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Report to the Governor and the General Assembly of Virginia

Operations and Performance of the Office of the State Inspector General

2019

JLARC
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

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WHAT WE FOUND

OSIG's staffing has stabilized and employee satisfaction is high

The Office of the State Inspector General (OSIG) faced significant organizational challenges during its early years. The agency has had three different inspectors general since it was created in 2012. OSIG also experienced extraordinarily high staff turnover, largely because staff from other agencies were required to transfer to OSIG.

Under the current inspector general, though, OSIG is showing signs of stabilizing and beginning to build a positive organizational culture. OSIG's current employees report being satisfied with OSIG as a place to work. Staff turnover has slowed, and the agency now has a well-defined organizational structure, along with well-defined administrative and financial policies.

WHY WE DID THIS STUDY

In 2018 the Joint Legislative Audit and Review Commission (JLARC) directed its staff to study the operation and performance of the Office of the State Inspector General.

ABOUT OSIG

The Office of the State Inspector General (OSIG) is a relatively new state agency that was created in 2012. OSIG took over some investigative staff and functions that existed at other agencies but also was given a new responsibility to conduct performance audits of state agencies.

OSIG is not adequately fulfilling its intended role as a centralized investigative agency

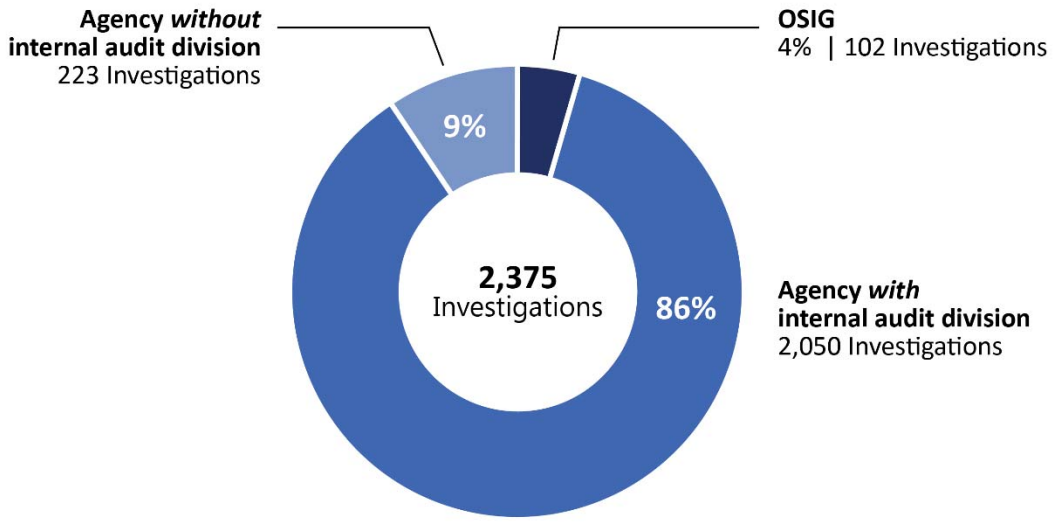
OSIG has effectively promoted the State Fraud, Waste, and Abuse Hotline, providing multiple ways for state employees and the public to report allegations of potential wrongdoing in state government. When OSIG conducts its own investigations, the investigations use appropriate techniques that result in sound conclusions. Its investigators are well qualified, experienced, and each is certified as an investigator by the Association of Inspectors General.

However, OSIG conducts a small portion of the state's investigations into fraud, waste, or abuse, despite its role as the state's inspector general and its statutory duty to investigate such allegations. OSIG has conducted less than 5 percent of all investigations for the State Fraud, Waste, and Abuse Hotline since the agency's inception; and most of its own investigations concern allegations of criminal conduct. The vast majority of investigations into allegations of administrative violations are conducted by other agencies' internal audit divisions. Some administrative investigations are also conducted by designated "hotline coordinators" at agencies without internal audit divisions. These coordinators have other responsibilities and are not trained as professional investigators.

OSIG's heavy reliance on other agencies to investigate allegations of fraud, waste, or abuse appears counter to legislative intent and inconsistent with Virginia's transition to a centralized inspector general. A key benefit of a centralized, statewide inspector

general is the ability to ensure that investigations are conducted independently by investigators with the proper training and experience.

Vast majority of hotline investigations have been conducted by agencies with an internal audit division (FY13–19)



NOTE: JLARC analysis of OSIG data. Percentage totals do not sum because of rounding.

OSIG has not adequately fulfilled its statutory responsbility to oversee behavioral health and developmental services facilities and providers

OSIG has met its requirement to inspect Department of Behavioral Health and Developmental Services (DBHDS) facilities annually and established a complaint line to receive complaints from individuals receiving services from DBHDS or community-based providers regulated by DBHDS. However, OSIG has not adequately promoted the complaint line or established a structured process for investigating complaints.

More fundamentally, though, OSIG has done little else to meaningfully fulfill its statutory role to identify issues related to quality and safety that need to be addressed. Its oversight of community-based providers has been minimal. It also has done little to analyze available DBHDS data to identify problems across facilities or providers.

OSIG has struggled to build a fully effective performance audit function

OSIG's performance audit function is still a work in progress. When the agency was created, OSIG had few staff with the expertise to conduct performance audits. Consequently, OSIG built staff capacity over time and now employs 15 performance audit staff.

OSIG's performance audits have been of uneven quality and take too long to conduct. This is largely due to the difficulty OSIG has had building a staff to effectively conduct performance audits. An OSIG staff member observed that "new employees get here and show they really do not have any knowledge of performance auditing."

OSIG needs to scale back the performance audit function and strengthen it. Some of the staff positions currently allocated to performance audits need to be reallocated to investigations and behavioral health oversight.

WHAT WE RECOMMEND

Legislative action

- Direct OSIG to better fulfill its intended role as Virginia's central investigative agency by directly investigating the state's most serious allegations of administrative violations (including at higher education institutions).
- Direct OSIG to discontinue referral of allegations to agencies without internal audit divisions.
- Clearly define the goal of OSIG's oversight of behavioral health and developmental services facilities and providers.
- Direct OSIG to implement a plan to conduct effective system-level oversight of the quality and safety of behavioral health and developmental services facilities and providers.
- Limit OSIG to two performance audits per year for a four-year trial period.

Executive action

- Determine the number of investigative staff needed to fulfill the role as the state's centralized investigative agency and reallocate existing staff as necessary.
- Identify four to six highly capable performance auditors to implement a scaled-back performance audit program.
- Define a new performance auditor position that more accurately reflects the full range of skills needed.

The complete list of recommendations is available on page v.

Recommendations and Options: Operations and Performance of the Office of the State Inspector General

RECOMMENDATION 1

The Office of the State Inspector General should establish and implement a process by which its chief of investigations reviews and approves each decision to dismiss an allegation reported to the State Fraud, Waste, and Abuse Hotline without conducting an investigation. (Chapter 3)

RECOMMENDATION 2

The Office of the State Inspector General should develop and implement a more proactive and purposeful process to supervise investigations of allegations it has delegated to other agencies to ensure the quality, independence, and timeliness of investigations. (Chapter 3)

RECOMMENDATION 3

The Office of the State Inspector General (OSIG) should track the implementation status of recommendations made in previous OSIG investigations and encourage action on recommendations not yet implemented by agencies. (Chapter 3)

RECOMMENDATION 4

The General Assembly may wish to consider amending § 2.2-309.B of the Code of Virginia to require that the Office of the State Inspector General directly investigate the state's most serious allegations of administrative violations and only refer allegations for investigation to other agencies that (i) are below a dollar threshold (to be developed by the inspector general); (ii) would not reflect poorly on agency leadership if proven true; and (iii) appear relatively straightforward to investigate. (Chapter 3)

RECOMMENDATION 5

The General Assembly may wish to consider including language in the Appropriation Act directing the Office of the State Inspector General to discontinue its practice of referring allegations for investigation to agencies without internal audit divisions and directly investigate these allegations. (Chapter 3)

RECOMMENDATION 6

The Office of the State Inspector General should determine the number of investigative staff needed to fulfill its intended role as the state's centralized investigative agency and reallocate existing staff to meet that need. (Chapter 3)

RECOMMENDATION 7

The General Assembly may wish to consider repealing § 2.2-309.B of the Code of Virginia so that OSIG will have full discretion to investigate all serious allegations of waste, fraud, or abuse at public institutions of higher education. (Chapter 3)

RECOMMENDATION 8

The Office of the State Inspector General should develop and implement a program for regularly promoting awareness of its complaints line among residents of facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and individuals receiving services from community-based providers regulated by DBHDS. (Chapter 4)

RECOMMENDATION 9

The Office of the State Inspector General should develop written criteria and guidance for consistently determining which complaints regarding services provided or regulated by the Department of Behavioral Health and Developmental Services (DBHDS) it should investigate directly or refer to DBHDS. (Chapter 4)

RECOMMENDATION 10

The General Assembly may wish to consider amending § 2.2-309.1 of the Code of Virginia to more clearly establish that the primary goal of the Office of the State Inspector General's oversight of the Department of Behavioral Health and Developmental Services and community-based providers is to identify system-level issues that affect quality of care and safety across facilities or providers and recommend solutions to address them. (Chapter 4)

RECOMMENDATION 11

The General Assembly may wish to consider including language in the Appropriation Act to direct the Office of the State Inspector General (OSIG) to develop and implement a plan to conduct system-level oversight of the quality of care and safety across Department of Behavioral Health and Developmental Services facilities and community-based providers. The plan should set forth the primary oversight activities that OSIG plans to undertake, as well as the number of additional staff positions and types of expertise necessary to carry out these activities. OSIG should submit the plan to the House Appropriations and Health, Welfare and Institutions Committees, and the Senate Finance and Education and Health Committees no later than June 30, 2020. (Chapter 4)

RECOMMENDATION 12

The General Assembly may wish to consider including language in the Appropriation Act directing the Office of the State Inspector General (OSIG) to conduct only two performance audits annually in FY21–24. Each year one audit topic should be chosen by the chief of staff in consultation with the governor's cabinet and one audit topic should be chosen by OSIG. (Chapter 5)

RECOMMENDATION 13

The Office of the State Inspector General should consult with the Department of Human Resource Management to define a performance auditor position that more accurately reflects the full range of skills needed. (Chapter 5)

RECOMMENDATION 14

The Office of the State Inspector General should consult with the Department of Human Resource Management to identify four to six highly capable performance auditors to implement a scaled-back performance audit program. Individuals can be from the current performance audit staff and individuals hired under a newly defined performance auditor position that have the full range of skills needed. (Chapter 5)

OPTION 1

The General Assembly could direct staff with the Joint Legislative Audit and Review Commission to conduct a follow-up review of the Office of the State Inspector General performance audit program after FY24 to determine whether the scaled-back program has been successful. (Chapter 5)

1 Virginia Office of the State Inspector General

SUMMARY Inspectors general exist to promote government accountability and ensure that agencies and programs are operating efficiently and effectively. Virginia's Office of the State Inspector General is one of only nine statewide centralized inspector general offices in the U.S. OSIG was created in 2012 by consolidating the inspector general functions at four state agencies. OSIG has a broad range of statutory responsibilities, including operating the State Fraud, Waste, and Abuse Hotline and conducting investigations; overseeing state facilities and service providers for individuals with behavioral health and developmental disabilities; and conducting performance audits of state agencies. OSIG is a relatively small state agency, with an annual appropriation of $6.8 million and 40 staff in FY20.

In 2017 the Joint Legislative Audit and Review Commission (JLARC) directed its staff to review the Office of the State Inspector General (OSIG). The office was created in 2012 and had not been reviewed. The mandate for this study directed JLARC staff to evaluate OSIG's

- overall performance, management, and stability;
- effectiveness, efficiency, and independence as the state's centralized inspector general;
- role and authority in inspecting and investigating incidents in jails and other state facilities where individuals are held (see sidebar);
- role in conducting performance evaluations of state agencies; and
- sufficiency of staffing levels and staff expertise. (See Appendix A for the study mandate.)

OSIG's role and authority in jails is addressed in the JLARC report ***State Oversight of Local and Regional Jails.***

To address the study mandate, JLARC staff conducted surveys of state agencies that have undergone performance audits by OSIG, internal audit directors regarding the State Fraud, Waste, and Abuse Hotline, and OSIG staff; conducted interviews with staff at OSIG and other state agencies, staff in other states with centralized inspector general offices, and stakeholders and experts on governmental oversight; analyzed data on allegations submitted to the hotline and state agency staffing data; reviewed the research literature on a variety of topics related to inspectors general and governmental oversight; and conducted structured assessments of subsets of OSIG performance audits and fraud investigations conducted by OSIG and other state agencies. (See Appendix B for the research methods used in this study.)

Virginia created a centralized office of the state inspector general to improve state government

Governor McDonnell's 2010 Government Reform and Restructuring Commission concluded that a centralized inspector general would better be able to investigate allegations of fraud, waste, and abuse and improve agency performance generally.

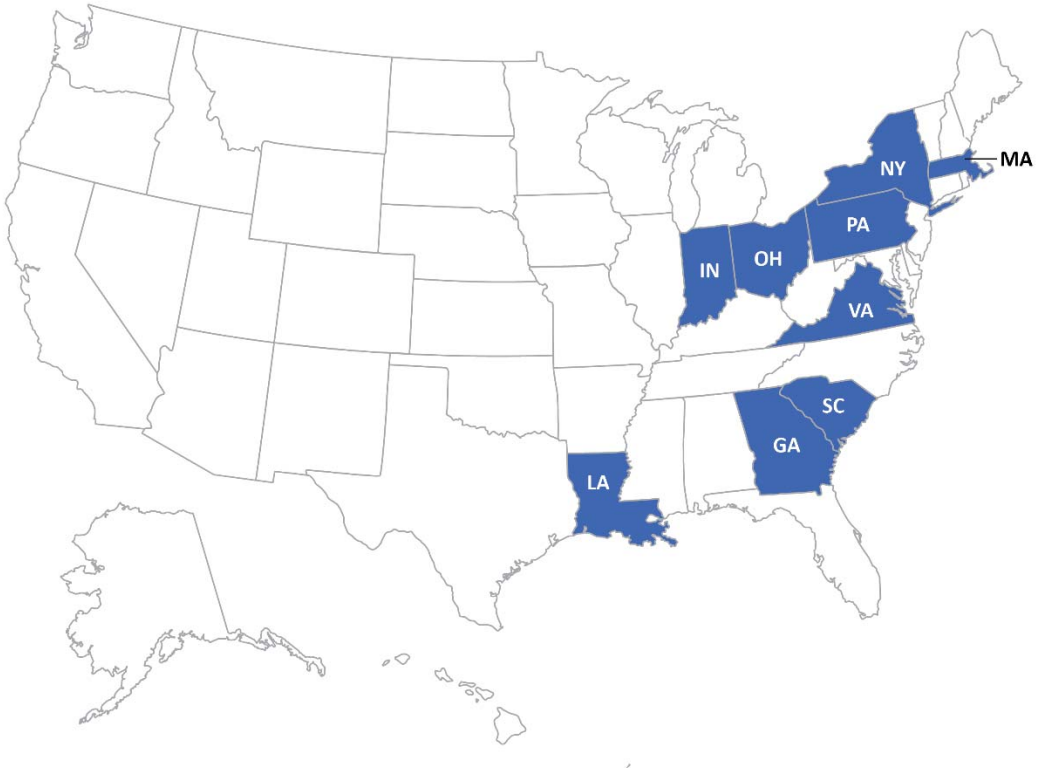
The 2012 General Assembly created OSIG as Virginia's statewide inspector general by consolidating the inspector general functions of the four state agencies with inspectors general (IG): the Departments of Behavioral Health and Developmental Services (DBHDS), Corrections (DOC), Juvenile Justice (DJJ), and Transportation (VDOT). Operation of the State Fraud, Waste, and Abuse Hotline and oversight of internal audit divisions in state agencies were transferred to OSIG from the Division of the State Internal Auditor within the Department of Treasury. Some staff were transferred to OSIG, while other staff remained at these agencies to continue to operate smaller internal audit and investigative divisions. OSIG also was tasked with several new responsibilities, including conducting performance reviews of state agencies.

IGs typically exist to ensure government accountability and promote efficient and effective government agencies and programs. They typically fulfill this role by investigating allegations of fraud, waste, and abuse; conducting audits or performance evaluations of state agencies or programs; and undertaking more specific oversight activities, such as monitoring particular types of programs or facilities where individuals are held.

IGs are fairly common throughout government. A 2015 study found 73 IGs at the federal level, 109 at the state level, and 47 at the local level. IGs vary significantly in their responsibilities, authority, and independence. For example, centralized and statewide IGs are likely to have a broad range of investigative and oversight responsibilities, while an IG with a specific government agency is likely to have responsibilities unique to its agency and programs. Lastly, IGs can have more or less independence depending on several factors, such as their funding source, the process for selecting the inspector general, and to whom the inspector general reports.

Virginia is in the minority of states, though, with a centralized statewide inspector general. Only nine states, including Virginia, have centralized statewide IGs (Figure 1-1). The remaining 41 states have IGs for one or more state or local agencies, but these do not have jurisdiction across state government.

FIGURE 1-1
Only 9 states have centralized, statewide inspectors general



SOURCE: JLARC analysis of information from the Association of Inspectors General.

Virginia's Office of the State Inspector General has several responsibilities

The General Assembly tasked OSIG with several responsibilities aimed at ensuring efficiency, effectiveness, and integrity across state government. OSIG has three primary statutory responsibilities:

- conducting investigations into allegations of fraud, waste, or abuse in state and non-state agencies, such as state boards and commissions;
- conducting oversight of DBHDS facilities and community providers of services for individuals with a mental illness or developmental disability; and
- conducting performance audits of state agencies and programs.

These statutory responsibilities give OSIG review authority over all executive branch entities, including the state's 15 public higher education institutions as well as state boards and commissions. OSIG also has authority to investigate potential fraud, waste, or abuse involving local departments of social services. OSIG's oversight authority generally does not extend to entities in the legislative or judicial branch.

OSIG operates the state fraud hotline and investigates fraud, waste, and abuse allegations

OSIG receives allegations of fraud, waste, or abuse in state government and conducts or coordinates investigations to determine whether these acts are taking place. As required by statute, OSIG receives allegations from state agencies about potentially fraudulent transactions involving state entities or local constitutional officers and appointed officials. The vast majority of allegations are submitted through the State Fraud, Waste, and Abuse Hotline, which OSIG is required by statute to operate. The hotline was originally established through an executive order in 1992, and since then governors have revised the guidelines for its operation. In 2012, Governor McDonnell issued an executive order (EO52) making the hotline available to all Virginia citizens in addition to state employees. OSIG continues to operate the hotline under this executive order.

Since OSIG began operating the hotline in July 2012, more than 4,100 allegations of fraud, waste, or abuse have been submitted. (Each allegation may include multiple instances of alleged wrongdoing.) About 58 percent of those allegations have resulted in a formal investigation. Many of the hotline allegations received by OSIG staff involve employee abuse of state leave policies, such as not working a full day or not using required leave, or the misappropriation of state funds or property.

OSIG has broad authority to access state agencies and exercise law enforcement powers as part of its investigations. The agency has six investigators with law enforcement authority. (OSIG has statutory authority to employ up to 30 investigators with law enforcement authority). These investigators, as well as the inspector general, have authority to issue summonses for violations of statutes OSIG is required to enforce; obtain and serve criminal warrants; and administer oaths to receive complaints and conduct investigations. As part of its investigations, OSIG also has authority to enter any state agency unannounced, question any agency staff or contractors, and access any records or data.

OSIG has oversight of DBHDS facilities and community-based providers

OSIG conducts several oversight activities related to state facilities and community-based providers serving individuals with behavioral health needs or developmental disabilities. OSIG is required by statute to conduct annual inspections of state facilities and providers for the purpose of preventing problems, abuses, and deficiencies and improving the effectiveness of services through policy and operational recommendations. OSIG conducts annual inspections of the 13 state facilities operated by DBHDS, including the nine state hospitals for individuals with serious mental illness. OSIG also reviews some complaints it receives regarding behavioral health and developmental disability facilities and community-based providers, and certain deaths of individuals they served.

OSIG conducts performance audits of state agencies and public higher education institutions

In addition to the functions transferred to OSIG from other state agencies, the agency was given a new responsibility to "conduct performance reviews of state agencies to assess the efficiency, effectiveness, or economy of programs …". Under this authority, OSIG can review any executive branch entity, including the state's 15 public colleges and universities.

Since OSIG's creation in FY12, the agency has completed 32 performance reviews, or "performance audits" (sidebar). These reviews have covered 18 state agencies in seven different secretariats as well as three higher education institutions.

Performance reviews are conducted by staff and senior auditors at OSIG. Reports from performance reviews are published on OSIG's website and provided to the agency being reviewed, the relevant cabinet secretary, the governor's office, and the chairs of the relevant legislative committees and any advisory or oversight committees.

Performance reviews vs. performance audits vs. investigations. OSIG has operationalized its statutory direction to "conduct performance reviews" by adopting the widely accepted Government Auditing Standards term "performance audit." OSIG performance audits are intended to review detailed aspects of state programs, activities and functions, while its investigations examine specific allegations of waste, fraud, and abuse.

OSIG has no oversight authority of local and regional jail operations or state correctional facilities

OSIG has limited responsibility related to adult and juvenile correctional facilities. OSIG's only oversight responsibilities for local and regional jails stem from its general oversight responsibilities of DBHDS-licensed providers; jail inmates are some of the many individuals served by these providers. However, statute explicitly states that OSIG does not have any oversight authority "over the operation and security of local jails that is not specified in other provisions of law." OSIG has done little work related to jails. Of the 20 published behavioral health and developmental disability reports, only two relate to jails: a 2014 review of mental health services in jails and a 2014 review of a death in the Hampton Roads Regional Jail.

OSIG's oversight of adult and juvenile correctional facilities is limited as well. On a quarterly basis, OSIG staff review data on critical incidents in state prisons and juvenile justice facilities and summarize any trends in an annual report.

Other entities have responsibilities similar to OSIG's

Numerous other executive branch and legislative entities have responsibilities similar to OSIG. In addition to OSIG, several other state entities are responsible for investigating allegations of fraud, waste, and abuse. Statute requires state and local officials to report to OSIG, the Auditor of Public Accounts (APA), and Virginia State Police any potentially fraudulent transactions involving state funds or property by an officer or employee of state or local government. VSP also has authority to conduct a broad range of criminal investigations. Other entities are responsible for investigating specific types of potential fraud. For example, the Office of the Attorney General and

the Department of Medical Assistance Services investigate Medicaid provider and recipient fraud, and the Department of Taxation investigates state tax fraud.

At least four other state entities have responsibilities similar to OSIG's oversight of wrongdoing at behavioral health, developmental disability, and correctional facilities. DJJ, DOC, and DBHDS investigate allegations and critical incidents including deaths within their own facilities (juvenile correctional and detention centers, state prisons, and state DBHDS facilities respectively). Moreover, since 2018, staff for the Board of Corrections have reviewed deaths occurring in local and regional jails.

OSIG is led by the State Inspector General and employs 40 staff

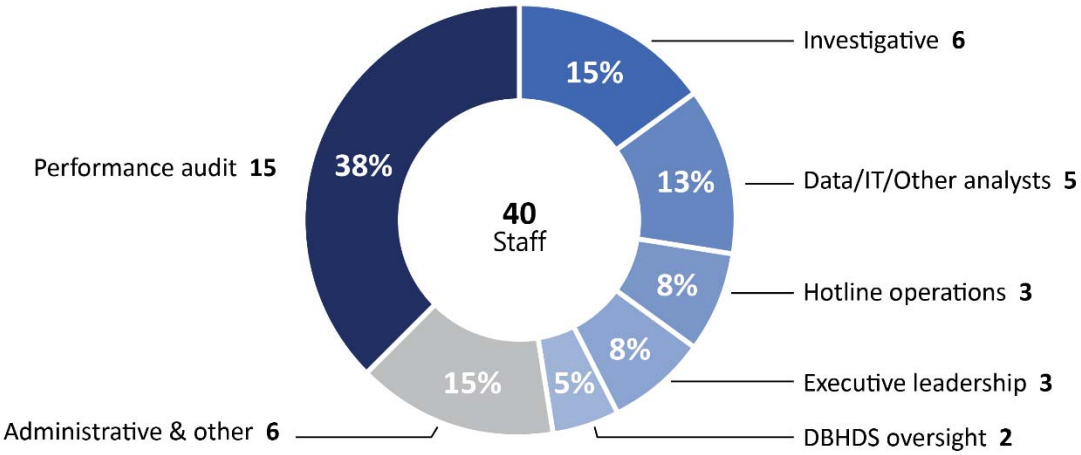
The agency is led by the state's inspector general, who is appointed by the governor and confirmed by the General Assembly to a four-year term. Other than the inspector general, all OSIG staff are classified staff subject to the Virginia Personnel Act. OSIG is an executive branch agency but exists outside the secretariat structure. The inspector general reports to the governor's chief of staff.

Compared with many state agencies, OSIG has a relatively small annual budget and staff. OSIG was appropriated $6.8 million for FY20. Two-thirds of this appropriation came from general funds, and most of the remainder was from the Highway Maintenance and Construction fund. Salaries and benefits account for about three-quarters of agency expenditures; no other category of expenditures exceeds 5 percent of the total.

OSIG has a total of 40 staff, the maximum it is authorized to employ. About 40 percent of its staff are performance auditors (Figure 1-2). Since its creation in 2012, the number of staff has ranged from its maximum to as few as 25. OSIG consists of two primary divisions. The Audit division is responsible for conducting performance audits. All other agency functions fall under the Investigations and Administration division (Figure 1-3).

FIGURE 1-2

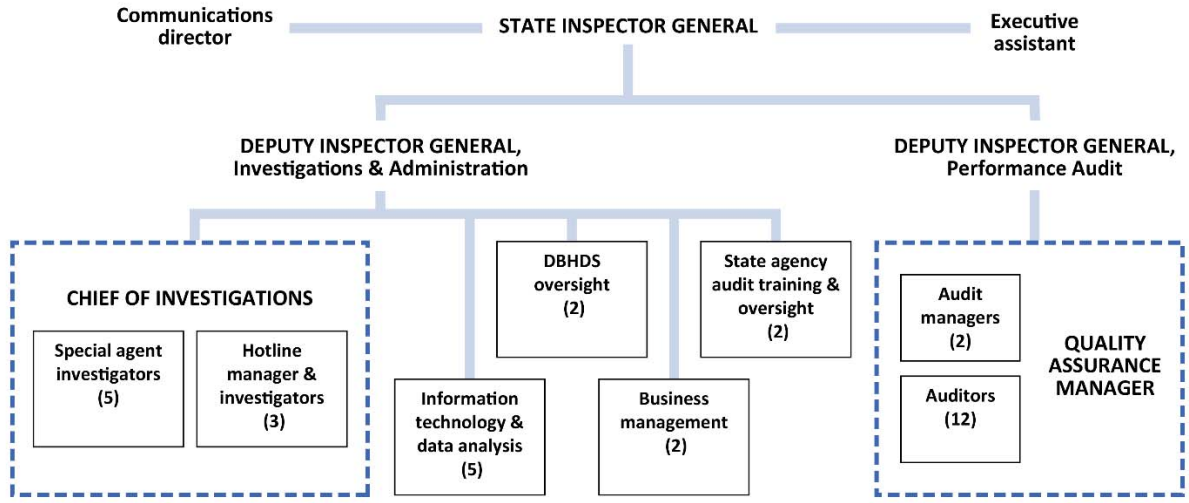
OSIG employs 15 performance audit staff, in addition to investigators and other oversight, executive, and administrative staff



SOURCE: JLARC analysis of OSIG staffing data as of July 2019.
NOTE: Other includes two staff responsible for state agency audit training and oversight. Investigative staff have law enforcement authority.

FIGURE 1-3

OSIG is primarily organized under two deputy inspectors general; one for investigations and administration and another for performance audits



SOURCE: JLARC analysis of OSIG organizational chart as of July 2019.

2 Management of OSIG

SUMMARY The Office of the State Inspector General (OSIG) faced significant organizational challenges in its early years. It has had three different inspectors general since 2012. Many of the staff who were mandated to transfer to OSIG from other agencies were dissatisfied and have since left. Under the current inspector general, though, OSIG is showing signs of stabilizing and beginning to build a positive organizational culture. OSIG's current employees report being satisfied with OSIG as a place to work, and the high staff turnover rates of 2017 and 2018 have dropped in 2019. OSIG also now has a well-defined organizational structure, and well-defined administrative and financial policies.

Building a new state agency can be challenging. The newly appointed agency leadership must create an environment in which staff can be productive as the agency builds the processes and structures necessary to function effectively. Staff need to believe in the agency's mission and have the right skills to effectively perform their jobs. As with any state agency—but especially one that is relatively new—the agency must also be well managed to achieve its mission in an effective and efficient manner.

The Office of the State Inspector General (OSIG) was created in 2012 by consolidating several functions—and some of the employees that performed them—from other agencies. This created additional challenges beyond just those associated with building a new agency. Staff from multiple agencies needed to blend together into a cohesive new group, which can also be difficult to accomplish.

Building OSIG was challenging amid leadership turnover and staff dissatisfaction

OSIG has had three inspectors general since it was created seven years ago. OSIG's first inspector general resigned less than two years after the agency was created. The agency's second inspector general served a little more than two years before the General Assembly declined to reconfirm her appointment in February 2017. Several current and former OSIG staff described a decline in agency morale after she was not reconfirmed. The current inspector general served in an acting capacity for more than a year, was permanently appointed in April 2018, and confirmed by the General Assembly in February 2019.

OSIG initially was staffed through mandatory transfers of staff from other state agencies. Staff from the Departments of Corrections (DOC), Juvenile Justice, Transportation (VDOT), and Behavioral Health and Developmental Services (DBHDS) generally were required to transfer to the newly created OSIG. Some staff wanted to transfer,

but many did not. In some cases, OSIG reached agreements with these agencies that allowed staff to work at OSIG temporarily and transfer back.

According to current and former OSIG staff, many employees were dissatisfied because their responsibilities changed when they transferred to OSIG. For example, several investigators who transferred from DOC were frustrated they were primarily investigating administrative rather than criminal allegations at OSIG. These individuals eventually left OSIG. Some audit staff who previously worked in the internal audit divisions at VDOT or DOC left OSIG because they were tasked with conducting performance audits, which require different skills.

Staff also were dissatisfied because of pay inequities at the new agency. In some cases, salary levels varied substantially among staff with the same job positions and similar levels of state service. This was due to differing salary structures at employees' previous agencies. According to current and former staff, the pay inequities contributed to poor morale among lower paid employees performing the same work as their higher paid colleagues.

Staff turnover contributed to changes in OSIG's organizational structure. As staff in supervisory roles left, the organizational structure was often changed to ensure that front-line staff still had supervisors.

Though it is difficult to fully quantify the negative effect of these challenges, it is evident through the agency's staff turnover rate. Without stable staffing, it is extremely difficult to make improvements and build on them over time as a new agency matures. OSIG's employee turnover was higher than the state average in four of the last five years. There was a noticeable spike in turnover during the period that the previous inspector general was not reconfirmed. More than one-third of the agency's staff left in FY17–18. Of the original OSIG staff, only six still remain.

OSIG appears to be stabilizing and building a positive organizational culture

OSIG appears to be stabilizing as an organization and is showing signs of developing a positive organizational culture (Table 2-1). The current inspector general has been in the position for more than two years, including seven months since being confirmed by the General Assembly. Within the past year, OSIG's leadership has begun to focus on strategic initiatives to improve the agency's work culture and overall effectiveness. In January 2019, OSIG reorganized its divisions into a more logical structure that allows for greater coordination among related units. In spring 2019, the inspector general concluded a series of meetings with each OSIG employee to address any concerns about the agency's management.

TABLE 2-1
OSIG's staffing is stabilizing and it now has a positive organizational culture

Assessment criteria	JLARC assessment
Stable staffing supported by a positive organizational culture	●
Well-defined organizational structure	●
Well-defined administrative policies and procedures	●

SOURCE: JLARC.

Staff turnover may be stabilizing, and staff now report being satisfied with OSIG's organizational culture

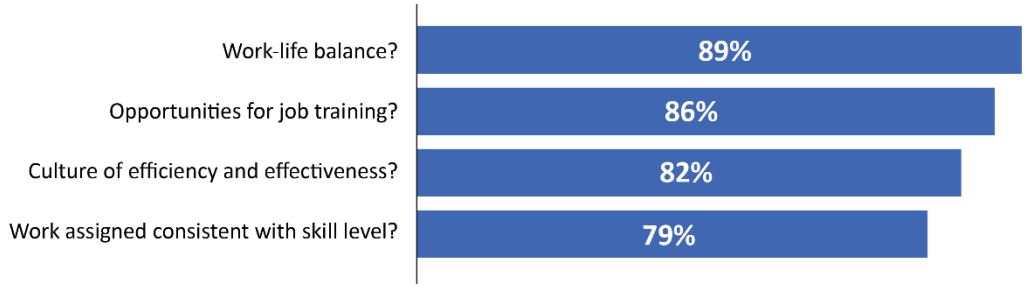
After unusually high staff turnover in previous years, staff turnover may decline going forward. Only three of the 28 staff (11 percent) responding to a JLARC survey (sidebar) indicated they are considering leaving OSIG within the next year. Staff morale has markedly improved. Nearly 90 percent of OSIG staff responding to the survey said they are satisfied overall with OSIG as a place to work. Most staff also expressed satisfaction with various aspects of the job, including their work-life balance and the opportunities for job training (Figure 2-1).

For this study, JLARC staff conducted a **survey of 30 classified staff at the Office of the State Inspector General.** Twenty-eight OSIG staff (93 percent) responded to the survey.

The survey asked questions about staff satisfaction with various aspects of their workplace and whether OSIG senior leadership is effectively managing the office.

(See Appendix B for more information about this survey.)

FIGURE 2-1
OSIG staff are now generally satisfied with key aspects of their jobs



SOURCE: JLARC survey of OSIG staff.

OSIG now has a well-defined organizational structure, and financial and administrative policies

OSIG now has a well-defined organizational structure. The current organizational structure places the performance audit division under one deputy inspector general, with the investigations, DBHDS oversight, internal audit oversight, and business and IT units under another deputy inspector. Similar organizational structures are used by other inspector general offices throughout the country. OSIG's current structure is an improvement from previous structures that artificially segmented parts of the agency. For example, OSIG recently better integrated hotline staff with special agent investigative staff under a deputy inspector general to ensure coordination between the two groups.

OSIG has well-developed policies and procedures needed to implement its administrative and financial functions. In 2017, the Auditor of Public Accounts conducted an Internal Control Questionnaire review of OSIG's policies and procedures for key administrative and financial functions, including payroll and human resources, revenues and expenses, procurement and contract management, and information technology and security. The review found that OSIG generally had adequate policies and procedures, but cited OSIG for outdated fiscal and accounting documentation and a lack of policies for processing disbursements. OSIG addressed both concerns later in 2017.

OSIG also has developed key policies and procedures needed to ensure that it can function effectively as an inspector general office. The agency has several policies intended to maintain staff independence and objectivity. For example, OSIG has a "Statement of Objectivity" form that requires staff to list any personal or professional relationships, previous responsibilities, biases, or financial interests that might impair their objectivity. OSIG law enforcement investigators are required to complete the form annually, and performance audit staff complete it before beginning a new audit. Additional key policies include:

- ***standards of ethics and conflicts of interest***, which covers the types of political activities staff can engage in, prohibits interests in any contracts with OSIG, and provides guidance on other ethics topics;
- ***information security policy***, developed to comply with state IT security standards; and
- ***background check policy***, describing the types of information reviewed during a background check of any prospective employee.

3 Investigations of Fraud, Waste, and Abuse

SUMMARY Despite its role as Virginia's centralized inspector general, the Office of the State Inspector General (OSIG) conducts a small portion of the state's total investigations into fraud, waste, or abuse in state government. OSIG has conducted less than 5 percent of all investigations for the State Fraud, Waste, and Abuse Hotline since the agency's inception; and most of its own investigations concern allegations of criminal conduct. The vast majority of investigations into allegations of administrative violations are conducted by other agencies' internal audit divisions. Some administrative investigations are also conducted by designated "hotline coordinators" at agencies without internal audit divisions. These coordinators have other responsibilities and are not trained as professional investigators. This heavy reliance on investigations by other agencies, particularly by agencies without internal audit divisions, is not consistent with the objective of a centralized, statewide inspector general. It also appears contrary to the Code of Virginia's mandate that the state inspector general "shall" have the "duty" to investigate allegations of fraud, waste, or abuse. Going forward, OSIG should prioritize its own investigations program by conducting investigations into the most serious allegations of administrative violations, rather than having other agencies—including institutions of higher education—conduct such investigations on its behalf. OSIG should reallocate some of its existing positions to investigations so it can better fulfill its role as the statewide, centralized investigative agency.

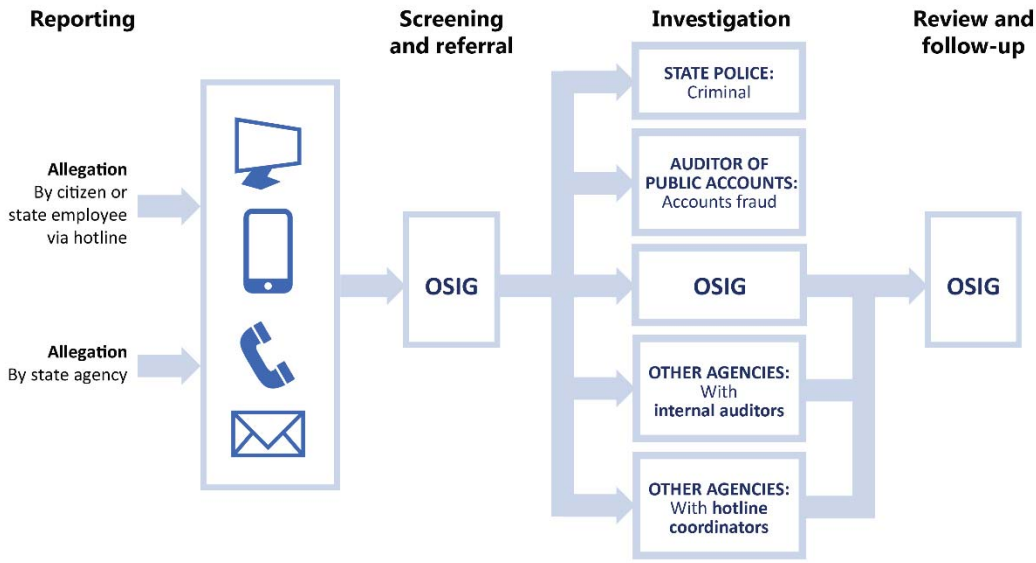
The Office of the State Inspector General (OSIG) is required by statute to receive and investigate allegations of fraud, waste, or abuse at state agencies. An effective investigation program helps to improve government efficiency and effectiveness by identifying wasteful or fraudulent practices. An effective investigative program also is a key way to deter fraudulent, wasteful, or abusive practices.

OSIG receives allegations from citizens and state employees through the State Fraud, Waste, and Abuse Hotline (Figure 3-1). Agencies are required to notify OSIG, State Police, and the Auditor of Public Accounts when a fraudulent financial transaction is suspected. Once OSIG receives an allegation, hotline staff screen the allegation to decide whether an investigation is warranted, and if so, whether that investigation should be conducted by OSIG law enforcement investigators or another agency on behalf of OSIG.

The appropriate agency then investigates the allegation, which can conclude fairly quickly or take several months or longer, depending on the severity and complexity of the allegation. Investigations generally conclude whether the allegations made can be substantiated, and can result in criminal or disciplinary action against the individuals

involved. Investigations also can make recommendations to strengthen policies and procedures to prevent future fraud, waste, or abuse.

FIGURE 3-1
Allegations are reported to OSIG, which then screens and refers certain allegations for investigation



SOURCE: JLARC staff review of Code of Virginia and interviews with state agency staff.

OSIG effectively promotes awareness of fraud hotline but needs to improve its screening process

An effective investigation program starts with easily accessible and well-known avenues to report potential waste, fraud, or abuse. Allegations should then be screened to determine whether an investigation is warranted. OSIG effectively promotes the State Fraud, Waste, and Abuse Hotline, and though its screening process is generally effective, it sometimes prematurely dismisses allegations (Table 3-1).

TABLE 3-1
OSIG effectively promotes its hotline but prematurely dismisses some allegations

Assessment criteria	JLARC assessment
Promotes awareness of reporting options	●
Screens allegations effectively to determine whether to investigate	◐

SOURCE: JLARC adaptation of Principles and Standards for Offices of Inspector General, Association of Inspectors General.

OSIG adequately promotes the State Fraud, Waste, and Abuse Hotline and ensures allegations can easily be reported

OSIG adequately promotes awareness of the potential for wrongdoing in statement government among state employees and to the public. The agency e-mails information about the hotline to all state employees twice a year. In 2012, Governor McDonnell issued executive order 52, allowing the hotline to accept allegations from any citizen of Virginia, not just state employees. In recent years, OSIG staff have promoted the hotline through appearances on local radio and TV programs and at community events (sidebar).

OSIG has been recognized for its efforts to promote the State Fraud, Waste, and Abuse Hotline. In 2018, the agency received a Capital Award of Merit from the Public Relations Society of America for its campaign to raise public awareness of the hotline. The campaign targeted the Richmond, Tidewater, and Charlottesville regions and resulted in a 60 percent increase in allegations made to the hotline.

The hotline appears accessible to state employees and members of the public. Similar to other state and federal fraud hotlines, allegations of wrongdoing can be reported to OSIG's hotline in a variety of ways. Individuals can report allegations by calling and speaking to hotline staff during business hours, leaving a voicemail after hours, or sending an email or physical letter.

To provide a more anonymous reporting method, in 2017 OSIG developed an online form allowing individuals to report:

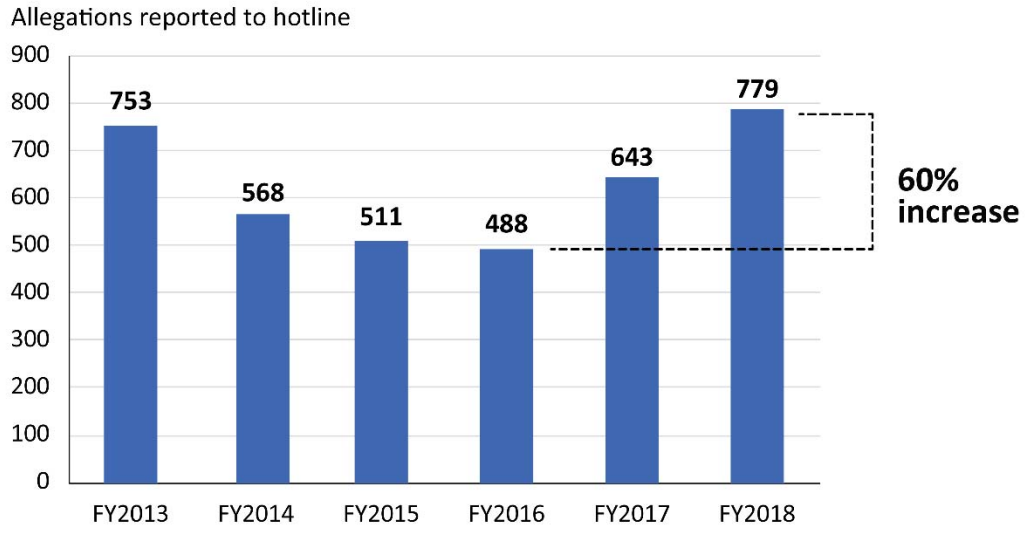
- the dates, times, and locations of the alleged wrongdoing;
- the agency and division involved; and
- the names of the subjects involved.

The online form is likely one of the main reasons the state has received an increasing number of hotline allegations in recent years (Figure 3-2). About half of the allegations OSIG received through the hotline in FY18 came through the online form.

OSIG's hotline screening process is generally effective but sometimes dismisses allegations prematurely

OSIG uses well-defined criteria and extensive guidance materials to assess whether an allegation submitted to the hotline falls within the hotline's jurisdiction and warrants an investigation. The criteria address the severity of the allegation and evidence supporting the allegation, among other relevant factors. The Hotline Policies and Procedures Manual developed by OSIG includes a lengthy list of the types of allegations that are not within the scope of the hotline. For each allegation received, OSIG's hotline staff complete a screening form designed to determine whether the allegation is within the jurisdiction of the hotline and meets five additional criteria.

FIGURE 3-2
Hotline allegations increased substantially after launch of online form in 2017



SOURCE: JLARC analysis of OSIG data.
NOTE: An allegation is defined as a phone call, web form, or email describing alleged wrongdoing. Each allegation may contain multiple types of wrongdoing.

For this study, JLARC staff surveyed **state agency internal audit directors.** Representatives for 19 of the 32 agencies with internal audit divisions responded (59 percent). The survey included questions about OSIG's screening of allegations submitted to the hotline, as well as the office's overall administration of the hotline.

(See Appendix B for more information about this survey.)

Using these criteria, OSIG staff are generally making reasonable decisions regarding whether to investigate or dismiss complaints reported to the hotline. Since OSIG was created, the agency has dismissed approximately one-quarter of the more than 4,000 allegations submitted to the hotline. Hotline staff indicated they dismiss allegations most frequently because they do not meet established criteria or because they lack information. A JLARC review of allegations dismissed by OSIG found that most allegations had a reasonable basis for being dismissed, and OSIG's hotline staff typically forward allegations that should be investigated. Most internal auditors at other agencies agreed that OSIG forwards allegations that merit formal investigation (sidebar).

Sometimes, however, OSIG prematurely dismisses allegations that may warrant an investigation. The JLARC review of dismissed allegations found that nearly 20 percent were dismissed because of a lack of information from the complainant—even though OSIG staff easily could have gathered additional information to better determine whether an investigation was needed. For example, two dismissed cases involved allegations that employees were abusing state leave policies or not working full 8-hour days. In both cases the complainants provided the employees' names and the state agency where they worked. However, OSIG staff dismissed the allegations because the complainants did not provide the specific dates and times of the allegations. OSIG staff could have contacted the agency to collect more information about the allegations before dismissing them entirely.

Other agencies handling complaints have more structured processes for the dismissal of allegations. This is true at the Virginia Department of Health Professions (DHP),

which receives allegations of wrongdoing by health-care providers, such as doctors and nurses. DHP staff confer with DHP board members, or designated board staff, before dismissing an allegation deemed within jurisdiction of the department. Board members or designated staff have sole authority to prioritize allegations for investigation; determine when additional information is needed before opening a formal investigation; and dismiss allegations for any reasons other than a lack of jurisdiction. According to DHP staff, this process helps ensure that decisions are made objectively based on the severity and credibility of the complaint rather than caseloads or available staffing resources.

Some hotlines are more proactive in gathering additional information about a complaint before determining whether it should be investigated or dismissed. In some cases, this confirms the need for an investigation. In other cases, it yields compelling reasons to dismiss the allegation. For example, intake staff with one federal government hotline often identify deliberately false allegations by gathering additional information to assess a complainant's motive. If a complainant alleges wrongdoing by his or her supervisor, staff at the federal hotline determine whether the complainant was recently subject to any disciplinary actions that might provide a motive for retaliation.

OSIG should improve its existing screening process to ensure that allegations are not prematurely dismissed. In addition, OSIG should give the chief of investigations responsibility to review every allegation proposed for dismissal to verify that there is a reasonable basis for doing so without a full investigation. OSIG's chief of investigations has supervisory authority over the hotline and its intake staff (as well as OSIG's law enforcement investigators).

RECOMMENDATION 1

The Office of the State Inspector General should establish and implement a process by which its chief of investigations reviews and approves each decision to dismiss an allegation reported to the State Fraud, Waste, and Abuse Hotline without conducting an investigation.

OSIG is not adequately fulfilling its intended role as state's centralized investigative agency

A primary benefit of a centralized inspector general is an improved ability to investigate allegations of fraud, waste, and abuse in state government effectively and independently. To fulfill its potential, a centralized inspector general's office must employ enough trained and experienced investigators to investigate the most serious and credible allegations of wrongdoing. Delegation of investigations to other agencies should be limited to less serious allegations and only to agencies with the expertise and independence to conduct an effective investigation. OSIG does not allocate enough staff to effectively perform its investigative mission and sometimes inappropriately refers

allegations to agencies that are not necessarily capable of conducting an effective investigation (Table 3-2).

TABLE 3-2
OSIG does not allocate enough staff to its investigative unit and sometimes refers allegations to agencies not equipped to investigate

Assessment criteria	JLARC assessment
Allocates agency resources to effectively achieve mission	○
Refers allegation only to entities suited to conduct investigations	◐

SOURCE: JLARC adaptation of Principles and Standards for Offices of Inspector General, Association of Inspectors General.

OSIG conducts relatively few investigations and employs far fewer investigators than authorized

Before OSIG's creation, the state's waste, fraud and abuse hotline was operated by the Division of the State Internal Auditor, which did not have investigators with law enforcement authority. When OSIG was created, the General Assembly expressly granted OSIG the authority to employ its own investigators with law enforcement authority.

Although the General Assembly created OSIG to centralize investigations of wrongdoing in state government (sidebar), the office conducts only a small percentage of investigations received by the State Fraud, Waste, and Abuse Hotline. Since OSIG's inception, it has conducted less than 5 percent of all hotline investigations into allegations of waste, fraud, or abuse by state employees (Figure 3-3). The relatively small percentage of investigations conducted by OSIG raises questions about whether the agency is fulfilling legislative intent and effectively achieving its core mission as the state's central investigative agency.

The General Assembly intended for OSIG to be among the state's primary investigative agencies. OSIG's statute states that OSIG "shall" have the "duty" to investigate fraud, waste, abuse, or corruption. Much of the benefit of a centralized inspector general is having highly qualified, professional investigators who report to an appointed inspector general who can ensure competence, objectivity, and independence. However, OSIG has referred more than 95 percent of the hotline allegations it deemed worth investigating to other agencies to investigate on its behalf.

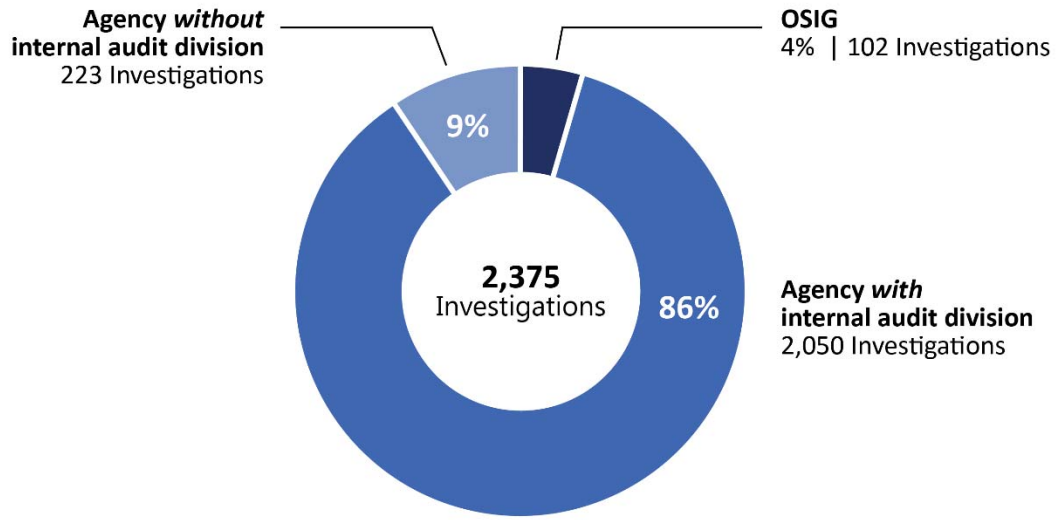
The **executive order governing hotline investigations** directs OSIG to "ensure that investigation and resolution activities are undertaken in response to allegations" and be "cost-effective" and "assigned to other agency investigative staffs when appropriate to avoid unnecessary duplication."

OSIG leadership cites executive order 52 to explain why the agency refers most of its cases to other agencies. The executive order states the importance of "cost-effectiveness" and avoiding "unnecessary duplication" (sidebar). That executive order, however, had the same language in 2010 (prior to OSIG's creation as a centralized statewide agency) as the revised version did in 2012 (after OSIG's creation). OSIG staff interviewed by JLARC noted there has been a historical reluctance by the agency to proactively assert its authority to investigate, especially at agencies with internal audit divisions.

In interviews with JLARC staff, OSIG leadership said the agency did not have enough investigators to conduct more investigations. OSIG currently employs 10 investigative staff, including six investigators with law enforcement authority, three hotline staff,

and one forensic analyst. At times, OSIG has employed just two law enforcement investigators. However, the General Assembly appears to have intended for the centralized inspector general to have a much more robust investigative staff. The Code of Virginia authorizes OSIG to employ up to 30 investigators with law enforcement authority.

FIGURE 3-3
Vast majority of hotline investigations are conducted by agencies with an internal audit division (FY13–19)



NOTE: JLARC analysis of OSIG data. Percentage totals do not sum because of rounding.

OSIG directly investigates hotline allegations involving potential criminal conduct

OSIG coordinates with Virginia State Police to determine which agency will investigate allegations of criminal conduct. The process of deciding whether OSIG or VSP will conduct a criminal investigation is governed by a memorandum of understanding between OSIG and VSP. Both agencies agree the memorandum clearly defines roles and responsibilities and that they have an effective working relationship.

OSIG investigates hotline allegations that may involve criminal conduct (in addition to allegations of criminal activity it receives directly from state agencies). By agency policy, criminal allegations received by hotline intake staff are referred to OSIG's law enforcement investigators for criminal investigations (sidebar). Most of the more than 100 hotline investigations conducted by OSIG investigators have been into allegations involving potential criminal conduct.

In the past, some hotline allegations involving criminal conduct were delegated to the agency where the wrongdoing allegedly occurred, largely because minimal information was shared between hotline staff and OSIG investigators. However, two initiatives

Fraud investigations can be conducted as **criminal or administrative** investigations. Criminal investigations are necessary when allegations involve potential criminal violations and must be conducted by investigators with law enforcement authority. Administrative investigations focus on violations of state policies and do not require law enforcement authority.

OSIG also refers some **non-criminal fraud** allegations to the Auditor of Public Accounts. OSIG does not have a memorandum with the Auditor of Public Accounts, but both agencies reported working effectively when necessary.

provide greater assurance that OSIG now will investigate hotline allegations involving criminal conduct rather than delegating them. First, in early 2019 OSIG changed its organizational structure to place hotline intake staff and OSIG investigators under the chief of investigations. The previous organizational structure placed these two groups in separate divisions. These staff reported to different supervisors and shared little information. Partly due to this change, nearly half of the 30 open OSIG investigations are looking at hotline allegations. Second, as of September 2019, OSIG is in the process of filling the vacant position responsible for overseeing hotline intake staff with a certified law enforcement investigator. An investigator with experience conducting criminal investigations will be better able to identify hotline allegations that may have a criminal component.

OSIG refers administrative investigations to qualified internal audit divisions but also to agencies less qualified to investigate

Allegations of fraud, waste, or abuse involving potential administrative violations (rather than criminal allegations) can vary substantially in their severity. Some allegations involve comparatively minor violations, such as an employee not working a full 8-hour day, not complying with state leave policies, or wasting time during the workday. Other allegations involve more serious administrative violations with more substantial implications for the integrity of state government. For example, failing to comply with the Virginia Public Procurement Act may not involve criminal conduct but could result in a substantial financial loss for the state.

OSIG delegates nearly all hotline allegations involving administrative violations that merit investigation back to the agency where the alleged wrongdoing took place—regardless of the severity of the allegation. OSIG staff do not use any defined criteria to identify more serious administrative allegations for which investigation by a centralized inspector general office would be appropriate. OSIG typically investigates only administrative allegations involving the head of an agency or investigative staff at the agency where the alleged wrongdoing took place. OSIG delegates the allegation to an agency's internal audit division, if the agency has one. For agencies that do not have an internal audit division, the allegation is delegated to a designated point of contact, called a "hotline coordinator."

Of the 2,375 **investigations into allegations received by OSIG's State Fraud, Waste, and Abuse Hotline** since FY13, 25 percent of the investigations verified the allegations, while 57 percent did not. An additional 18 percent of investigations did not verify the allegations but resulted in recommendations to improve policies or internal controls.

Most hotline investigations—86 percent—have been conducted by internal audit division staff, who typically have skills and expertise well suited to investigative work (Figure 3-3). Agencies with internal audit divisions tend to be larger (e.g., Departments of Corrections, Transportation, and higher education institutions). These audit divisions are usually staffed by individuals with investigatory expertise who do not have major responsibilities outside of investigations or audits.

Almost 10 percent of investigations, though, are conducted by agencies with hotline coordinators, who are less equipped to conduct independent and rigorous investigations. Coordinators have other job responsibilities, which can limit their ability to conduct an independent investigation. The agency head serves as the hotline coordinator

at 10 agencies. In several other agencies, another senior leader serves as the hotline coordinator. These coordinators may have conflicts of interest, such as administrative responsibility over the program or function where fraud allegedly occurred. In fact, OSIG has referred at least one investigation to a coordinator who supervises or was involved in the subject of the investigation (Case Study 3-1).

CASE STUDY 3-1
OSIG sent procurement fraud allegation to be investigated by an employee who oversaw the office under investigation

In 2018, OSIG received an allegation that a state agency's procurement division was involved in fraudulent activities.

The agency in question did not have an internal audit division, so investigations typically were conducted by the designated hotline coordinator. In this agency, the designated employee was broadly responsible for personnel and administration.

OSIG referred the procurement fraud allegation to this agency's hotline coordinator. However, as director of personnel and administration, the hotline coordinator also oversaw the agency's procurement operations. Consequently, the agency official overseeing procurement was tasked with investigating the allegation of procurement fraud.

The agency's investigation concluded that the allegation was largely unsubstantiated.

Agencies without internal audit divisions may also lack the expertise needed to conduct an effective investigation. The designated hotline coordinators receive fewer referrals and often direct other agency staff to conduct investigations. Therefore, it is unlikely coordinators develop much expertise conducting investigations. Agencies without internal auditors reported that, on average, four different people have conducted an investigation in the last two years. One agency reported that 10 different people had conducted an investigation.

OSIG's own investigations are effective, but it does not adequately supervise other investigations

OSIG has an effective in-house investigation program with qualified and independent investigators who consistently collect sound evidence to support investigative findings. OSIG investigations are conducted efficiently and in a timely manner (Table 3-3). However, OSIG does not adequately supervise investigations by other agencies to assure their quality.

TABLE 3-3
OSIG's own investigations are effective, but the agency does not adequately supervise investigations by other agencies

	Assessment criteria	
	Sufficiently thorough investigative techniques, and sound conclusions?	Efficient, timely, and well documented?
Investigations conducted directly by OSIG investigators	●	●
Assurance through OSIG supervision about investigations conducted by other agencies	◐	◐

SOURCE: JLARC adaptation of Principles and Standards for Offices of Inspector General, Association of Inspectors General.

OSIG has qualified investigators who are properly independent

A **certified inspector general investigator** is required to complete training provided by the Association of Inspectors General. The training covers seven core competencies, including investigative techniques, professional standards for investigations, procurement fraud, and computer crime.

OSIG investigators have extensive experience and investigative training. Each investigator is a certified inspector general investigator (sidebar) and has previously conducted investigations for state and local governments. For example, two investigators had conducted criminal investigations for local police departments for more than a decade.

The agency also works to ensure OSIG investigators have proper independence and no conflicts of interest. OSIG investigators annually complete a statement of objectivity that requires them to disclose any relationships or other interests that could hinder their independence during an investigation.

OSIG's investigations use thorough investigative techniques and generally reach sound conclusions

In addition to investigating allegations of criminal conduct received through the hotline, OSIG's six law enforcement investigators conduct investigations into allegations involving criminal activity that come from agencies themselves. These allegations typically involve fraudulent financial transactions. OSIG's six law enforcement investigators generally use appropriate investigative techniques that result in thorough findings and sound conclusions. A JLARC assessment of a sample of OSIG investigations found investigators used key investigative methods, collected sufficient evidence, and reached well-supported findings that were well documented (Case Study 3-2).

CASE STUDY 3-2
OSIG embezzlement investigation

In 2014–15, OSIG investigated alleged embezzlement involving the disposal of surplus property by an employee at the Virginia Department of Forestry (DOF).

OSIG used multiple investigative techniques, including interviewing the accused employee, other DOF staff, and the winning bidders of the surplus items; and reviewing documents, such as emails and copies of money orders and cancelled checks. During the course of the investigation, OSIG also reviewed DOF's process for disposing of surplus property.

OSIG investigators determined that the employee embezzled or misappropriated a total of $6,925 in surplus property, including a small firetruck and a passenger van. The employee embezzled $1,700 by telling winning bidders to make checks payable to her personally. The employee was terminated by DOF.

Prosecutors with the Office of the Attorney General (OAG) are satisfied with the quality of OSIG fraud investigations, which OAG uses to decide whether to prosecute fraud cases. According to OAG's prosecutors, OSIG investigators provide the information that would be expected of experienced investigators and are responsive to follow-up information requests.

OSIG does not adequately supervise delegated investigations and cannot provide full assurance of their effectiveness

OSIG provides little supervision of hotline investigations delegated to state agencies, providing little assurance that the investigative methods are thorough and the findings are supported and reasonable. OSIG also does not ensure that investigators conducting these investigations have adequate independence and investigative expertise. This passive approach is not fully consistent with the Association of Inspectors General's emphasis on the need for supervision of investigations.

Despite this lack of supervision, JLARC did not find any evidence of deficiencies in investigations conducted by other state agencies. A JLARC assessment of a sample of 14 investigations conducted by other state agencies—including agencies with and without internal audit divisions—found that most of these investigations were reasonably thorough and included sufficient evidence to support investigative findings. Additional investigative methods, though, could have been used in two cases reviewed to ensure thoroughness.

However, insufficient supervision creates the potential for inadequate investigations. OSIG staff do not verify that an investigation by another agency is conducted by an employee with adequate investigative expertise and without conflicts of interest. OSIG staff do not know who conducted the investigation until they receive the investigative report. OSIG also provides limited supervision of investigations by other agencies

while they are being conducted. For example, OSIG has set a target for agencies to complete investigations within 60 days. However, OSIG makes limited effort to ensure that they are completed within this timeframe or verify that reasonable progress is being made. OSIG staff notify agencies of overdue cases every 90 days, but agencies generally do not respond to these notifications, and OSIG makes no additional effort to follow up with agencies.

Finally, OSIG conducts relatively limited reviews of investigations once they are complete. OSIG staff do not review any supporting documentation to verify that there is sufficient underlying evidence to support the findings, nor do they routinely ask follow-up questions. OSIG periodically conducts "workpaper reviews" of a subset of agencies' hotline investigations to determine whether the evidence was sufficient to support investigative findings. These workpaper reviews, though, have primarily been of investigations conducted by other agency internal audit divisions and not those conducted by hotline coordinators at agencies without internal audit divisions.

RECOMMENDATION 2

The Office of the State Inspector General should develop and implement a more proactive and purposeful process to supervise investigations of allegations it has delegated to other agencies to ensure the quality, independence, and timeliness of investigations.

OSIG does not consistently monitor implementation of recommendations from investigations

Investigations into alleged fraud, waste, or abuse frequently result in **recommendations to improve policies or strengthen internal controls.** These recommendations are intended to prevent future fraud and can be made even when an investigation does not substantiate an allegation.

OSIG is not consistently monitoring the implementation of recommendations made as a part of fraud investigations (sidebar). Beginning in FY17, OSIG staff began annually requesting that agencies provide the status of recommendations from previous investigations. According to OSIG staff, agencies implemented all 170 recommendations made as part of hotline investigations during FY18. However, it is unclear whether OSIG has maintained verifiable documentation supporting this implementation rate.

OSIG also does not conduct any follow up with agencies on the status of recommendations made by OSIG's law enforcement investigators. Since OSIG was created, the investigations conducted by the agency have included 33 recommendations for agencies to reduce the risk of future wrongdoing. OSIG staff indicated that the status of these recommendations historically has not been tracked because of a lack of sufficient staff resources or a case management system. However, periodically following up with agencies about recommendations does not necessarily require substantial time or sophisticated software.

RECOMMENDATION 3
The Office of the State Inspector General (OSIG) should track the implementation status of recommendations made in previous OSIG investigations and encourage action on recommendations not yet implemented by agencies.

Investigations by other agencies are not always completed within OSIG's target timeframes but are generally well documented

There are no widely recognized benchmarks for how long investigations into fraud, waste, and abuse should take. Generally, investigations should be done in a timely manner to make it more likely relevant stakeholders will remember key details and related documentation will still be available.

Since 2013, only about half of the hotline investigations conducted by other agencies on OSIG's behalf have been completed within OSIG's 60-day target. Another 19 percent were completed within 90 days. A little more than 10 percent of investigations took longer than 180 days to complete. Some complex investigations can take longer to complete because they require additional investigative techniques or collaboration with other law enforcement entities.

Workpapers that are compiled during an investigation also are important to ensure transparency. The investigation workpapers reviewed by JLARC showed that investigations generally have been well documented. An exception is that in 2018 OSIG found four investigations conducted by the Virginia Department of Social Services that had no documentation.

OSIG should conduct more investigations rather than refer them to other agencies

OSIG's investigative program does not fully meet the General Assembly's intent to have a highly-qualified, centralized investigative staff to investigate the most serious allegations of fraud, waste, and abuse. OSIG staff have conducted less than 5 percent of all hotline investigations since the agency was created. Although OSIG is directly investigating hotline allegations that include potential criminal conduct, the agency refers nearly all other allegations of administrative violations to the agencies where the alleged wrongdoing occurred. OSIG employs 10 investigative staff, despite being authorized to employ up to 30.

OSIG staff have described a historical reluctance to assert its authority to directly conduct investigations rather than refer them to other agencies. However, the Code of Virginia includes clear and authoritative language that OSIG "shall" investigate and has a "duty" to investigate allegations of fraud, waste, and abuse. A key benefit of a centralized, statewide inspector general is the ability to ensure that investigations are conducted without bias in a fully independent manner. OSIG leadership asserted that

they do not have enough staff to conduct more investigations, even though the agency is authorized to employ substantially more investigators.

OSIG needs to prioritize its own investigative responsibility to more fully meet its statutory mandate. Historically, OSIG's default approach has been to refer hotline investigations to the agencies where the alleged wrongdoing occurred and to conduct investigations itself only under limited circumstances (such as when the allegation involves criminal conduct or the agency head). Under a centralized investigations program, OSIG's default approach should be to conduct investigations itself and only refer less serious allegations to other agencies.

OSIG needs to assume responsibility for investigating the state's most serious administrative allegations, whether they involve an agency with an internal audit division or not. Allegations could be referred for investigation by another agency if they meet established criteria developed by OSIG. For example, allegations could be referred to other agencies with internal audit divisions if they meet all three of the following criteria:

- below a specific threshold dollar amount (e.g. $25,000);
- unlikely to reflect poorly on agency leadership if proven true; and
- appear relatively straightforward to investigate (e.g. narrow scope, less complex, do not require sophisticated investigative techniques)

The state should give OSIG more statutory direction regarding its role as the centralized, statewide investigative agency. OSIG will then need to use its expertise and judgment to decide, on a case-by-case basis, which allegations meet all three criteria for referral and which it should directly investigate. Some types of allegations may be less likely to meet all three criteria and therefore will need to be investigated directly by OSIG. For example, alleged violations of state procurement policies or the Virginia Public Procurement Act may often exceed a threshold of $25,000, or could negatively affect the reputation of the agency and its senior leadership if allegations are founded. In contrast, allegations of employee leave abuse would be more likely to meet all three criteria for referral.

RECOMMENDATION 4

The General Assembly may wish to consider amending § 2.2-309.B of the Code of Virginia to require that the Office of the State Inspector General directly investigate the state's most serious allegations of administrative violations and only refer allegations for investigation to other agencies that (i) are below a dollar threshold (to be developed by the inspector general); (ii) would not reflect poorly on agency leadership if proven true; and (iii) appear relatively straightforward to investigate.

The General Assembly also may wish to clarify for OSIG that its role as the centralized, statewide investigative agency precludes the need to rely on the network of hotline coordinators to conduct investigations. OSIG also should no longer refer any allegations of administrative violations received through the hotline to agencies *without* internal audit divisions—regardless of the severity of the allegation. These hotline coordinators have other job responsibilities and generally are not fully trained as professional investigators.

RECOMMENDATION 5

The General Assembly may wish to consider including language in the Appropriation Act directing the Office of the State Inspector General to discontinue its practice of referring allegations for investigation to agencies without internal audit divisions and directly investigate these allegations.

OSIG will not need additional funding or additional staff positions to conduct these additional investigations. Instead, OSIG will need to reallocate some of its current positions to investigative positions to better fulfill its role as the centralized, statewide inspector general. It is unclear, though, exactly how many positions OSIG should reallocate as investigative positions. Agencies without internal audit divisions conducted an average of 35 hotline investigations annually between FY13 and FY19. So OSIG would need to reallocate several of its positions as investigative positions to conduct these investigations in the future. OSIG also will need additional investigators to investigate the states' most serious administrative allegations. OSIG will need to determine the number of additional investigators required to handle these cases after it assumes responsibility for investigating them. It is unlikely, though, that OSIG would need to allocate the full 30 investigative positions as authorized in the Code of Virginia.

RECOMMENDATION 6

The Office of the State Inspector General should determine the number of investigative staff needed to fulfill its intended role as the state's centralized investigative agency and reallocate existing staff to meet that need.

Finally, OSIG has limited statutory authority to investigate allegations of fraud, waste, or abuse involving the state's 15 higher education institutions. OSIG is required by statute to refer any allegations involving a higher education institution to the institution's internal audit division, unless it has "reasonable and articulable causes" for conducting the investigation itself or the allegation involves the institution's president or internal audit division. Between FY13 and FY18, a little more than 400 allegations involved higher education institutions and resulted in an investigation (about 18 percent of all hotline investigations during this period). OSIG referred nearly all these allegations back to the higher education institutions where the alleged wrongdoing occurred.

As with executive branch agencies, OSIG should be investigating the state's most serious administrative allegations involving institutions of higher education. OSIG should refer back to the college or university only allegations that are below a threshold dollar amount, not likely to reflect poorly on leadership if proven true, and relatively straightforward.

Therefore, the statutory provision (§ 2.2-309.B) that potentially limits OSIG's authority to investigate allegations of fraud, waste, and abuse involving institutions of higher education should be repealed.

RECOMMENDATION 7

The General Assembly may wish to consider repealing § 2.2-309.B of the Code of Virginia so that OSIG will have full discretion to investigate all serious allegations of waste, fraud, or abuse at public institutions of higher education.

4 Oversight of Department of Behavioral Health and Developmental Services

SUMMARY Since its creation, OSIG has been responsible for oversight of the Department of Behavioral Health and Developmental Services (DBHDS) and the community-based providers it regulates. OSIG has developed a complaint line to receive complaints about services at DBHDS facilities or provided by community-based providers. However, OSIG has not adequately promoted the complaint line, refers most complaints to DBHDS for investigation, and lacks a structured process for determining which complaints it will investigate. OSIG inspects DBHDS facilities annually but rarely reviews community-based providers. Its inspection and other oversight reports often lack useful information, and OSIG has done little analysis of DBHDS data to identify systemic problems. OSIG has struggled to interpret and fulfill its statutorily defined oversight role. Consequently, the General Assembly needs to clarify that OSIG's primary oversight focus should be identifying system-level issues that affect quality of care and safety across facilities and providers and recommending proposed solutions to address them.

The Office of the State Inspector General (OSIG) carries out several activities to fulfill its responsibility to oversee the Department of Behavioral Health and Developmental Services (DBHDS) (sidebar). OSIG is required by statute to inspect facilities and providers and make policy and operational recommendations to "prevent problems, abuses, and deficiencies" and improve the effectiveness of their programs and services. The agency also responds to complaints regarding DBHDS facilities and community-based providers. OSIG has assigned one to three staff to this responsibility over the last several years.

DBHDS operates 13 facilities. It also regulates licensed providers and funds Community Services Boards (CSBs), which are local publicly funded providers. Throughout Chapter 4, "community-based provider" refers to both licensed providers and CSBs.

OSIG's current oversight activities consist primarily of receiving complaints and inspecting DBHDS's nine psychiatric hospitals, two training centers, medical center, and sexually violent predator treatment center. Though not explicitly required by statute, OSIG operates a complaint line (distinct from its State Fraud, Waste and Abuse Hotline), which receives and responds to complaints about DBHDS's facilities or community-based providers. OSIG's annual inspections of DBHDS's facilities focus on a different aspect of operations each year. Previous topics include environmental safety, abuse/neglect investigations, and discharge planning. In addition to annual inspection reports, OSIG publishes reports on other operations and services at DBHDS.

OSIG's oversight of DBHDS is rare for an inspector general's office but an important responsibility for Virginia. Only one of the nine other states that have a centralized inspector general office have a similar responsibility. (Appendix D provides more information about statewide, centralized inspector general offices in other states.) DBHDS services are vital for supporting individuals with mental illness, substance use

disorders, or developmental disabilities. A federal lawsuit against DBHDS prompted the creation of DBHDS's inspector general more than a decade before OSIG was created. Given the complex needs of the population served by DBHDS and community-based providers, there likely will be continued challenges for the agency.

OSIG receives or investigates few complaints about DBHDS

The Code of Virginia states that OSIG "shall provide oversight and conduct announced and unannounced inspections of state facilities and of providers... on an ongoing basis in response to **specific complaints of abuse, neglect, or inadequate care"** (§ 2.2-309.1).

Statute requires OSIG to accept complaints about facilities and community-based providers under DBHDS's jurisdiction (sidebar). To accomplish this, OSIG established a complaint line dedicated specifically to allegations of abuse, neglect, or inadequate care at DBHDS facilities and community-based providers. The agency receives these complaints through a phone number and email address. Complaints may come from individuals receiving services, their family members, Adult Protective Services, legislators' constituent offices, or any other source. These complaints range widely in potential severity (from insufficient recreation time to physical abuse), magnitude (from an issue affecting one individual to an issue across multiple facilities), and credibility. OSIG's response can vary from informal advice over the phone to a published report documenting the incident's causes and remedial recommendations.

OSIG has done little to promote its DBHDS complaint line (in contrast to its efforts to promote the State Fraud, Waste, and Abuse Hotline). In addition, OSIG refers many of the complaints it receives back to DBHDS. The agency monitors allegations it has referred to DBHDS for investigation but has no structured process for prioritizing the types of complaints to refer or investigate directly. In addition, OSIG historically has not allocated enough staff to its behavioral health oversight program to operate an effective complaint function (Table 4-1).

TABLE 4-1
OSIG has not adequately carried out several aspects of its complaint line

Assessment criteria	JLARC assessment
Promotes awareness of reporting options	◐
Screens and refers complaints by prioritizing those that appear to be most serious	◐
Allocates sufficient agency resources to operate an effective complaint line	○

SOURCE: JLARC adaptation of Principles and Standards for Offices of Inspector General, Association of Inspectors General.

OSIG does not adequately promote its complaint line

OSIG primarily advertises its complaint line through flyers at each DBHDS facility. However, DBHDS facilities have not consistently posted the flyers. According to OSIG staff, their FY19 inspection found four of the 13 facilities lacked flyers. In contrast with OSIG's Fraud, Waste, and Abuse Hotline, OSIG has never e-mailed DBHDS employees alerting them to the existence of its complaint line. Facility employees sometimes can be in the best position to report potential policy, procedural, or resource problems at facilities.

OSIG's website lacks basic information about its complaint line. As of August 2019, the website listed only an email address for complaint submissions and not the dedicated phone number, despite OSIG's internal complaint plan indicating contact information will be posted online.

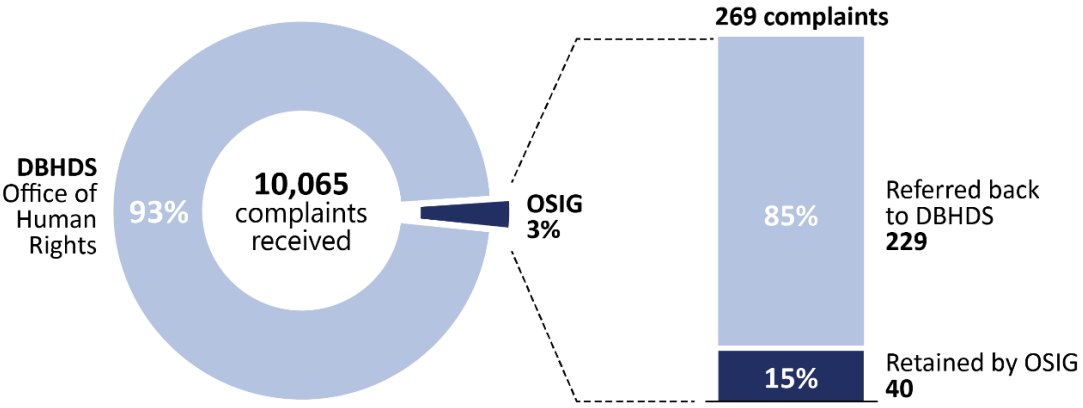
In addition, OSIG has not publicized its complaint line to individuals served by community services boards (CSBs), which provide publicly funded mental health, substance use disorder, and developmental disability services. OSIG also has not publicized its complaint line to individuals served by private providers. In fact, three of four stakeholder groups interviewed by JLARC were not aware that OSIG maintained a complaint line. OSIG staff say they did not promote the complaint line in CSBs and among service recipients because they were concerned they did not have enough staff to handle the potential volume of complaints. This also is in part why the vast majority of the complaints OSIG receives are about DBHDS facilities and not community-based providers.

OSIG receives far fewer complaints than DBHDS. DBHDS's Office of Human Rights administers the agency's processes for facility and community-based provider investigations of human rights complaints, such as abuse and neglect. It alone received 36 times the number of complaints as OSIG in FY19 (Figure 4-1).

OSIG does not devote enough staff to adequately maintain its DBHDS complaint function

OSIG refers most of the complaints that it receives to DBHDS rather than doing its own investigation. Current staff say they refer most complaints to DBHDS (Figure 4-1), while staff reported referring 32 percent of complaints in FY18 and 71 percent of complaints in FY17. OSIG staff sometimes monitor referred cases, such as requesting updates on their status or advocating for more in-depth investigations. OSIG staff describe spending considerable time on referred complaints, as do DBHDS staff. It is difficult to determine the value of OSIG's oversight of referred complaints because OSIG did not formally track the conclusion of complaints consistently until FY20. This lack of data prevents determining how frequently allegations were verified or whether the original problem was resolved.

FIGURE 4-1
OSIG receives a very small percentage of total complaints and refers the vast majority of them back to DBHDS for investigation (FY19)



SOURCE: JLARC analysis of data from OSIG and DBHDS, and interviews with OSIG and DBHDS staff.
NOTE: The figures in the bar graph are estimates provided by OSIG staff because the agency did not have reliable data. The figures are based on OSIG complaint processes in summer 2019.

OSIG indicates it refers most complaints back to DBHDS because of the agency's limited staff dedicated to DBHDS oversight. Former OSIG staff said they often referred complaints to DBHDS because of a high workload or lack of staff with relevant expertise, rather than considering the complaint's severity. Current staff describe working considerable overtime to keep up with complaints, which may not be sustainable over the long term.

OSIG lacks structured process for assigning responsibility for investigating complaints

OSIG does not have a structured process for deciding whether to investigate complaints directly or refer them to DBHDS. OSIG only uses vague criteria that lack strategic direction and detail to adequately determine when OSIG should investigate an allegation directly. As a result, some high-risk complaints are investigated directly by OSIG staff while others are referred to DBHDS. In addition, some less serious complaints are investigated by OSIG, while others are referred to DBHDS.

OSIG needs to more fully develop its complaints line to ensure it is a useful resource for individuals receiving services from DBHDS facilities or community-based providers. To do so, OSIG should take two steps. First, it should ensure there is adequate awareness of the function by more regularly publicizing it throughout DBHDS facilities and community-based providers. Second, OSIG should develop better defined and more strategic criteria for consistently identifying the most serious complaints that warrant review by an independent inspector general. At a minimum, these criteria should prioritize for investigation by OSIG complaints

- alleging a pattern of serious harm—or risk of imminent serious harm—to individuals served by DBHDS facilities or community-based providers;
- alleging that inadequate care by a DBHDS facility or community-based provider contributed to the death of an individual; or
- alleging inadequate care of individuals that come from employees of DBHDS or community-based providers who may be unwilling to report complaints to their employer.

In developing these criteria, OSIG should seek input from DBHDS staff and stakeholder groups, as well as other state agencies operating comparable complaint lines. Once it finalizes its criteria, OSIG staff should develop written guidance describing how it will use these criteria to consistently identify the most serious complaints for its own investigation.

RECOMMENDATION 8

The Office of the State Inspector General should develop and implement a program for regularly promoting awareness of its complaints line among residents of facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and individuals receiving services from community-based providers regulated by DBHDS.

RECOMMENDATION 9

The Office of the State Inspector General should develop written criteria and guidance for consistently determining which complaints regarding services provided or regulated by the Department of Behavioral Health and Developmental Services (DBHDS) it should investigate directly or refer to DBHDS.

OSIG inspects DBHDS facilities but has done little else to meaningfully fulfill its statutory role

OSIG is statutorily required to inspect DBHDS facilities. Inspections can be especially valuable for vulnerable populations that are under the control of the facility and its personnel. DBHDS facilities are subject to a variety of oversight entities that periodically conduct inspections. For example, training centers and the medical center are required to be inspected by the Virginia Department of Health at least every 15 months, while the psychiatric hospitals are required to be inspected every three years by the Joint Commission, a national accrediting entity. In addition to inspections of facilities, statute states that OSIG's oversight responsibilities extend to community-based providers (licensed providers and CSBs).

OSIG's inspections have focused on important aspects of DBHDS facility operations. However, OSIG has done very little oversight of community-based providers and has

conducted only limited analysis of DBHDS data to identify systemic problems across DBHDS facilities and community-based providers (Table 4-2).

TABLE 4-2
OSIG inspections address appropriate topics, but the agency has largely ignored community-based providers and does not regularly analyze DBHDS data

Assessment criteria	JLARC assessment
All DBHDS facilities are subject to unannounced annual inspections	●
Inspections focus on high-risk aspects of DBHDS facility operation	●
Oversight encompasses all entities required by OSIG's statute: DBHDS facilities, CSBs, and licensed providers [a]	◐
Inspection reports and other oversight reports include useful information and recommendations	◐
Analyzes DBHDS information over time to direct future oversight activities	○

SOURCE: JLARC adaptation of Principles and Standards for Offices of Inspector General, Association of Inspectors General.
NOTE: [a] Code explicitly directs OSIG to "make policy and operational recommendations… monitor, and review the quality of services" for facilities, CSBs, and licensed providers (§ 2.2-309.1).

OSIG inspects DBHDS facilities annually but rarely conducts oversight of community-based providers

OSIG seems to have fulfilled its statutory requirement to "conduct unannounced inspections at each state facility at least once annually." The agency appears to have inspected each DBHDS facility as required annually from FY13 through FY19. However, its FY18 inspections did not result in a written report because, according to OSIG staff, the FY18 inspections did not produce enough quality research. As part of FY19 inspections, OSIG staff repeated FY18 research activities more thoroughly. Facility inspections over the FY13–19 period appear to have been unannounced. However, inspections seem to be clustered within a short timeframe each year, which may allow facilities to assume they will be inspected soon after inspections begin at other facilities.

OSIG's DBHDS facility inspections focus each year on a different aspect of operations, and the topics seem to be reasonable. For example, previous inspections have focused on the physical safety of residents in facilities, how effectively allegations of abuse and neglect are investigated, and the adequacy of the planning undertaken before a resident is released from a facility.

In FY19, OSIG's performance audit staff began conducting DBHDS facility inspections, advised by its DBHDS oversight staff. OSIG cited a variety of reasons for this change, including the benefits of additional staff to visit facilities and the audit expertise of the performance audit division. Because the report documenting FY19 inspections has not been published as of September 2019, it is not clear how this new approach will affect the timeliness and quality of OSIG's inspections report. However,

DBHDS staff expressed significant concerns regarding the performance audit division's lack of subject-matter familiarity, which has substantially increased the time needed by DBHDS to facilitate OSIG's inspections.

OSIG has focused primarily on DBHDS facilities and has conducted little oversight of CSBs or community-based providers. Only four of OSIG's 21 reports relate to CSBs or community-based providers. OSIG noted it has focused on DBHDS facilities because CSBs are audited by DBHDS. However, DBHDS only conducts administrative, financial, and compliance audits of CSBs, which do not assess the quality of care. The relative lack of oversight of these community-based providers is potentially problematic because they are responsible for critical services, such as opioid withdrawal treatment and emergency response to individuals experiencing a psychiatric crisis. In addition, they serve many more people than DBHDS facilities.

OSIG's inspection and other oversight reports are of mixed usefulness

OSIG's inspection and other reports have not consistently resulted in useful information about problems and potential solutions. Interviews with DBHDS and other stakeholders (sidebar) revealed that OSIG reports often summarized problems that were already known rather than providing new information about the causes of the problem or proposing solutions that had not yet been considered. Additionally, DBHDS and stakeholders noted that OSIG reports sometimes focused on relatively less consequential problems and did not consider the most useful information. JLARC identified several reports that could be more useful:

JLARC interviewed DBHDS management and stakeholders to evaluate OSIG's reports. Stakeholders represented providers or recipients of services in DBHDS's jurisdiction.

- Not collecting or reporting the most useful information – OSIG reviewed injuries reported by community-based providers and recommended improving the information given to the Regional Quality Councils, which are five groups of regional representatives dedicated to improving developmental disability services. As part of its review, OSIG observed meetings and reviewed documents. OSIG did not, though, interview any members of the Regional Quality Council to ask them whether they would find more information useful and, if so, what types of information could be provided.
- Recommendations not addressing the root cause of problems – OSIG identified several serious problems with DBHDS's Quality Improvement Committee, including that it reviews only developmental disability issues and not behavioral health issues. However, OSIG's recommendations did not address any of these serious problems. Instead, recommendations focused on using more consistent data definitions and providing better training.

However, some reports do contain useful information based on in-depth research, such as a 2018 report finding that DBHDS facilities do not sufficiently address critical events, such as resident injuries. Multiple research methods supported OSIG's conclu-

sion, including interviews with DBHDS staff about their approach to monitoring corrective action plans and training needs, comparisons of job requirements for facility risk managers, and an assessment of the accuracy of internal documentation of critical events.

Collectively, OSIG's DBHDS inspection reports and its other oversight reports have made 158 recommendations. OSIG does not, however, track implementation of all its recommendations. OSIG and DBHDS both indicate, though, that most of OSIG's 92 recommendations to DBHDS have been implemented.

OSIG has done little analysis of DBHDS data to identify systemic problems

OSIG has not adequately used available DBHDS data resources to identify potential systemic problems, which has further limited its ability to conduct effective oversight. OSIG is required by statute to "monitor serious incident reports and reports of abuse, neglect, or inadequate care." DBHDS maintains databases that hold such information about DBHDS facilities and community-based providers, because they are mandated to report all injuries, deaths, use of seclusion or restraint, and allegations of abuse/neglect to DBHDS. DBHDS also maintains considerable information about its own licensing inspections and investigations.

Despite the availability of these databases, OSIG generally has not used this information to identify systemic problems or trends that need to be further reviewed or addressed as contemplated by statute. This data could be a valuable tool to analyze DBHDS operations and services to identify and address common problems among DBHDS facilities and community-based providers. DBHDS staff and stakeholders emphasized that this type of comprehensive analysis would be the most valuable oversight role OSIG could perform. OSIG has at times analyzed DBHDS data in its inspection and other reports, such as identifying the most common types of injuries reported by community-based providers.

OSIG needs clarification on oversight that meaningfully addresses quality and safety issues

Though it is rare for a centralized inspector general to have responsibility for behavioral health and developmental services oversight, it likely is in the state's best interest for OSIG to continue to have this responsibility. The population receiving behavioral health and development services is vulnerable, has complex needs, and is substantial. The state's financial investment is considerable, and fulfilling the criteria of its settlement agreement with the federal Department of Justice (DOJ) requires complex and challenging changes to policies and services.

Statutory direction to OSIG includes a variety of oversight responsibilities. OSIG has struggled to interpret this direction and translate it into a meaningful oversight function. The agency has never engaged in a purposeful process to determine its oversight

approach, such as identifying critical oversight not conducted by DBHDS or other entities, activities where an independent perspective would be most valuable, or the DBHDS services most in need of scrutiny.

To help OSIG better direct its oversight, the agency's oversight of DBHDS and community-based providers needs to be more clearly defined statutorily. Once its role has further been clarified, OSIG should develop and submit a plan detailing how it will fulfill a more clearly defined oversight role with the goal of system-level quality and safety. In the development of the plan, OSIG should seek input from DBHDS management, the Secretary of Health and Human Resources, and stakeholder groups.

In addition to responding to serious complaints from individuals regarding DBHDS services and conducting inspections of DBHDS facilities and community-based providers, OSIG seems best positioned to focus on comprehensive, system-level oversight. Broader oversight would focus on identifying issues that affect the quality of care and safety across multiple facilities or community-based providers and recommending solutions to address them. OSIG could use complaints, various DBHDS databases, stakeholder perspectives, inspection results, and other sources of information to determine what aspects of the behavioral health and developmental disability system could most benefit from oversight.

RECOMMENDATION 10

The General Assembly may wish to consider amending § 2.2-309.1 of the Code of Virginia to more clearly establish that the primary goal of the Office of the State Inspector General's oversight of the Department of Behavioral Health and Developmental Services and community-based providers is to identify system-level issues that affect quality of care and safety across facilities or providers and recommend solutions to address them.

RECOMMENDATION 11

The General Assembly may wish to consider including language in the Appropriation Act to direct the Office of the State Inspector General (OSIG) to develop and implement a plan to conduct system-level oversight of the quality of care and safety across Department of Behavioral Health and Developmental Services facilities and community-based providers. The plan should set forth the primary oversight activities that OSIG plans to undertake, as well as the number of additional staff positions and types of expertise necessary to carry out these activities. OSIG should submit the plan to the House Appropriations and Health, Welfare and Institutions Committees, and the Senate Finance and Education and Health Committees no later than June 30, 2020.

5 Performance Audits of State Agencies and Programs

SUMMARY OSIG's performance audit function is still a work in progress. When it was created, OSIG had few staff with the expertise to conduct performance audits. Consequently, OSIG built its performance audit staff over time to 15 employees. OSIG recently adopted the Government Auditing Standards, which are the recognized standard to guide performance audits. Recent audits released by OSIG have been of uneven quality; some findings and recommendations are sound, while others are not. The performance audit reports are generally well written, though, and OSIG now uses an improved report format featuring a summary and agency responses to findings throughout the report. OSIG has struggled to build a staff that can effectively conduct performance audits. Many staff lack the qualifications to be fully effective. The performance audit function needs to be scaled back, and some of the positions need to be reallocated to investigations and DBHDS oversight. The audit function needs to be strengthened through more qualified staff and greater engagement by executive leadership.

The Office of the State Inspector General (OSIG) is required to "conduct performance reviews of state agencies to assess the efficiency, effectiveness, or economy of programs." OSIG has fulfilled this requirement by conducting performance audits, and is now using the Government Auditing Standards maintained by the U.S. Government Accountability Office to guide its audits. OSIG currently has 15 performance auditors on staff.

Stakeholders are aware OSIG is a resource for audits but few request OSIG audits

The scope and scale of state government operations necessitates strategically deciding which programs or agencies should be the subject of a performance audit. The state has relatively few performance audit resources. (OSIG and JLARC are the only two entities in state government that conduct substantial numbers of performance audits each year). There are many state agencies and programs and nearly all of them can benefit from a periodic performance audit by an independent, outside entity.

Most cabinet secretaries know they can request an OSIG performance audit and cited the benefit that an effective performance audit can have for an agency or program under their purview, according to a JLARC survey. The topics recently audited by OSIG have included some directly requested by cabinet secretaries, though most have been identified internally by OSIG (Table 5-1).

TABLE 5-1
Most key executive branch stakeholders are aware they can request a performance audit, though most recent topics have been identified by OSIG

Assessment criteria	JLARC assessment
Executive branch stakeholders are aware of OSIG performance audit function as a resource to improve agencies and programs	●
Topics selected reflect stakeholder interest to ensure sufficient follow-through on performance audit results	◐

SOURCE: JLARC staff.

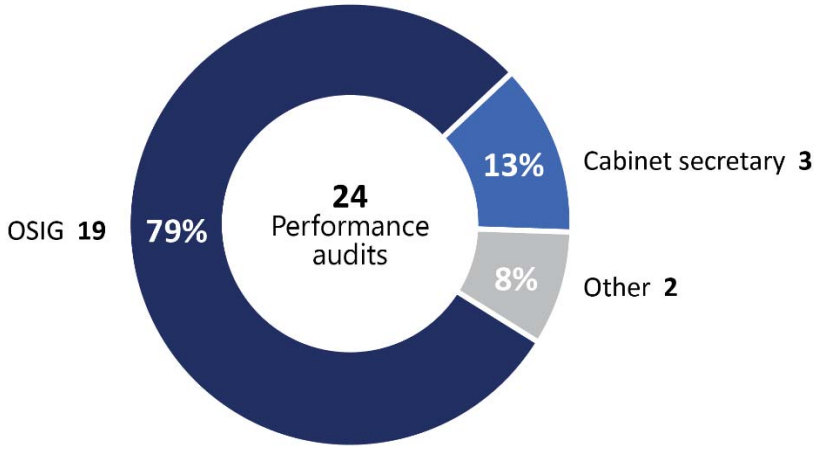
Most performance audit topics are selected by OSIG staff

OSIG changed how it identified performance audit topics. Before 2015, OSIG staff selected audit topics from a risk assessment of all executive branch agencies conducted for the agency by Deloitte. Topics are now chosen based on input from cabinet secretaries, issues identified in the media, and audit topics examined by inspectors general in other states.

OSIG chooses performance audit topics based on a variety of factors, including input from secretariats, issues covered by the media, and topics that other states' inspectors general offices review (sidebar). This has resulted in OSIG conducting performance audits on a wide variety of topics. OSIG's recent performance audit topics are primarily generated by its own staff, rather than by the governor's office, cabinet, or other executive branch leadership. Since 2016, OSIG staff generated topics for 19 of the 24 performance audits it has released through June 2019 (Figure 5-1). OSIG also has conducted performance audits of topics at the request of cabinet secretaries, including:

- Health and Human Resources Subrecipient Monitoring
- Virginia Correctional Enterprises
- The Peninsula Airport Commission

FIGURE 5-1
About 80 percent of recent performance audit topics have been selected by OSIG



SOURCE: JLARC staff analysis of prior OSIG performance audit topics.
NOTE: Includes reports released between 2016 and June 2019.

Cabinet secretaries reported being generally aware that OSIG exists as a resource that can be used to audit state programs or agencies. OSIG audits can be especially useful to newly appointed secretaries. For example, one cabinet secretary noted that he:

> Used it primarily, as I was new to the secretariat, to engage the commissioner about her [agency's] performance, leadership, teamwork, opportunities for improvement. It gave objective information that formed the basis of a detailed discussion of agency strategy, key services, challenges, and opportunities.

In contrast, when an audit is of a topic not a priority or not of special interest to the governor or cabinet secretaries, it is likely to be less impactful. OSIG staff themselves are aware of this potential, with one OSIG staff member remarking: "I don't know whether anyone in the governor's office or the cabinet secretary ever contacts the agency to see what they are doing to deal with control deficiencies or wasteful practices."

Each OSIG performance audit is distributed to the relevant agency head, the chief of staff and deputy chief of staff in the governor's office, the relevant cabinet secretary, and the chairmen of the money committees and relevant standing committees. However, it may be that merely distributing reports is not adequate to ensure sufficient attention and follow-through. One cabinet secretary noted that:

> Given the amount of work that goes into these, I am thinking that OSIG should present their findings to the relevant agency leadership and relevant secretaries in a group setting with time to discuss the findings and implications for management and legislation surrounding the agencies activities.

Audit planning has improved, but audit teams struggle to efficiently conduct audits

OSIG's approach to audit planning has improved over time, and its audits are well documented once they are completed. Audit teams have difficulty, though, executing the audit plans and adapting them as necessary throughout the audit process (Table 5-2). Effective audits must be well planned, use the appropriate research methodologies to meet audit objectives, and be well documented. Absent these key aspects of the audit process, it is less likely an audit will be completed in a timely manner and in an efficient way that is least burdensome to the audited agency.

TABLE 5-2
OSIG audits are now well planned and well documented, but audits are not always executed in an efficient manner

Assessment criteria	JLARC assessment
Audits are well planned and consist of well-defined scope and objectives and appropriate research methods	◐
Audit plans are executed efficiently and completed in a timely manner	○
Audit documentation is comprehensive and well organized	●

SOURCE: JLARC staff assessment based on applying a JLARC adaptation of *Government Auditing Standards,* United States Government Accountability Office.

Audit planning has improved as OSIG has gained more experience conducting performance audits

JLARC assessed a sample of OSIG performance audits. JLARC staff evaluated OSIG's performance audit division against standards established by the U.S. Government Accountability Office and those used in other peer review assessments of performance audit programs. The review was conducted simultaneously by two different JLARC staff, whose evaluations were averaged to produce an aggregate score. This included a review of seven performance audits, including those conducted in summer 2019.

More information is provided in Appendix C.

An effective performance audit must be well planned, with a clearly defined scope and objectives. A well-planned performance audit should use the appropriate research methodologies that allow the team to collect sufficient evidence to answer audit objectives. A poorly planned audit can be unnecessarily burdensome on the subject agency, because the audit team is not purposeful about the information it requests and with whom it meets. Poorly planned audits also tend to take longer than necessary, which results in research findings that can be out-of-date.

OSIG's performance audit planning has improved since the agency's inception. Some of the agency's initial performance audits featured overly broad, poorly defined audit objectives. However, a JLARC staff assessment of a sample of seven OSIG performance audits and their supporting documentation found that recent audit planning documents include more precise audit objectives and better detail the research methodologies that will be used. Agencies subject to OSIG performance audits also indicate that OSIG notifies them when a performance audit has begun and that they understand OSIG's audit objectives.

Some audits have taken a long time to complete and agencies say some audit teams appear unprepared

Despite improved audit planning, OSIG's performance audit teams still struggle to efficiently execute audits and complete them in a timely manner. A sound audit plan is necessary but not sufficient. It is also important that audit staff are prepared to conduct planned research and make efficient use of their time with staff at the agencies being audited.

When a team struggles to conduct an audit efficiently, it often manifests in lengthy audits. OSIG's recent performance audits have taken nearly two years to complete. A recently completed audit—which reviewed grant sub-recipient monitoring by the De-

partment of Social Services, Department of Medical Assistance Services, and the Virginia Department of Health—lasted almost 2.5 years and involved 13 different performance audit staff. OSIG staff themselves realize this is a problem:

- "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."
- "It takes too long to complete performance audits the way we are doing them. Cutting down the one-year time to six months would greatly help with the audit fatigue faced by many of the auditors."

Audits require experience and judgment to be prepared to collect information from agencies in an efficient and effective manner. Less than half of the agencies that have been the subject of an audit agreed that the OSIG team was well organized and prepared (sidebar). Several of these agencies commented on how OSIG's lack of preparation made the audit more burdensome.

JLARC surveyed agencies about OSIG performance audits. Surveys were sent in May 2019 to 19 agencies that had been audited by OSIG since 2016. A total of 17 agencies (89 percent) responded to the survey. More information is in Appendix B.

- "It seemed to take an inordinate amount of time, going over the same items again and again, for OSIG to grasp our processes... It was very frustrating."
- "Meetings were held so often that we actually started tracking how much time (and therefore money) we were spending answering their questions. Meetings and questions were often repeated."
- "There was significant turnover within the OSIG team. This caused a lot of backtracking over topics already covered and catching new staff up and there was a negative impact to our agency staff, as a result. In some cases, new OSIG members commented on the lack of usable information left by their predecessor."

It appears that over time, OSIG's inability to efficiently and effectively conduct performance audits is hindering OSIG's efforts to gain cooperation from agencies. In fact, the majority of staff in OSIG's performance audit division do not believe that agencies respond to their requests for information in a timely manner. This is likely due in part to agencies not believing OSIG is well organized or prepared, and therefore not worth the time and effort to comply with OSIG requests.

Audit documentation is comprehensive and well organized

OSIG's performance audits are well documented once they are completed. The agency uses a document management system, SharePoint, to organize and maintain files for each performance audit. This allows the audit team to structure its documentation and research throughout the audit process. The JLARC staff assessment of a sample of performance audits found that audit documentation was generally well organized and comprehensive.

Reports are well written, but findings and recommendations are of uneven quality

OSIG's reports have evolved since the program's inception to be generally well written. However, the findings and recommendations they contain are of uneven quality (Table 5-3). Ultimately, an audit's usefulness is based on its findings and recommendations and how it conveys them in a final report. Effective performance audits require research findings supported by sound evidence and recommendations to address any deficiencies found in agencies and programs. The audit findings and recommendations should be documented and conveyed in a clear and straightforward written report to help ensure agencies can use them to improve.

TABLE 5-3
OSIG's audits are well written, but some include weak findings or problematic recommendations

Assessment criteria	JLARC assessment
Findings are well supported by evidence, are based on objective criteria, and include information on the cause and significance of any deficiencies	◐
Recommendations address findings, are clearly worded, and likely to have a net benefit	◐
Audit report is appropriately structured and well written, using clear language accessible to non-subject matter experts	●

SOURCE: JLARC staff assessment based on applying a JLARC adaptation of *Government Auditing Standards*, United States Government Accountability Office.

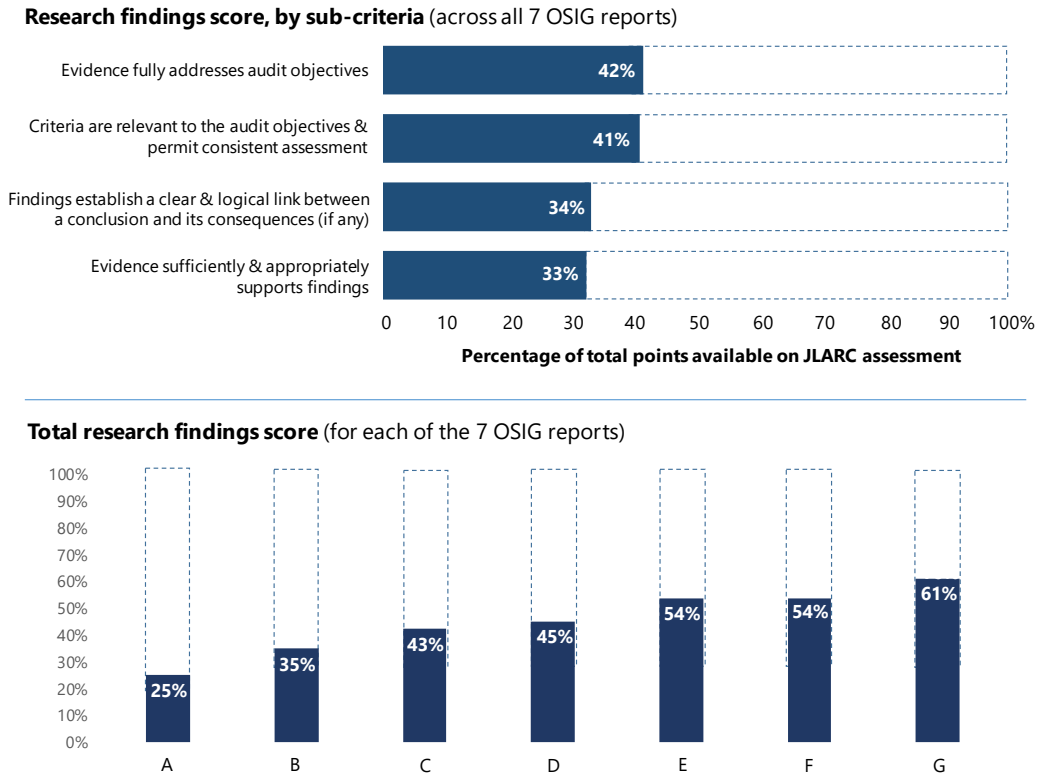
OSIG's research findings are of uneven quality

The "findings" of a performance audit serve as the basis for determining whether changes are necessary in an agency or program. Effective findings must be based on sufficient evidence and compare agency or program performance to relevant and objective criteria. When a performance audit finds problems, the audit should clearly identify the negative consequences and potential root causes of the performance problems (sidebar).

Elements of a finding. Government auditing standards (8.116) require a finding to include four key elements: the condition, criteria, effect, and cause. Collectively, these four key elements demonstrate an agency's performance and how it compares to relevant benchmarks or standards.

The JLARC staff assessment of a sample of seven OSIG performance audits found that multiple reports included findings of uneven quality (Figure 5-2). Some findings were adequately supported by evidence. Other findings, though, were not. Not all findings even addressed the audit objectives cited in the written report. An example of a finding not supported by adequate evidence and of a finding lacking key elements are shown in Figure 5-3.

FIGURE 5-2
OSIG's audits included findings lacking sufficient evidence or that did not adequately identify negative consequences of performance problems

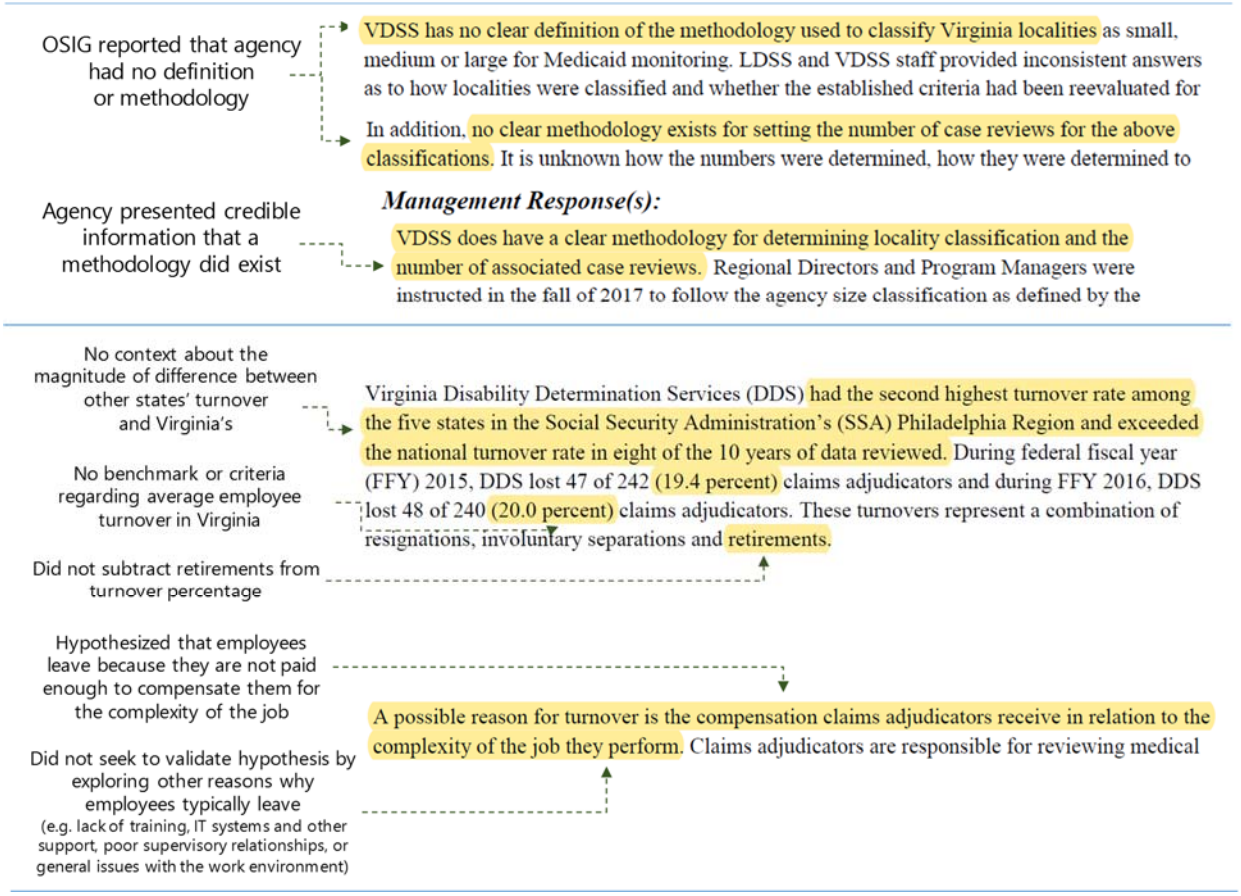


SOURCE: JLARC staff scoring of a sample of seven OSIG performance audits produced between 2016 and 2019.
NOTES: Scoring was performed independently by two JLARC staff using the scoring methodology and criteria based on adaptation of *Government Auditing Standards*, United States Government Accountability Office.

Despite OSIG's recent efforts to improve its performance audit program through adopting the Government Auditing Standards and training its staff, the JLARC assessment could not detect a pattern of improvement from audits conducted several years ago to audits released this summer. The audit that scored the most points on research findings was released by OSIG in May 2017. The audit released in April 2019 scored less than half of the total possible points, and the audit released in June 2019 scored just more than half of the total possible.

Audited agencies' perception of audit findings reflected the same uneven quality across OSIG's performance audits. Just more than half of the agencies that have been the subject of a performance audit believed findings in the audit were either "useful" or "somewhat useful." This demonstrates that in certain cases, the performance audits were likely worth their associated administrative burden. The remaining agencies responding to JLARC's survey, though, reported that research findings were "not useful." These agencies most frequently indicated OSIG's research findings were not useful because they were not supported by adequate evidence.

FIGURE 5-3
Examples of OSIG findings not adequately supported by evidence



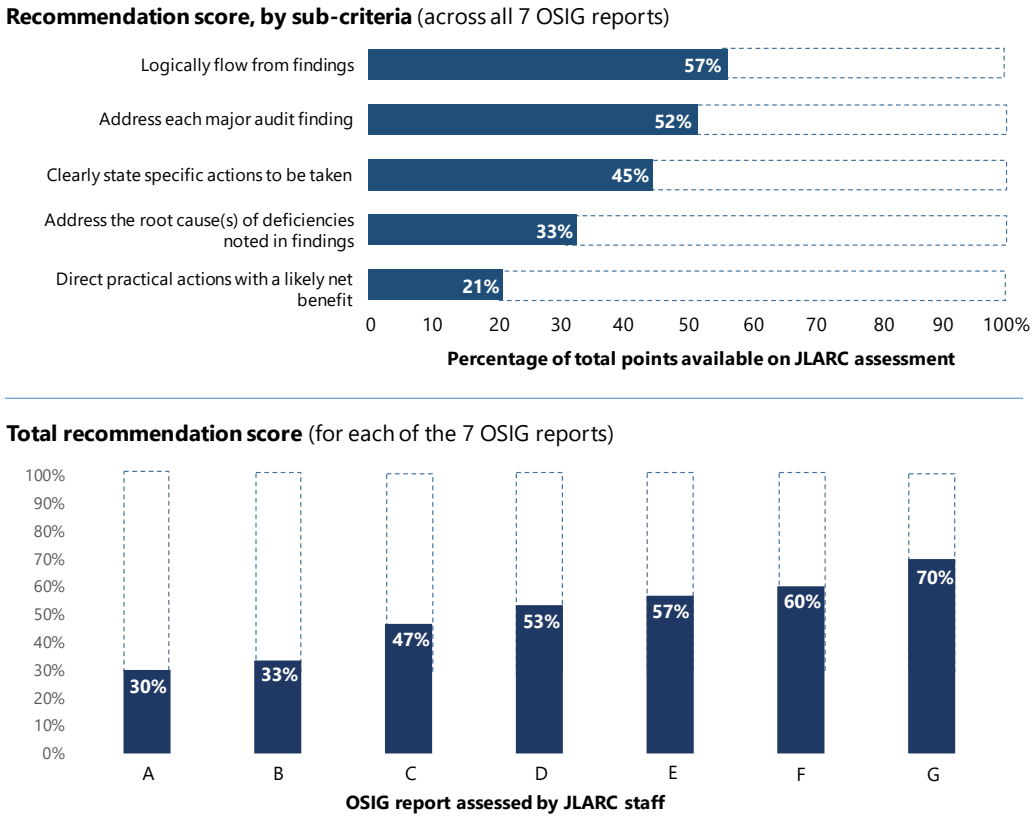
SOURCE: JLARC staff excerpts from OSIG performance audits.

Recommendations are of uneven quality though some agencies have found OSIG's recommendations useful

Effective recommendations can serve as the "blueprint" to improve an agency or program. Recommendations should clearly state who should take a specific action. Recommendations also should weigh the administrative burden that change imposes, and be likely to result in a net benefit to the agency or program itself, stakeholders, or citizens.

Multiple reports included recommendations of uneven quality (Figure 5-4). A majority of recommendations logically flowed from a finding, but a substantial portion did not. Some recommendations were not practical. One recommendation, for example, was for an agency to notify the governor when the Department of Planning and Budget—his own budget office—denied funding for an IT system.

FIGURE 5-4
OSIG's audits included recommendations that did not address deficiencies or were not practical



SOURCE: JLARC staff scoring of a sample of seven OSIG performance audits produced between 2016 and 2019.
NOTES: Scoring was performed independently by two JLARC staff using the scoring methodology and criteria based on adaptation of *Government Auditing Standards*, United States Government Accountability Office.

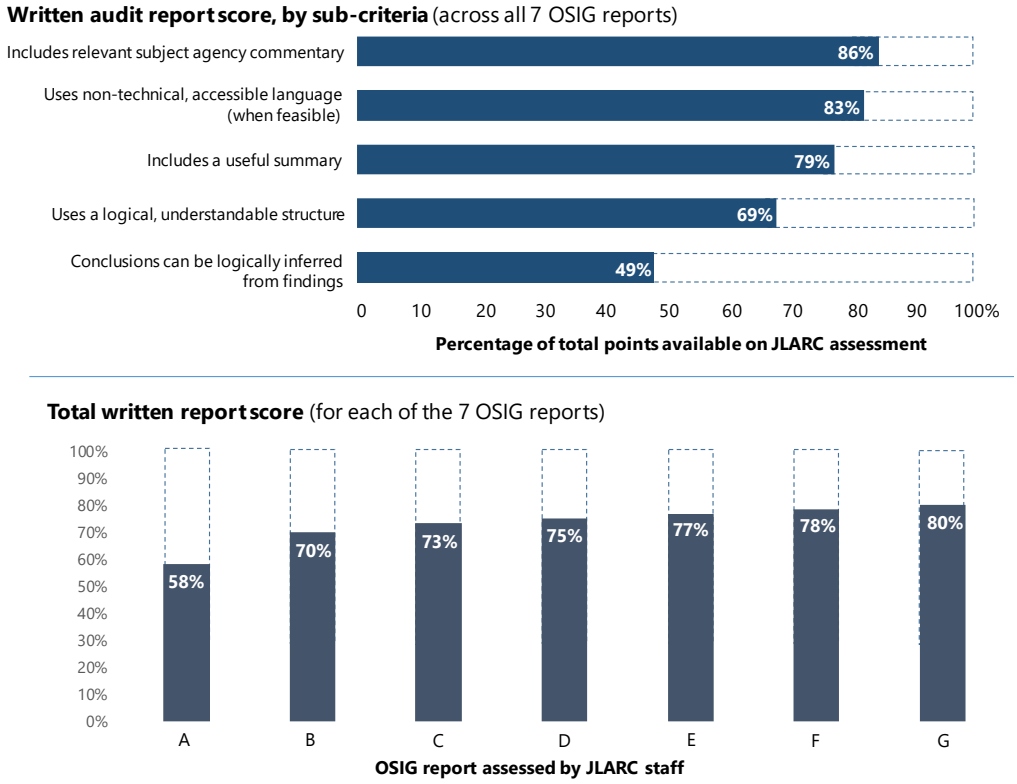
Agencies' perspectives reflected the same uneven nature of the quality of recommendations. Slightly more than half of the agencies that have been the subject of a performance audit believed the recommendations were either "useful" or "somewhat useful." The other half of agencies responding to the JLARC survey did not believe OSIG's performance audit recommendations were useful. Two reasons were typically cited by agencies. First, sometimes the agency was already doing what OSIG recommended. Second, agencies noted that audit recommendations were not always adequately supported by the findings or other research conducted by the audit team.

OSIG recently has begun to include an appendix to their reports listing what the agency indicates it will undertake in response to each recommendation. This is a valuable tool that improves the likelihood that recommendations will be implemented.

OSIG performance audits are generally structured effectively and well written

Despite the deficiencies in the core components of an audit—findings and recommendations—the audit reports themselves are generally well written (Figure 5-5). The JLARC staff assessment scores for the written audit report were considerably higher than the scores for the report's findings and recommendations. Also in contrast with the quality of the research findings, there was a detectable improvement over time in the written audit reports. The first report reviewed by JLARC, released in 2016, lacked a summary and did not include any comments from the subject agency. OSIG's audit reports now include a useful summary and commentary from the subject agency after each recommendation.

FIGURE 5-5
OSIG's audits reports are well written and include a useful summary and agency commentary



SOURCE: JLARC staff scoring of a sample of seven OSIG performance audits produced between 2016 and 2019.
NOTES: Scoring was performed independently by two JLARC staff using the scoring methodology and criteria based on adaptation of *Government Auditing Standards*, United States Government Accountability Office.

OSIG has struggled to build a staff that can effectively conduct performance audits

OSIG has had difficulty developing a full team of qualified, well-trained audit staff and supervisors to effectively conduct performance audits. While the Government Auditing Standards OSIG now follows include guidance about the *process* of conducting a performance audit, effectively conducting a performance audit still requires considerable *staff* expertise, experience, and judgment.

OSIG performance audit staff collectively lack some qualifications necessary to be fully effective

OSIG had very few staff qualified to conduct performance audits when the agency was created. Few (if any) of the staff that were transferred to OSIG had experience conducting performance audits. Nearly all staff came from investigative, internal control, or financial audit backgrounds.

It also appears that the job role under which OSIG's performance auditors are categorized does not fully reflect the skillset needed. OSIG performance auditors are classified under the DHRM Audit and Management Services career group, which includes some—but not all—of the qualifications necessary (Table 5-4). The Auditor I job role in that career group, for example, is described as "professional auditors performing or assisting with well-defined auditing responsibilities for the purpose of ensuring compliance with program requirements and evaluating the integrity of business operating systems." Some skills required for the Auditor I job are applicable for OSIG's performance audit function, such as determining audit objectives and analyzing or evaluating data. However, the role requires a much broader skill set. For example, effective performance audits require knowledge of research methodology, analytical and statistical techniques, and the ability to make recommendations for improvement. In addition, there are few performance audits that require knowledge of accounting or collection procedures.

Other skills necessary to be an effective performance auditor are described in another career group, Policy Analysis and Planning. The Policy Analysis and Planning career group describes "analytical work related to agency organization and operations; agency and state programs, plans, performance measures, policies, and procedures; regulatory and legislative processes; statistics; economics; central budgets; and research, development, and evaluation." Within that group are a series of policy job roles. The Policy and Planning Specialist I job role, for example, better describes at least some of the applicable skills required for a performance auditor (Table 5-4). The job role includes "providing management with a comprehensive view of operations by contributing to the preparation of reports, conducting analytical and statistical research and by providing alternative solutions and assessments of the long range impact of work processes and other implications of studies and projects."

Table 5-4
Auditor job role used by OSIG includes some, but not all, necessary skills

	Necessary	Helpful	Not necessary
Auditor I			
Applies knowledge of accounting functions or principles, general business transactions, collection procedures, and/or applicable automated accounting systems			✓
Conducts internal, external, tax, health insurance, data processing, interstate, or other auditing assignments		✓	
Provides assistance in determining audit objectives	✓		
Analyzes program requirements and participates in the development of audit procedures	✓		
Audits and analyzes data and the application of applicable professional principles and standards	✓		
Requires knowledge of state and federal laws, rules, and regulations	✓		
Ability to research, investigate, analyze, reconcile, and evaluate data	✓		
Interacts frequently with internal and external customers using both verbal and written communication skills to discuss financial and or business processes or issues	✓		
Policy & Planning Specialist I			
Data collection, specialized research, agency organizational studies, strategic planning, and statistical analyses	✓		
Frequent contact with agency employees and managers to gather data or discuss findings	✓		
Applies knowledge of research methodology; statistical and analytical techniques; and strategic planning, theory, and process	✓		
Ability to analyze and compile data and to write reports and recommend actions	✓		

SOURCE: JLARC analysis of information from the Virginia Department of Human Resource Management.

Most OSIG performance audit staff have academic backgrounds in accounting or business, which is not training directly relevant to performance auditing. Only one member of the performance audit staff has an educational degree (public administration) that may have provided training in the analytical skills needed.

OSIG staff themselves recognized the mismatch between the skills of OSIG auditors and the skills required for conducting performance audits:

- "Nobody had experience in conducting performance reviews or performance audits."
- "New employees get here and show they really do not have any knowledge of performance auditing."

Comments from agencies that were the subject of OSIG audits cited a similar gap in skills.

- "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. The amount of staff time necessary to bring the OSIG auditors up to speed sufficient for them to begin to make suggestions represents a far larger inefficiency than any identified by OSIG."

Management has not provided sufficient guidance to performance audit staff

Effective performance audits require adequate supervision, particularly for new, inexperienced staff members. Experienced supervisors are essential to helping less experienced staff define audit objectives, develop rigorous research methodologies, and produce sound research findings and recommendations. Some performance audits are relatively straightforward and can be conducted without much supervision. Other performance audits can be extremely complex; adequate supervision can make the difference between effective and ineffective audits.

Comments from OSIG staff themselves revealed a desire for more guidance and supervision of performance audit staff:

- "I would like more direction from management/senior management on projects. The staff's vision for what is being audited is not shared by management. This causes scope creep and wasted time."
- "Little guidance is received when beginning a project. The attitude is more or less 'here's an assignment; figure it out.' Staff questions are met with vague answers or no answers at all."

As noted above, several of the performance audits reviewed by JLARC staff included particularly weak findings or recommendations, which in addition to stemming from a lack of fully qualified audit staff, are also symptomatic of ineffective supervision. Ultimately, supervisors and OSIG senior leadership are responsible for their agency's products. Several of the performance audits reviewed by JLARC staff include unsubstantiated or incomplete findings.

OSIG supervisors and leadership should not have allowed reports to be finalized and released to the public that included unsupported findings or recommendations. The agency being audited receives, and then must react to, information that is not fully reliable or useful. Furthermore, producing reports with these deficiencies over time degrades the reputation of OSIG, which makes it more difficult for the agency to have authority and respect in future audits.

OSIG performance audit function needs to be scaled back and strengthened

OSIG's performance audit function is still a work in progress; the performance audit unit has produced uneven work in recent years. Executive branch leadership is not sufficiently engaged in identifying performance audit topics or ensuring follow-through on recommendations. OSIG has had difficulty recruiting and retaining a sufficiently qualified performance audit staff.

OSIG needs to scale back the size of its performance audit program and reallocate some performance auditor positions to its other core functions of investigating fraud, waste, and abuse and providing oversight of the Department of Behavioral Health and Developmental Services. OSIG then needs to improve the quality and supervision of this smaller performance audit program.

OSIG should conduct two performance audits per year in FY21–24. The smaller performance audit program would be implemented over the next four years, serving as a trial period across two different administrations. The governor's office should take more ownership of the performance audit function through selection of one audit topic per year and ensure follow-through on recommendations. The governor's chief of staff should work with the inspector general to select this topic based on input from cabinet secretaries and other members of the executive leadership. At the conclusion of each of these audits, the relevant cabinet secretary, agency head, key governor's office staff, and relevant DPB staff could be offered a briefing on the audit results.

OSIG also, though, needs to still maintain a degree of independence, and should retain the authority to select the other performance audit topic. The agency has been developing a broader and deeper understanding of state government through its work and can use that understanding to determine government agencies and programs that may benefit from a performance audit.

To effectively address these two topics per year, OSIG also needs to ensure it has properly trained and experienced performance auditors. The agency should identify the most capable individuals among its current performance auditors and hire other auditors as necessary under a DHRM job role that includes the full range of necessary skills—not just accounting. In re-allocating positions to other core functions, it is unlikely that the individuals currently in those positions possess the necessary qualifications for the new roles (especially to be investigators). OSIG would also, therefore, need to work closely with DHRM on how to transition current staff to other roles as it reduces its performance audit program and increases its investigative and behavioral health oversight programs.

At the end of this four-year trial period, the General Assembly could choose to direct JLARC to conduct a follow-up review of the OSIG performance audit program. The follow-up review would seek to determine whether (1) executive branch leadership

The U.S. Government Accountability Office (GAO) does work at **the request of Congressional committees and individual members.** In FY18, GAO received 786 requests from congressional committees. GAO follows the *"GAO's Congressional Protocols,"* which detail how GAO undertakes this work requested by elected officials while still ensuring the necessary objectivity and independence.

have found the OSIG performance audit function valuable and utilized the audit results; (2) OSIG has been able to perform its performance audit function with adequate independence—especially for audit topics selected by the chief of staff; and (3) the performance audits more consistently include sound findings and recommendations.

RECOMMENDATION 12

The General Assembly may wish to consider including language in the Appropriation Act directing the Office of the State Inspector General (OSIG) to conduct only two performance audits annually in FY21–24. Each year one audit topic should be chosen by the chief of staff in consultation with the governor's cabinet and one audit topic should be chosen by OSIG.

RECOMMENDATION 13

The Office of the State Inspector General should consult with the Department of Human Resource Management to define a performance auditor position that more accurately reflects the full range of skills needed.

RECOMMENDATION 14

The Office of the State Inspector General should consult with the Department of Human Resource Management to identify four to six highly capable performance auditors to implement a scaled-back performance audit program. Individuals can be from the current performance audit staff and individuals hired under a newly defined performance auditor position that have the full range of skills needed.

OPTION 1

The General Assembly could direct staff with the Joint Legislative Audit and Review Commission to conduct a follow-up review of the Office of the State Inspector General performance audit program after FY24 to determine whether the scaled-back program has been successful.

Appendix A: Study mandate

Resolution of the Joint Legislative Audit and Review Commission directing staff to review the Office of the State Inspector General

Authorized by the Commission on October 10, 2017

WHEREAS, it has been five years since the creation of the Office of the State Inspector General (OSIG) as an executive branch agency; and

WHEREAS, the OSIG was created by consolidating a variety of functions that existed at other agencies; and

WHEREAS, when created, the OSIG was granted a new function to evaluate state agency performance; and

WHEREAS, the OSIG is statutorily directed to inspect facilities and providers; review and make comments on Departments of Behavioral Health and Developmental Services (DBHDS), Corrections, and Juvenile Justice reports and critical incident data; investigate state agency operations and evaluate state agency performance; investigate complaints alleging fraud, waste, abuse, or corruption; and administer the State Fraud, Waste and Abuse Hotline; and

WHEREAS, the OSIG has full authority to inspect DBHDS facilities and mental health units in correctional facilities, but has less clear and more limited authority to inspect and investigate incidents in jails and non-DBHDS state facilities where individuals are held under state authority; and

WHEREAS, OSIG's investigative and performance evaluation roles create the potential for duplication with other state agencies that have similar missions; and

WHEREAS, the OSIG has authority to designate up to 30 of its staff with the same powers as a sheriff or a law-enforcement officer when investigating allegations of criminal behavior; and

WHEREAS, the OSIG was appropriated $6.7 million (FY17), the majority of which was general funds, and employs 33 full-time equivalent staff, and staffing has fluctuated annually; and

WHEREAS, other states use centralized and decentralized structures that feature varying degrees of independence to perform inspection, investigation, performance evaluation, and fraud complaint response functions; now, therefore be it

RESOLVED by the Joint Legislative Audit and Review Commission (JLARC) that staff be directed to review the Office of the State Inspector General. In conducting its study, staff shall evaluate the agency's (i) role and authority in inspecting jails and state facilities where individuals are held; (ii) role and authority in investigating incidents in jails and state facilities where individuals are held; (iii) role in performance evaluations of state agencies; (iv) sufficiency of staffing levels and staff expertise (v) performance, management, and stability; and (vi) effectiveness, efficiency and independence of the current centralized OSIG in general, and as compared to when its role was de-centralized in different agencies. Staff shall make recommendations as necessary and review other issues as warranted.

All agencies of the Commonwealth shall provide assistance, information, and data to JLARC for this study, upon request. JLARC staff shall have access to all information in the possession of state agencies pursuant to § 30-59 and § 30-69 of the Code of Virginia. No provision of the Code of Virginia shall be interpreted as limiting or restricting the access of JLARC staff to information pursuant to this statutory authority.

JLARC staff shall complete its work and submit a report of its findings and recommendations to the Commission by December 10, 2019.

Appendix B: Research activities and methods

Key research activities performed by JLARC staff for this study included:

- interviews with OSIG, other state agencies, Virginia stakeholders, national experts, and other states' offices of inspector general (OIGs);
- surveys of OSIG staff, agencies subject to performance audits, stakeholders representing the intended audience of performance audits, and hotline coordinators;
- analysis of data from OSIG and statewide databases;
- structured reviews of selected OSIG performance audits and investigations;
- review of other documents, including those by OSIG, other Virginia agencies, Virginia stakeholder groups, and other states' OIGs; and
- review of national literature pertaining to inspectors general or specific OSIG functions.

(See Appendix B of JLARC's 2019 "Virginia's Oversight of Jails" report for research relating to OSIG's responsibilities relating to jails and the state's approach to jail oversight.)

Interviews

JLARC staff conducted 98 interviews during research for this report. Key interviewees included:

- OSIG leadership and staff,
- other state agencies' leadership and staff,
- Virginia stakeholders,
- National subject-matter experts, and
- other states' offices of inspectors general.

OSIG leadership and staff

JLARC staff conducted 46 interviews with staff and leadership at OSIG, including:

- the inspector general;
- the managers of each OSIG functional division; and
- staff or contractors responsible for the State Fraud, Waste, and Abuse Hotline; investigations; performance audits; Department of Behavioral Health and Developmental Services (DBHDS) oversight; and administration.

In total, 25 current or prior OSIG employees (including contractors) were interviewed. Half of staff employed as of July 10, 2019 participated in an interview with JLARC. These interviews were used to understand the work processes used to carry out the agency's primary responsibilities; any changes to these processes since OSIG was created; and staff perspectives on OSIG's mission, challenges, and work culture. Interviews were also used to clarify the meaning of OSIG data.

Other state agencies

JLARC staff conducted 33 interviews with nine state agencies other than OSIG. These interviews were conducted for a range of purposes.

- To gain information on OSIG's performance audits, JLARC interviewed two representatives of agencies that had been the subject of an OSIG performance audit.
- To obtain perspectives on other agencies' approaches to conducting investigations, or perspectives on OSIG's investigations and hotline, JLARC interviewed the Department of Corrections, Office of Attorney General, Virginia State Police, Department of Health Professions, Department of Juvenile Justice (DJJ), and DBHDS.
- To enable a comparison of DBHDS and OSIG's activities and obtain perspectives on OSIG's DBHDS oversight function, JLARC conducted 21 interviews with DBHDS staff. These included interviews with four deputy or assistant commissioners and four division/office directors.
- To understand OSIG's quarterly reports regarding DJJ incidents, JLARC interviewed representatives of DJJ.

Additionally, JLARC staff attended a meeting of the State Board of Behavioral Health and Developmental Disabilities Services.

Stakeholders

JLARC staff interviewed five stakeholder groups who represented recipients or providers of DBHDS services: Mental Health America of Virginia, the disAbility Law Center of Virginia, the Virginia Association of Community Services Boards, National Alliance on Mental Illness—Virginia, and the Arc of Virginia. Interview topics included these groups' use of OSIG's DBHDS oversight reports, understanding of its complaint function, and opinions on OSIG's role.

National experts

JLARC staff interviewed experts from five national associations or federal agencies. The Association of Inspectors General, Government Accountability Office, and National Conference of State Legislatures provided information about various approaches of inspectors general across the state, best practices for performance audits, and best practices for fraud investigations. The National Association of State Directors of Developmental Disabilities Services and National Conference of State Legislatures provided information about states' oversight of behavioral health and developmental disabilities services.

Other states

JLARC staff conducted interviews with OIGs at eight states with statewide OIGs: Georgia, Indiana, Louisiana, Massachusetts, Ohio, Pennsylvania, and South Carolina. States were selected for in-depth interviews based on diversity in the age, size, and mission of their inspectors general. In four interviews, at least one participant included the inspector general or deputy inspector general.

Additionally, JLARC staff interviewed a representative of another state's DBHDS-equivalent to learn about its oversight of behavioral health and developmental disabilities.

Surveys

JLARC staff developed and administered three surveys for this study.

Survey of OSIG staff

A survey was administered to all OSIG leadership and staff with the exception of the inspector general and the two deputy inspectors general. Topics included OSIG's management of employees and job satisfaction. It also asked specialized questions about the work of the performance audit and investigations divisions because those were the only two divisions with enough employees to assure anonymity of responses. Of the 30 employees to which the survey was administered 28 responded, for a response rate of 93 percent. Information from the survey is used in Chapter 2.

Survey of internal audit directors at state agencies

A survey was administered to the internal audit directors at 32 state agencies and higher education institutions. The survey included questions on various aspects of the State Fraud, Waste, and Abuse Hotline, including:

- OSIG's screening and referral of allegations submitted to the hotline;
- OSIG's overall administration of the hotline; and
- the usefulness of OSIG's hotline guidance and technical assistance

Representatives for 19 of the 32 agencies surveyed completed surveys, for a response rate of 59 percent. The survey is used in Chapter 3 of the report.

Survey of agencies that underwent OSIG performance audits

A survey was administered to the leadership of 19 state agencies and higher education institutions that underwent OSIG performance audits between 2016 and 2019. The survey included questions about

- how a performance audit by an independent entity could benefit the agency;
- how useful OSIG's findings were in identifying opportunities to improve the agency, and the reasons any findings were not fully useful;
- how useful OSIG's recommendations were in identifying strategies to improve agency performance, and the reasons any recommendations were not fully useful;
- the agency's experience working with the OSIG audit team; and
- any suggestions for improving the usefulness of OSIG's performance auditing.

A total of 17 agencies completed surveys, for a response rate of 89 percent. The survey is used in Chapter 5 of the report.

Data collection and analysis

JLARC staff analyzed data from six OSIG and the Department of Human Resource Management databases.

Turnover

JLARC staff obtained data from DHRM's employee and transactions databases to calculate the annual voluntary turnover rate for each agency between FY13 and FY19. OSIG's voluntary turnover rate was compared to the average and median annual voluntary turnover rate of (1) all state agencies and (2) agencies with at least 15 to 100 employees during the period studied. For this review, the voluntary turnover rate is the total number of employees who left the respective agency for reasons other than retirement, long-term disability, dismissal, or death divided by total number of employees at the end of the fiscal year (Chapter 2).

Staffing

JLARC staff obtained OSIG's internal human resources data on all employee actions (e.g., employment, terminations, promotions) since FY13 (as of March 22, 2019). This data was used to analyze changes in the number and allocation by function of OSIG staff over time.

State Fraud, Waste, and Abuse Hotline and OSIG Investigations

JLARC staff obtained OSIG's database of allegations submitted to the hotline since the agency was created in 2012. The data were used to analyze the

- types of allegations submitted and state agencies represented,
- the percentage of allegations that resulted in investigations,
- the lengths of investigations,
- the outcomes of those investigations, and
- any differences between hotline investigations conducted by OSIG, agencies with internal audit divisions, and agencies with hotline coordinators.

JLARC staff also analyzed OSIG data on investigations conducted by the agency's law enforcement investigators, including the types of allegations investigated, the lengths of investigations, and the outcomes of investigations.

Structured OSIG document reviews

JLARC staff conducted structured assessments of OSIG performance audits; investigations by OSIG staff and other state agencies for allegations submitted to the State Fraud, Waste, and Abuse Hotline; and DBHDS oversight reports.

Performance audits

JLARC staff conducted a structured assessment of a subset of seven OSIG performance audits. The audits assessed and the methodology used are described in Appendix C. The purpose of the assessment was to determine the extent to which OSIG performance audits were consistent with recommended standards for effective audits.

Investigations

JLARC staff selected investigations conducted between 2017 and 2019. Investigations were selected to ensure a mix of outcomes (allegations substantiated, not substantiated, not substantiated but recommendations made to strengthen internal controls), types of allegations (criminal and administrative), and—for hotline allegations—investigations conducted by agencies with and without internal audit divisions.

DBHDS oversight reports

JLARC staff reviewed all formal documents produced by OSIG's DBHDS oversight staff for the purpose of analyzing the frequency and subjects of recommendations. These documents consisted of published reports and formal letters or memos that were not published since OSIG's creation. A limitation was that OSIG does not retain reliable records of unpublished DBHDS oversight write-ups (particularly reviews of individual complaints or incidents), so there may be additional documents containing recommendations that were not known to current OSIG staff and thus not provided to JLARC. JLARC's analysis of the entities to which recommendations were directed is summarized in Chapter 5.

Review of documents

JLARC staff identified and reviewed a wide variety of documents to inform its study of OSIG, including:

- agency-wide OSIG policies, publications (e.g., annual reports, workplans), and organization charts;
- policies, processes, working notes, reports, publications, internal communications, external communications, workplans, project plans, and EWPs of particular OSIG divisions;
- Virginia state statute, regulations, Appropriation Acts, and executive orders;
- publications by other Virginia agencies relating to OSIG's history (including the Auditor of Public Accounts, Office of the Attorney General, and Governor's Commission on Government Reform & Restructuring) and staff qualification (the Department of Human Resource Management);
- publications of policies of Virginia state agencies with comparable responsibilities to OSIG, including the Office of the Chief Medical Examiner and Department of Health Professions;
- publications about behavioral health and disability services in Virginia, including the disAbility Law Center of Virginia, National Alliance on Mental Illness of Virginia, DOJ settlement agreement Independent Reviewer, and Joint Subcommittee to Study Mental Health Services in the Twenty-First Century;
- DBHDS policies, staff guidance, strategic plans, annual reports, and other documents pertaining to DBHDS's oversight of facilities and services; and
- documents describing other states' OIGs, including their websites, annual reports, specific investigations and audits, statute, and regulations.

Review of national research

JLARC staff reviewed and synthesized publications by federal agencies as well as national associations, advocacy groups, and other national entities. This included a review of the documents nationally recognized as best practices for OIGs and other auditors: (1) "Quality Standards for Federal Offices of Inspector General" by the Council of the Inspectors General on Integrity and Efficiency, (2) "Principles and Standards for Offices of Inspector General" by the Association of Inspectors Generals, and (3) "Generally Accepted Government Auditing Standards" by the U.S. Government Accountability Office. A 2013 study of state inspectors general by Connecticut General Assembly's Office of Legislative Research and a 2015 article entitled "Crafting accountability policy: Designing offices of inspector general" published in the *Policy and Society* journal (Volume 34, Issue 2) were key resources on the variation between, and history of, OIGs.

For its review of OSIG's DBHDS oversight function, JLARC staff reviewed national literature on standards for behavioral health and developmental services, including publications by The Joint Commission, the Centers for Medicare and Medicaid Services, Administration for Community Living; as well as the Offices of Inspector General of the U.S. Health and Human Services, Department of Veterans Affairs, and Department of Justice.

Appendix C: JLARC assessment of OSIG performance audits

JLARC staff conducted a structured assessment of a subset of seven OSIG performance audits (Table C-1). The purpose of the assessment was to determine the extent to which OSIG performance audits were consistent with recommended standards for effective audits. JLARC staff selected its subset to include audits recently completed as well as older audits to determine how the quality of OSIG audits has changed over time. JLARC staff also selected its subset to include audits identified as more or less useful by OSIG staff and audited state agencies.

TABLE C-1
Subset of OSIG performance audits assessed by JLARC staff

Performance audit	Date audit released
Virginia Department of General Services: eVA eProcurement Bureau	June 2019
Health and Human Resources Subrecipient Monitoring	April 2019
Virginia Department of Social Services: Implementation of the Virginia Case Management System	March 2018
Department for Aging and Rehabilitative Services: Disability Determination Services Program	February 2018
Department of Small Business and Supplier Diversity: Small, Women-owned, and Minority-owned Business Certification Program Performance Audit	December 2017
Virginia Department of Aviation Peninsula Airport Commission Oversight	May 2017
Virginia Polytechnic Institute and State University Performance Review	October 2016

SOURCE: JLARC.

Assessment methodology

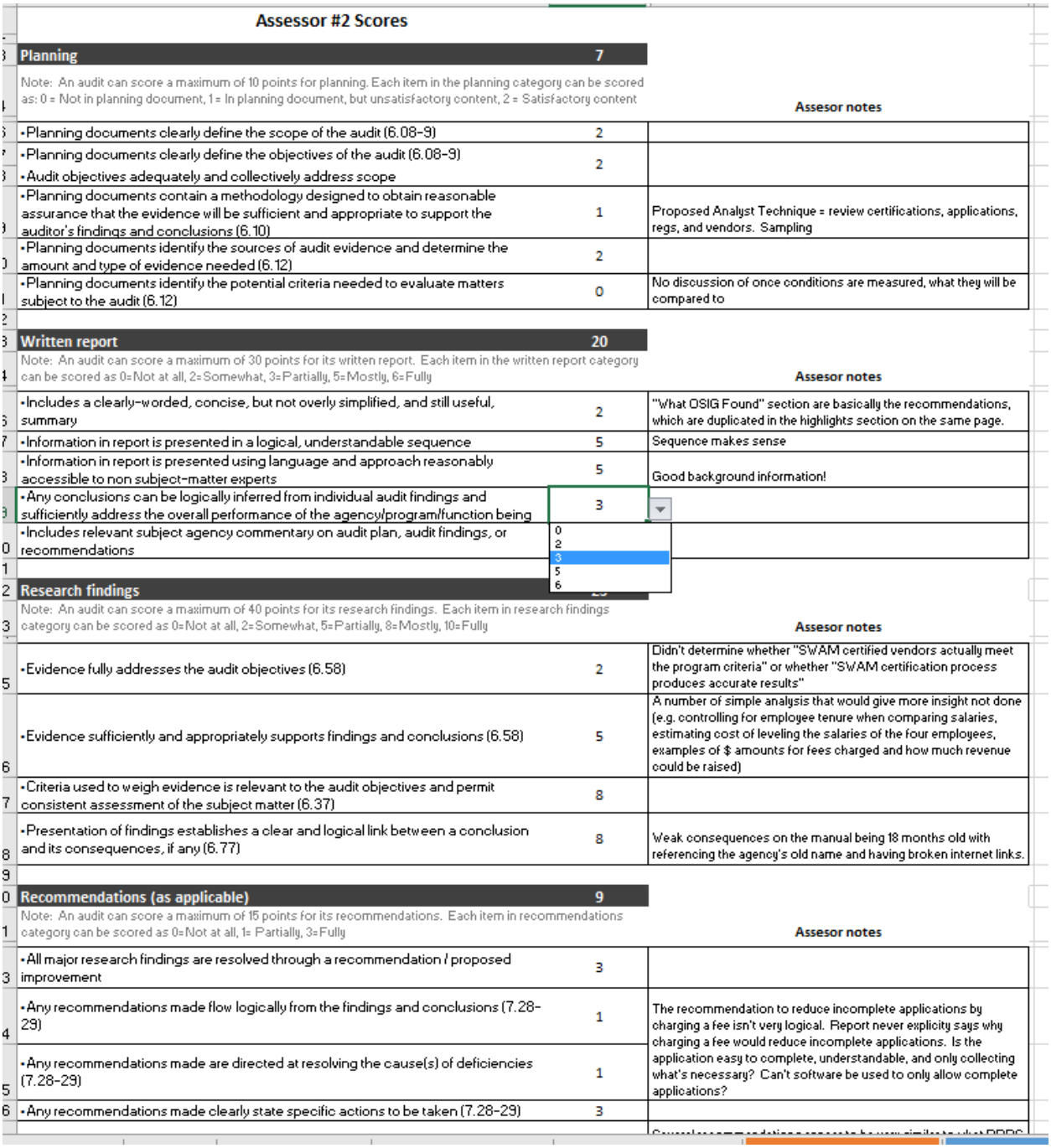
To assess OSIG performance audits, JLARC staff developed an assessment framework adapted from the *Government Auditing Standards* developed by the United States Government Accountability Office (GAO). GAO standards were adapted to incorporate aspects of peer review assessments conducted by the National Conference of State Legislatures and the National Legislative Program Evaluation Society. JLARC staff developed criteria for assessing five aspects of each audit: planning, written report, research findings, recommendations, and documentation (Table C-2). For each audit, JLARC staff scored each criterion on the extent to which it met the applicable standard. The criteria across all five assessment categories collectively totaled 100 points. The research findings were weighted the most with a maximum possible score of 40. The written report received the second-highest weight with a maximum score of 30.

TABLE C-2
Criteria for assessment OSIG performance audits

Assessment criteria	Maximum score
Planning criteria	***10***
Planning documents clearly define the scope of the audit (6.08-9)	2 = Satisfactory content 1 = In planning document but unsatisfactory content 0 = Not in planning document
Planning documents clearly define the objectives of the audit (6.08-9) Audit objectives adequately and collectively address scope	
Planning documents contain a methodology designed to obtain reasonable assurance that the evidence will be sufficient and appropriate to support the auditor's findings and conclusions (6.10)	
Planning documents identify the sources of audit evidence and determine the amount and type of evidence needed (6.12)	
Planning documents identify the potential criteria needed to evaluate matters subject to the audit (6.12)	
Written report	***30***
Planning documents clearly define the scope of the audit (6.08-9)	6 = Fully 5 = Mostly 3 = Partially 2 = Somewhat 0 = Not at all
Planning documents clearly define the objectives of the audit (6.08-9)	
Audit objectives adequately and collectively address scope	
Planning documents contain a methodology designed to obtain reasonable assurance that the evidence will be sufficient and appropriate to support the auditor's findings and conclusions (6.10)	
Planning documents identify the sources of audit evidence and determine the amount and type of evidence needed (6.12)	
Research findings	***40***
Evidence fully addresses the audit objectives (6.58)	10 = Fully 8 = Mostly 5 = Partially 2 = Somewhat 0 = Not at all
Evidence sufficiently and appropriately supports findings and conclusions (6.58)	
Criteria used to weigh evidence is relevant to the audit objectives and permit consistent assessment of the subject matter (6.37)	
Presentation of findings establishes a clear and logical link between a conclusion and its consequences, if any (6.77)	
Recommendations	***15***
All major research findings are resolved through a recommendation / proposed improvement	3 = Fully 1 = Partially 0 = Not at all
Any recommendations made flow logically from the findings and conclusions (7.28-29)	
Any recommendations made are directed at resolving the cause(s) of deficiencies (7.28-29)	
Any recommendations made clearly state specific actions to be taken (7.28-29)	
Any recommendations made direct practical actions with a likely net benefit (7.28-29)	
Documentation	***5***
Supporting documentation (workpapers) is comprehensive and well organized	5 = Fully 2 = Partially 0 = Not at all
Total maximum score	***100***

SOURCE: JLARC.

OSIG audits were assessed independently by two JLARC staff. The two JLARC staff each used their own Microsoft Excel file embedded with the same scoring criteria and weighting. An assessment score was selected using a pre-populated "pick list" for each criteria, which was then automatically totaled to produce a category score. Staff also made notes where relevant on the scoring sheet to indicate reasons for the scores provided. An example of an assessor's scoring sheet is shown below:



Assessor #2 Scores

Planning	**7**	
Note: An audit can score a maximum of 10 points for planning. Each item in the planning category can be scored as: 0 = Not in planning document, 1 = In planning document, but unsatisfactory content, 2 = Satisfactory content		**Assesor notes**
•Planning documents clearly define the scope of the audit (6.08-9)	2	
•Planning documents clearly define the objectives of the audit (6.08-9) •Audit objectives adequately and collectively address scope	2	
•Planning documents contain a methodology designed to obtain reasonable assurance that the evidence will be sufficient and appropriate to support the auditor's findings and conclusions (6.10)	1	Proposed Analyst Technique = review certifications, applications, regs, and vendors. Sampling
•Planning documents identify the sources of audit evidence and determine the amount and type of evidence needed (6.12)	2	
•Planning documents identify the potential criteria needed to evaluate matters subject to the audit (6.12)	0	No discussion of once conditions are measured, what they will be compared to
Written report	**20**	
Note: An audit can score a maximum of 30 points for its written report. Each item in the written report category can be scored as 0=Not at all, 2=Somewhat, 3=Partially, 5=Mostly, 6=Fully		**Assesor notes**
•Includes a clearly-worded, concise, but not overly simplified, and still useful, summary	2	"What OSIG Found" section are basically the recommendations, which are duplicated in the highlights section on the same page.
•Information in report is presented in a logical, understandable sequence	5	Sequence makes sense
•Information in report is presented using language and approach reasonably accessible to non subject-matter experts	5	Good background information!
•Any conclusions can be logically inferred from individual audit findings and sufficiently address the overall performance of the agency/program/function being	3	
•Includes relevant subject agency commentary on audit plan, audit findings, or recommendations		
Research findings		
Note: An audit can score a maximum of 40 points for its research findings. Each item in research findings category can be scored as 0=Not at all, 2=Somewhat, 5=Partially, 8=Mostly, 10=Fully		**Assesor notes**
•Evidence fully addresses the audit objectives (6.58)	2	Didn't determine whether "SWAM certified vendors actually meet the program criteria" or whether "SWAM certification process produces accurate results"
•Evidence sufficiently and appropriately supports findings and conclusions (6.58)	5	A number of simple analysis that would give more insight not done (e.g. controlling for employee tenure when comparing salaries, estimating cost of leveling the salaries of the four employees, examples of $ amounts for fees charged and how much revenue could be raised)
•Criteria used to weigh evidence is relevant to the audit objectives and permit consistent assessment of the subject matter (6.37)	8	
•Presentation of findings establishes a clear and logical link between a conclusion and its consequences, if any (6.77)	8	Weak consequences on the manual being 18 months old with referencing the agency's old name and having broken internet links.
Recommendations (as applicable)	**9**	
Note: An audit can score a maximum of 15 points for its recommendations. Each item in recommendations category can be scored as 0=Not at all, 1= Partially, 3=Fully		**Assesor notes**
•All major research findings are resolved through a recommendation / proposed improvement	3	
•Any recommendations made flow logically from the findings and conclusions (7.28-29)	1	The recommendation to reduce incomplete applications by charging a fee isn't very logical. Report never explicity says why charging a fee would reduce incomplete applications. Is the application easy to complete, understandable, and only collecting what's necessary? Can't software be used to only allow complete applications?
•Any recommendations made are directed at resolving the cause(s) of deficiencies (7.28-29)	1	
•Any recommendations made clearly state specific actions to be taken (7.28-29)	3	

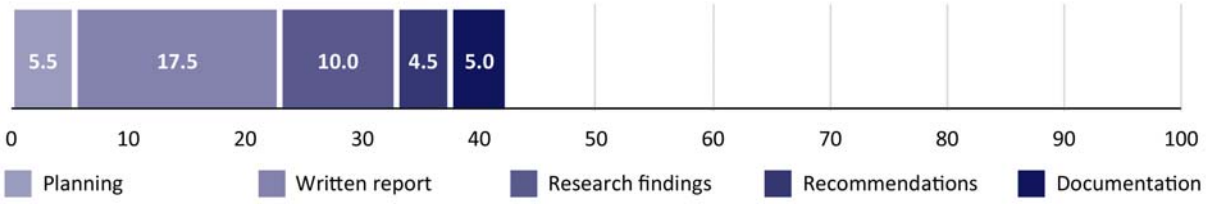
After assessing the first OSIG audit, the two JLARC staff compared their approach and results to ensure that assessment criteria were being applied consistently by both staff. In assessing each audit, JLARC staff relied on the written audit report as well as audit working papers maintained by OSIG. Working papers also were used to assess the planning for each audit and better understand the research findings and recommendations where necessary.

After the two JLARC staff completed their assessments, their scoring sheets were combined and their individual scores averaged to produce a final score for each audit, in each assessment category.

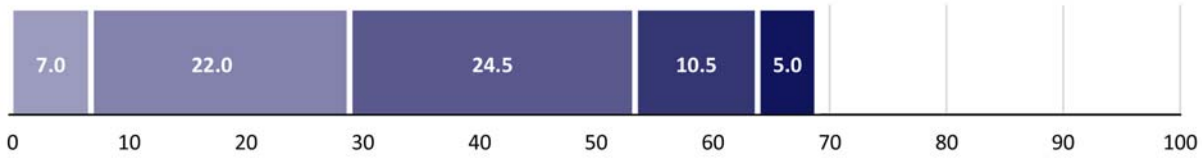
Assessment results

The average score for each of the seven performance audits is shown below. Each assessment category is shown in the graph as follows:

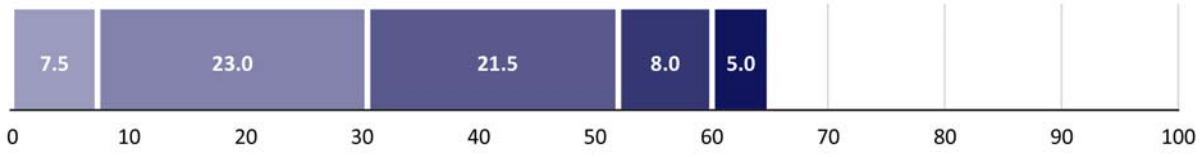
Virginia Polytechnic Institute and State University Performance Review, October 2016



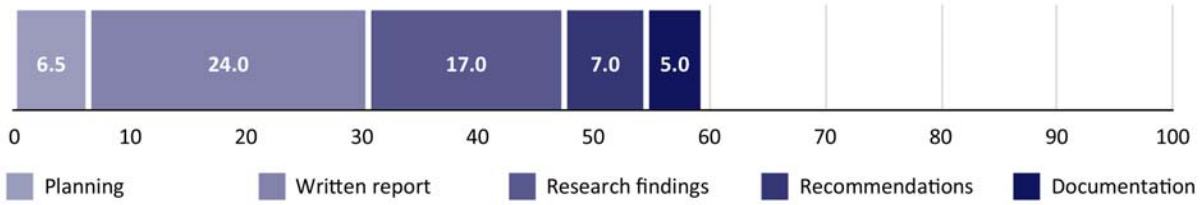
Virginia Department of Aviation Peninsula Airport Commission Oversight, May 2017



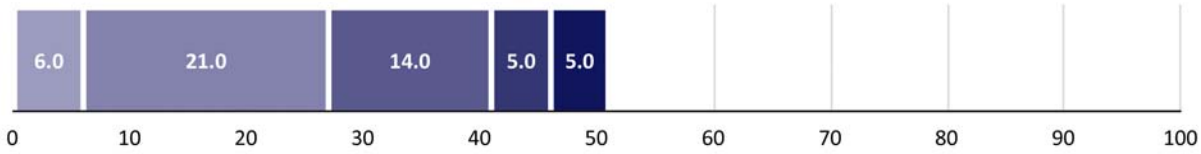
Department of Small Business and Supplier Diversity: Small, Women-owned, and Minority-owned Business Certification Program Performance Audit, December 2017



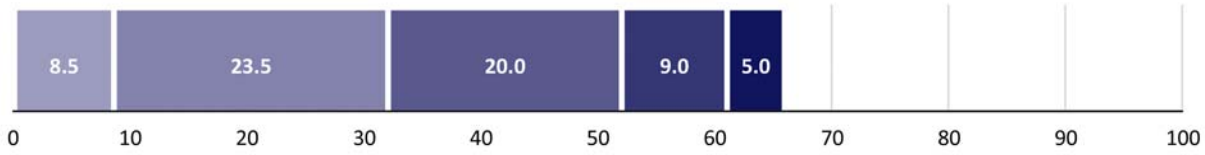
Department for Aging and Rehabilitative Services: Disability Determination Services Program, February 2018



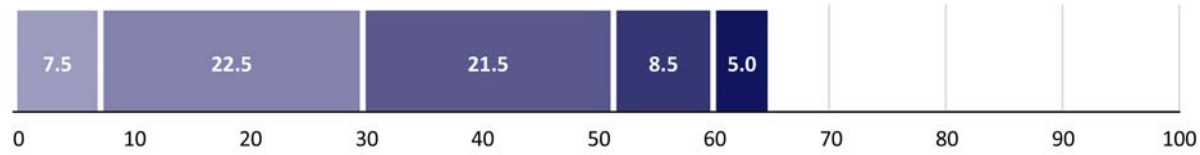
Virginia Department of Social Services: Implementation of the Virginia Case Management System, March 2018



Health and Human Resources Subrecipient Monitoring, April 2019



Virginia Department of General Services: eVA Procurement Bureau, June 2019



Appendix D: Centralized inspector general offices in other states

Similar to Virginia, each of the eight centralized inspector general (IG) offices in other states operates a fraud hotline and investigate fraud allegations (Table D-1). Other responsibilities and authorities vary widely. Besides Virginia, only one other IG conducts performance audits—South Carolina. Just two other IGs have dedicated oversight of a specific government agency or program:

- Massachusetts's IG operates specialized units to provide oversight of the state Department of Transportation, Executive Office of Health and Human Services, and Massachusetts State Police. It is also a member of a state panel overseeing state-funded school construction.
- Pennsylvania's IG "investigates and prosecutes welfare fraud and conducts collection activities for the public benefits programs administered by" the state's Department of Human Services.

TABLE D-1
The functions of the nine centralized IGs vary

		Functions				
State	**Year of creation** [a]	**Fraud hotline**	**Fraud investigations**	**Performance audits**	**Other government-wide function**	**Oversight of specific agency/ program**
Georgia	2003	✔	✔		✔	
Indiana	2005	✔	✔		✔	
Louisiana	1988	✔	✔			
Massachusetts	1981	✔	✔	[b]	✔	✔
New York	Unknown	✔	✔		✔	
Ohio [c]	1988 [e]	✔	✔			
Pennsylvania	1987	✔	✔		✔	✔
South Carolina	2012	✔	✔	✔		
Virginia	2012	✔	✔	✔	✔	✔
Total (9)		**9**	**9**	**2**	**6**	**3**

SOURCE: Websites, publications, statutes, and regulations of states' IGs, as well as interviews with eight states' IGs.
NOTE: The table provides information only about states' centralized IGs, and not about any IGs wholly dedicated to specific agencies or programs. For example, information for New York refers to its State Office of the Inspector General and not its Office of the Workers' Compensation Fraud Inspector General. The District of Columbia has a centralized IG but was excluded because it is not a state. [a] If the IG was created by executive order prior to statute, the earlier date is used. [b] JLARC was unable to conclusively determine if this is an IG function, but it does not appear to be the IG's primary function. [C] Information reflects the Ohio Inspector General, not the Ohio Legislative Office of Inspector General.

Additionally, IGs can be responsible for other government-wide functions, such as:

- Training: Georgia's IG provides anti-fraud training. The IGs in Indiana, New York, and Pennsylvania provide ethics training. Massachusetts' IG trains Certified Public Purchasing Officials.
- Guidance: Indiana's IG provides advisory opinions about ethics issues. Massachusetts' IG issues guidance on varying topics (e.g., audits, procurement).
- Construction/procurement: New York's IG monitors procurement and contract management for certain construction projects. Massachusetts' IG reviews public design, construction, and real property transactions; helps the state develop policies in these and other related areas; and operates a hotline for suspected procurement fraud.
- Miscellaneous: Pennsylvania's IG is responsible for pre-employment background investigations for certain state government positions, including executive-level appointments. Indiana's IG collects state employees' financial disclosure statements. Georgia's IG oversees sexual harassment investigations conducted by state agencies.

These nine centralized IGs were created in the last few decades and have varying authorities. Massachusetts created the oldest centralized IG in 1981, and South Carolina and Virginia created the newest IGs in 2012 (Table D-1). All centralized IGs possess formal authorities to compel information to fulfill their responsibilities, such as accessing records and questioning state employees. However, only four states granted law enforcement authority to their IGs: Indiana, Louisiana, Pennsylvania, and Virginia.

The jurisdiction of the centralized IGs is generally limited to state government agencies in the executive branch. Any jurisdiction over local government is typically through following state or federal funding. An exception is the Massachusetts IG, whose jurisdiction includes cities and towns. Additionally, centralized IGs' jurisdiction tends to exclude the judicial or legislative branches. Again, the Massachusetts IG is an exception (but lacks the jurisdiction to investigate the legislature). Ohio has an Office of the Inspector General covering entities under the governor's authority and a Legislative Office of Inspector General covering entities under the state legislature's authority.

Appendix E: Agency response

As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff sent an exposure draft of this report, or relevant sections of it, to the Office of the State Inspector General, the Department of Behavioral Health and Developmental Services, and to the governor's chief of staff.

Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report.

This appendix includes a response letter from the Office of the State Inspector General.

COMMONWEALTH OF VIRGINIA
Office of the State Inspector General

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September 10, 2019

Hal E. Greer, Director
Joint Legislative Audit and Review Commission
919 E. Main St., Suite 2101
Richmond, VA 23219

Dear Mr. Greer:

Thank you for the opportunity to review and comment on the Exposure draft JLARC report, *Operation and Performance of the Office of the State Inspector General*. We appreciate the Commission's goal of reviewing the Office of the State Inspector General's (OSIG) performance in meeting our mission and mandates established in Code of Virginia Chapter 3.2. The report includes information and recommendations that will benefit our office going forward as we continually evaluate how we can improve and provide the greatest benefit to our stakeholders.

We appreciate your recognition that OSIG is a relatively new agency that initially had significant challenges due in part to how we were created, and that we have stabilized and are building a positive organizational culture. In spite of these initial difficulties, including considerable staff turnover, OSIG has continually improved our audit, inspection and investigation efforts.

We are addressing many of the issues you identified during the review, and have already implemented several of your recommendations. But we know we can always do better. This report, in addition to information and recommendations from our current strategic planning process being led by Virginia Commonwealth University's Performance Management Group and an upcoming independent quality assurance review through the Association of Inspectors General, will help guide OSIG's continuing improvement efforts.

We look forward to working with members of the General Assembly as we continue our mission of rooting out fraud, waste and abuse in state government through our investigations; improving the quality of care and investigating allegations of abuse, neglect and inadequate care through our behavioral health and developmental services oversight activities; and making executive branch state agencies more efficient and effective through our audits.

Sincerely,

Michael C. Westfall, CPA
State Inspector General

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