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An Audit Report on Management Controls at the Dallas County Community Mental Health and Mental Retardation Center

November 1997

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Key Points of Report

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Overall Conclusion

Major managerial deficiencies exist in the Dallas County Community Mental Health Mental Retardation Center (Center). These deficiencies include the Board of Trustees' (Board) tendency to micromanage the operations of the Center and the staff's tendency to ignore established policies and procedures. Collectively, these deficiencies reduce the Center's ability to safeguard its assets and ensure its goals and objectives will be fully accomplished. Its budgeted revenues for fiscal year 1997 totaled $74 million, including $34.2 million in state general revenue funds.

Key Facts and Findings

- The actions of the Board have detracted from the effective and efficient accomplishment of the Center's goals and objectives. The Board periodically abandoned its oversight role to perform functions normally conducted by Center management.

- The Center has not effectively used its Internal Auditor to reduce the risk that errors or irregularities could occur without detection.

- The Center does not routinely follow its established policies and procedures, and there are several significant areas where policies and procedures have yet to be developed. The Center has overbilled consumer trust funds or Medicaid for applied income and rent and it has deposited Medicaid payments for clients no longer with the Center due in part to inadequate policies and procedures.

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Office of the State Auditor

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This financial and compliance audit was conducted in accordance with the General Appropriations Act, 75th Legislature, Article II, Section 73, Rider 33.

Executive Summary

Major deficiencies exist in the Dallas County Community Mental Health and Mental Retardation Center's (Center) design or implementation of management controls in several areas. These deficiencies include the Board of Trustees' tendency to micromanage the operations of the Center and the staff's tendency to ignore established policies and procedures. Collectively, these deficiencies reduce the Center's ability to safeguard assets and ensure its goals and objectives will be fully accomplished. In fiscal year 1997, the Center reported total revenues of $74 million, including $34.2 million in state general revenue funds.

Improve Board Oversight and Internal Audit Functions

The actions of the Center's Board of Trustees (Board) have detracted from the effective and efficient accomplishment of the Center's goals and objectives. The Board has periodically abandoned its oversight role to perform functions normally conducted by management, jeopardizing the Board's effectiveness. This could lead to control environment weaknesses, like the reportable condition and the material weaknesses noted by an independent auditor in the Center's fiscal year 1996 audit.

The relationships established between the Board, advocacy groups, and Center staff members have not promoted a spirit of cooperation that ensures optimal service delivery for consumers. Without good and positive relationships, the exchange of ideas and information and the public relations image of the Center may suffer. A concurrent review by the Texas Department of Mental Health and Mental Retardation's Quality Management Division raised similar issues. (See Appendix 2.)

The Center has not used its internal audit function effectively, which increases the risk that material errors and irregularities may occur and not be detected in a timely manner by management. Also, the Internal Auditor is not in compliance with the *Standards for the Professional Practice of Internal Auditing*. Internal audits are an important tool to reduce risk through evaluation of key control systems.

Develop Policies and Procedures and Ensure That They Are Followed

Policies and procedures related to client trust funds, applied income and rent, and Medicaid payments either did not exist or were not being followed, resulting in overpayments to the Center. Documentation to support withdrawals from some consumer trust funds was incomplete. In addition, the Center did not maintain individual consumer accounts receivable ledgers so it was unable to determine what consumers owed the Center on a monthly basis. Collections from consumers were made sporadically and were often incorrect. For example, some consumers were double-billed and over-billed for applied income and rent. In other cases, the Center did not collect the rent to which it was entitled. Medicaid payments were deposited for consumers who were no longer at the Center. Also, Medicaid and applied income payments collected by the Center sometimes exceeded the established vendor rate. The Texas Department of Mental Health and Mental Retardation will issue separate reports covering the audit work it performed.

The Center did not effectively use or analyze available information to support the decisions

regarding the purchase of two major real estate acquisitions totaling $2.5 million. The purchases will end up costing the Center approximately $770,840. Additionally, sufficient funding to complete the upgrades at the River Bend facility may be unavailable.

The anticipated upgrade costs at the time of purchase for these two acquisitions totaled $195,000. However, as a result of insufficient cost evaluation reports, the total upgrade costs incurred to date, plus the anticipated future upgrade costs to be incurred by the Center, are estimated at $965,840 or a 400 percent increase over anticipated upgrade costs.

Improve Management of Human Resources

Management controls in the Human Resources Division are poor. Performance evaluations, which are critical to providing feedback to staff on job performance, were eliminated by the last Chief Executive Officer. Without performance evaluations, staff members do not receive formal feedback on their job performance and may not perform in an optimal manner to reach the Center's goals.

Center staff members do not always attend required training, and management has no means of tracking compliance. The Texas Department of Mental Health and Mental Retardation's Quality Management Review survey team found that some staff members in service delivery positions have not learned or retained some of the basic principles of internal and external customer service. (See Appendix 2.)

Important information and documents required by laws, regulations, and policies are not included in either the personnel files or separate files. (Separate files contain information that is not kept in personnel files for confidentiality reasons.) Some personnel files are missing documentation to support staff members' credentials, qualifications and other employability factors such as driving records and criminal background checks. This information directly affects the quality and safety of services provided to consumers.

Also, in some cases inappropriate information has been included in personnel files. These conditions could potentially expose the Center to litigation. Currently, there is no follow-up check routinely performed to help ensure that personnel files are complete and that inappropriate information is removed.

Other Areas Need Improvement

The Center needs to correct unresolved issues from a 1996 external audit. Also, improvements are needed in the contract management process and the consumer billing system.

Summary of Responses

The Center's Board and management generally agree with the recommendations. Their responses can be found following each recommendation.

Summary of Audit Objective and Scope

The audit's objectives were to evaluate management control systems within the Center, including its management of resources, and to identify its strengths and opportunities for improvement.

The scope of this audit included consideration of the Center's overall management control systems.

Section 1:

Improve the Board Oversight and Internal Audit Functions

The actions of the Dallas County Community Mental Health and Mental Retardation Center's Board of Trustees have detracted from the effective and efficient accomplishment of the Center's goals and objectives. The Board periodically abandoned its oversight role to perform functions normally conducted by Center's management.

The relationships established between the Board of Trustees, advocacy groups, and Center staff members have not promoted a spirit of cooperation that ensures optimal service delivery for consumers. A concurrent review by the Texas Department of Mental Health and Mental Retardation's Quality Management Division raised similar issues. (See Appendix 2.)

Additionally, the Center has not effectively used its Internal Auditor to reduce the risk that errors or irregularities could occur without detection. An effective internal audit function can greatly assist the Board of Trustees and the management of the Center in helping to ensure that established controls are operating as intended.

Section 1-A:

Ensure the Board Maintains an Appropriate Relationship With Center Staff

The Board has periodically become involved in the daily functions of the Center rather than participating in its normal capacity as an oversight body, which could render the staff ineffectual on a day-to-day basis. This could lead to control environment weaknesses, like the reportable condition and the material weaknesses noted in the Center's fiscal year 1996 audit.

Eighty percent of the Board members interviewed indicated that the Board has had difficulty maintaining the separation between its role and the role of Center staff. Fifty percent of the Board members interviewed did not think the Board's oversight of the Center was effective; they thought the Board tended to micromanage the Center. Over 60 percent of the staff members and 80 percent of the advocates interviewed also believed that the Board micromanaged the Center.

High turnover in the leadership of the Center led to the Board's micromanagement. This condition of micromanagement did not develop from any one specific action, but rather from a history of actions taken by the Board and by poorly managed Board meetings. Figure 1 on the next page illustrates some examples of the Board's activities that appear more operational in nature

and are indicators of micromanagement by the Board:

Figure 1

Examples of the Board's Operational Activities	
September 4, 1996	The Board passed a motion that all job descriptions for each position contained in the Center's Exempt Organizational Plan must be approved by the Board.
September 25, 1996	The Board approved job descriptions for 14 positions in the Center's Exempt Organization Plan.
October 23, 1996	The Board approved changes to the Center's Exempt Organizational Plan.
March 26, 1997	By approving mid year budget revisions, the Board effectively acknowledged that this short term "band-aid" for balancing the deficit in Adult Mental Health resulted from a lack of long-range planning.
May 10, 1997	A reorganization chart, collectively prepared by three Board members, was submitted as a proposal for reducing administrative overhead.
June 25, 1997	Board approval was required for accelerating the implementation schedule of new software products.
June 25, 1997	A Board member wanted staff to track administrative time because of the high administrative overhead.

Source: Board minutes and Board meeting audio tapes

One of the primary duties of the Board of Trustees is to select and support the most qualified Chief Executive Officer to manage the Center. While the Board is responsible for setting broad policy direction, the day-to-day operations of the Center are the Chief Executive Officer's responsibility.

Recommendation:

The members of the Board of Trustees should distance themselves from operational issues and provide the Chief Executive Officer with the support and latitude needed to effectively manage the Center's daily activities.

Board of Trustees' Response:

See section 1-B for combined response to section 1-A and 1-B.

Section 1-B:

Improve Relationship Between the Board, Center Staff, and Advocacy Groups

Relationships between the Board and advocacy groups and between the Board and Center staff are not always positive. Without positive relationships, the exchange of ideas and information and the public relations image of the Center may suffer. Thirty percent of Board members, 60 percent of staff members, and 80 percent of advocates interviewed believe that the relationship between the Board and advocacy groups is not a positive one. Sixty percent of staff and all of the advocates interviewed believed the relationship between Center staff and the Board was not positive, although none of the Board members believed this to be true. Also, 80 percent of the advocates interviewed indicated that the Board intimidates them during Board meetings and does not provide a supportive atmosphere for consumers.

In reviewing transcripts and tapes of Board meetings we noted a number of indicators of the Board of Trustees' poor relationships, including the following:

- August 7, 1996 - A Board member wanted the record to reflect that he was out of the room when the Commissioner of the Texas Department of Mental Health and Mental Retardation made statements about the new budget because the Board Chair asked him not to make comments that might embarrass the Commissioner. The Chair promised that the fiasco of demoralizing staff and community members would not be tolerated again.

- February 14, 1997 - The Commissioner appeared before the Board because for several months, he had heard from staff, legislators, and advocates about their inability to penetrate the Board.

  One Board member indicated unawareness of any specific problems with advocates and had only heard vague comments about what the Board had done. The Board member did not know what the advocates were complaining about.

  The Commissioner indicated the advocates were concerned that the hostile environment surrounding Board meetings made advocates and consumers feel threatened. The advocates were also concerned that they would run the risk of attack if they spoke their minds. In addition, they were concerned that Center staff members were regularly exposed

to public humiliation or ridicule for not being prepared or not having good answers.

The Commissioner was also concerned that the Board had stepped beyond the policy role into operational issues, rendering the Center's staff ineffectual on a day-to-day basis. He also indicated that key staff members felt paralyzed because they believed the Board would attack them in public.

- February 26, 1997 - A Board member motioned to approve a three-month Parent Advocate contract with an advocacy group, which had become a very sensitive issue, and then voted "no" on the same motion.

Poor relationships are not conducive to the meaningful exchange of information necessary for the Board to make important policy decisions. Additionally, one responsibility of the Board is to enhance the organization's public image. Often the Board is the main contact that constituents, the public, and the media have with the Center. Perceptions that the Board does not have good relationships with advocates, consumers, and Center staff detract from the Center's accomplishments and do not give the Center a positive public image.

Recommendation:

Enhance the Center's public image by consistently building positive and effective relationships with advocates, consumers, and all persons interested in the Center. Additionally, conduct all Board and committee meetings in a way that opens channels of communication and preserves the honor and dignity of all persons involved.

Board of Trustees' Response:

The Board of Trustees of Dallas County MHMR Center wishes to express its appreciation to the Office of the State Auditor of the Great State of Texas for this opportunity to respond to the Board Oversight section of the Audit Report for our Center dated November 1997.

There has admittedly been a tumultuous relationship among the Board of Trustees, advocacy groups and Center staff during part of the period covered

by your audit. During this period there was substantial turnover in the Senior Management of the Center (Chief Executive Officer, Chief Financial Officer, Medical Director, etceteras) and the Center's independent auditors issued a management report citing material weakness in the financial function of the Center. The Board of Trustees during this period believed that it was necessary to become more involved in the management of the Center than would normally be the case and than is the case at the present time.

Since that period, the Senior Management Positions have all been filled, the Center is in substantial compliance with the Independent Auditor's recommendations and there has been a 55% turnover of Trustees. As a result of the turnover of Trustees, we believe that substantial progress has already been made and that there now exists a spirit of cooperation between the Board of Trustees, the advocacy groups and the Center staff, and that the present members of the Board of Trustees are very careful to promote that spirit of cooperation and to maintain the separation between the Board and Staff functions. As an example of the kind of cooperation we have reached, the Board recently took steps to revise Board Policy deleting the requirement that the Board approve the Chief Executive's organization chart. The Board will review other current policies to ensure the proper separation between governance and day to day operations.

Since a majority of Trustees have been appointed subsequent to the major problems cited in your report, we respectfully request that the State Auditor revisit this issue, interview Center staff, advocacy group members and Trustees and read minutes of recent meetings to understand the positive change that has taken place.

Section 1-C:

Improve the Internal Audit Function to Address Risks to the Center

The Center has not used its internal audit function effectively, which may increase the risk that material errors and irregularities will occur and not be detected in a timely manner by management. Also, the Internal Auditor is not in compliance with the *Standards for the Professional Practice of Internal Auditing*. Internal audits are an important tool to reduce risk through evaluation of key control systems.

The Center does not appear to have a good understanding of the internal audit function. For example, the current job description of the Internal Auditor states that the position will ensure internal control and that the Chief Executive

Officer will determine the specific operation to be audited or reviewed. Good business practices and the *Standards for the Professional Practice of Internal Auditing* dictate that management is responsible for internal controls and that the subject of audits should be based on an assessment of risks by the Internal Auditor with input from Board members and management.

Further evidence of the need for an effective internal audit function can be found by reviewing the large number and serious nature of management letter findings from the Center's fiscal year 1996 audit. The independent auditor reported that the internal control environment hinders the consistent production of reliable and timely financial information, which constitutes a reportable condition for a material weakness. Also, as described in Section 2 of this report, we noted during the course of this audit a number of policies and procedures that were not being followed. With an effective internal audit function many of these issues could have been identified and reported to management for corrective action before being noted in an external audit.

Other instances of noncompliance with the *Standards for the Professional Practice of Internal Auditing* include:

- The Internal Auditor has not prepared signed written audit reports documenting audit results.
- The Internal Auditor does not report to the Board of Trustees.
- The fiscal year 1997 audit plan will not be completed, and auditor independence is questionable because the Internal Auditor has been assigned operational duties in the Accounting Department.
- Policies and procedures for the internal audit function do not exist.

Recommendations:

The Board of Trustees and management should review the concepts of internal auditing in order to develop an understanding of the role of the Internal Auditor. The Board should become more actively involved with the internal audit function. One suggestion is to establish an audit committee to meet periodically with the Internal Auditor. At these meetings, Board members could provide input into the risk assessment process, approve the audit plan, review the progress of the Internal Auditor in addressing the audit plan, approve significant deviations from the plan, and evaluate the Internal Auditor's performance.

The job description for the Internal Auditor should be revised. Center management should accept responsibility for establishing and maintaining an effective system of internal control. The Internal Auditor should be responsible for periodically testing the controls management has established.

Management should promote and support the Internal Auditor's development and adherence to policies and procedures that help ensure compliance with the *Standards for the Professional Practice of Internal Auditing*. The policies and procedures should include developing an audit plan based on risk, preparing signed written reports, and providing for the organizational independence of the Internal Auditor.

Management's Response:

Administratively, the Internal Audit function reports to the CFO. Both the CFO and the CEO have issued a memorandum to the Internal Auditor stating that he/she has unrestricted access to the Board of Trustees to report on any findings deemed necessary. The Internal Auditor routinely attends all Board meetings, and will also attend meetings of the Board's Business and Finance Committee.

In order to increase the effectiveness of the Internal Audit function, Policies and Procedures will be developed outlining Internal Audit's purpose, scope, authority, responsibility, and organizational independence in accordance with the Standards for the Professional Practice of Internal Auditing. The Internal Auditor's job description will be reviewed and revised.

To ensure that necessary actions are taken to address internal controls and relative risks associated with achieving the Agency's management objectives, an Audit Committee will be established by the Board of Trustees. The Audit Committee will meet with the Internal Auditor periodically to review the audit plan, review the progress in addressing the audit issues and risks identified in the plan, discuss findings and implementation of corrective actions, and evaluate the Auditors performance. Formal signed audit reports will be presented to the Audit Committee documenting audit findings and recommendations for improvement.

Timetable for Implementation:

By January 1, 1998

Implementation and Monitoring to be performed by:

CEO, CFO, Board of Trustees

Section 2:

Develop Policies and Procedures and Ensure That They Are Followed

The Center does not routinely follow its established policies and procedures, and there are several significant areas where policies and procedures have yet to be developed. The Center has over-billed consumer trust funds or Medicaid for applied income and rent and it has deposited Medicaid payments for clients no longer with the Center due in part to inadequate policies and procedures.

(Please see Management's overall comment to Section 2 following the recommendation for Section 2-A.)

Section 2-A:

Develop and Enforce Policies and Procedures Related to the Management of Consumer Trust Funds, Applied Income and Rent, and Medicaid Payments

Policies and procedures related to client trust funds, applied income and rent, and Medicaid payments either did not exist or were not being followed, which resulted in overpayments to the Center. Documentation to support withdrawals from some consumer trust funds was incomplete. In one instance, the same copy of a cash register receipt was used with the date altered to make two withdrawals of $200 each. In addition, the Center has not maintained individual consumer accounts receivable ledgers, leaving it unable to determine what consumers owe the Center on a monthly basis. Collections from consumers are made sporadically and are often incorrect. For example, some consumers have been double-billed and over-billed for applied income and rent. In other cases, the Center has not collected the rent to which it is entitled. Medicaid payments have been deposited for consumers who are no longer at the Center. Also, Medicaid and applied income payments collected by the Center sometimes exceeded the established vendor rate.[1]

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[1] The Texas Department of Mental Health and Mental Retardation audited the billings, receivables, cash receipts, and cash disbursements for Consumer Trust Funds at eight Intermediate Care Facility for the Mentally Retarded group homes and the Home and Community-Based Services Program. It will issue separate reports covering each audit in the near future. For a completed copy of these reports contact the Management Audit Section of the Texas Department of Mental Health and Mental Retardation.

Recommendation:

Develop and enforce policies and procedures regarding accounting for consumer trust funds, applied income and rent, and Medicaid payments.

Management's Overall Comment to Section 2:

We are in the process of reviewing, developing and updating DCMHMR policies and procedures for Medicaid payments and Applied Income for consumers living in our ICF-MR facilities.

Timetable for implementation:

By January 1, 1998

Implementation and Monitoring to be performed by:

Director of MR services, Trust Fund Supervisor

Management's Response to Section 2-A:

We are reviewing DCMHMR's current policies and administrative procedure 4.01.05 governing the Trust Fund. During this process, we will review the policy and procedure for compliance with the performance contract with TXMHMR, and Generally Accepted Accounting Principles.

Currently, original documentation to support withdrawals is required before new check requests are processed for consumers. Checks have the consumer as the payee whenever possible and all major purchases require receipts. Policies and procedures are also being reviewed and updated regarding Applied Income; amended procedures will include reconciliation of consumer checking accounts, review of receipts documenting expenditures, and the determination of receivable balances.

Timetable for Implementation:

By February 1, 1998, Quarterly reviews.

Implementation and Monitoring to be performed by:

Internal Audit, Controller, Trust Fund Supervisor

Section 2-B:

Develop and Follow Policies and Procedures for Major Real Estate Acquisitions

The Center did not effectively use or analyze available information to support the decisions to purchase two major real estate acquisitions totaling $2.5 million. As a result, the Center will spend approximately $770,840 in unanticipated upgrade costs. Additionally, sufficient funding to complete the upgrades at the River Bend facility may be unavailable. The Center contracted to purchase the facilities at 4645 Samuell Boulevard on October 17, 1995, for a cost of $695,000, and to purchase the facilities at 1380 River Bend on March 25, 1996, for a cost of $1.86 million. The anticipated upgrade costs at the time of purchase for these two acquisitions totaled $195,000. However, as a result of insufficient cost evaluation reports, the total upgrade costs incurred to date, plus the anticipated future upgrade costs to be incurred by the Center, are estimated at $965,840 (a 400 percent increase over anticipated upgrade costs).

The cost evaluation reports prepared for the purpose of evaluating a purchase/lease decision for these acquisitions did not include present value computations, appropriate input from the Center's maintenance staff, or appropriate input from the Center's computer information system staff. Good management practices dictate the inclusion of appropriate evaluations on prospective real estate acquisitions by staff members or consultants prior to any purchase decision.

Recommendation:

Develop policies and procedures to guide staff in the purchase of major real estate acquisitions. A needs analysis and/or a cost benefit analysis should be performed prior to any major acquisition. The analysis should include formal input from the Center's staff and management and/or from outside consultants. The preparation of the analysis should be monitored and reviewed for completeness and appropriateness by a knowledgeable management committee.

Management's Response:

DCMHMR's current Board Policy and Administrative Procedure on Property/Facility Acquisition (3.03.01) provides for notification and approval for the acquisition of real property by TXMHMR and the Dallas County

Commissioners Court.

Key provisions of DCMHMR's Board Policy and Administrative Procedure on Property/Facility Acquisition (3.03.01) include documentation of the property search process, conditions under which property may be purchased, purchase records and documentation, notification of Dallas County Commissioners Court and TXMHMR, and TXMHMR approval process.

Although the Agency has no immediate plans to acquire additional real estate, the policy and procedure are currently being reviewed to incorporate a Needs Analysis which will included input from the Board of Trustees, center's management staff, outside appraisers, architects and engineers prior to any major acquisition.

The Agency is currently exploring the cost effectiveness of creating/budgeting a position for a Facility Manager to coordinate this process, including routine preventive maintenance and the adequacy of insurance coverage.

Timetable for Implementation:

By December 31, 1997

Implementation and Monitoring to be performed by:

Chief Executive Officer and Chief Financial Officer

Section 2-C:

Develop and/or Enforce Other Administrative Policies and Procedures

Our review of selected policies and procedures showed numerous instances of noncompliance. Additionally, we noted several instances where a policy or procedure was not established to address various situations. Without the existence and enforcement of policies and procedures, the Center's resources are at risk of waste or abuse. Additionally, policies and procedures are necessary to ensure that management's directives are carried out consistently and to comply with state statute.

- Use of Cellular Phones and Pagers - The Center's policies and procedures require proper justification and approval prior to the issuance of cellular phones and pagers. However, current procedures do not address the physical issuance or return of these items. Our sample of 24 requisitions for cellular phone use showed that nine (38 percent)

requisitions could not be located. Although staff members were able to locate five of the nine requisitions prior to the end of the audit, four remained missing. Of the remaining 15 requisitions that we reviewed, three (20 percent) did not have proper justification for issuance of a cellular phone, and 13 (87 percent) requisitions did not have the required approval. Our review of 20 pager requisitions showed that none had proper justification, 17 (85 percent) did not have proper approval, and 11 (55 percent) did not have proper authorization.

By not following established procedures, the Center may be incurring cellular phone and pager expenses that are unnecessary to conduct Center business. As of June 1997, the Center was billed for 235 cellular phones. Annual cellular phone expenses have fluctuated between $130,747 and $212,586 for fiscal years 1994 through 1996. The average monthly cost of these phones for the first ten months of fiscal year 1997 was $15,529. This situation likely occurred because the Purchasing Department does not routinely follow up on missing forms and missing information.

- Travel Expenses - Our review of 54 vouchers included 8 travel advances and 6 out-of-state travel vouchers. Of the eight travel advances in our sample, which had been outstanding from one to ten months, none had the required daily record of expenses. Three of the undocumented advances belonged to one staff member. The eight travel advances in our sample total $2,690.

  Of the six out-of-state travel vouchers, four (67 percent) were lacking the required approval of the Chief Executive Officer. This stems from the fact that new administrative personnel in each section are making travel arrangements; furthermore, there are no controls in place to prevent out-of-state travel without Chief Executive Officer approval.

  Without ensuring that expense reports are submitted following travel advances, the Center may be providing travel funds in excess of expenses actually incurred. This is due in part to the Fiscal Section having no system or tickler file to follow up on missing documentation for travel advances. By not following the Board policy that requires the approvals and reports, excessive out-of-state travel could be occurring throughout the Center without timely detection by management.

- Non-Travel Advances - While conducting our analysis of travel advances, we discovered two advances totaling $400 that were not travel related. No receipts were turned in to support these advances,

which were for gifts and a Christmas party. Also, there is no policy or procedure that covers non-travel advances. Without requiring receipts, the Center cannot ensure that the cash it advances is used for the purposes intended and that any excess cash advanced is returned to the Center.

- Leave Requests - Our review of the January 13, 1997, payroll showed that 5 of 60 sampled employees (8 percent) were either missing requests for leave or had improperly approved requests for leave. Further, the interim Chief Executive Officer approved his own leave for this period. Requests for leave should be approved by the immediate supervisor. Without proper leave approval unit supervisors may not be aware of impending staff leave, and may not be able to arrange for necessary coverage. The primary reason for this occurrence is that there is no financial consequence for failure to approve leave requests.

- Operating Manuals - Staff members have not developed operating manuals specific to their areas. Without operating manuals, inconsistencies may occur in handling similar transactions. Operating manuals are also important to provide guidance to new employees and for use in cross training.

  For example, the Maintenance Department does not have a written organizational structure, an established maintenance policy and procedures manual, or an established maintenance schedule. An effective maintenance department must have the ability to analyze the condition of plant assets, determine the need for repair, renovation or replacement, and assist the organization in the economic preservation of property and equipment. The current condition of the Maintenance Department makes it unable to effectively maintain Center assets, which will result in increased costs and economic inefficiencies for the center.

- Investment Policy - The Center is not in compliance with its investment procedures or the Public Funds Investment Act. As a result, the Center lacks important administrative procedures that could result in investment reporting deficiencies. Procedure 4.04.02, revised on April 26, 1997, requires the Chief Executive Officer to establish written administrative procedures for the Center's investment program:

  - These procedures have not been written. Documenting the procedures was delegated to the Controller, who was unable to complete this documentation due to time constraints. If the

Controller were to leave the Center, there would be no written procedures regarding the Center's investment program.

- Some requirements of the Public Funds Investment Act (Act) have not been incorporated into the Center's policy. These requirements are intended to provide the reader of the quarterly investment reports with useful information about the performance of the portfolio. The policy does not contain new requirements imposed by the Act in fiscal year 1996 that require quarterly reports to be signed by the investment officer. Additionally, beginning and ending market value, book value, and maturity dates of each separately held asset are to be reported quarterly.

Recommendations:

- Reconcile cellular phone and pager requisitions with the master lists. The Purchasing Department should inform staff that service will be terminated without a requisition containing proper justification, approval, and authorization. Also establish policies and procedures for issuing cellular phones and pagers based on the needs of the Center. Include a system to return these items to the Purchasing Department for reissuance when no longer needed.

- To control travel advances, the Fiscal Section should set up a tickler system to assist in collecting expense documentation to support advances. A tickler system would also prevent employees who have unsettled advances from receiving additional advances. The number of individuals with the authority to book out-of-state travel should be limited. Arrangements should be made with the travel agency to accept out-of-state travel arrangements only from these individuals. Inform staff of this policy.

- Develop and implement policies and procedures to address non-travel advances. The policies and procedures should not only include proper justification for the advance, but also a time-sensitive requirement to submit an expense report and original receipts justifying the expenditure.
- Comply with policies and procedures regarding leave approval. Accountability would be improved if a Board-designated Board member approved leave for the Chief Executive Officer.

- Develop operating manuals for departments. The manuals should include appropriate goals, objectives, and procedures.

- Ensure that investment procedures are documented in a timely manner. Also, amend the current investment policy to include the new requirements of the Public Funds Investment Act.

Management's Response:

- *Use of Cellular Phones and Pagers Corrective Action Response - Agency Policies 3.01.02 and 3.01.03 are being reviewed and updated to ensure the adequacy of controls over the requisition and use of cellular phones and pagers. The Purchasing Department coordinates the purchases/rentals of all cellular phones and pagers, and requires a Justification Form reflecting approval and authorization prior to issuance to employees.*

  Cellular phone/pager usage, billings and compliance with Agency policy will be reviewed by Internal Audit on a quarterly basis. This process will also include a review of the Purchasing Department documentation and control over cellular phones. The findings and recommendations resulting from Internal Audit's review will be communicated by formal report to the CFO, CEO and the Board of Directors.

- *Travel Expenses Corrective Action Response - The Agency's Policy on Travel Expenses (4.04) is currently being reviewed and revised to incorporate by reference the applicable provisions of the State Travel Allowance Guide.*

  The revised policy will also re-emphasize the requirement for out-of-state travel to be approved by the CEO in advance of travel. Travel reimbursement requests will be required to be submitted within five working days of completion of travel. Travel advances will be offset against the applicable travel reimbursement request. Except in emergencies, future Travel Authorizations and Travel Advances will not be approved until prior travel expenditures and advances have been brought to closure.

Timetable for Implementation:

February 28, 1998.

Implementation and Monitoring to be performed by:

CFO, CEO, Board of Trustees

- *Non-Travel Advances Corrective Action Response - The Agency is currently drafting a Policy/Administrative Procedure on non-travel cash advances. Such advances will be limited to unique and/or emergency situations; payroll advances will not be approved. Non-travel advances should be rare, and require the approval of the CEO or CFO. The procedure will include requirements for the provision of original receipts documenting the nature of the approved expenditure submitted within five working days of the advance.*

  Timetable for Implementation:

  January 31, 1998

  Implementation and Monitoring to be performed by:

  Managers, Department Heads, Accounts Payable, CFO, CEO

- *Leave Requests Corrective Action Response - The Center will distribute a memorandum to all staff to re-emphasize enforcement and compliance with the Procedure on Paid Leave Accrual, Utilization, Carry-Over and Payoff (5.01.06) which contains a requirement for advance approval of non-emergency leave requests. The policy will be revised to incorporate the recommendation that a Board-designated Trustee approve leave for the Chief Executive Officer.*

  Timetable for Implementation:

  December 31, 1997

  Implementation and Monitoring to be performed by:

  Managers, Department Heads, Human Resources

- *Operating Manuals Corrective Action Response - Although an ongoing process, Desk Top Procedures are being developed where appropriate to provide specific operating guidelines and to ensure consistency in performing daily job functions.*

  Timetable for Implementation:

  Ongoing Process - Prior to Fiscal Year End (FY '98)

  Implementation and Monitoring to be performed by:

Managers, Department Heads

- *<u>Investment Policy Corrective Action Response</u> - The Administrative procedure on Financial Investments (4.01.02) was revised on April 26, 1997 to incorporate recommendations made by the External Auditors and to comply with the Public Funds Investment Act. The new policy was based on the Texas Council's format. Investment reports, reflecting the nature of the investment and the quarterly earnings, are currently made to the Board of Trustees on a quarterly basis.*

  The Center is currently reviewing its Investment Policy for compliance with the Public Funds Investment Act, and will update as necessary. Future portfolio performance reports submitted for Board approval will include the signature of the investment officer. Additionally, the beginning and ending market value, book value, earnings, and maturity dates of each investment will be reported.

  Timetable for Implementation:

  February 28, 1998

  Implementation and Monitoring to be performed by:

  CFO, CEO, Board of Trustees

Section 3:

Improve Management of Human Resources

Management controls in the Human Resources Division are poor. Performance evaluations, which are critical to providing feedback to staff members on their job performance, were eliminated by the last Chief Executive Officer.

Center staff members are not attending training, and management has no way of knowing who is current in required training. The Texas Department of Mental Health and Mental Retardation's Quality Management team found that some staff members in service delivery positions have not learned or retained some of the basic principles of internal and external customer service. (See Appendix 2.)

Important information and documents required by laws, regulations, and policy are not included in either the personnel files or separate files. Some of this information, including licensure, education, driving record, and criminal background checks, directly effect the quality of service provided to

consumers.

(Please see Management's overall comment to Section 3 following the recommendation for Section 3-A.)

Section 3-A:

Develop a System of Regular Performance Evaluations

Performance evaluations were not completed within the past year for a sample of 52 staff members who had been at the Center for longer than one year. Without performance evaluations, staff members do not receive formal feedback on their job performance and may not perform in an optimal manner to reach the Center's goals. According to current staff members, a prior Chief Executive Officer abolished performance evaluations two to three years ago. Performance evaluations should be done on a regular basis in order to recognize good performance and formally communicate areas in need of improvement.

Recommendation:

We recommend that a regular system of performance evaluations be developed and implemented. This system should be based on the duties, knowledge, and skills set forth in the job description for each position. These evaluations should include specific descriptions of behaviors. Evaluators should have training in the process to ensure fairness and uniformity, so that the process is most beneficial to the Center and its employees.

Management's Overall Comment to Section 3:

Improve Management of Human Resources Corrective Action Responses - 1) The Center is currently reviewing all Human Resources Policies and Procedures to include current job descriptions and performance appraisals for all employees, and improve internal controls. 2) The new appraisal process, effective September 1, 1997, will include input from internal and external customers, as well as the employee and supervisor. 3) It is not the Center's practice to include criminal background checks in personnel files; they are maintained in a separate file. Other missing information (licenses, degrees and driving records) was not, however, in accordance with Center procedure.

A new Human Resources File Clerk position will review all personnel files during each calendar year (one-twelfth of all existing files per month, in addition to all new files) for compliance with all relevant standards. 4) Training attendance will be made mandatory in new administrative procedure # 5.01.12, and the procedure will include penalties (e.g., suspensions) for non-compliance. These processes will be monitored via the HR Quality Management Plan.

Timetable for Implementation:

Appraisal Procedure initiated September 1, 1997. Implementation of new procedures procedure will begin January 1, 1998.

Implementation and Monitoring to be Performed By:

Director of Human Resources

Management's Response to Section 3-A:

At the time of the audit process, staff was developing an evaluation process to include supervisors, peers, customers and subordinate staff. The procedure has been completed, approved, and presented to supervisors and managers. As of September 1997, employees are entering the appraisal process on or before their anniversary dates. The process is based on the employee's job description and offers opportunities for development of staff falling below an acceptable standard. The functions of this process are outlined in the new administrative procedure # 5.01.10.

The Human Resources Department will maintain a tracking and reporting system that will monitor the timely completion of all appraisals and provide updates of outstanding appraisals. This process will be monitored via the Human Resources Quality Management process, assigned to the Employee Relations Coordinator.

Timetable for Implementation:

Appraisal Procedure initiated September 1, 1997.

Implementation and Monitoring to be Performed By:

Director of Human Resources

Section 3-B:

Ensure Training Requirements Are Completed

Center staff members do not always attend required training, and management has no means of tracking compliance. Portions of the Texas Administrative Code, the Texas Health and Safety Code, as well as the Texas Commission on Alcohol and Drug Abuse Compliance Guide, require certain training. Failure to maintain staff training as required could be construed as negligence on the part of the Center.

Further evidence of the need to improve staff training was found during the Texas Department of Mental Health and Mental Retardation's concurrent Quality Management Review. The survey team received seven complaints about physicians

refusing to see patients during scheduled or walk-in appointments. The team attributed the nature of these complaints to:

> two systemic failures: in planning, deploying, and managing Psychiatric resources to provide the highest quality of services possible; in staff development, which should ensure that providers learn to see 'patients' as equal citizens and customers with dignity and rights.

Training is not up-to-date because there are no consequences for failure to attain and maintain the required training status. Also, there are no notifications of needed training or updates provided to supervisors or staff members on a regular basis.

Recommendation:

Required training should be clearly identified in a format useful to supervisors and staff. Policies and procedures should be developed to help ensure that staff members attain and maintain required training, including appropriate consequences for failure to do so. A capability should be developed to inform staff members and supervisors of needed training in a timely manner. This requires a clear commitment to training at the highest levels of the organization.

Management's Response:

The former tracking system will be down-loaded into the new Human Resources Ross system, providing a centralized location for all training data.

Reports will be generated to show the outstanding training required by each Center employee. All delinquent staff will be given 120 days to comply with current training requirements; competency may be demonstrated by one of the six methods described in administrative procedure 5.01.12. Documentation of "make-up" training will be certified and forwarded to Human Resources for system in-put. Current training documentation, in-put and tracking will be in accordance with administrative procedure 5.01.12. This process will be monitored via the Quality Management Plan Section II A, C and D assigned to HR Lead Trainer.

Timetable for Implementation:

Procedure to be initiated November 15, 1997. Tracking systems to be merged by January 1, 1998. Mandates of procedure to be begin January 1, 1998.

Implementation and Monitoring to be Performed By:

Human Resources Recruitment/Training Manager

Section 3-C:

Correct Deficiencies in the Maintenance of Personnel Files

Some personnel files are missing important documentation to support staff members' credentials, qualifications, and employability factors. Also, some personnel files contain inappropriate information. These conditions could potentially expose the Center to litigation. Currently, there is no routine check to ensure that personnel files are complete and that inappropriate information is removed.

- Current Licensure Checks - Our sample of 60 personnel files produced 7 employees who are required to maintain professional licenses for their positions. Of these seven, two (29 percent) did not contain proof of current licensure. By not ensuring current licensure, the Center may be exposed to additional liability through failure of professional staff to attain or maintain required licensure. For example, one physician is working under a restricted license according to the National Medical Database, but no record of these restrictions appears in the physician's personnel records.

  Proof of licensure and its currency should be present for each employee requiring a license. Regular checks with licensing boards should be made to ensure that licenses have not been suspended or revoked. Currently, no person or department is assigned responsibility for

verifying the credentials of professional staff members. Responsibility is not clearly assigned to ensure current licensure in good standing, and no one checks disciplinary actions taken by licensing boards to ensure that licenses are current and valid.

- Educational Level Documentation and Verification - Documentation of the highest required education level was not found in 27 of 60 (45 percent) personnel files sampled. The typical support for education level in the files sampled generally consisted of a copy of a diploma, or sometimes a copy of a transcript. In only one case was there a record of a confirmation with the original source. Without source verification and adequate documentation, personnel hired may not meet the educational requirements necessary to perform the job. This could increase the Center's exposure to risk based on negligence.

  Minimum education levels required for positions should be documented in the personnel files, and either obtained from or verified by the original source for authenticity. It has been accepted practice at this Center to rely on copies of diplomas and unofficial transcripts for proof of college-level work, and to require no documentation of high school or GED attainment, even though required for positions.

- Driving Record Checks - Our sample of 60 personnel files showed that 14 (23 percent) contained no evidence of a check of the employee's driving record within the past year. Without these annual checks, the Center is exposed to additional liability because drivers with unidentified past driving violations, or even suspended licenses, may continue to drive on Center business. For example, one Center employee was arrested in April 1997 after three driving- under-the-influence convictions. The employee was driving with a suspended license and had a Center consumer in the vehicle at the time of the arrest.

  Employees' driving records should be checked at least annually if they are required to transport consumers. Currently, these annual updates are supposed to be carried our for all employees in one large request by the Safety Officer to the Texas Council of Community Mental Health Centers; however, the list of employees provided by Information Services for this purpose is not complete. Further, there is no follow-up check by supervisors directly responsible for assigning employees to drive.

- Criminal Background Checks - Our sample of 60 personnel files

showed that three (5 percent) did not have criminal background checks requested for new employees. Without these checks, personnel may be hired who have criminal records, including convictions for violent crimes and abuse. It is a good business practice to request criminal background checks on each employee within a few days of employment.

- Employment Eligibility Forms (I-9s) - Our sample of 51 personnel files showed that four I-9s (8 percent) were either not present or were improperly completed. The Center is subject to fines and penalties if these forms are not properly completed or if a person not authorized to work in the United States is hired. The Immigration Reform and Control Act of 1986 requires that all employees hired after April 1986 must have a properly completed Employment Eligibility Form before their third working day.

- Applications for Employment - Our review of 60 personnel files showed that three (5 percent) did not contain a completed Application for Employment. All applicants should complete an Application for Employment when applying for a position, and this document should then be retained in the personnel file. Without this document, important information may not be available to Human Resources personnel, as well as supervisors, when an employee is hired.

- Job Descriptions - Our sample of 60 personnel files showed that 24 (40 percent) did not include a current job description for the employee. New job descriptions are described as "in process," and few have been discussed with, and signed by, the affected employee. Without current job descriptions, duties and qualifications for positions may be unclear to staff and supervisors. It may also be more difficult for supervisors to counsel employees in the absence of a clear description of the job. Further, FLSA determinations for overtime classification may be incorrect if no current job descriptions is in place.

  It is good business practice for each employee to have a job description that clearly describes:

  - The job to be performed
  - Reporting relationships within the Center
  - Minimum qualifications for the job
  - Specific duties, knowledge, and skills required for satisfactory job performance

Each employee should review and sign the job description or otherwise indicate familiarity with it.

- Inappropriate Information and Documents Present in Personnel Files - Our review showed that a picture, birth date, other EEO information, or medical history information were included in 11 (18 percent) of the 60 personnel files sampled. The inclusion of inappropriate information in the personnel files may increase the Center's exposure to legal risk. Employees may believe that personnel actions were taken based on irrelevant or inappropriate information.

  Information irrelevant to the workplace should not be included in the personnel file, especially information that might be used to discriminate against a protected class. Medical information should be present only when directly related to job performance. These standards are present in the Equal Employment Opportunity Commission regulations and the Americans with Disabilities Act, among others.

Recommendations:

- Develop a function to verify professional credentials and assign it with the responsibility to ensure that all professional staff members who are required to be licensed have and maintain current licensure in good standing.

- After determining what minimum educational requirements are necessary for each position, policies and procedures should be developed and implemented to ensure that original source verification of the required educational level is obtained for each applicant in a timely manner.

- Develop the capability to produce an accurate list of current employees as needed. This list should be supplied to unit managers to verify completeness and accuracy immediately prior to the annual driving record checks.

- Develop and implement a policy and procedure to ensure that a criminal background check is requested on each new employee within three days of employment, and that regular checks be instituted to ensure that a response is received. Appropriate procedures should be developed to check new employees from other states.

- Develop and implement a policy and procedure that provides a check for presence and accuracy of the I-9 forms before the third day of employment and dictates appropriate corrective measures to ensure that forms are obtained and completed in a timely manner.

- Develop and implement a procedure that provides a follow-up check for the presence, accuracy, and completion of Applications for Employment before employment interviews are conducted.

- Develop a job description for each employee. The job description should be signed by each employee after a review with the supervisor and filed in the appropriate personnel file.

- Develop and implement policies and procedures that require regular reviews of personnel files and related material for inappropriate and prohibited information, with appropriate methods for correction.

Management's Response:

It is acknowledged that certain documents were missing from personnel files, and that there was no process to review personnel files for standards compliance. However, a monthly review of one-twelfth of all active personnel files is now included in the job description of the newly created HR File Clerk. Also, a routine quality check on newly created files will be conducted on an on-going basis. These functions will be monitored through the Quality Management Plan for Human Resources.

Timetable for Implementation:

File clerk position to be filled by November 15, 1997.

Implementation and Monitoring to be Performed By:

Human Resources Recruitment/Training Manager

- *Current Licensure Checks - Staff has presented to the Chief Executive Officer a proposed administrative procedure (# 5.01.12) which mandates that new employees be current on required competencies within 60 days of employment and that existing employees renew expirations no more than thirty (30) days after credentials expire. Failure to comply will result in suspension of employment and may lead to termination. The outcomes of this procedure will be monitored*

and evaluated through the Human Resources Quality Management Plan, Section II A, C, and D. Licensing Boards will be consulted on a regular basis.

Timetable for Implementation:

Procedure to be initiated by November 15, 1997. Procedural sanctions to begin January 1, 1998.

Implementation and Monitoring to be Performed By:

Human Resources Recruitment/Training Manager

- *<u>Educational Level Documentation and Verification</u> - Personnel procedure on Employee Management shall be revised no later than November 30, 1997 to require that educational credentials required for a position must be verified via the original source for new hires. Currently, HR staff accepts only original documents from which copies are made for personnel files. In the future, the Human Resources Department will provide written affirmation that original documents were presented during the hiring process.*

  Timetable for Implementation:

  Procedure to be revised by November 30, 1997. Procedural sanctions to begin January 1, 1998.

  Implementation and Monitoring to be Performed By:

  Procedure to be revised by the Human Resources Employee Relations Officer. Written affirmations to completed by Recruitment/Training Manager.

- *<u>Driving Record Checks</u> - The Center's current practice is to review driving records of all staff on an annual basis; all new employees are checked during the first week of New Employee Orientation. Upon implementation of this procedure, there was a discrepancy in the data from two systems, resulting in the omission of some record checks. The discrepancy between the systems has been addressed; the routine practice of annual checks will now reveal all driving record issues.*

Timetable for Implementation:

Annual checks are currently in place. The discrepancy with the two data systems was addressed by implementation of the Ross Data System.

Implementation and Monitoring to be Performed By:

Quality Management Safety Officer

- *<u>Criminal Background Checks</u> - Background checks are not kept in the personnel file, but are retained in a separate file for confidentiality. Background checks on the three employees in question were, however, not found in the separate file. It is the Center's normal practice to check criminal backgrounds within three (3) days of employment. However, two of the checks in question were for the newly hired Chief Executive Officer and Chief Financial Officer. It was the early opinion of the human resources screening person that the outside search firm involved in the hiring of the CEO and CFO would conduct criminal background checks within the prescribed time frame. When staff realized that documentation was not provided, background checks were ordered immediately and revealed no findings. The background check for the other employee has been ordered by staff and records will be updated. Again, the new HR clerk position will require quality checks on files for new hires. Any missing background checks will be brought to the attention of the Recruitment/Training Manager.*

  Timetable for Implementation:

  File clerk position to be filled by November 15, 1997. Missing background checks are currently completed with no findings.

  Implementation and Monitoring to be Performed By:

  Human Resources Recruitment/Training Manager

- *<u>Employment Eligibility Forms (I-9's)</u> - All I-9's were present in a separate file for employees hired after April 1986. It is acknowledged, however, that four of the 60 reviewed were not properly signed by the Human Resources staff person. As mentioned above, the job description of the new HR Clerk position will require monthly checks on all existing files and a quality review on all newly created personnel files.*

  Timetable for Implementation:

  File clerk position to be filled by November 15, 1997. I-9 findings are currently corrected.

Implementation and Monitoring to be Performed By:

Human Resources Recruitment/Training Manager

- *Applications for Employment - The above mentioned quality check by the new HR clerk position will correct this finding.*

  Timetable for Implementation:

  File clerk position to be filled by November 15, 1997.

  Implementation and Monitoring to be Performed By:

  Human Resources Recruitment/Training Manager

- *Job Descriptions - At the time of the audit, position descriptions were being formulated, confirmed, and signed by employees, as a component of the performance appraisal process. Quality control initiatives built into the appraisal procedure will mandate current job descriptions (See Administrative Procedure 5.01.10).*

  Timetable for Implementation:

  The Performance Appraisal Procedure was initiated on September 1, 1997. All job descriptions are expected in from Unit Managers by January 1, 1998.

  Implementation and Monitoring to be Performed By:

  Human Resources Recruitment/Training Manager

- *Inappropriate information and documents present in personnel files - Inappropriate documents have been removed from the files in question. The quality review of files by the HR clerk mentioned above will resolve this issue.*

  Timetable for Implementation:

  File clerk position to be filled by November 15, 1997.

  Implementation and Monitoring to be Performed By:

  Human Resources Recruitment/Training Manager

Section 4:

Improve the Contract Management Process

The contract management process needs improvement to ensure better

contracts and monitoring procedures. The Center expended $13 million in fiscal year 1996 on contracting, not including the administrative contracts. This represents 19.8 percent of the fiscal year 1996 expenditures. Due to recent legislation, including House Bill 2377 (74th Legislature) and House Bill 1734 (75th Legislature), mental health community centers will call on community centers to increase contracting activities. Therefore, it will be important to have an effective contract management system to compete in the changing environment. An effective system of contract management should be sufficient to ensure that public funds are used appropriately and efficiently.

Contract administration at the Center is divided into five areas: administrative contracts, direct purchased services, service provider contracts for mental health, mental retardation, and children and adolescents. Improving the following would make the contracting process stronger, more consistent, and more efficient:

- The process used to review direct purchased service contracts and administrative contracts before they are executed is ineffective. In some direct purchased service contracts, the total contract amount did not equal the total of the monthly payments and contract extensions listed. As a result, one contract contained a payment of $92,010 for fiscal year 1997 that the provider believed it would receive but will not. Other examples include (1) an instance in which the written dollar amount did not correspond with the numerical dollar amount and (2) one contract that was not signed by the contracting parties.

  Administrative contracts were noted where the purchase requisition did not correspond to the amount originally approved by the Board. Additionally, changes in provider rates were not documented. It is difficult to enforce a contract with inconsistencies, especially when they are associated with payment clauses. Errors such as these could affect the services provided to clients.

- The Center does not have a documented rate setting methodology to determine what to pay most contractors. Without a documented rate setting methodology, the Center cannot be sure that it is using its contracting dollars in the most efficient manner possible. Instead, the Center uses state and federal methodologies for Intermediate Care Facility for the Mentally Retarded, vocation services, and supported housing programs.

- Standardized, minimum monitoring procedures have not been developed for any of the five contract administration areas. Therefore,

comparisons of monitoring results and their impact between programs is difficult. Monitoring for direct purchased service contracts is centralized; however, monitoring for all other contracts is decentralized and varies greatly. Since some contracts have a centralized monitoring function and others have a decentralized monitoring function, the procedures performed during monitoring depends on the individual monitor.

Monitoring of contracts should be performed to ensure that the contractor is complying with the contract and with Center and Texas Department of Mental Health and Mental Retardation rules. This cannot be effectively accomplished if basic procedures are not performed for each contractor.

- Contractors are not sanctioned, which could cost the Center in the event it is sanctioned by the Texas Department of Mental Health and Mental Retardation for a contract violation that is partly the fault of the contractor. If the contractors are partly responsible for the Center receiving a sanction, they should share in any monetary sanction.

- Ensure that all contracts contain the necessary contract provisions. The Center uses both standard and non-standard contracts. It appears that contracts have adequate provisions; however, some contracts are stronger than others because they contain certain provisions that the others do not. The contract is the Center's main source of protection if there are performance issues with the contractor. Therefore, it is important to ensure the contract is as strong as possible.

Recommendations:

- Institute a review system for contract provisions. This can be accomplished by creating a checklist identifying all areas that need to be reviewed. Ensure that numerical amounts match written amounts. Ensure that payments equal the total contract amount. Note any discrepancies in the provider file. Ensure that if a contract extension is granted, the total contract amount is adjusted to reflect the extension. Also, ensure that all necessary parties have signed the contracts.

- Develop a uniform rate setting methodology. If it is not possible to develop a Center-wide methodology, then develop one for each division. This methodology should be documented. Require that the

method for obtaining the contract amount be documented when developing a request for proposal (RFP) or awarding a contract.

- Develop minimum basic monitoring policies and procedures. The policy should require that all contracts receive at least some minimum amount of monitoring. The procedures should also detail the work to be performed during a monitoring visit. Monitoring activities should specifically address compliance with contract provisions for performance, financial, and oversight requirements.

- Review and evaluate the inclusion of negotiating sanctions into contracts for failure to serve an agreed-upon number of consumers.

- As contracts are negotiated or renegotiated, ensure that all necessary provisions are included. Include the following provisions (as applicable) to strengthen the Center's contracts and better protect its position:

  - Require reimbursement by the contractor if it is determined that it did not provide services intended by the contract.

  - Include the performance measures, outcomes, and targets that will be used to evaluate the effectiveness of the contractor.

  - Incorporate the RFP and the RFP response by reference in the contract.

  - Stipulate that if funds are not available from the State or Federal Government, the terms of the contract will be renegotiated or the contract will be terminated.

  - Define the types of sanctions that will be imposed if the contractor does not meet and comply with the contract provisions.

  - Require professionals such as physicians and pharmacist to produce updated copies of their licenses for the Center's records.

Management's Response:

DCMHMR did not have personnel dedicated to contract management until April, 1996 when a Senior Contract Manager position was created and filled. The initial focus of the contracts office was the Performance Contract with the Texas Department Of Mental Health and Mental Retardation (TDMHMR). It was necessary to educate all management staff regarding the requirements and accountabilities mandated by the contract which represented forty-five million dollars of a seventy-five million dollar budget and establish monitoring tools for managers to assure compliance with contract provisions. The second focus of the new contract management office was to begin to centralize monitoring and oversight of the fourteen million dollars in purchased service contracts for mental retardation, child and adolescent and adult mental health services. Over the next eighteen months, three contract liaisons were employed, at staggered intervals, and assigned the task of monitoring purchased service contracts with external agencies. For Fiscal Year '98, a full time Legal Counsel position was created and assigned administrative oversight to the Contract Management division. That position has been filled, with the attorney scheduled to begin work November 1, 1997.

The Center is currently reviewing and developing procedures for contract management. These procedures will include procurement for both community based services and direct consumer services, contract development, monitoring, renewal and approval requirements, and a dispute resolution and appeals process. For Fiscal Year 98 a contract review and approval process was implemented which assured all contracts were reviewed by relevant senior staff and the attorney prior to being forwarded to the Chief Executive Officer for signature. This approval process will be incorporated into the procedures under development. Additional areas to be addressed within the procedures, with appropriate monitoring tools developed, as indicated, include: development of a uniform rate setting methodology, development and implementation of a risk assessment process, and development and implementation of contract monitoring checklists. All contracts contain performance measures, outcomes and targets to monitor effectiveness and sanction provisions that mirror those imposed on the Center via the Performance Contract with TDMHMR. This information is contained in all contract templates which were reviewed and refined in these areas for the FY '98 contract term. Similar reviews will continue with each new contract developed or renewed, as new requirements are mandated by TDMHMR and local concerns.

Finally, a contract data base is in the process of development. The data base will contain basic contract profile information as well as performance data to

be used in evaluation of contractor performance. Contract Performance Profiles were initiated for both contract and Center provided services during FY '97. This information was provided to management staff and the Board of Trustees and used in decision making regarding the Center budget and contract renewal. This process will be reviewed and refined in FY '98.

Timetable for Implementation:

Initiated August, 1997. Procedures completed by March 1, 1998. Review and Evaluation Ongoing Process.

Implementation and Monitoring to be performed by:

Legal Counsel, Senior Contract Manager, Chief of Authority Functions, CFO and CEO

Section 5:

Correct Deficiencies Noted in the Center's Fiscal Year 1996 Audit

There remain significant issues from the fiscal year 1996 single audit findings because stated corrective actions have not been implemented. These unresolved issues adversely affect the internal control environment at the Center, leaving it exposed to the risk that errors and irregularities could occur without timely detection by management.

- Information Services - Only 1 of 11 recommendations made in the November 1996 management letter issued by the Center's external auditor regarding information systems had been implemented by the end of our fieldwork. For each of the remaining ten recommendations, the original target implementation date had been revised to a later date. Since the remaining recommendations concern such sensitive issues as policies and procedures over computer information security, change controls, access controls, and the disaster recovery plan, the failure to promptly implement these recommendations greatly increases the risk over the loss and/or misuse of sensitive data. Further, management's decision to give a lower priority to these recommendations intensifies the overall risk of the Information Services Division.

- Financial Accounting and Reporting - Our review showed that five of seven (71 percent) corrective actions have not been implemented; many of the deficiencies in the accounting and control systems of the Center still exist. As a result, the internal control environment continues to hinder the consistent production of reliable and timely financial information.

- Reportable Condition - Cash - Two of three (67 percent) noted corrective actions have yet to be implemented. Investigation and write off of reconciling items are not being done on a timely basis.

- Accounting Policies and Procedures - None of the three noted corrective actions have been implemented. Updated accounting policies and procedures and job descriptions for the accounting positions still do not exist. As a result, personnel may be unsure of their duties and responsibilities. Further, the lack of a policies and procedures manual may result in confusion regarding the Center's major accounting processes, especially in the case of new employees.

- Cash Deposits - Although the Center has addressed both of the corrective actions, the issue has not been adequately resolved. There remain problems with the reporting units' consistently following the policies and procedures regarding timely cash deposits. This may lead to understatements of cash and revenues and may facilitate misappropriation of funds.

- Fixed Assets - The Center did not complete an inventory of fixed assets, as recommended, and has not fully implemented either of the two corrective actions noted for this finding. As a result, fixed assets may become lost when moved from one reporting unit to another, and fixed asset lists may be inaccurate.

Many of these unresolved issues are due to the major delays in the installation of the new accounting and payroll systems. Some issues remain unresolved because of various priorities established in the accounting section. Yet others exist because of the lack of formal policies and procedures, as well as the inconsistent enforcement of established policies and procedures.

Recommendations:

- Reevaluate and reprioritize the current commitments of the Information Services Division, giving significant emphasis to ensuring that the remaining information services-related recommendations are implemented no later than their revised target dates.

- Ensure that the new accounting and payroll systems are fully

operational by the revised timetables.

- The Accounting Section should review and update accounting policies and procedures, internal controls, and job descriptions, and provide continuing education to appropriate accounting staff.

- Enforce the established policies and procedures over cash deposits and the transfer and disposal of fixed assets.

Management's Response:

- *Information Services - While the new software system implementation projects have taken higher priority over all other IS activities, much work has been accomplished to implement the recommendations in the November, 1996 Deloitte and Touche management letter. A brief re-cap of the eleven recommendations are: Two have been completed; Three have active plans in place that require formal documentation in a policy and procedure format only; Five have action plans that need completing and require formal documentation in a policy and procedure format; and One recommendation is awaiting another discussion with Deloitte and Touche over applicability (scheduled to begin in October, 1997). It is expected that all plans of correction will be completed by February 28, 1998.*

- *Financial Accounting and Reporting - The Fiscal department is in the process of reviewing its accounting system for compliance with Governmental Accounting Standards. The department is also in the process of scheduling training courses and CPE's in fund accounting. The accounting records have been brought up to date and the implementation of the ROSS accounting system will provide the agency with the tools necessary to provide more timely financial information and accommodate fund accounting. Job descriptions for the fiscal department have been updated, and we are in the process of drafting desk top procedures to provide guidance in the performance of day-to-day duties.*

- *Reportable Conditions Cash - All agency bank accounts have been reconciled and tied to the General Ledger. Old outstanding checks and reconciling items have been adjusted.*

- *<u>Accounting Policies and Procedures</u> - Job descriptions have been updated and we are in the process of reviewing policies and procedures. With the implementation of the ROSS accounting system, we now have the ability to provide more timely financial information, including budget comparisons.*

  In-service training, work sessions, and regular accounting staff meetings have already begun. We are in the process of identifying continuing professional training courses based on the individual needs of the staff.

- *<u>Cash Deposits</u> - The center has issued a memorandum to all personnel involved in cash transactions requiring compliance with agency cash policies. We have already initiated a daily cash monitoring system to track daily deposits for the various locations.*

- *<u>Fixed Assets</u> - The agency is currently in its second phase of a center-wide fixed asset inventory. A computer listing of all assets and asset inventory tag numbers, along with inventory instructions and forms were sent out to all reporting units. We are in the process of keying in all inventory changes, and will send out another set of inventory forms to update the current information. Since the agency has not updated the fixed asset inventory in two years, the verification process will be time consuming.*

Timetable for Implementation:

March 1, 1998.

Implementation and Monitoring to be performed by:

CFO, Controller, Internal Audit

Section 6:

Implement a Consumer Billing System

The Center has no automated method to track individual consumer accounts receivable. As a result, Medicaid billing is not reliable. The Center has to resubmit rejected Medicaid claims, which is inefficient, and it cannot forecast cash availability. The General Ledger Accounting System and the Client Billing System do not interface. Any payments received are posted directly to the revenue account in the General Ledger Accounting System. Although the payments are also posted to the separate Client Billing System, these payments are identified only by reporting units, not by individual account. Therefore, it is not possible for these systems to calculate a particular consumer's account balance, or to perform an accounts receivable aging analysis.

The Center has a new automated accounting system which has the capability to process accounts receivable, but there have been consistent delays in the installation of the new system. A billing service has been employed to process billings, but the service has been unable to organize receivables on an individual client account basis.

Management's objectives for accounts receivables should be to ensure that reported receivables accurately reflect all bona fide receivables, and should provide data necessary to forecast cash availability and analyze the efficiency of the collection process while safeguarding assets.

Recommendation:

The implementation of a client billing system should be given top priority. An aging analysis should be done at least monthly. If the Center continues to prefer a decentralized billing structure, allowing clerks physically located at provider locations to originate billing, then the Center should perform an organizational and operational review of the appropriate accounting processes to ensure accuracy and compliance. This review should include an analysis of the duties and responsibilities of a billing manager and an analysis of procedures to provide edit checks for both routine and technical billing errors.

Management's Response:

The implementation of the new client billing system (SMS Allegra Patient

Registration System and Patient Accounting System) is on track for a February 1, 1998 go live. This project has been given very high priority since the inception of the new information system projects, as evidenced by the amount of staff resources and consultant expenses expended on this project.

Timetable for Implementation:

February 1, 1998

Implementation and Monitoring to be Performed by:

CIO, CFO

Appendix 1:

Objectives, Scope, and Methodology

Objectives

Our audit objectives were to evaluate management control systems within the Dallas County Community Mental Health and Mental Retardation Center, including its management of resources, and to identify strengths and opportunities for improvement. The audit evaluated the control systems in place as of August 1997.

Management controls are policies, procedures, and processes used to carry out an organization's objectives. They should provide reasonable assurance that:

- Goals are met.
- Assets are safeguarded and efficiently used.
- Reliable data is reported.
- Laws and regulations are complied with.

Management controls, no matter how well designed and implemented, can only provide reasonable assurance that objectives will be achieved. Breakdowns can occur because of human failure, circumvention of control by collusion, and the ability of management to override control systems.

Scope

The scope of this audit included consideration of the Center's overall management control systems: policy management, information management, performance management, and resource management.

Consideration of the Center's policy management systems included a review of:

- Processes used to develop, document, communicate, enforce, and revise Center policies and procedures

- Processes used to classify, select, develop, evaluate, organize, supervise, and oversee the Center's human resources and organization structure

- The status of policy-management related findings and recommendations included the Center's fiscal year 1996 independent audit report

Consideration of the Center's information management included a review of the status of information management-related findings and recommendations included the Center's fiscal year 1996 independent audit report.

Consideration of the Center's performance management systems included a review of processes used to monitor and adjust its goals, objectives, and strategies.

Consideration of the Center's resource management systems included a review of:

- Processes used to ensure that the cash activity of the Center is adequately controlled

- Processes used to ensure that amounts due the Center are collected

- Processes used to ensure that plant and other assets are economically purchased/constructed, and adequately protected against waste and abuse

- Processes used to ensure that compensation systems effectively control labor costs, improve employee productivity, and boost quality of services

- Processes used to ensure that expenditures for operating activities are legitimate and appropriate uses of Center funds

- Processes used to ensure that purchased services and other program costs are legitimate and appropriate uses of Center funds

A review of each of the control areas revealed some specific issues that were examined further.

Methodology

The audit methodology consisted of gaining an understanding of each control system. In select areas, tests were then performed to determine if the control systems were operating as described. The results were evaluated against established criteria to determine the adequacy of the system and to identify opportunities for improvement.

An understanding of the control systems was gained through interviews with the Board of Trustees, management, and staff. Reviews of Center documents were also used to gain an understanding of the control systems in place. Control system testing was conducted by comparing the described and actual processes. The testing methods primarily consisted of document analysis, process and resource observation, and employee interviews.

The following criteria were used to evaluate the control systems:

- Statutory requirements
- Center policies and procedures
- Texas Department of Mental Health and Mental Retardation ICF-MR Standards for Participation
- 1997 Mental Health Community Services Standards
- General and specific criteria developed by the State Auditor's Office Inventory of Accountability Project
- State Auditor's Office Project Manual System

This audit was conducted in collaboration with the Texas Department of Mental Health and Mental Retardation. Fieldwork was conducted from July 1997 through September 1997. The audit was conducted in accordance with applicable professional standards, including:

- Generally Accepted Government Auditing Standards
- Generally Accepted Auditing Standards

The following members of the State Auditor's Staff performed audit work:

- William D. Hastings, CPA (Project Manager)
- Steve Crone, CPA
- Jerry Davis, CMA
- Verma Elliott
- Pat Keith, CQA (Audit Manager)
- Deborah L. Kerr, Ph.D. (Audit Director)

The following members of the Texas Department of Mental Health and Mental Retardation performed audit work:

- Eleo Del Toro

- Angela English, MS, LPC, LMFT, CH't
- Brenda Loney, CPA
- Carol Luckow
- Brad A. Pierson, LMSW-ACP
- Robert Rosales

Appendix 2:

Texas Department of Mental Health and Mental Retardation Oversight Survey, Dallas County Community Mental Health and Mental Retardation Center

Executive Summary

On July 14 -31, 1997, a TXMHMR MH Quality Management Survey Team conducted a limited survey of Dallas County MHMR Center to determine the level of compliance with Requisite and specific Organizational aspects of the 1997 Mental Health Community Services Standards. This focused survey was conducted as part of the more comprehensive audit conducted by the Office of the State Auditor. The focus was on Human Resources, Quality Management, and the effectiveness of the MHA's organizational systems in assuring the delivery of high quality behavioral health care. The major findings are summarized as follows:

During the MH QM survey, ten (10) Requisite Standards were cited. Requisite standards (coded "R") require 100% compliance because they directly address consumer protection, advocacy, safety, and health. These have been presented under separate cover and discussed at length with the pertinent MHA staff. A plan for improvement has been received which is currently being reviewed by MH QM.

The preponderance of survey evidence reveals that the MHA has not developed an integrated and coordinated approach for taking corrective action to ensure that deficiencies and barriers to quality service provision are corrected. For at least the past twelve months, staff report a sense of discontinuity and fragmentation; a sense that no one is really in charge to manage the change process, arbitrate interdepartmental conflicts, or provide clear direction for the agency as a whole. Evidence of fragmentation is seen in the isolation of one administrative function from the other due to vertical and insular lines of authority, and the absence of an integrated management information system, which inhibits the efficient performance of vital local authority functions (billing summaries, caseload distribution and management, staff and provider profiling, and monitoring required training are examples).

The performance of the MHA's leadership has been inadequate to the tasks required by a MHA in the areas of credentialing, staff training, and peer review. This places the agency's mission at significant risk, because DCMHMRC staff are not attending the training, and management has no way of knowing who is current in required training. The more critical outcome of this breakdown is that some

staff in the foremost service delivery positions have not learned or retained some of the basic principles of internal and external customer service, how to be advocates for people with severe and persistent mental illnesses, or a commonly understood approach to principles of rehabilitation and recovery from serious mental illness; all of which are leadership issues. The MHA also lacks a system for credentialing new staff, establishing and maintaining documentation of required competencies, and for retaining the most qualified and best performing personnel. For further clarification, please see the findings in the areas of Abuse/Neglect/Exploitation reporting, Rights, Access, Continuity of Services, and Utilization Management.

In the Adult Outpatient Clinics, efforts began several months ago to introduce accountability, at the provider level, for all the required processes and outcomes of services. While these efforts are appropriate, they are both overdue and systemically impaired by the organizational structure (including the lines of supervision) which readily lends itself to stalemate when conflicts should be arbitrated and resolved. For example, Individual Service Coordinators, Nurses, and Physicians have not been held accountable to performance measures, practice standards, or standards of advocacy and rights protection, due to discipline-based, vertical, and insular lines of authority. This structure rests in part on faulty interpretations of peer review requirements which confuse the need for *clinical* supervision and peer review with immunity from *administrative* accountability. Thus shared supervision is obstructed and interdisciplinary progress towards common goals is neutralized.

Data is collected, and service providers are profiled by scores on the internal review tools, but not by such critical measures as follow-up to missed appointments, percentage of direct service time, or quality service complaints. No formal productivity expectations have yet been established for any providers. Summary workload analysis reports produced thus far reflect only physician contacts per day and contact hours. These reports reveal, on their face, a lack of internal control over the MHA's psychiatric services. In the aggregate, physician utilization is simply not managed based on the data presented.

Although some planning has occurred in the area of Utilization Management, and some draft UM protocols and procedures exist, the MHA has not yet implemented a center-wide program to concurrently manage and control utilization of services and staff resources.

With approximately five Individual Service Coordinators per clinic, and caseloads as high as 400, and no lower than 150, according to staff interviewed (workload analysis data and verbal reports do not reconcile), the MHA has been unable to implement consistent, *concurrent* UM for all consumers served, or to provide the

essential services of care coordination, planning and linking necessary for persons with severe and persistent disabilities, and required by the Community Service Standards. The data resulting from internal program reviews supports these findings.

For at least the past three years, the DCMHMR Quality Management department has been conducting internal program reviews as required by Standards, analyzing very similar data trends, and producing largely identical management reports. As a department, QM is an outstanding performer within the agency. However, unified management decisions are not being made and implemented on the basis of the data produced.

Conspicuously absent, in the opinions of the staff members interviewed, is a fair and uniform system of accountability to policies, procedures (of which few actually exist to guide staff), performance measures, or the requirements contained in job descriptions, standards and rules (e.g., "what happens when staff do not maintain currency with required training?" Answer: "Nothing happens"). For example, as was the finding during the last MH QM survey, the MHA has not ensured that employees of Dallas County MHMR Center, administration and contract provider staff have received pre-service training elements prior to assuming work, and there is no effective monitoring to ensure that staff who are due for annual refresher training actually attend the training. Administrative staff interviewed for this survey were themselves out of currency with required training.

MHA staff interviewed during the survey reported some recent changes for the better, as well as hope for continued progress under the leadership of the new Chief Executive Officer. However, it must also be noted that the staff members interviewed consistently expressed a profound lack of confidence in the Board of Directors, reporting that the governing body micromanages most if not all management decisions. The common opinion expressed by the staff is the Board is unsupportive at best, and that prolonged inaction and even gridlock occur at the management level as a consequence of what is characterized as the Board's "punitive" style.

In summary, leadership has yet to set direction, involving local stakeholders, and to create a culture of continuous quality improvement with accountability. The responsibility for leadership extends to a Board that has not taken as its role to include leadership in setting broad based goals for planning, policy and resource allocation.

Appendix 3:

Financial Information

Figure 2

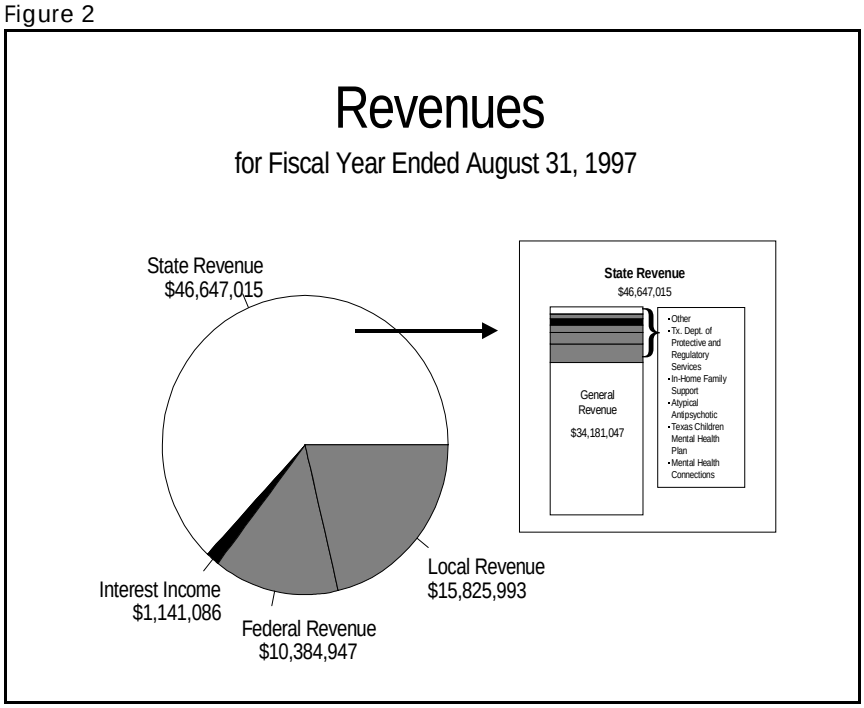

Figure 3