Section 3: Organizational Assessment

Viewpoints: In their opening interview with the team, the acting director and acting chief deputy director identified organizational weaknesses as a possible factor in administrative performance problems. They felt that fiscal and IT processes should be centralized at headquarters for better control. They also felt that a "shadow" administrative structure existed in the LTCS division that needed to be melded into the formal administrative structure of a new state hospital department.

The administrative deputy director agreed with this assessment and later submitted a proposal to the team to consolidate the accounting functions entirely at headquarters. The LTCS deputy director also recommended greater centralization.

The team's review concurred with the finding that organizational weaknesses were affecting performance but did not agree that centralization was the solution. Instead, the team found that headquarters was itself weak and not performing at a level to justify any expansion of its duties until those weaknesses are corrected. Moreover, administrative processes are currently reasonably organized, even if weak in some functions. Centralization would not result in benefits and would jar the one level of organization that is performing reasonably well, the hospitals, thereby disrupting overall department performance.

Note that the team did not conduct workload analyses; observations about staffing levels are general assessments or identification of functions not being performed. The team was selective in its review given time constraints.

This section is organized by broad administrative findings and selected administration functions (budgets, accounting, personnel, and business services). Information technology organizational issues are discussed in Section 5. Medical organizational issues are discussed in Section 6.

Broad Administrative Findings

- **Revise the Deputy Director Structure**

Current structure: The current deputy director structure provides an LTCS deputy director over the hospitals, an administrative deputy director, a chief information officer, and a deputy director over legal and forensic services.

Proposed structure: As discussed in Section 2 and shown in Appendix 2.B, the team proposes a reorganization of the deputy director structure as follows: a deputy director for hospital operations (new), a clinical deputy director who is a psychiatrist (new), an administrative deputy director, a chief information officer, and a deputy director over legal

services, the mentally disordered offender program, and the sexual offender commitment program.[1] The LTCS division would be distributed among the two new divisions.

- ✓ This proposed restructuring is expected to improve fiscal accountability by putting hospitals under a deputy director (operations) whose specific mandate is to balance mission pressures with resource realities.
- ✓ Adding a clinical deputy director who is a psychiatrist—preferably with forensic qualifications—addresses several needs:
  - Currently, clinical guidance at headquarters focuses primarily on the Enhancement Plan which was not designed for a forensic population.[2] The focus needs to broaden and the forensic nature of the population considered more strongly in the development of treatment programs. Hence the team recommends a division led by a psychiatrist with forensic qualifications, drawing on a team that has all the clinical disciplines represented, including pharmacists and physician-surgeons.
  - Successful cost containment requires participation from the clinical staff. The balance between cost consciousness and sound treatment must be negotiated carefully. The department is more likely to find this balance with clinical representation on the senior executive team.

➢ **Recognize the low level of administrative resources system-wide**

Headquarters

- ✓ Headquarters is thinly staffed in most areas that the team reviewed (primarily administrative and ancillary functions attached to the executive office).
- ✓ Headquarters lacks the staffing capacity for analysis of hospital operations and therefore is poorly prepared to provide direction using the traditional top-down management model.
- ✓ The following headquarters functions are missing or staffed *extremely* minimally: budget policy, tracking of personnel movement, bed utilization planning, operations cost containment analysis, auditing, facilities management and capital outlay planning, training, health and safety,[3] strategic planning, and public information.
- ✓ Given budget constraints, the team recommends that the department consider a federated model in which hospitals and headquarters team together to develop plans, policies, procedures, and oversight mechanisms. This may allow limited headquarters staff to be used in the most effective fashion.
  - A federated approach will rely on a few primary committee structures. For administrative issues, formalize the senior administrative council with

[1] The Conditional Release Program would be placed under the clinical deputy director. The Correctional Services and Support Program would be placed under the operations deputy directors.

[2] Most of the doctors interviewed for this report agreed with the goal of the plan but felt that implementation has resulted at times in a dilution of patient care and treatments that are off target for a forensic population.

[3] Health and safety includes workers' compensation.

membership as follows: the administrative deputy director, the hospital administrators, and the chief of the fiscal unit.[4]

- For the clinical area, formalize the existing medical council with membership as follows: the clinical deputy director, the hospital medical directors, and the operations deputy director or designee.[5]
- The operations division's analog to the council concept would be the deputy director and executive directors. Membership should include the clinical deputy director or designee and the administrative deputy director or designee.
- Committee structures bring their own set of management problems. To be successful, leadership needs to be well organized and foster participation. Agendas are necessary as is documenting decisions and assignments. The team sees taking minutes as headquarters' responsibility.

✓ Even with this approach, the team believes that additional staff will be needed in at least three program areas at headquarters (see the discussion on analytic capacity below).

Hospitals[6]

✓ Hospitals' non-level-of-care (NLOC) positions have disproportionately felt the brunt of staffing reductions over the years. Attempts to take staffing cuts from level-of-care (LOC) positions are viewed by control agencies as disingenuous, since funding for these positions is reinstated each year as a part of the population budget change proposal (BCP).

✓ Hospitals' NLOC positions also feel the impact of the hiring freeze disproportionately. Primary attention is given to freeze exemptions for LOC positions.[7]

✓ Hence, the hospitals' administrative structure is weakened. When headquarters borrows positions from hospitals (and makes them pay for those positions), a strained situation becomes worse.

✓ Nonetheless, the reallocation of positions across levels of the organization at times may be the best alternative of poor choices. This reallocation, if it occurs, should be based on a formal workload assessment, be conducted in cooperation with the hospitals, and be approved by control agencies through the normal budget process, since different appropriations are involved. See Appendix 3.A for a listing of hospital positions currently being borrowed by headquarters.

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[4] Other staff would sit with the group on an issue-specific basis. This council would authorize other standing groups that report to it to ensure cross-organization collaboration on the identification and resolution of administrative issues.

[5] Again, other staff members from the clinical division, the operations division, and the administrative division would participate in the council on an issue-specific basis. And, the council would authorize other standing groups that report to it to ensure collaboration in the identification and resolution of clinical issues.

[6] See Appendix 3.B for state hospital and psychiatric program executive and fiscal organization charts.

[7] The latest hiring freeze is reportedly the first time that the hospitals have been subjected to the requirement to hold positions vacant.

- **Address the poor capacity for analysis at headquarters**

The organizational capacity for analysis is thin at headquarters.

- The budget office, as discussed below, operates at a technical level. Even with additional training, the team believes that staffing levels are too low for the office to take on a meaningful policy advisory role.
- Movement of patients to accommodate census changes and operational need does not appear to be guided by formal analysis that is presented in a department-wide plan.
- In this era of state fiscal constraints, the department lacks the analytic resources to develop plans to adjust to reduced resources.

If the department is to redesign itself into a more cost-conscious service provider, the team recommends analytic support in several key areas.

- **Budget policy**: Size the budget office to 1) review BCPs for policy coherence and completeness of cost/benefit considerations, 2) review hospitals' expenditure projections to form an independent assessment of accuracy, and 3) advise the executive directors, the deputy directors, and the executive office of likely impacts of external and internal budget pressures.
- **Bed utilization planning**: Create a bed utilization unit that addresses capacity planning and patient movement by commitment type and operational needs (e.g., violence, geriatrics, skilled nursing needs). The unit would recommend strategies for matching facility design and usage to population acuity characteristics, and would be a major source of input to capital outlay planning. The team sees this function placed under the deputy director of operations.
- **Cost containment analysis**: Create a cost containment unit that systematically collects cost savings concepts, developing them into full proposals with feasibility assessments and cost/benefit analysis. Vest this function with the deputy director of operations since that division has the most in-depth knowledge of hospital operations.

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Administrative Programs: Budgets

Organization of responsibilities:

- ✓ **Resource acquisition**:
  - **Non-population BCPs:** Hospitals prepare budget concept papers which are forwarded to the LTCS division. The LTCS fiscal unit in turn rewrites them, obtains internal approval to proceed, prepares formal BCPs, and passes them through the budget office for technical costing.
  - **Population budget change proposals (LOC positions only)**: The LTCS fiscal unit uses a two-year straight-line regression methodology to project patient

census changes. These changes are applied to staffing standards for LOC positions. Operating expenses adjustments, when the Department of Finance (Finance) allows them, are based on a three-year straight-line regression analysis of operating expenses. These data are summarized into a population BCP which goes through the budget office for technical costing.

- ✓ **Position control**:
  - The budget office identifies for each hospital, using the allocation process described below, how many positions by classification are to be added to or subtracted from the hospital's Schedule 8 based on approved budget adjustments (and considering population-driven changes). This occurs once a year, whereas allocation changes based on population movement occur twice a year.
  - Hospitals update their Schedule 8 listing of positions and submit these directly to the budget office for use in the Schedule 7A process.
  - Hospitals reclassify their positions using Forms 607. However, for most hospitals, these do not go through the LTCS fiscal unit for verification of availability of funds. The 607s are sent to the budget office, which also does not certify availability of funds. Reclassifications above a certain dollar level are forwarded for approval to Finance.[8,9]
- ✓ **Budget schedules**: Other than the Schedules 8 and 7A discussed above, budget schedules are prepared by the budget office for submission to Finance. In prior years, hospitals have assisted in preparing their portion of the reimbursement schedule but participation has not been consistent.
- ✓ **Budget allocations and allotments**:
  - Hospitals receive budget allocations from the LTCS fiscal unit based on a formula-driven approach keyed to actual patient population. The staffing standards used for resource acquisition are also used for dividing the hospital appropriation into allocations.
  - The LTCS fiscal unit reports this division of funds to the accounting office.
  - The accounting office, through the State Controller's Office, sets up a corresponding sub-appropriation for each hospital out of the main hospital appropriation.
  - Headquarters units do not receive allotments. They do not perform expenditure analyses. At least one unit, however, does verify transaction accuracy.

[8] The Duty Statement and Request document is the first part of the process. It goes to the hospital personnel office to request the change. If the change is approved in concept, the Form 607 is sent to the hospitals' personnel office and from there to the budget office.

[9] For headquarters positions, Form 607s should also be routed through the Accounting Office to update the tabling of employees for labor distribution. However, this does not always occur.

- ✓ **Expenditure analysis**:
  - Hospitals analyze their expenditures. However, most do not load allotments into CALSTARS. Instead, they enter allotments (sometimes, just personal services and operating expense totals) into spreadsheets, download the corresponding expenditures, and most manage from a very simple allotment/expenditure (chart of accounts) ledger structure. Until very recently, hospitals did not use common coding conventions. The Fiscal Officer's Group is presently reviewing expenditure allotment codes for consistency in the type of code, and types of expenditures to be posted within those codes.
  - The budget office does not receive the hospitals' off-system allotment expenditure reports and does not analyze hospital expenditures.
  - The team could not determine the degree of expenditure analysis the budget office performs for headquarters expenditures, because the unit was 50 percent vacant when the team first arrived, and the budget officer left shortly thereafter. However, absent unit-level allotments it is unlikely that the budget office could analyze at a level lower than program and fund source.
  - Headquarters units, lacking allotments, do not analyze their expenditures.
  - The LTCS fiscal unit reviews hospitals' off-system allotment/expenditure reports to assess overall appropriation status. It authorizes transfer of funds between hospitals when it deems necessary.
- ✓ **Appropriation control**:
  - Hospital appropriation: Control of the hospital appropriation is a shared responsibility among the hospitals, the LTCS division, and the administrative fiscal branch. Hospitals manage their allocations and report expenditures to the LTCS fiscal unit. The unit reviews hospital allocations for adjustment necessary to match appropriation changes mid-year, or to reallocate funds between hospitals to mitigate shortfalls.[10] The accounting office makes matching adjustments to the sub-appropriations at the State Controller's Office. The budget office advises the LTCS fiscal unit of appropriation changes per direction from Finance. The population estimate is updated twice a year via the Governor's Budget and May Revision processes.
  - Headquarters appropriation: The budget office and accounting office manage headquarters appropriations. Divisions are not involved.

[10] The LTCS fiscal unit also withholds a portion of the appropriation to meet emergencies. Unused funds are allocated to hospitals part-way through the year. In addition, the fiscal unit sets up a joint-purchase allocation for the hospitals which is managed out of headquarters.

Resource levels:

- ✓ Most hospitals have one budget position not counting the fiscal officer (accounting administrator I or II) who is also usually over accounting functions. Most of the budget positions are analyst classifications; some are lower classifications.
- ✓ The headquarters budget office has eight analysts, two supervisors, and a staff services manager II/III budget officer. Three of these positions have been borrowed from hospitals, one of which was the hospital's budget person.

Observations

Budget Office

- ✓ The budget officer position, which is currently vacant, has turned over several times in the last few years. Continuity is an issue.
- ✓ The budget office is not yet fully staffed. In addition, at the time of this report more than half the analysts and one of the supervisors have little or no prior experience in budgeting.
- ✓ There is no internal training or mentoring for budget analysts at headquarters or at the hospitals.
- ✓ Staffing levels appear lower than in comparable departments.
- ✓ The budget office operates at a technical rather than a policy level.
- ✓ The budget office does not perform an oversight function for either headquarters or hospital expenditures. Both levels of the organization have been experiencing appropriation or category deficits.
- ✓ The budget office does not effectively communicate basic information pertaining to budget/fiscal matters to internal stakeholders.
- ✓ Fiscal drills driven by external stakeholders (i.e., Finance) are not always routed through or coordinated by the office, creating misunderstanding or gaps in the information.
- ✓ Senior budget office managers and division management participated in unauthorized transfers of expenditures at year-end, apparently over several years. In some cases there was no point in these actions since notification to Finance would have sufficed to authorize the movement of expenditure authority.
- ✓ Internal processes have deteriorated over time and need to be reestablished between the accounting and budget offices. For example, Form 607s should be consistently routed to the accounting office to update labor distribution tables.

LTCS Fiscal Unit

- ✓ The fiscal unit performs some of the hospital oversight functions that would normally be performed by a budget office. However, it does not conduct detailed expenditure analyses, have enforcement responsibility for budgetary control, or (at the time of this review) have a technical understanding of budgeting.
- ✓ In some cases the value added by passing routine budgetary paperwork through the LTCS division was not clear.
- ✓ The population estimate, population BCP development, and allocation management appropriately belong in a program-based unit such as the LTCS fiscal unit but need to

be tightly coordinated with the budget office. (Note: The team has observed specific weaknesses in the resource acquisition process. Also, the LTCS fiscal unit reports a discrepancy between required staffing levels per the staffing standards and the number of LOC positions in the Schedule 7A. These issues are discussed in Section 4.)

Hospitals

- ✓ The hospitals centralized their budget management as they slipped into deficit. Several hospitals previously allocated funds to various hospital managers; most no longer do so.
- ✓ Overall, hospital budget management is unsophisticated. Most organizations with $150+ million budgets (as most of the hospitals have) operate with more complex budget systems, charts of accounts, tools, and formal budget training.
- ✓ Despite this lack of budget sophistication, the hospitals do collect significant amounts of operational and cost data. For the most part, this data is not channeled into the budget process and generally does not connect with CALSTARS.
- ✓ Hospitals' deficits do not appear to be strongly related either to their budget expertise or to their systems. However, there is a specific problem with reconciliation of the Schedule 7A to allocations. See Section 4.
- ✓ Some hospitals are more sophisticated than others in fiscal management. They have desktop systems that could be shared with other hospitals.
- ✓ Headquarters has budgeting tools that it could share with the hospitals.

Conclusions

- ✓ Overall, management of the budget varies from weak (most hospitals) to extremely weak (headquarters budget office). The LTCS fiscal unit performs satisfactorily, but its tools are based on staffing standards that do not reflect critical hospital operations. (See Section 4 for more discussion.)

Budget Office

- ✓ The budget office's upper management and division leadership failed in a primary fiscal responsibility by participating in the movement of expenses without authorization at year-end.
- ✓ The budget office is not staffed to perform fiscal services for hospitals or to function as fiscal policy advisor for the executive office, the programs, and the hospitals. It cannot perform satisfactorily in a technical capacity at the present time given its training needs.
- ✓ Sound leadership and training for the budget office is critically needed.
- ✓ The budget office needs to prepare and distribute unit (or division) allocations to headquarters managers.
- ✓ The budget office should train divisions to monitor their expenses and address budget problems promptly, once its own training needs are met.
- ✓ Headquarters and hospitals should evaluate what budgeting tools they can share.

LTCS fiscal unit

- ✓ The fiscal unit should divest itself of routine budget duties and focus on overall program cost analysis and cost containment.[11]
- ✓ Because the LTCS fiscal unit needs to coordinate tightly with the budget office, it would benefit from budget training.

Hospitals

- ✓ Hospitals are not trained in state budget practices or in the principles of resource acquisition and lack necessary tools.
- ✓ Fiscally strong hospitals should assist other hospitals in improving their budget practices.
- ✓ The majority of the hospitals are staffed on paper adequately for the very simple budget management they are currently performing.[12] However, they are not staffed adequately for the type of budget management they *should* be doing, given that each hospital is essentially the same in size as a medium-large department.
    - Hospitals should use more allocations codes for better budget monitoring.
    - Hospitals should implement more cost centers for better understanding of operational costs (see Section 4, #3).
    - Hospitals should give their managers allocations so they can participate in cost analysis and control. The current centralized management of funds works against this principle.

Recommendations

Budget office/divisions

- ➢ To ensure timely submission of budget documents to Finance, the budget office must immediately fill all vacancies. It also needs additional temporary help to meet training and workload demands this fall.
- ➢ The administrative division must espouse and practice a strong ethic for correct budget management and reporting of problems.
- ➢ Staff the headquarters budget office correctly for working with hospitals and providing budget policy assistance. This is work that previously was not performed.
- ➢ Prepare and distribute unit allocations as quickly as possible after fall budget preparation is completed and training requirements are met. Begin with budgeting at the division level to ease the transition. (The draft unit allotments, previously prepared by the budget office but never distributed, are too detailed.)
- ➢ Train the headquarters divisions in budget management. Ensure that each division has an administrative assistant to assist with transaction reconciliation

[11] There may be other administrative duties that can be placed elsewhere. Positions that review facility proposals might be located with a facilities planning and capital outlay unit.

[12] The exceptions are Vacaville PP, Salinas Valley PP, and Napa SH, the latter of which needs headquarters to return its budgeting position that was borrowed. Overall, headquarters has borrowed fiscal positions from the hospitals, reducing their effective staffing levels. The hiring freeze and the deficit have both prevented positions from being filled.

and expenditure control. This same assistant could assist the division with other administrative processes.

- Evaluate and share appropriate budgeting tools among the levels of the organization.

LTCS fiscal unit

- Reorganize the duties of the fiscal unit so that it no longer performs budget office functions and focuses instead on program cost analysis and cost containment. Move that revised function from the LTCS division to the deputy director of operations or to the administrative division.

Hospitals

- Develop a plan to gradually increase the sophistication of hospital budget management.
  - Establish a hospital-based fiscal advisory position by expanding the duties of one of the fiscal officers.
    - This position would help train the other hospitals on budget management.
    - Atascadero SH is the logical candidate to take on this role, based on the team's observations. That hospital's fiscal officer is already recognized throughout the system as the natural lead.
  - Task the fiscal officers as a group to develop a plan for increasing hospital budgeting strength, under the leadership of the fiscal advisory position.
  - Provide the hospitals with appropriate budget management tools. In the team's view, Atascadero SH has the best linked spreadsheet applications for budgeting among the hospitals. Share the system. Also share headquarters' tools (such as the Excel version of the Schedule 8) with the hospitals.
- As hospital budget systems evolve in complexity, staff them correctly.
  - Begin by returning the fiscal positions that headquarters has borrowed from the hospitals.
  - Perform a workload analysis at each step of system expansion and solicit resources as needed.

Administrative Programs: Accounting

Organization of responsibilities: Hospitals and headquarters are independent entities for accounting purposes, receiving and paying its own claims, managing its own books, and closing its own records. Headquarters performs additional duties at year-end, moving funds between hospitals if necessary to ensure payment of payroll. The department uses CALSTARS as its accounting system.

Resources: The headquarters accounting office has 23 staff, eight supervisors and one manager (staff services manager III). Two of these positions have been borrowed from the hospitals and three are permanent positions in the blanket. The office reports through a fiscal assistant deputy director to the administrative deputy director. The hospitals each have an average of 12.8 accounting staff, led by an accounting administrator I/II. The psychiatric programs have 1.8 staff, led by a senior accounting officer. The hospital accounting offices report through the fiscal officer to the hospital administrator.

Observations

Headquarters:

- ✓ The accounting office management and division leadership moved expenses without authorization to facilitate year-end closing.
- ✓ The accounting office is not viewed as service-oriented by the hospitals. The office has not provided assistance to the hospitals, even though office position levels are justified in part by its oversight duties.
- ✓ The office has not demonstrated an understanding of hospital fiscal operations.
- ✓ The office has not demonstrated a grasp of the interaction between the budget office, LTCS fiscal unit, and accounting.
- ✓ The office gives direction to the hospitals without determining hospitals' operational impact, sometimes making existing problems more difficult. The team observed instances of this during year-end closing.
- ✓ The office was contributory to the loss of reconciliation between hospital allocations and SCO sub-appropriations.
- ✓ Office staffing may need to be reassessed based on programs that have been dropped as part of realignment.

Hospitals:

- ✓ Decentralized accounting meets hospitals' operational needs. It permits timely payment of claims and allows the hospitals to manage their vendor relations.
- ✓ Centralization provides no clear advantage for fiscal accountability.
- ✓ Hospital accounting units appear generally competent.[13]
- ✓ Deficits create significant vendor problems and add to hospital workload.
- ✓ Accounting staffing levels at hospitals *on paper* appears reasonable. However, some accounting positions have been borrowed by headquarters or are vacant due to the hiring freeze, exam problems, or the need to meet salary savings. Therefore, effective staffing resources are less than appear on the Schedule 7A.
- ✓ Hospitals do not appear to be using many of the functions in CALSTARS and would benefit from training on options in system implementation. This might help with budgeting as well.

[13] The team did not verify compliance with the 2008 Office of State Audits and Evaluations (Finance) internal controls audit. See Appendix 4.A for supplemental audit information.

Conclusions

- ✓ Overall organization of accounting services appears reasonable.

Accounting Office

- ✓ The office is staffed in numbers and levels to oversee the hospitals, but does not.
- ✓ When the office does perform in an oversight role, it fails to consider hospital input.
- ✓ The office failed in performance of fiscal responsibility by participating in the movement of expenses without necessary authorizations.
- ✓ The office has failed to demonstrate an understanding of the relationship of fiscal systems in the department.

Hospitals

- ✓ The hospitals' need for the accounting positions borrowed by headquarters should be weighed against headquarters' accounting needs, if any.
- ✓ The hospitals would benefit from a service-oriented headquarters office which is knowledgeable about hospital fiscal operations and willing to work cooperatively with hospitals on gradual improvements to the implementation of CALSTARS.

Recommendations

- ✓ The administrative division must instill in the accounting office, from the top down, a strong ethic for fiscal management and reporting of problems (Fiscal Integrity and State Manager's Accountability Act of 1983; FISMA).
- ✓ The team recommends leaving the current accounting structure in place as long as the department uses CALSTARS as its accounting system. Future accounting systems such as FI$Cal may drive a re-examination of this issue.
- ✓ Prior to the accounting office expanding its oversight of hospitals, skills and knowledge of hospital fiscal operations and a better service ethic must be firmly in place.
- ✓ In addition to CALSTARS online information, the accounting office should retain copies of year-end financial statements for analysis and future research purposes.
- ✓ In order to perform an oversight role, duty statements must be rewritten to include hospital oversight responsibility.
- ✓ Evaluate headquarters' accounting office staffing based on workload justification.
- ✓ Return borrowed fiscal positions to the hospitals if merited by a workload comparison.
- ✓ The hospital fiscal advisory position (recommended under the budgeting assessment above) should work with the hospital fiscal officers to improve the implementation of CALSTARS at the hospitals. The operational benefit will be better information on program costs.
    - Consider contracting with Finance or hiring a retired annuitant with CALSTARS systems analysis skills to assist the fiscal officers with system design issues.
    - Ensure hospitals know how to access the Uniform Codes Manual, State Administrative Manual, Leg Info Website, etc.
    - In addition to the assistance provided by the hospital fiscal advisory office, each hospital should have an assigned accountant liaison in the accounting

office. The liaison should be able to answer accounting questions and share information.

- ✓ Accounting managers should visit hospitals to gain an understanding of operational needs and issues. Train the office to a "service with control" standard.
- ✓ Provide on-site training on state fund accounting at headquarters and in the hospitals.

Administrative Programs: Personnel

Organization of responsibilities:

Selection Services: This function is partly decentralized. Headquarters sends out an exam plan every year requesting the hospitals' input on what exams are needed. The hospitals submit their requests, and headquarters reviews and finalizes this into the department's exam calendar. Headquarters initiates various parts of the exam, develops the job analysis, and prepares and releases the exam bulletin. The hospitals develop exam questions and send them to headquarters for review, revision, and approval.[14] The hospitals receive and process the exam applications, select their own exam panels, schedule the exam, and arrange the logistics. Job analyses for statewide classes go to the State Personnel Board (SPB) for approval prior to exam release. [15] Atascadero SH has delegated management of its exams, although exam packages go through headquarters for approval. "Continuous testing" exams are delegated to the state hospitals who receive and process exam applications, select their own panels, schedule the exams, and arrange the logistics. Exam questions are developed by the hospitals and sent to headquarters for review, revision, and approval.[16]

Classification and pay: This function is partly decentralized. Each hospital originates its own duty statements, organization charts and Form 625s (requests for upgrades). Form 625s come to headquarters for review and approval on all positions. Out-of-class requests are handled by the hospitals for the first 120 days and by headquarters if they go over 120 days. Each hospital also handles its own position control, although it interacts with the budget office on the latter.

Transactions: This function is decentralized. Hospitals prepare the documents and key them directly with the State Controller's Office. Headquarters handles its own transactions and has also performed an oversight function for at least one hospital that experienced workforce management problems in its transactions unit.

[14] Coalinga SH is the exception. Due to recent exam problems, headquarters has temporarily assumed more complete control over the process for Coalinga SH.

[15] There is a process problem here that is discussed in Section 4. In brief, exams are essentially in suspense until full job analyses can be prepared. There are over 300 classifications and each analysis takes several months to complete.

[16] There is a process problem here that is discussed in Section 4. In brief, exams are essentially in suspense until full job analyses can be prepared. There are over 300 classifications and each analysis takes several months to complete.

Resources: The headquarters personnel office has 17 staff, one supervisor, four managers, and is led by a staff services manager III. Two of these positions have been borrowed from the hospitals and two are intermittent retired annuitant positions in the blanket. The office reports to the assistant deputy director administrative services. The hospitals each have an average of 21 personnel staff, two supervisors, and one manager who are led by a staff services manager II, human resources director who reports directly to the hospital administrator.

Observations

Headquarters personnel office:

- ✓ Staff is knowledgeable and well trained.
- ✓ There appears to be too much headquarters approval needed for hiring, exams, and classification and pay.
- ✓ Current managers seem willing to delegate more to the hospitals.
- ✓ Exam job analysis is backlogged, with the work far outstripping available staff.[17]
- ✓ Classification and pay functions are performing too slowly.
- ✓ The team observed frustration with the hospitals over specific issues, such as exams gone awry.

Hospitals:

- ✓ The personnel units at the hospitals are knowledgeable and well trained.[18] However, they feel headquarters does not recognize this.
- ✓ The managerial/supervisory structure for personnel is the same at each hospital, regardless of size. The office reports through the human resources director to the hospital administrator.[19]
- ✓ The broad issues that concern hospitals are recruitment, overtime, Family Medical Leave Act (FMLA) usage, out-of-class processing, and the increase in adverse actions. See Section 4 for a discussion of out-of-class processing.
- ✓ The personnel officers and human resources directors feel there is an overall lack of communication from headquarters. In the past, monthly human resources forums were held but not everyone agreed that they were helpful.
- ✓ The hospitals all commented on what they saw as a weak service orientation in headquarters (failure to acknowledge requests, poor response times, and special requests with unreasonable deadlines).
- ✓ The hospitals want processes and procedures in writing to minimize conflicting instructions.

[17] One estimate given to the team was that it would take 10 years, using both headquarters and hospital staff, to redo job analyses to the format that the State Personnel Board wants. The team has not verified this estimate but concurs that the workload is major.

[18] There were specific performance problems, however, with the transactions unit at Salinas Valley PP.

[19] The exception is Vacaville PP which has a richer structure based on an activity—supervision of Salinas Valley PP—which it does not actually perform. The team recommends the reporting point and position levels in this personnel office be revisited.

- ✓ The Enhancement Plan increased the workload (more hospital staff, overtime, and temporary help) in personnel offices, without corresponding staffing adjustments.
- ✓ The hiring freeze and FMLA have both increased the workload in personnel offices, without a staffing adjustment. Depending on location, other issues can affect workload: immigration clearance for Atascadero SH; religious accommodation for Patton SH.
- ✓ Timeframes imposed for special requests are often unreasonably short—an hour at times—with no explanation for why the information is needed or how it is being used.

Conclusions

- ✓ The team sees competent people in both headquarters and the hospitals, with poor communication hampering teamwork.
- ✓ More face-to-face interaction would help build mutual knowledge of missions and respect, and better ability to negotiate due dates.
- ✓ Job analysis workload must be addressed so that the hospitals' positions can be filled permanently. The number of acting assignments in the hospitals is unmanageably large.
- ✓ The hospitals' personnel offices are staffed sufficiently and have the competence for greater decentralization of functions.

Recommendations

- ➢ Where allowable, decentralize processing tasks more completely, reshaping headquarters into a "service with control" role.
- ➢ Negotiate a solution with SPB that leaves the workload for job analysis within practical reach of the department. The problem is impeding hospital operations.
- ➢ Evaluate turn-around times in the classification and pay unit.

Administrative Programs: Contracting and Procurement

Organization of responsibilities: Procurement is completely decentralized and appears to work well (i.e., no further discussion). Contracting is partially decentralized and is experiencing problems in the approval process. Hospitals may approve contracts up to limits discussed below. Headquarters sets boilerplate language for certain kinds of contracts and reviews and approves contracts over specified dollar levels.

Resources: Each hospital typically has one to four employees in procurement and contracting. Headquarters has six employees reviewing contracts in the business services office and one employee in the LTCS division also reviewing contracts. Currently, the administrative deputy director signs off on all contracts over $50,000.

Contracts

Observations

- ✓ Managers at headquarters and in the hospitals all appear competent.
- ✓ Hospitals have delegated authority for contracts up to $50,000, or up to $250,000 if the contract is awarded to a small business provided two or more small businesses bid on the contract.
- ✓ Headquarters did not advise the hospitals that they could contract on their own authority for up to $250,000, subject to the conditions noted above, and did not set up the signature processes to allow this to happen.
- ✓ Contract approval processes are extremely slow (often 9 to 12 months), creating operational problems for hospitals. See Section 4 for more discussion.
- ✓ The level of position (deputy director) signing contracts over $50,000 appears to be too high, creating a bottleneck.
- ✓ Review through the legal office adds to the bottleneck often enough to suggest that hospital operational impact is not being considered.[20]
- ✓ Hospitals have been denied information about where their contracts are in the review and approval cycle.
- ✓ There are process problems with personal service contracts for medical professionals who work on staff. See Section 4 for additional discussion
- ✓ There may be some DGS contracting rules that are not being followed (e.g. splitting contracts).

Conclusions

- ✓ Headquarters appears reluctant to empower hospitals. If there are specific reasons to withhold allowable delegations, these were not communicated to the team.
- ✓ Bottlenecking of contract processing is occurring at the level of the deputy director and in the legal office.

Recommendations

- ➢ Delegate more completely.
- ➢ Reduce the contract approval time to no more than three months. See Section 4 for further discussion.
- ➢ Assist the hospitals in addressing contract needs.
- ➢ For accountability, rely on written policies and procedures that are created collaboratively, rather than time-consuming review loops at headquarters.
- ➢ Formalize the business services officers group. Assign a permanent legal liaison to the group for continuity in the provision of contracting legal advice.
- ➢ Place headquarters' contract signature responsibilities with the business services office.
- ➢ Update the signature cards for contracts so that hospitals can take advantage of the $250,000 contract threshold.

[20] Hospitals report that the legal office often makes only minute changes (sometimes changing its own boilerplate).

- Charge headquarters with conducting periodic audits of hospitals' contracting practices.
- Create a system to communicate contract location and status. This function will be automated in the new Fi$Cal system, but implementation of that system in DMH may be at least five years away.
- Consider broader use of centralized contracting in certain areas (such as for lab services) for cost savings, but do so collaboratively with the hospitals and avoid time delays that hamper hospital operations.