



**CHESAPEAKE INTEGRATED
BEHAVIORAL HEALTHCARE**

PERFORMANCE AUDIT

JULY 1, 2014 THROUGH JUNE 30, 2015

**CITY OF CHESAPEAKE, VIRGINIA
AUDIT SERVICES DEPARTMENT**

June 30, 2015

The Honorable Alan P. Krasnoff and
Members of the City Council
City of Chesapeake
City Hall – 6th Floor
Chesapeake, Virginia 23328

Dear Mayor Krasnoff and Members of the City Council:

We have completed our review of Chesapeake Integrated Behavioral Healthcare (CIBH) for Fiscal Years (FY) 2014-15. Our review was conducted for the purpose of determining whether CIBH was providing services in an economical, efficient, and effective manner, whether its goals and objectives were being achieved, and whether it was complying with applicable City and Department policies and procedures and financial administration regarding cash control and handling, access control, drug policies, and billings and accounts receivables.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

CIBH was tasked with providing behavioral healthcare services to Chesapeake citizens and support and assistance to people whose lives were affected by mental illness, substance abuse, intellectual disability, and other developmental difficulties. To that end, they offered in-office services such as individual, family, and group counseling, initial screening and assessment, psychiatric services and medication management. In addition, CIBH staff went into the community to conduct emergency mental health screenings, provide case management services, conduct developmental assessments, present drug and alcohol prevention training classes, and deliver assertive community treatment to individuals with serious mental illness who can benefit from closer monitoring and more intensive treatment. Vocational and pre-vocational services were offered to adults with serious mental illness and/or intellectual disability, and residential services for provided for those with severe needs at the Highlands Place Intermediate Care Facility for Individuals with an Intellectual Disability (ICF-IID). Ancillary services such as transportation to and from appointments and assistance applying for various benefit programs was offered as available.

For Fiscal Year (FY) 2014-15, CIBH had an operating budget of \$22,399,059. The department had an authorized complement of just over 245 full-time positions. CIBH funding sources included Federal, State, and City funds as well as client payments in the form of self-pay and insurance payments. The central office and primary treatment facility were located in the Great Bridge section of the City on Great Bridge Boulevard. Additional locations included Coastal Clubhouse, the psychosocial rehabilitation facility, located next to the central office, the Intermediate Care Facility for individuals with intellectual disability on Rokeby Avenue, the Community Options Program, and the day support program for individuals with intellectual disability and the library café located in the South Norfolk library.

Based on our review, we determined CIBH was accomplishing its overall mission of providing a variety of behavioral healthcare services that were critical to helping individuals integrate into the community and improving their quality of life. However, we did identify several areas of concern that needed to be addressed. Those areas included cash handling and receipts, accounts receivable, pharmacy control procedures, and card access controls.

This report, in draft, was provided to CIBH officials for review and response and their comments have been considered in the preparation of this report. These comments have been included in the Managerial Summary, the Audit Report, and Appendix A. CIBH concurred with most of the report's recommendations and had either implemented or begun the process of implementing many of them. CIBH's management, supervisors, and staff were very helpful throughout the course of this audit. We appreciated their courtesy and cooperation on this assignment.

Sincerely,



Jay Poole
City Auditor
City of Chesapeake, Virginia

C: James E. Baker, City Manager
Dr. Wanda Barnard-Bailey, Deputy City Manager
Joseph J. Scislowicz, Executive Director, CIBH

Managerial Summary

A. Objectives, Scope, and Methodology

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individuals with intellectual disability and the library café located in the South Norfolk library. Just prior to this audit, a significant personnel change occurred that affected several of the audited areas. CIBH's Assistant Director position was converted to Director of Administrative Services to provide closer oversight of the fiscal, reimbursement and information technology areas. CIBH's long-term Fiscal Administrator was promoted to Director of Administrative Services, and a new Fiscal Administrator hired as a replacement.

Major Observations and Conclusions

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B. Performance Information

CIBH's mission was to provide the 230,000 citizens of Chesapeake with comprehensive community-based services and support for residents with mental health, substance abuse, and intellectual disability needs, including services for infants with developmental delays. This mission was accomplished through CIBH's offerings of treatment and support that assisted Chesapeake residents in managing their illnesses and helped individuals integrate into the community and improved their quality of life. To meet this goal, CIBH offered services which included individual and group therapy, psychiatric services, day support, intermediate care, early intervention and prevention services as well as case management.

1. Performance Measures

In providing services CIBH, in addition to its' paid staff, was assisted by volunteers in various roles throughout the organization. In FY 2012-13, 5,220 hours were volunteered, or an additional 2.5 full-time equivalent workers. The FY 2014-2015 budget included 4,600 volunteer hours.

In FY 2014-15, for the three main treatment areas, CIBH was expected to provide 21,517 hours of outpatient services, 13,312 hours of case management, and 6,554 hours of emergency services in Mental Health; 23,810 hours of outpatient services, service to 1,232 outpatients, and 1,155 days of detox services in Substance abuse; and 20,000 hours of early intervention, 40,000 hours of day support, and 8,400 hours of staffing for 280 families and 373 case management clients experiencing Intellectual Disabilities. All these numbers either increased or stayed the same relative to the prior fiscal year.

C. Financial Control Issues

Our review of financial controls at CIBH identified a number of concerns that needed prompt attention. First, cash handling controls were not sufficiently developed, which placed sizable amounts of cash collections and petty cash at risk. Review of accounts receivables showed that the billings for the Intermediate Care Facility were not being paid by Medicaid and that a significant amount of past due billings were not pursued during a period of staff shortage. Reconciliations of client payments between the Credible AR and the Treasurer's system were several months behind and had segregation of duty issues. Finally, banking procedures for affiliated corporations and personal client accounts could be enhanced.

1. Cash Handling, Petty Cash and Settlement Processes

Finding – CIBH's procedures for cash handling, petty cash (p/c) and settlement processes did not sufficiently address cash handling, petty cash, settlement, internal controls, and the safeguards over assets. In addition, there was minimal oversight and monitoring of the front office and petty cash operations.

Recommendation - CIBH should develop and document cash handling, cash settlement process, and petty cash (p/c) policies and procedures so that cash is adequately safeguarded. In addition, CIBH should develop an ongoing oversight and monitoring process to ensure adherence to cash handling and cash control procedures, and individuals responsible for p/c operations should provide oversight and monitoring over the p/c operations to ensure that documented procedures were being followed.

Response – CIBH has complied with all recommendations by improving the City's cash collection and petty cash procedures to include cash settlement reconciliation signed by supervisors and the use of new petty cash receipts. Random unannounced cash collection audits and semi-annual petty cash audits will be conducted bi-monthly by Fiscal staff to monitor ongoing compliance with the revised procedures. Physical security of petty cash funds has been improved through use of locked cash drawers and a two-part combination for the front office safe. Two inactive/low activity petty cash funds have been dissolved. (Note – the full text of the CIBH response is included in the body of the audit report.)

2. Medicaid and Accounts Receivable

Finding – CIBH had an accounts receivable balance in excess of \$2,816,364, of which almost \$635,000 could be considered uncollectable. There was also an additional \$1.0 million in receivables from other sources, of which almost \$400,000 was over six months old and could be considered uncollectable.

Recommendation – CIBH should ensure that all necessary billing requirements for new services are understood and readily executable so that they can be fully implemented in sufficient time to avoid writing offs.

Response – CIBH received reimbursements of \$2,051,327 in June 2015 related to the ICF and has resolved all known issues related to billing the ICF and fully expects to collect all revenue with the exception of the foreseen pre-certification costs already allowed for. The pre-certification receivables have been written off. The ICF has new management and is fully engaged in following the Medicaid procedure manual and ICF protocols that could prevent timely billing for services. The reimbursement unit has also hired a part-time temporary position to aide in recovering any aged receivables, and intends to monitor the workload of the current staff during the fully staffed period to ensure adequate staffing needs. (Note – the full text of the CIBH response is included in the body of the audit report.)

3. Segregation of Duties – Front Desk Staff

Finding – The CIBH front desk staff responsibilities for data entry and reconciliation were not sufficiently segregated. In addition, reconciliations against the City's financial system were not being completed in a timely fashion.

Recommendation – CIBH should take steps to improve segregation of duties for its reimbursement staff, and should also ensure that reconciliations against City financial records are completed in a timely manner.

Response – The PeopleSoft general ledger entry, Credible Client AR entry, and handling of cash deposits into the Treasurer's system are conducted by three separate individuals in all cases. Sufficient segregation of duties does exist. Staffing shortages that delayed the reconciliation of AR deposits between the Treasurer's system and the subsidiary ledger in Credible have been resolved, and these reconciliations have returned to a monthly frequency. The overall reconciliation of AR between the general ledger and subsidiary ledger has always and continues to be conducted monthly.

4. Banking Procedures for CIBH-affiliated nonprofits

Finding - Bank procedures for Elizabeth River Properties of Chesapeake and CSB of

Chesapeake, Inc. lacked adequate segregation of duties. Also, account balances exceeded the FDIC insurance limit.

Recommendation – CIBH should address the banking procedure control issues associated with its affiliated corporations

Response - Elizabeth River Properties of Chesapeake, Inc. has a seven member board of Directors and is supported by two CIBH staff members (an Executive Director and a Housing Administrator) in addition to two contract positions (a bookkeeper and a property manager). The contract bookkeeper was vacated in October of 2014 and refilled in May of 2015. During the interim the ERPC Executive Director performed the duties of the bookkeeper. As a compensating control during this time period the Treasurer was asked to review the bank reconciliations. Now that the bookkeeper position has been refilled the practice will return to the bookkeeper performing the reconciliation and review of the bank reconciliations by the Executive Director. The bookkeeper does not have any banking authority. (Note – the full text of the CIBH response is included in the body of the audit report.)

5. Client Personal Fund Accounts

Finding - Policies and procedures for CIBH's personal resident accounts had not been updated and did not sufficiently address client check cashing processes, account cash limits, and client and guardian monthly statements.

Recommendation – Procedures for the handling of residents personal fund accounts should be updated.

Response - Consolidated monthly statements from the UP Center and Highlands Place will be mailed to each Authorized Representative assigned for each resident on a Monthly basis.

The following revised Resident Check Cashing Procedures have been implemented. The Account Technician will contact the Representative Payee to request resident's funds only when needed. Resident's personal funds account held at Highlands Place should always be \$80 or under. Upon receipt of the resident's check the check stub will be date stamped with the date of receipt and placed into safe. Staff will be notified via email that the resident has a check that needs to be cashed as soon as possible. The Account Technician is responsible for assuring that the resident's checks are cashed within 2 weeks of date of receipt of checks. Once the check has been cashed the check stub will then be date stamped with "Date cashed" and the deposit of the funds will be documented in the "resident's fund" excel spread sheet and a receipt will be filled out documenting the deposit of funds along with the completion of section III of the "Resident Funds Expenditure Request/Deposit Form.

D. Operations

Our review of several CIBH operational areas noted three areas where procedures could be enhanced. CIBH security of controlled substances and compliance with DEA regulations required prompt attention. Med Room Sample Drug controls and CIBH access card controls could be enhanced. Finally, CIBH should work with Human Resources to revise Administrative Regulation 2.44, so that more of its clinical staff was subject to testing, and review its conflict of interest practices.

1. Controlled Substances – PACT

Finding - The CIBH received, stored and delivered Schedule II and Schedule IV controlled substances (CS) for their clients; however, the CIBH was designated as an Alternate Delivery Site and was only licensed to receive, store and deliver Schedule VI medications. In addition, there was minimal management oversight and monitoring over PACT operations.

Recommendation – The CIBH should immediately discontinue receiving, storing, and delivering any Schedule II to Schedule V controlled substances. Additionally, management should take an active role in the ongoing oversight and monitoring of PACT operations.

Response - Schedule II through Schedule V controlled substances are no longer accepted into any CIBH facility. Pharmacies delivering medication, PACT staff and individuals bringing their medication into the building have been notified CIBH will not accept storage of Schedule II to Schedule V controlled substances on the premises. PACT supervisory/managerial staff monthly scan the medication delivery packing slips to assure no Schedule II to Schedule V medication has been delivered. Policies and procedures have been put into place to prevent the delivery and storage of Schedule II through Schedule V controlled substances. All PACT staff have been educated regarding these policies and procedures and have documented acknowledgment of receipt of such policies and procedures. Medication deliveries are reviewed to ensure that no Schedule II through Schedule V controlled substances are accepted into the building. The Medication Log is reviewed to ensure no Schedule II through Schedule V controlled substances are in the PACT medication room. (Note – the full text of the CIBH response is included in the body of the audit report.)

2. Pharmacy Control Procedures – PACT

Finding - The Program of Assertive Community Treatment (PACT) Division was not in compliance with Virginia Board of Pharmacy regulations as they related to delivery of dispensed prescriptions. PACT's policies and procedures did not sufficiently address the receipt, accountability, control, and safeguarding of drugs; employees were not properly trained on the handling and receipt of drugs; and incident reports were not always completed as required when incidents occurred.

Recommendation - The CIBH should comply with the Virginia Board of Pharmacy's regulation as it relates to the delivery of dispensed prescriptions. PACT procedures should be updated to address the receipt, accountability, control, and safeguarding of drugs and ensure that employees are properly trained. Additionally, incident reports should be properly completed and forwarded to the Quality Assurance division within 24 hours as required by policy.

Response - Policies and procedures have been put in place with regard to medication deliveries and medication brought into the facility by individuals receiving PACT services to ensure these medications are recorded in the medication inventory, and put into the correct medication storage bags. With respect to medication deliveries that come to the facility via mail, the packing orders are checked and confirmation of the receipt is faxed back to the vendor. (Note – the full text of the CIBH response is included in the body of the audit report.)

3. Psychiatric Med Room – Controls

Finding - Psychiatric (Psych) med room clients did not always sign for their drugs when they were dispensed. The inventory controls for drug samples held in the Psych med room needed to be redesigned. Further, inventory audits of sample drugs were not performed on a periodic basis.

Recommendation – CIBH should ensure that all drugs are signed for by clients when dispensed. Also, inventory control practices and form should be redesigned, and surprise Inventory audits should be performed on sample drugs at least quarterly.

Response - The Virginia Board of Pharmacy regulation:VAC18110-20-275, covering the delivery and dispensing of prescriptions to clients does not pertain to sample medications. The Virginia Board of Pharmacy does not regulate sample medications.

The original audit for client signature upon receipt of medications was not completed with a nurse present. The audit presented to me was a review of 209 charts with 184 missing signatures. Upon my review of the same 209 charts there were only 50 missing signatures. A total of 77 % of the charts did contain signatures. The discrepancy occurred because the Credible system only allowed the signatures to come up that were in a designated signature box on the med pick up service. (Note – the full text of the CIBH response is included in the body of the audit report.)

4. Cardkey Access Cards

Finding - Policies and procedures for the handling and control of access card issuance,

receipt, safeguarding, and accountability had not been developed, documented, and implemented. In addition, employees were not adequately trained on the handling of access cards, and there was minimal oversight over card access processes.

Recommendation – CIBH should develop, document, and implement access card handling process policies and procedures so that the integrity of the data on the card access system is accurate. Employees should be adequately trained on access controls. In addition, CIBH should develop an ongoing oversight and monitoring process to ensure adherence to access cards procedures.

Response - CIBH has implemented or is in the process of implementing the following changes:

- **Administrative MIS Staff have been issued individual accounts by the Main Card Access Administrator.**
- **A Formal Request to Add/Transfer/Remove user Access had been established suspensions and terminations are walked by the supervisor to MIS.**
- **MIS has begun to explore a process of exporting active card access accounts into a CSV file and comparing accounts against the active directory export form the network access. Those accounts that are outside of the network scope are then filtered by the internal HR list by the appropriate staff members.**

(Note – the full text of the CIBH response is included in the body of the audit report.)

5. Random Drug Testing

Finding - The CIBH required ongoing random drug testing for van drivers as a requirement of the City's Substance Abuse Policy (Administrative Regulation 2.44). However, it did not require ongoing random drug testing for employees such as Clinicians, Nurses, and Program Supervisors.

Recommendation –The CIBH should consider implementing an ongoing random drug testing program for positions such as Clinicians, Nurses, and Program Supervisors.

Response – As noted CIBH follows the current Administrative Regulation 2.44 as written. We are in favor of expanded testing of additional job classifications up to including all City of Chesapeake employees in the random pool. CIBH believes that every employee provides a vital role in the delivery of our services and the abuse of substances by any employee can negatively impact the quality of service to an individual.

6. Conflict of Interest Practices

Finding – CIBH did not have effective departmental conflict of interest practices.

Recommendation – CIBH should strengthen its conflict of interest review practices.

Response – CIBH will be implementing a standardized form that will be included in Credible. All employees will be required to complete the form on at least an annual basis or more frequently if they obtain outside employment during the year. Placing this form in Credible will allow us to better manage the completion of the form and to prepare additional analysis in a more efficient manner.

CHESAPEAKE INTEGRATED BEHAVIORAL HEALTHCARE

PERFORMANCE AUDIT

JULY 1, 2014 TO JUNE 30, 2015

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A. Objectives, Scope, and Methodology

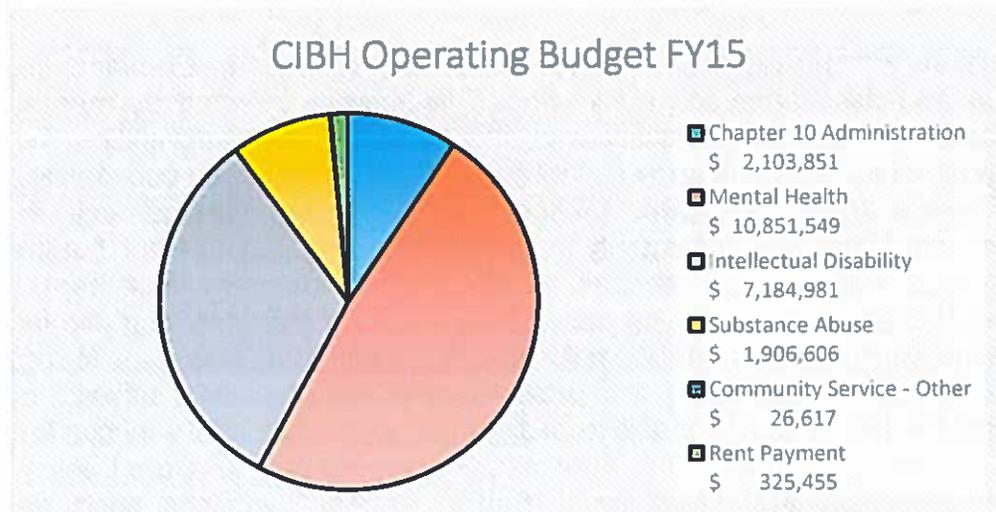
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CIBH was governed by a twelve-member community-based Board of Directors whose members were appointed by the City Council. They functioned as an administrative policy making board. The Executive Director reported directly to the Board Chair and Board of Directors. CIBH's Leadership Team was made up of an Executive Director, an Administrative Services Director, two Program Directors (mental health/substance abuse programs and intellectual disability programs), a Medical Director, and five Administrators overseeing (1) fiscal; (2) quality assurance, (3) management information systems; (4) long-term mental health/substance abuse programs; and (5) short-term mental health/substance abuse programs. Their staffing complement of 245 FTEs included clinical, administrative, and clerical employees.

For Fiscal Year (FY) 2014-15, CIBH had an operating budget of \$22,399,059. The department had an authorized complement of just over 245 full-time positions. CIBH funding sources included Federal, State, and City funds as well as client payments in the form of self-pay and insurance payments. The central office and primary treatment facility were located in the Great Bridge section of the City on Great Bridge Boulevard. Additional locations included Coastal Clubhouse, the psychosocial rehabilitation facility, located next to the central office, the Intermediate Care Facility for individuals with intellectual disability on Rokeby Avenue, the Community Options Program, the day support program for individuals with intellectual disability and the library café located in the South Norfolk library. Just prior to this audit, a significant personnel change occurred that affected several of the audited areas. CIBH's Assistant Director position was converted to Director of Administrative Services to provide closer oversight of the fiscal, reimbursement and information technology areas. CIBH's long-term Fiscal Administrator was promoted to Director of Administrative Services, and a new Fiscal Administrator hired as a replacement.



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Methodology

To conduct this audit, we reviewed CIBH's policies, procedures, and practices. We reviewed applicable city, state, and federal policies, and regulations, regarding various areas especially those governing the proper use, storage, and handling of controlled substances. This review included testing and evaluation of CIBH petty cash, cash handling and receipting practices, as well as testing of access cards and bank reconciliations. The security and legality of the Program of Assertive Community Treatment (PACT) and Psychiatric Medication Storage Rooms were tested, reviewed, and analyzed.

We reviewed prior internal audits and follow-up audits, agency reports, board packages, and elements of CIBH's upcoming peer review. In addition, we conducted site visits of various CIBH facilities including the ICF-IID houses and the central administration building. We also interviewed Department staff at all levels including administrative and clerical to obtain an understanding of overall operations.

B. Performance Information

CIBH's mission was to provide the 230,000 citizens of Chesapeake with comprehensive community-based services and support for residents with mental health, substance abuse, and intellectual disability needs, including services for infants with developmental delays. This mission was accomplished through CIBH's offerings of treatment and support that assisted Chesapeake residents in managing their illnesses and helped individuals integrate into the community and improved their quality of life. To meet this goal, CIBH offered services which included individual and group therapy, psychiatric services, day support, intermediate care, early intervention and prevention services as well as case management.

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2. Organization/Program Areas

To provide the citizens of Chesapeake needed services, CIBH was organized around three main behavioral health treatment categories: Mental Health, Intellectual Disability, and Substance Abuse. These categories were supported by two other programmatic areas: Administration, and Other Community Outreach.

a. Mental Health and Substance Abuse Services

CIBH was committed to providing integrated services to individuals dually diagnosed with mental health and substance abuse issues. To accomplish this, mental health and substance abuse services were consolidated under one Director of Mental Health and Substance Abuse Services. The division identified services as either short-term or long-term. Two Program Administrators oversaw delivery of services, one for short-term, the other for long-term services.

Short-Term Services provided multiple outpatient services including:

- **Access and Triage Services** helped citizens obtain mental health, intellectual disability and substance abuse services at CIBH. Brief crisis intervention, consultation, and referrals offered for other needed community services. Pregnant women seeking substance abuse treatment received priority services which were available within 48 hours of initial contact.
- **Emergency Services** ensured that mental health evaluation/consultation, pre-admission screening for inpatient hospitalization, crisis intervention and stabilization were available twenty-four hours a day/seven days a week.
- **Outpatient Services** provided mental health and/or substance abuse treatment through individual and group therapy for children, adolescents, adults, and families.
- **Intensive Outpatient Program** assisted individuals requiring intensive substance abuse treatment support by providing group therapy three times per week and individual therapy weekly.
- **The Therapeutic Day Treatment Program for Children and Adolescents** provided clinical services in the classroom for those having significant functional impairment in school due to mental, behavioral, or emotional illness.
- **Psychiatric Services** provided evaluation, on-going medication management, and nursing services to adults, adolescents and children.
- **Contracted Services** were provided through community partnerships for individuals in need of inpatient substance abuse services as well as methadone treatment.

Long-term Services were available for individuals diagnosed with a serious mental illness and included:

- **Case Management** to assist individuals with serious mental illness (SMI) and their families in finding medical, psychiatric, social, vocational/educational, residential and other supports necessary for them to meet their identified long and short term goals.
- **Mental Health Skill Building Services** to provide training and support to enable individuals with serious mental illness to achieve and maintain community stability and independence. Special emphasis is giving to training in building skills related to health and safety, activities of daily living, use of community resources, medication management, monitoring health, and nutrition.
- **The PACT (Program of Assertive Community Treatment) Team** to provide comprehensive, community based treatment for those who need ongoing, drop-in services to enable to live successfully in the community and minimize the need for continued psychiatric hospitalizations.
- **Coastal Clubhouse**, a rehabilitation program for adults with serious mental illness and/or co-occurring disorders. It provided skills training, peer support, pre-vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency.

b. Intellectual Disability Services Division

CIBH's Intellectual Disability Services Division assisted individuals with intellectual disability and/or developmental delays. The division was comprised of four distinct units:

- **Case Management** assisted individuals in finding medical, psychiatric, social, vocational/ educational, residential and other supports necessary for them to meet their identified long and short term goals. These goals were addressed through coordinating services and treatment planning, linkage to services and supports, and monitoring of the quality of services. Limited funds were available to provide support for emergency needs as well as respite care.
- **Infant Intervention and Prevention** made available an array of family-based developmental, educational, and therapeutic services to children birth to three years who had development delays, diagnosed disabling conditions and/or atypical development. Services included developmental assessments and referrals for occupational, speech, and other therapies.

Prevention services were designed to empower individuals, families, communities and systems to meet the challenges of life events and transitions without resorting to unhealthy behaviors. Their focus involved creating and implementing conditions that promoted healthy behaviors and lifestyles. Education was provided to youth, parents and caregivers and teachers. Information was also shared with local merchants in an effort to reduce underage access to tobacco and alcohol products.

- **Residential Services.** Highlands Place Intermediate Care Facility for Adult Individuals with Intellectual Disability (ICF-IID) was a residential program providing comprehensive, continuous health care and rehabilitation services to individuals with intellectual as well as physical and other disabilities. The goal of the program was to promote the functional status and independence of residents. Highlands Place consisted of two five-bed homes and was staffed 24 hours, 365 days per year.

The Family Care Program provided family oriented living arrangements for adults with an intellectual disability who would benefit from the opportunity to live in a family setting and participate in home and community life. The Family Care Program offered a stipend for approved family providers who receive necessary training to promote optimal independence and community integration for the individuals we serve.

The Supported Living Program was designed to enable adults with an intellectual disability to function as independently as possible in the community. The participants lived in their own residences and received services to enhance their skills in daily living and community integration. The residents received periodic drop-in visits by staff from private residential services vendors approved by CIBH.

- **Vocational Services.** The Community Options Program (COPS) offered supports and instruction to adults who were diagnosed with an intellectual disability and in many cases also had complex physical and/or sensory disabilities. These supports enabled program members to maximize their functional abilities and created opportunities for peer interactions. A program of community integration was also offered.

The Vocational Voucher Program provides funds to individuals with an intellectual disability to help them obtain services from day support, sheltered employment and supported employment providers. The program also offered funding for transportation services to and from the day program locations.

c. Administration Program

The Administration Program included the support services needed to maintain CIBH service divisions. This program area included the CIBH areas of budget, finance, reimbursement, payroll, information systems, as well as training and staff development.

In 2014 CIBH organized all of its administrative functions underneath a single Administrative Services Director to better coordinate and manage all the CIBH functions not associated directly with providing clients with services. The Fiscal Unit was responsible for budgetary functions, all financial reporting, and cash control and handling. Responsibility for receipting and depositing all cash and checks received by the CIBH is shared between clerical staff and the fiscal unit. All account reconciliations were performed by the Fiscal Unit. The payroll and human resources functions were also placed under the Administration Program.

Reimbursement Services was responsible for all of the various billings that CIBH processed for the services provided. These billings included Medicaid, Medicare, commercial insurers, individual self-payments, and any interagency charges. This unit also ensured that all payments were processed into the Credible system electronic medical record and were credited to the correct accounts.

Management Information Systems (MIS) was primarily tasked with keeping the Credible system used by CIBH up and running at all times. The Credible system was the backbone of CIBH for servicing clients. MIS also maintained all other software used by CIBH such as Excel, Word, and the Access Card Key system. Any hardware maintenance or other needs were also the responsibility of MIS.

d. Other Community Outreach Program Highlights

CIBH's Prevention Division partnered with various groups to provide services and some Community Service Grant funding. These groups included Chesapeake R U Ready and Chesapeake Parent Resource Center and offered workshops for parents on various topics to aid in subjects such as heroin addiction signs and symptoms, sexting, cyber bullying and nutrition. CIBH had also partnered with various churches to share advice with parents and youth. CIBH worked closely with Chesapeake Public Schools in and utilized Prevention staff to provide ongoing evidence-based programming such as Girl Power and Power Up for boys.

CIBH Community Services Grants was a need-based program that allocated funds to groups as determined by need. This program has been deemphasized in the FY 2014-2015 budget with over an 89% reduction in funding.

CIBH partnered with the Chesapeake Police and Sherriff's Department to provide Crisis Intervention Team (CIT) training for police officers. The purpose of the 40 hour CIT training program was to train officers how to better interact with individuals with behavioral health issues to protect both the officers and the individuals. Most importantly, the training helped officers obtain treatment for individuals in a mental health crisis rather than introducing them into the criminal justice system. CIBH also had a cooperative relationship with the Chesapeake Sheriff's Office. Having jail-based clinicians ensured that mental health care was continuous for incarcerated CIBH clients. CIBH staff provided continuous screenings for inmates with major mental illness to assess potential jail diversion options and to insure continuity of care.

In addition to Prevention Services, CIBH also partnered with Chesapeake Public Schools to provide school based services to children who had behavioral health issues. They had established Therapeutic Day Treatment Programs within four (4) elementary and middle schools. The clinicians at each school provided monitoring, redirection, individual and group sessions in the classroom.

C. Financial Control Issues

Our review of financial controls at CIBH identified a number of concerns that needed prompt attention. First, cash handling controls were not sufficiently developed, which placed sizable amounts of cash collections and petty cash at risk. Review of accounts receivables showed that the billings for the Intermediate Care Facility were not being paid by Medicaid and that a significant amount of past due billings were not pursued during a period of staff shortage. Reconciliations of client payments between the Credible AR and the Treasurer's system were several months behind and had segregation of duty issues. Finally, banking procedures for affiliated corporations and personal client accounts could be enhanced.

1. Cash Handling, Petty Cash and Settlement Processes

Finding – CIBH's procedures for cash handling, petty cash (p/c) and settlement processes did not sufficiently address cash handling, petty cash, settlement, internal controls, and the safeguards over assets. In addition, there was minimal oversight and monitoring of the front office and petty cash operations.

An effective cash control process should incorporate the following attributes:

- Documented cash handling, petty cash, settlement, and control procedures
- Safeguarded cash funds within the department
- Controlled duplicate keys and combinations to cash funds and safes
- System control totals for settlement of cash
- Defined and detailed daily settlement processes including settlement time(s), use of count sheets with signatures and dates, counts of the entire cash fund, processing of overage and shortages, and periodic surprise cash counts
- Defined cash exchange processes
- Reconciliation process for p/c funds
- Receipts utilized when funds were issued and returned
- Receipts for purchases were on hand and documented the use of funds
- Reconciliation forms reviewed by supervisor's and cash on hand verified
- Training provided for cashiers

We evaluated the cash handling, internal control processes, and safeguarding of assets in the front office operation to determine if cash handling processes were functioning as designed and cash funds were adequately controlled and safeguarded. We determined that procedures were incomplete and cashiers had not been adequately trained. Our testing and observations of the front office operation revealed the following conditions:

- a. Procedures for cash handling, settlement, and controls did not fully document the use of count sheets, surprise cash counts, use of system control totals, handling cash outages, and balancing and settlement processes.
- b. At night, all change fund lock boxes were placed in a floor safe (the safe door had a combination and key access) which was located in the Office Specialist II's office. The front office floor safe was not affixed to the wall/floor. In addition, five

(5) employees had access to the complete combination and key to the floor safe; therefore, the front office change funds were not adequately safeguarded when placed in the safe. Further, there was no camera located in the office where the safe was kept and an access log was not maintained to document who accessed the safe and the movement of items removed from or placed into the safe.

- c. The combination and key to the front office floor safe were not changed when employees left the employ of CIBH. The safe uses key access as well as a key-punch combination lock.
- d. Change funds for the four office cashiers were not maintained under their sole control, as one employee had the complete combination to each of the four lock boxes. In addition, this employee counted each change fund each morning but the funds were not counted in the presence of the employees who were responsible for them, compromising their sole control over the funds.
- e. There were over 310 employees who had cardkey access to the front office work area.
- f. One cashier did not keep her cash drawer locked when it was not being accessed. (The drawer was difficult to lock and needed to be repaired).
- g. The key to the front office safe door and security guard's master key, and cardkey access cards were kept in an unlocked drawer in the front office work area during the day and night.
- h. Office cashiers did not count their change fund at the end of each day as required by policy. Also, the Office Specialist II's change fund was not verified by a second person. Further, when change funds were counted the count was not documented on a cash count sheet.
- i. The Credible financial system reports were not being used that would have provided office cashiers with system generated cash, check, and credit/debit card control totals for cashiers to balance their cash funds at the end of each day. In addition, the Office Specialist II was manually reconstructing the day's transactions from the Credible system for each of the four cashiers change funds to ensure all processed transactions were accounted for before she could count each of the four change funds
- j. Daily settlement for the front office cashiers was performed by the Finance Accountant upon posting the deposit to the Treasurer's system instead of by the front office operations area; therefore, segregation of duties was compromised.
- k. Cashiers were not able to process any bankcard transaction for clients after 4:45 each day because the treasury system was down for the night at 5:00 PM. CIBH provided service to their clients until 7:00 PM each day. This situation diminished CIBH's ability to provide good customer service to their clients.
- l. There was no category established to allow CIBH to accept medical card payments; therefore, medical debit/credit cards could not be used by the CIBH clients to pay for their bill. This was an inconvenience for CIBH customers and could hamper their ability to collect payments from clients.
- m. A general ledger over/short account had not been established and utilized to process cashier outages. Response: While not required by City Finance policy, the CIBH will pursue implementation of an over/short account on the general ledger.

- n. Surprise cash counts were only performed once each year.
- o. There was little or no monitoring and oversight over the front office operation by the employee responsible for overseeing the cash operations for the CIBH.

In addition, petty cash (p/c) funds were not being handled consistently throughout the CIBH. We found that procedures were incomplete and did not fully address key controls for p/c funds. P/C cashiers were not adequately trained on the proper documentation and handling of p/c funds, and that there was little or no oversight and monitoring over p/c funds. We found the following related to CIBH's p/c funds:

- aa. Receipts for the disbursement of funds to make a purchase were not always used to document when cash was issued and returned to the p/c funds. When the unspent balance was returned original receipts when used were thrown away after funds were returned. This did not document the complete transaction; issuance of cash and the return of cash and the receipt for funds spent.
- bb. Receipts for purchases were not always annotated as to use of funds.
- cc. Some receipts indicated personal purchases along with CIBH purchases. Note that personal purchases were not reimbursed with city funds.
- dd. Some p/c cashiers purchased items and reimbursed themselves out of their own fund.
- ee. Three of the seven p/c funds counted had outages. These outages were not documented on the reconciliation forms when the cashiers replenished their p/c fund. In addition outages were not being processed to a general ledger over/short account when they occurred.
- ff. Cashiers were not required to attach adding machine tapes to reconciliation forms to substantiate the totals reflected on the form.
- gg. Cashiers did not always count their p/c fund when they requested cash replenishments from the Finance Department. In addition, cashiers were not required to use a count sheet to document the count of their p/c fund.
- hh. The Petty Cash Reconciliation Form did not provide a space to document supervisor signature and outages; therefore, outages were not annotated on the reconciliation forms.
- ii. Supervisors were not required to count p/c fund and sign as verifier at the time the reconciliation forms were completed and submitted to accounting for review.
- jj. The accounting division was required to verify all reconciliation forms before they were submitted to the Finance Department. When errors were found on the reconciliation forms, the accounting divisions altered the report to reflect the correct information. In addition, when these errors affected the cash on hand total included on the reconciliation form, no one recounted the cashier's p/c fund to determine if the correct amount of cash was on hand. In addition, when errors were identified by the accounting division they made alterations to the reconciliation forms by using whiteout tape and rewriting over the whiteout tape before the forms were forwarded to the Finance Department.
- kk. Divisions that had p/c cashiers provided little or no oversight to the p/c function.

- ll. All p/c funds were not kept under the sole control of the p/c cashier. We found that a \$50.00 p/c fund for adolescent substance abuse was left in an unlocked file cabinet. The fund was kept in a combination lock box; however, the complete combination was taped to the top of the box. In addition, the individual responsible for the fund had left the employ of the CIBH on 11/14/14 and the fund was not located until 12/17/14. Also, the substance abuse \$50.00 p/c fund was kept in a inter office mail envelope and locked in a safe, however, the cashier did not have access to the safe. In addition, five employees had complete access to the safe.
- mm. Several p/c funds that had not been replenished at least six times per year were not eliminated, as required by a Finance Department guideline. Two p/c funds had not been replenished since 2013.
- nn. The employee who had overall responsible for CIBH's p/c function for the CIBH provided little or no oversight and monitoring over the p/c operations.
- oo. Surprise cash counts were only performed once a year on p/c funds. The frequency of petty cash surprise audits will be increased to semi-annual and conducted by Finance staff

These conditions existed because existing city procedures did not provide the level of internal controls required by the internal auditors. Cashiers were not adequately trained. Also, an oversight and monitoring process had not been fully developed and implemented to ensure controls were in place and functioning as designed, and there was little or no oversight and monitoring of the petty cash custodian daily operations prior to processing custodian reimbursement requests which have and will continue to be reviewed by the Accountant and Fiscal Administrator when processing payments.. If cash handling and control procedures are not established and periodically evaluated and monitored, the risk exists that cash funds could be misappropriated.

Recommendation - CIBH should develop and document cash handling, cash settlement process, and petty cash (p/c) policies and procedures so that cash is adequately safeguarded. In addition, CIBH should develop an ongoing oversight and monitoring process to ensure adherence to cash handling and cash control procedures, and individuals responsible for p/c operations should provide oversight and monitoring over the p/c operations to ensure that documented procedures were being followed.

The cash control procedures developed should include:

- Adequate training for cash-handling and settlement personnel.
- Procedures for control of cash during the day and night.
- Control of keys and combinations.
- Procedures for handling overages and shortages when they occur, with an over/short general ledger created account to process outages.
- Settlement procedures that include daily system financial balancing totals, settlement times and dates, use of count sheets, cash exchange processes, cash counts for all funds including change funds, completion of settlement documents, signatures and dates, and adding machine tapes. The daily cash settlement

- process should require that cash funds be verified by one person, reconciled by another, and a settlement sheet be completed each day, even if there are no transactions. Deposits should be made no later than the next business day.
- Procedures for daily settlement should be performed by the office operations area rather than the accounts receivable division. In addition, daily settlement cutoff time should be changed so that cashiers can accept bankcard payments until 7:00 PM. (This was corrected during the audit).
- Restricted access to the front office work area
- A category code established with the bank to allow acceptance of medical credit cards for payment. (This was corrected during the audit).
- Surprise cash counts performed more frequently than once a year.
- Safes affixed to the wall/floor. In addition, track the movement of assets kept in the safe, and change combinations/keys when employees leave the employ of the CIBH.
- Control the security guard's master key, two access cardkeys, and the key to the front office safe to prevent unauthorized use.

In addition, petty cash procedures should include:

- Reconciliation procedures that include counting of cash on hand, use of count sheets, supervisor's verification of cash, receipts for purchases, supervisor's signature, documentation of outages on reconciliation forms, processing of outages to the general ledger, inclusion of expenses on receipts, use of adding machine tapes, and procedures for preparation of the reconciliation package sent to the City's Finance Department
- Review and evaluation of the ongoing need for p/c funds, using the Finance Department guideline that a p/c fund be replenished at least six times in a year.
- Prohibition of p/c cashiers from purchasing items using funds from their own p/c fund and then reimbursing themselves.
- Prohibition of p/c cashiers from purchasing personal items with CIBH funds.
- Discontinuing the use of whiteout tape to correct errors on financial documents.
- Recounting the p/c fund using a second person when errors are found on reconciliation forms that affect the remaining cash total.
- Having a supervisor account for p/c funds when an employee leaves the employ of the CIBH.
- Performing surprise cash counts more frequently than once a year.

Response – CIBH has complied with all recommendations by improving the City's cash collection and petty cash procedures to include cash settlement reconciliation signed by supervisors and the use of new petty cash receipts. Random unannounced cash collection audits and semi-annual petty cash audits will be conducted bi-monthly by Fiscal staff to monitor ongoing compliance with the revised procedures. Physical security of petty cash funds has been improved through use of locked cash drawers and a two-part combination for the front office safe. Two inactive/low activity petty cash funds have been dissolved.

Additionally, we offer the following comments related to specific issues mentioned:

Related to cash handling:

- **a. The current City policy does not require the use of a settlement sheet for daily cash collections. However, CIBH has implemented use of the day sheet settlement report suggested by the auditor that will provide a space to document supervisor verification of the teller's count and show any overage/shortage for the shift.**
- **b. Effective June 11, 2015, CIBH front desk staff will lock their cash drawers in their workstation drawer while on duty. This will assure the cash drawers remain under the control of the individual cashiers. At the end of the shift, the cashiers will take their drawers to the back room to complete the settlement reports and cash out. They will store their cash drawers with tills in the safe overnight. CIBH will investigate the feasibility of securing the floor safe to the floor. However, the floor safe weighs in excess of 500 pounds and would be extremely difficult to remove un-noticed. The most funds that will be stored in the safe overnight will be the till balances totaling \$300. Additional security cameras on the safe or counting area are not warranted at this time.**
- **c. Staff will be changing the safe combination to a split combination so that two individuals will be required to access the contents of the safe. A safe access log book will also be developed.**
- **d.: Cashiers will maintain sole control of their cash boxes by securing them in their desk drawers while on duty. Upon closing out, a supervisor or other staff will verify and sign the cashier deposit and till per the settlement report.**
- **e. There are several operational needs that require clinical staff to have access to the front office area. Tills and all cash on hand will be maintained under the sole control of each cashier during business hours or secured in the safe. Therefore, there is no longer any internal control risk from allowing general staff access to the front desk area.**
- **f. CIBH will assure all cash boxes are operating properly and that cashiers provide an additional layer of security by maintaining their cash boxes in the drawers of their workstations and under double lock security when they are away from their desk. Spare desk drawer keys will be kept in the safe.**
- **g. Our plan to change the safe combination will negate the need to use a key to open it. We plan to use the two part safe combination code instead of key access. The Security Guard's master key and back-up access cards will either be secured in a locked area with limited access or locked in the safe whenever not under the direct control of the security guard.**
- **h. CIBH will implement the use of the settlement sheet suggested by the Auditors. A separate settlement sheet was not previously required by City policy.**
- **i. The Credible reports will be used daily to identify the amount of cash, check, and charge that has been collected. This report will be used to draw the deposit on a daily basis. The till will always be restored to full value. Any overage/shortage will be posted to the ledger by use of a new over/short**

- account.
- j. Since one staff person was drawing the deposit (front desk teller) and another was recording the deposit (Finance Accountant), adequate segregation of duties was in place in the former system. However, to provide better point source control of the cash collections, the front desk supervisor is now recording the deposit in the Treasurer's system and securing the deposit immediately after confirming the teller's deposit and count. The Fiscal staff role is limited to reconciling the Treasurer's deposits to the Credible postings against the Client AR on a monthly basis.
 - k. We have changed our daily date cutoff period to be 3:00 so we can now accept all types of payments at all times.
 - l. CIBH has been established as a service provider authorized to accept medical payment cards from Flex Spending Account. Medical debit/credit cards are handled just like other debit/credit cards used for payment of CIBH client services.
 - m. While not required by City Finance policy, the CIBH will pursue implementation of an over/short account on the general ledger.
 - n. Surprise cash counts will be conducted by Finance staff bi-monthly for at least a year or until consistent compliance to the revised procedures can be demonstrated. Thereafter, audits will be conducted twice per year at the cashier level.
 - o. The front office staff is considered administrative support staff and all report through division supervisors to the lead administrative supervisor. While these employees do not report to Fiscal, the Fiscal Administrator will provide additional oversight of the cash operations through training, documentation review, and oversight of the surprise cash count reviews. The Fiscal Administrator will pass findings and recommendations to the Administrative Supervisor for personnel action if needed.

Related to petty cash:

- aa. The City petty cash policy does not require the use of a Petty Cash receipt even when petty cash advances are issued. We agree with the auditor that this process can be improved and have implemented use of the auditor's suggested Petty Cash receipt. The new receipt provides a place for the recipient and custodian to sign upon issuance and return of an advance. The form will be used for and submitted with each transaction even when an advance is not issued so that signatures of the custodian and recipient can be documented for all transfers of funds.
- bb. The new petty cash voucher provides a place to note the use and requesting program for petty cash funds.
- cc. While no internal controls issues were identified, staff will be encouraged when practical to request two separate transactions when making personal purchase at the same time as business purchases. If these are inadvertently combined by the vendor on the same invoice, we will continue to cross out the personal items on the receipt and only seek reimbursement for the business items.

- dd. Petty cash custodians are not precluded from purchasing items from their own fund provided the purchased items are for appropriate business needs. The new petty cash receipt will guarantee that another employee in addition to the custodian is involved in all petty cash disbursements thereby assuring two party involvement for all petty cash disbursements.
- ee. The new over/short account will apply to petty cash funds if needed. However, petty cash custodians are very rarely out of balance. What was identified as outages in the p/c funds by the auditors were actual petty cash advances that had been issued for valid purchases, but receipts were not in place to document the advances. The new petty cash receipt form now provided written and signed documentation supporting the full balance of the petty cash fund at all times.
- ff. Petty cash custodians and tellers will now be required to attach adding machine tapes to their settlement sheets when submitting to Finance for processing. Two additional adding machines will be purchased and placed in the back office for front desk cashier use while settling their funds.
- gg. The new petty cash settlement report requires count verification and signature of a supervisor before the report is sent to Finance to process the custodian's reimbursement.
- hh. The new petty cash settlement report provides a space for supervisor signature and over/short documentation.
- ii. Supervisors now count and sign the petty cash settlement report prior to submission of the reimbursement request to Finance. Note that under current City policy, supervisors are not required to count the p/c settlement because they are already signing the custodian's reimbursement request.
- jj. The new petty cash settlement report will be signed by the supervisor after verifying the count. Any over/short remaining will be documented and posted to the over/short account. The cashier and supervisor will each count and recount the totals on the reimbursement report until the proper totals are identified and recorded. Since this work will be conducted by program staff, the Finance accountant will have no need to alter the form in any way. If the Finance accountant identifies a need for further corrections, the report will be returned to the custodian and supervisor to be re-worked. A new settlement report may be created and signed by both the custodian and supervisor. Hand written changes may be made by a single pen line through the incorrect entry with an initial by both the custodian and supervisor for each item changed.
- kk. Like front desk staff, petty cash custodians are administrative staff who report through the departmental supervisors to the admin supervisor. The new requirement for the p/c supervisor to sign off on settlements will provide sufficient oversight of the p/c custodian. In addition, Finance and external auditors will continue to conduct annual petty cash surprise audits.
- ll. We have emphasized with supervisors that when staff leave they are to coordinate a final reconciliation of any petty cash funds and transfer the funds to another staff. This has also been added to our resigning employee checklist. Both these funds mentioned were identified as having very low

- usage and both have since been dissolved.
- mm. Two funds with low usage were immediately dissolved once the low usage rate became known to management.
 - nn. The new petty cash settlement process will require the supervisor to sign for each reimbursement request. When processing the reimbursement request, the Fiscal Administrator has and will continue to review the nature of the petty cash purchases, support, and quality of documentation before approving the custodian's reimbursement in the City's PeopleSoft system.
 - oo. The Fiscal Administrator will look for properly completed petty cash receipts and signatures as each p/c reimbursement is processed for payment.

2. Medicaid and Accounts Receivable

Finding – CIBH had an accounts receivable balance in excess of \$2,816,364, of which almost \$635,000 could be considered uncollectable. There was also an additional \$1.0 million in receivables from other sources, of which almost \$400,000 was over six months old and could be considered uncollectible.

Services should be billed as soon as possible after the services are rendered. Failure to do so puts the amount owed at risk of not being billed or rejected by the payer for not being timely. Also, accounts receivables should be constantly evaluated to ensure that all billing discrepancies were corrected and that past due amounts were followed up on. The longer an account goes unpaid, the more difficult it becomes to collect.

At CIBH, all services were billed monthly following CIBH established protocols and policies with the exception of the ICF houses that had not yet been authorized for billing by other state agencies. All billing tests and forms were completed in the order that the reimbursement unit was notified of them.

Highlands Place, an ICF project for CIBH's Intellectual Disability service program, began operations in May 2013, caring for clients. However, CIBH was not authorized by the authorizing state agencies (Virginia Department of Health, ICF facility surveyor; Myers and Stauffer, state rate setting division; DMAS, provider enrollment unit; and VAMMIS, Medicaid billing intermediary) until late October 2014. Testing began in early November 2014 with the understanding that all clinical documents had been submitted to the approving authorities. Error reports received from the billing agent were incurred due to clinical registration of clients admitted to the ICF houses and failure of the Medicaid provider enrollment unit to follow through on registration of the agency in the Medicaid web portal. Therefore CIBH had been engaged in the back-and-forth process of sending bills to the billing agent only to have them rejected for errors. CIBH then would correct the errors and resend.

Although the facility opened in 2013, it was not until early 2015 that the billing program met applicable standards. CIBH finally received authorization for each of the clients to be at the facility and billed to Medicaid in June 2015, and also received

reimbursements totaling \$2,051,327. In addition, Medicaid only paid for billings that were no more than a year old. ICF billings older than that totaled \$634,884. (Auditor's Note: This amount contained approximately \$51,000 that would normally be written off as the difference between the ceiling rate of \$828.83 and the CIBH allowed reimbursement rate of \$762.35. CIBH expected to file a cost settlement report to recover these costs).

The following table highlighted billed amounts and Medicaid receivables.

Table 1

ICF BILLED TOTALS BY YEAR			
2013	2014	2015 (as of 4/30/15)	Total
\$249,478	\$1,778,669	\$788,217	\$2,816,364

An additional \$1.0 million in accounts receivables were amounts owed from commercial insurances, self-payments, and other sources. This amount contained over \$400,000 that was outstanding six months or more, including \$257,057 in self-pays that were over one year old and should have been sent to debt set-off (DSO). An additional \$80,000 was due from commercial insurance agencies and may still be recoverable.

The Medicaid billing situation occurred because an eligibility form was not completed through Social Services when the clients were first admitted to the facility. This situation was compounded by difficulties in establishing the claim parameters when the reimbursement system was being tested. In addition, the reimbursement section operated short staffed for a period of 9 to 12 months due to staff FMLA absences. During that time period it was the priority of the reimbursement unit to continue to provide customer service on a day-to-day basis to presenting clients and ensure that all services provided were billed timely to prevent write offs due to insurance timely filing rules. Also, follow up on aged receivables were delayed.

Even if the CIBH accounts receivable write offs occur in a timely fashion, without timely reimbursement of amounts due CIBH, the risk exists that the amounts will become uncollectible. Late payments put a strain on cash flow by potentially requiring the City to use other funding sources to fund projects, which may diminish the availability of funds for other operations and could adversely impact other missions of CIBH and the City. For each month that passes where Medicaid is not billed, approximately \$170,000 becomes uncollectable. There has been active monthly billing and payment for Medicaid receivables. The past due Medicaid receivables have been incurred for the ICF only, all of which will be collectible, with the exception of the precertification costs.

Recommendation – CIBH should ensure that all necessary billing requirements for new services are understood and readily executable so that they can be fully implemented in sufficient time to avoid writing offs.

CIBH should ensure new projects have timely review of milestones for correctness and completion, particularly as they relate to billing/reimbursement requirements. CIBH

should also review the workload of the reimbursement section to ascertain if additional staffing, either permanent or temporary, is required to process the past due account receivables. Additionally, CIBH should review having a person trained in reimbursements for the client intake process to identify and collect amounts owed from self-pay clients.

Response – CIBH received reimbursements of \$2,051,327 in June 2015 related to the ICF and has resolved all known issues related to billing the ICF and fully expects to collect all revenue with the exception of the foreseen pre-certification costs already allowed for. The pre-certification receivables have been written off. The ICF has new management and is fully engaged in following the Medicaid procedure manual and ICF protocols that could prevent timely billing for services. The reimbursement unit has also hired a part-time temporary position to aide in recovering any aged receivables, and intends to monitor the workload of the current staff during the fully staffed period to ensure adequate staffing needs.

Additionally, we offer the following comments related to specific issues mentioned:

- **The Medicaid billing situation occurred due to new program start up and clinical failure to submit client enrollment documentation. Follow up occurred on all known agency, clinical, and reimbursement issues promptly. The attached timeline indicates active pursuit on all levels of governmental and reimbursement oversight during this grueling process (Auditor's Note – Timeline is included as Appendix B.)**
- **The reimbursement unit followed up on all error reports and denials weekly and sometimes daily to bring the ICF's to the brink of acceptable billing of services provided. Rejected billing was not due to the reimbursement unit as all billing processes were in place and followed according to agency protocols.**
- **Although Medicaid only paid for billing no more than 12 months old, CIBH allowed for pre-certification write offs. Authorization for billing was assigned the date of March 3, 2014. As is customary with the start of an ICF, billing is only authorized after licensure and certification from two separate State Agencies. Amounts related to the precertification period were written off in June 2015. Billings from March 3, 2014 were also submitted by the reimbursement unit with the intention of getting a denial to circumvent timely filing deadlines that would allow the agency to bill for services over 1 year old if it was documented that billing had been submitted prior to the twelve (12) month timely filing limitation. All services with a date of March 3, 2014 forward that remain in the accounts receivable are collectible. To be conservative, it is CIBH practice to create an allowance for and exclude all services dates that exceed one year from the net accounts receivable.**
- **The difference between the ceiling rate and the reimbursement rate that was noted as potentially being uncollectible; it in fact collectible. The process for reimbursement for an ICF is actually a two part system. Individual claims are filed for the dates that the residents are in the ICF and annually a cost**

settlement report (similar to a tax return) is filed to settle the difference between the ceiling rate and what was reimbursed. Facilities can be paid the full difference if their actual costs per resident day exceed the ceiling rate; CIBH will fall into this category as additional costs beyond base operational costs are included in the calculation. We have chosen to keep this amount in our accounts receivable.

In summary related to the accounts receivable for the ICF, all potential revenue for this program has either already been collected or will be collected. There has been no loss of revenue or negative financial impact to operations that resulted from the delays.

- CIBH continues to follow agency protocols for pursuing commercial and self-pay amounts owed. The DSO policy does not allow for sending clients still in service with CIBH to DSO to prevent exacerbation of their conditions. The collectability of accounts transferred to Debt set-off is uncertain and for the reason it is CIBH's practice to create an allowance for these amounts which excludes the balance from our net accounts receivable. Any balances transferred to debt set-off are pursued by the State Treasurer through the Department of Taxation. All non-debt set-off aged receivables are currently being pursued.

Attachments: Timeline of ICF Startup – Appendix B
Excel ICF spreadsheet – Appendix C

3. Segregation of Duties – Front Desk Staff

Finding – The CIBH front desk staff responsibilities for data entry and reconciliation were not sufficiently segregated. In addition, reconciliations against the City's financial system were not being completed in a timely fashion.

According to the US Government Accounting Office's Standards for Internal Control in the Federal Government (GAO-14-704G):

Component of Internal Control	Application to Guidance Processes
<p><i>Control activities</i></p> <p>Internal control activities help ensure that management's directives are executed. Control activities are the policies, procedures, techniques, and mechanisms that enforce management's directives. They help ensure that actions are taken to address risks. The control activities should be effective and efficient in accomplishing the agency's control objectives.</p>	<p>The agency should maintain written policies, procedures, and processes to ensure that once the appropriate level of review has been determined, agency officials understand the process to adequately review guidance prior to issuance. Written policies and procedures should designate:</p> <ol style="list-style-type: none"> 1. the appropriate level of review to maintain appropriate segregation of duties, and 2. the means by which management can comment on the draft guidance and program staff can address those comments.

One CIBH receptionist was responsible for receiving mail, separating client payments from other received mail, acting as CIBH's operator/receptionist, making data entries to Credible (CIBH's financial reporting system), and preparing an Excel spreadsheet of data entered into Credible for review. This receptionist was often interrupted to provide customer service and forward phone calls, which sometimes resulted in data entry errors. However, data entries to Credible were not verified for accuracy against client payments before the spreadsheet was forwarded to a second employee, an accountant. This accountant was responsible for verification and correction of data entry errors and reconciling the Credible system entries against mailed-in client check payments.

We noted that this accountant was authorized to make adjustments to the initial Credible system entries and therefore could overwrite these entries. The accountant also took deposits of clients' checks to the Treasurer. While the Credible system included an audit trail that identified changes made by users, this information was not easily accessible. Additionally, the accountant was responsible for reconciling CIBH's deposits against the City's PeopleSoft financial system and Credible. However, this reconciliation had not been performed for at least six months, and the accounts were at least \$120,000 out-of-balance.

These situations were the result of long standing staff practices which had not been sufficiently addressed. However, unless the segregation of duty and timely reconciliation issues are addressed, CIBH runs an increased risk for misreporting of revenue and misappropriation of funds.

Recommendation – CIBH should take steps to improve segregation of duties for its reimbursement staff, and should also ensure that reconciliations against City financial records are completed in a timely manner.

CIBH should attempt to separate the initial error correction that the accountant performs from the deposit function. CIBH should also periodically review any user changes to initial data entries in the Credible system. CIBH should also require that the accounts receivable reconciliation against PeopleSoft and Credible be completed on at least a monthly basis, with any long-term unexplainable discrepancies written off. Finally,

CIBH should consider cross-training and staff rotation to assure familiarity and to allow reconciliations by alternate staff members when needed.

Response – The PeopleSoft general ledger entry, Credible Client AR entry, and handling of cash deposits into the Treasurer’s system are conducted by three separate individuals in all cases. Sufficient segregation of duties does exist. Staffing shortages that delayed the reconciliation of AR deposits between the Treasurer’s system and the subsidiary ledger in Credible have been resolved, and these reconciliations have returned to a monthly frequency. The overall reconciliation of AR between the general ledger and subsidiary ledger has always and continues to be conducted monthly.

4. Banking Procedures for CIBH-affiliated nonprofits

Finding - Bank procedures for Elizabeth River Properties of Chesapeake and CSB of Chesapeake, Inc. lacked adequate segregation of duties. Also, account balances exceeded the FDIC insurance limit.

Adequate segregation of duties is required to reduce the probability of actual impropriety or the appearance of impropriety. One of the key components of an effective internal control process is the need for segregation of duties. Segregation of duties has as its primary objective the prevention of fraud and errors, accomplished by assigning to different staff duties that would inherently increase the risk involved in a process if completed by the same person. Some examples would include the receipting of checks and the ability to process charge-offs, or the writing of checks and the reconciliation of the bank account.

Bank procedures for the Elizabeth River Properties of Chesapeake and the CSB of Chesapeake, Inc. did not have adequate segregation of duties. We noted the following:

- One individual made deposits, wrote checks, and reconciled the bank accounts (both corporations);
- Elizabeth River Properties of Chesapeake had eight individuals who were authorized signors on each of their various bank accounts. The total dollar amount in these accounts as of 4/30/15 was \$905,667.00. CSB of Chesapeake had four individuals who were authorized signors on each of their various banking accounts. The total dollar amount in their various banking accounts as of April 30, 2015, was \$416,895.00. Each of these individuals could withdraw funds from the various banking accounts at any time without notification.
- We also noted that the balances for Elizabeth River Properties of Chesapeake, Inc. at the various banks exceeded the \$250,000 per institution FDIC deposit insurance coverage limit.

These situations occurred because segregation of functions had not been established for bank processes. Additionally, the corporation's boards decided to have numerous authorized signors on their various bank accounts, which increased the risk to the accounts. If these situations are not addressed, the related corporations will place itself at risk for exposure to possible losses.

Recommendation – CIBH should address the banking procedure control issues associated with its affiliated corporations

CIBH should ensure that the banking procedures for its affiliated corporations include adequate segregation of duties. In addition, the number of authorized signors on banking accounts should be restricted to the extent practical. Further, the amount of funds maintained at any banking institution should not exceed the \$250,000 FDIC deposit insurance coverage limit.

Response - Elizabeth River Properties of Chesapeake, Inc. has a seven member board of Directors and is supported by two CIBH staff members (an Executive Director and a Housing Administrator) in addition to two contract positions (a bookkeeper and a property manager). The contract bookkeeper was vacated in October of 2014 and refilled in May of 2015. During the interim the ERPC Executive Director performed the duties of the bookkeeper. As a compensating control during this time period the Treasurer was asked to review the bank reconciliations. Now that the bookkeeper position has been refilled the practice will return to the bookkeeper performing the reconciliation and review of the bank reconciliations by the Executive Director. The bookkeeper does not have any banking authority.

The number of authorized signers on the bank accounts was discussed with the Board of Directors at their June 24th board meeting. The number of signers will be reduced to three per account. The bank balance by institution is discussed at each board meeting and determinations are made if funds will be moved. The Treasurer and Executive Director will move funds to reduce any exposure from the FDIC coverage limits. The amount that exceeded FDIC limits at April 30, 2015 was \$9,446.52.

CSB of Chesapeake, Inc. is composed of three board members and supported by one CIBH staff member. The number of banking transaction per year is less than five; given this low level of activity additional staffing is not practical. As a compensating control the Board members review the transaction ledger at their annual meeting. The President will also begin to review bank statements monthly for activity and irregularities.

5. Client Personal Fund Accounts

Finding - Policies and procedures for CIBH's personal resident accounts had not been updated and did not sufficiently address client check cashing processes, account cash limits, and client and guardian monthly statements.

As was the case for CIBH's cash handling, adequate controls over personal CIBH resident cash accounts were required to prevent theft or other misuses of cash. These controls included segregation of duties, proper authorization, adequate documents and records, physical controls, and independent checks on performance.

Our review of CIBH's records for resident client's personal fund accounts identified several issues:

- There was an excessive amount of cash being held in these accounts based on the spending needs of the clients. The cash amounts in the accounts ranged from \$50.00 to as high as \$500.00.
- Resident client personal accounts were replenished by a check received from "the UP Center" made payable to the client, and clinicians were required to accompany the client to the bank to endorse and cash their checks. We found that these checks were being held for at least three to four weeks before they were cashed.
- Monthly statements for the resident accounts indicating deposits and expenditures were not being sent to the client and their guardian.

These situations existed because CIBH procedures did not sufficiently address these issues. Maximum cash limits had not been established for the accounts. The employee responsible for the resident's accounts thought that "the UP Center", an outside company, was sending monthly statements to the clients and guardians; therefore, no one was sending statements to the customer. If these situations are not address personal client funds could be lost.

Recommendation – Procedures for the handling of residents personal fund accounts should be updated.

CIBH should consider the following changes:

- Establish maximum cash limits for resident client accounts.
- Establish a process that ensures timely replenishment of client accounts.
- Send out monthly statements to clients and guardians.

Response - Consolidated monthly statements from the UP Center and Highlands Place will be mailed to each Authorized Representative assigned for each resident on a Monthly basis.

The following revised Resident Check Cashing Procedures have been implemented. The Account Technician will contact the Representative Payee to request resident's funds only when needed. Resident's personal funds account held at Highlands Place should always be \$80 or under. Upon receipt of the resident's check the check stub will be date stamped with the date of receipt and placed into safe. Staff will be notified via email that the resident has a check that needs to be cashed as soon as possible. The Account Technician is responsible for assuring that the resident's checks are cashed within 2 weeks of date of receipt of checks. Once the check has been cashed the check stub will then be date stamped with "Date cashed" and the deposit

of the funds will be documented in the “resident’s fund” excel spread sheet and a receipt will be filled out documenting the deposit of funds along with the completion of section III of the “Resident Funds Expenditure Request/Deposit Form”.

D. Operations

Our review of several CIBH operational areas noted three areas where procedures could be enhanced. CIBH security of controlled substances and compliance with DEA regulations required prompt attention. Med Room Sample Drug controls and CIBH access card controls could be enhanced. Finally, CIBH should work with Human Resources to revise Administrative Regulation 2.44, so that more of its clinical staff was subject to testing, and review its conflict of interest practices.

1. Controlled Substances – PACT

Finding - The CIBH received, stored and delivered Schedule II and Schedule IV controlled substances (CS) for their clients; however, the CIBH was designated as an Alternate Delivery Site and was only licensed to receive, store and deliver Schedule VI medications. In addition, there was minimal management oversight and monitoring over PACT operations.

In 2009, the Drug Enforcement Agency (DEA) prohibited Community Services Boards from holding and distributing controlled substances (CS), or Schedule II to Schedule V drugs. The DEA ruled that when these CS were dispensed they must be delivered to the ultimate user of the CS. In addition, if employees obtained controlled substances for their clients and were not the ultimate user of the controlled substance, they would be considered in violation of federal law.

During our audit, we investigated a situation that involved missing controlled substances. We discovered that the CIBH had been receiving, storing, and delivering CS on behalf of their clients, contrary to federal law. CIBH was only licensed to maintain Schedule VI drugs on their premises. The issue of maintaining controlled substances at the CIBH was originally discussed in 2009, and again in 2013, when missing CS were investigated by CIBH’s Quality Assurance staff. As a result of that investigation, the PACT area prepared a corrective action plan to discontinue keeping CS, and addressed the control weaknesses outlined in their report.

However, during a more recent CIBH investigation (December 2014), it was determined that the corrective action plan provided by the PACT area had not been implemented, and the PACT area continued to receive, store, and deliver Schedule II and IV CS at the CIBH for their clients. The internal control weaknesses that were reported in 2013, had not been corrected. In conclusion, CIBH management provided minimal oversight and monitoring over the implementation of the PACT area action plan, to ensure that corrective action was implemented, and that all internal control weakness had been addressed.

This situation existed because the PACT area did not implement the action plan to correct the internal control weaknesses found during the initial investigation. The PACT area continued to maintain controlled substances at CIBH when they were only licensed to hold Schedule VI drugs, and there was minimal oversight and monitoring of PACT operations to ensure that the action plan was properly implemented. If these situations are not addressed the risk of loss or misuse of drugs will continue to exist and the CIBH will continue to be in violation of Federal law.

Recommendation – The CIBH should immediately discontinue receiving, storing, and delivering any Schedule II to Schedule V controlled substances. Additionally, management should take an active role in the ongoing oversight and monitoring of PACT operations.

Further, the following items need to be addressed:

- Internal control weaknesses indicated in the Quality assurance report dated in 2013 should be addressed.
- Only Schedule VI drugs should be kept by the CIBH.

Response - Schedule II through Schedule V controlled substances are no longer accepted into any CIBH facility. Pharmacies delivering medication, PACT staff and individuals bringing their medication into the building have been notified CIBH will not accept storage of Schedule II to Schedule V controlled substances on the premises. PACT supervisory/managerial staff monthly scan the medication delivery packing slips to assure no Schedule II to Schedule V medication has been delivered. Policies and procedures have been put into place to prevent the delivery and storage of Schedule II through Schedule V controlled substances. All PACT staff have been educated regarding these policies and procedures and have documented acknowledgment of receipt of such policies and procedures. Medication deliveries are reviewed to ensure that no Schedule II through Schedule V controlled substances are accepted into the building. The Medication Log is reviewed to ensure no Schedule II through Schedule V controlled substances are in the PACT medication room.

Management has hired a new PACT program supervisor and senior clinician III for oversight to the program. The PACT supervisor will regularly meet with PACT staff to review and update the application of the policies and procedures as needed. The PACT supervisor will keep the PACT administrator informed of compliance with policies and procedures and of any barriers/noncompliance that may arise for further problem solving/follow up. The PACT supervisory/managerial staff will also conduct unannounced random checks with the PACT nurse present of medication to assure only Schedule VI medication is stored.

2. Pharmacy Control Procedures – PACT

Finding - The Program of Assertive Community Treatment (PACT) Division was not in compliance with Virginia Board of Pharmacy regulations as they related to delivery of dispensed prescriptions. PACT's policies and procedures did not sufficiently address the receipt, accountability, control, and safeguarding of drugs; employees were not properly trained on the handling and receipt of drugs; and incident reports were not always completed as required when incidents occurred.

The Virginia Board of Pharmacy's regulation 18 VAC 110-20-275, for the delivery and the dispensing of prescriptions to their clients stated as follows:

"C. Delivery to a practitioner of the healing arts licensed by the board to practice pharmacy or to sell controlled substances or other authorized person or entity holding a controlled substances registration authorized for this purpose.

1. A prescription may be delivered by a pharmacy to the office of such a practitioner or other authorized person provided there is written contract or agreement between the two parties describing the procedures for such a delivery system and the responsibilities of each party.

2. Each pharmacy using this delivery system shall maintain a policy and procedure manual that includes the following information:

a. Procedure for tracking and assuring security, accountability, integrity, and accuracy of delivery for the dispensed prescription from the time it leaves the pharmacy until it is handed to the patient or agent of the patient;

b. Procedure for providing counseling;

c. Procedure and recordkeeping for return of any prescription medications not delivered to the patient;

d. The procedure for assuring confidentiality of patient information; and

e. The procedure for informing the patient and obtaining consent if required by law for using such a delivery process.

3. Prescriptions waiting to be picked up by a patient at the alternate site shall be stored in a lockable room or lockable cabinet, cart, or other device which cannot be easily moved and which shall be locked at all times when not in use. Access shall be restricted to the licensed practitioner of the healing arts or the responsible party listed on the application for the controlled substances registration, or either person's designee."

Other notes from the regulations:

- Copies of forms to be utilized should be included in the policy and procedure manual.
- Description of supplies used to deliver prescriptions should be included in the policy and procedure manual.
- Designation of other persons who may access the dispensed drugs shall be in writing and available for review by an agent of the board."

PACT had three incidents that involved missing drugs. These incidents were reported to the Quality Assurance staff on December 10 & 30, 2014, respectively. Two of these incidents involved missing Schedule II Controlled Substances (CSs) which the CIBH was not registered to receive, store, or hold. For one of the reported incidents, drugs were received on December 24, 2014 but were not verified or accounted for, and were not immediately placed in the PACT Med room when received. The drugs were left uncontrolled in PACT's office until December 29, 2014, at which time a 30 day supply of a CS was found to be missing. (Auditor's Note – all three incidents were reported by CIBH to the Police).

In reviewing this matter, we identified the following control issues:

- Procedures for tracking, receipt, accountability, control, and safeguarding for the delivery of prescriptions from the time it left the pharmacy until it was handed to the client were not sufficiently documented and therefore were not followed.
- PACT employees were not properly trained on drug handling, receipt and control processes and were unaware that they were only authorized to have Schedule VI drugs.
- One pharmacy was delivering Schedule II to Schedule V CSs to the CIBH, which was not authorized to receive them. Instead PACT received, stored and held CSs for their clients, including Schedule II CSs for two (2) clients and Schedule IV CSs for fourteen (14) clients.
- Drugs delivered to the CIBH were signed for by the receiving individual but were not verified and accounted for upon receipt. Also, copies of the signed receipt logs were not maintained by the PACT division; therefore, there was no record of the date and time when drugs were received and who received the drugs. Additionally, drugs were not immediately placed in the PACT med room upon receipt.
- The PACT office did not have a unique lock on their office door and we determined that 28 individuals had access to the key or master key to the PACT office door. Further, incident reports were not completed and sent to the Quality Assurance area within 24 hours of the incident as required by policy.

We also identified security and operations issues with PACT:

- The PACT med room was accessed by combination lock and key and no one could remember the last time the combination and key were changed.
- There were no cameras located in the PACT med room.
- The PACT med room was located on the second floor and the PACT office was located on the first floor. There was no lockable facility in the PACT office to place

- drugs to better serve the needs of the client.
- The movement of drugs from the PACT med room to the PACT office was not documented.
 - Panic alarms were not installed in the PACT office.
 - No time schedule was established for clients to pick-up their drugs. Therefore, employees were constantly interrupted.
 - Clients were not required to sign for drugs they received.
 - Drugs were stored in lockable tote bags; however, bags were not kept locked.
 - Keys to client drug lock boxes were not accounted for at the end of each day.
 - In the office, 11 employees worked in very close quarters in a windowless room (it did have a Dutch door). The nurses and clinicians had no dividers between their work spaces, and employees talked on the phone, typed, waited on clients at the door, and administered drugs to clients. These conditions did not provide a productive work environment for employees.
 - We observed that staff opened the Dutch door by reaching the inside knob rather than using their key for access their work area.

These situations existed because the PACT division did not comply with the Virginia Board of Pharmacy's regulations as it related to the delivery of dispensed prescriptions. Also, PACT procedures were outdated and did not address all the operations performed by PACT. Additionally, drugs received by PACT were not properly accounted for, controlled, and safeguarded. Further, incidents that occurred were not reported to CIBH's Quality Assurance division timely, and there was limited monitoring and oversight over PACT operations.

Although the amount of CS missing was relatively small (a 30-day supply or less or less in each case), the control weaknesses identified provided an opportunity for larger quantities of drugs to be lost or taken. If this situation is not addressed, there is a high risk that this condition could continue to exist, and the CIBH will continue to be in violation of the Virginia Board of Pharmacy's regulations.

Recommendation - The CIBH should comply with the Virginia Board of Pharmacy's regulation as it relates to the delivery of dispensed prescriptions. PACT procedures should be updated to address the receipt, accountability, control, and safeguarding of drugs and ensure that employees are properly trained. Additionally, incident reports should be properly completed and forwarded to the Quality Assurance division within 24 hours as required by policy.

PACT should take corrective actions on the following issues:

- a. Ensure that PACT receives, holds, and stores Schedule VI drugs only
- b. Restrict the number of employees who can receive drugs for the division.
- c. Designate a Nurse Supervisor position to oversee and monitor nurse and clinician activities, and control drugs.
- d. Document and transfer drugs needed for the day's work to the person responsible for the control of the drugs.
- e. Install a lockable facility that is attached to the wall

and/or floor in the PACT office for the storage of drugs. In addition, the PACT med room should be considered the reserve supply of drugs for the PACT division and, when drugs are needed for clients, the drugs should be transferred to the working supply which will be kept in the PACT office. Records should be maintained that document the tracking of all drugs from the time they were received to issuance to the client.

- f. Change combinations and keys to the PACT med room when employees leave the employ of the PACT division.
- g. Install panic alarms in the PACT office so that they can be activated in the case of an emergency.
- h. Consider installing a card access reader to the PACT med room to identify when and who accessed the PACT med room.
- i. Consider installing a camera in the PACT med room.
- j. Keep Tote bags that hold drugs locked at all times.
- k. Consider establishing specific times when clients can receive and/or pick up drugs.
- l. Require clients to sign for the drugs they receive.
- m. Define the roles and responsibilities for nurses and clinicians and cross train employees on each other's functions to better serve clients.
- n. Account for keys to client lock boxes at the end of each day.
- o. Improve the work environment to the extent practical.
- p. Require PACT employees to use their key to access the PACT office rather than reaching over the Dutch door.

Response: We offer the following comments related to specific issues mentioned:

- a. Policies and procedures have been put in place with regard to medication deliveries and medication brought into the facility by individuals receiving PACT services to ensure these medications are recorded in the medication inventory, and put into the correct medication storage bags. With respect to medication deliveries that come to the facility via mail, the packing orders are checked and confirmation of the receipt is faxed back to the vendor.**
- b. Management is working to restrict the number of staff who are authorized to accept medication deliveries.**
- c. To better supervise and monitor the medication delivery and administration, one Registered Nurse position will be assigned administrative and medication control duties such as managing medication inventory, repackaging medication into pill packs, reconciling medication deliveries and reconciling medication returned from deliveries by PACT staff that could not be delivered to individuals receiving PACT services.**

To also better supervise and monitor the medication delivery and administration, the other Registered Nurse position will be assigned supervisory duties over the PACT Licensed Practical Nurses and be directly involved in the delivery of medication in the community to individuals who receive PACT services, including administering injections, and ensuring individuals who receive PACT services get to medical and lab appointments. Both Registered Nurses will be cross trained to be able to provide back up to one another's supervisory roles when needed.

- d. Staff will follow the PACT Medication Administration Standard Operating Procedures for the documentation and transfer of the day's drugs pending the implementation of the on-site pharmacy.
- e. A depository vault has been installed to secure delivered Schedule VI medication when a PACT nurse is unavailable. A key safe has also been installed to secure the key that accesses the vault storing Schedule VI medication on site when not secured in the combination locked medication room, This key safe will also store the keys that access lock boxes in individual's residences. Accompanying log books have been created, to document the storage and retrieval of these medications and keys to provide an audit trail of stored medications and keys in the PACT office. A policy was put in place to ensure that Schedule VI medications stored in the depository vault are taken immediately to the PACT medication room to be secured as soon as a PACT nurse is available.
- f. Policies and procedures have been put in place to require the combination of the PACT medication room lock is changed at least every six months, at any time a PACT nurse or physician leaves the employment of the PACT program, in the event that a PACT nurse/physician is suspended as the result of a disciplinary action, or in response to any other situation or investigation that warrants the combination to the lock be changed.
- g. A panic alarm attached to a lanyard was placed in the PACT office so staff have access to a panic alarm should a crisis arise in the PACT office.
- h. A request was made to have a card access reader installed for the PACT medication room but have been informed that the work order cannot be completed until December 2015.
- i. A camera was installed in the PACT medication room.
- j. Locks for the PACT medication delivery bags were purchased and put into use.
- k. Policies have been put in place and individuals receiving PACT services have been informed that between 8:00 a.m. and 9:00 a.m. is the period when

morning medication can be picked up at the PACT office. Individuals receiving PACT services have also been informed that between 3:00 p.m. and 5:00 p.m. is the period of time when afternoon medication can be picked up at the PACT office.

- l. A medication delivery form has been developed for individuals receiving medication to document their receipt. Supervisory staff have implemented a medication storage consent form that individuals have signed to authorize storage of their medications at CIBH.**
- m. The role of each staff type: Clinician I, Clinician II, Clinician III, Licensed Practical Nurse, Registered Nurse, Peer Support and Program Supervisor is being better defined, and all staff will be trained regarding their prospective roles and the roles of other employees in the PACT program.**
- n. Lock-box keys will be stored in a secure safe. Lock-box keys will be accounted for at the end of each working day by review of the Lock-box key log by supervisory staff**
- o. The PACT office has been cleaned and will continue to be reorganized in an effort to provide more space for staff working in that office to improve the working environment.**
- p. PACT staff have also been informed they are required to use a key rather than reaching over the Dutch door for access to the PACT office.**

3. Psychiatric Med Room – Controls

Finding - Psychiatric (Psych) med room clients did not always sign for their drugs when they were dispensed. The inventory controls for drug samples held in the Psych med room needed to be redesigned. Further, inventory audits of sample drugs were not performed on a periodic basis.

The Virginia Board of Pharmacy's regulation 18 VAC 110-20-275, covering the delivery and dispensing of prescriptions to clients, required that a dispensed prescription be tracked, secured, and accounted for from the time it left the pharmacy until it was handed to the patient or agent of the patient.

Using an automated report on Credible, we determined that numerous clients had not signed for their drugs. CIBH concurred with our observation and noted that clients frequently refused to sign for their drugs, and that nurses annotated the system indicating that the client had not signed. However, the nurses did not consistently place their notes in the same place in Credible. Therefore, management had to search three locations to determine the status of client signatures. In addition:

- We performed a test count of several sample drug types and had a 100% error rate.**

- The inventory log for sample drugs did not reflect a running balance and needed to be redesigned.
- Surprise inventory audits were not performed for sample drugs on a periodic basis. In addition, when audits were performed, and outages occurred, they were not researched to determine why the outages occurred.

These situations existed because reports had not been developed to extract data from the Credible system for easy management review. The drug sample inventory log was not designed to show all necessary information needed to reflect the amount of drugs received, issued, and the remaining inventory balance. In addition, audits were not being performed on a quarterly basis. If these situations are not addressed, the control weaknesses identified provided an opportunity for drugs to be lost or stolen.

Recommendation – CIBH should ensure that all drugs are signed for by clients when dispensed. Also, inventory control practices and form should be redesigned, and surprise Inventory audits should be performed on sample drugs at least quarterly.

Psych management should consider the following corrective actions:

- Establish a standard as to how and where to document signature exceptions in Credible system.
- Redesign the sample drug inventory log to reflect all the necessary information to account for the sample drugs.
- Research errors identified as a result of audits to determine what caused the errors.

Response - The Virginia Board of Pharmacy regulation:VAC18110-20-275, covering the delivery and dispensing of prescriptions to clients does not pertain to sample medications. The Virginia Board of Pharmacy does not regulate sample medications.

The original audit for client signature upon receipt of medications was not completed with a nurse present. The audit presented to me was a review of 209 charts with 184 missing signatures. Upon my review of the same 209 charts there were only 50 missing signatures. A total of 77 % of the charts did contain signatures. The discrepancy occurred because the Credible system only allowed the signatures to come up that were in a designated signature box on the med pick up service. The current Administration and Delivery of Medication policy only states the nurse will complete the Medication pick up service in Credible. Each part of the service to be completed is not broken down. One of the sections for the service is a client signature. Therefore in order for the nurse to document the service fully she or he would need to obtain a client signature. As with many of the functions in Credible the technology provides multiple avenues to accomplish the same task. When it is not possible to obtain a client signature (for a med delivery) in Credible using the signature box in the service; nurses are printing the service, obtaining a pen and ink signature and scanning the paper in the clients EMR

attaching it to the Med delivery service or in the Attachment section of the record. This is an acceptable means of obtaining client signature and both sections are used to scan paper services. This method requires increased steps on the nurses' part and is only used when clients are unable to physically walk back to the nurses' office, medications are delivered to the client by CIBH, Credible does not allow for a signature due to technical difficulty, client refusal to use the electronic system, etc.

The multiple options allowed by Credible to complete a task is one of the advantages to the Electronic Medical record and is standard in the daily use of documenting the services we provide to our clients. It would defeat the level of technology and benefits of the EMR if we mandate one method of maneuvering the computer to complete a service. As we grow and change with technology so should our policies in regards to the use of our client records.

Given the number of charts our nurses touch for a med delivery on a weekly or monthly basis the review of 209 charts may not give an accurate look at our error rate. However; based on the 209 charts reviewed --23% of the charts did not have a client signature. While I believe it will be difficult to reach 100% due to our client population and nature of our work I do believe we can improve on the number of medications delivered with a client signature. Client signature for med pick up is now part of the QA Matrix for Psych services. The expectation was shared with all the nurses in September of 2014 and continues to be a focus for Psych Services. The samples reviewed did reveal our method of tracking samples was not sufficient. This had traditionally not been an area of focus as the Board of Pharmacy does not regulate samples and the common practice for out-patient offices does not include the signing of samples in and out with regular audits. The form being used was one we had recently adopted in an effort to monitor sample medications as a result of a directive from the Executive Director after recommendations were made from a former employee. The form was not as "fine tuned" as needed. Under the recommendation of Tony Markun, City Auditor's Office a new form was implemented in November 2014 with a minimum of a quarterly review. The form includes a running balance of sample medications. The most recent review was completed on 6-3-2015. The new form has improved the number of outages that occur.

The document provided to me from the audit stated that when "outages occurred, they were not researched to determine why the outages occurred". In fact, whenever an "outage" is discovered by a nurse efforts are made to identify the source of the "outage" determine who signed a med in or out and failed to put the correct numbers in the correct areas, or who delivered a sample and did not sign the sample out or who accepted medications from a drug rep without signing a med in. Since the Sample Log Form was initiated the number of outages has decreased.

The policy titled "Administration and Delivery of Medication" for Psych Services has been revised to say specifically 1. A client signature will be obtained with each med delivery. 2. Having the client sign in the designated box in the EMR is the first option with a pen and ink signature scanned in under the above mentioned circumstances. 3. The scanned in signature should be attached to the service. The policy titled "Obtaining Medications" for Psych services addresses the delivery of sample medications. The policy has been tweaked to include the quarterly reviews.

4. Cardkey Access Cards

Finding - Policies and procedures for the handling and control of access card issuance, receipt, safeguarding, and accountability had not been developed, documented, and implemented. In addition, employees were not adequately trained on the handling of access cards, and there was minimal oversight over card access processes.

Access cards provide a secure and reliable form of identification. They are used as a sound means for verifying an individual employee's identity and are strongly resistant to identity fraud, tampering, and counterfeiting. In addition, access cards are easily authenticated electronically and can be used to restrict access to secured areas. Failure to assign a specific employee name to access cards diminishes the value of a secure and reliable form of identification.

An effective control process for handling access cards should incorporate:

- Documented policies and procedures for receipt, issuance, and accountability of access cards
- Adequate training for employees handling access cards
- Safeguarding of access cards
- Access changes documented and approved before system changes are made
- Logged recording of the movement of access cards
- Name of the person receiving the card and an expiration date entered into the system at the time of issuance
- Retrieval and disabling of access cards immediately when employees are terminated
- Periodic audits of access card processes
- Adequate oversight

We evaluated CIBH's access card handling process to determine whether controls for the receipt, issuance, safeguarding, and accountability of access cards were in place and functioning as designed. We found that policies and procedures had not been developed, documented, or implemented for access card processing within CIBH, and employees had not been adequately trained on the handling of access cards. Our review of the records revealed that unauthorized individuals were allowed access to a restricted area without obtaining documented approval from the area manager.

In addition, individuals who made changes to the card access system shared the user ID and system password; therefore, the identity of the person(s) who made system changes were described on the system history as CCBS. These same individuals could grant access for themselves to any location in the City, and no compensating control had been put in place to review all the system changes made by these individuals. Also, one of these individuals had access to loner cards with no names assigned to the cards. Additionally, we found that there were forty nine (49) access cards with no names assigned and 51% of those cards had not been used for at least six (6) months, had not been retrieved from the user, and had not been disabled on the card access system.

Further, our review and testing of card access records revealed the following:

- The Human Resources Department (HR) issued initial and replacement access cards for CIBH employees. We were informed that 60 to 90% of the cards issued by HR did not work when they were received. The CIBH Management Information System (MIS) employees were making edits to the cards received to make them functional, but they had not communicated the error information to the HR department. Therefore, documented access information annotated on the access cards by HR was not in agreement with the information indicated on the cards that were edited.
- MIS disabled the access cards of employees that were terminated, or placed on suspension by the CIBH. However, because these cards were not disabled correctly on the card access system, the cards remained active, without MIS's knowledge.
- A comprehensive list of all access cards received by the CIBH without assigned names was not maintained by the MIS division. In addition, we found that all divisions did not maintain a log that recorded the issuance and return of assigned cards and, for those divisions that did maintain a log, the information recorded on the logs was not consistent from division to division.
- MIS division had granted four employees access to a restricted area of the CIBH without the permission and documented approval of the manager responsible for the restricted area. These access changes were made with only a verbal request.
- Access cards without assigned names had never been audited to ensure that records were properly maintained and that all issued and unissued access cards were accounted for and properly controlled when not in use. In addition, an audit of the assignment of access cards had never been conducted to ensure that employees only had access to required areas. For example, our review indicated that 310 employees had access to the front office work area (restricted area).
- Some Access cards without assigned names were issued to volunteers; However, their names and an expiration date were not entered into the card access system at the time of issuance.
- Access cards for volunteers, suspended employees, and terminated employees were not retrieved by their supervisors at the time their service ended.

This situation existed because documented policies and procedures for the handling of access cards were non-existent, employees were not adequately trained, audits of access cards without assigned names and the assignment of access cards

reflected on the access card system had never been performed. Also, employees shared the system ID and password to make access changes on the system. In addition, the CIBH did not keep a comprehensive record of the number of access cards with no names that had been received by the department. Also, there was minimal oversight over the card access processes.

If this situation is not addressed, the risk exists that unauthorized employees will be allowed access to restricted areas of the CIBH. In addition, if cards without names are used to commit an illegal act, the cardholder's identity would not be able to be determined.

Recommendation – CIBH should develop, document, and implement access card handling process policies and procedures so that the integrity of the data on the card access system is accurate. Employees should be adequately trained on access controls. In addition, CIBH should develop an ongoing oversight and monitoring process to ensure adherence to access cards procedures.

The card access procedures developed should address the following areas:

- Discontinue the sharing of ID's and passwords to the access card system.
- Discontinue making access changes upon verbal request. A request-for-card access change form be developed that documents the request for the change, the signature of the requesting manager/supervisor, and the approval of the work area manager/supervisor.
- Compensating controls should be developed and put in place to determine that all access card changes are authorized.
- Review and evaluate the card access system to ensure that employees only have access to necessary areas within the CIBH. In addition, if exceptions are found where access is not needed, reconfigure access areas as deemed necessary.
- The HR department should be notified when initial and replacement access cards do not work, so that corrections can be made to the malfunctioning access cards.
- MIS employees should be trained on how to disable access cards when employees are terminated or placed on suspension.
- Access reports should be developed and reviewed on a periodic base to ensure that only authorized employees are accessing restricted areas of the CIBH.
- A comprehensive list of all access cards received by the CIBH with no names assigned should be maintained. In addition, we suggest creating a form that tracks the issuance and return of these cards. Access cards with no names that are assigned to a volunteer, loner, intern, security guard, etc., should have the name of the assigned individual and expiration date entered into the card access system when the cards are assigned.
- Retrieval of access cards should be added to the exit form to remind managers/supervisors to retrieve access cards from employees that leave.
- Periodic audits should be performed on access cards without assigned names to ensure that records were properly maintained and that all issued and unissued access cards were accounted for and properly controlled when not in use. In addition, a periodic audit of the assignment of access cards reflected on the card access system should be performed to ensure that employees had access to

required areas only.

Response - CIBH has implemented or is in the process of implementing the following changes:

- **Administrative MIS Staff have been issued individual accounts by the Main Card Access Administrator.**
- **A Formal Request to Add/Transfer/Remove user Access had been established suspensions and terminations are walked by the supervisor to MIS.**
- **MIS has begun to explore a process of exporting active card access accounts into a CSV file and comparing accounts against the active directory export form the network access. Those accounts that are outside of the network scope are then filtered by the internal HR list by the appropriate staff members.**
- **A review of zones and levels of access is underway to establish the proper security levels with employee roles within the organization.**
- **A "how to document" has been created in the MIS instruction set of what steps are used to remove or suspend account access.**
- **The MIS Administrator has proposed a consolidation of temporary card disbursement and inventory tracking through the EHR system and has submitted the process for review by the Leadership Team in CIBH and the auditor. All card inventory and tracking for 224 and 216 Great Bridge Blvd will be handled through this process. This process will allow for a consolidated approach to identifying who cards are temporarily assigned without giving administrative access to the Card Access system within the city.**

5. Random Drug Testing

Finding - The CIBH required ongoing random drug testing for van drivers as a requirement of the City's Substance Abuse Policy (Administrative Regulation 2.44). However, it did not require ongoing random drug testing for employees such as Clinicians, Nurses, and Program Supervisors.

Administrative Regulation 2.44, the City's Substance Abuse Policy, required random testing as follows: "Effective January 1, 1995, employees covered by the Omnibus Transportation Employee Testing Act of 1991 (generally, vehicle operators and vehicle maintenance staff) were placed in a separate drug/alcohol testing group. The random selection procedure is computer generated using a random number generator and the file identifier of these employees. The Contract Substance Abuse Program Administrator will generate a list of employees to be randomly tested and will forward that list on a monthly basis to the Department of Human Resources."

We found that the CIBH only performed random drug tests on its' van drivers, as required by policy. However, certain other employees such as Clinicians, Nurses, and Program Supervisors, were required to be drug tested as a condition of employment but

were not required to be subjected to random drug testing. These job classifications handled drugs as part of their job responsibilities and could be considered as a similar job classification to Emergency Medical Technicians (EMTs) who were subject to random drug testing.

This situation existed because these job classifications were not addressed within Administrative Regulation 2.44; therefore, the CIBH did not require random drug testing for them. If this situation is not addressed there risk exists that one of these employees could develop a substance abuse issue that would not be identified.

Recommendation – CIBH should consider implementing an ongoing random drug testing program for positions such as Clinicians, Nurses, and Program Supervisors.

CIBH should identify the critical job classifications that should require random drug testing. CIBH should also consult with Human Resources so that Administrative Regulation 2.44 can be updated to include their request for these changes. (Human Resources was in the process of reviewing and updating AR 2.44 at the time of our audit).

Response – As noted CIBH follows the current Administrative Regulation 2.44 as written. We are in favor of expanded testing of additional job classifications up to including all City of Chesapeake employees in the random pool. CIBH believes that every employee provides a vital role in the delivery of our services and the abuse of substances by any employee can negatively impact the quality of service to an individual.

6. Conflict of Interest Practices

Finding – CIBH did not have effective departmental conflict of interest practices.

Employees are responsible for performing their duties in good faith and in the best interests of the employer. In particular, employees are expected to avoid activities, agreements, business investments, interests, or other situations that materially conflict or appear to conflict with the interests of the employer or interfere with the individual's duty to loyally serve the employer to the best of his or her ability.

The City of Chesapeake Employee handbook states:

“In an effort to ensure that no conflict of interest exists, employees must promptly inform their supervisor if they are employed elsewhere in addition to their position with the City. This includes both full-time and part-time positions outside of the City organization. A description of the outside position, date of hire, and number of hours committed to outside employment is required.”

Each year, CIBH supervisors sent out an e-mail asking staff if they had any jobs or additional activities outside of their existing CIBH duties. Since there was no standard form to fill out or procedure to follow, the responses from the staff varied from full disclosure to no response at all depending on the supervisor and their handling of the data collection. When responses were received, CIBH Human Resources staff was required to enter the information into the Credible system. In cases where responses were not received, nothing was done. The assumption was made that those who did not respond did not have additional work outside of the City. The data in the Credible system was available should any one need to review it.

This situation resulted from lack of emphasis on conflict of interest issues by CIBH. However, without an effective conflict of interest policy CIBH risks being unaware of circumstances where their employees may be motivated to act in a manner that is not consistent with the goals and objectives of CIBH.

Recommendation – CIBH should strengthen its conflict of interest review practices.

CIBH should require all employees to report their outside employment and other related activities, using a standardized "Acknowledgement of Outside Employment and Other Activities" form. CIBH should then review these forms for completeness and possible conflict of interests, using criteria it develops that address the department's specific conflict of interest concerns, and ensure that the data is centralized for further review should the need arise.

Response – CIBH will be implementing a standardized form that will be included in Credible. All employees will be required to complete the form on at least an annual basis or more frequently if they obtain outside employment during the year. Placing this form in Credible will allow us to better manage the completion of the form and to prepare additional analysis in a more efficient manner.

APPENDIX A

RESPONSE FROM

CHESAPEAKE INTEGRATED BEHAVIORAL HEALTHCARE

MEMORANDUM

TO: Jay Poole
Director, Audit Department

FROM: Joseph Scislowicz, LPC
Executive Director



DATE: July 8, 2016

RE: Operational Audit Findings

I received the finding of the operational audit conducted by your staff. The findings have been reviewed by me and members of my management staff. Attached you will find our responses. If you have any questions or could like other information, feel free to call me at 819-6215.

C. Financial Control Issues

1. Cash Handling, Petty Cash and Settlement Processes

Finding – CIBH's procedures for cash handling, petty cash (p/c) and settlement processes did not sufficiently address cash handling, petty cash, settlement, internal controls, and the safeguards over assets. In addition, there was minimal oversight and monitoring of the front office and petty cash operations.

Recommendation - CIBH should develop and document cash handling, cash settlement process, and petty cash (p/c) policies and procedures so that cash is adequately safeguarded. In addition, CIBH should develop an ongoing oversight and monitoring process to ensure adherence to cash handling and cash control procedures, and individuals responsible for p/c operations should provide oversight and monitoring over the p/c operations to ensure that documented procedures were being followed.

Response – CIBH has complied with all recommendations by improving the City's cash collection and petty cash procedures to include cash settlement reconciliation signed by supervisors and the use of new petty cash receipts. Random unannounced cash collection audits and semi-annual petty cash audits will be conducted bi-monthly by Fiscal staff to monitor ongoing compliance with the revised procedures. Physical security of petty cash funds has been improved through use of locked cash drawers and a two-part combination for the front office safe. Two inactive/low activity petty cash funds have been dissolved.

Additionally, we offer the following comments related to specific issues mentioned:

Related to cash handling:

- a. The current City policy does not require the use of a settlement sheet for daily cash collections. However, CIBH has implemented use of the day sheet settlement report suggested by the auditor that will provide a space to document supervisor verification of the teller's count and show any overage/shortage for the shift.
- b. Effective June 11, 2015, CIBH front desk staff will lock their cash drawers in their workstation drawer while on duty. This will assure the cash drawers remain under the control of the individual cashiers. At the end of the shift, the cashiers will take their drawers to the back room to complete the settlement reports and cash out. They will store their cash drawers with tills in the safe overnight. CIBH will investigate the feasibility of securing the floor safe to the floor. However, the floor safe weighs in excess of 500 pounds and would be extremely difficult to remove un-noticed. The most funds that will be stored in the safe overnight will be the till balances totaling \$300. Additional security cameras on the safe or counting area are not warranted at this time.
- c. Staff will be changing the safe combination to a split combination so that

two individuals will be required to access the contents of the safe. A safe access log book will also be developed.

- d.: Cashiers will maintain sole control of their cash boxes by securing them in their desk drawers while on duty. Upon closing out, a supervisor or other staff will verify and sign the cashier deposit and till per the settlement report.
- e. There are several operational needs that require clinical staff to have access to the front office area. Tills and all cash on hand will be maintained under the sole control of each cashier during business hours or secured in the safe. Therefore, there is no longer any internal control risk from allowing general staff access to the front desk area.
- f. CIBH will assure all cash boxes are operating properly and that cashiers provide an additional layer of security by maintaining their cash boxes in the drawers of their workstations and under double lock security when they are away from their desk. Spare desk drawer keys will be kept in the safe.
- g. Our plan to change the safe combination will negate the need to use a key to open it. We plan to use the two part safe combination code instead of key access. The Security Guard's master key and back-up access cards will either be secured in a locked area with limited access or locked in the safe whenever not under the direct control of the security guard.
- h. CIBH will implement the use of the settlement sheet suggested by the Auditors. A separate settlement sheet was not previously required by City policy.
- i. The Credible reports will be used daily to identify the amount of cash, check, and charge that has been collected. This report will be used to draw the deposit on a daily basis. The till will always be restored to full value. Any overage/shortage will be posted to the ledger by use of a new over/short account.
- j. Since one staff person was drawing the deposit (front desk teller) and another was recording the deposit (Finance Accountant), adequate segregation of duties was in place in the former system. However, to provide better point source control of the cash collections, the front desk supervisor is now recording the deposit in the Treasurer's system and securing the deposit immediately after confirming the teller's deposit and count. The Fiscal staff role is limited to reconciling the Treasurer's deposits to the Credible postings against the Client AR on a monthly basis.
- k. We have changed our daily date cutoff period to be 3:00 so we can now accept all types of payments at all times.
- l. CIBH has been established as a service provider authorized to accept medical payment cards from Flex Spending Account. Medical debit/credit cards are handled just like other debit/credit cards used for payment of CIBH client services.
- m. While not required by City Finance policy, the CIBH will pursue implementation of an over/short account on the general ledger.
- n. Surprise cash counts will be conducted by Finance staff bi-monthly for at least a year or until consistent compliance to the revised procedures can be demonstrated. Thereafter, audits will be conducted twice per year at the

cashier level.

- **o. The front office staff is considered administrative support staff and all report through division supervisors to the lead administrative supervisor. While these employees do not report to Fiscal, the Fiscal Administrator will provide additional oversight of the cash operations through training, documentation review, and oversight of the surprise cash count reviews. The Fiscal Administrator will pass findings and recommendations to the Administrative Supervisor for personnel action if needed.**

Related to petty cash:

- **aa. The City petty cash policy does not require the use of a Petty Cash receipt even when petty cash advances are issued. We agree with the auditor that this process can be improved and have implemented use of the auditor's suggested Petty Cash receipt. The new receipt provides a place for the recipient and custodian to sign upon issuance and return of an advance. The form will be used for and submitted with each transaction even when an advance is not issued so that signatures of the custodian and recipient can be documented for all transfers of funds.**
- **bb. The new petty cash voucher provides a place to note the use and requesting program for petty cash funds.**
- **cc. While no internal controls issues were identified, staff will be encouraged when practical to request two separate transactions when making personal purchase at the same time as business purchases. If these are inadvertently combined by the vendor on the same invoice, we will continue to cross out the personal items on the receipt and only seek reimbursement for the business items.**
- **dd. Petty cash custodians are not precluded from purchasing items from their own fund provided the purchased items are for appropriate business needs. The new petty cash receipt will guarantee that another employee in addition to the custodian is involved in all petty cash disbursements thereby assuring two party involvement for all petty cash disbursements.**
- **ee. The new over/short account will apply to petty cash funds if needed. However, petty cash custodians are very rarely out of balance. What was identified as outages in the p/c funds by the auditors were actual petty cash advances that had been issued for valid purchases, but receipts were not in place to document the advances. The new petty cash receipt form now provided written and signed documentation supporting the full balance of the petty cash fund at all times.**
- **ff. Petty cash custodians and tellers will now be required to attach adding machine tapes to their settlement sheets when submitting to Finance for processing. Two additional adding machines will be purchased and placed in the back office for front desk cashier use while settling their funds.**
- **gg. The new petty cash settlement report requires count verification and signature of a supervisor before the report is sent to Finance to process the custodian's reimbursement.**

- hh. The new petty cash settlement report provides a space for supervisor signature and over/short documentation.
- ii. Supervisors now count and sign the petty cash settlement report prior to submission of the reimbursement request to Finance. Note that under current City policy, supervisors are not required to count the p/c settlement because they are already signing the custodian's reimbursement request.
- jj. The new petty cash settlement report will be signed by the supervisor after verifying the count. Any over/short remaining will be documented and posted to the over/short account. The cashier and supervisor will each count and recount the totals on the reimbursement report until the proper totals are identified and recorded. Since this work will be conducted by program staff, the Finance accountant will have no need to alter the form in any way. If the Finance accountant identifies a need for further corrections, the report will be returned to the custodian and supervisor to be re-worked. A new settlement report may be created and signed by both the custodian and supervisor. Hand written changes may be made by a single pen line through the incorrect entry with an initial by both the custodian and supervisor for each item changed.
- kk. Like front desk staff, petty cash custodians are administrative staff who report through the departmental supervisors to the admin supervisor. The new requirement for the p/c supervisor to sign off on settlements will provide sufficient oversight of the p/c custodian. In addition, Finance and external auditors will continue to conduct annual petty cash surprise audits.
- ll. We have emphasized with supervisors that when staff leave they are to coordinate a final reconciliation of any petty cash funds and transfer the funds to another staff. This has also been added to our resigning employee checklist. Both these funds mentioned were identified as having very low usage and both have since been dissolved.
- mm. Two funds with low usage were immediately dissolved once the low usage rate became known to management.
- nn. The new petty cash settlement process will require the supervisor to sign for each reimbursement request. When processing the reimbursement request, the Fiscal Administrator has and will continue to review the nature of the petty cash purchases, support, and quality of documentation before approving the custodian's reimbursement in the City's PeopleSoft system.
- oo. The Fiscal Administrator will look for properly completed petty cash receipts and signatures as each p/c reimbursement is processed for payment.

2. Medicaid and Accounts Receivable

Finding – CIBH had an accounts receivable balance in excess of \$2,816,364, of which almost \$635,000 could be considered uncollectable. There was also an additional \$1.0 million in receivables from other sources, of which almost \$400,000 was over six months old and could be considered uncollectible.

Recommendation – CIBH should ensure that all necessary billing requirements for new services are understood and readily executable so that they can be fully implemented in sufficient time to avoid writing offs.

Response – CIBH received reimbursements of \$2,051,327 in June 2015 related to the ICF and has resolved all known issues related to billing the ICF and fully expects to collect all revenue with the exception of the foreseen pre-certification costs already allowed for. The pre-certification receivables have been written off. The ICF has new management and is fully engaged in following the Medicaid procedure manual and ICF protocols that could prevent timely billing for services. The reimbursement unit has also hired a part-time temporary position to aide in recovering any aged receivables, and intends to monitor the workload of the current staff during the fully staffed period to ensure adequate staffing needs.

Additionally, we offer the following comments related to specific issues mentioned:

- The Medicaid billing situation occurred due to new program start up and clinical failure to submit client enrollment documentation. Follow up occurred on all known agency, clinical, and reimbursement issues promptly. The attached timeline indicates active pursuit on all levels of governmental and reimbursement oversight during this grueling process (Auditor's Note – Timeline is included as Appendix B.)
- The reimbursement unit followed up on all error reports and denials weekly and sometimes daily to bring the ICF's to the brink of acceptable billing of services provided. Rejected billing was not due to the reimbursement unit as all billing processes were in place and followed according to agency protocols.
- Although Medicaid only paid for billing no more than 12 months old, CIBH allowed for pre-certification write offs. Authorization for billing was assigned the date of March 3, 2014. As is customary with the start of an ICF, billing is only authorized after licensure and certification from two separate State Agencies. Amounts related to the precertification period were written off in June 2015. Billings from March 3, 2014 were also submitted by the reimbursement unit with the intention of getting a denial to circumvent timely filing deadlines that would allow the agency to bill for services over 1 year old if it was documented that billing had been submitted prior to the twelve (12) month timely filing limitation. All services with a date of March 3, 2014 forward that remain in the accounts receivable are collectible. To be conservative, it is CIBH practice to create an allowance for and exclude all services dates that exceed one year from the net accounts receivable.
- The difference between the ceiling rate and the reimbursement rate that was noted as potentially being uncollectible; it in fact collectible. The process for reimbursement for an ICF is actually a two part system. Individual claims are filed for the dates that the residents are in the ICF and annually a cost settlement report (similar to a tax return) is filed to settle the difference

between the ceiling rate and what was reimbursed. Facilities can be paid the full difference if their actual costs per resident day exceed the ceiling rate; CIBH will fall into this category as additional costs beyond base operational costs are included in the calculation. We have chosen to keep this amount in our accounts receivable.

In summary related to the accounts receivable for the ICF, all potential revenue for this program has either already been collected or will be collected. There has been no loss of revenue or negative financial impact to operations that resulted from the delays.

- CIBH continues to follow agency protocols for pursuing commercial and self-pay amounts owed. The DSO policy does not allow for sending clients still in service with CIBH to DSO to prevent exacerbation of their conditions. The collectability of accounts transferred to Debt set-off is uncertain and for the reason it is CIBH's practice to create an allowance for these amounts which excludes the balance from our net accounts receivable. Any balances transferred to debt set-off are pursued by the State Treasurer through the Department of Taxation. All non-debt set-off aged receivables are currently being pursued.

**Attachments: Timeline of ICF Startup – Appendix B
Excel ICF spreadsheet - Appendix C**

3. Segregation of Duties – Front Desk Staff

Finding – The CIBH front desk staff responsibilities for data entry and reconciliation were not sufficiently segregated. In addition, reconciliations against the City's financial system were not being completed in a timely fashion.

Recommendation – CIBH should take steps to improve segregation of duties for its reimbursement staff, and should also ensure that reconciliations against City financial records are completed in a timely manner.

Response – The PeopleSoft general ledger entry, Credible Client AR entry, and handling of cash deposits into the Treasurer's system are conducted by three separate individuals in all cases. Sufficient segregation of duties does exist. Staffing shortages that delayed the reconciliation of AR deposits between the Treasurer's system and the subsidiary ledger in Credible have been resolved, and these reconciliations have returned to a monthly frequency. The overall reconciliation of AR between the general ledger and subsidiary ledger has always and continues to be conducted monthly.

4. Banking Procedures for CIBH-affiliated nonprofits

Finding - Bank procedures for Elizabeth River Properties of Chesapeake and CSB of Chesapeake, Inc. lacked adequate segregation of duties. Also, account balances exceeded the FDIC insurance limit.

Recommendation – CIBH should address the banking procedure control issues associated with its affiliated corporations

CIBH should ensure that the banking procedures for its affiliated corporations include adequate segregation of duties. In addition, the number of authorized signers on banking accounts should be restricted to the extent practical. Further, the amount of funds maintained at any banking institution should not exceed the \$250,000 FDIC deposit insurance coverage limit.

Response - Elizabeth River Properties of Chesapeake, Inc. has a seven member board of Directors and is supported by two CIBH staff members (an Executive Director and a Housing Administrator) in addition to two contract positions (a bookkeeper and a property manager). The contract bookkeeper was vacated in October of 2014 and refilled in May of 2015. During the interim the ERPC Executive Director performed the duties of the bookkeeper. As a compensating control during this time period the Treasurer was asked to review the bank reconciliations. Now that the bookkeeper position has been refilled the practice will return to the bookkeeper performing the reconciliation and review of the bank reconciliations by the Executive Director. The bookkeeper does not have any banking authority.

The number of authorized signers on the bank accounts was discussed with the Board of Directors at their June 24th board meeting. The number of signers will be reduced to three per account. The bank balance by institution is discussed at each board meeting and determinations are made if funds will be moved. The Treasurer and Executive Director will move funds to reduce any exposure from the FDIC coverage limits. The amount that exceeded FDIC limits at April 30, 2015 was \$9,446.52.

CSB of Chesapeake, Inc. is composed of three board members and supported by one CIBH staff member. The number of banking transaction per year is less than five; given this low level of activity additional staffing is not practical. As a compensating control the Board members review the transaction ledger at their annual meeting. The President will also begin to review bank statements monthly for activity and irregularities.

5. Client Personal Fund Accounts

Finding - Policies and procedures for CIBH's personal resident accounts had not been updated and did not sufficiently address client check cashing processes, account cash limits, and client and guardian monthly statements.

Recommendation – Procedures for the handling of residents personal fund accounts should be updated.

Response - CIBH has established maximum cash targets for residential client accounts of no more than \$80 per client to be maintained on site at the ICF. Client funds are now drawn only as needed upon request by ICF staff to the clients' representative payee. Funds not immediately needed by the clients remain under the control of the representative payee for each client. The representative payee is responsible for providing the clients statements of their account activity as per guidelines. Policies and procedures have been updated accordingly.

D. Operations

1. Controlled Substances – PACT

Finding - The CIBH received, stored and delivered Schedule II and Schedule IV controlled substances (CS) for their clients; however, the CIBH was designated as an Alternate Delivery Site and was only licensed to receive, store and deliver Schedule VI medications. In addition, there was minimal management oversight and monitoring over PACT operations.

Recommendation – The CIBH should immediately discontinue receiving, storing, and delivering any Schedule II to Schedule V controlled substances. Additionally, management should take an active role in the ongoing oversight and monitoring of PACT operations.

Response - Schedule II through Schedule V controlled substances are no longer accepted into any CIBH facility. Pharmacies delivering medication, PACT staff and individuals bringing their medication into the building have been notified CIBH will not accept storage of Schedule II to Schedule V controlled substances on the premises. PACT supervisory/managerial staff monthly scan the medication delivery packing slips to assure no Schedule II to Schedule V medication has been delivered. Policies and procedures have been put into place to prevent the delivery and storage of Schedule II through Schedule V controlled substances. All PACT staff have been educated regarding these policies and procedures and have documented acknowledgment of receipt of such policies and procedures. Medication deliveries are reviewed to ensure that no Schedule II through Schedule V controlled substances are accepted into the building. The Medication Log is reviewed to ensure no Schedule II through Schedule V controlled substances are in the PACT medication room.

Management has hired a new PACT program supervisor and senior clinician III for oversight to the program. The PACT supervisor will regularly meet with PACT staff to review and update the application of the policies and procedures as needed. The

PACT supervisor will keep the PACT administrator informed of compliance with policies and procedures and of any barriers/noncompliance that may arise for further problem solving/follow up. The PACT supervisory/managerial staff will also conduct unannounced random checks with the PACT nurse present of medication to assure only Schedule VI medication is stored.

2. Pharmacy Control Procedures – PACT

Finding - The Program of Assertive Community Treatment (PACT) Division was not in compliance with Virginia Board of Pharmacy regulations as they related to delivery of dispensed prescriptions. PACT's policies and procedures did not sufficiently address the receipt, accountability, control, and safeguarding of drugs; employees were not properly trained on the handling and receipt of drugs; and incident reports were not always completed as required when incidents occurred.

Recommendation - The CIBH should comply with the Virginia Board of Pharmacy's regulation as it relates to the delivery of dispensed prescriptions. PACT procedures should be updated to address the receipt, accountability, control, and safeguarding of drugs and ensure that employees are properly trained. Additionally, incident reports should be properly completed and forwarded to the Quality Assurance division within 24 hours as required by policy.

Response: We offer the following comments related to specific issues mentioned:

- a. Policies and procedures have been put in place with regard to medication deliveries and medication brought into the facility by individuals receiving PACT services to ensure these medications are recorded in the medication inventory, and put into the correct medication storage bags. With respect to medication deliveries that come to the facility via mail, the packing orders are checked and confirmation of the receipt is faxed back to the vendor.**
- b. Management is working to restrict the number of staff who are authorized to accept medication deliveries.**
- c. To better supervise and monitor the medication delivery and administration, one Registered Nurse position will be assigned administrative and medication control duties such as managing medication inventory, repackaging medication into pill packs, reconciling medication deliveries and reconciling medication returned from deliveries by PACT staff that could not be delivered to individuals receiving PACT services.**

To also better supervise and monitor the medication delivery and administration, the other Registered Nurse position will be assigned supervisory duties over the PACT Licensed Practical Nurses and be directly involved in the delivery of medication in the community to individuals who receive PACT services, including administering injections, and ensuring

individuals who receive PACT services get to medical and lab appointments. Both Registered Nurses will be cross trained to be able to provide back up to one another's supervisory roles when needed.

- d. Staff will follow the PACT Medication Administration Standard Operating Procedures for the documentation and transfer of the day's drugs pending the implementation of the on-site pharmacy.
- e. A depository vault has been installed to secure delivered Schedule VI medication when a PACT nurse is unavailable. A key safe has also been installed to secure the key that accesses the vault storing Schedule VI medication on site when not secured in the combination locked medication room, This key safe will also store the keys that access lock boxes in individual's residences. Accompanying log books have been created, to document the storage and retrieval of these medications and keys to provide an audit trail of stored medications and keys in the PACT office. A policy was put in place to ensure that Schedule VI medications stored in the depository vault are taken immediately to the PACT medication room to be secured as soon as a PACT nurse is available.
- f. Policies and procedures have been put in place to require the combination of the PACT medication room lock is changed at least every six months, at any time a PACT nurse or physician leaves the employment of the PACT program, in the event that a PACT nurse/physician is suspended as the result of a disciplinary action, or in response to any other situation or investigation that warrants the combination to the lock be changed.
- g. A panic alarm attached to a lanyard was placed in the PACT office so staff have access to a panic alarm should a crisis arise in the PACT office.
- h. A request was made to have a card access reader installed for the PACT medication room but have been informed that the work order cannot be completed until December 2015.
- i. A camera was installed in the PACT medication room.
- j. Locks for the PACT medication delivery bags were purchased and put into use.
- k. Policies have been put in place and individuals receiving PACT services have been informed that between 8:00 a.m. and 9:00 a.m. is the period when morning medication can be picked up at the PACT office. Individuals receiving PACT services have also been informed that between 3:00 p.m. and 5:00 p.m. is the period of time when afternoon medication can be picked up at the PACT office.

- i. A medication delivery form has been developed for individuals receiving medication to document their receipt. Supervisory staff have implemented a medication storage consent form that individuals have signed to authorize storage of their medications at CIBH.**
- m. The role of each staff type: Clinician I, Clinician II, Clinician III, Licensed Practical Nurse, Registered Nurse, Peer Support and Program Supervisor is being better defined, and all staff will be trained regarding their prospective roles and the roles of other employees in the PACT program.**
- n. Lock-box keys will be stored in a secure safe. Lock-box keys will be accounted for at the end of each working day by review of the Lock-box key log by supervisory staff**
- o. The PACT office has been cleaned and will continue to be reorganized in an effort to provide more space for staff working in that office to improve the working environment.**
- p. PACT staff have also been informed they are required to use a key rather than reaching over the Dutch door for access to the PACT office.**

3. Psychiatric Med Room – Controls

Finding - Psychiatric (Psych) med room clients did not always sign for their drugs when they were dispensed. The inventory controls for drug samples held in the Psych med room needed to be redesigned. Further, inventory audits of sample drugs were not performed on a periodic basis.

Recommendation – CIBH should ensure that all drugs are signed for by clients when dispensed. Also, inventory control practices and form should be redesigned, and surprise Inventory audits should be performed on sample drugs at least quarterly.

Response - The Virginia Board of Pharmacy regulation:VAC18110-20-275, covering the delivery and dispensing of prescriptions to clients does not pertain to sample medications. The Virginia Board of Pharmacy does not regulate sample medications.

The original audit for client signature upon receipt of medications was not completed with a nurse present. The audit presented to me was a review of 209 charts with 184 missing signatures. Upon my review of the same 209 charts there were only 50 missing signatures. A total of 77 % of the charts did contain signatures. The discrepancy occurred because the Credible system only allowed the signatures to come up that were in a designated signature box on the med pick up service. The current Administration and Delivery of Medication policy only states the nurse will complete the Medication pick up service in Credible. Each part

of the service to be completed is not broken down. One of the sections for the service is a client signature. Therefore in order for the nurse to document the service fully she or he would need to obtain a client signature. As with many of the functions in Credible the technology provides multiple avenues to accomplish the same task. When it is not possible to obtain a client signature (for a med delivery) in Credible using the signature box in the service; nurses are printing the service, obtaining a pen and ink signature and scanning the paper in the clients EMR attaching it to the Med delivery service or in the Attachment section of the record. This is an acceptable means of obtaining client signature and both sections are used to scan paper services. This method requires increased steps on the nurses' part and is only used when clients are unable to physically walk back to the nurses' office, medications are delivered to the client by CIBH, Credible does not allow for a signature due to technical difficulty, client refusal to use the electronic system, etc.

The multiple options allowed by Credible to complete a task is one of the advantages to the Electronic Medical record and is standard in the daily use of documenting the services we provide to our clients. It would defeat the level of technology and benefits of the EMR if we mandate one method of maneuvering the computer to complete a service. As we grow and change with technology so should our policies in regards to the use of our client records.

Given the number of charts our nurses touch for a med delivery on a weekly or monthly basis the review of 209 charts may not give an accurate look at our error rate. However; based on the 209 charts reviewed --23% of the charts did not have a client signature. While I believe it will be difficult to reach 100% due to our client population and nature of our work I do believe we can improve on the number of medications delivered with a client signature. Client signature for med pick up is now part of the QA Matrix for Psych services. The expectation was shared with all the nurses in September of 2014 and continues to be a focus for Psych Services. The samples reviewed did reveal our method of tracking samples was not sufficient. This had traditionally not been an area of focus as the Board of Pharmacy does not regulate samples and the common practice for out-patient offices does not include the signing of samples in and out with regular audits. The form being used was one we had recently adopted in an effort to monitor sample medications as a result of a directive from the Executive Director after recommendations were made from a former employee. The form was not as "fine tuned" as needed. Under the recommendation of Tony Markun, City Auditor's Office a new form was implemented in November 2014 with a minimum of a quarterly review. The form includes a running balance of sample medications. The most recent review was completed on 6-3-2015. The new form has improved the number of outages that occur.

The document provided to me from the audit stated that when "outages occurred, they were not researched to determine why the outages occurred". In fact, whenever an "outage" is discovered by a nurse efforts are made to identify the source of the "outage" determine who signed a med in or out and failed to put the

correct numbers in the correct areas, or who delivered a sample and did not sign the sample out or who accepted medications from a drug rep without signing a med in. Since the Sample Log Form was initiated the number of outages has decreased.

The policy titled "Administration and Delivery of Medication" for Psych Services has been revised to say specifically 1. A client signature will be obtained with each med delivery. 2. Having the client sign in the designated box in the EMR is the first option with a pen and ink signature scanned in under the above mentioned circumstances. 3. The scanned in signature should be attached to the service. The policy titled "Obtaining Medications" for Psych services addresses the delivery of sample medications. The policy has been tweaked to include the quarterly reviews.

4. Cardkey Access Cards

Finding - Policies and procedures for the handling and control of access card issuance, receipt, safeguarding, and accountability had not been developed, documented, and implemented. In addition, employees were not adequately trained on the handling of access cards, and there was minimal oversight over card access processes.

Recommendation – CIBH should develop, document, and implement access card handling process policies and procedures so that the integrity of the data on the card access system is accurate. Employees should be adequately trained on access controls. In addition, CIBH should develop an ongoing oversight and monitoring process to ensure adherence to access cards procedures.

Response - CIBH has implemented or is in the process of implementing the following changes:

- **Administrative MIS Staff have been issued individual accounts by the Main Card Access Administrator.**
- **A Formal Request to Add/Transfer/Remove user Access had been established suspensions and terminations are walked by the supervisor to MIS.**
- **MIS has begun to explore a process of exporting active card access accounts into a CSV file and comparing accounts against the active directory export form the network access. Those accounts that are outside of the network scope are then filtered by the internal HR list by the appropriate staff members.**
- **A review of zones and levels of access is underway to establish the proper security levels with employee roles within the organization.**
- **A "how to document" has been created in the MIS instruction set of what steps are used to remove or suspend account access.**
- **The MIS Administrator has proposed a consolidation of temporary card disbursement and inventory tracking through the EHR system and has submitted the process for review by the Leadership Team in CIBH and the**

auditor. All card inventory and tracking for 224 and 216 Great Bridge Blvd will be handled through this process. This process will allow for a consolidated approach to identifying who cards are temporarily assigned without giving administrative access to the Card Access system within the city.

5. Random Drug Testing

Finding - The CIBH required ongoing random drug testing for van drivers as a requirement of the City's Substance Abuse Policy (Administrative Regulation 2.44). However, it did not require ongoing random drug testing for employees such as Clinicians, Nurses, and Program Supervisors.

Recommendation – CIBH should consider implementing an ongoing random drug testing program for positions such as Clinicians, Nurses, and Program Supervisors.

Response – Consolidated monthly statements from the UP Center and Highlands Place will be mailed to each Authorized Representative assigned for each resident on a Monthly basis.

The following revised Resident Check Cashing Procedures have been implemented. The Account Technician will contact the Representative Payee to request resident's funds only when needed. Resident's personal funds account held at Highlands Place should always be \$80 or under. Upon receipt of the resident's check the check stub will be date stamped with the date of receipt and placed into safe. Staff will be notified via email that the resident has a check that needs to be cashed as soon as possible. The Account Technician is responsible for assuring that the resident's checks are cashed within 2 weeks of date of receipt of checks. Once the check has been cashed the check stub will then be date stamped with "Date cashed" and the deposit of the funds will be documented in the "resident's fund" excel spread sheet and a receipt will be filled out documenting the deposit of funds along with the completion of section III of the "Resident Funds Expenditure Request/Deposit Form".

6. Conflict of Interest Practices

Finding – CIBH did not have effective departmental conflict of interest practices.

Recommendation – CIBH should strengthen its conflict of interest review practices.

Response – CIBH will be implementing a standardized form that will be included in Credible. All employees will be required to complete the form on at least an annual basis or more frequently if they obtain outside employment during the year. Placing this form in Credible will allow us to better manage the completion of the form and to prepare additional analysis in a more efficient manner.

APPENDIX B

TIMELINE OF ICF STARTUP

Timeline of ICF Startup

Activity	Dates
Meetings with the state on downsizing South Eastern Virginia Training Center and developing residential resources in the community. Information sharing with Board and City management.	2009 forward
Designation of a portion of CSB fund balance for use for the ICF construction	July 2010
Identified land for use	February 2011
Supervisory staff recruitment and in place for program development	December 2010 – February 2013
Ground Breaking	June 2011
Funding Agreement between State and City signed	July 2011
City Council briefing on ICF	September 2011
Contract signed between State and contractor to build ICFs	September 2011
Construction complete and ICF turned over to CIBH	Fall 2012
Assets placed in service	January 2013
Hiring and training of non-supervisory staff	January 2013 forward
Licensed as a group home by DBHDS	May 2013
First Resident moved in 1829 Rokeby	May 2013
Licensed as an ICF by DBHDDS	March 2014 & May 2014
First Resident moved in 1825 Rokeby	February 2014
ICF Certified by Dept of Health	January 2014 & April 2014
Submission of Pro Forma Cost Report to Medicaid for rate setting	April 2014 & July 2014
Separate NPI Numbers Applied for	June 2014
Medicaid Rates Approved	July 2014 & September 2014
Apply for Provider Number for ICF's	July 2014
Medicaid Enrollment Application Submitted	August 2014
Medicaid Enrollment Application Approved	October 2014
Credible Client Billing Info Set Up	November 2014 – January 2015
Medicaid ICF Billing Submissions w/Error Reports	November 2014 – February 2015
Medicaid VAMMIS Application Re-Opened	March 2015
Medicaid VAMMIS Approval for Testing	April 2015
Medicaid Billing Ongoing Testing	April 2015
Medicaid DMAS 122 & 225 Forms Submitted to DSS	April 2015 - May 2015
Medicaid Client PIRSR Registration Submitted	May 2015
Awaiting PIRSR Approval Letters	June 2015
Claim payment received	June 19, 2015

APPENDIX C

ICFIID BILLING TOTALS

ICFID BILLING TOTALS BY YEAR

MAY 31 2013 THRU MAR 02 2014 PRE-CERTIFICATION WRITE-OFFS	2014 BILLED	2014 PAID	2015 BILLED	2015 PAID	TOTAL MEDICAID BILLED (THRU 5/31/15)	TOTAL MEDICAID PAID (as of 06/30/2015)
\$ 348,937.43	\$ 1,656,002.34	\$ 1,133,293.65	\$ 991,280.68	\$ 918,033.15	\$ 2,647,283.02	\$ 2,051,326.80

NOTES: DIFFERENCE = PATIENT PAY AMTS., RATE VS. CEILING AMT., TIMELY FILING AMTS. RESUBMITTED

