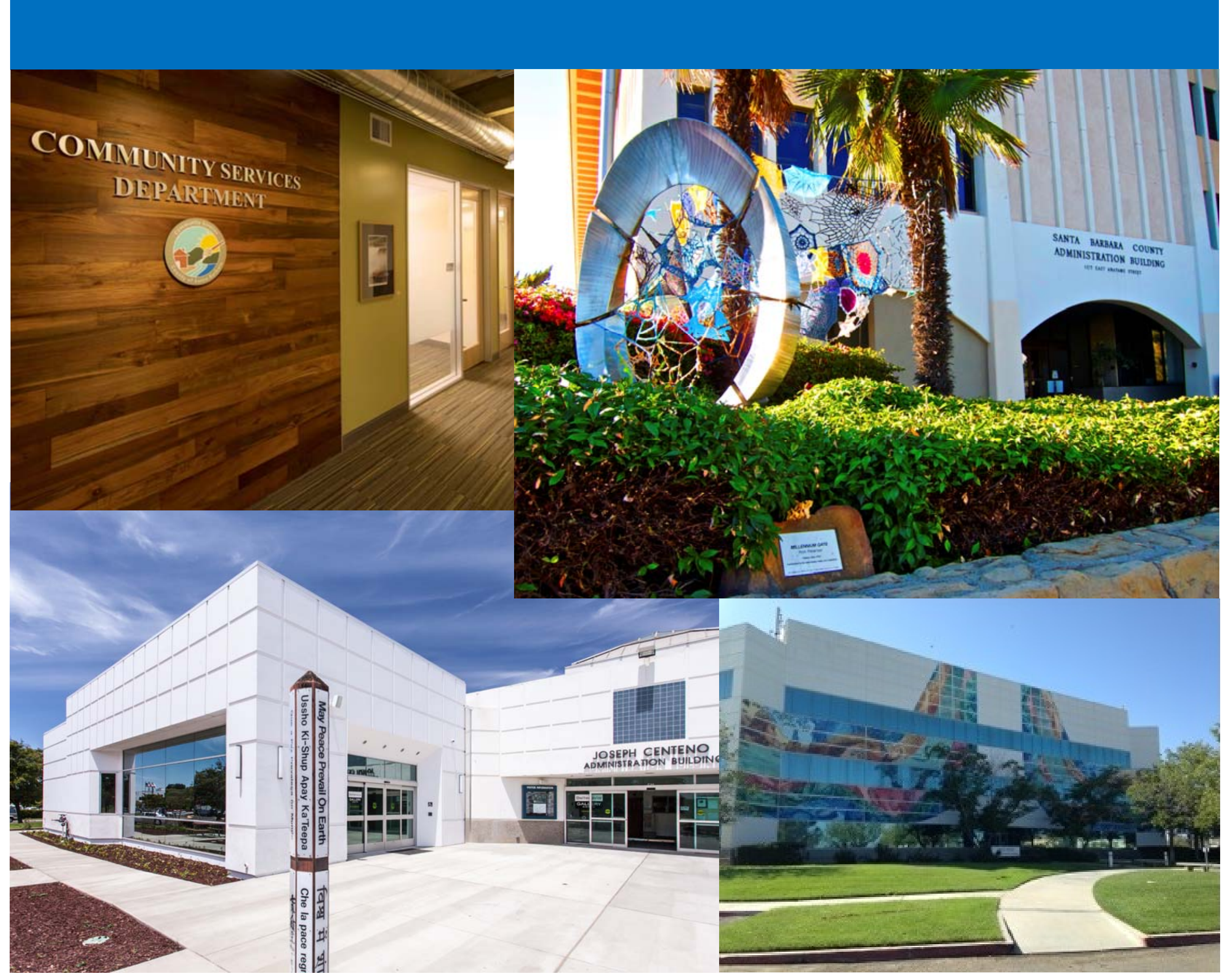

External Monitoring Reports

of County Departments, Performed by State, Federal, and Other Outside Agencies

July 1, 2015—June 30, 2016

COUNTY OF SANTA BARBARA CALIFORNIA

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Department External Monitoring

The County as a whole, and specific County Departments, are subject to monitoring by various external agencies. The majority of monitoring is performed to ensure that State and Federal funds awarded to the County are spent in accordance with certain laws and regulations. Instances of non-compliance may result in 1) a requirement to give funds back to the funding agency, 2) reduced funding in future years, and/or 3) higher monitoring costs.

Monitoring can occur on different levels such as an audit, review, or specific procedures performed on certain processes. Additionally, monitoring periods may vary (i.e. annually, quarterly, or on a one-time basis).

The Auditor-Controller requests that all monitorings performed over County departments are reported to the Auditor-Controller's office. This report presents information on monitoring reports received by the departments during fiscal year 2015-16. Any reports that were presented to the County Board of Supervisors separately, such as the Comprehensive Annual Financial Report and the Single Audit Report, are not included in this report. We have not evaluated the Departments' responses regarding their corrective action.

Risks are assigned to each of the programs based upon monitoring results. The color coding indicates the following:

Red: Potential for large dollar amount of error or loss, significant lack of monitoring or breakdown in compliance, or wide-spread violation of law.

Yellow: Potential for moderate dollar amount of error or loss, some violation of policy, other compensating procedures may exist to correct issue. When an audit report indicates that a breakdown in compliance occurred, risk will be assessed at yellow. Non adherence to policies and procedures, lack of self-monitoring, and a possible future loss of outside funding due to non-compliance will also be assessed at yellow.

Green: Low dollar amount of error or loss, other compensating procedures exist, or minimal program impact.

A listing of all external monitorings assessed as Green is included on the next page. The remaining pages present department specific monitorings assessed as Red and Yellow and list recommendations made by the external agency and the corrective action taken by the department.

Department External Monitoring

List of Low-Risk (**Green**) Reports

The following County departments had the following program monitorings that either had no findings or findings with little or no dollar amounts of error or loss, strong existing compensating procedures, or findings with minimal program impact:

Department	Programs Monitored	Monitoring Agency
Auditor-Controller	Cost Allocation Plan 2016-17	CA State Controller
Auditor-Controller	Property Tax Apportionment and Allocation System Audit	CA State Controller
Behavioral Wellness	External Quality Review Organization Review 2015-16	U.S. Dept. of Health & Human Services
CEO	General Liability Claims Audit	Risk Management Services
CEO	Emergency Operations Center- Refugio Oil Spill	Santa Barbara County Grand Jury
Human Resources	Controlled Substance and Alcohol Testing	CA Highway Patrol
Probation	California Law Enforcement Telecommunications System	Department of Justice
Public Health	Medicare Cost Report Settlement FY 2013-14	National Government Services
Public Health	Medicare Cost Report Settlement FY 2014-15	National Government Services
Public Health	Health Center Medi-Cal Reconciliation	CA Dept. of Health Care Services
Public Health	Maternal, Child and Adolescent Health Program Contract Audit	CA Dept. of Health Care Services
Public Health	Women, Infants and Children Program Review	CA State Controller
Public Health	Ryan White Part B On-site Monitoring	CA Dept. of Public Health
Public Health	Nutrition Education and Obesity Prevention Annual Review	CA Dept. of Public Health
Public Works	Transportation Development Act Fund Audit	Moss Levy CPAs
Public Works	Public Transit Fund Audit	Moss Levy CPAs
Social Services	IHSS Medi-Cal Eligibility Data System	CA Dept. of Social Services

Behavioral Wellness

Behavioral Wellness had six monitorings performed by the State. The monitorings included two External Quality Review Organization (EQRO) reviews for fiscal years 2014-15 and 2015-16, two Psychiatric Health Facility (PHF) Medicare surveys, a PHF inpatient review, and an audit of Good Samaritan Shelter Inc. (GSSI) cost report. The 2015-16 EQRO is presented on page two. The remaining monitorings are presented below.

Program	Risk	Rationale
GSSI Audit		Moderate dollar amount of questioned costs
EQRO Review 2014-15		Failure to follow policies & procedures
PHF Medicare Survey 9/2015		Breakdown in compliance
PHF Medicare Survey 6/2016		Breakdown in compliance
PHF Inpatient Review		Breakdown in compliance

Purpose of Monitoring

1. GSSI Audit: Ensure that cost reports as settled reconcile to GSSI's cost report and related financial records, that a proper accounting system and related documentation were maintained to support reported revenues and expenses, and that reported costs were allowable for the fiscal period ended June 30, 2012.
2. EQRO Review: Annual system and quality review of Behavioral Wellness' Mental Health Plan (MHP).
3. PHF Medicare Survey 9/2015: Survey was to verify compliance with Federal regulations for Psychiatric Health Facilities.
4. PHF Medicare Survey 6/2016: Survey was to verify compliance with Federal regulations for Psychiatric Health Facilities.
5. PHF Inpatient Review: Ensure the county-owned and operated Short-Doyle/Medi-Cal funded programs complied with State and Federal laws and regulations for the Medi-Cal program from January 1, 2015 through March 31, 2015.

Findings

1. GSSI Audit: An overpayment of $87,515 by the County to GSSI was a result of an improper basis of allocation used to allocate cost. Additionally, GSSI could not accurately identify indirect costs allocated to its various programs.
2. EQRO Review: The review showed improvements from prior years. However, five out of the seven prior year findings were only partially addressed.

Additional monitorings on next page.

Findings (continued)

3. PHF Medicare Survey 9/2015: The Director of Nursing does not have a Master's degree in psychiatric or mental health nursing. The facility failed to provide the following:
   i. Medical records containing the determination of the degree and intensity of the treatment.
   ii. Master Treatment Plans that identified patient related short-term goals in observable and measurable terms as well as plans that identified staff interventions to address treatment needs.
   iii. Active individualized treatment for two of eight active sample patients who required alternative treatments.
4. PHF Medicare Survey 6/2016: The survey showed the hospital failed to ensure the safety of its patients and properly document, safeguard, and administer drugs as specified in the policies and procedures. The survey included 44 findings. For brevity we have presented a few of the findings included as follows:
   i. Hospital staff used a "single patient use only" glucometer device on multiple patients, putting each patient at risk of infection from blood borne pathogens.
   ii. The facility incorrectly administered duplicative doses of pain relief medication or administered correct medication in an untimely manner.
   iii. Medications found inside the drug room were undocumented.
   iv. The facility failed to ensure that unauthorized personnel did not have access to the hospital drug storage area. One surveyor found a janitor who was unauthorized in the drug storage room alone.
5. PHF Inpatient Review: $221,790 due to the State for disallowed acute and administrative days.

Corrective Action Taken

1. GSSI Audit: The Department added a cost allocation worksheet as a required element of the annual cost report submission process. This worksheet allows for a simple, uniform way to evaluate the allocation basis that the provider has used versus the acceptable State standard basis. Using this required worksheet as a benchmark for allowable cost allocation method allows the Department to evaluate the appropriateness of the allocation basis used by the provider.
2. EQRO Review: The objectives were accomplished by the fiscal year 2015-16 EQRO review.
3. PHF Medicare Survey 9/2015: The Department implemented and trained staff on a patient engagement tool which allows patients to choose from a menu of services offered. The Director of Nursing and the Director of Social Services will audit interdisciplinary treatment plans to verify treatment modalities are specific and individualized.

Additional monitorings on next page.

Corrective Action Taken (continued)

4. PHF Medicare Survey 6/2016:
    i. The facility purchased a new hospital-grade multi-user glucometer device. A cleaning and disinfectant guide, entitled "Cleaning of Glucometers" is available in the medication room. The multi-use glucometer device is cleaned with Sani cloth wipes in accordance with manufacturer instructions after use on each patient. Compliance with cleaning/disinfecting multi-use glucometer devices is monitored through the Quality Assessment and Performance Improvement (QAPI) program.
    ii. A national healthcare regulatory compliance consulting firm developed the "Pro Re Nata (PRN) Medication Policy", which specifies indications to prevent therapeutic duplication when it is unnecessary. The Nursing Supervisor discussed the survey findings with the contracted pharmacy with special emphasis on the expectation that medication will be delivered timely. The Nursing Supervisor also discussed the survey finding with nursing staff with special emphasis on notifying leadership and the physician if unable to obtain mediations. Compliance with medication administration is monitored through the QAPI program.
    iii. The PHF implemented a newly structured QAPI Program after engaging a national healthcare regulatory compliance consulting firm. One quality indicator is controlled substance storage and management.
    iv. Policy was reviewed and revised to include janitorial staff as those staff members authorized to access the medication storage area. All controlled substances are locked and not accessible.
5. PHF Inpatient Review: A follow up review was performed and found that County was in compliance with the required Federal regulations (42 CFR §482.61 Special Medical Records and 42 CFR §482.62 Special Staff Requirements). Additionally, the findings in the Statement of Deficiencies were reduced to two items.

Public Health

Public Health had eight State monitorings which included two Medicare cost report settlements for fiscal years 2013-14 and 2014-15, a federally qualified health center (FQHC) Medi-Cal reconciliation for fiscal year 2011-12 for the Santa Maria Women's center, a Maternal, Child, and Adolescent Health program contract audit, a Women, Infants, and Children program review, a Ryan White Part B review, and a Nutrition Education and Obesity Prevention annual review. All of these monitorings are presented on page two. Public Health also received an additional FQHC Medi-Cal reconciliation for the Santa Barbara County Health Centers for fiscal year 2011-12 which is presented below.

Program	Risk	Rationale
FQHC SB Health Centers		Moderate dollar amount of questioned costs

Purpose of Monitoring

To review and reconcile the annual Medi-Cal prospective payment system settlement for all visits previously paid on an interim basis for Medi-Cal beneficiaries.

Findings

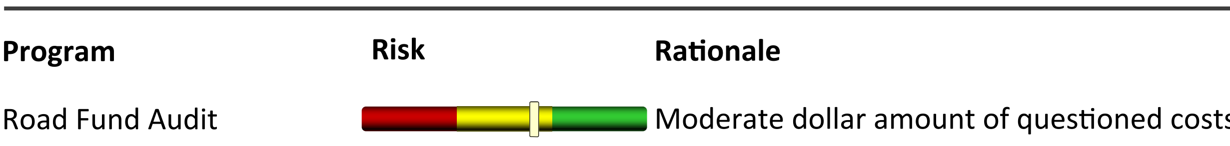
$444,174 due to the State for payments made to the clinic as a result of the FQHC Prospective Payment (PPS) being set too high. Due to the implementation of the Health Center Electronic Health Record, the PPS rate was set for a visit volume for fiscal year 2011-12 that was not achieved because of the learning curve associated with the new system. Interim payments were set at a historical standard that was not reached for that fiscal year.

Corrective Action Taken

The Department reimbursed the State $444,174. Although no further corrective action was required relative to the settlement, Public Health worked closely with staff and providers to train and make system and workflow changes to its practice to increase patient visit volume and no further future reconciliation settlements have occurred.

Public Works

Public Works had three monitorings which included two audits performed on the Public Transit and Transportation Development Act funds for fiscal years ended June 30, 2014 and 2015 which are presented on page 2. The third audit was performed on the Road Fund.



Program	Risk	Rationale
Road Fund Audit		Moderate dollar amount of questioned costs

Purpose of Monitoring

To determine whether the department accounted for and expended its Road Fund money in compliance with Article XIX of the California Constitution, the Streets and Highways Code, and the State Controller's Office Accounting Standards and Procedures for Counties manual from July 1, 2004 through June 30, 2013.

Findings

The department charged the Road Fund $136,700 for negative interest during fiscal years 2004-05, 2005-06, 2007-08. Negative interest charges are not considered road or road-related expenditures.

Corrective Action Taken

The Department reimbursed the Road Fund with the reduction of General Fund contributions for the negative interest in April 2016.

Sheriff

The Sheriff had one monitoring of the Santa Barbara County Jail intake screening process performed by the Santa Barbara County Grand Jury.

Program	Risk	Rationale
Intake Screening		Failure to follow policies and procedures

Purpose of Monitoring
To determine whether the Santa Barbara County Jail (Jail) is operating within the scope of California Code of Regulations Title 15 and the Santa Barbara Sheriff's Office Custody Operations Policy and Procedures Manual as of June 2016.

Findings
The audit report identified the following findings:

- Department staff has not always confirmed arrestees were medically cleared by Corizon Health staff prior to classification and placement into the Jail population.
- Department staff did not follow procedures, policies, and protocols pertaining to the intake process of arrestees.
- The department does not have adequate oversight methods in place for ensuring Corizon Health staff are following their medical intake procedures.
- The department is using an antiquated paper system for maintaining inmate medical records.
- The Medical Process Overview Chart does not reflect changes in the administration of the medical intake prescreening questionnaire.
- Revisions are needed to the department's Custody Operations Policy and Procedures Manual.

Corrective Action Taken
The Department continues to use Corizon Health registered nurses to conduct all medical intake screening of arrestees and will include this provision in all future contracts. The Department also updated their Custody Operations Policy and Procedures Manual to include details on the classification process.

Social Services

The Department of Social Services (DSS) had 28 State monitorings performed. Four Medi-Cal Eligibility Data System monitorings were performed from October 2015—May 2016 and are presented on page two. The State also performed monitorings on the following programs: In Home Supportive Services (IHSS), Supplemental Nutrition Assistance Program (SNAP), Workforce Investment Act (WIA). *To improve readability, the purpose of monitoring, findings, and corrective action sections are combined by program.*

Program	Risk	Rationale
IHSS		Breakdown in compliance; failure to follow policies & procedures
SNAP		Breakdown in compliance; failure to follow policies & procedures
WIA		Breakdown in compliance; failure to follow policies & procedures

In-Home Supportive Services (IHSS):

Quality Assurance Review: Reviewed the IHSS Quality Assurance program and needs assessment process as of October 2015. The review found multiple instances of unclear, missing, or error in documentation as further detailed below.

- Unclear or missing documentation of the Hourly Task Guidelines (HTG) (assessment and calculation of hours for each authorized service) in 15 of the 41 cases reviewed.
- There are 25 potential HTG exceptions depending on the client's need. If exceptions apply, documentation is needed to support the reason authorized hours do not fall within the HTG. Of the 198 instances where exception language was required, 50 instances were identified where HTG exceptions should have been better documented.

Corrective Action Taken:

A workgroup consisting of Quality Assurance, Department Business Specialists, supervisors and social workers was formed to develop a documentation tool. The documentation tool will assist the social workers to more fully document the individual tasks in order to meet CDSS guidelines. The documentation tool is being finalized and will be implemented soon.

CalFresh (SNAP):

Case Approval and Denial Reviews: Reviews evaluate if benefits were approved or denied correctly for each month from March 2015 through March 2016. Out of 21 reviews, there were two over payments of benefits (one due to the client's failure to provide correct information). There was also one case where DSS prematurely denied benefits, and one case where DSS discontinued benefits without timely notifying the participant.

Corrective Action Taken:

Immediate steps were taken to correct the budgeting and recoup the two over issuances. Staff was reminded of the importance of timely notification and processing of period reports at Team meetings attended by supervisors, lead workers, Department Business Specialists and management.

Additional monitorings on next page.

Workforce Investment Act (WIA):

WIA Youth Program Fiscal and Procurement Review: Determines the level of compliance with applicable Federal and State laws, regulations, policies, and directives related to the WIA Youth grant regarding financial management and procurement. There was one review conducted, which covered fiscal year 2014-2015. The area of non-compliance identified during the review was that the County does not have a signed Resource Sharing Agreement in place between the Workforce Service Center in Santa Maria and the Employment Development Department for the current period. The State found that overall, the County is meeting applicable WIA requirements.

Corrective Action Taken: The County was in the midst of lengthy negotiation in attempt to procure a Resource Sharing Agreement during the review. Since the monitoring report date the Department has entered into a Resource Sharing Agreement with the Employment Development Department.

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