Bar settled before trial about 90 percent of cases in which the accused attorney participated. However, he recently estimated that this percentage has decreased to about 75 percent.

The recent trend in the number of cases going to trial is consistent with these policy changes. The former chief trial counsel said that he does not track the average costs of a case that proceeds to trial, and explained that the decisions to prosecute are based on the merits of the cases and not the costs. Although decisions may not be based primarily on financial considerations, we believe the State Bar would benefit from at least understanding roughly how much it spends on trials—especially since the number of trials has nearly doubled in the past few years. Specifically, the number of trials commenced in the State Bar Court each year has increased from 65 in 2004 to 127 in 2008.

We recommended that the State Bar account separately for the expenses associated with the various functions of the disciplinary system, including its personnel costs. This can be accomplished through a study of staff time and resources devoted to a specific function. We also recommended that the State Bar ensure that all its offices track expenses consistently.

State Bar's Action: Pending.

In its 60-day response, the State Bar stated that beginning with its 2010 budget it will adjust its methodology to track the component costs of its disciplinary system separately and consistently. The State Bar also stated that it will "meet and confer" with the union representing its employees about our recommendation to complete a time study.

Finding #2: The State Bar was unaware that its investigation case processing time has increased.

Our analysis demonstrated that the length of time to process cases proceeding beyond intake is generally increasing. Specifically, in 2004 the State Bar staff took more than 360 days to process 378 of 3,853 cases received in the investigation and trial unit, or 10 percent. In 2007 the proportion of cases taking longer than 360 days had increased to 13 percent. Additionally, from 2004 to 2005, although the number of cases taking more than 360 days to resolve in the State Bar Court decreased from 172 to 131, or 5 percent, the number of cases already pending for more than 360 days increased from 160 to 209 cases, or 31 percent.

When we asked the State Bar why it is taking longer to process cases beyond the intake stage, the former chief trial counsel noted that according to the State Bar's analysis of investigation processing time, the trend has decreased over the past five years except for a slight increase in 2008. After discussing with the State Bar its methodology for calculating its average investigation processing time, we determined that it is not calculating this average in a way that fully represents yearly trends. According to the program/court systems analyst (systems analyst), the State Bar combines average processing time to compute a single average for all cases closed since 1999 as opposed to calculating a separate average based on cases closed for a particular year. However, this is not a meaningful measure

of current yearly investigative case processing times because the number of cases from which the State Bar generates the averages continues to grow and includes data from years that do not apply to the relevant reporting year.

Using the State Bar's method to calculate the average processing times for closed investigations resulted in average processing times that ranged from a high of 197 days in 2004 to a low of 186 in 2007. In contrast, when we used what we believe to be a more representative method that only considers the time investigations remained open during a given year, whether eventually closed or forwarded to the next stage, average processing times were generally longer. Using this method, the average processing times for the State Bar's investigations ranged from a low of 168 days in 2004 to a high of 205 days in 2006 before declining to 202 days in 2007.

We recommended that the State Bar adjust its methodology going forward for calculating case processing times for investigations so that the calculations include time spent to process closed and forwarded cases for the relevant year only. For example, for its 2009 annual discipline report, the State Bar should report the average processing time for only cases it closed or forwarded to the State Bar Court in 2009.

State Bar's Action: Pending.

In its 60-day response, the State Bar stated that it will include this information in its 2009 annual discipline report to be issued by April 30, 2010.

Finding #3: The State Bar could better inform the Legislature by including all relevant information when it reports its backlog.

In its annual discipline report, the State Bar reports a case as part of its backlog when its staff has not resolved the case within six months of its receipt or when the State Bar designates the case as complex and has not resolved it within 12 months of receiving the complaint. However, the State Bar does not include seven other types of cases when it reports its backlog. Specifically, the State Bar only reported 1,178 of the 3,020 total cases, or 39 percent, that were not resolved within six months from 2005 through 2008.

Additionally, the number of complex cases over 12 months old has increased from 2005 through 2008 from 74 to 95, or 28 percent. Because the State Bar designates cases as complex and does not include them in the backlog until they are over 12 months old, separately identifying them from noncomplex cases would allow stakeholders to better understand reasons for fluctuations. Further, the State Bar does not count inquiries in the intake unit that do not move on to the investigations unit—even though these issues could remain in intake for more than six months. Because the annual discipline report notes that the investigation and trial unit strives to complete investigations within six months after receipt of the complaint (or 12 months if they are designated as complex), the State Bar is not providing complete and clear information regarding its backlog when it does not identify or explain its reason for not including inquiries.

Over the past five years, the State Bar has also changed the types of cases that it includes in its annual discipline report, which makes year-to-year comparisons difficult. Additionally, beginning in 2008, the State Bar excluded cases in its backlog that were being handled by special deputy trial counsels, who are outside examiners. Although the State Bar noted this change in its 2008 discipline report, it did not explain the reason for the revision. Finally, the State Bar reports its backlog by case and not by member, which further decreases the number of cases that could be included in the backlog count. In some circumstances, multiple attorneys can be named on the same complaint, but the State Bar only includes one in its backlog calculation, even if separate cases are opened that would otherwise be included. The interim chief trial counsel believes that it is appropriate to report backlog by case and not by member because the complaint, whether it alleges misconduct by one or more attorneys, is generated from

a single complaint made by one complaining witness and, for the most part, the issues and evidence are the same. However, the backlog table in the State Bar's annual discipline report does not indicate that the backlog is reported by case rather than by member.

We recommended that the State Bar include additional information regarding backlog in its annual discipline report to the Legislature. Specifically, the State Bar should identify the number of complex cases over 12 months old in its backlog. Additionally, we recommended that it identify in its annual discipline report the types of cases that it does not include in its calculation of backlog and explain why it chooses to exclude these cases. Specifically, the State Bar should identify that it presents its backlog by case rather than by member, and that it does not include intake, nonattorney, abated, and outside examiner cases. Finally, we recommended that the State Bar identify the composition of each year's backlog to allow for year-to-year comparisons, as the law requires.

State Bar's Action: Pending.

In its 60-day response, the State Bar stated that it will include this information in its 2009 annual discipline report to be issued by April 30, 2010.

Finding #4: The State Bar has not updated the formula it uses to bill disciplined attorneys and it does not consistently include due dates on bills.

For those costs it is allowed to recover from disciplined attorneys, the State Bar uses a formula—a fixed amount primarily based on how far the case proceeds through the disciplinary system before resolution—to bill attorneys who are publicly disciplined. Although discipline costs have increased 30 percent during the last five years, the State Bar has not updated this formula since it became effective beginning in 2003.

Additionally, undermining any attempt to track the billing and payment of attorneys' disciplinary expenses is the fact that the State Bar does not consistently include due dates for when payments must be made when billing disciplined attorneys. Our review of 28 bills sent to attorneys in 2006 and 2007 found that attorneys promptly paid their discipline bills at a much greater rate if the due date was explicitly stated on the bill. For the 15 bills with specific due dates, 14 attorneys, or 93 percent, paid their bills in full by the due date. For the 13 bills we reviewed with no specific due date, only one attorney paid by the end of the next fiscal year. By not including specific due dates on its bills to disciplined attorneys, the State Bar is much less likely to recover costs as promptly as it could.

Further, according to the assistant supervisor of membership billing, the State Bar cannot reasonably predict the amount of recovery costs it expects to receive from disciplined attorneys in a given year because in many cases the bills do not include any set due date for when payments must be made. Consequently, the State Bar cannot adequately evaluate its discipline cost recovery collection efforts or fully budget for such collections. According to a summary report of amounts billed and received, in 2007 and 2008, the State Bar collected an average of 63 percent of the amount it billed. Although these percentages provide some context about collections, they are somewhat misleading and not necessarily a useful measure of the effectiveness of the State Bar's efforts. This is because the State Bar does not match the percent collected with the corresponding amount billed. In fact, payments often are received years after they are billed. Using detailed payment information provided by the State Bar, we determined that of the $1.1 million billed for recovery costs in 2008, only $229,000 was collected in that year, or about 21 percent.

We recommended that the State Bar update annually its formula for billing discipline costs and include due dates on all bills so that it maximizes the amounts it may recover to defray the expense of disciplining attorneys. Additionally, to report accurately its collection amounts and to analyze the effectiveness of its collection efforts, we recommended that the State Bar track how much it anticipates receiving against how much it actually receives in payments for discipline costs each year.

State Bar's Action: Partial corrective action taken.

In its 60-day response, the State Bar stated that it is in the process of retaining a consultant to review and update the formula to fix the amounts of disciplinary cost that may be assessed against a disciplined lawyer, including a methodology that will facilitate an annual adjustment to the amounts. The State Bar is adjusting its billing system to separately provide notice of due dates to disciplined members upon the effective date of the court order assessing costs. The State Bar is also working with the vendor to make adjustments to existing programs in its new database application so that it can include, track, and report the recommended data.

Finding #5: The State Bar does not track how much it spends on cost recovery efforts.

Before April 2007 the State Bar's efforts to recover costs associated with disciplined attorneys typically included billing the disciplined attorneys through annual membership bills and contracting with a collection attorney. Effective April 1, 2007, the State Bar received California Supreme Court approval of a rule to enforce as a money judgment, disciplinary orders directing payments of costs. A money judgment is an order entered by a court that requires the payment of money. The State Bar contracted with a collection attorney to pursue collections from disciplined attorneys owing the largest unpaid amounts to the Client Security Fund. The State Bar agreed to pay the collection attorney 25 percent of the net funds recovered. Also, if no recovery was obtained, the State Bar agreed to pay the expenses the collection attorney incurred. According to its discipline payments summary report, the collection attorney collected $11,600 for the State Bar in 2007, but he was paid $19,400 in recovery fees and expenses. For 2006 through 2008, the collection attorney collected $156,600, and the State Bar received $63,900, or 41 percent, of the total amount recovered.

According to the State Bar's acting general counsel, the legal work required to prepare a money judgment is labor intensive, and in an effort to avoid having the collection agency conduct this legal work, the State Bar is currently using its own in-house staff. However, when we asked about the cost of the efforts of its in-house staff, the general counsel told us that the State Bar does not specifically track all of these costs. After our request, the State Bar identified some estimates of in-house costs to prepare the money judgments, and the general counsel acknowledged that paying the higher 25 percent of recovered costs might be more cost beneficial than having the State Bar staff conduct this work.

The State Bar's discipline payments summary shows that for 2006 through 2008, it collected $3 million in discipline costs and Client Security Fund recoveries from its in-house billing efforts, but it does not track its costs associated with making these recoveries. We acknowledge that because of statutory restrictions on the amount of discipline costs that can be recovered, the State Bar is limited to recovering substantially less than its costs. However, conducting a cost-benefit analysis of its collections efforts would allow the State Bar to evaluate and determine whether more cost-effective alternatives exist that could potentially increase the net amount that it recovers.

In an effort to provide the State Bar with some alternative best practices regarding cost recovery efforts, we asked two state agencies about methods they use for collecting money owed to them. A representative told us about the Franchise Tax Board's (Tax Board) Interagency Intercept Collections Program (intercept program) that offsets a debtor's state tax refund by the amount owed to a state entity. According to the intercept program participation booklet for 2009, the cost for the program is approximately 25 cents per account.

We recommended that the State Bar complete a cost-benefit analysis to determine whether the benefits associated with using collection agencies outweigh the costs. If it determines that the collection agencies are, in fact, cost-effective, the State Bar should redirect in-house staff to other disciplinary activities. Finally, the State Bar should also research the various collection options available to it, such as the Tax Board's intercept program.

State Bar's Action: Partial corrective action taken.

In its 60-day response, the State Bar stated that it is gathering and reviewing data and estimates to complete its cost-benefit analysis.

Finding #6: The State Bar's office of probation has not determined appropriate workload levels for staff to monitor probationers effectively.

Over the past five years, the probation office's caseload has increased nearly 10 percent, making it more difficult for its staff to manage disciplined attorneys effectively. The probation office believes that it is understaffed, but it is unsure whether its recent request for an additional probation deputy position will fulfill its needs.

In a memo to the deputy executive director requesting an additional probation deputy position, the former chief trial counsel noted that with existing caseloads, it has become increasingly difficult, if not impossible, for probation deputies to oversee probation in a timely, effective manner. The memo further notes that an additional probation deputy will reduce the current caseload and increase the probation office's ability to effectively fulfill its function. However, the additional probation deputy will only decrease the overall caseload to around 175 cases per deputy. According to the supervisor of the probation office, because of increases in alternative discipline cases and other changes to the probation office's responsibilities, she is still in the process of monitoring staff workloads and determining the appropriate caseload. Until the State Bar determines that its probation deputies have reasonable workloads, it cannot be sure that they are devoting the amount of attention necessary to effectively monitor probationers.

We recommended that the State Bar continue its efforts to determine the appropriate caseload level for its staff to effectively monitor probationers and adjust staffing as appropriate.

State Bar's Action: Partial corrective action taken.

In its 60-day response, the State Bar stated that it recently hired an additional probation deputy and will continue to monitor caseload levels to evaluate appropriate staffing levels for effective monitoring of probationers. Additionally, in November 2009, the State Bar informed us that it is in the process of retaining a measurement consultant to evaluate the office of probation's appropriate workload. The State Bar also stated that it is working with its staffs' union to define the duties of employees that will participate in a time and resources study. According to the State Bar, once the time study is completed it will be better equipped to determine how time used in the office of probation and what the best allocation of resources and workload is.

Finding #7: The office of probation is not fully meeting its strategic goals to help attorneys successfully complete probation and to protect the public.

The probation office has not fully met its mission of assisting attorneys to successfully complete probation and of protecting the public because it did not always promptly communicate attorneys' probation terms and did not refer probation violations to the Office of the Chief Trial Counsel consistently or promptly. Specifically, for eight of the 18 initial probation letters that we reviewed from cases closed in 2008, the probation office sent the initial letters communicating the terms of probation to disciplined attorneys between eight and 72 days after it received the related court orders. Although the probationer is ultimately responsible for meeting the terms of probation, the State Bar's probation deputy manual requires its probation deputies to send a letter to the affected attorney within seven days of receiving the court order.

The probation office has also not promptly referred attorneys who have violated their probationary terms to the Office of the Chief Trial Counsel, and in some cases, referred the same type of violation inconsistently. Related to eight of the 20 probation case files we reviewed that the State Bar closed

in 2008, probation office deputies had prepared 11 referrals of probation violations to the Office of the Chief Trial Counsel. For five of the 11 referrals, probation deputies took well over a month after the violation occurred to refer the violation. In fact, the timing of these five referrals ranged from 96 days to 555 days after the violation occurred, with probation deputies taking more than 500 days for two of the referrals.

Because attorneys are still often able to practice law during their probationary period, unnecessary delays in making referrals for violations may allow an errant attorney to continue to practice law and represent clients. Further, when the probation office does not make referrals promptly, it is not meeting its goal of protecting the public. Finally, when staff are not consistent or prompt in referring violations, it may create a perception of favoritism or leniency, and could undermine the efforts of the Office of the Chief Trial Counsel to enforce disciplinary standards.

We recommended that the State Bar ensure that it effectively communicate with and monitor attorneys on probation by ensuring that staff comply with procedures for promptly sending initial letters reminding disciplined attorneys of the terms of their probation. We also recommended that to make certain that it does not create a perception of favoritism or leniency, the State Bar increase compliance with its goal to improve timeliness and consistency of probation violation referrals to the Office of the Chief Trial Counsel. If the State Bar believes instances occur when probation staff appropriately deviate from the 30-day goal, it should establish parameters specifying time frames and conditions acceptable for a delay in the referral of probation violations and clearly document that such conditions were met.

State Bar's Action: Partial corrective action taken.

In its 60-day response, the State Bar stated that it will review its procedures for notifying disciplined attorneys of the terms of their probation and will take steps to ensure greater compliance and prompt notice to probationers. The State Bar also stated that it is reviewing its handling of, and procedures for, probation violation referrals to increase compliance with its goal of improved timeliness and consistency and to assure perceptions of fairness, which may include establishing standards for determining and documenting when it may be appropriate not to refer matters for probation violation within the 30-day goal.

Finding #8: The State Bar has not fully addressed concerns identified in a review of its cost recovery process.

Although the State Bar contracted with a consultant in September 2007 to review interdepartmental processes surrounding its cost recovery processes, including its planned cost recovery system, the State Bar did not fully address recommendations for improving internal control weaknesses that the consultant identified. In response to some of the concerns raised in the consultant's review, the State Bar indicated that it would achieve corrective action through various functions and processes associated with the new cost recovery system it was developing. Although it anticipated that the new cost recovery system would resolve the deficiencies, the State Bar did not obtain the new system immediately and is still in the process of fully implementing it.

We recommended that the State Bar fully implement recommendations from audits and reviews of the State Bar and its functions. Further, we recommended that the State Bar ensure that its new cost recovery system and related processes address the issues identified in the consultant's 2007 report on its cost recovery process.

State Bar's Action: Corrective action taken.

In its 60-day response, the State Bar indicated that it had completed this recommendation. According to the response to the audit report, the State Bar stated that it had implemented changes in its manual and automated processes and controls to address issues raised in the 2007 report on its cost recovery process. These processes and controls apply to the new cost recovery system. Because it did not inform us of these changes until after it had received a draft copy of our report, we were not able to verify whether these changes fully address our concerns. As part of our next statutorily required audit, we plan to review the cost recovery system to determine whether the new system corrects the identified issues.

Finding #9: The State Bar's audit and review unit does not ensure its recommendations are implemented.

In keeping with one of its goals to enhance the quality of the Office of the Chief Trial Counsel's investigations and prosecutions the State Bar's audit and review unit has identified some recurring deficiencies and recommended providing training during its periodic audits of case files. However, it could do more to ensure that staff receive appropriate training in areas that need improvement. According to State Bar policy, twice each year staff in its audit and review unit review at least 250 recently closed disciplinary cases and complete a checklist to determine whether staff followed specific requirements and whether the files include appropriate documentation. After each audit, the audit and review unit prepares a summary report of the deficiencies found and submits it to the Office of the Chief Trial Counsel for consideration. The summary also identifies training opportunities. According to the audit and review manager, she makes such recommendations in areas where errors could be avoided by training staff to properly follow policies and procedures.

We reviewed five audit summaries covering September 2005 through February 2008 and noted several recurring deficiencies and related recommendations for training. When we asked the State Bar for documentation that it had followed up on these and other recommendations from its audits, the audit and review manager told us no documentation of the implementation of recommendations exist. She further stated that the managers within the units generally address concerns through a combination of discussing specific issues with the State Bar staff, discussing general issues at their unit meetings, informally reminding unit staff, or raising the issues with supervisors. However, the number of recurring deficiencies present in the summaries suggests the need for a more formal process of ensuring corrective action. Without a formal process to ensure that its recommendations from the audit summaries are implemented, the audit and review unit is not maximizing the value it can add to improve the quality of investigations and prosecutions.

We recommended that the State Bar's audit and review unit establish a formal process to follow up on and ensure implementation of recommendations from its twice yearly audits.

State Bar's Action: Partial corrective action taken.

In its 60-day response, the State Bar stated that it is developing an office protocol or procedure to ensure that staff within the Office of the Chief Trial Counsel are advised of the findings of the biannual audits. The State Bar also stated that this protocol or procedure will include specific training of staff to ensure corrective action is taken where appropriate.

Finding #10: The State Bar has partially implemented three and fully implemented seven of our 2007 audit recommendations.

Our April 2007 report titled *State Bar of California: With Strategic Planning Not Yet Completed, It Projects General Fund Deficits and Needs Continued Improvement in Program Administration* (2007 030), included 10 recommendations to the State Bar. The State Bar has fully implemented seven of the recommendations related to improvement of its strategic plans and tracking and

monitoring grant recipients under its legal services trust fund program. However, it has only partially implemented the three other recommendations related to improving the State Bar's disciplinary system, which is also the subject of the current report.

In 2007 we recommended that, after the Supreme Court's approval, the State Bar should complete its cost recovery database and input all available information on the Client Security Fund and on disciplinary debtors, implement its proposed policy for pursuing debtors, and complete its assessment of the costs and benefits of reporting judgments to credit reporting agencies. Although the State Bar has implemented its pursuit policy and obtained a new database that will capture amounts owed and payments received from individual debtors, it has not yet entered all of the Client Security Fund and disciplinary debtors' information. In May 2009 the State Bar's acting general counsel stated that he expects the new database to be fully online within 60 days.

Additionally, the State Bar has only partially implemented our 2007 recommendation related to its reduction of backlogged cases. Although the State Bar reported in its annual report that it has decreased its disciplinary case backlog from 327 cases in 2007 to 311 cases in 2008, it has still not reached its most recent goal of having no more than 250 backlogged cases. Finally, the State Bar has not fully implemented the recommendations from our 2007 audit related to its compliance with two State Bar policies established to improve its processing of disciplinary cases.

We recommended that the State Bar continue acting on recommendations from our 2007 report related to continuing its efforts to enter all of the Client Security Fund and disciplinary debtor information into its database, taking steps to reduce its inventory of backlogged cases, and improving its processing of disciplinary cases by more consistently using checklists and performing random audits.

State Bar's Action: Partial corrective action taken.

In its 60-day response, the State Bar stated that it has completed the uploading of Client Security Fund and disciplinary debtor information required for tracking it cost recovery efforts from its existing database into its new database and application.

Additionally, the State Bar stated that it continues to focus its efforts on keeping the backlog as low as possible, gives higher case processing priority to newer cases that pose the greatest risk of harm to the public rather than older less serious matters, and since 2004 the statutory backlog as of December 31 each year has improved significantly while taking into account office and case priorities, which can vary from year to year. However, as we previously noted in response to the State Bar's comments to our report, because the types of cases that the State Bar has included in its backlog calculations has varied over the years, it is difficult to make a meaningful assessment of the progress the State Bar has made in reducing its backlog.

Finally, the State Bar stated that it will continue its random audit of open investigations and its efforts to ensure that checklists are continued to be used by staff in a productive and meaningful way to help ensure compliance with the office's significant case processing policies and procedures.

Finding #11: The State Bar cannot implement the information technology portion of its strategic plan without additional resources.

Although the State Bar implemented the four recommendations from our 2007 audit related to updating its strategic plan, it has only secured funding for a portion of its planned technology initiatives. In our 2007 audit, we recommended that the State Bar should either take the steps necessary to ensure that 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. During our current review we found that departments within the State Bar currently use Microsoft Excel spreadsheets or other methods to capture this information. The manager of planning and administration indicated that the State Bar plans to implement a new

information technology system that will capture this strategic planning data and allow centralized access to the departments' performance indicators. In reviewing the State Bar's Information Technology Strategic Plan (IT plan), which outlines the State Bar's strategic goals and objectives for information technology, we noted that its IT plan included an implementation plan that identified steps the State Bar determined were necessary to attain its vision for information technology. Although the planning efforts related to its information technology needs are detailed, the State Bar has yet to secure funding for all of its plans.

We recommended that the State Bar follow its IT plan to ensure that it can justify requests to fund the remaining information technology upgrades.

State Bar's Action: Partial corrective action taken.

In its 60-day response, the State Bar stated that it will continue to follow its IT plan.

State Compensation Insurance Fund

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

ALLEGATION I2007-0909 (REPORT I2009-1), APRIL 2009

State Compensation Insurance Fund's response as of October 2009

An employee of the State Compensation Insurance Fund (State Fund) failed to report 427 hours of absences. Consequently, State Fund did not charge the employee's leave balances for these absences, and it paid her $8,314 for hours that she did not work.

Investigative Highlight . . .

An employee of the State Compensation Insurance Fund (State Fund) failed to report 427 hours of absences. Consequently, State Fund did not charge the employee's leave balances for these absences, and it paid her $8,314 for hours that she did not work.

Finding: The employee failed to report 427 hours of absences.

During the 12-month period we reviewed, the employee submitted only eight monthly attendance reports instead of 12, and none of those reports were accurate. By comparing what the employee stated on the reports with other information about her actual attendance—including building access logs, telephone records, and computer activity records—we determined that the employee was absent for full or partial days on which the employee reported that she was present. These absences occurred in February through June, and in August, September, and December 2007. Moreover, by not submitting attendance reports for January, July, October, and November 2007, she received credit for perfect attendance for two months even though State Fund records described above show that the employee was absent. For the remaining two months, the same records indicate that the hours charged against the employee's leave balances were not sufficient to cover her absences.

In addition, the employee's supervisor exerted lax or nonexistent oversight over her attendance reporting, which raises concerns about the attendance reporting of other employees in the unit. Furthermore, when the supervisor discovered in March 2008 that the employee had not submitted an attendance report for November 2007, the supervisor attempted to resolve the matter by submitting a report for processing. However, when she did so, the supervisor added to the inaccurate reporting because the document stated that the employee was at work on two days that other records indicate she was absent. Further, the supervisor failed to capture eight hours of absences resulting from the employee arriving late or leaving early during the month.

To address the time and attendance abuse by the employee and potential abuse by other employees, we recommended State Fund do the following:

- Fully account for the employee's time by charging her leave balances for the hours she did not work or by seeking reimbursement from the employee for the wages she did not earn.
- Take appropriate disciplinary action for the employee's time and attendance abuse and the lax oversight by her supervisor.

- Provide training to the employee and her supervisor on proper time reporting and supervisory requirements.

- Examine the accuracy of the time and attendance reporting by other employees who report to the same supervisor.

- Establish a process for increased scrutiny of the time and attendance reporting by all members of the employee's unit to ensure that State Fund resolves the reporting abuses discovered during this investigation.

State Fund's Action: Partial corrective action taken.

State Fund reported that it dismissed the employee in June 2009 and demoted the supervisor in July 2009. However, it indicated that the employee appealed her dismissal and the supervisor appealed her demotion. State Fund also reported that it would seek reimbursement from the employee for the wages she did not earn. Further, State Fund identified eight other employees who work for the supervisor, reviewed records establishing their attendance, and found no discrepancies in the employees' time reporting. Finally, in October 2009, State Fund notified us that it began requiring its supervisors to complete a weekly attendance report to ensure that employees' approved absences are properly recorded, tracked, and monitored.

Departments of Health Care Services and Public Health

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

REPORT NUMBER 2009-103, SEPTEMBER 2009

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

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

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

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

Audit Highlights . . .

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

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

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

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

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

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

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

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

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

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

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

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

Legislative Action: Unknown.

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

Board's Action: None.

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

Health Care Services' Action: Partial corrective action taken.

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

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

Public Health's Action: Corrective action taken.

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

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

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

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

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

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

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

Legislative Action: Unknown.

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

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

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

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

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

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

Health Care Services' Action: Pending.

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

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

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

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

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

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

Health Care Services' Action: Partial corrective action taken.

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

Public Health's Action: Partial corrective action taken.

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

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

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

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

Public Health's Action: Partial corrective action taken.

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

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

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

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

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

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

Health Care Services' Actions: Corrective action taken.

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

Public Health's Action: Pending.

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

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

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

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

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

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

Health Care Services' Action: Partial corrective action taken.

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

Public Health's Action: Partial corrective action taken.

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

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

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

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

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

Health Care Services' Action: Corrective action taken.

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

Veterans Home of California at Yountville

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

REPORT NUMBER 2007-121, APRIL 2008

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

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

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

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

Audit Highlights . . .

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

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

continued on next page . . .

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

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

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

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

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

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

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

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

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

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

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

Veterans Home's Action: Partial corrective action taken.

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

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

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

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

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

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

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

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

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

Veterans Home's Action: Corrective action taken.

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

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

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

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

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

Veterans Home's Action: Partial corrective action taken.

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

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

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

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

Public Health's Action: Corrective action taken.

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

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

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

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

Veterans Board's Action: Corrective action taken.

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

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

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

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

Veterans Affairs' Action: Corrective action taken.

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

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

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

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

Veterans Home's Action: Corrective action taken.

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

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

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

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

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

Veterans Home's Action: Corrective action taken.

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

California Department of Veterans Affairs

Although It Has Begun to Increase Its Outreach Efforts and to Coordinate With Other Entities, It Needs to Improve Its Strategic Planning Process, and Its CalVet Home Loan Program Is Not Designed to Address the Housing Needs of Some Veterans

REPORT NUMBER 2009-108, OCTOBER 2009

California Department of Veterans Affairs' response as of December 2009

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to provide information related to the California Department of Veterans Affairs' (department) efforts to effectively and efficiently address the needs of California's veterans. As part of our audit, we were asked to do the following:

- Review the goals and objectives in the department's current strategic plan to determine whether they adequately address the needs and issues in the veteran community, such as mental health and housing. Examine the methods the department uses to measure its performance and the extent to which it is meeting its goals and objectives.

- Determine the methods the department currently uses to identify and serve veterans, including performing a review of its interactions and agreements with other state departments and agencies that serve veterans.

- Identify the number of California veterans that received benefits from the CalVet Home Loan Program (CalVet program) for the most recent year that statistics are available and, to the extent possible, determine whether this program specifically benefits homeless veterans or veterans in need of multifamily or transitional housing.

- Review the programs administered by the department's Veterans Services division (Veterans Services), including whether it operates a program for homeless veterans, and determine the extent to which the department assists with the administration of these programs.

- Identify the federal disability benefits that qualifying veterans can receive and, for the last five years, determine the number of California veterans who annually applied for and received federal disability compensation and pension benefits (C&P benefits).

- Identify any barriers veterans may face when applying for federal disability benefits, the services the department offers to help veterans overcome such barriers, and the methods used by the department to improve the State's participation rate.

Audit Highlights . . .

Our review of the California Department of Veterans Affairs' (department) efforts to address the needs of California's veterans revealed the following:

» ***The department sees its role as providing few direct services to address issues California's veterans face, such as homelessness and mental illness. Instead, it relies on other entities to provide such services and its Veterans Services division (Veterans Services) is responsible for collaborating with these different entities.***

» ***The department has only recently shifted its attention from its primary focus on veterans homes, deciding that Veterans Services should take a more active role in informing veterans about available benefits and coordinating with other entities.***

» ***One of the department's primary goals for Veterans Services is to increase veterans' participation in federal disability compensation and pension benefits (C&P benefits). However, its ability to meet this goal is hampered by various barriers, including veterans' lack of awareness of the benefits, the complexity of the claims process, and delays at the federal level in processing these claims.***

continued on next page . . .

» *Both Veterans Services and the County Veterans Service Officer programs (CVSOs) assist veterans to obtain C&P benefits. However, better coordination with the CVSOs and the use of additional data may enhance Veterans Services' ability to increase veterans' participation in these benefits.*

» *The department did not formally assess veterans' needs or include key stakeholders such as the CVSOs in its strategic planning process, nor did it effectively measure its progress toward meeting the goals and objectives identified in its strategic plan.*

» *As of March 2009 the CalVet Home Loan program served 12,500 veterans. However, the program is generally not designed to serve homeless veterans or veterans in need of multifamily or transitional housing.*

Finding #1: Veterans Services provides minimal direct services to veterans, and is just beginning to improve its outreach activities.

Outside of the services provided by its veterans homes and CalVet Home Loan program (CalVet program), the department provides few direct services to meet the needs of California's veterans. Instead, Veterans Services is responsible for collaborating with the different agencies that provide services to veterans. However, it receives minimal funding for its operations—approximately 2 percent of the department's total budget—most of which is allocated to support a portion of the County Veterans Service Officer programs' (CVSOs) operations, as required by the State's budget act. With its remaining funding, Veterans Services does not administer formal programs that provide direct services to homeless veterans or those with mental health needs, but instead allocates limited funding for local activities that, in part, aim to increase veterans' awareness of benefits available for those with such needs. For instance, it provided $41,000 in fiscal year 2008–09 to support Stand-Downs, one- to three-day events that provide services such as food, shelter, and clothing to homeless veterans. Veterans Services also provided $270,000 of its Proposition 63 (Mental Health Services Act) funding to five of the CVSOs in fiscal year 2008–09 for the purpose of providing mental health information to veterans and referring them for services. However, Veterans Services distributed the funds to the five CVSOs it selected without entering into formal contracts that specify how the funds should be used. Without formal contracts, Veterans Services is limited in its ability to ensure that the funds it provided to the CVSO will be used for their intended purposes.

Under the department's direction, Veterans Services has recently taken a more active role in reaching out to veterans to inform them about available benefits. However, it has been hindered in this effort because the department lacks contact information for most veterans in the State. To improve its contact information, Veterans Services has recently begun using a reintegration form that asks veterans to list their contact information and identify the services they may be interested in pursuing. Veterans Services has also started to gather contact information from federal, state, and county entities to increase the department's ability to inform veterans about available benefits, and is working to improve the department's Web site. For example, in June 2009, Veterans Services added a new resource directory to the department's Web site and initiated an effort to increase the amount of information available to veterans on the Web site. However, despite these recent efforts, many of which began after the current deputy secretary of Veterans Services started in his position in July 2008, the department's prior lack of outreach may have contributed to veterans' lack of awareness of and failure to apply for available benefits.

To ensure that Mental Health Services Act funding is used for the purposes intended in its formal agreement with the Department of Mental Health, we recommended that the department, before awarding additional funds, enter into formal agreements with the respective CVSOs specifying the allowable uses of these funds. Further, we recommended the department ensure that Veterans Services continues to pursue its various initiatives related to gathering veterans' contact information and increasing veterans' awareness of the benefits

and services available to them. Additionally, we recommended that the department pursue efforts to update its Web site to ensure that it contains current, accurate, and useful information for veterans' reference.

Department's Action: Partial corrective action taken.

The department reported that it has entered into formal agreements specifying the allowable uses of Mental Health Services Act funds with five of the six CVSOs it selected to receive these funds in fiscal year 2009–10. The department projected that it would finalize the formal agreement with the remaining CVSO in San Bernardino County in January 2010, pending approval of the agreement by the county's board of supervisors. The department also reported that Veterans Services is continuing its efforts to gather veterans' contact information, including developing its veterans reintegration management system that Veterans Services will use to identify the veteran population in California, collect information regarding veterans' needs and concerns, and link veterans with available resources and benefits. The department told us that Veterans Services is working to establish a formal partnership with the Employment Development Department (EDD) by February 2010 to obtain the names and contact information of discharged veterans participating in the Transition Assistance Program. This program provides employment and training information to members of the armed forces within 180 days of separation or retirement to ease their transition from military to civilian life. Additionally, the department reported that it will solicit a contract to scan hard-copy veterans contact information it receives from the U.S. Department of Defense into an electronic format by January 2010, and projected that it would have the information fully scanned by April 2010. The department also stated that it has begun working with the Office of the Chief Information Officer for California to expedite the redesign of its Web site, including the development of a veterans Web-portal, which it projects it will complete in January 2010.

Finding #2: Veterans Services' efforts to collaborate with other state entities are largely in the beginning stages, and it has not strategically assessed which entities to work with.

The department's deputy secretary of Veterans Services acknowledged that the department has only recently stepped up its efforts to collaborate with other state entities. Focusing on the department's collaboration efforts, excluding any collaborations undertaken by the individual veterans homes, department officials provided documentation to show that as of August 2009 the department had five formal agreements with four other state entities, of which three started in June 2007 or later. In addition to its formal agreements, the department has made efforts to informally collaborate with nine other state entities. All but one of these efforts are overseen by Veterans Services and are in the early stages of development. Prior to hiring the deputy secretary of Veterans Services in July 2008, the department had three informal collaborations with other state entities, two of which were related to providing educational opportunities to veterans. Since that time, the department has begun working to collaborate with six additional state entities. Three of these collaborations—with the California Labor and Workforce Development Agency, the California Department of Consumer Affairs, and the California Volunteers—were in the very early stages, with no explicit agreements, timelines, or plans in place, as of August 2009.

Veterans Services recent efforts to work with other state entities highlights the need for it to develop a formal process to ensure that it is identifying agencies that can assist it to better serve veterans. According to the deputy secretary of Veterans Services, in selecting which state entities to approach, he and the department's executive team selected those that they knew offered services to veterans or believed could be helpful in fulfilling the department's goals. The deputy secretary of Veterans Services explained that there was no formal process for deciding which entities to approach and no lists indicating any established priorities. Unfortunately, because it did not engage in a formal approach to these efforts, Veterans Services may have missed key entities that it could work with to increase veterans' awareness of available benefits or enhance the services available to veterans. For example, a 1994 state law requires that state licensing boards consult with the department to ensure that the education, training, and experience that veterans obtain in the armed forces can be used to meet

licensure requirements for regulated businesses, occupations, or professions. The department's current administration discovered this law in 2009 and has only recently contacted the California Department of Consumer Affairs to address this requirement.

To adequately identify the service providers and stakeholders that could assist Veterans Services in its efforts to increase veterans' awareness of available benefits, we recommended that the department ensure that Veterans Services implement a more systematic process for identifying and prioritizing the entities with which it collaborates. Further, we recommended that the department ensure that, where appropriate, it enters into formal agreements with state entities Veterans Services collaborates with to ensure that it and other entities are accountable for the agreed-upon services and that these services continue despite staff turnover, changes in agency priorities, or other factors that could erode these efforts.

Department's Action: Partial corrective action taken.

In its 60-day response, the department reported that Veterans Services has developed criteria and recommendations for identifying and prioritizing the entities with which it collaborates. The department told us that its executive team is scheduled to meet in January 2010 to approve Veterans Services' recommendations, and stated that by May 2010 it would establish an advisory committee of those entities to advise the department's secretary regarding the needs of California's veterans. Additionally, the department asserted that it is working to formalize its collaboration with the Department of Alcohol and Drug Programs in a memorandum of understanding by February 2010, and reported that is working to establish formal agreements with EDD by February 2010, and with the departments of Motor Vehicles and Consumer Affairs by July 2010.

Finding #3: Veterans face various barriers in applying for C&P benefits and the department could more effectively communicate its concerns about these barriers to the U.S. Department of Veterans Affairs.

California's veterans participate in C&P benefits at rates that are significantly lower than those in other states with large veteran populations, and the department has made increasing veterans' participation in these benefits a primary goal for Veterans Services. However, Veterans Services' ability to influence participation in these benefits is affected by various barriers veterans may face in applying for C&P benefits, such as the complexity of the claims process and the U.S. Department of Veterans Affairs' (federal VA) delay in processing the claims. Although the department is aware that the claims process may pose various barriers to veterans applying for these benefits, it could not provide documentation demonstrating that it had communicated these concerns to the federal VA. Nevertheless, the former secretary of the department explained that the length of time it takes the federal VA to process claims is believed to be a problem experienced by veterans in all states, and that it was a subject at meetings held by the National Association of State Directors of Veterans Affairs (NASDVA). He stated that he and the other NASDVA members directly addressed this issue by meeting with the federal VA's deputy undersecretary for benefits, and that they pressed this issue very hard. He further stated that the federal VA consistently answered that it was experiencing unprecedented increases in claim submissions and was hiring and training more staff to address the increase in claims.

Additionally, according to the secretary for administration, Veterans Services has met informally with the federal VA's regional leadership at the CVSO training sessions, which are held three times a year, and informed them of the department's concerns regarding the claims process, including its complexity. He also stated that department staff periodically meet with federal VA staff at the VA's regional offices to communicate their concerns. To the extent these barriers continue to exist, it is increasingly important for the department to continue to communicate its concerns regarding the claims process to ensure that veterans can receive their benefits in a timelier manner.

To ensure that the federal VA is aware of the barriers veterans face in applying for C&P benefits, such as the complexity of the claims process, we recommended that the department continue its efforts, and formalize these efforts as necessary, to communicate these concerns to the federal VA.

Department's Action: None.

The department did not specifically address this recommendation in its 60-day response to our audit report.

Finding #4: Veterans Services and the CVSOs do not specifically share the same goal of increasing veterans' participation in C&P benefits.

Although both the CVSOs and Veterans Services can assist veterans in applying for C&P benefits, the CVSOs play a key role in informing veterans about all available benefits and do not specifically share the same goal of increasing veterans' participation in these benefits. In particular, the six officers of the CVSOs that we interviewed tended to have more general goals, such as reaching out to as many veterans and veterans' groups as possible and providing veterans with the best possible service. Some CVSOs have numeric goals specific to processing claims for other types of benefits or for increasing overall productivity. These differing goals may hinder Veterans Services' efforts to increase veterans' participation in C&P benefits.

As part of its efforts to coordinate with the CVSOs, Veterans Services communicates the department's goals at conferences and sends e-mails to the CVSOs about the department's commitment to be at or above the national average in terms of veterans' participation in C&P benefits, according to the deputy secretary of Veterans Services. Further, the deputy secretary for administration stated that the department informs the CVSOs where each county stands in the number of veterans receiving C&P benefits by forwarding participation reports from the NASDVA. However, part of the challenge Veterans Services faces is that the presence of a CVSO in each county is an optional function and the CVSOs exist solely under the control of their respective county's board of supervisors. Thus, according to the deputy secretary of Veterans Services, the department would be overstepping its authority by setting goals for the CVSOs relating to C&P benefits and outreach. As a result, to the extent that the counties' board of supervisors establish goals for the CVSOs that differ from the department's goals, the department may be limited in its ability to increase veterans' participation in C&P benefits.

To better coordinate efforts to increase the number of veterans applying for C&P benefits, we recommended that Veterans Services formally communicate its goals to the CVSOs and work with them to reach some common goals related to serving veterans.

Department's Action: Partial corrective action taken.

In its 60-day response to our audit report, the department told us that it had communicated its goal of increasing veterans' participation in C&P benefits to the CVSOs. The department also entered into a formal agreement with the California Association of County Veterans Service Officers (association) in December 2009. The agreement is for an indefinite period of time, and summarizes agreements reached by the association and the department to establish a process by which both parties may seek input into the development of their respective strategic plans. In the agreement, both parties agreed to consider each other's input in the development of goals and objectives and recognized that neither has direct control over the goals and objectives set by individual counties, but agreed to foster common goals in order to provide a more consolidated effort to meet the needs of California's veterans. The department and the association also plan to hold meetings between the department's executive staff and the association's strategic planning committee three times per year (spring, fall, and winter) to discuss veterans needs, progress reports on accomplishing specific objectives, and other issues.

Finding #5: Additional information could enhance the department's ability to increase veterans' participation in C&P benefits.

The department relies heavily on the CVSOs to initiate and develop veterans' claims, including claims for C&P benefits, and to inform veterans about available benefits. However, the department has missed the opportunity to obtain key information from the CVSOs that could help Veterans Services better assess the State's progress in increasing veterans' participation in C&P benefits. In connection with the $2.6 million in annual funding that the department provides to the CVSOs, a state regulation requires the CVSOs to submit workload activity reports to the department within 30 days of reporting periods established by the department. In implementing this state regulation, the department has required the CVSOs to submit workload activity reports to Veterans Services that include the number of claims they filed that they believe have a reasonable chance of obtaining a monetary or medical benefit for veterans, their dependents, or their survivors. The department uses these data to allocate funding to the CVSOs. However, these workload activity reports do not separately identify the total number of claims filed for C&P benefits by each CVSO, and the department has not required the CVSOs to include this information in the reports.

Further limiting Veterans Services' ability to influence the State's rate of participation in C&P benefits is that it has minimal information on the effectiveness of the CVSOs' outreach activities, as it does not monitor or review these activities. As a result, it has minimal assurance that these efforts are sufficient to increase the State's participation in C&P benefits. However, Veterans Service may have an opportunity to assess the adequacy of the CVSOs' outreach efforts as part of an annual report the department is required to submit to the Legislature. Specifically, state law requires the department to report annually on the CVSOs' activities and authorizes it to require the CVSOs to submit the information necessary to prepare the report. Veterans Services is responsible for compiling this report, and the department could require the CVSOs to submit information on their outreach activities. In part, Veterans Services could use this information to assess the adequacy of the CVSOs' outreach activities and determine where and how it could target its own outreach efforts in counties with greater need—such as those lacking resources to conduct adequate outreach. In doing so, Veterans Services could increase veterans' awareness of C&P benefits and potentially increase their participation in these benefits.

Additionally, Veterans Services could make use of data from the NASDVA and U.S. Census Bureau to better focus its outreach efforts and coordination with the CVSOs. For example, among the six counties we reviewed, Los Angeles may have the greatest potential for increasing veterans' participation in C&P benefits. Specifically, veterans in this county have the lowest rate of participation in C&P benefits—almost 2 percentage points lower than the State's average of 11.77 percent as of September 2007—and the largest number of veterans not receiving C&P benefits. Los Angeles County also has the greatest number of veterans with disabilities, which is an indicator of veterans' potential need for disability compensation benefits. Specifically, more than 32,000 veterans were receiving disability compensation benefits as of September 2007, while the U.S. Census Bureau data indicate that there were nearly 100,000 veterans with disabilities in the county in 2007. This analysis suggests that if Veterans Services were to focus its efforts toward increasing veterans' participation in disability compensation benefits in Los Angeles County, it could generate the highest value for its efforts. Performing a similar analysis of all California counties and including other data that Veterans Services could obtain from the CVSOs, such as the number of claims filed for C&P benefits, may allow Veterans Services to focus its limited resources on the areas with the highest potential for increasing veterans' participation in C&P benefits.

To ensure that it has the information necessary to track progress in increasing veterans' participation in C&P benefits, and to identify where and how best to focus its outreach efforts, we recommended that Veterans Services require the CVSOs to submit information on the number of claims filed for C&P benefits and information on their outreach activities. Further, we recommended that as Veterans Services expands its efforts to increase veterans' participation in C&P benefits, it use veterans' demographic information, such as that available through the U.S. Census Bureau, to focus its outreach and coordination efforts on those counties with the highest potential for increasing the State's rate of participation in C&P benefits.

Department's Action: Pending.

The department reported that it is working to revise its workload activity reporting requirements to increase the level of detail it obtains from the CVSOs, including information on the number of C&P claims filed and awarded. According to the department, it plans to deploy the new workload activity reporting requirements with the development of its Statewide Administration Information Management system (SAIM system). Additionally, the department told us that it plans to negotiate changes in the memorandum of understanding it has with the CVSOs regarding the annual funding the department provides to them. These changes will include obtaining information about CVSOs' outreach activities to better ensure that the department identifies where and how best to focus its outreach and coordination efforts. The department estimated that its negotiation with the CVSOs will be complete in March 2010. Further, the department reported that it will require CVSOs to submit information on their outreach activities as part of the bi-annual reports they submit to Veterans Services, which the department uses to compile its annual report to the Legislature. The department projects that the CVSOs will include this information in their bi-annual reports due in July 2010. However, the department did not specify how it intends to use this information to better focus its outreach and coordination efforts with the CVSOs. Additionally, the department did not specifically address the recommendation regarding its use of veterans' demographic information, such as that available through the U.S. Census Bureau, to focus its outreach and coordination efforts on counties with the highest potential for increasing the State's rate of participation in C&P benefits.

Finding #6: A new system may improve the collection and review of CVSO data, including information on claims for C&P benefits.

Recognizing that it lacks an effective means to monitor the processing of claims by CVSOs and to collect information on veterans' demographics, Veterans Services initiated a joint effort with the CVSOs in 2009 to create the SAIM system. According to the deputy secretary of Veterans Services, the SAIM system will enhance the department's ability to track the number and quality of claims for C&P benefits processed by the CVSOs and submitted to the federal VA. Specifically, the SAIM system will allow department staff to review the claims to ensure that they include certain items, such as any attached documentation and medical records used to substantiate the claims. Well-substantiated claims receive quicker rating decisions in the federal VA claims processing system. According to the deputy secretary of Veterans Services, an additional benefit of the SAIM system is that the department will have access to counties' contact information for the veterans they serve, to use for outreach purposes. The department is in the beginning stages of the process necessary to implement the SAIM system and has developed a budget change proposal requesting funding to cover the administrative costs of such a system. The proposal, according to the deputy secretary of Veterans Services, has been submitted to the Department of Finance (Finance) for review.

Department officials also indicated that the SAIM system would enable it to meet its legal requirements regarding auditing CVSO workload reports and verifying the appropriateness of college fee waivers. Although the audit committee did not specifically ask us to evaluate the department's auditing of CVSOs, when we inquired about the SAIM system we learned that the department is not auditing the CVSOs' workload reports, described previously, as required by state law. Department officials stated that the department is currently unable to audit these reports due to resource constraints and the amount of time that would be required to conduct audits at the CVSOs.

Because the department is not verifying the accuracy of the college fee waivers processed by the CVSOs as required by state law, the State may be granting too many college fees. Under the College Fee Waiver program, veterans' dependents who meet the eligibility criteria may have their college tuition waived if they attend a California Community College, a California State University, or a University of California campus. According to the deputy secretary of Veterans Services, in fiscal year 2007–08, the CVSOs processed 15,000 fee waiver applications, which resulted in the granting of $42 million in fee waivers. Department officials acknowledged that the department did not verify the appropriateness of the fee waivers as required by state law, and recognized that this places the State at risk of waiving college fees erroneously.

We recommended Veterans Services continue its efforts to pursue the SAIM system to enable it to monitor the quantity and quality of claims processed by the CVSOs, and ensure it meets legal requirements regarding auditing CVSO workload reports and verifying the appropriateness of college fee waivers. To the extent that Veterans Services is unsuccessful in implementing the SAIM system, the department will need to develop other avenues by which to meet its legal requirements.

Department's Action: Pending.

In its 60-day response, the department reported that the feasibility report for the SAIM system was under review by the Office of the Chief Information Officer for California. If approved, the department projected that it will start using the SAIM system at the beginning of fiscal year 2011–12.

Finding #7: The department did not adequately assess veterans' needs in preparing its strategic plan.

The department missed two steps critical to ensuring that it provides services appropriate to meet veterans' needs in developing its strategic plan covering fiscal years 2007–08 through 2011–12. Specifically, it did not formally assess veterans' needs and concerns, and it did not formally involve the CVSOs when developing the plan. According to its deputy secretary for administration, the department did not perform a structured, formal assessment of veterans' needs as part of its strategic planning process. Such an assessment might include a process, such as surveying veterans and organizations that serve veterans, for identifying key needs and prioritizing how the department will address the identified needs. Instead, the deputy secretary for administration explained that the department obtains information about the needs of veterans through a variety of interactions with the veteran community and veteran stakeholders, such as staff participation in national forums and conventions. He indicated that the department believes its current methods are sufficient to get a good sense of the needs in the veteran community. Although these interactions may provide department officials with some information on the needs of veterans, a formal assessment to identify veterans' needs would minimize the risk that the department is overlooking, or that it is undertaking inappropriate efforts to address, the key needs of the veteran community.

Further, although the department stated that it partners with CVSOs to ensure that veterans and their families are served and represented, the deputy secretary for administration stated that the department did not formally survey the CVSOs or other stakeholders to identify and prioritize the needs of the veteran community as part of its strategic planning process. However, guidelines for strategic planning developed by Finance—which provide a framework to assist state agencies in developing their plans—say the first step in a successful strategic planning process includes soliciting input from external stakeholders. Formally involving the CVSOs in the strategic planning process would allow the department to more completely evaluate the needs of the veteran community, given the department's reliance on the CVSOs to perform direct outreach to veterans.

Only three of the six CVSO officers that we interviewed were familiar with the department's strategic plan and none of those three were involved in the plan's development. The remaining three were not familiar with the plan at all. Of the three that responded to the question regarding whether the plan addressed veterans' needs, only the CVSO officer in Solano County responded that it did address veterans' needs. The CVSO officer in San Diego County expressed concern that the plan placed too much emphasis on the veterans homes, stating that the potential efforts of Veterans Services were not given sufficient attention. Similarly, the CVSO officer in Los Angeles County stated that although the plan primarily addressed veterans' needs related to the CalVet program and the veterans homes, more attention and resources were needed to expand the information on benefits and to address homelessness and unemployment among veterans. The officers of the six CVSOs identified for us a range of needs and concerns in the veteran community, including some not listed in the department's strategic plan, such as concerns about access to health care.

To ensure that it properly identifies and prioritizes the needs of the veteran community, we recommended that the department conduct a formal assessment of those needs, including soliciting input from the CVSOs.

Department's Action: Pending.

The department reported that it plans to seek proposals from major educational institutions to conduct a formal research project to identify the needs of California Veterans. The department has developed a request for proposals for the project, which it plans to issue in January 2010. The department reported that it plans to award the contract in February 2010, and have the contractor complete the study by June 2010. Among other things, the scope of work defined in the request for proposals includes a search of existing research and literature related to identifying shortfalls in services provided to veterans, a survey of California veterans and their families to assess, in part, their service-related needs, and a written report that details the analysis of findings from the literature search and the survey. The department stated that it will conduct surveys of veterans using available contact information, and told us that it plans to post the survey on-line in January 2010, publish the resulting findings in May 2010, and incorporate the results of the survey into its annual strategic planning process by July 2010. The department also reported that it intends to hold public hearings to assess the needs of California's veterans, and stated that the first hearing is scheduled to occur in February 2010 in Monterey County. Finally, although the department stated that it plans to develop a committee to advise the department's secretary on identifying the needs of California's veteran population by January 2010, it did not specify whether representatives from the CVSOs will be on the committee, and did not identify how its agreement with the California Association of County Veterans Service Officers ties into its research to identify the needs of California's veterans.

Finding #8: The department's strategic plan does not specify how goals will be met and lacks adequate measures for assessing progress.

Although the department has identified certain needs and concerns of the veteran community in its strategic plan covering fiscal years 2007–08 through 2011–12, the plan's goals and objectives do not sufficiently identify the steps the department will take to address these needs. The plan describes 12 critical issues and challenges the department believes it faces. According to the deputy secretary for administration, these issues and challenges represent the department's priorities and include veterans' critical needs that the department identified in its strategic planning process. Five of the 12 critical issues and challenges identified in the strategic plan relate to the veterans homes, but the department also identified homelessness among veterans and the need for services to meet the needs of newly returning combat veterans.

Despite this, the goals and objectives expressed in the strategic plan, which relate to the successful delivery of programs and services to California's veterans and their families, do not include any mention of these needs. By not sufficiently aligning its goals and objectives with all of the needs it has identified, the department risks being unable to ensure that its activities sufficiently address them. Further, Finance's strategic planning guidelines indicate that goals and objectives are key components of strategic planning. They also state that goals represent the general ends toward which agencies direct their efforts, and that objectives should be measurable, time-based statements of intent, linked directly to these goals, that emphasize the results of agency actions at the end of a specific time. However, the department's five strategic goals and many of the 29 related objectives do not provide this level of guidance.

Additionally, in its strategic plan, the department specifies that divisions will develop, track, and report detailed action plans and performance measures. According to the deputy secretary for administration, to operationalize its strategic plan, the department asked each division and support unit to develop action plans for meeting the strategic plan's goals and objectives. Because the strategic plan's objectives fail to mention how the department will address the needs of homeless veterans or of newer veterans, we expected that the action plans would clearly specify how the divisions' activities would meet these

needs. However, the action plans we reviewed do not do so. For example, the July 2007 action plan for Veterans Services—the division responsible for conducting the department's outreach activities related to increasing veterans' awareness of available benefits—does not include specific reference to the homeless among veterans or the needs of newer veterans returning from Iraq and Afghanistan who may be in need of mental health services or health care benefits.

Further, according to the department's deputy secretary for administration, the activities included in each division's annual action plan are, in fact, the performance measures called for by the department's strategic plan. These action plans, however, do not allow the department to effectively gauge its progress in accomplishing its goals and objectives. The deputy secretary for administration indicated that there was no short list of critical activities in the action plans that were identified as the key performance measures for each division. According to Finance's strategic planning guidelines, to retain focus on only the most significant objectives in the plan, the agency should select only the most pertinent measures for each objective for which data can be collected. In contrast, the department has identified every activity in its 40-page set of action plans as a performance measure, reducing its ability to focus on those with the highest priority.

To ensure that its strategic plan identifies how the department will address the needs and concerns of veterans, we recommended that the department develop measurable goals and objectives, as well as specific division action plans that directly align with the needs of the veteran community that it identifies in the plan.

Department's Action: Partial corrective action taken.

The department published its new strategic plan in August 2009, and published a formal implementation plan that includes measurable goals, objectives, and plans of action in October 2009. In its 60-day response to our audit report, the department told us that it plans to incorporate goals more specific to veterans' needs into its new strategic and implementation plans once it completes its formal research project to identify the needs of California's veterans, described in its response to finding #7.

Finding #9: The department has not followed key monitoring procedures suggested by its strategic plan and Veterans Services' strategic plan does not align with the department's plan.

The department has not followed key monitoring procedures called for by the strategic plan, such as conducting quarterly progress assessments and publishing annual performance measure reports. The strategic plan states that the department will assess its progress quarterly toward achieving predetermined goals and objectives and publish a performance measure report annually. Our review found that the department did not consistently perform these quarterly assessments, did not publish an annual performance report, and did not assess its progress toward meeting its strategic plan's goals and objectives. The department's failure to monitor its progress and remain actively engaged in its strategic planning process limits its ability to measure whether it is meeting its goals, to evaluate how effectively it is meeting the needs of veterans, to adjust its activities to changing circumstances, and to inform itself and stakeholders about its progress.

Additionally, the Veterans Services' strategic plan is not linked to the department's plan. In addition to participating in the department's strategic planning process, Veterans Services has developed its own independent strategic plan. Although it developed action plans as part of the department's overall strategic planning process, Veterans Services also continued to update its own strategic plan, which includes separate action plans. The most recent version of Veterans Services' strategic plan covers fiscal years 2009–10 through 2013–14. According to the deputy secretary of Veterans Services, this plan is the one to which it holds itself accountable. He noted that Veterans Services develops specific items in its strategic plan independently, without the direct input of the department's acting secretary or the executive team, although the executive team receives copies of Veterans Services' strategic plan, is

aware of its activities, and assists with its goals where appropriate. The existence of multiple, competing plans reduces the department's ability to ensure that its divisions and support units are undertaking activities that contribute to the department's overarching goals and objectives.

We recommended that to ensure it effectively measures progress toward meeting key goals and objectives, the department follow the provisions in its strategic plan requiring it to establish performance measures, conduct and document quarterly progress meetings, and publish annual performance measure reports. Further, to ensure coordination in its efforts to achieve key goals and objectives, we recommended that the department eliminate Veterans Services' strategic plan or ensure that the plan is in alignment with the department's strategic plan.

Department's Action: Pending.

The department did not specifically address these recommendations in its 60-day response to our audit report. However, it did specify in its formal implementation plan for its new strategic plan that there will be no individual strategic plans at the divisional level.

Finding #10: Despite recent declines, Veterans' participation in the CalVet program may increase in the future.

Although the number of veterans participating in the CalVet program has declined each year since June 30, 2006, the deputy secretary of the program expects more veterans to participate in the future. The number of veterans with CalVet program loans decreased from about 14,600 as of June 30, 2006, to approximately 12,500 as of March 31, 2009. According to the deputy secretary of the CalVet program, the decline can be attributed to several factors, including that the CalVet program's interest rates have become less competitive than those offered by other lending institutions. However, the deputy secretary of the CalVet program believes opportunities exist to lower these interest rates in the future and increase participation in the program.

Nationally, market interest rates generally declined during 2006 through 2008, and information compiled by the CalVet program shows that during the period between July 2006 and November 2008, the CalVet program offered interest rates that were lower than the average interest rates offered by the Federal Home Loan Mortgage Corporation.[1] However, beginning in December 2008, the interest rates offered by the CalVet program became less competitive, providing an economic incentive for veterans to obtain new loans, or to refinance their existing loans, outside of the program. In spite of this, the deputy secretary of the CalVet program anticipates that veterans' participation in the program will substantially increase in the future because the department is attempting to decrease the interest rates it offers on loans by becoming an approved lender with the Federal Housing Administration. He explained that as an approved lender, the CalVet program will be able to work with the Government National Mortgage Association (Ginnie Mae) to guarantee CalVet program loans, and that in working with the Ginnie Mae, the department may attract more veterans to the program by offering lower interest rates on its loans.

In order to attract more veterans to the CalVet program, we recommended that the department continue working with the Federal Housing Administration and the Ginnie Mae to lower its interest rates on loans.

Department's Action: None.

The department did not address this recommendation in its 60-day response to our audit report.

[1] The Federal Home Loan Mortgage Corporation is a shareholder-owned company created by the U.S. Congress in 1970 to stabilize the nation's mortgage markets and expand opportunities for homeownership and affordable rental housing.

Finding #11: The State's CalVet program would need to be redesigned to fund multifamily housing or to better serve homeless veterans.

The audit committee asked us to determine whether the CalVet program specifically benefits homeless veterans or veterans in need of multifamily or transitional housing. We determined that the program is generally not designed for these purposes. For instance, federal law allows the CalVet program to use bond funds issued after 1986 to finance loans to veterans for housing with up to four separate living units, and both federal and state law allow veterans to purchase such properties using CalVet funds if they occupy one of the units as their principal residence. However, current state law makes it impractical for veterans to purchase properties with more than one unit, because it effectively prohibits veterans from renting out the unoccupied units. Specifically, state law provides that properties financed with CalVet funds are not intended to become investment, rental, or business properties, although state law does authorize the CalVet program to give written consent to a veteran who wishes to lease property purchased with CalVet program financing under some conditions. Because of these restrictions, the CalVet program does not issue loans on properties with more than one unit, according to the department's manager of the escrow and post-closing unit.

Further, although state law allows the CalVet program to lease out its repossessed properties and give priority for these leases to public or private organizations serving homeless veterans, the CalVet program has limited ability to lease out these properties. According to the deputy secretary of the CalVet program, without additional funding, the law does not present a viable economic solution to serve homeless veterans or veterans in need of transitional housing. The deputy secretary listed several reasons why the department sells rather than leases out its repossessed properties, the main reason being the higher costs associated with leasing out the properties. Additionally, the types of housing in the CalVet program's portfolio and the fluctuations in the number of repossessed properties also limit the program's ability to address homeless veterans' needs by leasing its repossessed properties. According to the deputy secretary, most CalVet program properties are not suitable for more than one family because they generally have only two or three bedrooms. Further, the CalVet program can lease its repossessed properties to organizations serving homeless veterans only if the properties are zoned for that use. Thus, the viability of allowing public or private organizations to use CalVet program properties to serve homeless veterans would be limited.

Additionally, a state law, effective January 2009, authorizes the department to apply to the California Debt Allocation Committee for permission to issue private activity bonds for qualified residential rental projects (residential projects). According to a legislative committee analysis, the legislation that enacted this law sought to address the need for transitional and permanent housing for veterans and their families by identifying a source of funding the department could use to fund affordable multifamily housing. However, according to the deputy secretary of the CalVet program, the law does not authorize the department to use the money derived from the sale of private activity bonds to fund residential projects, and legislation would need to be passed explicitly permitting the CalVet program to make loans for these projects. Our legal counsel agrees that state law would need to be clarified for the department to construct or make loans for these projects. Also, according to our legal counsel, the law would need to be further clarified if the Legislature's desire was to limit residency in these projects to veterans, because it does not authorize the department to impose this limitation. Finally, although the federal government makes funding available to provide services to homeless veterans through the federal VA's homeless Grant and Per Diem program, according to our legal counsel, state law does not currently provide the department with sufficient authority to participate in the program.

We recommended to the Legislature that if it believes the department should play a larger role in funding multifamily housing for veterans, providing transitional housing for veterans, and addressing the housing needs of homeless veterans, it would need to modify or clarify state law to authorize the department to provide such services.

Legislative Action: Unknown.

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

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 December 2009

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

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.*
- *The board lacks the necessary system documentation for CaRES.*

continued on next page . . .

» *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.*

require board analysts to perform to ensure that they pay only eligible bills. Further, 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: Partial corrective action taken.

In its one-year response dated December 2009, the board identified four key goals that it is using in measuring the success of its implementation of the strategic plan and in maximizing assistance to victims and their families. Based on its response, the status of the board's efforts in establishing and measuring goals are at various stages as shown in the Table:

GOAL	STATUS
Achieve a 10 percent reduction in processing times for applications and payments by July 2009.	The board reported that processing times have increased due to an increase in applications and the impact of furloughs in fiscal year 2008–09. The board states that it remains committed to reducing processing times in the future.
Achieve a 10 percent increase in customer and stakeholder satisfaction by July 2009.	The board reported that it has completed surveys of customers and stakeholders and now has a baseline to measure progress. The board plans to periodically survey stakeholders to measure changes in satisfaction.
Achieve a 10 percent increase in public awareness by July 2009.	The board reported that it is creating a baseline measure that will allow the program to more accurately gauge the success of the outreach efforts. The board stated it is creating the baseline as part of its 2010 outreach and advertising effort and expects results will be final by the end of 2010.
Increase revenue recovery efforts to support a stable restitution fund.	The board reported an increase in revenue-generating activities. In its 60-day response, the board stated that it would measure success performing a quarterly assessment of the year-to-date revenue in the Restitution Fund and compare it to the same period the year before.

Additionally, the board reported that it has established a target minimum fund balance to avoid financial shortfalls and plans to reassess the target balance annually and adjust as appropriate. Finally, with regard to ensuring that it is carrying out its support activities in the most cost-effective manner, the board reported that it continues to measure administrative support costs, also referred to as program support costs, as a percentage of total program expenditures, excluding revenue-generating program costs. The board reported that it reduced its support costs to 28 percent in fiscal year 2008–09. Because total program expenditures include compensation payments, such a measurement is similar to comparing program support costs to compensation payments, the measure we highlighted as being informative. However, the board has not yet identified a specific goal for its program support costs that it believes, if achieved, would result in it carrying out its support activities in the most cost-effective manner possible. The board reports that it is in the process of conducting a process improvement analysis of the entire program. The board views this analysis as a critical step in determining what might be an appropriate goal and plans to also use it to determine specific operational changes that will result in additional cost reductions.

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: Corrective action taken.

In its six-month response, the board reported that it updated training modules to include an emphasis on correctly documenting the basis for eligibility decisions. The board also reported that it provided refresher training to staff in May 2009.

In its one-year response, the board reported that it has provided additional training sessions covering claim processing and eligibility determination, which includes training on evaluating information to determine eligibility and properly documenting the results. Additionally, the board reported that it completed its new procedure manual, which is accessible to staff on-line.

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, including appropriate time frames for following up as well as the number of attempts the staff should complete. We also recommended that the board 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: Partial corrective action taken.

In its 60-day response, the board identified two problems that led to delays in processing. The first was the lack of necessary information on applications that precludes the board from beginning to process the applications. The second was the untimely submission of information from providers regarding verification information and from law enforcement regarding crime reports. The board stated that it was developing an on-line application to deal with the problem regarding incomplete applications. The board also stated that it was developing a new procedure manual that would provide step-by-step instructions for staff to follow when verifying applications and bills, including time frames for follow-up. In its one-year response, the board reported that it has completed the on-line application design and testing and successfully piloted the application in four counties. The board stated that it is planning the rollout to the remaining counties in the second quarter of 2010. The board stated that it expects the on-line application to speed processing because it provides help to applicants so they can provide all the required information. Additionally, the board reported that it has completed the procedure manual. The procedure manual provides specific guidance for when and how often staff should follow up with verifying entities.

In its six-month response, the board reported that it amended its provider and other outreach presentations to specifically emphasize the importance of returning crime reports and verification information in a timely manner. The board also reported that it has established and implemented new subpoena procedures for obtaining law enforcement reports.

Finally, the board agrees with our recommendation concerning notification of applicants of the board's recommended decisions, and this change was incorporated into a proposed regulation package. In its one-year response, the board reported that the regulation changes were adopted in April 2009.

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: Corrective action taken.

In its 60-day response, the board reported that its training presentation now includes stronger emphasis on reimbursement sources. In its one-year response, the board states that it provided reimbursement training for staff in 2009 and plans to offer it again in February 2010. The board also reported that its new procedure manual is now complete. Finally, regarding maintaining documentation of its formal approval of applications and bills, the board reported that its fiscal division is now responsible for this 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: Corrective action taken.

In its six-month response, the board reported that it had completed the appeals chapter of its procedure manual. The procedure manual includes time frames for how long the intake and analysis processes for appeals are expected to take.

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: Partial corrective action taken.

In its six-month response, the board reported that it implemented monitoring tools to measure key performance indicators of CaRES system health and that the measures are tracked on a daily basis to provide real time and trend information on CaRES performance. Additionally, the board reported that it completed the data dictionary for CaRES.

In its one-year response, the board stated that it is continuing its effort to maximize its use of CaRES. The board stated that it has developed a corrective action plan that it uses for identifying issues that must be addressed and is tracking the progress of issues. Additionally, the board stated that it hired a database architect to identify structural problems and provide detailed recommendations on how to address these issues in CaRES. The board expects the architect's final assessment and recommendations in December 2009. Further, the board stated that it established a CaRES Change Control Board to review and prioritize modifications and that this is an ongoing process. The board also reported that it is in the process of developing system documentation and dependency diagrams of CaRES.

Finally, the board reported that it continues to work closely with JP office staff to resolve CaRES issues as they arise. The board stated that it conducts regular conference calls with county JP offices and problems relative to CaRES are communicated and tracked in a bi-weekly operational meeting. The board also stated that it actively solicits feedback from a cross-section of representatives relative to CaRES performance problems.

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: Partial corrective action taken.

In its 60-day response, the board stated that its lead brochure provides referral and contact information for each assistance center in the State and that its Web site includes links to the assistance centers. However, these materials were previously provided and the board has not increased its emphasis on the advantages of working with the assistance centers in these materials. The board stated that it performs outreach presentations with representatives from the assistance centers to law enforcement agencies and strongly recommends that law enforcement refer claimants to the assistance centers.

In its one-year response, the board stated that it has increased the number of counties serviced by the existing 21 JP offices from 23 in 2008 to 26. The board also stated that to keep services local and provide the fastest, most efficient service to applicants, it has begun transferring applications received at headquarters to the JP office that handles that county. According to the board, this gives each JP office the opportunity to work with the applicant through the life of the claim and to make sure that the applicant gets connected to local services, if needed. As a result of these actions, the board stated that local JP offices will process eligibility and losses for nearly all applications generated by crimes in 47 of the 58 counties.

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: Corrective action taken.

In its one-year response, the board reported that it had developed an inventory monitoring system that identified minimum and maximum workload that is acceptable at each processing center and steps to take if any of the centers are outside of the normal processing parameters. The board stated that program managers meet periodically to discuss the workload and transfer work between centers using established transfer criteria. Additionally, the board stated that its JP offices and headquarters staff are monitoring the number of applications and bills processed and beginning in early November 2009, management meet weekly to evaluate the inventory and production across the entire program. The board also reported that CaRES is now capable of and is producing reports as needed.

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: Corrective action taken.

In its six-month response, the board reported that it completed its Comprehensive Communication and Outreach Plan and had begun implementation. According to the board, the final plan was developed in partnership with the directors of the county victim witness assistance programs and JP units throughout the State, considered many demographic and crime statistics, and was shared with a variety of victim advocacy groups and other stakeholders.

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: Partial corrective action taken.

In its one-year response, the board reported that its Comprehensive Communication and Outreach Plan identifies the use of 10 existing metrics and the development of additional metrics that are and will be used to establish benchmark awareness levels, prioritize projects, target underserved and hard-to-reach populations, and evaluate the effectiveness of overall outreach efforts. The board also reported that to more definitively measure its success in achieving outreach goals, it is in the process of establishing a baseline from which it may accurately measure goals. The board stated that it has developed the methodology to perform a survey to establish a baseline and plans to execute the survey by late 2009. Additionally, the board reported one of the metrics in its plan is an evaluation of applicants' responses to how they heard about the program and that it is using the responses to focus and evaluate research efforts.

The board also reported that it had established an outreach budget for fiscal years 2008–09 and 2009–10, incorporating all the elements of the Comprehensive Communication and Outreach Plan.