



**FOLLOW-UP AUDIT REPORT
OF THE
HEALTH AND HUMAN SERVICES
DEPARTMENT**

CONDUCTED NOVEMBER 6, 2009

**PRESENTED BY MILTON DURAN
DIRECTOR OF INTERNAL AUDIT
DONA ANA COUNTY**



January 4, 2010

Brian Haines, County Manager
Sue Padilla, Assistant County Manger
Sylvia Sierra, Health & Human Services Director

The Internal Audit Department conducted a Follow-Up Audit of the **Health and Human Services Department** beginning on November 6, 2009. The purpose of the review was to determine the status of corrective measures taken by management to remedy the findings of the recent audit report.

Audit Scope

Controls associated with the functions performed by this department were reviewed to evaluate the level of corrective actions taken since distribution of the audit report. The operating effectiveness was also evaluated to ensure that risks have been adequately mitigated or managed. Policies and procedures were reviewed to determine the continued adequacy of internal controls and to ensure that processes are documented.

Summary of Audit Findings

The original audit report disclosed forty-one (41) findings, which were grouped into nine major categories. Thirty-five (35) or 85% of the findings have been fully resolved. The six outstanding items are training for outside indigent care agencies, payroll processing, completing documentation of desk procedures, staff turnover, reviews of contractor performance, and documentation of delivered contractor services.

The Internal Audit Department is appreciative of the cooperation and assistance provided by the Director, management and staff during the course of this audit.

M. A. Duran

Milton A. Duran
Director of Internal Audit

cc: Internal Audit Committee
Board of County Commissioners

TYPE III MATERIAL FINDINGS

FINDING #1 – INTERNAL CONTROL ISSUES

1. Policies and Procedures

a. There are no written policies and procedures for the DWI staff to administer department activities.

Status: Corrective action completed. Written policies and procedures are now documented and in effect. Employees have been trained and procedures are being followed and management monitors performance.

b. The Indigent Health Care staff needs current operating guides for daily use. There is no evidence that staff training is held on a regular basis.

Status: Operating guidelines and policies have been prepared. There is no evidence that staff training is held on a regular basis. Additionally, Service Providers claim that the lack of training for their staff leads to inconsistencies.

1b. Recommendations for Policies and Procedures

It is recommended staff training should be recurring, consistent, and documented to ensure compliance with stated policies. In addition, health services providers who perform these services must also be provided consistent and documented training.

1b. Management response by S. Sierra, Director, Jamie Michaels, Manager, Department Manager.

There were seven (7) I-reach system training classes provided to HHS and other agency staff members in 2009 and more is planned.

The Board of County Commissioners approved a resolution in December 2009 that provided guidance for the program. As a result, HHS staff can begin coordinating the training opportunities. Initial discussion has been conducted with the I-reach Administrator to provide training, develop standard operating procedures, and create a user manual for the providers. These will be based on the resolution approved by the Board.

2. Procurement Procedures

a. The scopes of service in contracts do not clearly identify responsibilities of each party.

Status: Corrective action taken. Scope of services is drafted by HHS personnel and reviewed by the Contract Administrator and Purchasing department prior to issuing the final contract for signatures.

b. Required procurement process circumvented in a case where a disbursement was made prior to approval of the purchase order.

Status: Corrective actions have been completed. All contracts are now reviewed by the Purchasing Department. A checklist verifying that supporting documents are properly completed and signed is now maintained in the contract file. Vender services cannot begin until the contract is signed by the County Manager.

3. Payroll Policies

Original Finding: Time sheets are self prepared and entered without independent review and verification. There is no process in place to verify hours worked by all employees.

Status: Corrective actions in process. The department will participate in the installation of a county wide time Kronos timekeeping system that should address the department's unique needs.

3. Recommendations for Payroll Policies:

It is strongly recommended that the HHS Department be one of the county units identified for installation of the Kronos Timekeeping system. Until installation occurs, it is strongly recommended that careful oversight and supervision of the interim process continue.

3. Management Responses for Payroll Policies by S. Sierra, Director:

HHS staff members developed a policy and procedure for time reporting using the current paper time sheets. Supervisors are responsible for tracking employees' presence and verifying their time sheets. After reviewing time sheets and monitoring staff, supervisors are aware of their staff members' work time.

The department is one of the areas scheduled for the Kronos time keeping system implementation and the equipment including the clock has been ordered. Once it is received, HHS staff will receive training and the new time reporting system will be implemented. Payroll based on the time clock system will improve accountability.

4. Fiscal Responsibility

a. The department provides internally prepared "invoices" on behalf of the supplier/ vendors.
Status: Corrective action completed. The department procedures have been amended to include the vendor's original invoice with supporting documentation received.

5. Entity Risk Assessment

a. Evidence of insurance binders in contracts was not documented.
Status: Corrective action completed. Purchasing department maintains a document checklist to monitor that certificates of insurance are received timely.

b. Staff background checks on staff members who perform community outreach functions with elderly persons, children and indigent persons are currently not a condition of employment. This poses an unmitigated risk to this service area.
Status: Corrective action in process. The HR department has contracted with an independent party to provide background checks on applicable employees. Background checks are documented.

FINDING #2 – OVERRIDE OF MANAGEMENT CONTROLS

A database analysis of processed claim transactions by the Indigent Health Care (IHC) showed excessive management overrides of required applicant document requirements to verify residency, income and other required information.

Status: Override authority is now limited to the Department Director. The I-Reach data system contains override controls and provides periodic reports for continuous monitoring.

Recurring instances were noted that applications for health services were approved for applicants who used another person's social security number, or presented incomplete documentation or other misleading information in support of an Indigent Health Care application. An additional six case files were noted "as approved" when policy required the applicant be denied. Policy provides that presentation of false information or misrepresentations by an applicant requires that the application be denied. These instances are the work product of the service providers. There is currently no method to verify accuracy of

tracking applications or claims processed by external agencies. These agencies independently approve applications unilaterally without County review. The IHC staff performed a limited review of applications and found a high error rate. Training was provided to agency staffs to reduce the error rate; however, the need for additional efforts is indicated.

In addition, during a walk through of the controlled document area on 11-24-09, HIPAA violations were noted. Several 'non-health care' employees have access to the area where medical files are maintained. Management should address HIPAA requirements and to avoid breaches of security and privacy conditions.

#2 Recommendations:

It is recommended that all claims and applications from other agencies be regularly reviewed and monitored by management. Continued notation of errors should be addressed by management with the provider agencies.

Senior management should address HIPAA issues and develop institutional expertise to monitor compliance with all security and privacy requirements. Segregation and security of health file could be achieved in part by physical segregation from DWI activities.

#2 Management responses by S. Sierra, Director:

There have been no overrides since the release of the first audit report. The recent resolution passed by the Board of County Commissioners will clarify the program requirements and allow the HHS Department to move forward with training for the providing agencies to further limit eligibility errors and inconsistencies.

Management is addressing HIPAA compliance. Most of these issues will be addressed with the implementation of the data management system that will store all documents electronically and in compliance with HIPAA. Removal and archiving of paper documents will be completed when the third party contractor assumes processing responsibilities.

FINDING #3 – INTERNAL MANAGEMENT ISSUES

a. Policies and procedures, organizational charts and directives to staff members related to their job function requirements are either not maintained or are not provided when required.

Status: Corrective action in process. The department has prepared documented and trained staff with the department policies and procedures. Desk top procedures for all individual jobs are currently in process of preparation.

b. Original finding. Staff turn-over is high in the department.
Current finding. Staff turnover continues high within the department.

#b Recommendations:

It is recommended the Department management determine the causes for staff turnover, and work with the Human Resources Department and other applicable areas to improve staff retention.

#b Management response by S. Sierra, Director

As of the first pay period in 2009 there were 42 staff members. A total 39 were regular positions and three were temporary positions. Of the 39, eight have left the county. After reviewing the exit interviews, resignation letters, and surveys, HHS management determined that people cited personal or family reasons such as career advancement or family priorities as the most common reason for leaving. HHS management has met with HR staff several times to review the department's turnover issues and discuss staff retention.

FINDING #4- CONTRACT COMPLIANCE AND ANNUAL EVALUATIONS

Original **finding** disclosed that contracts did not have adequate evidence of annual evaluations on proof of delivery.

Status: Corrective action completed. Proof of delivery documents are maintained in a locked storage area in the custody of the contract coordinators. Supporting documents are reviewed and approved prior to authorizing payment. Documents are stored by contractor name and contract name for easy retrieval and reference.

FINDING #5- PROOF OF DELIVERY OF SERVICES ISSUES

A review of selected invoices from contractors revealed lack of proof of required deliverables or poor forms of substantiation of delivery of services on monthly billings.

Status: A significant improvement was noted in the review and documentation process of expenditures. Some contractor invoice substantiations were not adequate to meet the requirements of the contract. Follow-up letters to contractors are often needed to obtain the requested documentation. A total of 27 disbursements to contractors were reviewed. Seven deficiencies (26%) were noted as exceptions.

#5 Recommendation: The increased scrutiny for the appropriate documentation of contractor deliverables has eliminated many of the poor previous practices, but close monitoring should continue. Repeated contractor deficiencies should be noted in the files for the annual review of performance or document cause for termination. It is recommended that the compliance review activities and personnel be transferred to the Finance/ Purchasing department. This will allow HHS to focus on delivery of services and will provide added segregation of duties and accountability for contract reviews and administration.

#5 Management response by S. Sierra, Director:

The seven deficiencies were isolated to three vendors over a two year period. Deficiencies related to first vendor included not invoicing within several months of the contract execution date. Deficiencies related to the second vendor also included not invoicing within several months after the contract execution date, and performance issues described in finding number seven. The third vendor has not requested or received formal approval for subcontracting in two instances.

In these cases, HHS staff members worked with the contractors to assist them in providing the appropriate documentation for billing. These vendors have since submitted appropriate invoices. The third contractor is submitting a formal request for subcontractors.

FINDING #6 – APPROPRIATE USE OF FUNDS

There were instances of potential inappropriate use of funds.

Status: Corrective action in process. The HHS and Finance Departments are developing policies on defining appropriate expenditures for grants and department operations related to travel expenses and staff meals. Procedures are in place in Finance to ensure compliance with final established policy.

FINDING #7- Lack of monitoring contractors performance

Contracts are often renewed without reviews on whether the contractor adequately performed the services. Evaluations of Contractor Performance are not completed. Additionally, the required 'Evidence of Services' contract section is not always completed to determine if substantial compliance has been met to merit contract renewals.

Status: Five (12%) of 42 contracts reviewed did not document appropriate performance reviews in prior year contracts to justify contract renewals and extensions. Additionally, a review of selected contracts identified that duplicate services or services previously purchased (and not delivered) were contracted again with the same contractor or in some cases with other contractors. Coordination of required services should be closely reviewed by management.

#7 Recommendation: -

It is recommended that management perform an annual review of the contractor on or before the expiration of the contract. New contracts and contract renewals should be executed timely. If performance is not acceptable, the contractor should be notified and required to fulfill requirements. Management controls should be established to coordinate services requirements and monitor for possible duplication of services.

#7 Management response by S. Sierra, Director:

The five contracts were isolated to two vendors over a two year period. There was a lack of documentation in the contract file for the first vendor. In this case the final documentation submitted by the vendor was not in the contract file but in the program coordinator's files. This document summarized site visits and included a concept document for the project. Additional contracts have been utilized to further develop the project and to operationalize the concept to begin planning and developing based on county resources. In another contract, this same vendor not only reported the number of people trained in the County but the total trained in the State. This contractor received funding from several different agencies to provide this training, and used the reports to demonstrate how local funds were leverage to increase capacity, although it was difficult to determine what funds were used for the local training. HHS staff will address this by revising the reporting format.

The second contract was funded by state funds not county. The HHS Department was a flow through for the State's Children Youth and Families Department. The HHS Department has and continues to meet the contractual requirements with the State through this contractor; in fact the amount of funds for the contractor's services has increased. This contract was a fixed price contract that states "the provider understands and agrees that performance must substantially meet pro-rata benchmarks and is subject to performance reviews throughout the contract period and that the outcomes of these reviews may result in recommendations for reduced funding and/or contract termination for failure to perform". The HHS Department staff and director determined that the provider substantially met the benchmarks. The

contract required 50 parents and 68 children to *graduate*, and the provider graduated 40 adults and 45 children. The contract required 65 families and 85 children to be *served*, and the provider served 81 families and 119 children.

HHS management will provide guidance to continually improve internal communication for coordinating services requested in contracts and monitoring contracts for possible duplication of services. In addition, the new contract format being used does not include the language allowing providers to substantially meet the benchmarks in a fixed price contract. Therefore, performance monitoring will be more defined.

FINDING #8- Lack of staff training, lack of equipment, resources or reference materials

Through inquiry and observations, it was noted that staff does not maintain a current set of State requirements for reference by staff and clients. The DWI Grant requires that the department meets all current requirements and regulations.

Status: Corrective action completed. The DWI department has received appropriate authority to acquire equipment to meet its compliance with program regulations.

FINDING #9- Financial reporting or document deficiency

1. Periodic reviews of approved access to computer systems and Banner are not reviewed and approved by the Department Head. Changes to varying levels of authority delegated to employees should be maintained in a current condition with the IT Department.

Status: Corrective action completed. Procedures now in place with the IT personnel to regularly monitor access authorizations and ensure controlled appropriate changes.

2. Several quarterly grant reports were not reconciled to general ledger.

Status: Corrective action completed. Procedures now in place with the Finance specialist in the department to ensure reconciliations are complete and documented prior to release of reports. Checklists are used to properly document review and approval of grant reports.