Compliance Plan
## Contents

Overview of Compliance Program 03
Scope of Compliance Issues 03
Compliance Program Authority 05
Key Components of the Compliance program 07
Chief of Compliance 10
Compliance Committee 13
Code of Conduct 15
Reporting and Investigative Process 16
Comprehensive Training & Education 17
Written Policies & Procedures 19
Annual Risk Assessment 20
Accessible Lines of Communication & Prompt Corrective Action 21
Internal Monitoring & Auditing 25
Enforcing Standards Through Clear Disciplinary Guidelines 27
Program Evaluation 29
Maintenance of Records 30
Auditor-Controller Fraud, Theft & Loss 31
OVERVIEW OF COMPLIANCE PROGRAM

The Department Behavioral Wellness Compliance Plan is designed with the intent of creating a process for ensuring the Department’s compliance with Federal and State health care statutes and regulations, Department and County policies & procedures, and the ethical treatment of clients and families in the areas of mental health services and substance use disorder programs. In addition to ensuring a robust and detailed Compliance Program, the Compliance Plan is also intended to serve as a means of advancing the values and guiding principles to which the Department adheres in its delivery of services to the community:

- Quality services for persons of all ages with mental illness and/or substance abuse
- Integrity in individual and organizational actions
- Dignity, respect, and compassion for all persons
- Active involvement of clients and families in treatment, recovery, and policy development
- Diversity throughout our organization and cultural competency in service delivery
- A system of care and recovery that is clearly defined and promotes recovery and resiliency
- Emphasis on prevention and treatment
- Teamwork among department employees in an atmosphere that is respectful and creative
- Continuous quality improvement in service delivery and administration
- Wellness modeled for our clients at all levels; i.e., staff who regularly arrive at the workplace healthy, energetic and resilient
- Safety for everyone

This Compliance Plan adheres to the program integrity requirements of the Department of Health Care Services’ Mental Health Plan and to the Drug-Medi-Cal Organized Delivery System. Together, these programs will be referenced in this Plan as the Behavioral Health Services Program. In addition, this Compliance Plan: abides by the requirements of Title 42 CFR Section 438.608; Section 6032 Deficit Reduction Act of 2005 (DEFRA); and the False Claims Act (31 USC Section 3729-3733). The Department Compliance Program ensures that the requirements of the Health Insurance Portability & Accountability Act (HIPAA), privacy expectations for Substance Use Disorder programs under 42 CFR Part 2, and where more stringent, State law requirements such as mental health privacy requirements pursuant to CA Welfare & Institutions Code section 5328, are followed.

Scope of Compliance Issues:

The scope of activities under the purview of the Compliance Program includes, but is not limited to, improper practices involving billing for services; soliciting, offering, or receiving kickbacks; conflicts of interest; improper service reimbursement; sharing of confidential information; engaging in behavior that falls within the ambit of fraud, waste and abuse; and unethical behavior on the part of the Department employees, temporary staff and contractors. Other areas of concern would include client
documentation abuses such as misrepresenting a diagnosis to justify payment; unbundling services; and falsifying medical necessity criteria, plans of treatment, and medical records to justify payment.

In addition, The Compliance Program has established sub-committees in the following areas to ensure that proper oversight and controls are in place:

1. **Documentation Sub-Committee**: focuses on the results from the monthly chart review monitoring, as well as addressing documentation issues, new forms, note review, and service disallowances.

2. **Safety & Risk Sub-Committee**: Clinic Safety Representatives meet to discuss safety concerns within their clinics, discuss safety training needs, develop safety drills, and discuss ways to minimize risk within the clinic settings.

3. **Privacy & Security Sub-Committee**: in collaboration with the Public Health Department, addresses operational issues around privacy and security compliance, including development of relevant policies and procedures.

4. **Policies & Procedures Sub-Committee**: provides a forum for discussion and amendment of new policies and procedures as well as older policies and procedures that require review and update, before review and action at the Compliance Committee meetings.

**PURPOSE:**

The Compliance Program is designed, and will be implemented and enforced, to promote the Department’s understanding of, and adherence to, the requirements of state and federal statutes and regulations as well as other requirements that are applicable to the Department’s business, and to detect, respond to, and prevent violations of those requirements. The Program’s design incorporates the nine elements that represent the industry standard for the scope of a Compliance Program:

1. Written standards, policies and procedures
2. Designated Compliance Officer with a High Level of Oversight and Delegation of Authority
3. Comprehensive Training & Education
4. Accessible Lines of Communication
5. Internal Monitoring & Auditing
6. Enforcing Standards through Clear Disciplinary Guidelines
7. Prevention and Prompt Corrective Action when Necessary
8. Conducting an Annual Risk Assessment
9. Program Evaluation

The Compliance Program will pursue the following goals and objectives:

1. Maintenance of a working environment that promotes ethical values, exemplary behavior and compliance with the letter and spirit of all applicable laws and regulations.
2. Development of a Program that encourages employees, temporary staff and contractor staff to demonstrate the highest ethical standards in performing their daily tasks.


4. Oversight of a disclosure system (e.g., telephone and e-mail Compliance Hotline) that requires the Department to respond to reports by employees or others of a suspected violation of law or regulation or the principles of the Program.

5. Identification of those situations in which the laws, rules and standards of state and/or federal programs or other applicable laws and regulations may not have been followed, and facilitation of the correction of any such practices.

6. Development and implementation of policies and procedures to ensure compliance with laws and regulations of the Medicare and Medi-Cal programs and other applicable laws and regulations.

7. Training and communication around those policies and procedures that ensures employees, temporary staff, and contractor staff understand and comply with state and federal laws and regulations as well as County and Department policies and procedures.

8. Assurance that compliance related documents are retained and kept secure, as required by state and federal law and regulation, for the appropriate length of time.

9. Monitoring and management of any potential conflicts of interest.

10. Establishment of disciplinary policies that are prompt, effective, and consistent and that will ensure that employees are disciplined based on the severity of the violation, and not on the basis of their position or tenure with the Department.

11. Assurance that government inspections and audits proceed in a smooth and professional manner and that all requests and concerns are addressed promptly and appropriately.

**OPERATIONS:**

1. **Compliance Program Authority**

   a) **Executive Oversight**

      The Department’s Executive Team, which has oversight responsibility for the Department, will provide strategic direction to the Compliance Program. The Chief of Compliance will provide operational updates and report on issues and concerns during the Executive Team’s regular meetings, during Leadership meetings, and more frequently when specific issues arise.

   b) **Chief of Compliance**

      The Department Chief of Compliance is delegated authority for development and day-to-day operation of the Compliance Program. The Chief of Compliance shall report directly to the Department Director and will have a working relationship with County Counsel, County Risk Management, and the Auditor/Controller’s Office.
c) Compliance Committee

The Behavioral Wellness Compliance Committee is a multi-disciplinary body composed of the administrative and clinical leadership of the Department. The Compliance Committee will assist the Compliance Officer in the operation, oversight, and evolution of the Compliance Program. The Compliance Committee shall meet monthly.

d) County Counsel, Risk Management, and the Auditor/Controller.

The Chief of Compliance will collaborate with County Counsel, Risk Management, and the Auditor/Controller on an “as needed” basis with respect to issues that arise in the operations of the Compliance Program.

e) The Director of Behavioral Wellness will approve additions to the Annual Work Plan.

f) Organizational Chart

2. Key Components of the Compliance Program
a) Chief of Compliance and Compliance Committee

The Chief of Compliance, with the assistance and support of the Compliance Committee, will be responsible for the development, operation, and general management of the Compliance Program.

b) Code of Conduct

The Department will establish a Code of Conduct, which will govern the proper conduct of the Department employees and will require all employees, temporary staff, and contractor staff to comply with the ethical and legal standards outlined in the Compliance Program.

c) Compliance Standards

The Compliance Program will establish standards, including policies and procedures, to facilitate adherence to applicable laws and regulations.

- The Chief of Compliance, in collaboration with the Compliance Committee, will conduct an annual Risk Assessment of the Department to identify those areas where there is a substantial risk for non-compliant conduct.

- The Chief of Compliance will ensure the development of compliance standards by responsible functional areas.

- Compliance standards will conform to the well-published standards pertaining to Santa Barbara County employees and their respective recognized employee organizations. These standards appear on the Santa Barbara County web site. Links to relevant memos of understanding appear at: [http://www.sbcountyhr.org/relations/mou/index.html](http://www.sbcountyhr.org/relations/mou/index.html)

- In addition, civil service rules governing Santa Barbara County employees may be found at: [http://www.sbcountyhr.org/staffing/csrules/index.html](http://www.sbcountyhr.org/staffing/csrules/index.html).

- The Chief of Compliance will ensure that the Department operates a comprehensive Privacy program and that staff are trained on privacy standards yearly.

d) Effective Reporting and Investigative Processes

The Chief of Compliance will establish a processes for the reporting and investigation of potentially non-compliant practices and conduct, as outlined in this Plan.

- Each employee will be responsible to notify his or her supervisor in a timely manner of any violations or suspected violations of the standards for ethics and legal conduct. As an alternative, an employee may follow the reporting procedure.

- A telephone and e-mail Compliance Hotline is available to all employees, contractors, or community members who wish to report actual or perceived violations of law, regulation, or applicable Department policies and procedures.
Employees will not be subject to reprisal, including discharge, demotion, suspension, threats, harassment, or discrimination for reporting, in good faith, any action that they suspect violates the law or established standards. Any employee engaging in an action of reprisal for any good faith reporting shall be subject to discipline and/or discharge.

e) Effective Training and Communication Programs to Alert Employees of Their Responsibilities

The Chief of Compliance has the general responsibility to oversee the development and implementation of employee communications and training programs to achieve adherence to the Compliance Program. The communication and training programs shall include the following areas:

- Identification of resources to provide effective compliance training and educational programs;
- Specific new employee orientation for the Compliance Program;
- Department-specific training and educational programs in identified high-risk areas and annual on-going trainings;
- Annual review of ethics and legal compliance issues via Code of Conduct training.

Employees will be informed that compliance with both the Department Code of Conduct and the requirements of the Compliance Program is a condition of employment.

f) Monitoring Compliance with Compliance Program Standards and Policies

- The Compliance Program will include monitoring systems designed to detect ethical or legal violations, and a reporting system whereby employees may report suspected violations of standards for ethical and legal conduct.

- The Chief of Compliance and Compliance Committee shall:
  
  (i) Identify monitoring required to verify adherence to and awareness of compliance policies throughout the Department;

  (ii) Conduct special audits as necessary to verify adherence to the Department compliance policies and procedures. These monitoring activities may include: 1) on-site visits; 2) interviews with personnel; 3) reviews of written materials and medical documentation; and 4) trend analysis studies.

g) Evaluation and Corrective Actions of the Compliance Program

The Compliance Committee will monitor the Program on an on-going basis. Through monitoring, the Chief of Compliance and Compliance Committee will ensure that the Program is evolving to meet the needs of the Department. Monitoring should include:

- identifying any areas where compliance efforts break down or pursuit of the nine elements is insufficient or inadequate; and
- Tracking changes in laws or regulations and modifying Department policies and procedures or business practices accordingly.
Based on the outcomes of monitoring, the Chief of Compliance and Compliance Committee will modify the Compliance Program as appropriate.

On at least an annual basis, the Compliance Committee will conduct a formal evaluation that demonstrates to the Executive Committee that:

- The Code of Conduct, policy statements and other written compliance communications were distributed to all targeted employees;
- All vendors or independent contractors have received compliance communications pertinent to them;
- All scheduled training has occurred;
- Internal reviews and monitoring have taken place for targeted risk areas;
- Violations or other problems identified in the review process have been addressed appropriately;
- Employees are being encouraged to report violations without fear of reprisal;
- The disciplinary process has been functioning as intended; and,
- The Compliance Program has been reviewed for possible improvements.

h) Creating an Annual Audit Plan

The Compliance Program’s Annual Audit Plan describes the activities to be implemented in the current year, in support of the Department’s overall Compliance Program. Items included in the Annual Audit Plans will be informed by the outcomes of the annual Risk Assessment process. The Audit Plan will track and monitor items on the Risk Assessment to ensure that areas of particular concern are being addressed and resolved as a means of improving the Department’s compliance efforts. The Audit Plan may include activities that will be tracked and monitored yearly with little modification, as well as, “one time” projects unique to that year.

The Compliance Audit Plan Report will document the completion of and summarize compliance activities, providing analysis where appropriate. The report will organize the supporting documents for each year’s compliance activities to ensure ready access to information as needed. The Audit Plan will be presented to the Compliance Committee for approval.
Chief of Compliance

The Department Chief of Compliance is delegated authority for the development, operation, and oversight of the Compliance Program. The Chief of Compliance reports directly to the Department Director and has a working relationship with the Office of County Counsel, County Risk Management and the Auditor/Controller.

PURPOSE:

A Chief of Compliance contributes to the fulfillment of the Department’s compliance commitment by planning, designing, implementing and refining the Compliance Program. This involves developing standards, coordinating compliance training and education, conducting or arranging internal audits, identifying compliance issues and trends, investigating and resolving compliance complaints and promoting an awareness and understanding of the positive ethical and moral practices consistent with the mission and values of the Department and those required by state and federal law.

QUALIFICATIONS:

The Department has established the following qualifications for the person holding the position of Chief of Compliance:

**Minimum Requirements**

- Five years of responsible experience in a supervisory, administrative, or managerial capacity working in any of the following areas: compliance, organizational development, quality management, quality control, including at least two years in a health care agency.

- Graduation from an accredited college or university with major course work in public administration, organizational development, and/or health care.

- Has a Juris Doctorate or has received certification as a Healthcare Compliance Professional from a National Certification Board.

- Has not been found to be in violation of any laws, regulations, or Department policies.

- Possesses values and principles that are representative of the Department.

- Understands, accepts, and embraces the principles to be achieved with a Compliance Program for the Department.

- Has a working clinical knowledge of mental health and alcohol and drug service delivery practices.

**The Ideal Candidate**

- Is knowledgeable in areas of compliance, organizational development, quality assurance, utilization management, and fiscal operations.
• Works collaboratively with other managers and employees to accomplish common goals

• Has excellent communication skills, both oral and written.

• Has the demonstrated ability to manage various projects and programs.

**DUTIES:**

The Chief of Compliance has the following responsibilities:

• In coordination with the Compliance Committee and Executive Team, designs and implements the Compliance Program;

• Reports to and advises the Department Director regarding compliance issues including regulatory, fiscal, operational and quality assurance matters;

• The Chief of Compliance participates as part of the Executive Management Team, but also stands apart from the Team to ensure that members of the Executive Team are held to the same standards as all Department employees with regard to complying with legal, policy, and ethical requirements;

• Chairs the Compliance Committee;

• Maintains a document control system for all reports and operations of the Compliance Committee including minutes of meetings, audit and monitoring reports, corrective actions, disciplinary actions, investigations, disclosures, government inspections, training and education activities;

• Facilitates development of compliance Code of Conduct Standards;

• Monitors and keeps current with laws, regulations, standards and organizational guidelines;

• Conducts an annual Risk Assessment with the Compliance Committee to highlight risk areas that guide the development of the Annual Work Plan.

• Develops, coordinates and participates in a multifaceted educational and training program that focuses on the elements of the Compliance Program and seeks to ensure that all appropriate employees are knowledgeable of, and comply with, pertinent state and federal standards;

• Assesses the need for additional training and education;

• Develops a structure that enables employees to report violations to the Compliance Program and/or to the Chief of Compliance, including effective use of a “Hotline,” without fear of reprisal;
• Arranges and coordinates internal audits for the purpose of monitoring and detecting non-compliance with applicable laws and Compliance Program requirements;

• Ensures that the system is adequately publicized and that allegations of non-compliance are investigated and responded to promptly;

• If any non-compliance is detected, ensures that it is investigated, a corrective action is developed and carried out, and that compliance is achieved and sustained;

• Works with Human Resources to ensure a workforce with high ethical standards, including the establishment of minimum standards for conducting appropriate background/reference checks on potential new employees;

• As appropriate, recommends disciplinary action for violation of standards;

• Monitors the effectiveness of the Compliance Program on a regular basis;

• In conjunction with the Compliance Committee, improves the Compliance Program on a continual basis and implements changes on an ongoing basis to improve the prevention/detection of any non-compliance, as well as to address changes in both the Department’s needs and State and Federal laws and regulations;

• Upon request, prepares an annual budget for Compliance activities, taking the Department’s resources into consideration.
Compliance Committee

The Compliance Committee will advise the Chief of Compliance and assist in the implementation of the Compliance Program.

PURPOSE:

The purpose of the Department Compliance Committee is to provide organizational support, create agency-wide awareness of the Compliance Program, and advise the Department Chief of Compliance, the Department Director and Executive Team on the development and implementation of the Compliance Program.

MEMBERSHIP:

The members of the committee shall be as follows:

- Chief of Compliance
- Medical Director
- QCM Psychiatrist
- Assistant Director
- Deputy Director for Administration and Operations
- Division Chief for Clinical Operations
- ADP Division Chief
- Information Technology Division Chief
- QCM Manager
- Informatics Manager
- Regional Managers
- Consumer Empowerment & Cultural Competence Manager
- Training Coordinator
- Policies & Procedures Coordinator
- Medical Records Administrator
- Patients’ Rights Advocate
- Department Privacy Officer
- Other QCM staff as assigned
- Ad hoc invited staff

DUTIES:

The members of the Compliance Committee are charged with the following duties and responsibilities:

- Have knowledge of, and receive updates on, the Department’s regulatory environment and legal requirements with which the Department must comply and identify specific risk areas through annual Risk Assessments;
• Stay up to date on existing Department policies and procedures; recommend policies and procedures for review and update; participate in the development and amendment of policies and procedures to ensure that changes in the laws or operations of the Department are addressed;

• Review and recommend Code of Conduct Standards, and other policies and procedures that promote adherence to the organization’s Compliance Program;

• Monitor communication methods and training programs to ensure that employees and affiliated professionals receive proper information about the Compliance Program, including their duties under it;

• Receive reports and determine the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as the Compliance Hotline and other fraud reporting mechanisms;

• Recommend a system to solicit, evaluate and respond to suspected cases of noncompliance;

• Monitor internal and external audits and other investigations for the purpose of identifying areas of risk and deficiency experienced by the Behavioral Health Services Program, and subsequently recommend appropriate corrective and preventive action;

• Consider how to create a culture of compliance through all functions of the Department, not just in those areas routinely associated with compliance operations (e.g., Code of Conduct; Hotline; concerns about fraud).

• Assign duties to individuals to ensure implementation of the Compliance Program.
**Code of Conduct**

**PURPOSE:**

The Compliance Program will ensure that there is an established Department Code of Conduct that is provided to all Department employees, temporary staff, and contracted providers. Each employee, temporary staff and contractor staff will be required to certify his or her acceptance of this Code as condition of ongoing Department affiliation. Code of Conduct training will be required annually.

**PROMOTING AWARENESS OF THE CODE OF CONDUCT:**

1. **Distribution:**
   
   a) A copy of the Code of Conduct will be provided to all employees and temporary staff of the Department at the time of their initial hiring and posted to the Behavioral Wellness web site.
   
   b) A copy of the Code of Conduct will also be furnished to all contractors, including all independently contracted health care providers, at the time a contract is entered into or renewed. Contractors are required to disseminate this Code of Conduct to all program staff and/or develop their own internal Code and related policy and procedure requiring adherence to the Code of Conduct.

2. Upon receipt and review of the Code of Conduct, employees shall certify their intention to abide by it on the attached form. These forms will be retained by the Department’s Training Program.

3. The Chief of Compliance will track the certifications via training participation made by employees and temporary staff and regularly report to the Compliance Committee regarding progress towards 100% certification by all staff.

4. The Code of Conduct will be available to all the Department employees, temporary staff and contracted providers through the Department’s website.

5. A sample acknowledgement form for the Code of Conduct is provided on the following page.
Acknowledgment Process

Behavioral Wellness requires all employees and temporary staff to sign an acknowledgment confirming they have received the Code of Conduct, understand it represents mandatory policies of Behavioral Wellness, and agree to abide by it. New employees and temporary staff are required to sign this acknowledgment as a condition of employment. Each Behavioral Wellness employee and temporary staff is also required to participate in annual Code of Conduct training. The Department’s Training Program will retain records of such training. New employees and temporary staff must receive a physical or electronic copy of the Code of Conduct within 30 days of employment.

Acknowledgment

I certify that I have received the Behavioral Wellness Code of Conduct. I understand it represents mandatory practices and policies of the organization, and I agree to abide by them.

____________________________________
Signature

____________________________________
Printed Name (as listed in personnel records)

____________________________________
Facility

____________________________________
Date
Comprehensive Training & Education

**PURPOSE:**

The Department will oversee a training program to support the ongoing education of Behavioral Wellness employees, temporary staff and contract providers regarding information and expectations of the Compliance Program, and to provide continuous updates on changing legal, regulatory, operational, and industry developments, as warranted to maintain an informed workforce.

**MINIMUM TRAINING REQUIREMENTS:**

Department employees and temporary staff will complete the following trainings within thirty days of commencing employment with the Department and then annually thereafter:

- HIPAA & Privacy Information
- Code of Conduct

Other mandatory trainings will include:

- Documentation Training/Medical Necessity Standards
- Cultural Competence
- Consumer and Family Culture
- Substance Use Disorder programs
- Cybersecurity

Other regularly offered trainings will include:

- Complaint/Grievance and State Fair Hearing Process
- Notices-of-Action for Beneficiaries
- Note Review
- Law & Ethics Updates
- Billing and Coding Procedures
- Specific trainings on the Department’s recently approved policies & procedures
- Additional training as identified

Trainings will be offered in person or through the electronic Relias Learning platform.
ADDITIONAL TRAINING FOR THE CHIEF OF COMPLIANCE

The Chief of Compliance will complete regular trainings on compliance related subject matters to stay abreast of legal updates and compliance trends. Training through a recognized compliance association is preferred.
WRITTEN POLICIES AND PROCEDURES

PURPOSE

The Department will oversee a Policy and Procedure Program that develops, reviews, approves and implements policies and procedures based on current laws and regulations, guidance from the State Department of Health Care Services, and that addresses operational changes within the Behavioral Health Services Program. Policies and procedures will provide guidance and direction to employees, temporary staff and contracted staff regarding performance expectations for Department operations.

OVERVIEW OF THE POLICY AND PROCEDURE DEVELOPMENT AND REVIEW PROCESS

1. The Office of Strategy and Quality Care Management, the Compliance Program, and various Department subject matter experts will notify the Policy & Procedure Program of the need to develop or amend a policy and procedure.

2. Policy & Procedure Program staff will work with subject matter experts and the Policy & Procedure Sub-Committee to draft and review the new or amended policy and procedure.

3. Clinical and administrative policy and procedures that are ready for review and approval will be placed on the agenda of the next monthly Compliance Committee meeting. The Compliance Committee may approve, deny, or suggest modifications to the draft policy and procedure, or may request input from other programs or committees. A policy and procedure that has been denied or returned for further modification will be brought back to the Compliance Committee for review and approval when ready. An approved policy and procedure then will be submitted to the Department Director for final review and approval.

4. Psychiatric Health Facility (PHF) policy and procedures that are ready for review and approval will be placed on the agenda of the next monthly Medical Practices Committee (MPC) meeting. The MPC may approve, deny, or suggest modifications to the draft policy and procedure, or may request input from other programs or committees. A policy and procedure that has been denied or returned for further modification will be brought back to the MPC for review and approval when ready. An approved policy and procedure then will be brought to the PHF Governing Board for final review and approval.

5. Policy and procedures that have been approved by the Compliance Committee and the PHF Governing Board will be submitted to the Director for final signature.

6. Approved policies and procedures will be publicized through the monthly Director’s Report; the Community Based Organization monthly meeting; regular Behavioral Health System of Care e-mail communications; and program level updates.

7. Policies and procedures that will have a significant impact on the Department’s employees and temporary staff will be uploaded onto the electronic Relias Learning platform for tracking of training completion.
ANNUAL RISK ASSESSMENT

PURPOSE:

Annually, the Compliance Committee will complete a Compliance Risk Identification Survey to identify, evaluate and prioritize the compliance risks the Department may face. All members of the Compliance Committee will participate in the Risk Assessment process. The objective of this process is to determine to which risks the Department is most vulnerable, and how well controlled those risks are. Once the highest risks are agreed upon by the Compliance Committee, the Chief of Compliance will add those risks to the Annual Audit Plan for mitigation and monitoring.

RISK ASSESSMENT PROCESS

1. In the beginning of the calendar year, the Chief of Compliance will distribute the Compliance Risk Identification Survey tool to all Compliance Committee members.

2. Compliance Committee members will have one to two months to complete the Compliance Risk Identification Survey tool and to submit their responses to the Chief of Compliance.

3. The Chief of Compliance will compile the responses from all Committee members and provide the compilation to the Committee as part of the next monthly Compliance Meeting packet.

4. The Committee will review and discuss the responses from fellow Committee members and will determine the top five to six risks, based on: the level of risk; the likelihood that the risk will impact the Department; potential liability for not mitigating the risk; and how the Department will mitigate the risk. The Committee will vote on the risk priorities that it wants to carry over to the Annual Audit Plan.

5. The Audit Plan will set forth specific processes the Department will take to mitigate the prioritized risks from the Risk Assessment process.
ACCESSIBLE LINES OF COMMUNICATION & PROMPT CORRECTIVE ACTION

PURPOSE:

The objective of the Compliance Hotline is to provide a mechanism for employees, temporary staff, and contractor staff to report any activity that may violate the Department Mission, Compliance Program, or state, federal or local law and regulations. The goal of the Compliance Hotline is to present opportunities for the identification, investigation, correction, and prevention of inappropriate activities.

As stated in the Code of Conduct, it is the Department’s expectation that every employee, temporary staff, and contracted staff will report any activity he or she reasonably suspects is in violation of laws, regulations, ethical standards, or the Department policies. The person need not be certain that the violation has occurred in order to report it. Reports can be made through the chain of command, directly to the Chief of Compliance or Compliance Program staff, or through the Compliance Hotline. Reporting enables the Chief of Compliance to investigate potential problems quickly and to take prompt action to resolve them.

Reports of violations may be made without fear of retribution and will be handled in a manner that protects the privacy of the reporter to the extent legally possible. The Compliance Hotline provides an alternative mechanism for individuals to report information about known or suspected non-compliance when the individual is uncomfortable using his or her chain of command, since reports can be made to the Compliance Hotline anonymously.

All Compliance Hotline reports will be evaluated promptly, thoroughly, and fairly by persons having a sufficient level of expertise and knowledge with regard to the issue presented by the reporter.

HANDLING A HOTLINE COMPLAINT:

If a Department employee, temporary staff or contractor staff suspects that a law, regulation, ethical standard, or policy is being violated, he or she is encouraged to communicate the issue using the normal chain of command. If he or she feels uncomfortable talking to the direct supervisor, he or she should voice the concern to the next supervisory level, up to and including the highest level of management. If the staff member does not wish to report a compliance concern through the normal chain of command, the concern can be reported through the Compliance Hotline:

- (805) 884-6855; or
- through the e-mail Compliance Hotline, which can be accessed through the Behavioral Wellness.org County web page, at http://www.countyofsbc.org/behavioral-wellness/compliance.sbc.

1. Structure

   a) The Compliance Hotline is supported by the Compliance Program staff with backup from the Quality Care Management staff.
b) The Compliance Hotline is available 24 hours a day, seven days a week. Calls received will be responded to within 2 business days of receipt.

c) Every reporter has the option to remain anonymous; the caller’s phone number is not identified or traced and the e-mail reporting form does not require inclusion of contact information.

d) Reports to the Compliance Hotline are treated as confidential and private.

e) Retaliation against those who submit a Compliance Hotline report will not be tolerated. The Compliance Program will coordinate with the Department’s Human Resources program to ensure that no person will be subject to any adverse action because of a report he or she made due to an honest belief that a compliance violation was occurring. However, if the subsequent investigation reveals that the reporter intentionally made up, exaggerated, or otherwise distorted a report of wrongdoing – whether to protect himself or herself or to hurt someone else – the reporter will not be afforded this level of protection.

2. Calling/Reporting

a) Upon receipt of a report, Compliance Program staff will log the communication. To the extent made available by the reporter, the following information will be documented on the Compliance Hotline Log.

- Date of the call
- Clinic, program or service where the activity is occurring
- Any relevant information concerning the allegations
- Name of caller (unless anonymity is preferred)
- Contact phone number for caller (unless anonymity is preferred)

Phone calls to the Compliance Hotline must be logged. E-mail communications may be maintained in an e-mail file.

b) If the communication is a suggestion or general inquiry, the information will be referred to the appropriate Department clinic, program or service, and an annotation reflecting this referral will be made in the log.

3. Follow-Up & Investigation

a) After receipt of the communication, the Chief of Compliance or designee will document the relevant information, and identify the management team for the division, program or service identified in the communication.

b) For cases where an identified reporter has left a voice or e-mail message with contact information, the Chief of Compliance or designee will contact the reporter within two business days from the date of receipt of the report to confirm receiving the communication.

c) The Chief of Compliance or designee will review the initial intake information on the log or e-mail and determine if additional information is necessary to develop an investigative plan. If the call falls into the category of “fraud, theft and loss of property” as defined by the Auditor-Controller’s Policy (effective 12/31/2011 and attached to this Compliance Plan), the Chief of Compliance will contact the Auditor-Controller’s office and follow that policy and procedure. The
Chief of Compliance will also contact the Department of Health Care Services at the numbers specified through current State-County contracts in cases where the fraud, waste and abuse is related to the Medi-Cal mental health program or Substance Use Disorder Organized Delivery System.

If the call does not fall into this category, and additional information if required, the Chief of Compliance will contact the reporter if known. If the communication is anonymous, the Chief of Compliance or designee will evaluate the communication to determine if the case can be investigated without obtaining additional information. If the Chief of Compliance or designee determines that an anonymous call cannot be investigated without additional information, the case will be reviewed by the Executive Team for determination of appropriate action.

d) The Chief of Compliance or designee will review the information reported and determine what issues must be addressed to resolve the matter. As part of this process, the Chief of Compliance or designee may elect to consult with responsible management or other subject matter experts, as appropriate. In addressing the issues raised by the report, the Chief of Compliance or designee should consider broad policy issues raised by the matter, and not just the allegations raised by the reporter in the specific instance. If there is any doubt as to the appropriate questions to be answered or if the case raises unusual or especially troubling issues, the Chief of Compliance will coordinate with the Department Director and/or County Counsel.

e) For calls not covered by the Auditor-Controller’s policy “Santa Barbara Fraud, Theft, and Loss Policy,” investigators external to the Department will be included after consultation with the Director and the Department’s Human Resources program, as appropriate.

f) The Chief of Compliance or designee will establish an investigation plan that estimates the necessary amount of time to allow for the investigation, which ordinarily should not exceed 30 days.

g) Under ordinary circumstances, the management of the clinic, program or service will be informed of the investigation. However, if it appears that management at the clinic, service or program may be implicated in the matter, notification of such management only will be made after further evaluation by the Department Director, or County Counsel if appropriate. Prior to determining the appropriate personnel to assist in conducting the investigation, the Chief of Compliance or designee will consider the level of resources available to the Department. On occasion, a multi-disciplinary team will be appropriate.

h) The Chief of Compliance will consider the following guidelines:

- Investigations of quality care issues should be coordinated with the Quality Care Management program;
- Investigations of employee relations matters should be coordinated with the Department’s Human Resources program;
- Other County staff will be utilized as appropriate.

i) The Chief of Compliance or assigned investigator will develop a detailed investigative plan, interview appropriate personnel, and review available documents. The results of the investigation will be documented. At the end of the investigation, the Chief of Compliance will determine whether the report is substantiated.
j) The Chief of Compliance will develop an appropriate corrective action plan based on the investigation findings. If disciplinary or more serious corrective action is necessary, the Chief of Compliance will coordinate with the Department’s Human Resources program, the Director, and County Counsel as appropriate. The Chief of Compliance will communicate with the management of the clinic, program or service about the substantiated findings of the investigation and the corrective action plan that has been developed.

k) The corrective action plan will be carried out as documented.

l) For investigations in which the disciplinary and/or corrective action has been completed, as well as for all unsubstantiated cases, a closeout report will be generated that describes the allegations and facts of the case, investigative approach and result, conclusions, and disciplinary or corrective action as appropriate. This memorandum may be generated by the Chief of Compliance or the individual that conducted the investigation.

m) For unsubstantiated cases, the Chief of Compliance will use best efforts to contact the Compliance Hotline reporter and the appropriate management of the clinic, program or service to communicate the closeout of the case. In providing information to the management of the clinic, program, or service, the Chief of Compliance will share that the report was not substantiated, but will not identify the reporter or any particular facts that could divulge the identity of the reporter.

4. Oversight

a) The Chief of Compliance will make regular reports to the Compliance Committee and Department Director on communications to the Compliance Hotline, and if appropriate, Investigations and Corrective Action Plans underway, as well as final outcomes.

b) Reports will be adjusted for attorney-client privileged information, as well as the confidential nature of specific investigations and corrective action plans.
Internal Monitoring & Auditing

PURPOSE:

To ensure that the Compliance Program is effective and the Department’s performance complies with legal and regulatory requirements and its policies & procedures, the Department will monitor the activities of its own programs and those of its contract providers that are subject to regulatory requirements, and the findings will be routinely reported to the Compliance Committee, the Department Director, and the Executive Team. The Department Compliance Program will coordinate with other Department programs to perform internal reviews to investigate indications of non-compliance revealed by monitoring activities, the Compliance Hotline and other sources.

MONITORING AND AUDITING PROCESS:

1. Reviews will be conducted to measure the Department’s compliance with programmatic areas such as, but not limited to, the following:

   - Exclusion Lists
   - Compliance Hotline
   - Compliance Education
   - Medical Necessity Determinations
   - Assessment and Treatment Plan Reports
   - Progress Notes and Note Review
   - Full Service Partnerships
   - Billing and Coding
   - Site Certification
   - Clinical Staff Licensure
   - Psychiatric Health Facility admissions and Lengths Of Stay

2. Additional reviews will be conducted to investigate specific concerns identified within the Department and those that may be identified by an outside agency, whether Federal or State.

3. Reports created as a result of these reviews present the opportunity to specifically address concerns arising in areas such as documentation, client services and billing.

   As an example, the Department’s regular chart review process focuses on general documentation compliance and provides an opportunity for program leaders to address issues worthy of a more in depth exploration. The standards for this review process include:

   - Direct examination of individual charts and trend issues identified by documentation reports.
   - Review by Utilization /Quality Care Management staff will result in findings being reported to Clinical Supervisors, Regional Managers, and senior administrative staff at the Clinical Documentation Sub-Committee.
   - Findings that indicate services have been billed, claimed, or documented in error will result in recommendations to the Chief of Compliance and the Fiscal program that the following occur: remedial trainings, claim reversals or cost report adjustments.
4. Monitoring techniques and review processes may include:

- Site visits;
- Sampling protocols that permit the Compliance Committee to identify and review variations from an established baseline;
- Unannounced audits and investigations;
- Examination of the Department's complaint and grievance logs;
- Interviewing personnel involved in management, operations, coding, claim development and submission and other related activities;
- Developing questionnaires to solicit impressions of a broad cross-section of the Department's employees and staff;
- Reviewing written materials and documentation prepared by the different divisions of the Department; and
- Trend analyses, or longitudinal studies, that seek deviations, positive or negative, in specific areas over a given period.

5. Specific monitoring tools include, but are not limited to:

- Medical Necessity Documentation
- Cases identified through Compliance Hotline or HIPAA Privacy notifications
- Cases identified by Incident Reports
- Training attendance reports
- Grievance reports
- Acute hospital days
- Inpatient Administrative days
- Other reports developed as indicated

6. Variations from compliance standards and cases of non-compliance will be documented and reported to the Chief of Compliance for follow-up and possible investigation to determine the cause of the deviation.

7. The Chief of Compliance will be responsible to carry out or delegate to appropriate staff the development and implementation of any corrective action plans. Corrective action plans also will be shared at Compliance Committee meetings, as appropriate.

8. Reports from ongoing monitoring efforts will be maintained by the Chief of Compliance and reviewed with the Director, the Executive Team, and the Compliance Committee.
Enforcing Standards Through Clear Disciplinary Guidelines

PURPOSE:
Detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of the Department. The Compliance Program will ensure that detected misconduct is promptly investigated and corrective action is carried out responsively and responsibly.

Upon report or reasonable indication of suspected noncompliance, the Chief of Compliance or designee will promptly investigate the conduct in question to determine whether a material violation of applicable law, rule, regulation, or Department policy & procedure has occurred.

If the complaint or report indicates that it involves the Auditor-Controller’s Policy regarding “Fraud, Theft and Loss “(dated December 2011 and attached to this Compliance Plan), the Chief of Compliance or designee will immediately follow the outlined Policy and Procedure. Cases involving fraud, waste and abuse related to the Medi-Cal mental health programs or Substance Use Disorder Organized Delivery System also require the Chief of Compliance to contact the Department of Health Care Services at the numbers specified through current State-County contracts.

DETERMINING WHETHER A VIOLATION HAS OCCURRED

1. Alleged violations may be detected through one of several means:
   - Compliance Hotline;
   - Employee reports to supervisor, who then reports through appropriate chain of command and/or to the Chief of Compliance or designee;
   - Routine monitoring/review of processes and related reports;
   - Ad hoc audits and self-assessments.

2. Depending upon the nature of the alleged violations, an internal investigation may include:
   - Interviews;
   - Review of relevant documents;
   - Research of regulations, contracts, literature, other background information (memoranda, policies and procedures, etc.);
   - The assistance of Risk Management, Auditor-Controller or County Counsel.

3. If an investigation of an alleged violation is undertaken and the Chief of Compliance believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those individuals will be placed on leave from their current work activity until the investigation is completed.

4. Records of the investigation will contain documentation of the alleged violation, a description of the investigative process (including the objectivity of the investigators and methodologies utilized), copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, and the results of the investigation (e.g., any disciplinary action taken and any corrective action implemented).
5. The Chief of Compliance will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

**TAKING CORRECTIVE ACTION**

1. The Chief of Compliance will work with the appropriate County staff to take or direct appropriate corrective action, including prompt identification of any overpayment, and imposition of proper disciplinary action, where applicable, in accordance with the County’s standards of disciplinary action, the *Civil Service Rules*. Pursuant to the *Civil Service Rules*, disciplinary action may be taken against employees for such acts as:

   - Willful or negligent violation of the provisions of the *Civil Service Rules*, or other applicable written and published Departmental rules and policies.
   - Inefficiency, incompetence, or negligence in the performance of duties, including failure to perform assigned tasks or failure to discharge duties in a prompt, competent, and responsible manner.
   - Careless, negligent, or improper use of County property, equipment, or funds, including use for private purposes or involving damage or risk of damage to property.
   - Bribery or other unlawful gifts or gratuities.
   - Unauthorized release of confidential information from official records, as defined by law.
   - Conviction of a crime which relates to the qualifications, functions, or duties of the employee’s position.
   - Falsified job information to secure a position.

“Disciplinary Action” as defined in the *Civil Service Rules* means dismissal, suspension, disciplinary demotion, reduction in salary, disciplinary probation, or formal written reprimand. *See County Civil Service Rules*, [https://countyofsb.org/hr/civil-service-rules/rules.sbc](https://countyofsb.org/hr/civil-service-rules/rules.sbc). Immediate removal may be appropriate in instances where the employee’s conduct is of such a nature that removal is necessary to avert harm to the County or to the public. *Civil Service Rule* 1205.

2. If it is determined that the violation was caused by improper procedures, misunderstanding of rules or system problems, the Chief of Compliance will work with the Department’s Executive Team to take prompt steps to correct the problem.

3. At the conclusion of any investigation, the Chief of Compliance will review the circumstances that formed the basis for the investigation to determine whether there is potential for similar problems to arise in the future. The Chief of Compliance will recommend modifications to Department operations as necessary to detect and prevent other inappropriate conduct or violations from occurring in the future.

4. The Chief of Compliance will keep the Department Director apprised of the progress of investigation, relevant findings, and provide recommendations for corrective action.
Program Evaluation

**PURPOSE:**

The Chief of Compliance will work with the Compliance Committee at the beginning of each fiscal year to discuss the effectiveness of the Compliance Program and whether new strategies and approaches should be implemented to advance the goals of the Program. Approaches to evaluate the Program may include:

1. Modifying the structure of Compliance Committee meetings;
2. Adding or removing issues reviewed at the meeting;
3. Conducting surveys of the Department employees and contract provider staff, and
4. Seeking feedback from leadership outside of the Compliance Committee members.
Maintenance of Compliance Records

PURPOSE:

The Compliance Program receives and generates a substantial volume of documents, and other information, in both electronic and hardcopy format. Certain records must be maintained for given periods of time specified by applicable laws/regulations or by contractual obligations. Other records should either be retained or destroyed according to a standard policy.

The Chief of Compliance will maintain and dispose of compliance related records in accordance with applicable statutes and regulations; additional records may be maintained as necessary to support the Department’s Compliance Program.

RECORD RETENTION GUIDELINES:

1. The Compliance Office will retain records that may substantively affect the obligations of the County. Records maintained in the Compliance Office include:
   - Compliance Hotline reports and worksheets
   - Policy memoranda and other communiqués
   - Meeting records (agendas, minutes, etc.)
   - Reports to the Compliance Committee
   - Corrective Actions and their resolutions
   - Results of auditing and monitoring activities

2. Records will be secured to protect employee and patient privacy rights, as well as Departmental proprietary information. These records will be maintained in a secure area and within locked cabinets. Access to compliance records will be controlled by the Chief of Compliance or designee.

3. All records will be maintained for the minimum period required by applicable state or federal laws and regulations.
POLICY

Policy to provide direction on Fraud, Theft, and Loss for the County of Santa Barbara

1.1 Purpose

The purpose of this policy is to affirm the Board of Supervisors' commitment to maintain a tone of integrity throughout the County, increase management's focus on anti-fraud controls, decrease County losses, and increase the efficiency and results of investigations of fraud, theft, and loss.

1.2 Authority

1.2.1 American Institute of Certified Public Accountants

The American Institute of Certified Public Accountants' audit standards recommend that organizations consider certain best practices to reinforce a strong ethical culture.

1.2.2 Santa Barbara County Board of Supervisors

Resolution No. 11-432

The Board of Supervisors affirms its commitment to maintain a tone of integrity throughout the County, increase management's focus on anti-fraud controls, decrease County losses, and increase the efficiency and results of investigations of fraud, theft, and losses. In addition, the Board desires to adopt policies and procedures as recommended by the Auditor-Controller, for reporting acts that are considered to be fraudulent and to set forth the steps to be taken when fraud or other related dishonest or inappropriate activities are suspected.

1.3 Definitions

1.3.1 American Institute of Certified Public Accountants

A national professional organization of Certified Public Accountants (CPAs). It sets ethical standards for the profession and U.S. auditing standards for audits of private companies, non-profit organizations, federal, state and local governments.

2.1 Attachments and Historical Documents

2.1.1 Fraud, Theft, and Loss Policy
2.1.2 Board Letter
2.1.3 Resolution 11-432

Subject: County of Santa Barbara Fraud, Theft, and Loss Policy
Responsible Department: All Departments Original Policy: 12/11

November 2019 Revision
Purpose: The purpose of this policy is to affirm the Board of Supervisors’ commitment to maintain a tone of integrity through the County, increase management’s focus on anti-fraud controls, decrease County losses, and increase the efficiency and results of investigations of fraud, theft, and loss.

Scope: This policy applies to any irregularity, or suspected irregularity involving employees, consultants, vendors, contractors, interns, volunteers, outside agencies, districts with funds in the County Treasury, and/or any other parties with a business relationship with the County. It will deal primarily with any loss occurring as the result of fraud, theft, or loss of a county asset as opposed to accidental damage to or destruction of an asset that would be handled through normal Risk Management channels. In addition, this policy assigns responsibility for the development of adequate internal controls and performance of investigations related to fraud.

Fraud may be defined as any intentional act or omission designed to deceive others, resulting in the County suffering a loss and/or the perpetrator achieving a gain.

- The terms defalcation, misappropriation, and other fiscal irregularities may refer to, but are not limited to:
  - Any dishonest or fraudulent act.
  - Forgery or alteration of any document or account.
  - Forgery or alteration of a check, bank draft, or any other financial document.
  - Misappropriation of funds, securities, supplies, or other assets.
  - Impropiety in the handling or reporting of money or financial transactions.
  - Accepting or seeking anything of material value from contractors, vendors, or persons providing services/materials to the County.
  - Destruction, removal, or inappropriate use of records, furniture, fixtures, and equipment; and/or use of those assets for private or personal gain.
  - Authorizing or receiving compensation for hours not worked.
  - Misrepresenting financial operating results to obtain funding.
  - Any similar or related irregularity to those specified above.

If there is any question as to whether an action constitutes fraud, contact the Internal Audit Division of the Auditor-Controller’s Office for guidance.

Losses of County property, including cash, arising from any circumstance, must also be reported under this policy. Cash shortages occurring as part of cashiering operations should be reported in accordance with the County’s Cash Handling Manual.

Policy: Santa Barbara County Administration and all levels of management are responsible for the detection and prevention of fraud, defalcation, misappropriation, and other fiscal irregularities. Management should be familiar with the types of improprieties that might occur within his or her area of responsibility, and be alert for any indication of irregularity.
It is the policy of this County to protect and safeguard the money and assets placed in its trust by the public to the best of its ability. This responsibility extends to each of its employees. The County of Santa Barbara has a zero tolerance for fraud. Any individual that is found to have engaged in fraudulent activity, as defined by this policy, is subject to disciplinary action by the County, including dismissal and prosecution by appropriate law enforcement authorities.

**REPORTING RESPONSIBILITIES AND PROCEDURES:**

Fraud that is detected or suspected must be reported immediately and simultaneously to a direct supervisor and the Internal Audit Division of the Auditor-Controller’s Office. If the immediate supervisor is suspected as being a party to the improprieties or irregularities, the next higher supervisor should be informed.

**Welfare Fraud** involves theft of County funds by welfare recipients, or theft of their benefits by others. Those cases should be referred directly to the District Attorney’s Welfare Fraud Division.

**Workers’ Compensation Fraud** involves knowingly false or fraudulent statements of any fact relative to workers’ compensation payments and costs. Those cases should be referred directly to the District Attorney’s Workers’ Compensation Fraud Division.

Fraud not included in the above two types but involving COUNTY funds or committed by COUNTY employees, vendors, contractors, etc. This includes the misuse of County credit cards for purchase of personal items or use of fuel in personal vehicles as well as submitting fraudulent travel and or expense claims. These should be handled in accordance with the procedures stated below.

**Theft or the loss of cash or assets** shall also be immediately reported to the Internal Audit Division of the Auditor-Controller’s Office.

**INVESTIGATIVE RESPONSIBILITIES AND PROCEDURES:**

Any irregularity that is detected or suspected **must** be reported immediately to the Internal Audit Division of the Auditor-Controller’s Office who will coordinate the investigation with the District Attorney’s Office and/or appropriate law enforcement.

The Internal Audit Division of the Auditor-Controller’s Office, in conjunction with the District Attorney’s Office (if necessary), shall evaluate suspected fraud and initiate any necessary investigative activity without regard to the suspected wrongdoer’s length of service, position/title, or relationship with the County.

*It is NOT the responsibility of the employee or the supervisor to investigate the allegations.* In fact, any attempts to do so may damage the validity of the review/audit/investigation. *It IS the responsibility of that individual to forward the allegation to the next level of management and to the Internal Audit Division of the Auditor-Controller’s Office.*

The Auditor-Controller’s Office will coordinate all investigations with the District Attorney, law enforcement agencies, and other appropriate agencies. In instances where an individual directs the internal or external activities of an agency or department, the allegations will be referred to the next level of management and appropriate law enforcement.
enforcement agencies, County Counsel, Risk Management, Human Resources, and other affected Departments or agencies (both internal and external) as needed.

**AUTHORIZATION FOR INVESTIGATING SUSPECTED FRAUD:**
Where there exists reasonable cause, and to the extent permitted by law, the Auditor-Controller’s Office is authorized upon the initiation of a review, audit, or investigation, and after consulting with appropriate management personnel, to have free and unrestricted access to all County records and premises, whether owned or rented.

Employees are required to cooperate during any review, audit, or interview when asked questions. In the event that they believe they are suspect and express a desire for representation, interviews of that individual will only continue by the Auditor-Controller’s Office in coordination with other Departments.

**CONFIDENTIALITY:**
During the investigation, members of the investigation team shall maintain the confidentiality of information received. Upon conclusion of an investigation, results will be made available as allowed by law. A report of losses and disposition will be provided to the Board of Supervisors on an annual basis.

**PREVENTION:**
Internal controls are a coordinated set of policies and procedures that reflect a comprehensive strategy for achieving management objectives. Internal controls to prevent fraud should be established by Departments. Departments should review the County’s policies and procedures including, but not limited to, travel, the FIN manual, payroll, and cash handling guidelines to ensure that they are incorporated into Departmental policies and processes. The Internal Audit Division of the Auditor-Controller’s Office is available to assist Departments in reviewing processes for adequate internal controls.
Board of Supervisors

Agenda Letter

Clerk of the Board of Supervisors
105 E. Anapamu Street, Suite 407
Santa Barbara, CA 93101
(805) 568-2240

Agenda Number:

Department Name: Auditor-Controller  Department No.: 061
For Agenda Of: 12/13/2011  Placement: Departmental  Estimated Time: 10 minutes
Continued Item: No  If Yes, date from: Vote Required: Majority

To: Board of Supervisors

From: Department Director(s)  Contact Info:
Robert W. Geis, CPA, CPFO (x2100)
Heather Fletcher, CPA, CFE* (x2456)
*Certified Fraud Examiner

Subject: Fraud, Theft, and Loss Policy

County Counsel Concurrence Auditor-Controller Concurrence
As to form: Yes  As to form: N/A

Other Concurrence: N/A  As to form: N/A

Recommended Actions:
a). Adopt the attached Resolution Adopting the County of Santa Barbara Fraud, Theft, and Loss Policy.

Summary Text:

Due to accounting scandals, the American Institute of Certified Public Accountants (AICPA), promulgated new auditing standards to recommend that organizations consider certain best practices to reinforce a strong ethical culture. Over the past few years, predominately due to economic conditions, an increased number of reports of stolen County property have been made to the Auditor-Controller. To reaffirm the Board of Supervisors’
commitment to maintain a tone of integrity through the County, increase management’s focus on anti-fraud controls, decrease County losses, and increase the efficiency and results of investigations of fraud, theft, and loss, we recommend that the attached policy be adopted by your Board.

**Background:**

Section 316 of the Auditing Standards promulgated by the AICPA, *Consideration of Fraud in a Financial Statement Audit*, emphasizes the responsibility of governments to design and implement systems and procedures for the prevention and detection of fraud and for ensuring a culture and environment that promotes honesty and ethical behavior. The Government Finance Officers Association recommends that every government establish a policy to encourage and facilitate the reporting of fraud or abuse and questionable accounting practices.

Page 2 of 3

Santa Barbara County Administration and all levels of management are responsible for the detection and prevention of fraud, defalcation, misappropriation, and other irregularities. Fraud may be defined as any intentional act or omission designed to deceive others, resulting in the County suffering a loss and/or the perpetrator achieving a gain. Management should be familiar with the types of improprieties that might occur within his or her area of responsibility, and be alert for any indication of irregularity.

The Association of Certified Fraud Examiners (ACFE), the world’s largest anti-fraud organization, publishes a Report to the Nations on Occupational Fraud and Abuse (the Report). According to the 2010 Report, the median cost of fraud in government was $100,000 per scheme. Although the loss is low compared to other industries, it is second in frequency only to the banking and financial services industry.

During calendar year 2010, an increased number of losses were reported to the Auditor-Controller’s Office. Specifically, 12 incidents, including seven cash losses, were reported. In previous years, Departments only reported one or two incidents per year. In observing Departmental processes, we noticed differences in communication of suspected fraud upward to management and coordination between necessary Departments.

The Board of Supervisors adopted a resolution pursuant to Government Code Section 26883. Resolution 21387 requires that the Auditor-Controller audit the books, accounts, money and securities of any Department, office, board, or institution under its control and of any district whose funds are kept in the County Treasury. The Auditor-Controller’s report on any such audit shall be filed with the Board of Supervisors and the District Attorney.

It is important to define the roles in investigation to properly coordinate and overcome inconsistencies, duplication of efforts, and a lack of communication between parties. So that an investigation is not jeopardized, it is extremely important that Departmental staff not attempt to self-conduct internal investigations. Instead, Departmental management and the Auditor-Controller’s Office should be immediately notified when a suspected theft occurs. Utilizing a consistent process to assemble an investigation team will ensure that the proper individuals are involved to achieve the outcome most beneficial to the County and its constituents. In the recommended policy, the Auditor-Controller’s Office, Internal Audit Division, and the District Attorney’s Office are responsible to lead and coordinate the investigation. The attached flowchart depicts Internal Audit’s anticipated coordination of resources.

Public reporting of losses shows that a government is transparent and accountable to its constituents. Governments that publicly report fraud, how it occurred, and steps taken to deal with the issue, are far more credible than if it is not reported at all. Furthermore, reporting serves as a mechanism to deter and prevent future fraud occurrences. As part of the recommended process, a report of investigated losses will be provided to the Board of Supervisors on an annual basis.

**Performance Measure:**

Provide auditing services to minimize internal control risks and County losses.

**Fiscal and Facilities Impacts:**
Budgeted: Yes

**Fiscal Analysis:**
N/A

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Page 3 of 3

**Staffing Impacts:**
N/A

**Special Instructions:**
None

**Attachments:**
Resolution Adopting the County of Santa Barbara Fraud, Theft, Loss Policy County of Santa Barbara Fraud Policy Fraud Reporting Flowchart Loss of Public Property Report

**Authored by:**
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**cc:** Chandra Wallar, County Executive Officer Joyce Dudley, District Attorney