

LEGISLATIVE AUDIT COMMISSION



Review of
Department of Public Health
Two Years Ended June 30, 2009

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REVIEW: 4346
DEPARTMENT OF PUBLIC HEALTH
TWO YEARS ENDED JUNE 30, 2009

FINDINGS/RECOMMENDATIONS - 22

ACCEPTED - 7
IMPLEMENTED - 15

REPEATED RECOMMENDATIONS - 19

PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 25

This review summarizes the auditors' report of the Illinois Department of Public Health for the two years ended June 30, 2009, filed with the Legislative Audit Commission May 11, 2010. The auditors performed a compliance examination in accordance with State law and *Government Auditing Standards*.

The Department of Public Health promotes the health of the citizens of Illinois through the prevention and control of disease and injury. The Department, in partnership with local health departments and other agencies, employs population-based approaches in its prevention programs. The Department carries out its mission through six major program areas: Policy, Planning and Statistics; Health Promotion; Health Care Regulation; Health Protection; Women's Health; and Preparedness and Response.

During most of the two-year period under review, Dr. Damon T. Arnold was the Director of the Department. Dr. Eric Whitaker resigned on September 30, 2007 and Dr. Arnold became the Director on October 1, 2007. Dr. Damon was not previously employed by the Department.

The average number of employees was:

Division	FY09	FY08	FY07
Director's Office	71	66	65
Finance and Administration	133	126	125
Policy, Planning and Statistics	74	73	71
Health Promotion	54	55	62
Health Care Regulation	310	318	313
Health Protection and Laboratories	404	406	396
Women's Health	24	22	20
Preparedness and Response	47	38	40
TOTAL	1,117	1,104	1,092

Expenditures From Appropriations

The General Assembly appropriated \$456,090,700 to the Department in FY09. Of the total appropriation, \$161.5 million was from the General Revenue Fund, and the remaining \$295 million was from 55 other funds. Total expenditures were \$361,745,181 in FY09 compared to \$359,274,059 in FY08, an increase of \$2.47 million, or 0.69%. Appendix A presents a summary of appropriations and expenditures for FY07-FY09 by both fund and major object code. Expenditures from most funds showed small changes from FY08 to FY09. Some of the significant changes in expenditures were as follows:

- The Multiple Sclerosis Research grant program began in FY09 funded by special lottery games. Expenditures were \$1 million.
- Death Certificate Surcharge Fund expenditures increased about \$1.9 million due to increased contractual services payments and grants to local governments.
- Public Health Special State Projects Fund expenditures increased about \$2.4 million because the Department began paying facility management charges to CMS for public health laboratory facilities.
- African-American HIV/AIDS Response Fund expenditures were \$0 due to the Department encountering difficulties with the grantee of the funds.
- Trauma Center Fund expenditures decreased \$2.6 million due to fewer grants awarded in FY09.

Lapse period expenditures were \$57.9 million, or 16%.

Cash Receipts

The Department of Public Health has collection responsibility for licenses, fees, or other types of revenue that are deposited into the General Revenue Fund. The Department's General Revenue Fund cash receipts decreased from \$3.3 million in FY08 to about \$2.3 million in FY09. Overall receipts increased slightly from \$176.66 in FY08 to \$176.86 million in FY09. Appendix B provides a summary of the Department's cash receipts. Most of the Department's receipts are from federal grant revenue (\$135.8 million) and fees and licenses (\$24.4 million).

Property and Equipment

Appendix C provides a summary of property and equipment for which the Department was accountable during FY09 and FY08. The value of the Department's property and equipment decreased from \$28,703,317 as of July 1, 2007 to \$27,410,148 as of June 30, 2009. The value of the Department's equipment is by far its largest asset at almost \$27.4 million.

Activities and Performance Indicators

Appendix D provides a summary of the Department's activities and performance indicators. The information was taken directly from the Agency's Service Efforts and Accomplishments forms for FY09 and FY08.

Accountants' Findings and Recommendations

Condensed below are the 22 findings and recommendations included in the audit report. Nineteen were repeated from prior audits. The following updated responses are presented on the basis of updated information provided by Dr. Damon Arnold, Director and staff, via electronic mail received March 3, 2011.

Accepted or Implemented

- 1. Develop a comprehensive grant administration program that includes the development and implementation of written procedures over the awarding of all of the Department's grant awards; reviewing the programmatic and financial reports of grant recipients; scheduling, conducting, and documenting grantee site visits; and, collecting refunds due to the Department in a timely manner. (Repeated-2007)**

Findings: The Department of Public Health (Department) did not adequately document its procedures and monitoring of its awards and grants programs. During FY08 and FY09, the Department expended \$178,331,050, or 25%, of its \$721,019,240 total expenditures for awards and grants.

Auditors selected ten programs for testing and examined 91 grant agreements totaling \$26,213,577 and noted the following weaknesses:

- The Department does not have written procedures established to guide its administration of the awards and grants programs tested.
- The Department did not ensure that the reports for 72 of the 91 (79%) grants tested, which total approximately \$21,524,676, were monitored by desk reviews. For these 72 grants, the Department did not follow up on missing program or financial reports, nor did the files contain documentation of any other monitoring activities. Two of the 72 grants resulted in refunds of \$41,631 and \$36,050, respectively, which were not collected in a timely manner after the conclusion of the grant period due to poor monitoring efforts.

Department management attributed the ongoing weaknesses in grant administration to lack of staff, oversight, and competing priorities.

Accepted or Implemented – continued

Updated Response: Implemented. During 2010, the Illinois Department of Public Health (IDPH) instituted a grants review process to achieve several goals. First, IDPH established a formal grant application and review process to ensure compliance with SB51. Second, the grants review process was developed to offer the public and potential grantees information about grant funding opportunities at the Department. Third, through the creation of a grants review committee (GRC), IDPH ensures grant applications are independently reviewed and evaluated before being recommended for action by the Department.

IDPH has also created a standard application and budget template utilized for all IDPH funding opportunities. These templates are publicly posted via the IDPH website. The Grants Review Committee (GRC) has been assembled into eight teams that have received professional development training on how to assess grant funding applications and to date have reviewed over 330 grant applications.

2. Obtain and review detailed documentation prior to paying for the consolidated services to ensure only paying for services incurred on its behalf by DCMS. (Repeated-2007)

Findings: The Department made payments for press information officers, graphic designers, rent, and information technology (consolidated services) to the Department of Central Management Services (CMS), without sufficient supporting documentation.

During the examination period, the Department was billed a total of \$25,265,790 for consolidated services. Auditors tested 120 detail billing invoices from CMS totaling \$5,615,824 for consolidated services and noted the following:

- Nine vouchers totaling \$87,572 for services relating to Press Information Officers' management and 1 voucher totaling \$1,383 for services related to graphic designers did not contain adequate supporting documentation.
- Six vouchers totaling \$490,160 for building rent expenses which did not include adequate supporting documentation, and the Department was unable to provide the corresponding CMS rates for rent of the properties included on the vouchers.
- One voucher totaling \$810,000 for information technology services only included a billing invoice cover sheet. No detail regarding the hours of service, rate per hour of service, cost of materials, or other applicable billing detail was included with the invoice.

The Department stated they paid the invoices as billed by DCMS because they considered the information provided by DCMS to be sufficient.

Updated Response: Implemented. All necessary documentation from DCMS is now being received for payments for these consolidated DCMS functions which include facilities, PIOs and graphics.

- 3. Require and maintain sufficient documentation to ensure that all billed contracted services have been provided and that the expenditures are reasonable and necessary. (Repeated-2007)**

Findings: The Department did not have adequate support for Interagency Agreements with the Office of the Governor detailing the methodology for determining the allocation to be paid by the Department for legal services provided to the State.

During the examination period, the Department processed 285 vouchers totaling \$1,086,263 for legal expenses. Auditors sampled 25 vouchers and noted 15 (60%) totaling \$227,614 pertained to 12 Interagency Agreements entered into with the Office of the Governor for services for advice, counsel, and, if appropriate, legal representation to the Office of the Governor, Department, and officers and employees of the State of Illinois, and such other legal services as requested. The Department's allocable share of the costs incurred under these Interagency Agreements ranged from 3% to 100%; however, there was no supporting documentation detailing the methodology used for determining the percent allocation to be paid. The Department, pursuant to communication received from the Office of the Governor, was simply instructed to pay the \$227,614 without supporting documentation for the Department's allocable share of expenses.

Response: Going forward, the Department will seek to obtain additional supporting documentation from the Governor's Office for any legal allocations in order to be consistent with the State Accounting Management System. Historically, it is our understanding that payment responsibility was assigned to particular State agencies based principally on the agencies' involvement in the subject matter of the litigation.

Updated Response: Implemented. During the current audit period, utilization of these type interagency agreements has been dramatically reduced/eliminated. If a determination was made regarding a specific allocation amount, the Department has questioned the methodology for doing so to ensure an equitable distribution of costs.

- 4. Comply with SAMS requirements to ensure accurate financial information is submitted to the Illinois Office of the Comptroller. Further, review and revise as necessary the current system used to gather and document the financial information that will be reported in the Office of the State Comptroller generally accepted accounting principles (GAAP) Reporting Package Forms. (Repeated-2003)**

Accepted or Implemented – continued

Findings: The Department did not correctly report financial information on the Grant/Contract Analysis (SCO-563) form to the Illinois Office of the Comptroller. The Department prepares a separate SCO-563 form for five funds.

During testing, auditors noted the Department inaccurately reported the non-cash award for Immunization Grants on one SCO-563 form. The Department reported \$76.159 million in expenditures, but the accuracy of that amount could not be determined due to insufficient documentation. Corrected expenditures were \$76.1 million, which resulted in a decrease of \$59 thousand for the program's expenditures.

In response to this finding from prior examinations, the Department stated it would reconcile the reports generated from the immunization data base system to reports that manually calculate the doses of vaccine received and distributed to make sure all doses received and distributed were accounted for accurately. Testing noted the Department did not implement either of these expected corrective action plans. Department personnel attributed the error to an ongoing flawed reporting mechanism within its immunization inventory database and the lack of information provided by the federal government's third party administrator.

Updated Response: Implemented. The Illinois Department of Public Health maintains reports of distribution of doses of vaccine as issued by McKesson Specialty. McKesson holds a federal contract with the Centers for Disease Control and Prevention to perform distribution of vaccine for 64 federal project areas administering the federal Vaccines for Children entitlement (VFC) program. IPDH does not maintain physical inventory or perform distribution of vaccine to health care providers enrolled in the VFC program. The department utilizes the McKesson reports to document and respond to the GAAP reporting package forms for the Office of the State Comptroller and to meet the mandated federal reporting for VFC.

- 5. Carefully review and report capital assets, including accumulated depreciation, accurately and in accordance with the procedures outlined in the SAMS manual. Also, correct and resubmit the capital asset forms to the Comptroller. (Repeated-2005)**

Findings: The Department did not accurately report accumulated depreciation information on the Capital Asset Summary (SCO-538) form to the Office of the State Comptroller for fiscal year 2009.

Auditors noted the Department's ending capital asset balance and accumulated depreciation at June 30, 2009 did not agree to property records maintained by the Department and was overstated by \$395,000.

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Department management attributed the error in reporting capital assets and accumulated depreciation at June 30, 2009 to human oversight, as the incorrect numbers were retrieved from the Department's records and recorded on the SCO-538.

Updated Response: Implemented. A review of processes has been completed and revised to ensure that proper reporting is done. FY10 reporting was done with the help of IOC to ensure the corrections were properly stated and in compliance. The Office of the Comptroller had recommended, rather than resubmit an older report, that we should show the correction on the FY10's reporting form.

6. Reconcile the death certificate surcharge revenue received each month to the Reports remitted and take the measures necessary to obtain any missing documentation. (Repeated-2007)

Findings: The Department did not reconcile the death certificate surcharge revenue received to that which was collected by the local registrars. In addition, the Department did not ensure all local registrars submitted the monthly Report to State Registrar of Vital Records for all Certified Death Copies Issued along with monthly fees (\$2 per copy) remitted to the Department.

The Department received approximately \$1.7 million of death certificate surcharge revenue in both fiscal year 2008 and 2009. Auditors noted \$100,015 of the FY08 revenue and \$119,605 of the FY09 revenue were not accompanied by a report indicating the number and type of death certificates issued by each local governmental unit. It was not possible for the Department to ascertain the completeness of those fees because no supporting document existed as evidence for the surcharges collected by the local registrars.

In response to this finding in the previous examination, the Department developed procedures to require all submissions to be reviewed monthly and information forwarded to employees concerning payments without the necessary documentation. Employees were then instructed to follow up with the respective locations to obtain the necessary reports. While this practice reduced the amount of revenue received without the required reports, it did not completely eliminate the issue. Department personnel stated normal staff turnover at local registration offices contributed to the lack of Reports submitted along with monthly fees.

Response: Accepted. On February 18, 2010, the Department sent a reminder letter, along with a new shipment of reporting cards to each local registrar and county clerk, emphasizing the statutory requirement to report and submit fees monthly to the department for all certified death copies issued. This reminder letter and additional reporting cards will be sent annually. Beginning with the start of the fiscal year, the Department will utilize a spreadsheet that will show all monies submitted and cards received within a specific month. Every month will be reconciled and any discrepancies will be noted.

Accepted or Implemented – continued

Updated Response: Implemented. On 7/1/10, the Department began utilizing a new Excel spreadsheet that reconciles cards and monies submitted the same month they are received.

7. Implement controls to ensure refunds are processed in compliance with the State statute. (Repeated-2007)

Findings: The Department did not have adequate controls over the processing of refunds. During the examination period, the Department processed 169 refunds totaling \$1,502,010. Auditors tested 25 refunds totaling \$697,359 and noted a general lack of documentation supporting the date of the refund check and the date the refund was received by the Department.

- 15 of 25 refunds totaling \$649,378 were not deposited in a timely manner, ranging from 1 to 141 days late.
- Eight of 25 (32%) refunds totaling \$47,307 could not be evaluated for the timeliness of the deposit because they did not contain a receipt date or a check date.

Additionally, four of 25 refunds totaling \$6,733 were not offset against the correct current expenditure accounts.

Response: Accepted. The Department has developed internal instructions to process all refund checks within the 24/48 hour requirement. Refund checks will be stamped, validated and deposited within 24/48 hours. In case more documentation is needed to identify the original voucher, the check will be copied and logged in. A copy of the check will be sent to the applicable division to research and provide the necessary documentation. All documentation has to be received from the division prior to the issuance of the Treasurer's office draft which usually takes a week. Once the draft and documentation is received, staff will be able to reconcile the draft, complete the C-64 and record the transaction into the proper account.

Updated Response: Implemented. The Department deposits and processes all refund checks within the 24/48 hours period.

8. Formally communicate security requirements to CMS, and establish and document guidelines that outline both the Department's and CMS' responsibilities. Specifically, continue to work with CMS to strengthen security parameters by reducing the number of users with security administration authority and routinely reviewing access rights to Department applications and data. Enforce the policy requiring the completion of a Security Agreement Letter by new employees.

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In addition, finalize and implement the security awareness program and ensure employees review security policies and procedures at least annually and sign a statement acknowledging they have read, understand, and agree to comply with the policies and procedures. (Repeated-2005)

Findings: The Department in conjunction with the Department of Central Management Services (CMS), had not established adequate controls for security of its computer resources. Many of the Department's IT functions were consolidated into CMS, with a physical move of equipment in April 2007. As a result, the Department and CMS have a shared responsibility over computer security. Although the Department had developed a security awareness program it had not been fully implemented.

In addition, during testing of computer security, auditors noted:

- An excessive number of users had powerful security administration authority.
- Access rights to Department applications and data were not routinely reviewed.
- Security Agreement Letters were not always completed as required.

Although the Department shares some responsibility with CMS, the Department has the ultimate responsibility to ensure its applications and data are adequately protected. Since many of these issues have been identified in the prior two examinations, it was incumbent upon the Department to ensure corrective actions were implemented to remedy the deficiencies.

Management stated that, as a result of staffing shortages, manual auditing and monitoring tasks were not performed as required. In addition, due to the CMS information technology consolidation initiative, the Department must rely on CMS staff for administering and securing the servers used to run the Department's applications. Management stated that they have been actively working with CMS staff to reduce the number of users with security administration authority and to implement reporting capabilities for routine review of inactive accounts.

Updated Response: Implemented. The Department continues to work with CMS regarding IT policy, software and hardware requirements and guidelines. The Department continues to monitor user access levels and status via routine audit reports provided by CMS and our own reporting tools.

The Security Agreement letter requirement has been replaced by the HR form and approval of requests documented through the Enterprise Security Request process managed by CMS via the Remedy system. Security Awareness Training is implemented and ongoing. Employees are notified and required to review the training on a yearly basis via the LMS application.

Accepted or Implemented – continued

9. **Formally communicate recovery requirements to CMS, and establish and document guidelines that outline both the Department's and CMS' responsibilities. Specifically, review and update Disaster Recovery Plan. Also, coordinate with CMS and perform and document tests of the Plan (in particular, all Category One applications should be subject to annual recovery tests at an off-site location) at least once a year. Additionally, continuously update the Plan to reflect environmental changes and improvements identified from tests. (Repeated-2005)**

Findings: The Department did not have a current Disaster Recovery Plan (Plan) and had not performed comprehensive disaster recovery testing.

One of the criteria for a Category One application is the annual recovery testing at an off-site location. The Department had not conducted recovery testing of all its critical mainframe applications at the off-site location in the last four years. In addition, the Department would be unable to recover the web-portal (this would impact the ability of local health entities to submit critical public health information to the Department), due to lack of equipment and a recovery site.

The Department established a Plan, which "details the precise instructions and actions required to recover the time critical information technology systems and services." However, the Plan contained outdated information.

Although the Department shares some responsibility with DCMS, the Department has the ultimate responsibility to ensure it has the capability to recover its applications and data.

Management stated due to staffing and equipment shortages the Department was limited in their ability to adequately test local area network critical applications.

Response: Accepted. The Department will formally communicate with DCMS to determine consistent policies and procedures for Business Continuity, Recovery and Testing to ensure recovery capabilities of applications and data via the Business Continuity Management Team (BCMT).

The BCMT members are currently coordinating with each Office to determine procedures for identified business function recovery to include category and priority within the office. The latest documentation is currently stored on a shared directory structure by designated Office staff. The documentation includes procedures for implementing the plan in response to an event. In addition, the Department has implemented a new State of Illinois Rapid Electronic Notification system designed to broadcast health alert messages to specific groups of users. This system has been extended to include all Department personnel for the purpose of business continuity/emergency notification messaging.

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Lastly the Department is currently working on a new Sharepoint portal with DCMS where all BC documentation will be securely stored by Office and maintained by the owner and responsible IT personnel. The new site will contain documentation of all identified business functions to include recovery requirements and application recovery and testing requirements when appropriate.

Updated Response: Implemented. The Department has begun regular – both announced and unannounced – SIREN drills. Recently, during the winter storm at the end of January and beginning of February 2011, the SIREN notification system was tested through its use during the event. It was utilized for both notifications to the employees regarding office closures as well as to alert the Gold Team for conference calls to discuss the situation. Additionally, on a monthly basis, the Department trains and tests the use of GROOVE for public health emergency response. This ensures the Department has plans in place to activate response personnel whether there is a business continuity situation or a disaster event.

The IDPH Sharepoint portal pages for COOP have been created and BCMT staff are working on loading plans and coordinating exercises and update access to the site with Office personnel.

10. Comply with the State Officials and Employees Ethics Act by developing a written policy regarding timekeeping requirements and requiring all employees to submit timesheets recording time spent on official State business to the quarter hour. (Repeated-2005)

Findings: The Department did not comply with the State Officials and Employees Ethics Act (Act) in the following manner:

- No written policies and procedures for timekeeping and reporting hours worked on official State business.
- All employees not required to submit timesheets documenting the time spent each day on official State business. In fiscal years 2008 and 2009, only 16 of 1,104 and 18 of 1,135, respectively, were required to submit daily timesheets.

Department management stated a new directive concerning timekeeping was not implemented and the Shared Services Initiative did not come to fruition for the Department. As a result, the Department did not modify or document its timekeeping requirements.

Updated Response: Implemented. The Time Reporting System Policy (TRS) was implemented in the Department on May 1, 2010. Electronic forms, instructions and Frequently Asked Questions were created for each bargaining unit with which the Department works as well as to non-union employees. Forms are available to all employees via the Department intranet.

Accepted or Implemented – continued

11. Ensure annual performance evaluations are completed in a timely manner for all employees in accordance with the Illinois Administrative Code and Department procedures. (Repeated-2007)

Findings: The Department did not perform employee performance evaluations on a timely basis. During a review of employee performance evaluations, auditors noted 34 of 50 employee performance evaluations tested were not completed in a timely manner. The delinquency ranged from 5 to 246 days late. One of the 34 delinquent evaluations had not been performed at all as of the date of testing.

In response to this finding from previous examinations, the Department established several new procedures; however, testing noted overdue evaluations increased from 21 of 50 (42%) tested in the previous examination to 34 of 50 (68%) in the current examination.

Department management attributed the failure to complete the evaluations timely to pressing workload demands that must be handled despite significant staffing limitations in addition to an increasing percentage of union supervisors, which requires a higher level of involvement in evaluations.

Response: Accepted. As noted in the finding the Department did establish a routine monitoring process for delinquent evaluations and applicable notification is made to the supervisor and the Office. The Department certainly agrees that performance evaluations are important and need to be completed in a timely manner to serve their intended purpose. The Office of Human Resources will continue to strive to improve timeliness of our evaluations.

Updated Response: Accepted. The Office of Human Resources (OHR) continues to provide updates and reminders to Department management regarding evaluation due dates.

12. Comply with the requirements of the State Finance Act by filing accurate Travel Headquarter Reports in a timely manner. (Repeated-2003)

Findings: The Department did not file its Travel Headquarter Reports (TA-2 Report) with the Legislative Audit Commission in a timely manner, from seven to 106 days late, or accurately.

Travel vouchers for eight of 20 employees tested listed headquarters on the vouchers different than that listed on the TA-2 Report. Further investigation noted the voucher headquarters and corresponding reimbursements were proper, but the TA-2 Reports were incorrect.

Department management attributed the late submissions and the errors on the TA-2 report to competing work demands.

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Response: Accepted. The Department will file timely reports inclusive of the upcoming report for July 15, 2010 to the Legislative Audit Commission. The Travel Office has improved follow-up and communication with program offices on employee's headquarters designation. Given that the majority of those employees in question have home as headquarters, the Travel Office will improve verification that the home address is in compliance with the documentation submitted prior to completion of the TA-2 Reports to the Legislative Audit Commission.

Updated Response: Accepted. Forms are completed and submitted.

- 13. Revise cellular phone policy to address the current environment where the use of a cellular phone is such a necessity. Advise employees to utilize toll-free information numbers when searching for an unknown phone number, as a first resort, rather than calling "411". Additionally, determine if the monthly minute packages within the telecommunication contracts are sufficient for needs and remind employees of the package limits in order to avoid incurring additional charges. Finally, implement controls to verify cellular phones are not utilized for personal use. If employees are abusing the privilege of utilizing a State-provided cellular phone, obtain reimbursement for personal calls and take appropriate disciplinary action.**

Findings: The Department did not maintain adequate control over its Department-owned cellular phones, did not review all phone charges, and did not have a policy regarding calls for information services. During the audit period, the Department expended \$2,216,641 for telecommunications services. Its authorized wireless communication device (cellular phone) listing contained 292 cellular phone numbers. Auditors examined 15 detailed telecommunication billings and the usage of 25 employees assigned a cellular phone to determine if the Department adequately monitored cell phone activity and noted the following:

- Supervisors only review calls made by employees on Department-owned cellular phones if the employees exceed the monthly minute package. In the instances where employees exceeded their monthly package in the sample of 15 billing statements, employees inaccurately certified to supervisors that cellular calls for 1,311 minutes totaling \$168 were for State business when the calls were of a personal nature and the employee owed reimbursement to the Department.
- For the 25 employees tested who were assigned a cellular phone, nine exceeded their monthly minute package limit on at least one of the 15 detailed billings tested. The excess amount was 5,939 regular minutes and 478 roaming minutes. The Department incurred charges of \$1,012 above the established monthly package rates for these minutes. Management could not demonstrate they reviewed the

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volume of State business activity and considered the most cost effective package size.

- Auditors reviewed the detailed cellular phone activity for the employees in the sample for the time period September 1, 2008 through June 30, 2009, and noted instances in those ten months of employees not exceeding the monthly package limit, but making calls which appeared to be unrelated to State business. Specific examples include an accounting employee, whose job duties do not require significant weekend or evening telephone activity, generating 1,329 text messages during business hours and over 1,000 during evening and weekend hours during those ten months. Department management did not monitor or verify the nature of these calls because they did not receive this activity listing for review nor did they receive monthly logs of cellular telephone calls, as required by Department Cellular and Cordless Telephone policy.
- Auditors questioned several calls due to the duration, time of day, and destination of the call, i.e. employees repeatedly calling information at “411”. In response to the inquiries, the Department provided satisfactory explanations for all but 665 minutes totaling \$116 of these calls. The Department explained that it does not have a policy governing the use of “411” to inquire of an unknown phone number and, as such, employees are not prohibited from utilizing it. The Department stated the remaining unexplained calls were made by employees who are no longer with the Department.

Department management stated the cellular phone has become an accepted piece of office equipment and the employees assigned cellular phones are employees whose job responsibilities require them to be available for State business 24 hours a day, seven days a week or during evening hours or weekends for meetings, surveys, and inspections, etc. The employees’ use of cellular phones is necessary for the Department to adequately function. Department management believed its specific policies regarding the use of cellular phones are outdated and will need to be updated.

Response: Accepted. Department management has already met with a variety of office staff charged with monitoring phone billings to help determine best practices and recommendations for improving consistency and for strengthening our review procedures. The Department will revise its cellular phone policy to take into account these best practices and recommendations and to specifically address the issues identified in the finding. The policy will include required explanations for any 411 charges (as a last resort), texting, roaming charges, overages of any applicable monthly minute packages and calls made that are lengthy and/or placed at seemingly odd times of the week, including weekends. Regarding the employee highlighted in the finding, that employee has both been counseled and her phone privilege suspended and is no longer assigned a State cell phone.

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Updated Response: Implemented. Each department fiscal office is aware of the necessity of routine and comprehensive review of phone bills, both for land lines and department issued cell phones. A new and more stringent directive has been prepared and issued.

14. Implement procedures to ensure that all employees assigned a State-owned vehicle certify annually that they are duly licensed and carry the minimum required insurance, in compliance with the Illinois Vehicle Code. (Repeated-2007)

Findings: The Department did not obtain annual certifications of vehicle insurance coverage for employees who were assigned State vehicles during the examination period as required by the Illinois Vehicle Code (Code).

The Department's fleet consisted of 84 and 86 vehicles for fiscal year 2008 and 2009, respectively. Of those, 61 were personally assigned to employees in FY08 and 60 in FY09. Auditors tested 25 personally assigned vehicles to ensure the appropriate annual certification of vehicle insurance coverage was obtained by the Department during each fiscal year. The Department could not provide evidence that it obtained the annual certifications for any of the employees personally assigned vehicles for FY08.

Department personnel attributed this recurring weakness to the fact that no formal procedures have been developed to ensure compliance with the Code.

Updated Response: Accepted. Forms for Insurance Liability have been forwarded to each employee for completion. Additionally, upon hire, new employees must complete Insurance Liability Form to ensure compliance.

15. Comply with the various reporting requirements or seek legislative remedy for statutory mandate provisions. (Repeated-1997)

Findings: The Department did not adhere to various reporting requirements established by State law. Auditors noted the following:

- The Illinois Welfare and Rehabilitation Services Planning Act (20 ILCS 10/3 and 4) requires the Department to prepare and submit to the General Assembly a comprehensive plan providing for the best possible use of available resources for development of the State's human resources and the provision of social services by the Department. The plan is required to be submitted on the first Friday in April of each odd-numbered year, but was not filed.

Department personnel stated the report due in April 2009 was not submitted since the Department did not provide direct services as it did prior to the formation of the

Accepted or Implemented – continued

Department of Human Services. The language of the Act had not been modified and the Department remained responsible for the submission of this report.

- The Nursing Home Care Act (210 ILCS 45/3-804) requires the Department to report annually to the General Assembly the performance of its State long-term care facility licensure inspections, survey and evaluation duties and its actions in enforcement under this Act, including the number and needs of Department personnel engaged in such activities. The report due April 1, 2008 was filed on August 1, 2008, 122 days late, and the Department did not file the report due April 1, 2009 as of the completion of testing.

Department personnel stated that the submission of the Long Term Care Annual Report was late because the required data for the report was not fully complete by the April 1 deadline. Additionally, staff shortages did not allow staff to dedicate their time fully to the completion of the report in a timely manner. The Department intends to introduce legislation to change the submission date of the report to July 1.

- The Civil Administrative Code of Illinois (Act) (20 ILCS 2310/2310-372) requires a Stroke Task Force to be created within the Department of Public Health. Further, the Act requires the Stroke Task Force to submit an annual report to the Governor and the General Assembly by January 1 of each year. The report due January 1, 2008 was filed on December 15, 2008, 348 days late, and the report due January 1, 2009 had not been filed as of the completion of testing. The Department attributed the noncompliance to staffing and time constraints and other competing demands.
- The Civil Administrative Code of Illinois (20 ILCS 2310/2310-397) established the Prostate and Testicular Cancer Program within the Department and states, "...the Department shall submit an Annual Report to the General Assembly and the Governor." The Department did not file any reports during the previous examination period. The 2007 fiscal year report was submitted on January 16, 2008, 200 days after fiscal year end. The 2008 fiscal year report was not submitted until August 12, 2009, which is 43 days after fiscal year end. Department personnel stated the report was not filed timely due to staffing and time constraints and other competing demands.

Updated Response: Accepted and partially implemented. The Division of Governmental Affairs has submitted a legislative proposal (HB3155) to provide for the amendment to the Nursing Home Care Reform Act which will change the reporting requirement date to July 1st. Regarding annual reports, protocols involving the submission of General Assembly reports have been developed to require program staff to submit documents for review and approval at least 60 days in advance of the statutory due date in order to improve timeliness.

16. Issue licenses as required by the Youth Camp Act and properly maintain supporting documentation in a timely manner. (Repeated-2003)

Findings: The Department did not issue youth camp license renewals upon expiration of previous licenses as required by State law. Among other regulations, the Youth Camp Act (210 ILCS 100/5) requires the Department to inspect the youth camp before issuing any license. All licenses shall expire on December 31 of the year of issue and shall be reissued annually upon application. Also, a Camp cannot operate without obtaining a license by use of an application made at least 45 days prior to the opening date of the Camp.

During the examination period, 126 youth camps were in operation. Auditors sampled the licenses issued during the examination period of 25 youth camps, 12 in operation for the summer months only, 12 in operation year round, and one could not be determined. The documentation provided for the remaining 24 camps contained the following weaknesses:

- Two of the 12 year round camps were not issued a license for calendar year 2009, although inspections of those camps occurred and the camps were in operation during that period.
- Four of the 12 year round camps were issued renewal licenses one to 97 days after the expiration date of December 31, 2007.
- Auditors could not determine when the renewal license was issued for two of the 12 year round camps in calendar year 2008 because Department personnel could not provide the documentation, thinking it had been misfiled.

Department personnel stated that there were still several issues that impacted the youth camp licensing program and caused delays in licensing. In cases where an inspector found violations, the camp was given a period of time to correct the violations which caused the licenses to be issued a significant amount of time after the expiration of the previous license. In some instances, camp owners failed to properly execute the renewals, pay the appropriate fees or accommodate the Department's inspection, resulting in the license being issued after the expiration date. Additionally, Department personnel stated that due to staffing issues in the regional offices, annual inspections were sometimes out of sync with the licensure renewal resulting in licenses being issued before an inspection was performed.

Response: Accepted. The data system that has been initiated by the Division of Environmental Health has improved the issuing of licenses in a timely fashion as compared to audit findings in the past. Maintenance of the program's licensing files has been impacted by the lack of staff necessary to support ongoing operations. Letters requesting that applicants provide correct and timely changes to the information on file with the Department have been sent with the latest renewal applications. The Division will work to ensure that all facilities are properly licensed and regional staff will be reminded to verify

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that the facility is properly licensed during any inspections and to update the data system as necessary.

Updated Response: Implemented. The Division continues to work closely with the facilities to ensure that all are properly licensed and regional staff has been notified to verify whether the facility is properly licensed during any inspections and to update the data system as necessary.

17. Comply with the requirements of the Illinois Migrant Labor Camp Law by timely inspecting and licensing migrant labor camps in accordance with State law or seek legislative changes. (Repeated-2003)

Findings: The Department did not inspect migrant labor camps (30 days prior to occupancy) or issue corresponding licenses (15 days prior to occupancy) as required by the Illinois Migrant Labor Camp Law. During the examination period, the Department inspected 63 migrant labor camps. Auditors tested a sample of 16 migrant labor camps and noted the following:

- 14 of 16 migrant labor camps tested were not inspected 30 days prior to the date that the occupancy and use of the camp was to commence. Inspections were made between 12 days prior to and 167 days after the proposed date of camp commencement.
- 15 of 16 migrant labor camps tested were not issued a license 15 days prior to the proposed date of camp commencement. Licenses were issued between one day prior to and 171 days after the proposed date of camp commencement.
- Six of 16 migrant labor camps tested were issued licenses before being inspected by the Department.
- One of 16 (6%) migrant labor camps selected for testing could not be examined because the Department was unable to locate the migrant labor camp application.

As it indicated in response to this finding in previous examinations, the Department stated it often receives notification of the establishment of migrant worker camp locations with limited notice prior to occupancy and commencement of camp functions due to the fluid nature of migrant camp establishments. Further, management stated the law is outdated and does not reflect the current practice of using hotels rather than camps for migrant workers.

Updated Response: Accepted and partially implemented: For the 2011 legislative session, the Department has proposed a legislative initiative to amend the law (HB3155).

18. Comply with all aspects of the requirements of the Field Sanitation Act or seek statutory change. (Repeated-2003)

Findings: The Department did not assess fines to violators upon inspection of farm operations as required by the Field Sanitation Act. Auditors noted all seven field inspections tested during FY08 and FY09 did not include the required assessment of fines, of no less than \$100, even though violations were noted on the seven field inspections.

Department personnel believes the Department's ability to assess fines for violations has served as an effective mechanism to ensure that the violations are immediately corrected, often while the Department's inspector is still on site. Thus, in the Department's view, it has not been necessary to levy actual fines in this program. The Department states that it would use that authority if the violation poses a severe health risk.

Updated Response: Accepted. For the 2011 legislative session, the Department proposed, but was not successful in advancing a legislative initiative to amend the law with regard to classifying any violations and the fines associated with each. The violations are considered minor and often are corrected on-site during the field inspection.

19. Comply with the Civil Administrative Code of Illinois by conducting a nurse incentive program study for medically underserved areas in Illinois. Additionally, continue efforts to implement the nurse assistant incentive program developed based upon the study completed during the examination period. (Repeated-2007)

Findings: The Department did not comply with requirements in regards to the nurse incentive program for medically underserved areas as required by the Civil Administrative Code of Illinois.

The Civil Administrative Code of Illinois (Code) (20 ILCS 2310/2310-225) states, "The Department shall undertake a study to determine what incentives might be necessary to attract nurses to practice in medically underserved areas of Illinois...Based upon the results of this study, the Department may implement a nurse incentive program, subject to available appropriations." This Code became effective January 1, 2000. The Department has yet to conduct the study. Department personnel stated the statute provided no due date for completion of the study and was subject to appropriation.

Updated Response: Implemented: The final CNA Incentive Program Study was completed in April 2008. The report was submitted to the Illinois General Assembly at that time. The development of the IL Administrative Code and curriculum for the Career Ladder/CNA II training program was completed in November 2010.

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20. Timely fill the vacancies on the Home Health and Home Services Advisory Committee as required by statute. (Repeated-2007)

Findings: The Department did not comply with all of the requirements of the Home Health, Home Services, and Home Nursing Agency Licensing Act (210 ILCS 55).

The Act mandates the Director of the Department appoint a Home Health and Home Services Advisory Committee composed of 15 persons to advise and consult with the Director in the administration of the Act. The Committee was comprised of 13 members and did not include a representative from a private not-for-profit home health agency or an institution-based home health agency, positions which are defined within the Act. These positions have been vacant since December 2007.

Department personnel stated two members resigned during the examination period and the Department is actively seeking replacements.

Response: Accepted. The one vacant position representing institution based home health agencies was appointed effective March 15, 2010. The second position representing private non-for-profit home health agencies was forwarded to the Director's Office for approval.

Updated Response: Implemented: The Board vacancy for the position representing the private non-for-profit home health agencies was filled by Michael Bader. His term expires on 3-15-13.

21. Verify the existence of a written policy concerning the use of restraints during on-site visits to nursing homes or seek legislative changes to the Act; obtain the date the nursing homes requested background checks to verify timeliness of the request; ensure Criminal History Analyses are performed within 14 days of completed background checks and contain all required elements; maintain dates of on-site inspections of facility plan reviews and ensure the reviews are performed timely; and, provide timely written approval of the Department's final inspection of facility plans.

Findings: The Department did not comply with all provisions of the Nursing Home Care Act. Testing of provisions of the Act noted the following weaknesses:

- During the examination period, the Department performed 336 on-site visits of nursing homes and generated a written survey of the results of each visit. Auditors sampled 25 of the surveys to determine whether the Department ensured the nursing home had a written policy regarding the use of restraints and seclusion. In 24 of the 25 inspections, the Department did not ensure the nursing home possessed such a written policy.

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Department management stated that a policy and procedure review is an outdated approach for conducting nursing home certification surveys. Further, management stated the Department does not inquire if a written policy concerning the use of restraints and seclusion exists unless a problem concerning such use is noted during the on-site visit because Federal guidelines require this approach and observation of residents in restraints, which the Department believes is a more stringent requirement. However, there is no federal requirement for facilities to have written policies on restraints and seclusion; therefore, this requirement of the Act exceeds federal certification requirements. As a result, the Department is required to ensure each facility has a written policy on restraints and seclusion.

- The Department prepared 1,538 Criminal History Analysis reports during the examination period. Auditors sampled 25 of these reports and noted:
 - 25 (100%) did not contain the date that the nursing home requested the background checks.
 - Eight were not completed within 14 days of receipt of the completed background check. The delinquency ranged from four to 60 days after the background check was completed.
 - Six did not contain a consultation with the identified offender's assigned parole agent or probation officer.
 - 18 did not contain a review of the statement of facts, police reports, and victim impact statements.

Department management stated it relies on the nursing homes to track the date the background checks are requested and on an external vendor to provide the information relating to police reports, statements of facts and victim impact statements. The vendor also attempts to contact parole agents and probation officers. Department management further stated it is often not possible to obtain the required information within the time period allotted by the Act.

- The Department performed 27 facility plan reviews of completed construction projects during the examination period. Auditors sampled seven of these reports and noted:
 - Two contained inadequate documentation which prevented the auditors from determining whether an on-site inspection was completed timely.
 - One project had an untimely on-site inspection, 3 days after the deadline.
 - Four projects were not timely approved for occupancy in writing to the applicant within 5 working days of the Department's final inspection, ranging from 12 to 66 days late.

Response: Accepted. The Department will work with the Governor's Office and the General Assembly to modify the Nursing Home Care Act to change the outdated standard regarding restraints. The current survey process mandated by the federal government is

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resident based and outcome oriented. Direct observation regarding the application of restraints and the overall federal objective to minimize the use of restraints is the current standard. Simply stated, the quality of care standard, reviewing resident care versus the review of paper and procedures, is the current federal standards so the Department believes the State statutory requirement should be modified.

With respect to the criminal history analysis, in the past the Department never required the nursing home to send us the date they requested the background check. In late 2009 the cover sheet from the nursing homes which they send us with the background check was modified to include a field for “request background check date”. The cases identified that were late were in the initial years of the program. The Department has since instituted a system that calls for documenting why cases are late and a better tracking and monitoring system so we can flag cases that are due.

The program has had great difficulty getting information from the parole and probation officers. They have not always cooperated with our requests for information within the strict time frame that is necessary. We will continue to work with the parole and probation authorities to improve collection of parole information. It should be mentioned that it is only a small subset of the cases reviewed as the probation issue relates only to those identified offenders that are currently on parole and not older cases. Similarly, the program will continue to work with police agencies to improve response rates and timeliness. Many of the local police departments don't have electronic archives so with the older cases it is difficult for them to locate applicable information.

Lastly, regarding facility plan reviews of completed construction projects, the Department will ensure both timely reviews of health care facilities and timely written approval of final inspection facility plans.

Updated Response: Accepted and partially implemented. Regarding outdated standards regarding restraints, legislation was introduced in the Illinois General Assembly to remedy this issue (HB3155). The vacant clerical support position for the Facility Plan Review Unit has been filled and the logging and tracking of plan reviews, documents and surveys is being caught up.

Regarding the Identified Offenders Program, many of the issues cited were addressed immediately and others have since been addressed with the involvement of the Illinois State Police. In addition, a state law was passed (Public Act 96-1372) which adjusted timeframes and made other procedural updates to the program.

22. Perform inspections of establishments prior to issuing a certification of registration as required by the Act.

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Findings: The Department did not inspect tattoo and body piercing establishments prior to issuing certificates of registration as required by State law.

During the examination period, 138 certificates of registrations were issued to tattoo and body piercing establishments. Auditors sampled 25 certificates of registration issued during the examination period and noted the Department did not perform inspections of the establishments' premises for 22 of 25 prior to issuing a certificate of registration.

Department management stated the inspection portion of the tattoo and body piercing establishment program did not begin until November 2009 for many of the State's local health departments and certificates were issued to establishments in operation prior to enactment of the Act.

Updated Response: Implemented: The Department contracts with certified local health departments, which are responsible for inspections of body art establishments prior to the issuance of certification and follow-up on complaints received about establishments that are not certified. In those jurisdictions where the local health department has chosen to not participate in the program, the Department's regional Food and Dairies staff are responsible for inspections and follow up on complaints.

Emergency Purchases

The Illinois Purchasing Act (30 ILCS 505/1) states "The principle of competitive bidding and economical procurement practices shall be applicable to all purchases and contracts" The law also recognizes that there will be emergency situations when it will be impossible to conduct bidding. It provides a general exemption for emergencies "involving public health, public safety, or where immediate expenditure is necessary for repairs to State property in order to protect against further loss of or damage ... prevent or minimize serious disruption in State services or to insure the integrity of State records, or to avoid lapsing or loss of federal or donated funds. The chief procurement officer may promulgate rules extending the circumstances by which a purchasing agency may make 'quick purchases', including but not limited to items available at a discount for a limited period of time."

State agencies are required to file an affidavit with the Auditor General for emergency procurements that are an exception to the competitive bidding requirements per the Illinois Purchasing Act. The affidavit is to set forth the circumstance requiring the emergency purchase. The Commission receives quarterly reports of all emergency purchases from the Office of the Auditor General. The Legislative Audit Commission is directed to review the purchases and to comment on abuses of the exemption.

During FY08, the Department filed two affidavits for emergency purchases totaling \$138,020.00 as follows:

- \$104,700.00 to for tetanus vaccine for persons in flood-ravaged areas; and
- \$33,320.00 for an audit of the license test for plumbers.

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During FY09, The Department filed one affidavit for an emergency purchase totaling \$48,787.80 for H1N1 flu diagnostics.

Headquarters Designations

The State Finance Act requires all State agencies to make semiannual headquarters reports to the Legislative Audit Commission. Each State Agency is required to file reports of all its officers and employees for whom official headquarters have been designated at any location other than that at which official duties require them to spend the largest part of their working time.

The Department did not file a report at the end of FY09, but the report filed on January 14, 2009 indicated there were 428 employees assigned to locations other than official headquarters.