



# Operation and Performance of the Office of the State Inspector General

**Commission Briefing**

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## Study mandate

- Review the Office of the State Inspector General (OSIG)
  - management and stability
  - effectiveness, efficiency, and independence of centralized inspector general
  - role and authority inspecting and investigating incidents in state facilities
  - role in performance audits of state agencies
  - adequacy of staffing levels and expertise

JLARC study resolution, authorized October 10, 2017. Resolution directive regarding jail oversight is addressed in a separate JLARC report *State Oversight of Local and Regional Jails*.

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## In brief

OSIG faced significant challenges early, but the current inspector general is building a positive organizational culture.

OSIG has not adequately fulfilled its role as the state's centralized investigative agency or its oversight role of DBHDS facilities and community-based providers.

OSIG's performance audit function is still a work in progress that should be scaled back so more of OSIG's staff positions can be dedicated to investigations and DBHDS oversight.

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## In this presentation

Background

Management of OSIG

Investigations of fraud, waste, and abuse

Oversight of DBHDS services

Performance audits of state agencies and programs

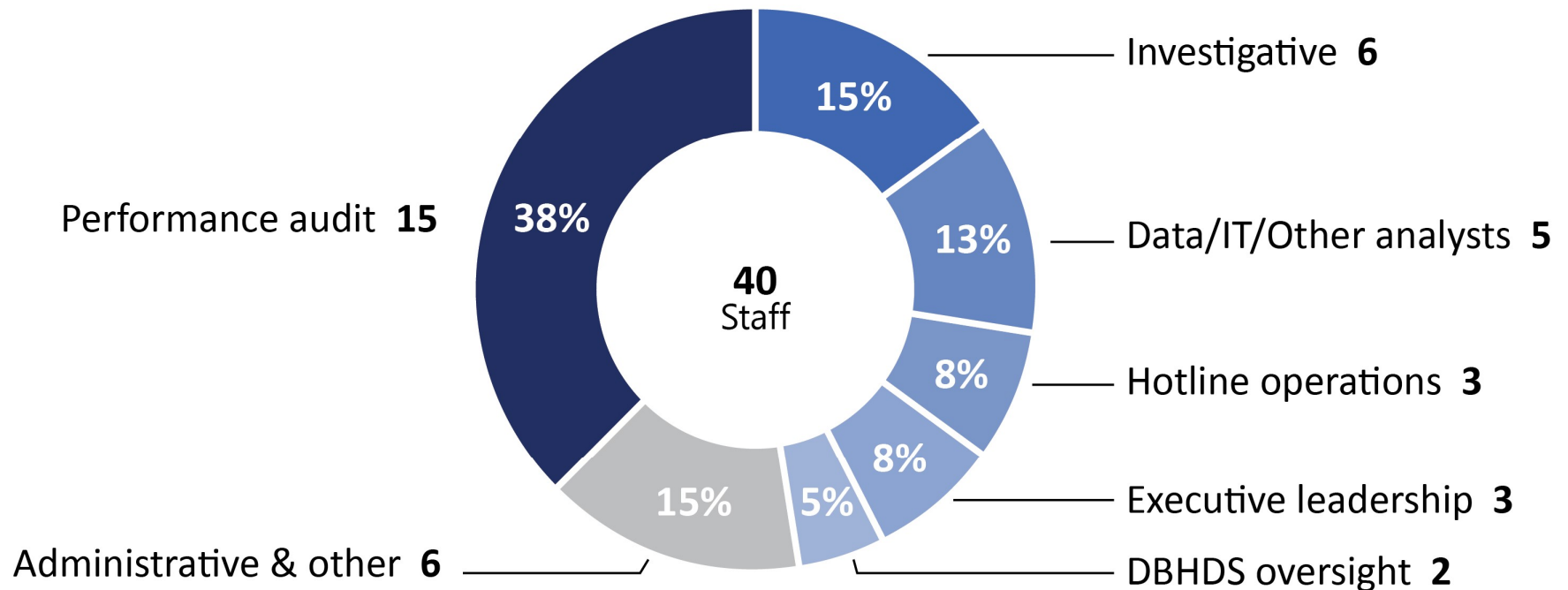
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## Centralized office of the inspector general was created in 2012

- OSIG created by consolidating inspector general functions at 4 agencies
  - DBHDS, DOC, DJJ, & VDOT
- OSIG was granted three primary responsibilities
  - Investigating allegations of fraud, waste, or abuse
  - Overseeing DBHDS facilities and community providers
  - Conducting performance reviews of state agencies and programs
- Virginia is one of nine states with centralized, statewide inspectors general

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**OSIG's budget is ≈\$6.8M, and it employs performance auditors, investigators, and other staff (FY20)**



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## Finding

Leadership turnover and staff dissatisfaction made OSIG's early years difficult, but the agency's culture is improving under the current inspector general.

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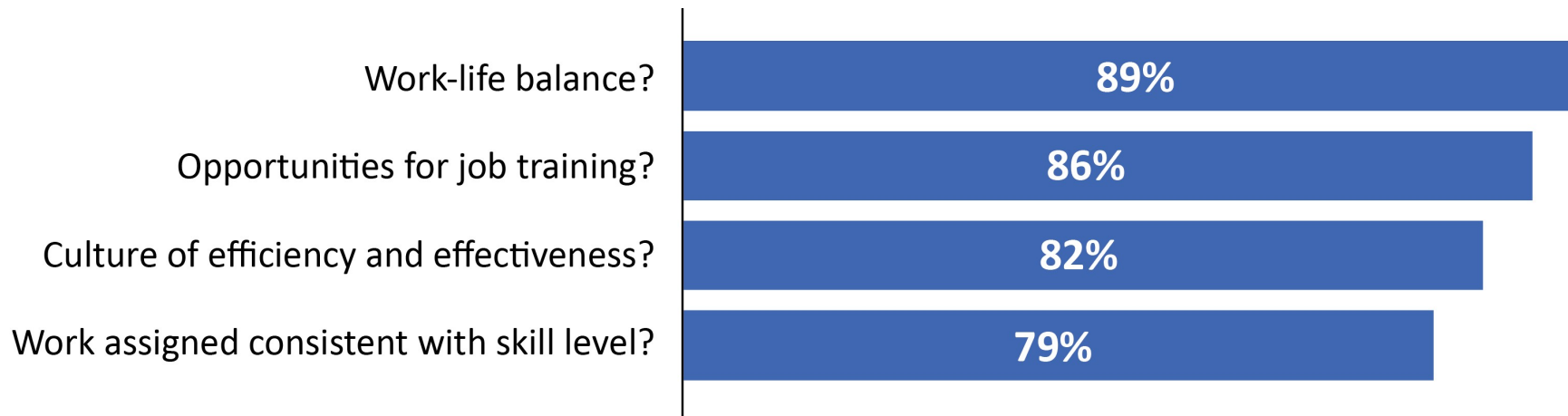
## OSIG has struggled with high turnover and dissatisfied staff

- Three inspectors general since agency was created
- OSIG staff turnover exceeded statewide average four of last five years
  - OSIG originally staffed with mandatory transfers from VDOT, DOC, DJJ, & DBHDS
  - Staff were dissatisfied with new responsibilities and pay inequities after transferring

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## OSIG is stabilizing and building a positive organizational culture

- Staff turnover has slowed
- ~90% of staff are now satisfied with working at OSIG



Source: JLARC survey of OSIG staff, June 2019.

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## Centralized inspectors general can improve the quality and independence of investigations

- Centralizes professional, qualified investigators in a single agency
- Ensures independent investigations because investigators are not employed by the agency where the violation allegedly occurred

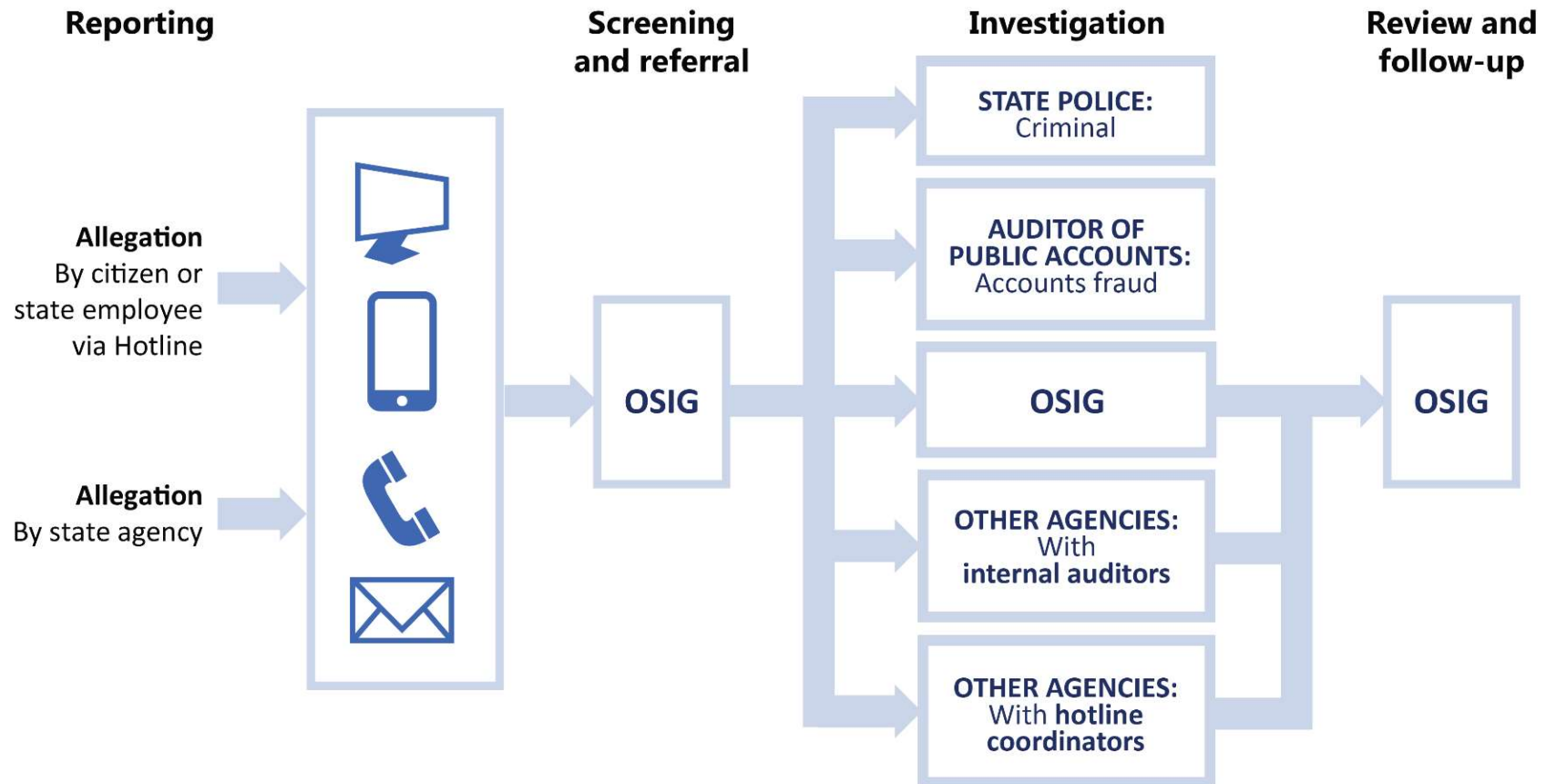
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## OSIG is directed to receive, screen, and investigate complaints

- §2.2-309. A. The State Inspector General shall have power and duty to
  - 3. Receive complaints from whatever source that allege fraud, waste, ... or corruption ... and determine whether the complaints give reasonable cause to investigate
  - 5. Investigate ... whether acts of fraud, waste, abuse, or corruption have been committed
  - 9. Oversee the Fraud, Waste, and Abuse Hotline

Note: Executive orders have been in place for several administrations citing “cost-effectiveness” and avoiding “unnecessary duplication” by using auditors at other agencies. However, this same language was in executive orders before the consolidated OSIG was created and still remained in the executive order after OSIG’s creation.

# Citizens or state agencies report allegations, which OSIG then screens and refers to other agencies



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## Finding

OSIG's process for determining whether to investigate or dismiss hotline allegations is generally effective. However, some allegations are prematurely dismissed.

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## OSIG decisions to investigate or dismiss hotline allegations are generally reasonable

- OSIG staff use well-defined criteria and extensive guidance materials to screen allegations
- Most dismissed allegations had reasonable basis for dismissal\*
- Most agency internal auditors said OSIG forwards allegations that warrant investigation\*\*

Sources: \*JLARC assessment of sample of dismissed allegations, 2019

\*\*JLARC survey of agency internal audit divisions, Summer 2019.

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## OSIG sometimes dismisses hotline allegations prematurely

- Nearly 20% of dismissed allegations were because of lack of information from complainant\*
  - OSIG staff could have easily gathered additional information
- Other complaint-based programs use more structured process for dismissing allegations
  - More proactively gather additional information before dismissing allegations

Source: \*JLARC assessment of sample of dismissed allegations, 2019.

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## Recommendation

OSIG should develop a process in which its chief of investigations must review and approve each decision to dismiss an allegation without an investigation.

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## Finding

When OSIG does conduct its own investigations, they are done by a small team of highly qualified investigators.

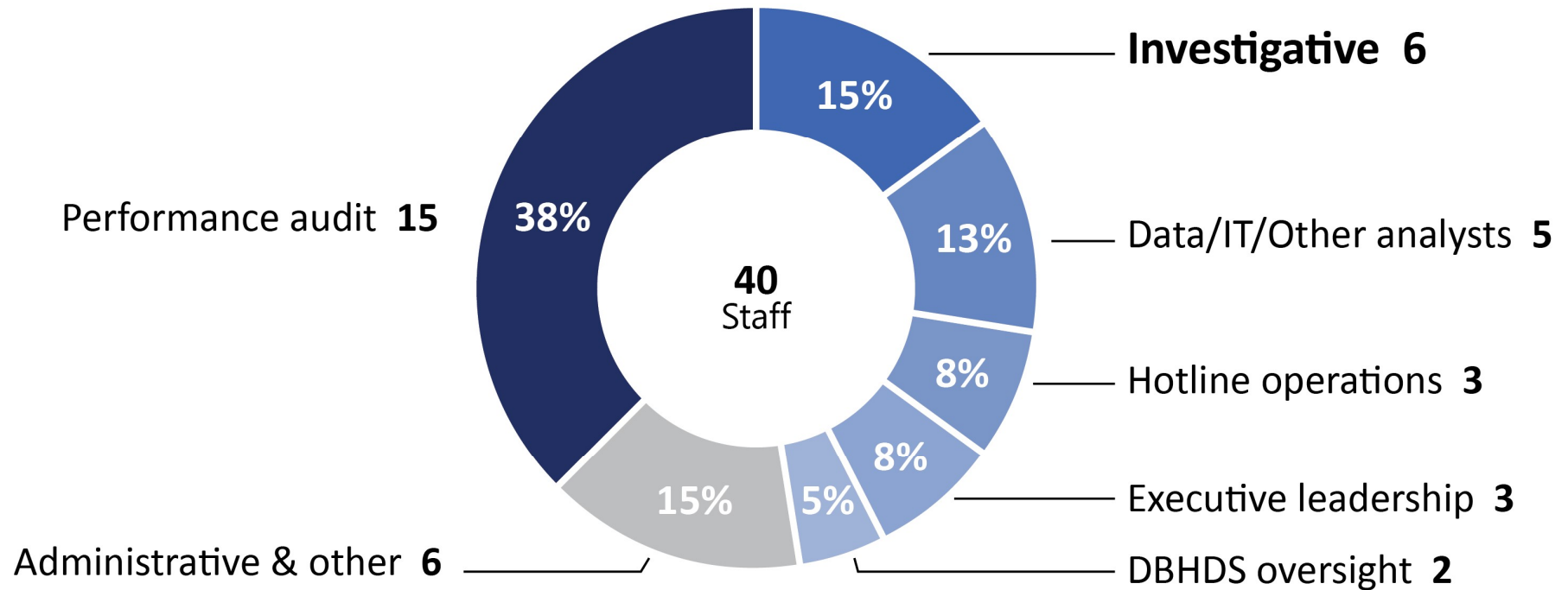
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## OSIG investigators are highly qualified and conduct quality investigations

- OSIG investigators have extensive experience and proper independence
  - Prior investigative experience
  - Certified by the Association of Inspectors General
- OSIG investigations use thorough investigative methods and reach well-supported conclusions
- OSIG historically conducts criminal investigations directly
  - Effective coordinating MOU with Virginia State Police

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## OSIG employs comparatively few investigators, given its centralized investigative role (FY20)



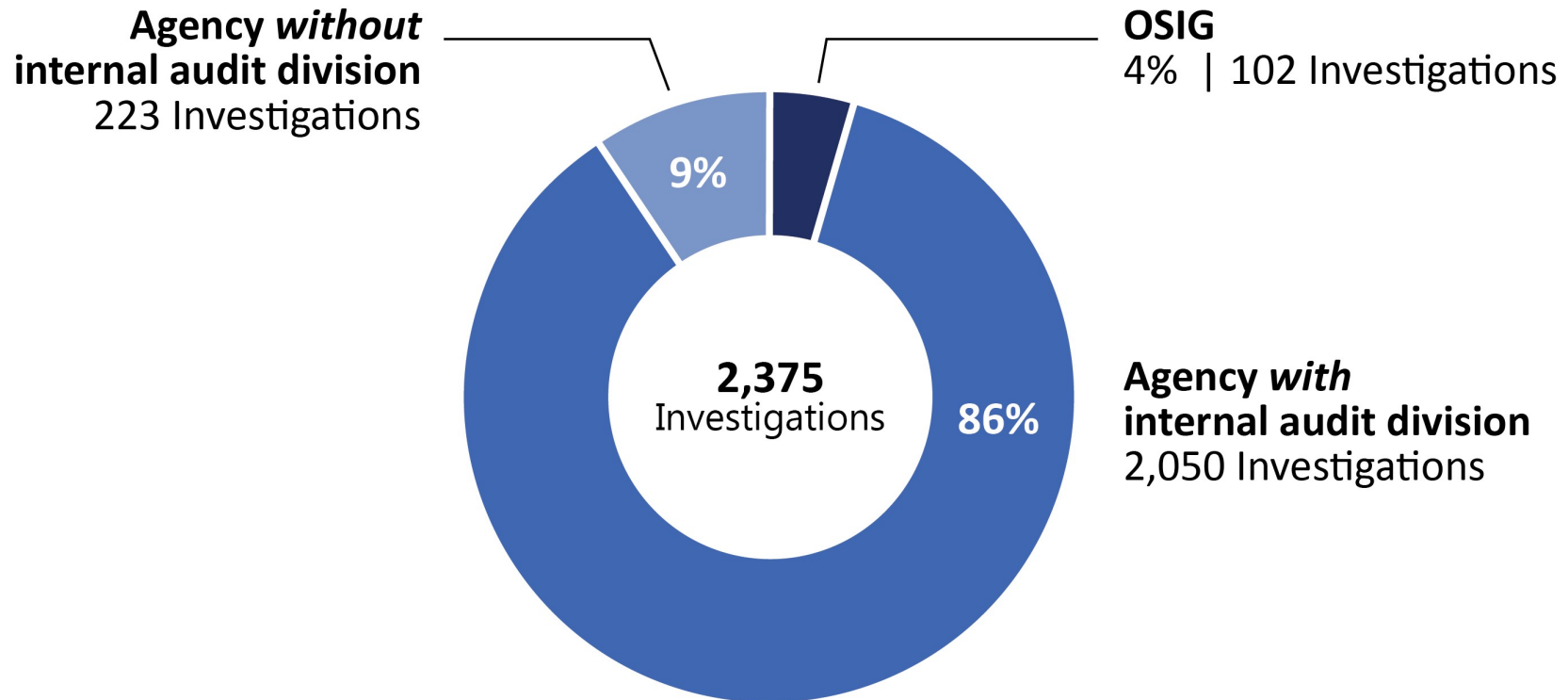
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## Findings

OSIG is not adequately fulfilling the General Assembly's intent to have a centralized program for investigating fraud, waste, and abuse. OSIG directly conducts only a small portion of the state's investigations into wrongdoing in state government.

OSIG does not adequately supervise investigations conducted by other agencies.

## OSIG has conducted only 4 percent of all hotline investigations (FY13–19)



Note: Higher education institutions account for about 10% of investigations conducted by agencies with internal audit divisions. OSIG has limited statutory authority to investigate allegations of wrongdoing at public higher education institutions.

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## OSIG delegated 9 percent of investigations to agencies without internal audit divisions

- Agencies without internal audit divisions use designated hotline coordinators, who are typically less qualified to conduct investigations
  - Usually lack investigative experience or training
  - May lack independence because of other job responsibilities
- The agency head serves as the hotline coordinator at 10 agencies

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## OSIG delegated most administrative allegations to other agencies regardless of seriousness

- Nearly 90% of hotline investigations conducted by agencies with internal audit divisions
  - Internal audit staff have skills well suited for investigations
- OSIG lacks criteria to identify more serious administrative allegations that warrant investigation by a centralized inspector general

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## A centralized OSIG seems well suited to investigate the state's most serious administrative allegations

- OSIG should delegate to other agencies only less serious administrative allegations
- Criteria for less serious administrative allegations could be those that are:
  - below a certain dollar threshold (≈\$25,000)
  - unlikely to reflect poorly on agency leadership if proven true
  - relatively straightforward to investigate

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## OSIG has not adequately supervised and followed-up on investigations conducted by other agencies

- OSIG does not verify that investigators have adequate expertise and independence
- Staff conduct limited reviews of completed investigations
  - OSIG staff generally do not review supporting documentation to verify evidence is sufficient

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## Recommendations

The General Assembly may wish to

- require that OSIG directly investigate the state's most serious allegations of administrative violations, including at institutions of higher education
- direct OSIG to discontinue its practice of referring any allegations to agencies without internal audit divisions and instead directly investigate these allegations

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## Recommendations

OSIG should reallocate its existing positions as necessary to adequately fulfill its role as the state's centralized investigative agency.

OSIG should develop and implement a more proactive and purposeful process for supervising investigations delegated to other agencies.

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## **OSIG established a complaint line to receive allegations of abuse, neglect, or inadequate care**

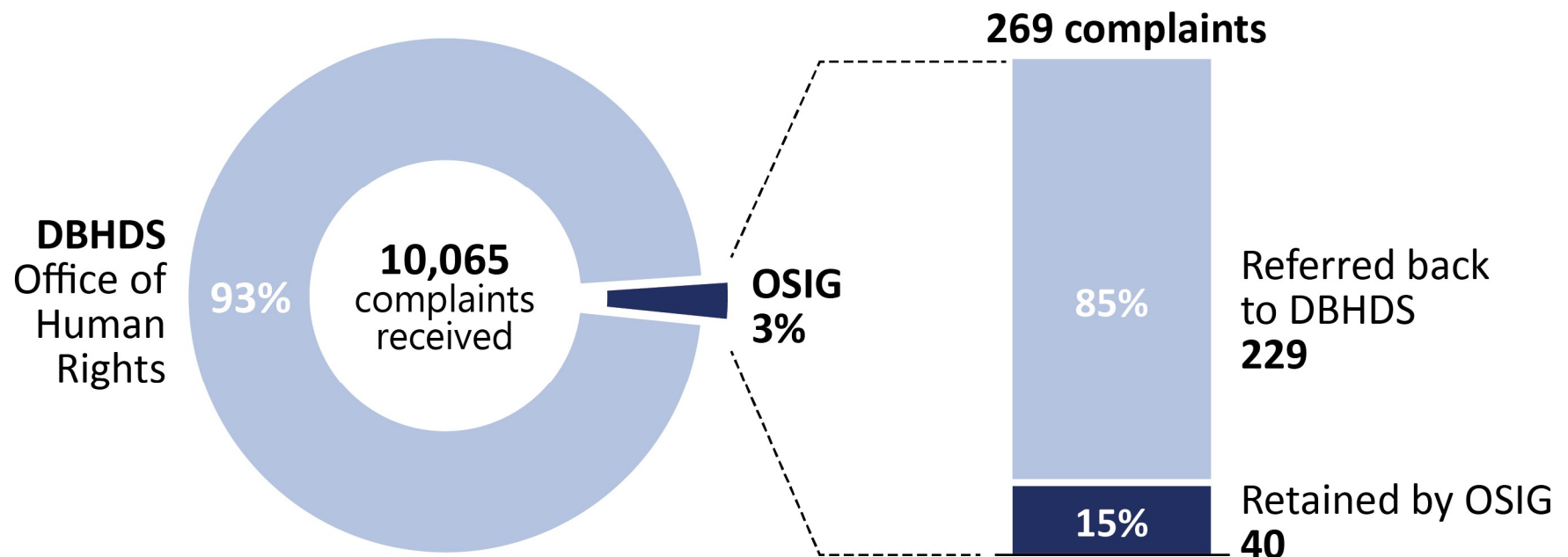
- OSIG receives these complaints through a phone number and email address
- Complaints come from individuals receiving services, their family members, Adult Protective Services, legislators' constituent offices, or any other source
- Complaints range widely in potential severity, magnitude, and credibility

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## Finding

OSIG has not adequately promoted its DBHDS complaint line and lacks a structured process for investigating complaints.

## OSIG receives relatively few complaints, and refers many to DBHDS to investigate (FY19)



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## OSIG lacks a structured process to determine whether it will investigate a complaint

- OSIG uses vague criteria that lack detail to adequately determine when OSIG should investigate an allegation directly.
- Without strategic criteria, OSIG sometimes refers serious complaints to DBHDS while also directly investigating less serious complaints

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## Recommendations

OSIG should regularly promote awareness of its complaint line.

OSIG should develop written criteria and guidance to consistently determine which complaints it should investigate directly or refer to DBHDS.

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## OSIG also is tasked with a variety of oversight activities related to behavioral health

- Inspect DBHDS training centers, psychiatric hospitals, and the medical center
  - Inspections can be especially valuable for vulnerable populations under the control of a facility.
- Monitor serious incident reports and reports of abuse, neglect, or inadequate care
  - Data most valuable for identifying systemic problems in the quality of care and safety.

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## Finding

OSIG inspects DBHDS facilities but has done little other meaningful system-level oversight to address serious quality and safety issues.

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## OSIG has inspected DBHDS facilities annually as required (FY13–19)

- Inspections usually have focused on key aspects of facility operations.
- OSIG's FY18 inspections, however, are being redone because they did not produce sufficient research to produce a quality report.

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## Beyond inspections, OSIG has done little else to meaningfully fulfill its statutory role

- OSIG has done little analysis of available DBHDS data to identify systemic issues related to quality and safety.
  - Injuries, deaths, abuse, neglect, seclusion/restraints
- OSIG has conducted minimal oversight of community services boards (CSBs) and other community-based providers.

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## Recommendations

The General Assembly may wish to:

- clarify for OSIG that the primary goal of its DBHDS oversight is to identify system-level issues affecting the quality of care and safety across facilities and providers and recommend solutions to address them.
- require that OSIG implement a plan for conducting system-level oversight, including how many of its staff positions it should reallocate to DBDHS oversight.

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## OSIG was given new performance review responsibility when created

- OSIG had few staff qualified to review state agency performance when it was created.
  - Staff came from investigative and financial audit backgrounds.
- Over time, OSIG has adopted the widely accepted Government Auditing Standards to conduct “performance audits.”
- OSIG’s performance audit staff are now the single largest group in the agency.
  - 15 staff, 38 percent of total OSIG staffing

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## State has ongoing need for performance audits of agencies and programs

- State agencies and programs can benefit from periodic review by outside entity
  - Cabinet secretaries cited benefit of an effective performance audit
- State has relatively few performance audit resources
  - OSIG
  - JLARC

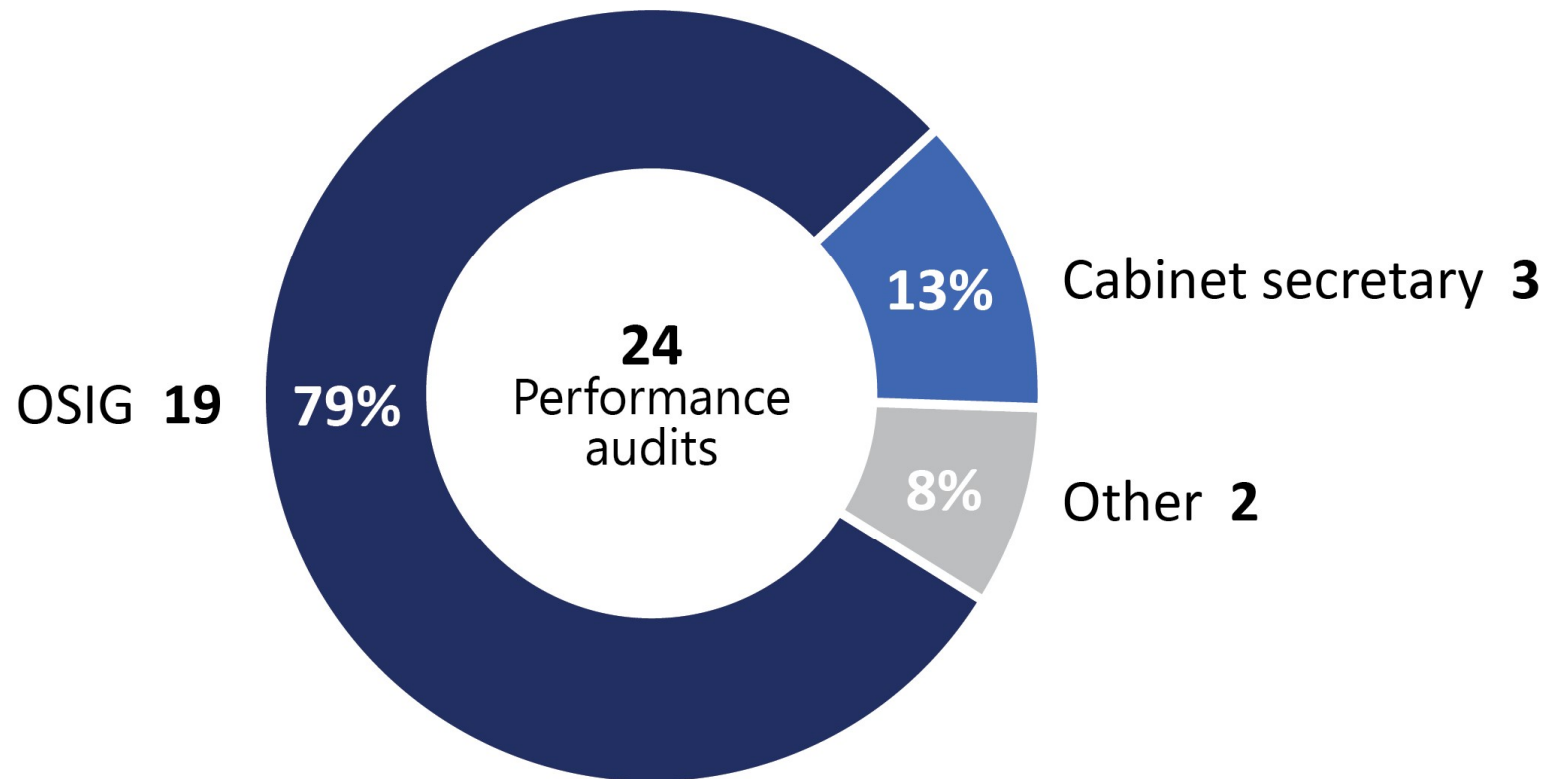
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## Finding

OSIG's performance audit function is a work in progress. Few of its audit topics are selected by executive branch leadership, and the quality of its recent audits has been uneven.

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## Most audit topics are selected by OSIG staff



NOTE: OSIG performance audits since 2016.

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## Audit planning has improved, but staff still struggle to conduct audits efficiently

- Recent audit plans include more precise objectives and detailed methodologies
- Recent audits have taken  $\approx 2$  years to complete
- OSIG staff cited timeliness and efficiency as issues

“The audit division does not efficiently conduct audits. They struggle to establish and stick with an effective scope for projects, which then lead to projects being too large and taking much longer than expected or intended.” – *OSIG staff*

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## A JLARC assessment concluded that OSIG's recent audits were of uneven quality

Assessment criteria	JLARC assessment
<u>Findings</u> - supported by evidence, based on objective criteria, address the cause and significance of deficiencies	
<u>Recommendations</u> - address findings, are clearly worded, and likely to have a net benefit	
<u>Report</u> - appropriately structured and well written, uses language accessible to non-subject matter experts	

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## Agencies recently audited by OSIG had mixed opinions about audit quality and usefulness

- About half the agencies that have been the subject of a performance audit believed findings were either “useful” or “somewhat useful.”
- The other half, though, reported that research findings were “not useful.”
  - Most frequently cited reason was that OSIG’s findings were not supported by adequate evidence.

Source: JLARC survey of agencies recently audited by OSIG, Summer 2019.

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## OSIG has struggled to build a full staff of effective performance auditors

- Have had to recruit and try to retain staff with a different skillset than investigations or financial audits
- Hired performance auditors under “auditor” job role
  - Requires knowledge of accounting functions, business transactions, and collections procedures
  - Financial and business expertise is not always necessary to conduct an effective performance audit
- Performance auditors need analytical skills, such as program evaluation, statistics & economics, and the ability to identify recommendations for improvement

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## OSIG staff themselves and some agencies have cited the gap in skills of OSIG's performance auditors

“Nobody had experience in conducting performance reviews or performance audits.”

OSIG  
staff

“New employees get here and show they really do not have any knowledge of performance auditing.”

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Other  
agency  
staff

“I think the auditors themselves had the right intentions; I just think they probably had more experience with investigations than performance audits.”

“Ultimately, OSIG is not staffed to be a useful performance audit organization. Their mission and staffing is focused on fraud or waste.”

Sources: JLARC surveys of OSIG staff and agencies recently audited by OSIG, Summer 2019.

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## OSIG's performance audit function needs to be scaled back and strengthened

- Performance audits are uneven in quality and can impose administrative burden on audited agencies.
- Function should be scaled back to two audits per year over four-year trial period.
  - increase involvement of executive branch leadership
  - improve quality and supervision

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## Recommendations

The General Assembly may wish to temporarily limit OSIG to two performance audits each year (FY21–24).

- One topic selected by the chief of staff
- One topic selected by OSIG

OSIG should work with DHRM to

- identify four to six highly capable performance auditors
- redefine its auditor position to reflect needed skills

Note: Will need to be undertaken as part of reallocation of existing OSIG positions to better fulfill statutory intent for centralized investigative and behavioral health and development services oversight functions.

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## Key findings

OSIG faced significant challenges early, but the current inspector general is building a positive organizational culture.

OSIG has not adequately fulfilled its role as the state's centralized investigative agency or its oversight role of DBHDS facilities and community-based providers.

OSIG's performance audit function is still a work in progress that should be scaled back so more of OSIG's allocated positions can be dedicated to investigations and DBHDS oversight.

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