Audit of the Hawaii Health Systems Corporation

A Report to the Governor and the Legislature of the State of Hawai‘i

Report No. 99-9
February 1999

THE AUDITOR
STATE OF HAWAI‘I

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawai'i State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. Financial audits attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. Management audits, which are also referred to as performance audits, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called program audits, when they focus on whether programs are attaining the objectives and results expected of them, and operations audits, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. Sunset evaluations evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. Sunrise analyses are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. Health insurance analyses examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. Analyses of proposed special funds and existing trust and revolving funds determine if proposals to establish these funds are existing funds meet legislative criteria.

7. Procurement compliance audits and other procurement-related monitoring assist the Legislature in overseeing government procurement practices.

8. Fiscal accountability reports analyze expenditures by the state Department of Education in various areas.

9. Special studies respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawai'i's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

THE AUDITOR
STATE OF HAWAI'I
Kekuanao'a Building
465 S. King Street, Room 500
Honolulu, Hawai'i 96813

OVERVIEW

Audit of the Hawaii Health Systems Corporation

Report No. 99-9, February 1999

Summary

The Hawaii Health Systems Corporation was established by the Legislature through Act 262, SLH 1996. The corporation assumes the responsibility of the Department of Health's Division of Community Hospital to manage the State's system of community hospitals. The hospitals had been under State control since 1969 and consists of acute care, long-term care, and rural hospitals situated on the various islands in the State. The purpose of the Act was to provide better health care to people by freeing hospital facilities from unwarranted bureaucratic oversight. Administratively attached to the Department of Health, the corporation is defined as a "public body corporate and politic and instrumentality and agency of the State." An 11-member board of directors is responsible for developing policies, procedures, and rules necessary to plan, operate, and manage the hospitals.

We found that the corporation's ability to establish a viable hospital system is hampered by a combination of restrictive personnel rules, an inadequate financial system, and deficient planning and implementation. Consequently, the corporation is unable to demonstrate whether it can achieve the expected benefits of converting from a state system to a public benefit corporation.

Act 262 provided the corporation little relief from the State's inflexible personnel system. The State's lengthy recruitment process slows the corporation's ability to meet changes in demand for patient care services. The existing collective bargaining agreements also constrain personnel management and hinder recruitment. Uniform compensation programs negotiated through collective bargaining causes difficulties for the hospitals to competitively recruit staff with essential skills or experience.

The corporation also inherited a deficient financial system that resulted from the division's poor management of information systems development. Despite expenditures of several million dollars, the division developed and implemented a hospital information system that could not generate necessary financial and operational information. Since the transition, the corporation has made some improvements in its financial system, but additional improvements are still needed.

We also found that the Board of Directors failed to assert adequate leadership to ensure an effective transition from a state hospital system to a corporate structure. The Board was formed in August 1996 and established policies to guide the transition. An acting chief executive officer was appointed by the board soon thereafter to implement its policies and directives. However, the Board failed to ensure its policies were properly implemented. Detailed transition plans were never developed and communications with employees and communities, essential for a successful reorganization, were inadequate.

We also found the corporation's procurement system deficient and lacking adequate management controls. The procurement system contained unclear policies and procedures, improper segregation of duties, and inadequate contract management. In addition, the corporation failed to plan and implement an efficient information system. The corporation lacks strategic information systems plans and has not adequately addressed the year 2000 problem.

Recommendations and Response

We recommended that the board develop a transition plan that includes detailed task descriptions, time frames, an implementation plan, a communication plan, and any additional legislation to help achieve its goals. The board should also amend its procurement policies and improve contract management procedures. We also recommended that the corporation's administration establish formal accounting policies and procedures and ensure their compliance. The administration should also improve the management of the information system and ensure all computer and automated medical equipment are year 2000 compliant.

The corporation basically agreed with the findings and recommendations of the audit except for comments about the Board of Directors. The corporation notes that the audit time period from July 1, 1996 through June 30, 1998 describes the "embryonic infancy" of a new organization and fails to consider post-audit developments and achievements. The corporation stated that the Board of Directors volunteered their services to develop and implement the corporation from a system that lacked any structure. The corporation further adds that concerns expressed in the audit have been resolved or are in the process of resolution.

We are encouraged by steps taken by the corporation, but we reemphasize the importance of the board to properly fulfill its responsibility of managing the corporation.

Marion M. Higa
State Auditor
State of Hawaii

Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813
(808) 587-0800
FAX (808) 587-0830

Audit of the Hawaii Health Systems Corporation

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 99-9
February 1999

Foreword

This is a report of our audit of the Hawaii Health Systems Corporation. This audit was conducted pursuant to Section 52 of Act 328, Session Laws of Hawaii 1997, which directed the State Auditor to perform a fiscal and management audit of the corporation.

We wish to express our appreciation for the cooperation and assistance extended by officials and staff of the Hawaii Health Systems Corporation.

Marion M. Higa
State Auditor

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Chapter 1

Introduction

The Legislature through a budget proviso in Section 52 of Act 328, Session Laws of Hawaii 1997, directed the State Auditor to perform a fiscal and management audit of the Hawaii Health Systems Corporation. The proviso requires that the audit include, but not be limited to, an analysis of accounting procedures, procurement and personnel practices, and fiscal accountability.

Background on the Hawaii Health Systems Corporation

In 1996, all operations of the Department of Health's Division of Community Hospitals were transferred to the Hawaii Health Systems Corporation. The Legislature created the Hawaii Health Systems Corporation, a public benefit corporation, to provide quality health care for the people of Hawaii. The corporation was provided greater flexibility and autonomy to compete and remain viable. However, in its first two years of existence, the corporation required emergency appropriations to maintain operations and struggled to provide expenditure information to the Legislature.

History of the community hospitals system

Hawaii's community hospital system traces its origins to the 1880s. Over 100 years ago, the Hawaiian monarchy created a system of district hospitals to provide health services to the neighbor islands. This system eventually evolved into a system of county hospitals. Between 1896 and 1908, the plantations created a number of hospitals for plantation workers. Some plantation hospitals were eventually phased out while others were retained and incorporated in the county hospital system.

The State gradually assumed responsibility for the county hospitals in the late 1960s. In 1967, several management responsibilities for the county hospitals were transferred from the counties to the State. Two years later, the state director of health became the sole "governing authority" over all county/state hospitals. In 1989, the Legislature organized the hospitals into a Division of Community Hospitals within the Department of Health.

The division managed 12 hospitals and one satellite medical clinic. The hospitals were classified as acute care, long term care, or rural. Acute care facilities provided full medical services such as surgical, medical, and critical care; obstetrics; pediatrics; psychiatric treatment; and physical and occupational therapy. Long term care facilities consisted of intermediate care and skilled nursing facilities that provided differing levels of medical and therapeutic care for the elderly or the chronically ill.

Rural centers were primarily skilled nursing facilities that provided limited acute care and/or longer term care for the elderly or the chronically ill. The hospitals and their locations are listed in Exhibit 1.1.

Exhibit 1.1
Community Hospitals by Type and Location

HOSPITAL TYPE	LOCATION
Acute Care Facilities	
• Hilo Medical Center*	Hawaii
• Maui Memorial Hospital**	Maui
• Kauai Veterans Memorial Hospital	Kauai
• Kona Community Hospital	Hawaii
Long Term Care Facilities	
• Maluhia Hospital	Oahu
• Leahi Hospital	Oahu
• Kula Hospital	Maui
• Samuel Mahelona Memorial Hospital	Kauai
Rural Facilities	
• Honokaa Hospital***	Hawaii
• Hana Medical Center****	Maui
• Ka'u Hospital	Hawaii
• Kohala Hospital	Hawaii
• Lanai Community Hospital	Lanai

*Acute and long term care provided.
**Maui Memorial Hospital's name was changed to Maui Memorial Medical Center during the audit.
***Honokaa Hospital's name was changed to Hale Ho'ola Hamakua.
****Act 263, SLH 1996 separated Hana Medical Center from the Division of Community Hospitals.

In 1990, the Legislature initiated a pilot autonomy project for Maui Memorial Hospital and Hilo Medical Center. The pilot project allowed the director of health to request waivers from other state agencies on certain policies, rules, or procedures that limited hospital efficiency. The purpose of the pilot project was to improve hospital accountability by eliminating administrative red tape. Between 1990 and 1994, similar "autonomous operations" status was granted to other hospitals and to the division administration.

The community hospitals system was primarily funded through special funds but often required additional support through general fund appropriations. Prior to 1995, each community hospital had its own special fund into which revenues earned by that hospital were deposited. Between 1989 to 1994, total special fund appropriations for the community hospitals rose from $92 million to $211 million. During the same period, the system also received general fund appropriations ranging from $8 million to $26 million each year. In addition, the system received emergency appropriations of $15 million in 1991 and 1992.

In 1995, the individual special funds were consolidated into a single special fund for the entire community hospital system. In 1995 and 1996, the Legislature provided smaller general fund subsidies to the community hospitals; however, they were offset by an increase in the special fund appropriation to approximately $275 million each year. In 1997, the community hospitals system received a $212 million special fund appropriation, $8 million general fund appropriation, and $12 million emergency general fund appropriation. During the 1998 legislative session, the corporation requested an emergency appropriation of $15.5 million for FY1997-98 and a $41 million general fund appropriation for FY1998-99. The Legislature appropriated $5 million in emergency funds for FY1997-98 and $8 million in general funds for FY1998-99.

Prior audits reveal problems

Despite legislative support for the community hospitals to improve the efficiency of operations, the hospitals continued to experience financial and management inadequacies that hampered operations.

Our 1988 report, *A Study of the County/State Hospital Program,* Report No. 88-8, found many operational and financial problems at the hospitals. Several years later, our *Study of the Division of Community Hospitals,* Report No. 92-6, found delays in billings and collections, accounts receivable balances higher than national averages, and other problems. Our 1995 *Audit of the Information System of the Division of Community Hospitals*, Report No. 95-21, cited ineffective management of information systems development, resulting in fragmented systems and inefficiencies.

Recent financial audits conducted by our office found several reportable conditions and material weaknesses in financial management and accounting policies and practices at Hilo and Kona hospitals. We also found Maui hospital's revenue and collection practices needed improvement and that financial reporting was inadequate.

Two studies were instrumental in creating the corporation

Two studies were significant in laying the groundwork for creating the Hawaii Health Systems Corporation. One study was published by our office, Report No. 92-6, *Study of the Division of Community Hospitals.* The other was published by a special task force initiated by the

Legislature. These studies provided useful information to guide the transition of the community hospital system to a public corporation.

Our 1992 study indicated that burdensome state laws and policies in budgeting, procurement, and personnel resulted in inefficiencies that hindered hospital financial management and operations. We found that state budget policies resulted in inadequate funding for the hospitals; state procurement rules produced delays in purchasing; and state personnel policies made it difficult for hospitals to hire qualified staff. The study recommended that the Legislature establish a public corporation to operate the community hospitals and suggested that a special master, along with a transition team, study and plan for the transfer.

In 1994, the Legislature created a task force to develop an organizational and functional plan to facilitate the transition of the Division of Community Hospitals to an agency for community hospitals. The task force hired consultants experienced in assisting other state public hospital systems with organizational and structural reform.

The task force's December 1994 preliminary report and January 1995 supplemental report also recommended that the community hospital system be transformed into a public benefit corporation. The task force's reports reiterated the findings of the Auditor's 1992 study and specified issues to be addressed before implementation. The report cited the State's inflexible budget process, stringent procurement requirements, and unresponsive personnel system as main hindrances to hospital efficiency and productivity. The task force recommended that the Legislature form a management transition team to address the hospital's financial reporting system and budget process, procurement process, and personnel system.

Act 262 creates the corporation in 1996

In 1996, the Legislature established the Hawaii Health Systems Corporation through Act 262, SLH 1996, now codified as Chapter 323F, Hawaii Revised Statutes (HRS). The purpose of the act was to provide better health care to people, including those served by small rural facilities, by freeing the facilities from unwarranted bureaucratic oversight.

The Hawaii Health Systems Corporation, administratively attached to the Department of Health, is defined as a "public body corporate and politic and an instrumentality and agency of the State." An eleven-member board of directors governs the corporation. Ten members are appointed by the governor and the director of health serves as an ex officio voting member. All assets, rights in property, used by or accruing to the Division of Community Hospitals were transferred to the corporation on November 30, 1996. Exhibit 1.2 displays a timeline of major events in the establishment of the corporation.

Exhibit 1.2
Significant Events in the History of the Community Hospitals and Formation of the Hawaii Health Systems Corporation

1967	Act 203 transfers hospital management functions from the counties to the State.
1969	The State takes control of the hospitals. The state director of health becomes the sole "governing authority" over all state/county hospitals.
1987	The auditor conducts a study of the county/state hospital program and finds numerous operational and financial problems.
1989	The Legislature reorganizes the hospitals into a Division of Community Hospitals.
1990	In the early 1990's, the Legislature establishes a "pilot project" providing Maui and Hilo community hospitals "autonomous operation" status.
1992	The auditor conducts a study of the division and finds problems with the computer system and financial management system. The study asserts that state policies worsen financial problems and recommends the establishment of a hospitals public corporation. From 1990 to 1994, the Legislature expands "autonomous operation" status to all 13 hospitals and the division.
1994	The Legislature enacts Act 266 creating a task force to develop organizational and functional plans for the transfer of the community hospitals to a corporation.
1995	The task force issues its report and recommends the creation of the Hawaii Health Systems Corporation.
1996	The Legislature enacts Act 262 establishing the Hawaii Health Systems Corporation. The act repeals Chapter 323, HRS, governing the community hospitals and designates a board of directors to manage the community hospitals. All rights and duties of the Division of Community Hospitals are to be transferred to the corporation by 11/96. The State will continue to provide administrative support until 11/98. 08/96 - The governor appoints the corporation's board of directors. 10/96 - The board appoints the Hilo Hospital administrator as the acting chief executive officer (CEO).
1997	The board hires a permanent CEO. The CEO establishes the corporate office at Leahi Hospital on Oahu.
1998	The corporation requests a $15.5 million emergency appropriation for FY1997-98 and a $41 million general fund appropriation for FY1998-99.

Act 262 vests the board with the authority to carry out the duties and responsibilities of the corporation. These responsibilities include developing policies, procedures, and rules necessary to plan, operate, and manage the community hospitals. The board's by-laws reiterate its ultimate responsibility for planning, operating, and managing the community hospitals.

The Hawaii Health Systems Corporation employs approximately 3,000 people and is the fifth largest public hospital system in the nation. The corporation is the largest provider of health care for neighbor island residents.

Objectives

1. Evaluate the effectiveness and adequacy of the implementation of the Hawaii Health Systems Corporation.

2. Assess the corporation's management controls over its financial and information management systems.

3. Make recommendations as appropriate.

Scope and Methodology

We reviewed the extent to which the board carried out its responsibilities to plan and manage the corporation. We examined the corporation's budgeting process and allocation methodology for distributing funds to hospitals. We also conducted site visits at selected hospitals to examine the policy and practices pertaining to procurement, personnel, and financial and information systems.

We examined the requirements analysis, implementation plans, and project files for the corporation's information system. We applied the State's standard for systems development, Systems Development Methodology (SDM), and the federal guide for developing long term care systems to the corporation's development efforts.

We assessed the effectiveness and adequacy of the corporation's procurement system and reviewed its structure and implementation. We judgmentally selected purchases and contracts made by the corporation and hospitals to assess their cost-effectiveness and to determine if they were made in compliance with applicable laws and/or policies. Our contract review included analyses of the corporation's contract administration, pre-contract analysis, vendor selection and award process, and contract monitoring.

We also assessed the management controls over the agency's financial accounting, expenditures, and revenues. We reviewed transactions, systems, and procedures relating to the corporation's and hospitals' accounting and internal control structure.

We reviewed pertinent laws, policies and procedures, by-laws, audits, and reports. We also reviewed planning documents, strategic and business plans, memoranda, correspondence, meeting minutes, and information systems documentation.

Our fieldwork included interviews with board members, corporation officers, management, and staff of the corporation and several hospitals. We also interviewed a consultant hired by the corporation and representatives from the Hawaii Government Employees Association (HGEA) and United Public Workers (UPW) union. We interviewed state officials and staff from the Department of Human Resources Development. Finally, we conducted interviews with users of computer systems and information system technical personnel.

We conducted follow-up on relevant findings and recommendations from previous audits that affected our audit objectives. The audit focused on the period from June 1996 to June 1998, but we examined earlier periods as necessary.

Our work was performed from March 1998 to June 1998 in accordance with generally accepted government auditing standards.

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Chapter 2

The Corporation Continues to Struggle to Achieve Effective Management

Management problems have hampered the transition of the State's community hospital system to the Hawaii Health Systems Corporation. A transition plan was never implemented, and state requirements restrict the effective use of personnel. In addition, pre-existing procurement and contracting problems have not been adequately addressed. Furthermore, planning and support for an information system are insufficient to adequately support the corporation's needs. Consequently, the corporation is unable to demonstrate whether it can achieve the expected benefits of converting to a public benefit corporation.

Summary of Findings

1. The Hawaii Health Systems Corporation's ability to establish a viable hospital system is hampered by a combination of deficient planning and implementation, an inadequate financial system, and restrictive personnel rules.

2. Poor management controls over procurement and contracting create opportunities for unauthorized purchases and result in waste.

3. The corporation's failure to effectively plan and control its computer systems created an inefficient health care information system that lacks statewide integration and will encounter problems in the year 2000.

A Smooth Transition Was Hampered by Inherited Obstacles and Poor Management

Progress has been hampered by the act that established the Hawaii Health Systems Corporation—Act 262, Session Laws of Hawaii (SLH) 1996, and a deficient information system that the corporation inherited from the State's Division of Community Hospitals. Although the intent of Act 262 was to free the community hospitals from bureaucratic oversight, it provided little relief from the State's inflexible personnel system. A new law may provide the corporation with the flexibility needed to effectively manage its personnel; however, it is too soon to assess its impact.

Although the corporation faced pre-existing problems, its Board of Directors failed to ensure that important tasks were completed to make possible a successful transition from a state agency to a private corporation. In addition, the board failed to effectively communicate to

hospital staff and the community about transition efforts. The corporation has been unable to reach operational goals and continues to require legislative support.

Effective use of personnel is hampered by state requirements

State civil service rules and collective bargaining requirements continue to limit the corporation's ability to effectively use personnel resources. Act 262, SLH 1996, which created the corporation, provided little relief from the State's inflexible personnel system. Although Act 262 allows the corporation to establish its own personnel system and to negotiate its own collective bargaining agreements, it still subjects the corporation to state civil service rules and collective bargaining requirements. These rules and requirements impose restrictive procedures and non-competitive compensation levels that continue to hinder the corporation's ability to attract needed personnel. Furthermore, the corporation's ability to negotiate collective bargaining agreements is constrained because any negotiated agreement is subject to the approval of other state parties. A recently passed law increases the corporation's flexibility in managing its personnel, but more time is needed to fully assess its impact.

A responsive personnel system is needed

Continued utilization of the State's personnel system hampers the ability of the corporation to meet staffing needs and market demands in a timely manner. To fill a position under the state personnel system, the corporation must go through a lengthy process that slows the corporation's ability to meet changes in demand for patient care services.

The corporation's ability to manage its personnel resources is also constrained by existing collective bargaining agreements that limit the corporation's ability to manage employees and address pay issues. The current collective bargaining agreements were negotiated without the corporation's involvement and may not adequately address staffing issues necessary to meet the unique needs of a health care system. In addition, uniform compensation programs negotiated through collective bargaining often make it difficult for the hospitals to competitively recruit staff with essential skills or experience. Consequently, the corporation faces a shortage of specialty providers such as physical therapists and occupational therapists.

Although Act 262 allows the corporation to negotiate its own collective bargaining agreements when the existing agreements expire, the corporation's negotiations are still governed by the Office of Collective Bargaining's procedures and approval process. Any negotiated agreement must be approved by the Office of Collective Bargaining and other applicable public employers. A negotiated agreement between the corporation and union can be disapproved by other affected public employers.

Hospitals require flexible labor and compensation arrangements to remain competitive and to meet the unique needs of a health care system. For example, hospitals often require flexible work arrangements for nurses because their services are needed continuously. However, the state personnel system constrains the corporation's ability to organize flexible work arrangements. A community hospital nurse's request to work half-time could be accommodated, but the hospital risks losing the remaining half of that nurse's appropriated position. This rigidity hurts recruiting efforts when health care professionals desire alternative work arrangements.

The state personnel system's process also increases costs for the corporation. For example, a Kauai community hospital required a registered professional nurse for its surgical services unit. The annual salary of a permanent registered professional nurse is approximately $46,000. However, because of the State's cumbersome hiring process, the hospital contracted with a private agency to provide nursing services. From August 1996 to August 1997, the hospital paid the private provider $120,000 for the needed services.

The inability to fill a vacant position in a timely manner results in lost revenues for the corporation. For example, one hospital estimates that it lost about $61,500 in revenues over a twenty month period due to a vacancy in its occupational therapy services unit. The inability to fill a vacancy quickly also impacts patient services. For example, if a certified registered nurse anesthetist position becomes vacant and remains unfilled, the hospital may be forced to limit surgical procedures.

Collective bargaining requirements that restrict the corporation's ability to set employee compensation levels make it difficult to recruit and retain qualified staff. One community hospital reports that a noncompetitive salary delayed the hiring of an x-ray technician and resulted in the loss of several other x-ray technicians. The hospital reports that some x-ray technicians quit in order to work for a private company that pays $3 more per hour than the hospital.

In addition, many qualified individuals are reluctant to become emergency hires. Emergency hires do not receive fringe benefits and do not necessarily receive any preferential treatment when the permanent positions become available. In 1994, the Legislature appropriated 75 exempt positions for the Division of Community Hospitals. However, the 1995 Task Force Report found that 75 positions were still insufficient to address the hospital's human resource needs. Moreover, the Legislature limited the use of these positions to clinical staff.

New law may provide increased flexibility

A 1998 law may provide increased flexibility for the corporation to manage personnel but the full impact of the law cannot be assessed at this

time. Act 229, SLH 1998, provides the corporation with position control management and the authority to negotiate specific terms and conditions of employment with collective bargaining units through memorandums of agreement. The corporation believes that this authority to negotiate memorandums of agreement allows the corporation to avoid getting approval from other civil service state agencies. Hospital administrators believe that position control management will give the corporation the authority and flexibility to manage positions and to authorize and establish positions without legislative approval. The corporation expects that Act 229 will save a considerable amount of time and effort in allowing the corporation to create or abolish positions without legislative approval. The law was recently passed and it is premature to fully evaluate the effects of this new legislation.

Corporation inherited an inadequate information system

In prior audits of the Division of Community Hospitals, we found a deficient information system that was not implemented statewide. Despite expenditures of several millions of dollars, the division poorly managed the development of its information system and implemented one that could not generate necessary financial and operational information to manage the community hospitals.

When the corporation was established, statewide implementation was still non-existent, and the computer systems used by the various hospitals were not integrated. These shortcomings continue to be major factors contributing to the deficiencies in the corporation's financial system.

Development of the system was poorly managed

The Division of Community Hospitals began implementing the Community Hospitals Information Processing System (CHIPS) in FY1986-87 at an estimated cost of $4.6 million. In our 1992 study, *Study of the Division of Community Hospitals,* Report No. 92-6, we found that expenditures for CHIPS had exceeded $11 million, but CHIPS was still unable to generate adequate financial and operational information needed to manage the hospitals. In our 1995 report, *Audit of the Information System of the Division of Community Hospitals,* Report No. 95-21, we found that the division was implementing several different systems for different hospitals. Instead of using one main software system to serve all hospitals, the division designated CHIPS to serve acute care hospitals and purchased different software systems for rural and long-term care hospitals. In addition, the division's failure to follow state planning guidelines and to maintain adequate documentation resulted in a fragmented information system.

The hospital's lack of an integrated information system handicaps the corporation's access to financial information and results in delays and inaccuracies in financial reporting. Our 1995 audit of the information

system found that five hospitals could not ensure proper billings because the system could not network patient information. Several hospitals compiled data manually while others had to re-enter data manually to transfer information. The corporation also discovered that the accounts payable and material management modules for the computer system serving the large hospitals were never installed.

Changes were made, but additional improvements are still needed

Since the transition, the corporation has taken steps to remedy the deficiencies that it inherited from the Division of Community Hospitals. For instance, the corporation changed the accounting method from a modified cash basis to an accrual basis. Hospitals are now able to prepare monthly financial reports that provide the corporation with the necessary information to plan, control, and predict financial performance. The corporation also made changes that improved billing and collections for some hospitals. Policies and procedures have been reviewed and revised; critical accounting positions were redescribed; and experienced staff have been hired. The corporation also installed the materials management and accounts payable computer modules into the main computer system which now automates a previously manual process. The two largest hospitals use these modules, and the corporation is planning to have all hospitals connected to the main computer system.

In addition to installing the previously omitted software modules, the corporation spent almost $3.4 million to improve the financial system it inherited from the Division of Community Hospitals. However, questions about the reliability and consistency of financial reports still linger. The corporation is currently assessing the upgrade of its main computer system and implementing its long term care system. As discussed in greater detail later in this chapter, we found deficiencies in the planning and implementation of this new system.

Board failed to effectively manage transition efforts

The corporation's Board of Directors is responsible for planning and managing the community hospitals. During the early stages of the transition from a state hospital system to a corporate structure, planning was recognized as essential to ensure success. However, the corporation's Board of Directors failed to assert the leadership necessary to ensure an effective transition. The board did not ensure that the transition was properly planned and failed to adequately inform the public and hospital staff about the transition. As a result, the transition was not completed, hospital staff morale suffered, and the public remained uninformed about the transition.

A transition plan was never developed

According to the bylaws of the corporation, the Board of Directors is responsible for establishing policies and planning and management of the hospitals. As such, the board should have developed a transition plan and detailed implementation tasks. Transition plans serve as guides by which an organization obtains and uses resources to reach its objectives; ensures procedures and activities are consistent with the chosen objectives; and monitors and measures progress so that corrective action can be taken if progress is unsatisfactory.[1] Without plans, the organization cannot be assured that objectives will be obtained.

Although the board established a policy to guide the transition, it failed to ensure the development of a transition plan. The board was formed in August 1996. In October 1996, an outline of a management plan was developed to address the board's policy. However, this outline did not contain task descriptions, designate responsibilities, or establish timelines to measure progress. Although several board members expressed the need for a transition plan, the board failed to ensure that one was developed. During the course of our fieldwork, we found no evidence of a transition plan.

Without proper planning, the board has been unable to monitor the progress of the transition. Act 262, SLH 1996, gave the board two years to establish the corporation. After the two year period ends on November 30, 1998, the corporation must be able to assume some of the functions previously provided by state agencies to the Division of Community Hospitals. However, we found that the corporation may not be ready to assume all functions by November 30, 1998.

Effective communication was lacking

Effective internal and external communication is essential for a successful reorganization. The American Hospital Association publishes guidelines to help health systems meet the challenge of balancing the needs of the community with the needs of the organization undergoing a reorganization or restructuring. The association recommends that health system leaders educate and inform the community about the changes taking place, develop a communication plan that involves and informs all constituencies including medical staff and employees, and work with the community to understand the issues involved in changing ownership or control.

Open communication is crucial to easing employee concerns about potential layoffs and other changes associated with a major restructuring. Although several board members recognized the importance of increased communication efforts, little was done to ensure that appropriate action was taken. A communication plan was never developed, and the board's communications with employees via weekly newsletters were inadequate

to relieve concerns and alleviate low employee morale. The weekly newsletters contained little information about the effect the transition would have on employees. For example, although several newsletters mentioned that a personnel system would be established, the newsletters failed to explain the new personnel system's impact on employees. The board needs to ensure that information about the transition process, budget cuts, and the effects on front-line hospital employees are adequately communicated.

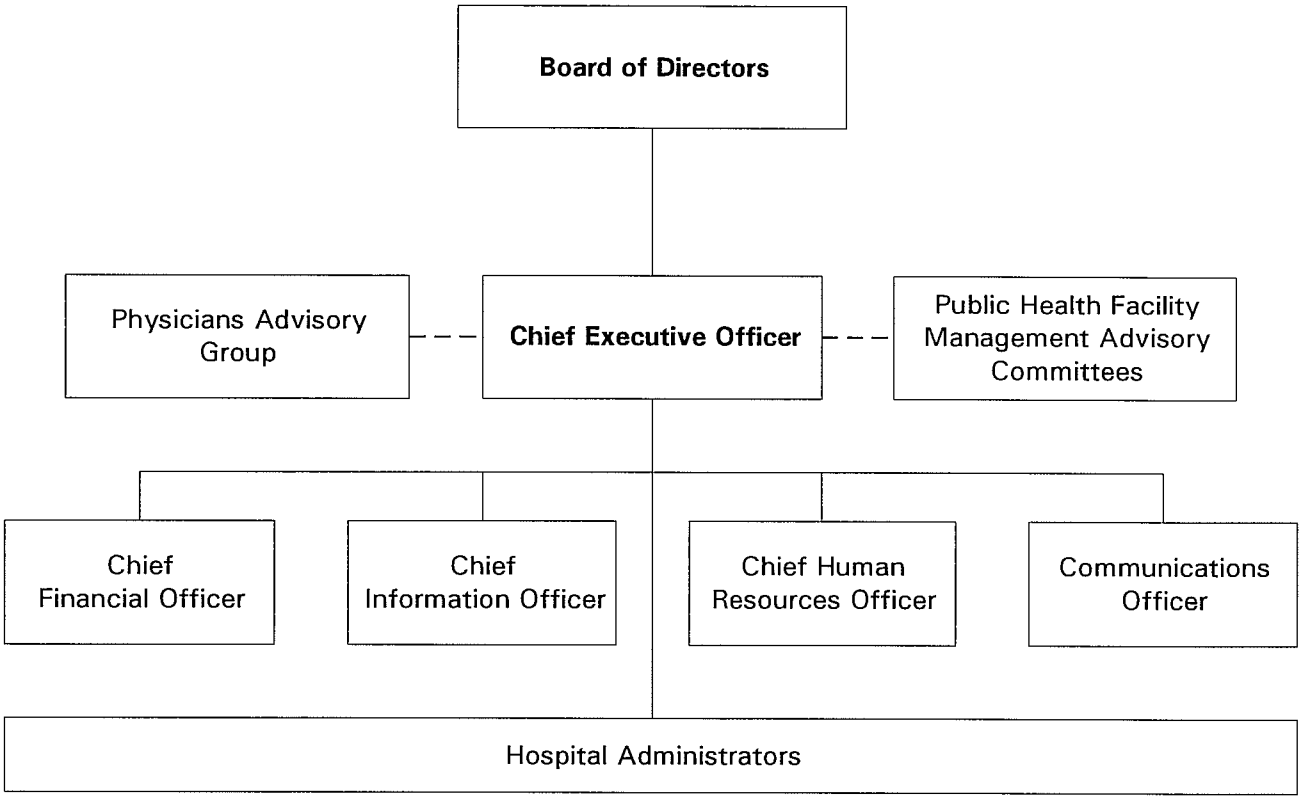
The board's communication with the community was also deficient. Act 262 required the formation of Regional Public Health Facility Management Advisory Committees by November 30, 1996 to advise the corporation on community needs and concerns. However, most of the committees were not formed until July 1997 and some committee chairs reported receiving little or no feedback from the corporation's acting chief executive officer. This failure to ensure proper communication caused one committee chair to speculate that the chief executive officer's actions may not have been in the best interest of the community. The acting chief executive officer left and a new chief executive officer assumed the role. We are encouraged that the new chief executive officer has taken steps to improve communications with the management advisory committees.

Deficiencies went unrecognized

A chief executive officer (CEO) is appointed to implement the policies and directives of the board. As an agent of the board, the CEO is responsible for the day-to-day planning and management of the corporation. Exhibit 2.1 illustrates the governance structure established by the board. In 1996, the board appointed an acting CEO and agreed to award him $100,000 to $150,000 if he accomplished certain tasks. The amount was to supplement his annual salary. Before the acting CEO left the corporation, the board awarded him a $125,000 incentive payment even though a number of assigned transition tasks were never completed. The acting CEO failed to develop transition and communication plans and did not complete the corporation's computer system. Moreover, although these major tasks were not done, the board passed a resolution praising his work.

The board should have evaluated the acting chief executive officer's performance against established goals, but we found no evidence of any official or written evaluations. Taking into consideration the number of tasks left incomplete, we question whether the $125,000 incentive payment was justified. Exhibit 2.2 illustrates the status of the acting CEO's assigned goals when he left the corporation.

Exhibit 2.1
Governance Structure of the Hawaii Health Systems Corporation



Source: *The Board Book*, Hawaii Health Systems Corporation, June 1997 and interviews with corporate officers.

Exhibit 2.2
Status of Performance Goals of the Former Chief Executive Officer

Goals Completed	Goals Not Completed
• Established management structure and put an interim management team in place.	• Complete the transition from a government entity to a private corporation.
• Organized the Board of Directors and established state-mandated board committees.	• Develop an operating plan with specific goals and objectives.
• Established and received state approval of a two-year budget.	• Put an information system in place.
* Established communication with system physicians.	
• Implemented a corporate set of books and had them in place by July 1997.	

Internal Control Structure Does Not Ensure Accountability

Management has a duty to develop and maintain a structure of internal controls. Proper internal controls allow management to:

1. Safeguard resources against waste, fraud, or inefficient use,
2. Encourage and measure compliance with agency policies, and
3. Evaluate the efficiency of operations.[2]

Good control procedures should provide proper authorization of transactions and activities, appropriate segregation of duties, and adequate documentation and recording of transactions and events.[3]

Accounting policies and procedures are non-existent

The corporation does not provide adequate guidance on accounting policies at the community hospitals. For example, the corporation primarily relies on memos and verbal instructions to guide accountants in producing financial reports. More guidance will improve confidence in the accuracy of the corporation's monthly financial reports and enhance their usefulness as planning tools.

We also found insufficient guidance for computing bad debt allowance. Without a uniform policy, the hospitals report bad debt expenses substantially below industry standards. To account for the hospitals' low estimates, the corporation adds approximately $2.5 million to the bad debt allowance computed and recorded by the hospitals.

In addition, the corporation also lacks a system-wide policy on allowing discounts for prompt patient payments. Without a policy, out of state patients who offer to pay their bills in cash or within a few days of billing in exchange for a discount may be unable to do so. Hospital staff have to refer these offers to managers who may not be available. A system-wide policy would enable hospital staff to handle and collect prompt payments.

Finally, the corporation needs to provide hospitals with a uniform rule on the use of tolerance thresholds for variances between purchase order and invoice totals. Different hospitals use various methods to determine the tolerance threshold when an invoice amount does not agree with the purchase order amount. Some hospitals use a percentage while others use a dollar amount. A uniform rule would promote greater consistency in reporting variances.

Procurement system is deficient

The corporation's procurement system lacks adequate management controls. Policies and procedures fail to address basic fundamental elements for internal control. In addition, ambiguous procurement policies allow various community hospitals to interpret the rules differently. Adequate guidance for selecting, monitoring, and controlling contractors is also missing. These and other deficiencies in the management control structure provide opportunities for unauthorized purchases, non-compliance with the rules, and non-cost effective contracts.

Unclear policies and procedures

Clear policies and procedures provide management with tools that educate, train, and guide procurement officers on necessary steps to accomplish a particular task. In addition, the Legislature encouraged the corporation to adopt rules consistent with the goals of public accountability and procurement practices. After seven iterations, the board established its procurement policies and procedures in April 1997. Despite the thorough review, the policies and procedures lack fundamental elements of internal control, create confusion, and result in noncompliance with procurement rules.

For example, the ambiguous policy on record filing requirements—a relatively routine procurement task—results in confusion among staff and inefficient use of time. One section of the policies and procedures manual requires hospitals to retain quotes for goods and services costing between $4,000 and $99,999. However, another section of the manual contradicts this policy by requiring quotes to be retained only for goods and services greater than $100,000. The ensuing confusion over this unclear policy creates extra work for the corporate procurement staff when hospitals call for clarification.

Another provision gives hospitals the ability to circumvent documentation requirements for purchases of goods and services under $50,000. The corporation's policies and procedures require hospitals to obtain two written quotes for goods and services costing between $25,000 to $99,000. However, the only requirement for an emergency purchase below $50,000 is the completion of a confirming purchase order. This provision allows hospitals to declare a purchase under $50,000 as an emergency without describing the emergency or obtaining written quotes. Without a description or written quotes, the corporation cannot ensure that the purchase is truly an emergency and is in the best interest of the corporation.

We found another provision that gives the CEO broad and arbitrary authority over discretionary purchases. The provision states that *"the chief executive officer may waive methods of procurement and/or dollar limit with written approval (discretionary purchases)."* This provision basically gives the CEO the power to bypass the entire procurement process. The policies and procedures manual does not provide additional clarification. How the waiver is accomplished or who provides the written approval is unclear. We conservatively estimate that the corporation has expended approximately $1.1 million on discretionary purchases since June 1996. The corporation should clarify requirements for discretionary purchases to ensure that vendors are given a fair opportunity to compete and purchases serve the best interest of the corporation.

Proper audit trail not maintained

Good internal controls require adequate documentation and records of transactions and events. To reduce the opportunity for fraud, each purchase should be adequately documented with records that can be audited. To provide an adequate audit trail, records should include: (1) a signed requisition, (2) an authorized purchase order, (3) a receiving document acknowledging receipt of the materials purchased, and (4) a vendor invoice matched against the original purchase and the receiving document to verify pricing and receipt of the materials purchased.[4] However, the corporation does not maintain proper audit trails and cannot ensure that purchases are properly authorized.

For example, approximately one half of the purchases we examined contained no purchase orders. For these purchases, a staff's phone or fax order bypassed the approval process, and management was informed of the purchase after it was made. We also found that the corporation's payment system does not always match invoices to corresponding purchase orders. The fiscal office simply sends the vendor's invoice to the staff who ordered the goods or services. The staff signs the invoice and returns the invoice to the fiscal office who then pays the vendor.

Without matching the purchase order to the invoice, the corporation is not assured that the goods are received or the services rendered are authorized.

At some hospitals, we found disorganized contract files that did not contain adequate documentation. For example, four out of five hospitals we tested did not always obtain or document the quotes required for small purchases. We found no evidence justifying why the quotes were not obtained, or in some cases, why the lowest quote was not chosen for purchases we sampled at the corporate office. Therefore, we were unable to determine whether the hospitals' purchases were made in the best interest of the corporation. In addition, we also found some contract files were unorganized or scattered. The absence of controls over contract files results in operational inefficiencies, promotes confusion, and impedes effective contract administration.

Improper segregation of duties

A fundamental concept of internal control is that no one person or department should handle all aspects of a transaction from beginning to end. At one hospital, we found improper segregation of accounts payable and purchasing duties in the hospital's Material Management/ Procurement department. The accounts payable function pays for goods that arrive from vendors. The purchasing function telephones vendors to place an order. The hospital placed the accounts payable function within the Material Management/Procurement department for convenience and operational efficiency. The placement allows accounts payable clerks to confirm and follow up on transactions with the purchasing and receiving sections. The hospital's placement allows the accounts payable clerks to purchase an item and pay for it.

Inadequate oversight by hospital administrators

At some hospitals, administrators do not have adequate oversight over daily purchasing activities. The corporation's policies designate the hospital administrator as being responsible for overseeing procurement. However, at two hospitals, we found purchases that bypassed the hospital administrator's approval or oversight. During our review, we found request for purchase forms that were not signed by the administrator. Therefore, the administrator does not receive notice of the purchase until it is paid for. Lax oversight by administrators encourages unauthorized purchases.

We also found that the Hilo Medical Center's administrator failed to maintain a written designation of the hospital's procurement officer. Instead, the Hilo Medical Center followed an informal, unwritten, and internal delegation of purchasing authority. The corporation should

ensure that hospitals prepare and file a written delegation of purchasing authority to clearly designate who can approve purchases and by which method of acquisition.

Contract management is inadequate

The corporation's lack of adequate supervision and oversight over contract management have resulted in non-cost-effective contracts and needless duplication of effort. Contracts contain vaguely defined scopes and costs and lack clear and measurable descriptions of deliverable items' incurred costs. Finally, the corporation failed to effectively monitor contract performance.

Contracts are poorly written

A properly planned and well written contract clearly defines the scope of services and a description of the expected outcome. The contract should clearly tie the contractor's remuneration to measurable "deliverables." However, we identified several consulting and professional services contracts with vaguely stated scopes and no measurable performance goals. This hinders the ability of the corporation to assess whether the contractors provided cost-effective services. As a result, the corporation has entered or undertaken disadvantageous contracts or contracts of questionable merit.

Between September 1996 and May 1998, the corporation spent over $5 million on consulting and professional services contracts with at least 18 contractors. Some of the corporation's contracts were poorly worded, contained insufficient scopes of services, and lacked associated output requirements. The following reflects vague scopes of responsibilities contained in several of the corporation's contracts:

- *"Contractor will assist the Acting CEO . . . and the Acting CFO in preparing a financial plan, including the supplemental and biennial budgets and a due diligence study"*
- *"In addition, Contractor will perform ad hoc assignments as coordinated by the Acting CEO."*
- *"Contractor will assist Acting CFO on cash management program, and monitoring (other consultants') due diligence contract"*
- *"Contractor will assist Acting CFO and Acting CEO in evaluating progress of accrual accounting crossover plan, Phase II information systems, HMSA negotiating term sheet, and reconcile the Deloitte A/R contract with the proposed Business Office re-engineering by Arthur Andersen."*

Loosely defined contracts impair evaluation of results and are inconsistent with cost-effective use of consulting services.

Duplicative work is performed

The corporation's inadequate oversight has also resulted in unnecessary duplication. Effective corporate guidance and oversight are essential to ensure that contracts support strategic goals, do not duplicate efforts underway elsewhere, and provide identifiable benefits. The corporation and one of the community hospitals hired two separate consulting firms to perform work related to billings and collections. This work was poorly coordinated and resulted in the two firms performing overlapping tasks, reporting similar findings and recommendations, and overburdening staff. One of the contracts was eventually suspended and none of the work performed by the consulting firm resulted in any significant beneficial changes.

The corporation also paid about $1.7 million to one consulting firm for professional services that are normally performed by hospital staff. Specifically, the corporation paid the consultant $1.2 million to collect accounts receivable. The purpose of the contract was to provide a one-time cash infusion from liquidating outstanding accounts and to relieve accounting staff from the labor-intensive collection activities of collecting on older accounts. The consulting firm collected $8 million over an eight month period in 1997. According to one hospital executive, the consultants "did bring in money faster than we could have done." However, this may have been caused by the lack of properly qualified and trained staff. The hospital filled only four of eight available billing/ collection clerk positions that were reclassified as recommended by our Report No. 92-6.

Monitoring is insufficient

The corporation also inadequately monitors its contracts. Hospital administrators are required to periodically review contracts less than $100,000; however, the hospitals we visited were not properly monitoring contracts. Of the five hospitals that we visited, three did not have a list of contracts; one had an incomplete list; and another had an outdated list. Furthermore, none of the hospitals had written contract monitoring procedures. The hospitals reported that they generally followed procurement policies and procedures for monitoring contracts. These policies and procedures recommend the maintenance of a contract management system data file; however, hospitals do not maintain adequate files. The system data file should contain an annual evaluation of how the contract is proceeding, but we found no evidence that evaluations were completed. The procurement policies and procedures do not provide additional detailed guidelines for monitoring.

Without adequate monitoring, projected savings may not be realized. In our prior audits, *Financial Audit of the Hilo Medical Center,* Report No. 96-4 and *Financial Audit of the Kona Community Hospital*, Report No. 96-17, we found that hospitals were not receiving cost-effective laboratory services from a private provider. The contract paid the laboratory services contractor more than what the hospital would receive from patients and third party payers for reimbursements. In July 1997, the corporation renegotiated the contract for a reported savings of $5 million. However, this figure may be inaccurate because the corporation has not verified that reimbursements from third party payers and patients are sufficient to cover the cost of the laboratory services.

Corrective measures have been instituted

The corporation has improved the process for assessing the need for consultants and has implemented several cost saving measures. For example, the corporation terminated open-ended contracts that paid consultants at an hourly rate. In addition, the corporation realized some cost savings when it hired a consultant as a temporary employee and paid him less than his previous contract amount.

The chief executive officer also intends to use the request for proposal process to contract with one consultant to produce Medicaid cost reports for the community hospitals and to perform annual financial audits. Previously, different audit companies performed financial audits of the twelve hospitals separately. The corporation may realize additional cost savings by consolidating the separate audits under one contract.

Although the corporation has made some improvements, we note that hospital employees are a resource that the corporation has not yet utilized to solve recurring problems and to improve productivity. Consultants hired to assess and improve hospital operations credit the hospitals' staff for being aware of problems and for providing the ideas for improving operations. In 1992, we suggested that the hospitals use "circuit riding" staff with specialized skills. Under circuit riding, pools of workers in hard-to-fill specialty areas are created and shared among facilities. Pooling employees minimizes costs for hospitals in remote areas by centralizing services such as data processing. This may also prove helpful in disseminating solutions for common problems between hospitals.

Corporation Failed to Plan and Implement an Efficient Information System

Overall management of the information system was inadequate under the Division of Community Hospitals and continues to be deficient under the corporation. Hospital computer systems maintain patient and accounting information; therefore, poor management over information systems has a direct effect over the corporation's financial system. A computer system should compile information into useful reports and allow management to determine the financial status of the corporation. The lack of integration among the various hospitals' computer systems results in inefficiencies which hinder the timely production and accuracy of financial reports. The corporation hired consultants to strengthen its information systems and made some improvements, but the corporation failed to develop a long-range strategic plan and is late in addressing Year 2000 requirements for computer-based equipment.

Strategic development plans are lacking

Strategic or long-range information systems plans support the strategic goals of an organization. Long-range plans establish the baseline for more detailed planning and sets the direction toward specific goals. We found no evidence that the corporation developed any strategic or long-range plans. Without a systematic approach to planning, cost-effective information systems cannot be implemented. Health care systems that have evolved in the absence of a carefully controlled planning process often encounter problems and inefficiencies in information processing. These inefficiencies result in redundant systems, duplicated files, and repetitive data.

A long range strategic plan would help the corporation achieve its goal of an integrated system. The planning process should begin with a review of the hospital's mission and major strategic objectives. The plan should document the current status of information systems for direct patient care, support services, administrative and financial control, and strategic decision support. After the objectives are defined, system integration should be addressed. The plan must assess the degree of system integration and the extent to which the system should be centralized or decentralized.[5] The degree of system integration will depend on several factors, such as the size of the organization, the desired degree of user control or central control, and special information requirements. The final elements of the plan are an overall schedule and a set of target dates for implementation. Although target dates are preliminary, they aid hospital management and board members in evaluating the commitment required to implement the system. The long-range plan is a dynamic instrument that should be periodically reviewed and annually updated.

Long-term care system was poorly planned and implemented

The corporation developed its long-term care information system in response to federal requirements that long-term care hospitals electronically transmit certain automated reports by July 1, 1998. Failure in meeting these requirements would result in a lower reimbursement rate for patient care and a loss of revenues for the corporation. Although the corporation implemented a long-term care information system, it did not determine how that system would interact with the main information system. As a result, billing and financial functions of long-term care hospitals remain inefficient and are not integrated with the corporation's main information system.

We found that the corporation implemented the long-term care information system without following the State's System Development Methodology. The State requires state agencies to use the System Development Methodology when developing or acquiring information systems. The methodology provides detailed guidelines and step-by-step descriptions of tasks that help ensure that the system meets user needs. One of the most important tasks is developing a system design plan. This plan describes what the system will do for the users and how it will be done. The corporation failed to develop a system design plan that specifically describes how the new system's information will be integrated with the corporation's existing system. Consequently, the corporation selected a vendor that provided a system that fails to meet hospital needs and lacks integration with the rest of the hospital's information system.

Although the hospitals are able to use the long-term care information system, the system is inefficient and has other deficiencies that raise questions over its cost-effectiveness. After selecting the vendor, the corporation separated implementation into a clinical and a financial component. The corporation implemented the clinical component and all eleven long-term care hospitals currently have the capability of meeting federal government requirements. However, during heavily used periods, users may wait over 30 minutes to log onto the system, and user requests are not responded to in a timely manner. Correcting these deficiencies will increase the total developmental cost. The long-term care information system software costs over $300,000, but the corporation has retained almost $150,000 because the system does not meet user requirements. In addition, the corporation has already spent almost $1.1 million for professional services, software upgrades, and other equipment for the system.

The corporation is also experiencing difficulties in implementing the financial component of the system. The financial component automates the patient accounting function to ensure accurate and timely billing of patients and third-party payers. Without the financial component, the long-term care hospitals are still without general ledger, automated

billing, and accounts receivable capability. Long-term care hospitals must manually input data into a different software program for accounts receivable and billing. The output from this program is then manually entered into a separate general ledger system that produces financial reports.

Policies and procedures are non-existent

The corporation's failure to establish definitive guidelines for acquiring software results in additional inefficiencies. The lack of policies over the purchase of software systems is not a new problem. In our 1995 audit, we found that the Division of Community Hospitals did not have a policy for the acquisition of computer software. Hospitals purchased software without the review or approval of the division. After purchasing the software, a hospital would then discover that the software was incapable of exchanging data with the main computer system. Our current audit found that written standards for the acquisition of computer hardware and software still do not exist.

Hospitals continue to use automated systems that do not communicate with or transfer data to the main information system. As a result, one hospital has to dedicate four full-time employees to manually input data received from other hospital departments' automated systems into the main information system. This operation costs the corporation over $100,000 in salaries and benefits per year. At another hospital three full-time employees input data at an annual cost of over $70,000.

Year 2000 problem has not been addressed

The Year 2000 problem results from the way dates are stored and processed in many computer systems. For the past several decades, programmers commonly used two digits to represent the year to save on expensive storage and processing costs. In the two digit format, the year 2000 is stored in the computer much like the year 1900 because the two digit format represents both numbers as "00." If corrective action is not taken, most computers will not work or will give false information after December 31, 1999. For example, a person born in 1935 will become 65 years old in year 2000, but the computer may report the age as -35 or 35. Some accounts receivable may be deleted because the computer interprets them as being uncollectible, and errors in scheduled lab tests, surgeries, and office appointments may occur. Failing to meet Year 2000 requirements could affect health care, business operations, and create future liabilities for the corporation.

The Year 2000 problem affects more than information systems. Medical equipment and devices have embedded chips that store and process dates. Embedded systems consist of any device controlled by a microprocessor with date sensitive logic. Most modern medical equipment use embedded microprocessors. When year 2000 arrives, some biomedical equipment

will stop working because the microprocessor within the equipment perceives that a hundred years passed since the last maintenance. Some of this equipment will not restart until maintenance has been performed. In some instances the equipment may simply have to be replaced. Elevators, power generators, and telecommunications systems that process information on dates may also be affected.

The corporation is still in the early phases of addressing the Year 2000 problem and will probably not correct all equipment in time. Other hospitals in Hawaii have been working towards Year 2000 compliance for over a year at costs ranging from $13 million to $15 million. The corporation must identify all computer systems, medical equipment, hospital infrastructures, and external sources requiring Year 2000 compliance. Any faulty equipment must be fixed or replaced and then tested. The corporation recently created a Year 2000 Project Team but anticipates hiring consultants to assist in the effort. It appears that the corporation will have a difficult time correcting the problem within the time available.

Conclusion

Approximately two years have passed since the governor appointed a Board of Directors to manage the Hawaii Health Systems Corporation. During those two years, the board hired executive officers, established a financial system, and delegated authority. However, the board has failed to plan and ensure that its policies are appropriately implemented in a cost-effective manner. The board failed to establish a transition plan, develop cost-effective procurement policies and procedures, and ensure the corporation's information system is adequately developed. These weaknesses will not ensure the establishment of a viable and competitive organizational structure. A strong board is needed to implement and monitor policies and enforce accountability.

Recommendations

1. The Board of Directors of the Hawaii Health Systems Corporation should develop a transition plan. At a minimum, the plan should include:

    a. Detailed descriptions of implementation tasks that still need to be done to complete the transition of the Division of Community Hospitals to a competitive and viable public benefit corporation;

    b. Justification for additional legislation that may be necessary to achieve goals;

    c. Specific time frames for when the tasks will be completed;

d. A communication plan for the community and hospital staff on issues involving the reorganization of the community hospitals; and

e. An implementation plan for its personnel system with specific time frames by which personnel related tasks will be accomplished.

2. The administration should establish formal policies and procedures for accounting practices, distribute the procedures to the facilities, and ensure that they are followed.

3. The board should amend its procurement policies. Specifically, the board should:

   a. require a formal analysis of:

      - the expected benefits and outcome for all contracts,
      - an assessment of alternatives, and
      - any recommendations by in-house staff which relate to the objectives of the contracts;

   b. require that the scope of services specified in contracts contain specific objectives and deliverables which can be measured and evaluated;

   c. develop clearly defined monitoring procedures;

   d. require an evaluation of each contract upon its completion to determine if objectives have been achieved;

   e. require complete contract documentation for personal services contracts; and

   f. ensure hospitals follow contracting procedures.

4. The administration should improve the management of information systems by:

   a. developing a strategic plan to define the long-term information systems needs; and

   b. establishing standards, policies, and procedures to control information systems acquisitions.

5. The administration should ensure that all computer and automated medical equipment are Year 2000 compliant to preserve uninterrupted quality patient care, to maintain business operations, and to avoid liability.

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Notes

Chapter 2

1. James A. F. Stoner and R. Edward Freeman, *Management*, 5th ed., Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1992, pp. 8-9.

2. Walter B. Meigs, et al., *Principles of Auditing*, 9th ed., Richard D. Irwin, Inc., Homewood, Illinois, 1989, p. 149.

3. Ibid., pp. 160-161.

4. Kowalski-Dickow Associates, Inc. in cooperation with the American Society of Healthcare Materials Management of the American Hospital Association, *Managing Hospital Materials Management*, American Hospital Publishing, Inc., an American Hospital Association Company, Chicago, Illinois, 1994, p. 64.

5. Charles J. Austin, *Information Systems for Health Services Administration*, 4th ed., AUPHA/Health Administration Press, Ann Arbor, Michigan, 1992, p. 54-55.

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Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Hawaii Health Systems Corporation on February 3, 1999. A copy of the transmittal letter to the corporation is included as Attachment 1. The corporation's response is included as Attachment 2.

The corporation basically concurs with the findings and recommendations of the audit except for comments about the Board of Directors. In its response, the corporation states that the audit time period describes the "embryonic infancy" of a new organization and fails to consider post-audit developments and achievements. The corporation stated that many of the audit findings have been resolved or are in the process of resolution.

The corporation also states that the audit covered the first 24 months of the corporation's operations and that the Board of Directors was not organized until several months into the audit period. The corporation further adds that a permanent Chief Executive Officer (CEO) was hired 13 months into the period and it was 19 months into the period before the CEO organized the primary corporate staff, established an office, and filled vacancies in leadership positions. The corporation asserts that after the audit ended, the Board of Directors implemented a concept of measurement and performance accountability to hold its leaders accountable. The corporation states that the Board of Directors volunteer their services to develop and implement a new concept in healthcare—a public benefit corporation. The corporation maintains that the Board should not be criticized during the first two years of the corporation's existence, but rather should be recognized as "unsung heroes."

We would note, however, that although the audit period covered the first 24 months of the corporation's existence, the Board's experience with hospitals should have produced greater results. Almost half of the board's membership has significant hospital experience while other members are also on the boards of large organizations. Three months after the corporation was formed, the board hired an acting CEO, who formed a management team. The acting CEO also established an office and filled leadership positions. The acting CEO managed the corporation until the permanent CEO was hired. Although the acting CEO left several tasks incomplete the Board nevertheless awarded him a substantial monetary bonus. We do not believe this kind of leadership is an acceptable holding of responsible parties accountable. The fact that board members are volunteers does not relieve the board of its management responsibility to properly manage a multi-million dollar corporation.

The corporation further asserts that the audit does not recognize significant accomplishments since the audit fieldwork was completed. In its response, which we have appended in its entirety, the corporation presented examples of actions that have recently taken place.

We are encouraged by the advances reported by the corporation. We made some editorial changes in our report for the purposes of clarity and style.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

February 3, 1999

COPY

Mr. Thomas M. Driskill, Jr.
President and Chief Executive Officer
Hawaii Health Systems Corporation
3675 Kilauea Avenue
Honolulu, Hawaii 96816

Dear Mr. Driskill:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Audit of the Hawaii Health Systems Corporation*. We ask that you telephone us by Friday, February 5, 1999, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Friday, February 12, 1999.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

ATTACHMENT 2

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N
"Touching Lives Everyday"

February 12, 1999

CFO-99-030

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa:

Thank you for the opportunity to respond to the draft *Audit of the Hawaii Health Systems Corporation.* Attached are comments that we ask that you include in the report.

I would again like to comment on the courteous, professional behavior of your staff during this process. Please do not hesitate to call me if you have questions or wish to discuss any portion of the Audit or our response.

Most sincerely,

Tom Driskill

THOMAS M. DRISKILL, JR.
President and Chief Executive Officer
Hawaii Health Systems Corporation

Attachment

HAWAII HEALTH SYSTEMS CORPORATION (HHSC)
RESPONSE TO LEGISLATIVE AUDIT
FOR THE PERIOD JULY 1, 1996 – JUNE 30, 1998

With the exception of comments about the Hawaii Health Systems Corporation (HHSC) Board of Directors, we basically agree with the findings of this audit. However, we must point out that the audit focuses on dated information. It took almost 30 years for the former Division of Community Hospitals to reach the level of inefficient performance described in this audit. The focus of the audit is on the first two years of the "turnaround" corporation, but the primary corporate staff was not fully on board until the last five months of the audit period. Almost all issues addressed in the audit can be attributed to the beginning of the corporation where there was only a small acting staff trying to manage a huge transition with limited expertise, no transition funding, and tremendous initial community anxiety. Nonetheless, concerns raised in this audit have been identified and corrected or are in the process of being corrected by HHSC.

This audit only covers the period of time from July 1, 1996 through June 30, 1998. Consequently, this period characterizes the way things were, not the way things are today. It does not take into consideration post audit developments that HHSC has undertaken nor does it acknowledge achievements that took place during the audit period but were recognized after the audit closed. This audit describes the embryonic infancy of a brand new organization. With the stroke of a pen, Act 262 created the fourth largest public hospital system in the country and the fifth largest employer in Hawaii with an effective date of July 1, 1996. However, the Act made no monetary allowance for the transition of the 12 independent hospitals located on 5 different islands being pulled together into one corporate entity, and the Act made no concession for more than $150 million in prior liabilities inherited by the corporation.

This audit covers the first 24 months of HHSC's operation, but it was several months into this audit period before the Board of Directors was identified and organized. It was five months before the State passed the operation of the 12 hospitals to the Board of Directors. Following an equal opportunity recruitment process and utilizing a national search firm, it was 13 months into this period before the first permanent Chief Executive Officer (CEO) was hired. It was 19 months into this period before the CEO was able to organize and hire the primary corporate staff, establish an office, and fill leadership vacancies that had occurred in 6 of the 12 hospitals. At the 19 month mark, the CEO entered the 1998 legislative session and spent the next 3 to 4 months working with the Legislature and the Governor to build both a cash and an accrual financial system so that HHSC could present meaningful information to the Legislature. Cash-based analysis is necessary for comparison with the way the rest of the State operates. Accrual accounting is necessary for representing more credible and accurate accounting information that provides the data necessary to build reserves for prior liabilities, such as workers' compensation, and for future needs, such as depreciation of equipment and facilities.

During FY 98, the Board of Directors introduced metrics for performance evaluation to hold HHSC leaders accountable for their actions. One day after the audit was closed (July 1, 1998), this concept of measurement and performance accountability was fully implemented by the Board of Directors through the simultaneous reorganization of HHSC into five separate regions, each with its own Regional CEO and regional management team reporting to the Corporate CEO with a corporate management team reporting to the Board of Directors. The Corporate CEO also receives advice from five Regional Management Advisory Committees (MACs), an Executive MAC, made up of the Chairs of the five regional MACs, and a Physicians Advisory Group (PAG) representing the medical staffs in all five regions. Each of these advisory committees now meet monthly with the Corporate CEO. An overlay of the developmental time frame for these advisory groups, plus the development of the current management structure, compared to the period covered by the audit offers a much better perception of the traumatic evolutionary early transition experienced by HHSC and the Board of Directors. To say that the Board, with its fiduciary responsibility, did not provide sufficient oversight and transition planning does not consider the total absence of a system structure when Act 262 created the corporation. The initial Board of Directors appointed by the Governor was composed of key business, labor, and healthcare system leaders here in the State of Hawaii. These individuals took time away from their other business endeavors to volunteer their services and accept fiduciary responsibility for the development and implementation of a new concept in healthcare for the State of Hawaii–a public benefit corporation.

Act 262 established the parameters for the new corporation. It retained all State civil service rules and collective bargaining agreements for the HHSC workforce, and it required continuation of all substantial levels of service that were in effect on July 1, 1996. It permitted some autonomy in governance, management, and procurement and implied that these degrees of autonomy would be sufficient to overcome the growing inefficiencies that had plagued the former Division of Community Hospitals for years and had cost the State millions of supplemental dollars. With these factors in mind and an understanding of the challenges facing HHSC, the Board of Directors should not be criticized for their efforts during the first two years of the corporation's existence, but rather, they should be recognized as "unsung heroes" who have given of themselves on a volunteer basis to make life better for the communities served by HHSC.

It is unfortunate that the audit, which closed on June 30, 1998, is not able to recognize the significant FY 98 HHSC accomplishments that have come to light in the more than seven months since the audit was completed. Accomplishments over the past seven months and operational successes for FY 98 that were subsequently documented after the audit cut off date address many of the concerns discussed in this audit.

We accept and understand that comments in the audit cannot go beyond the cut off date because it would require independent validation by the auditors of any information provided after the audit was closed. So we offer one single piece of paper attached to this response showing HHSC's FY 98 accomplishments as they have been validated and audited by the independent firm of Deloitte and Touche plus additional accomplishments recognized during the last half of calendar year 98. Please note that

Deloitte and Touche has given HHSC an unqualified "clean" financial audit for FY 98 with no material weaknesses (except for Year 2000 concerns which are now well in progress of resolution) compared to the FY 97 audit which was qualified and had numerous material weaknesses.

Concerns expressed in this audit have either already been resolved or are in the process of resolution. Examples of actions that have been taken:

Accounting Policies and Procedures - In the area of financial management and accounting, HHSC has implemented accrual accounting practices and has continued to improve and expand on monthly financial and operational reporting while at the same time identifying and beginning to fund reserves. Improvements in these areas were reflected in the unqualified audit opinion from Deloitte & Touche for the fiscal year ending June 30, 1998. Also, using this accrual accounting system, HHSC has been able to reflect leadership performance on a monthly basis and hold HHSC leaders accountable for their performance. This accountability to the Board is something that was never achieved during the previous 30 years of Division of Community Hospitals operations. In fact, HHSC now has developed and implemented a detailed system for performance evaluation of all exempt personnel where no evaluation system was in effect prior to July 1, 1996.

Strategic Planning - HHSC has developed, published, and is implementing a dynamic Strategic Plan to take the corporation and its hospitals into the 21st Century. In early October 1998, approximately 50 representatives of all HHSC stakeholder groups (Board of Directors, Unions, PAG, MAC, the Office of the Governor, and management) came together in Hilo for a weekend off site to formulate the HHSC Strategic Plan to carry the corporation into the year 2010. With professional facilitators, as well as on-site national healthcare expertise provided by the National Association of Public Hospitals and the Healthcare Association of Hawaii, the group formulated a strategic plan, with mission, vision, values, and strategies to carry HHSC into the 21st Century. HHSC now has strategic direction and has reoriented itself into a customer-focused organization with our three priority customer groups being our patients, our employees, and medical staff. Please refer to the reverse side of the one-page enclosure to this response for basic information on the new HHSC Strategic Plan.

Facility Planning - We agree that facility master planning was a longstanding weakness that HHSC inherited from the Division of Community Hospitals and have taken action to improve the management of our facilities. Over the past year, leadership and employees at all levels have identified over $65 million in facility improvements, repairs, and renovations that are needed and have submitted through the Department of Health directly to the Legislature for consideration. We have prioritized these requirements and have identified those that are most urgently required for fire, life, safety, and code compliance and for accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or Medicare and Medicaid certification. In addition, HHSC has engaged an engineering firm to conduct a baseline, professional assessment of all buildings. Final reports by facility, by building, will be completed prior to the end of the 1999 Legislature and will be shared with legislative leaders and their staffs.

Information Systems - We agree that the corporation did inherit an incomplete, fragmented and non-integrated hospital information system. The new HHSC information systems organization has been developed over the past year under the direction of the Chief Information Officer who was hired in September 1997. Initial staffing of key HHSC information management personnel was completed in March 1998, but we have continually had staff losses in this area with our personnel being hired by our competitors. The Information Technology (IT) Plan was under development when the audit was completed in June 1998. The completion of the IT Plan in July 1998 identified many of the reported weaknesses and appropriate actions necessary to address them. These include the methodology in selection of software and hardware systems, the integration of an enterprise system, the Y2K problem and the identification of an Information Systems (IS) Strategic Plan project.

The IS deficiencies identified in the legislative audit have been recognized by the Executive Information Systems Steering Committee (ISSC) and have been placed in the IT Plan for resolution. HHSC is addressing strategic direction for the organization by delineating what information systems are needed to meet our business objectives. As these systems are identified, HHSC will expand the strategic focus of the current IT Plan. System development and procurement are now monitored by the ISSC in such a fashion that will prevent the unauthorized procurement of systems that are not integrated into our current IS environment. Also, our current plan for centralization of all IS activities will remedy the many other deficiencies that the audit reveals.

We agree with the audit that inadequacies clearly exist with the Long-Term Care (LTC) system that was purchased prior to the employment of the present executive management team. The criticality of meeting the July 1, 1998 federal mandate to implement the Minimum Data Sets (MDS) requirements necessitated the implementation of the clinical system portion of the LTC system even though HHSC management became aware that the LTC system was not sufficient to meet both HHSC clinical and financial standards. HHSC had no other choice in order to meet the federal mandate if billing reimbursement was to be continued. The decision was to implement the clinical portion of the system, meet the federal mandate, then go back through a competitive RFP with proper specifications to get the correct system on board. (The $1.1 million stated in the audit on page 25 as the cost of the LTC system does not compare to our records. It is considerably higher than the cost HHSC reflects.) Currently, the corporation is moving forward with plans that will give us a clinical as well as robust financial information system for our long-term care facilities. The IT Plan also identifies the need and plans to integrate the financial reporting of the long-term and acute facilities.

We agree that the corporation had a late start in addressing the Y2K problem. A Y2K project has since been initiated and a structure is now in place to address all of the systems that are not Y2K compliant. Y2K teams are in place for applications, hardware, medical devices, facilities equipment, and external interfaces and an emergency funding request has been submitted to help cover these one-time costs. The HHSC Board of Directors is updated monthly on the status of Y2K.

Human Resource System – The HHSC civil service personnel jurisdiction was created on July 1, 1997. HHSC now has its own jurisdiction, separate from the executive branch jurisdiction. This change has provided us limited flexibility and the ability to make minor changes in our rules and regulations that are consistent with HRS Chapters 76,77, and 89. Legislation passed in 1998 (Act 229) empowers HHSC to enter into Memorandums of Agreement and to maintain employee position control. These added powers, while not a total solution, have provided some relief from the inflexibilities left intact by Act 262.

HHSC developed a Human Resources Plan that was shared with the legislative auditors, and the plan has been implemented. Under Act 262, the State agencies shall continue to provide transitional services to HHSC through November 30, 1999, at no charge. HHSC has completed the transition of personnel functions and has already assumed responsibility for all personnel-related functions from the State's Department of Human Resources Development (DHRD), effective August, 1998.

We are supportive of the Governor's bill for civil service reform that will assist HHSC and other State agencies to reduce the "red tape" and provide more flexibility in the management of our personnel system and human resources functions.

Contract Management - We have encountered many challenges in the management of contracts and the procurement process. While we have been quite effective at reducing costs of goods and services and at expeditiously acquiring goods and services, we have identified the need to better comply with our own policies and also the need to revise our policies and procedures to enable us to manage the procurement process more effectively. As a result, HHSC is in the process of revising and publishing new Policies and Procedures for Procurement in order to implement better management controls to improve compliance. An extensive training program will follow the adoption of the new rules.

In summation, we appreciate the professional manner and competence of the legislative audit staff. They were courteous at all times, and they were very sensitive to HHSC management's requirements of simultaneously undergoing a legislative audit in the midst of meeting the myriad of information requirements generated during the 1998 legislative session. We would also like to say it is appropriate to overlay HHSC accomplishments of the past 18 months on top of the audit report covering the 2-year period from July 1, 1996 to June 30, 1998. Most of these accomplishments are reflected in the HHSC Annual Report for the fiscal year ending June 30, 1998, that was provided to the Governor and to the Legislature, and in the single-page enclosure that lists HHSC accomplishments, July 1, 1997 – December 31, 1998. As a public benefit corporation of the State of Hawaii, we are proud of the leadership provided by our volunteer Board of Directors, and we are open at all times to public review. We welcome the opportunity to tell the story of both the improvements we have made and the improvements we are continuing to make in the quality of care we provide and in the efficiency of our operations.

HAWAII HEALTH SYSTEMS CORPORATION (HHSC)
JULY 1, 1997 – DECEMBER 31, 1998 ACCOMPLISHMENTS

Bottom Line Improvement:

- Reduced losses from $46M in FY 97 to $17.7 M in FY 98.
- Increased cash revenue by $26M (13.5% increase) while only increasing expense $3.3M (1% increase) in FY 98.
- Earned 95% of expenses with only 5% state contract services support in FY 98.
- Renegotiated individual contracts with each of 12 HHSC hospitals for third party payors and medical supply into more favorable system-wide contracts.
- FY 98 system financial audit not qualified "clean" with no material weaknesses compared to FY 97 audit qualified with material weaknesses.

Accounts Receivable:

- Reduced A/R by 20 days, from 109 to 88 (competitive with other healthcare systems) in FY 98.
- Reduced outstanding net A/R by $7M from $46M to $39M in FY 98.

Quality:

- Increased levels of services in several rural healthcare areas, no decrease of service in any community supported by HHSC (all service level improvements generate additional revenues for HHSC).
- Developed and implemented corporate compliance/quality improvement program for the system.
- Reorganized Board QI Committee and established corporate Quality Council-standardized quality work and reporting throughout the system.

Information Management:

- Initiated and began to implement Y2K compliance program.
- Consolidated mainframe from two to one location.
- Developed and implemented e-mail and internet mail.
- Developed and implemented full motion video telemedicine system for all HHSC hospitals.

Personnel:

- Established union partnership through monthly HGEA/UPW/HHSC leadership meetings.
- Reorganized enterprise into five regions with supporting corporate entity, recognized levels of work and decentralized empowerment.
- Implemented system fix for new Workers' Compensation problems.
- Initiated system-wide customer satisfaction training.
- Initiated system-wide employee satisfaction survey.

Community:

- Solidified community input process through markedly enhanced HHSC/MAC/PAG interaction
- Institutionalized Executive MAC and placed both chair of Executive MAC and PAG representatives on Board of Directors.

Strategic Planning:

- Three-day facilitated offsite in Hilo with 50 representatives from all HHSC stakeholder groups.
- Developed strategic plan/direction for corporation – customer focused road map to 2010. (See reverse side of this page.)

HAWAII HEALTH SYSTEMS CORPORATION

Values

Integrity
Caring
Innovation
Collaboration
Commitment
Community

Mission

Providing and enhancing accessible, comprehensive health care services that are:
Quality-Driven
Customer-Focused
Cost Effective

Vision

Be the:
Provider of choice for the communities we serve
Employer of choice for our staff
System of choice for our physicians

Strategies

- Creating a patient-centered, integrated system that cares for our customers throughout the "Cycle-of-Life."
- Providing a supportive, productive, and empowered work environment by investing in our employee partners through the allocation of proper training and resources, recognition, rewards, and encouraging a sense of ownership.
- Joining with our physician partners to plan for and provide the people, equipment, and information technology resources which will enable the integrated delivery of optimal, quality care for the communities we serve.