October 31, 2014

John Keel, CPA
Office of the State Auditor
206 East Ninth Street, Suite 1900
Austin, TX 78701

Dear Mr. Keel:

We have prepared this report on the activities of The University of Texas Southwestern Medical Center's Office of Internal Audit in compliance with the requirements established in the Texas Internal Auditing Act (Texas Government Code, Section 2102). This report provides information on our FY 2014 and 2015 audit plans, audits completed and recommendations. Our audit work for FY 2014 focused on key externally requested and Institutional risk-based areas including patient care, research, information technology, compliance, core business processes, and other areas based on risk.

Our recommendations will help enhance the effectiveness of Medical Center operations by improving internal controls such as the reliability and integrity of financial information, safeguarding of assets, compliance with applicable policies and procedures, economical and efficient use of resources and accomplishment of goals and objectives.

We appreciate the opportunity to participate in this process. For further information about the contents of this report and/or to request copies of audit reports, please contact me at 214-648-6106.

Sincerely,

Valla Wilson

cc: Kate McGrath, Governor's Office of Budget and Planning
Ed Osner, Legislative Budget Board
Internal Audit Coordinator, State Auditor's Office
Ken Levine, Sunset Advisory Commission
Daniel K. Podolsky, M.D., President, University of Texas Southwestern Medical Center

The University of Texas
Southwestern Medical Center
Internal Audit Annual Report for Fiscal Year 2014

October 31, 2014

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER

INTERNAL AUDIT ANNUAL REPORT FOR FISCAL YEAR 2014

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I. Compliance with House Bill 16: Posting the Internal Audit Plan, Internal Audit Annual Report, and Other Audit Information on Internet Web site

The UT Southwestern Internal Audit Office prepares an annual report and submits the report before November 1 of each year to the Legislative Budget Board, the Sunset Advisory Commission, the State Auditor and the Governor's Office of Budget and Planning. In accordance with House Bill 16 these reports have been made available on the UT Southwestern internet website.

Past reports (including required annual Internal Audit Plans) can be seen at: http://www.utsouthwestern.edu/legal/required-documents.html

II. Planned Work Related to the Proportionality of Higher Education Benefits

At the request of the Governor, an internal audit of the proportionality of higher education benefits process is underway during the first quarter of fiscal year 2015. A consistent audit methodology has been deployed across the UT System that will assess the reporting process and accuracy of benefits funding information provided to the State Comptroller as applicable under the General Appropriations Act, Article IX, Sec. 6.08: Benefits Paid Proportional by Fund. The audit will be complete by November 30, 2014.

III. Audit Plan for Fiscal Year 2014

FY 2014 Audit Plan Audit/Project	Hours
Financial Audits	
Credit Balance Review (MSRDP, Hospital, Clinics)	400
Faculty Service Plan Billing and Accounts Receivable Management Review	200
UT System Requested/Externally Required Audits	
FY2013 UTS Financial Statement Audit – Financial/IT (YE)	600
FY2014 UTS Financial Statement Audit – Financial/IT (Interim)	260
Presidential Travel and Entertainment Expenses Assistance	40
Direct Reports' Travel and Entertainment Expenses Review	300
UTS 142.1 Account Reconciliation and Monitoring Plan	100
Financial Audits Subtotal	1900
Operational Audits	
Risk Based Audits	

IRB Oversight Review	500
Charge Master Review (MSRDP, Hospital, Clinics)	400
Sample Offsite Clinic(s) Operational Review(s)	250
Denials Management Review (MSRDP, Hospital, Clinics)	300
Validation Audits	
Plant Operations Bidding to Contracting to Payment Review for Construction, Renovation, and Maintenance	400
PeopleSoft HCM Post Implementation Review (FY13 Follow-up)	300
Change in Management Audits	
Review of Office of VP for Technology Development	100
Review of Office of Communications, Marketing, Public Affairs	100
Consulting	
Consulting Clements Hospital Project Management Review/Participating	200
Operational Audits Subtotal	2550
Compliance Audits	
Risk Based Audits	
Clery Act and Incident Reporting Review	250
Time and Effort Reporting for Research Grants (including eCERT)	200
Other Audits	
SAO A-133	40
Texas Higher Education Coordinating Board Grants Review performed by UTSW	100
Compliance Audits Subtotal	590
Information Technology Audits	
Risk Based Audits	
Decentralized Application Inventory and Review (Phase 1 and Phase 2)	300
User Access Approval	200
PeopleSoft User Access Review	200
License Inventory Review	200
System Development Consulting Projects	
ICD10	100
Information Technology Audits Subtotal	1000
Remediation – Follow-up	
Follow-up Audits	
Audit Follow-up	500

Follow-up Audits Subtotal	500
UT System Support	
UTSW Internal Audit Peer Review Performed by External Provider	40
Annual Internal Audit Report	100
UT System Practice Plan Audit (IA Support)	60
UT System Support Subtotal	200
State/Federal Support	
Assistance to Budget Office for Legislative Budget Board Performance Measures	40
SAO Schedule of Expenditures of Federal Awards (SEFA)	40
SAO Comprehensive Annual Financial Report	40
State/Federal Support Subtotal	120
Projects/Audit Committee Reporting	
FY13 Audit Project Carryover Hours	573
Hotline/Special Projects	1200
Audit Committee Reporting	400
FY14 Annual Audit Plan & Risk Assessment	400
Projects/Audit Committee Reporting Subtotal	2573
Total Budgeted Hours	9,433

FY 2014 Audit Summary – Recommendations and Management Responses

Audit Project Number	14:01	**Name of Audit**	FY13 / FY14 UTS Financial Statement Audit (Year-end and Interim)	**Report Date**	N/A – Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Assistance Provided Only			**N/A**		**N/A**
Audit Project Number	14:02A	**Name of Audit**	Credit Balance Review - MSRDP	**Report Date**	7/2/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. Returned Check and Escheatment Procedures We recommend the following: a. For retuned checks dated within the last year, research the patient account and make at least one additional attempt to contact and deliver the refund to the appropriate recipient. For all returned checks greater than three years old, coordinate with Accounting and the Legal Affairs department to develop a process to appropriately escheat the checks to the Texas Comptroller of Public Accounts in accordance with state regulations. b. For any checks maintained in the MSRDP Finance department, implement a process to periodically reconcile checks to the tracking log to prevent misappropriation. c. Implement a process to enter a comment/note in Epic for patients with a returned check to prevent the reissuance of an additional check prior to research being conducted.			a. As a result of the audit, Management researched all current returned checks (i.e. from within the last year) and were able to re-issue all but three. These three checks, along with other returned checks greater than one year old were logged and will be secured in a safe and reconciled periodically (in accordance with "C" below). Live checks will be destroyed once confirmation is received that applicable checks have been escheated to the state. b. Management will coordinate with Accounting, Legal Affairs and Finance to establish an escheatment process to submit returned checks in accordance with State Regulations. c. A process has been implemented to log all returned checks coming into MSRDP and securing them in a safe while researching. Checks and the log will be reconciled monthly (at a minimum). d. An Epic adjustment code has been established for returned checks to patients and Management is working to establish a separate code for payor returned checks and any returned checks from the previous IDX system.		Fully Implemented

14:02A Credit Balance Review – MSRDP, continued

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
2. Credit Balance Processing We recommend the following: a. Based on resource analysis tools being implemented and as the third party agency begins working on aged credit balances, evaluate staffing levels to ensure that workflows are adequate to ensure timely processing of current credit balances. b. Consult with Physician & Specialty Contracting and/or Legal Affairs to consider establishing a process similar to the Hospital Patient Financial Services where certain low dollar credit balances are written off based on managed care contract provisions. c. Consult with Information Resources (IR) to investigate the credit balance account that was not properly routed to a refund queue to determine the cause of the issue and, if applicable, implement a solution. d. Implement a process to periodically reconcile credit balances generated in Epic PB to work queues to ensure proper interfacing.	a. Management will evaluate staffing levels and utilize the Resource Analysis Tool to assist in reassigning work queues and job responsibilities to ensure timely processing of current credit balances. b. Management will consult with Physician & Specialty Contracting to determine if there is language in our managed care contracts permitting low dollar credit balance write-offs. If this language exists, Management will adjust processes accordingly to begin writing off allowable balances. c. Management will consult with IR to investigate the account that was not properly routed to a refund queue and work to develop a solution, if applicable. d. Management will obtain the Operational Summary, Revenue Management and Finance Credit reports in order to begin reconciling credits to work queues on a periodic basis (i.e. monthly at a minimum). If these reports do not provide the information needed to perform reconciliation, Management will work with Information Resources to develop necessary reports.	Fully Implemented
3. Aged Credit Balances We recommend the following: a. Based on employee performance metrics, evaluate current staffing levels to ensure that workflows are adequate to ensure timely processing of current credit balances. b. Consult with Physician & Specialty Contracting and/or Legal Affairs to consider establishing a process similar to the Hospital Patient Financial Services where certain low dollar credit balances are written off. c. Continue with the plan to coordinate with the third party agency to process and clear aged credit balances.	a. Management will evaluate staffing levels and utilize the Resource Analysis Tool to assist in reassigning work queues and job responsibilities to ensure timely processing of current credit balances. b. Management will consult with Physician & Specialty Contracting to determine if there is language in our managed care contracts permitting low dollar credit balance write-offs. If this language exists, Management will adjust processes accordingly to begin writing off allowable balances. c. Management has revised workflows and distributed aged balances to the third party agency for review prior to training. Project implementation is in the final stages.	Fully Implemented

14:02A Credit Balance Review – MSRDP, continued

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
4. Epic PB User Access We recommend the following: a. Work with IR Practice Plan System Administration to conduct a comprehensive review of Epic Resolute PB user security access to ensure segregation of duties and consistency of user authorization among security classifications, workgroups and job functions. Establish the timing and frequency for ongoing reviews (e.g. annually). b. Consider modifying the write-off limits for Self-Pay & Insurance to "may" or "may not" perform write-offs only. Management should further continue leveraging systems and technology in implementing an automated notification process for communicating approved high dollar refunds to Accounting. c. Continue working with IR Practice Plan System Administration to assess the current Epic Professional Billing security structure and potential improvements to ensure more effective and efficient administration of user access.	a. Management will provide department Directors and Managers with reports of employees who's security did not fit the standard profile for their department or job function. b. Directors and Managers will evaluate security and make appropriate changes or document rational for different levels of security. c. A review process for internal transfers will be established to strengthen security for when employees move between departments and ensure that their access is appropriately adjusted if needed. d. An annual Security Committee (or similar process) will be established to review access for MSRDP billing staff and adjust access as necessary.	Fully Implemented
5. Epic Test Accounts in Production We recommend the following: a. HSIR management began deleting excessive test accounts identified during the audit. MSRDP management should continue to follow-up with HSIR to ensure that all identified test accounts not in compliance with policy are removed. b. Establish a process for HSIR and MSRDP management to routinely monitor (e.g. quarterly) test patient accounts in production and deactivate accounts not in compliance with the HSIR test accounts policy. Follow-up with staff responsible for creating the unauthorized test accounts for coaching and re-education of the policy.	a. IR will delete the excessive test accounts not in compliance with the existing test account policy. b. IR will develop reports for ongoing monitoring and maintenance, and work with MSRDP management when appropriate.	Fully Implemented
6. Policies and Procedures We recommend that management update policies and procedures related to MSRDP Credit Balance processes to reflect current processes in place. At a minimum they should include (1) workflow of credit balance accounts, including accounts to receive higher priority, (2) necessary approvals, (3) quality assurance processes, (4) monitoring activities, (5) timeliness guidelines and (6) low-dollar credit balance policy if established.	Policies and procedures will be updated to include the noted areas, at a minimum.	Fully Implemented

Audit Project Number	14:02B	Name of Audit	Credit Balance Review – Hospitals & Clinics	Report Date	7/2/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. Processing of Credit Balances We recommend the following: a. Establish a formalized process documenting the priority of credit balances to be worked. b. Establish and monitor KPIs and staff performance metrics and evaluate staffing levels to ensure that work flows are adequate for timely processing of credit balances (including miscellaneous Epic categories containing credit balances). c. Continue consulting with HSIR to investigate credit balance accounts that did not route to a credit queue to determine the cause of the issue and, where applicable, implement a solution. d. Implement a process to periodically (i.e. weekly or monthly) reconcile credit balances generated in Epic HB to system work queues to ensure proper interfacing.			a. PFS management agrees. b. PFS management agrees. The HB KPI threshold for credit balances is not to exceed three (3) days of Net A/R (Average Daily Revenue of 6,438,359); which is currently met. Current HB staff performance metrics is a manual calculated process and has been implemented for Private/Self pay credit balances. PFS Management plans to establish this same manual process for Government and Managed Care until such time reports are available. c. PFS management agrees. PFS and HSIR are further defining in Epic how to outline both credit/debit buckets and route the bucket or account (according to priority) to an account work queue and report productivity/outcomes. d. PFS management agrees. PFS and HSIR are working to ensure that when an account balance equals a credit balance it is reflected on an account work queue.		Substantially Implemented
2. Aged Credit Balances We recommend the following: a. Continue implementation of the plan to process the aged credit balances and establish periodic monitoring of the plan and communicate status updates to staff to ensure achieved targets are met. b. Ensure low dollar credit balances are reviewed and written off based on current policy. c. Establish key performance indicators (KPIs) and staff performance metrics and evaluate staffing levels to ensure that work flows are adequate to ensure timely processing of credit balances. Additionally, establish a formalized process documenting the priority of credit balances to be worked.			a. PFS management agrees and will continue implementing a plan to process the aged credit balances in Siemens. b. PFS management agrees and will continue review of low dollar credit balance. Current priority is highest dollar and greatest aged account. c. PFS management agrees. HB KPI is for credit balances not to exceed three (3) days of Net A/R. HB currently meets that target. Current HB staff performance metrics is a manual calculated process and has been implemented for Private/Self pay credit balances. PFS Management plans to establish this same manual process for Government and Managed for the purpose of reporting productivity.		Fully Implemented

14:02B Credit Balance Review – Hospitals and Clinics, continued		
Observation Recommendations	**Management Responses/Action Plans**	**Implementation Status of Action Plans**
3. Test Patient Accounts in Epic HB Production We recommend the following: a. HSIR management began deleting excessive test accounts identified during the audit. PFS management should continue to follow-up with HSIR to ensure that all identified test accounts not in compliance with policy are removed. b. Establish a process for HSIR and PFS management to routinely monitor (e.g. quarterly) test patient accounts in production and deactivate accounts not in compliance with the HSIR test accounts policy. Follow-up with staff responsible for creating the unauthorized test accounts for coaching and re-education of the policy.	a. IR will delete the excessive test accounts not in compliance with the existing test account policy. b. IR will develop reports for ongoing monitoring and maintenance, and work with PFS management when appropriate.	Fully Implemented
4. Manual Contractual Adjustments We recommend that management establish a process to monitor and audit a sample of manual contractual adjustments on a routine basis (e.g. weekly). The monitoring and sample audit results should be documented and coaching should be provided to staff where applicable.	PFS management agrees and is working with HSIR to create an exception report that displays an account in which a system contractual is manually reversed and a manual contractual >$1,000.00 is applied. Sample accounts will be audited, recorded and appropriately addressed.	Substantially Implemented

Audit Project Number	14:03	Name of Audit	Faculty Service Plan (FSP) Billing and Accounts Receivable Management Review	Report Date	8/29/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. Daily Reconciliation Procedures We recommend the following: a. In accordance with the existing policy: i. Ensure the Front Desk Customer Service Agents (CSAs) perform the DAR Reconciliation at the end of each day, including submission of all supporting documentation to the Supervisor/Manager responsible for the comprehensive review. Require those completing the reconciliation steps to initial and date the Daily Front Office Clinic Reconciliation Checklist. ii. Establish procedures to perform the EOD Cash Drawer Reconciliation at the end of each day. Because the Cash Office does not return the signed Cash Drawer Reports (CDRs) until several days after the day of service, consider performing the daily reconciliation from the original CDRs. Require those completing the reconciliation steps to initial and date the Daily Front Office Clinic Reconciliation Checklist. iii. Establish procedures to ensure the assigned Supervisor/Manager, who is independent of cash collection activities, performs the Front Desk Activity comprehensive review within five business days of the service day. This will include ensuring the DAR Reconciliation and the EOD Cash Drawer Reconciliation have been performed appropriately by the front office staff and that the documentation submitted is supported by the data found in Epic. b. Establish a separate procedure to match CDRs returned by the Cash Office to a control log of submitted deposits to ensure all deposits have been received by the Cash Office. Use a “Date Received” Stamp to determine if CDRs are returned by the Cash Office on a timely basis. Follow up on any unreturned CDRs to ensure all deposits have been made. c. Re-educate applicable personnel on all requirements of the policy. d. For those off-site clinics that do not report through the UTSSHP Physical Therapy department, continue consulting with applicable personnel to ensure compliance with policies related to daily reconciliations. e. Perform periodic monitoring for sustained compliance.			UTSSHP management agrees with the recommendations above and has already taken steps to update and improve the daily reconciliation process. The recommendations will be fully implemented.		Substantially Implemented

14:03 Credit Balance Review – FSP Billing and Accounts Receivable Management Review, continued					
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
2. Billing Timeliness – Prosthetics-Orthotics We recommend the following: a. Implement procedures to log invoices as they enter the audit process and as each stage of the audit process is completed. b. Establish routine monitoring procedures of the audit log to ensure invoices are addressed in a timely fashion and are expedited if necessary.			UTSSHP management agrees with the recommendations and has begun steps to re-implement a logging process that was previously in place. The recommendations will be fully implemented.		Substantially Implemented
3. Rehabilitation Counseling Private Pay Charges We recommend the following: a. For the nominal fees charged to see student interns, determine whether to waive the fee altogether or set a standard fee applicable to all indigent patients. b. For insured patients choosing to pay cash, set up a separate billing code in the fee schedule that will enable the charges to be processed in Epic.			UTSSHP management agrees with and will fully implement the recommendations.		In-process
4. Physical Therapy Billing We recommend the following: a. Investigate the encounter that was closed without charges to determine the cause of the error (e.g. user access issue, system issue, etc.). b. Based on the investigation, consult with applicable personnel (e.g. Information Resources or department personnel) to implement control procedures to prevent or detect encounters without charges from being closed in the system. c. In addition to providing open encounter reporting to Department Chairs, also provide to billing supervisors for review/follow-up.			UTSSHP management agrees with and will fully implement the recommendations.		In-process
Audit Project Number	14:04	**Name of Audit**	Presidential Travel and Entertainment Expenses Assistance	**Report Date**	N/A – Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Assistance Provided Only			**N/A**		**N/A**
Audit Project Number	14:05	**Name of Audit**	Direct Reports' Travel and Entertainment Expenses Review	**Report Date**	3/19/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
No Recommendations			**N/A**		**N/A**

Audit Project Number	14:06	**Name of Audit**	UTS 142.1 Annual Monitoring Plan Review	**Report Date**	11/6/2013
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
No Recommendations			**N/A**		**N/A**
Audit Project Number	14:07	**Name of Audit**	IRB Oversight Review	**Report Date**	N/A – In-process as of 8/31/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – In-process			**N/A**		**N/A**
Audit Project Number	14:08	**Name of Audit**	Charge Master Review (MSRDP, Hospital, Clinics)	**Report Date**	N/A – In-process as of 8/31/2014 (co-sourced with outside firm)
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – In-process			**N/A**		**N/A**
Audit Project Number	14:09	**Name of Audit**	Sample Offsite Clinic(s) Operational Review(s)	**Report Date**	N/A – In-process as of 8/31/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – In-process			**N/A**		**N/A**
Audit Project Number	14:10	**Name of Audit**	Denials Management Review (MSRDP, Hospital, Clinics)	**Report Date**	N/A – In-process as of 8/31/2014 (co-sourced with outside firm)
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – In-process			**N/A**		**N/A**
Audit Project Number	14:11	**Name of Audit**	Plant Operations Bidding to Contracting to Payment Review for Construction, Renovation, and Maintenance	**Report Date**	N/A – Consulting Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Consulting Assistance Provided Only			**N/A**		**N/A**

Audit Project Number	14:12	Name of Audit	PeopleSoft HCM Post Implementation Review (FY13 Follow-up)	Report Date	3/21/2014

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
1. Improve Monitoring Controls for Retirement Benefit Contributions We recommend the following: a. We understand the HCM programming team is in the process of developing system enhancements as a preventive control to automate suspension of retirement contributions when statutory limits are reached. This solution is currently scheduled to be implemented for the April 2014 payroll process. HR Benefits management should test system controls before implementation to ensure they are working as designed. HR Benefits management should ensure communications are made to all employees who were identified as having exceeded contribution limits and coordinate with Payroll to process W-2 corrections and 1099 forms as needed. b. To improve the detective control currently in place, HR Benefits management should ensure current queries or reports used to verify the automated limit checks are working as intended after each payroll process or at least monthly.	a. HR Benefits and Business Administrative Systems agree with the finding. The retirement limit functionality will be automated in the system. The HCM programming team will implement the retirement control specifications for managing the retirement limit functionality in PeopleSoft. We are currently testing for other retirement plans (TRS, TSA, TSA +50, TSA Roth +50 and DCP). Controls for both ORP and TRS will be implemented in time for the April Payroll. b. HR Benefits will coordinate with the Payroll Division to communicate W-2 and 1099 corrections to affected employees. c. Automated queries within the HCM system to monitor retirement contribution limits will be implemented.	Substantially Implemented
2. Implement Controls to Ensure Consistent Determination of Employee Retirement Benefits Eligibility We recommend the following: a. Implement HCM form edits to prevent inconsistencies between the FTE field on the Job Details form and Full Time/Part-Time status and Standard Hours fields on the Job Information form. b. Implement HCM audit features to track updates made to position records including user identity or source of change. Monitor change activities and provide additional targeted user training or re-training as needed. c. Continue investigating additional HCM automated controls and perform cost/benefit analysis for additional system changes. Where automated controls are not practical, develop exception reports to identify employees who are eligible for retirement benefits but are not contributing to a retirement plan, as well as instances where employees are not eligible but are contributing in error. d. Establish quality assurance function to review high risk transactions to ensure accuracy for benefit eligibility determination.	a. HR Benefits and Business Administrative Systems will activate customization to the MSS pages for implementation. This would include determination of time and effort, implementation date, prioritization and approval. b. We will implement the activation of HCM audit features and assess other additional automated or manual controls. Additionally, necessary user training will be provided.	In-process

14:12 PeopleSoft HCM Post Implementation Review (FY13 Follow-up), continued

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
3. Correct Medical Insurance Deductions We recommend the following: a. Create a warning message on the HCM data entry forms to alert users of conflicting input values. b. Implement an approval workflow step to allow HR Benefits staff to review changes before recording in the HCM system. This would eliminate the risk of data inconsistency noted above by allowing HR Benefits to correct erroneous transactions and properly schedule subsequent changes. c. Implement a system screen to view the history of changes and identify source of errors (i.e. an audit trail).	a. We will review current HCM warning messages and transaction input scenarios to determine where valid edit checks are not occurring and ensure they are established b. We will meet to plan, design and implement the recommended workflow step to allow HR Benefits to analyze the job data to ensure agreement of requested benefit changes. c. We will propose the activation of HCM audit features.	In-process
4. Ensure Payment of Medical Insurance Premiums for Employees on Extended Leave We recommend the following: a. Re-emphasize the need for communication of employee status from the hiring departments as well as insurance premium payment receipt between HR Benefits and Payroll. b. Automate the non-paid leave notification process in HCM. While the automation of the non-paid leave notification will take time to develop; in the interim, provide training to applicable individuals (i.e. departments identified with exceptions).	a. We will communicate the finding to campus departments as part of user refresher training. It will be reemphasized on the FAQ list and made part of the tips and tricks session of the HCM web-site. We will reemphasize that when errors are made the person identifying the issue will communicate with the person who initiated the transaction to minimize recurrence. b. In addition to the management response identified in the Executive Summary, we will determine the required HCM system functionality to set-up and capture the leave request information so that automated leave letters can be correctly generated off of HCM. We will review time and effort to determine implementation date, prioritization and approval process. Additionally, training will be provided to department individuals with exceptions noted during the audit.	Fully Implemented
5. Improve Controls over Longevity Pay Determination and Processing We recommend the following: a. Implement customized programming to consider the Benefits Profile in the calculation of longevity pay to ensure working retirees are excluded. b. Notify and coordinate retroactive adjustments with affected employees.	a. We will implement programming to consider the Benefits Profile in the calculation of longevity pay. We will review time and effort in order to determine implementation date. b. Human Resources Records Division will notify the affected employees of necessary adjustments.	Fully Implemented

14:12 PeopleSoft HCM Post Implementation Review (FY13 Follow-up), continued

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
6. Ensure Completeness of New Hire Health Insurance Coverage Election Forms We recommend the following: a. Expedite the automation of the health insurance coverage election and enrollment process for new hires through the employee self-service application versus the temporary manual process currently in place so that subscribers' input can be validated through the HCM system. b. Require the signing and retention of the Declaration of Tobacco Use or Non-Tobacco User as part of the employee's benefits file. The form can serve as a control to confirm employees' acknowledgement of tobacco use and coverage election. Re-emphasize the importance of correct entry of employee election documentation into the HR benefit system. If declaration is incomplete or not available, the employee should be contacted to complete the documentation in order to enter benefit elections in HCM. Further include a Tobacco Declaration section in the student employee health benefit election form.	HR Benefits agree and will reemphasize form completion and record retention requirements to all departments. We have already included the tobacco usage declaration section into the student health insurance election form.	In-process
7. Enhance Benefits Monthly Reconciliation Process Controls We recommend the following: a. Continue to prioritize requested system/programming fixes to ensure accurate eligibility is transferred to OEB and correct premium deductions are made in payroll. b. Cross-train and grant access to at least one other designated staff member to back up the HR Benefits Senior Analyst in the event this person is on leave for an extended period or otherwise unavailable. c. Update procedures for the Benefits Monthly Reconciliation Process to accurately and completely reflect the information required to cross-train other personnel to perform the process.	The Office of Human Resources and Business Administrative Systems agree with the recommendations provided by the Internal Audit team.	Substantially Implemented

Audit Project Number	14:13	**Name of Audit**	Review of Office of VP for Technology Development	**Report Date**	N/A – Deferred to FY 2015

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
N/A – Deferred to FY 2015	**N/A**	**N/A**

Audit Project Number	14:14	**Name of Audit**	Review of Office of Communications, Marketing, Public Affairs	**Report Date**	N/A – Cancelled due to leadership turnover
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Cancelled Due to Leadership Turnover			**N/A**		**N/A**
Audit Project Number	14:15	**Name of Audit**	Consulting Clements Hospital Project Management Review/Participating	**Report Date**	N/A – Consulting Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Consulting Assistance Provided Only			**N/A**		**N/A**
Audit Project Number	14:16	**Name of Audit**	Clery Act and Incident Reporting Review	**Report Date**	8/26/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. Identify Campus Security Authority (CSA) and Ensure Proper Training We recommend the following: a. Consult with Medical Center management (including Senior Leadership and Management from the various academic centers) to identify the remaining CSAs in accordance with the criteria outlined in the Clery Act. b. Once the remaining CSAs have been identified, establish and provide training for all CSAs so that they are aware of Clery Act requirements as well as their responsibilities and reporting requirements. As new individuals are designated as CSAs, establish a process to ensure that timely training is provided.			a. We agree with recommendations. The Chief of Police will work with the Executive Vice President of Business Affairs, Senior Associate Dean of Academic Administration, and Chief Compliance Officer to identify individuals by job function that would be a CSA. b. Once identified, training will be conducted for these individuals so they will know there job responsibilities.		In-process
2. Notice of Annual Security Report to Prospective Students and Employees We recommend the following: a. Develop and implement a process for notifying prospective students and employees of the Annual Security Report as required by the Clery Act (e.g. provided with informational employment documentation, during employee interview process, etc.). b. Consider modifying Human Resources website to include 1) a link to the most recent Annual Security Report, 2) a brief description of the report, and 3) a statement that the institution will provide a paper copy of the report upon request for greater transparency and availability to prospective students and employees.			We agree with recommendation and will update Medical Center employment documentation (e.g. packets provided at employment fairs, etc.) and the Human Resources website to contain a notice of the Annual Security Report (including a description of the report, the URL where the most recent report is located, and a statement that the institution will provide a paper copy upon request).		Substantially Implemented

14:16 Clery Act and Incident Reporting Review, continued

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
3. Campus Locations for Incident Reporting We recommend the following: a. Until the Archibus system is implemented, Police Department management should consult with the Planning and Institutional Studies office to obtain PeopleSoft reports noting new Medical Center controlled property for potential reporting purposes as needed. Further investigation may be required to determine whether the space qualifies for incident reporting in accordance with Clery Act requirements. b. As part of the Archibus system implementation, determine if the system can capture all required information for reporting purposes or if additional processes or periodic communications with the Planning and Institutional Studies or Student Affairs offices are necessary.	We agree with recommendation. We will setup communication with James Drake regarding newly obtained property. This will be conducted monthly.	Substantially Implemented

Audit Project Number	14:17	Name of Audit	Time and Effort Reporting for Research Grants	Report Date	N/A – Cancelled due to this project being on the Office of Compliance FY 2015 plan
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Cancelled due to this project being on the Office of Compliance FY 2015 plan			**N/A**		**N/A**

Audit Project Number	14:18	Name of Audit	SAO A-133 Assistance	Report Date	N/A – Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Assistance Provided Only			**N/A**		**N/A**

Audit Project Number	14:19	Name of Audit	Texas Higher Education Coordinating Board (THECB) Grant Review	Report Date	1/6/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
No recommendations			**N/A**		**N/A**

Audit Project Number	14:20	Name of Audit	Decentralized Application Inventory and Reviews (Phase 1 and 2)	Report Date	N/A – Deferred to FY 2015
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Deferred to FY 2015			**N/A**		**N/A**

Audit Project Number	14:21	**Name of Audit**	User Access Approval Review	**Report Date**	9/2/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. Improve Security Access for Decentralized Systems We recommend the following: a. Centrally manage all of those systems classified as high risk systems. b. Require a security survey be completed for all systems managed by the IR PMO or are above $25K. Information Security approval of survey is required before the purchases can be made. This will ensure departments are using the Lightweight Directory Access Protocol (LDAP) for authentication. c. Given the risk of lack of management of user access controls for certain applications conduct the following: i. Coordinate with department management to encourage or require the departments to manage user access via the SN system. ii. Where possible, offering user authentication to decentralized systems using the LDAP. This will ensure access to these decentralized systems is more appropriately managed when changes in user status such as terminations or transfers occur.			This was not part of the original scope of the IAR migration but it is a good recommendation. Review of decentralized systems will begin immediately following implementation of the system in late September 2014 with planned completion by Q2 2015.		In-process
2. Require and Document Management Approval When Approvers Delegate Authority We recommend that management implement an approval workflow, or procedure, that first requires documented Management approval with a specified duration for each occurrence of approver delegation.			SN has a built in delegation process that cannot be changed without customization from the vendor. The approval procedures and training documents will request that approvers forgo any additional delegation as each department has multiple approvers already listed.		Substantially Implemented
3. Require Each User's Department Management to Periodically Re-Certify Approvers We recommend that management require, at least annually, each user department's management to re-certify and date document its approval of their SN access request approvers.			Annual recertification will be conducted for all IAR approvers.		Substantially Implemented

14:21 User Access Approval Review, continued

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
4. Promptly Remove Approvers from the Approver Table Upon Transfer or Termination We recommend that management implement an alternative process for SN administrators, not department management, to delete transferring and terminated approvers. Whenever approver is terminated or transferred to another department, the SN administrators should timely remove the approver's name from the approver table, date document the approver's removal, and notify department management of the approver's removal. Further, include a daily Termination Report that captures the name of any approver who has a deactivated account from Active Directory. This daily Termination Report should go to the SN Administrator's Home Page. Thus, the SN administrators can maintain a current and accurate approver Table.	a. For terminated approvers, the SN administrators will monitor for when the accounts for these employees have been flagged as inactive in Active Directory and a SN administrator will remove them from the approver list. b. For transfers, the SAM group will create an approval group separate from SN. When approvers are transferred between departments their name is dropped from all SAM groups. This will serve as a flag to notify the SN administrator to remove the approver's name from their old department's IAR approval table. A secondary control to ensure the data is accurate will occur during the annual recertification process.	Substantially Implemented
5. Monitor Approvers Span of Responsibility to Ensure Appropriate Levels We recommend the following: a. Determine appropriate measures for approver span of responsibility and implement procedures to periodically evaluate approver volume of user access requests. b. Coordinate with and inform department management when access approval levels present a high risk of insufficient review. Obtain management's acknowledgement as to whether to continue or identify additional security access approver for managing volume levels appropriately.	Client Services will work with Information Security to determine appropriate criteria for span of control. We will provide reports to the departments to review instances where user to approver ratios or user access request volumes exceed criteria. While this is not in the critical path of the project, we will begin the review immediately after go live of the new SN system. We will have the notification process operational by December 31, 2014.	In-process

Audit Project Number	14:22	Name of Audit	PeopleSoft User Access Review	Report Date	N/A – Deferred to FY 2015

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
N/A – Deferred to FY 2015	**N/A**	**N/A**

Audit Project Number	14:23	**Name of Audit**	Software License Inventory Review	**Report Date**	7/14/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. Implement a Centralized Software Asset Management Program We recommend the following: a. Establishing a centralized software asset management program within Information Resources to increase effectiveness and efficiency and provide a single function to ensure compliance with vendor contracts as well as applicable UT System and Medical Center regulations, policies and procedures. We applaud IR management for implementing the Dell Kace tool, which can be a chief enabler to collect installed software data necessary to accomplish the goals of such a program. b. Alternatively, if a centralized software asset management program is not approved, management should ensure departments implement and are held accountable for proper software license management. This should include updating the software licensing governance provisions of the Information Security, Privacy and Resources Policy 252 (ISR-252) to more clearly identify responsibility and accountability for department managers and provide training for those designated as software asset managers to improve inventory and monitoring procedures.			We agree that we should evaluate a more formal accounting for software license purchases. Tracking and codifying all of this data will likely consume one to three FTEs, especially if we do it campus wide. This will require fundamental workflow changes in the manner that non-IR software is purchased, authorized for purchase, and deployed. Tracking licenses for the entire institution will require a dedicated role that will need to be trained in reviewing the various licensing models used for software products. In light of the above implications and since this will require dedicated IR resources, management will first conduct a 'Discovery Phase' analysis and present to senior management the scope and cost of a realistic and balanced central software license/ management program. Additional phases are required including: a. Training and compliance; b. Completing an accurate inventory of computer assets; c. Completing an accurate inventory of software licenses, and d. Reconciling both the above inventories. The initial Discovery Phase will be completed by September 1, 2014. The other phases will be completed if the project is approved. At a minimum, Information Resources and Information Security will provide training to ensure all departments are accountable for the requirements of Medical Center policy by November 1, 2014.		In-process
Audit Project Number	14:24	**Name of Audit**	ICD10	**Report Date**	N/A – Consulting Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Consulting Assistance Provided Only			**N/A**		**N/A**
Audit Project Number	14:28	**Name of Audit**	UT System Practice Plan Audit (IA Support)	**Report Date**	N/A – Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Assistance Provided Only			**N/A**		**N/A**

Audit Project Number	14:29	**Name of Audit**	Assistance to Budget Office for Legislative Budget Board Performance Measures	**Report Date**	N/A – Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Assistance Provided Only			**N/A**		**N/A**
Audit Project Number	14:30	**Name of Audit**	SAO Schedule of Expenditures of Federal Awards (SEFA)	**Report Date**	N/A – Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Assistance Provided Only			**N/A**		**N/A**
Audit Project Number	14:31	**Name of Audit**	SAO Comprehensive Annual Financial Report	**Report Date**	N/A – Assistance Provided Only
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
N/A – Assistance Provided Only			**N/A**		**N/A**
Audit Project Number	14:32.05	**Name of Audit**	Physician Quality Reporting System (PQRS)	**Report Date**	8/29/2014
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. Quality Reporting – Policies and Procedures We recommend the following: a. Complete the flow chart for the transition from Ambulatory Administration to UTSACN which is currently in process. b. Establish a responsible office and timeline in UTSACN for the creation and implementation of the remaining PQRS policy and procedure documents applicable to internal processes.			Management agrees with the recommendations.		In-process
2. Data Integrity - Reporting Transition and Challenges We recommend that further contractual provisions be explored with PHHS to enable timely access to records as well as relevant follow-up by responsible Medical Center personnel.			Management agrees with the observation. We confirmed with Office of Legal Affairs that the Medical Center entered an Organized Health Care Arrangement (OHCA) agreement with PHHS in December of 2010. This agreement was entered into in lieu of a business associate agreement. Reaching out to Parkland to coordinate the collection of this EHR quality data is an important next step and we will work towards establishing a process with PHHS to access relevant data.		In-process

FY 2013 Audits Completed in FY 2014 – Recommendations and Management Responses

Audit Project Number	13:10.96	**Name of Audit**	Procurement to Payment Process Review	**Report Date**	12/4/2013
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. The Need for a Center Led Organizational Structure We recommend the following: a. Initiate the process ownership shift towards centralization under one guiding leader. b. Collaborate and develop centrally standardized processes applied across the entire process so that best practices and support resources are shared equally (and not isolated) amongst Material Management departments in different entities. c. Educate personnel so they have a working knowledge of the standardized Material Management processes across the three entities. d. Review all current purchasing channels' volume and spend amounts, products types and other distinguishing factors collaboratively and cross-functionally to develop a plan for channel optimization going forward that is standardized, documented and easily interpreted by all. e. Continue to implement and refine the plan across the process comparing and sharing compliance level information from each department and identifying problematic areas and actions necessary to remedy such areas. f. Continue to capitalize on opportunities from PeopleSoft processing and reporting functionality. g. Continue to promote BuyCard and EZBuy options and educate users across the entire process. h. Conduct a full review of all current policies to reconfirm that they are up-to-date, reasonable and maintain the proper governance levels while still enabling efficiencies; i. Take steps to prepare for process consolidation and adopting a Lean mindset.			We understand and recognize the need for continuous process improvement for Materials Management. Our autonomous organizations have been successful in concentrating on specific customer service needs yet additional process efficiencies and best practices need to be implemented. A coordinated effort among central purchasing, hospital purchasing and physical plant will bring improvements in the utilization of PeopleSoft and other technology tools; optimize and standardize the best purchasing channels and metrics for utilization; and align purchasing policies. Materials Management will coordinate with the University Hospitals CFO to implement the purchasing card process. We will create policies to provide the centralized framework for purchasing practices and submit for approval by February 28, 2014. Standard process metrics will also be implemented by January 31, 2014. Additionally, we are collaborating with the other five UT Health Institutions in exploring a joint Procure to Pay outsourcing study. This effort is focused on leveraging a single business process outsourcing firm for the common procurement and payment activities of all the health institutions. Sub-processes that are being investigated are spending analysis, vendor record set up and maintenance and invoice receipt processing and payment processing.		Fully Implemented

Audit Project Number	13:15	Name of Audit	Environmental Health and Safety Review	Report Date	8/22/2014

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
1. Coordinate Medical Center Job Hazard Analysis and Monitoring of Mandatory Safety Training We recommend the following: a. Coordinate with HR, OCH and other necessary parties to promote an integrated JHA environment. The formation of a cross-functional workgroup would define job requirements, ensure adequate communication of JHA responsibilities, and implementation of applicable policies/procedures. Further considerations include: i. Establish ownership for creating, updating, and monitoring a comprehensive job hazard inventory among EH&S, HR, and OCH. One Department can be made responsible for the hazard inventory, and be integrated with those with knowledge of activities and related hazards. ii. Integrate requirements into the new hiring and job description modification processes including an evaluation of exposure, identification of job hazards for each job type and role including linkage of relevant risk, training, and controls to each hazard. Update hazard inventory as new tasks are created and identified. iii. Continue collaboration with OCH to reemphasize the mandatory aspect of WPP coverage and enrollment. WPP program brochure and online information should be updated to ensure consistency. b. Coordinate with Human Resources and other campus functions to recommend a formal process to executive leadership that identifies appropriate personnel required HazCom training. Additionally, responsibilities and accountability for hazardous chemical training for Hospital staff should be communicated in the same Policy. c. Coordinate with HR and the PeopleSoft HCM team to determine if employees who have jobs with hazard exposure can be identified and classified within HCM and required HazCom training could be tracked and monitored. d. HazCom policies and procedures should be updated at least every three years as well as after any major changes to organization or regulatory requirements.	a. The Office of Human Resources (HR): We will take an active role in the formation of a cross-functional workgroup and will coordinate, at minimum, representatives from HR, specifically WCI/Leave Administration and Compensation, from the Occupational Health department and from EH&S. b. The cross-functional team will hold discussions and establish a formal plan designed to promote a fully integrated JHA environment as recommended by this audit. c. Occupational Health and Aston Ambulatory Care Center: We have already had one meeting with EH&S to discuss several issues in which we should create a closer collaboration. d. EH&S management will coordinate with HR and OCH to discuss and assist in development of applicable Job Descriptions (JD) for Medical Center employees. e. EH&S will continue to work with HR, Institutional Compliance, Research and Health Care administrations, and all other key stakeholders to establish a formal Plan for Institutional Safety Training. This Plan will describe the available in-person and online HazCom and other safety training courses provided by EH&S. This Plan will include an updated policy that reflects the needs, requirements, and responsibilities for HazCom training. Interim date for this Plan is May 1, 2015. f. EH&S will coordinate with HR and the PeopleSoft HCM team to identify system flagging and controls for ensuring all appropriate personnel are identified and tracked for job hazard ongoing analysis, communications and ensuring training requirements are met. Target implementation date is September 1, 2015. g. EH&S will update policies as decisions are made for addressing job hazard analysis and training plans are formalized.	In-process

13:15 Environmental Health and Safety Review, continued		
Observation Recommendations	**Management Responses/Action Plans**	**Implementation Status of Action Plans**
2. Update Policies and Procedures We recommend that management allocate necessary resources to assess relevant policies and procedures. Update EH&S policies and procedures and conduct reviews to update every three years at a minimum. Management should institute a work plan and order of priority with input from the Policy Office, where applicable, to ensure systematic revision of policy documents at both institutional and department levels.	EH&S has been methodically submitting pertinent existing Policies and Procedures to the new Institutional Policy Office (IPO) for required reformatting and approval. EH&S will follow the schedule, requirements, and recommendations mandated by the Policy Office regarding Policies and procedures pertinent to EH&S. Other departmental policies and procedures will continue to be updated. EH&S will continue to monitor for regulatory changes that may merit immediate change to existing Policies.	In-process
3. Improve EH&S Governance We recommend the following: a. Share new plan of EH&S structure clarifying its responsibilities and accountability for proper management of environmental, health, and safety risks including Medical Center academics and research, hospitals, and clinics. EH&S will continue working with Medical Center executive management and will lead in promoting a single enterprise approach for managing risks. b. Update and implement Safety Advisory Committee Charters. A model charter typically incorporates a) its charge or mission statement defining the committee's purpose, goals and objectives, b) authority and responsibility, c) composition, including guidelines for committee member and chair appointments, d) location and timing of meetings, agenda development and drafting, review and approval of meeting minutes. Meeting quorums are recommended. c. Provide Medical Center Administration with relevant reports of environmental, health, and safety risk assessment, prioritization of high exposure areas, desired coverage to mitigate business, and compliance risks as the Institution continues to expand.	a. EH&S agrees with recommendations and will coordinate with other areas and the safety committees to improve overall governance for health and safety. b. Charters will be updated and provided to respective committees for review and approval. c. Once comprehensive risk assessment and mitigation strategies are finalized, reports will be provided.	In-process
4. Integrate EH&S into Capital Improvement and Real Property Acquisition Planning Processes We recommend that EH&S management coordinate with the Real Estate Office, Capital Project leaders and other parties involved in the acquisition, leasing and space renovations to be included early phase discussions of purchasing, acquiring, donating of a building or piece of property or renovating space. EH&S should conduct the required environmental and fire and life safety evaluations and provide timely reporting of exposures, potential hazards and deficiencies to all stakeholders. Report issues to the appropriate Safety Committees to minimize risks for the Medical Center and ensure compliance with UTS135 and UTS161 polices.	EH&S will coordinate with appropriate parties to participate in discussions in early planning phases for new construction, property acquisitions, leases and renovations to ensure appropriate environmental and fire and life safety evaluations are conducted and potential hazards and deficiencies are identified in accordance with UTS135 and UTS161. Issues will be appropriately reported to respective Safety Committees. Real Estate Services (RES) will continue to include EH&S in the real estate acquisition process of building or land. RES will be sure to afford EH&S the opportunity to review multi-Phase ESA Reports and well as fulfill its responsibilities outlined in UTS135 and UTS161 given buyer contract time frames.	Substantially Implemented

13:15 Environmental Health and Safety Review, continued		
Observation Recommendations	**Management Responses/Action Plans**	**Implementation Status of Action Plans**
5. Assess Resources to Ensure Adequate Coverage to Manage Environmental, Health. and Safety Risks We recommend that EH&S management take steps to fill or repurpose remaining open positions and assess the adequacy of resource levels in total as well as whether current resources are appropriately allocated across the various EH&S programs. EH&S management should continue providing Medical Center administration with relevant reports of environmental, health and safety risk assessment, prioritization of high exposure areas that incorporates current campus activities and future expansion, desired coverage, and resources ensuring adequate risk mitigation.	EH&S agrees with the recommendations. EH&S will continue in its assessment process and provide coverage needs for risk mitigation strategies. Any staffing deficiencies will be communicated to institution management and appropriate Safety committees to ensure Institutional compliance with UTS174 Sec 3.4 regarding having sufficient EH&S staffing and financial resources.	In-process
6. Implement Key Performance Measures For More Effective Monitoring We recommend the following: a. Implement new performance metrics recently drafted. Provide draft measures to all stakeholders for review and approval. Begin reporting measures on a regular basis. Once measures are in place, enhance monitoring procedures and evaluate and revise program goals as necessary. This would increase management's ability to identify and correct negative trends, gain timely visibility of all programs and processes, measure efficiencies/ inefficiencies, ability to make informed decisions and reiterate alignment with Institutional strategic goals and support annual work plan development, monitoring and completion. b. Provide Medical Center Administration with relevant reports of environmental, health and safety risk assessment, prioritization of high exposure areas, desired coverage to mitigate business and compliance risks as the Institution continues to expand. c. Update policies to reflect performance measures and hold all involved parties accountable for meeting measures.	EH&S agrees with and will implement the recommendations.	Substantially Implemented

Audit Project Number	13:17	Name of Audit	Clinical Trials Billing Review	Report Date	12/4/2013

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
1. Implement Velos Research Patient & Study Registration Data Monitoring We recommend the following: a. Ensure all active studies and enrolled patients, including those studies that were active before the implementation of Velos, are appropriately registered. Evaluate the best method for adding data for participants in legacy clinical trials to the Velos system. b. Research Administration should coordinate with Academic Information Systems (AIS) and Information Resources Practice Plan Administration (IR) to identify system reports for departments to use to reconcile system data to source documents such as an Informed Consent. c. Coordinate with AIS to explore implementation of additional field edits to ensure accurate data. d. Conduct independent quality reviews of registered studies and enrolled patients in Velos. Communicate results to the clinical departments and conduct refresher and/or targeted training for research teams as needed.	a. AIS and Research Administration have been working on the past year to identify the data dictionary and field integration between eIRB and Velos to improve data flow, consistency in data and ensure required data fields are captured. With the upgrade in Velos in December 2013, several of the data elements that have been identified in this audit report will be addressed. b. For monitoring for the data entry points and timely maintenance of the data by the research staff, OCRF will develop and implement a monitoring program including reports for: 1) Validating system integration between eIRB and Velos and between Velos and Epic are functioning and errors are resolved and 2) research teams are timely registering and maintaining participant data in Velos (which in turn will keep timely data in Epic). c. OCRF will continue to hold open forums and training on registering participants in Velos for the research community. OCRF will use the monitoring reports and data to measure effectiveness of training and refine as needed.	Substantially Implemented
2. Ensure Patient Records in Velos are reflected in Epic We recommend the following: a. Coordinate with AIS to define roles and responsibilities of each function for monitoring patient record data and establish timelines for the responsible owner to review and correct any errors in the patient data so that billing is accurate and timely. b. Document patient update/association issues and communicate those to the study teams for prompt corrective action and resubmission. c. Conduct monitoring and ongoing reviews of the “Research Patient Status Updates and Patient Enrollment” report. Based on the results of such reviews, conduct additional refresher and/or targeted training for department clinical trial coordinators.	a. The OCRF will work with AIS to clearly define and delineate roles and responsibilities and to refine outline process for correcting interface errors. A Roles and Responsibilities document shall be created and implemented as part of the monitoring activities. The plan will be completed by January 31, 2014 and the monitoring will be implemented by Q3 of FY 2014. b. For monitoring for the data entry points and timely maintenance of the data by the research staff, OCRF will develop and implement a monitoring program including reports for: 1) Validating system integration between eIRB and Velos and between Velos and Epic are functioning and errors are resolved; 2) research teams are timely registering and maintaining participant data in Velos (which in turn will keep timely data in Epic); and 3) research visits are scheduled and billing is correctly routed. The plan will be completed by January 31, 2014 and the monitoring will be implemented by the end of Q3 of FY 2014. c. OCRF will continue to hold open forums and training for research community on registering participants in Velos. OCRF will use the monitoring reports and data to measure effectiveness of training and refine as needed. OCRF will further coordinate with the Compliance Office and Health System to identify additional training for staff who are involved with scheduling of research visits. This is in process as training is ongoing on a monthly basis.	Substantially Implemented

13:17 Clinical Trials Billing Review, continued

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
3.	a.	
4. Research Charge Routing We recommend the following: a. Conduct more robust monitoring of research work queues to ensure correct routing and timely disposition of research charges. Quality results should be reported to clinical departments. b. Reemphasize the use of correct LOS codes to research departments responsible for processing research related charges.	b. OCRF will work the Health System and Billing Compliance to establish operational metrics, a monitoring program and resolution process to ensure that research work queues are timely processed and appropriately billed. The plan will be completed by the end of the first quarter 2014. Metrics will begin to be reported in second quarter 2014. c. OCRF will work with the Health System to revisit the use of generic Level of Service codes in the ambulatory EPIC system. This will be completed by January 31, 2014.	Fully Implemented
5. Update Registered Studies Data on Public Sites We recommend the following: a. Conduct on-going monitoring of registered studies at Clinicaltrials.gov and communicate issues to study teams for prompt action and follow up performed. b. Conduct additional refresher and/or targeted training for research departments as deemed appropriate. c. Consider adding an input field on the Velos Study screen to filter out research studies that are not required to be listed with Clinicaltrials.gov.	a. In anticipation of the new billing requirements that will be in effect in 2014, OCRF has been working with AIS to identify the studies in Velos that do not have the clinicaltrial.gov number recorded. OCRF is on target to have this data entry completed by January 1, 2014. OCRF is in the process of drafting and communicating to campus the change in billing requirements. This communication will be distributed to campus by December 31, 2013. b. For monitoring the data, OCRF will work with AIS to develop and implement a monitoring program that includes reports for comparing information between Clinical Trials.gov and the Velos System. The plan will be completed by mid -December 2013 and the process will be implemented by January 1, 2014. c. Based on the results of this monitoring report ongoing education will be provided. d. OCRF will develop and implement a process that will review new studies and confirm that where appropriate the clinicaltrials.gov number is recorded in Velos. The plan will be completed by mid-December 2013 and the process will be implemented by January 1, 2014. e. OCRF will work with AIS to develop a field in Velos which states that a Clinical Trials.gov number is not required so that monitoring reports can exclude studies for which this is not a regulatory requirement. OCRF anticipates having the field added by November 30, 2013 and implementing a process to mark each study by January 31, 2014.	Fully Implemented

Audit Project Number	13:22	Name of Audit	Texas Administrative Code (TAC) 202	Report Date	12/4/2013
Observation Recommendations			**Management Responses/Action Plans**		**Implementation Status of Action Plans**
1. Segregation of Duties We recommend that as IS migrates its policies to the Institutional Policy Handbook, IS should include directives that require the appropriate segregation of duties. These directives should include the management of roles, responsibilities, access privileges and level of authority to include control activities such as 1) allocating access rights and privileges based on only what is required to perform job activities; 2) periodic reviews of access rights to ensure that access is appropriate; and 3) business need and allocating roles for sensitive activities for clear segregation of duties.			Management has agreed to implement the recommendations made.		Fully Implemented
2. Business Continuity Planning We recommend the following: a. Continue to work closely with Business Continuity in their update of policies and standards to ensure that they: i. Guide Business Continuity planning efforts; ii. Establish the process for the escalation of business process impacting events; iii. Define the roles and responsibilities for identifying and recovering business processes; iv. Define communication pathways between Business Continuity, Disaster Recovery, Information Resources (IR) and the effected Business Process owners; and, v. Ensure Business Continuity plans are developed only after a BIA and recovery strategies have been respectively performed and identified. b. IS should continue to work closely with Business Continuity to establish a consolidated electronic system (eBRP) to perform the Business Owner survey and utilize this information to map business processes to the required technology components. c. Criticality of systems should be mapped to IT resources to establish institutional criticality and resiliency needs. This should ultimately result in the development of a formalized BIA. d. Once a BIA has been completed, IS should reconcile the already developed Disaster Recovery plans with the BIA to ensure that business requirements during a disaster and/or business disruption and the current institution's IS capability are still appropriate. A specific disaster recovery plan governing failover processes of critical systems should also be completed. e. IS should continue to work with critical IT system owners to conform existing disaster recovery plans to the institutional requirements and validate plans through testing.			Management has agreed to implement the recommendations made.		In-process

Audit Project Number	13:24	Name of Audit	Epic Resolute Hospital Billing Post-Implementation	Report Date	12/4/2013

Observation Recommendations	Management Responses/Action Plans	Implementation Status of Action Plans
1. User Access Privileges and Segregation of Duties We recommend the following: <u>PFS</u> a. Develop a comprehensive segregation of duties matrix which identifies incompatible user groups and security access. b. Obtain authorization for the five identified end-users granted super user access or request their access be re-provisioned to a security group appropriate for their job duties. c. Develop appropriate reports and implement procedures for periodic monitoring of super user activity for appropriateness and procedures should be implemented to, at least annually, re-certify users granted super user access. d. A sunset date should be established at which time all end-users with super user access can be re-assigned to security groups appropriate for their job duties. <u>HSIR</u> a. Ensure HSIR support staff establishes lines of communication to obtain a full understanding of end-user management's requirements for Epic HB functionality and segregation of duties as defined by the matrix referenced above. b. Define role-based templates granting the minimum access required for job duties based on the segregation of duties matrix referenced above and re-assign users where feasible. c. Similar to (b) above, users should only be assigned to customized security groups in the event that templates are not feasible. d. The number of HSIR staff granted super-user access should be evaluated and reduced wherever feasible e. The practice of assigning users to Epic HB model security classes should be eliminated. All users currently assigned to these groups should be re-assigned to templates or custom security groups as appropriate. f. Epic HB support staff should work with HSIR Technical Services and the System Access Management group to ensure provisioning procedures and the IAR form are synchronized with all of the above referenced changes. g. As a long-term solution, management should explore the capabilities for managing Epic role-based security with the Forefront IAM feature.	PFS and HSIR management agree with the recommendations. Corrective action will be implemented as follows: a. Super user access has been removed from one of the identified end-users effective October 9, 2013. One identified user was determined to be a consultant for the HSIR EMR team who requires super user access at this time. PFS management's request that the remaining three end-users be added to the list of authorized super users was approved by the University Hospital CFO on October 14, 2013. b. Within the limitations of Epic HB and provided work is not hampered, the group of end-users with super user access will be assigned a more restrictive template by January 31, 2014. c. All remaining recommendations will be considered, the issues researched and, where feasible, a plan developed to address the issues within 120 days after the upgrade of the Epic suite of applications in December 2013.	Fully Implemented

Explanation of Deviations from Fiscal Year 2014 Audit Plan

The FY 2014 audit plan noted above represents a modified plan that was approved by the Institutional Audit Committee in December 2013. The FY 2014 risk assessment was led by PricewaterhouseCoopers LLP (PwC) and the original audit plan was developed by PwC based on the risk assessment results. New leadership in the Office of Internal Audit reevaluated the FY 2014 audit plan and took the following steps to ensure an achievable plan was in place:

- Conducted rounding sessions with over 30 members of management across the institution including business owners for the projects identified on the plan. Meeting objectives were to:
  - Obtain feedback on needs of the internal audit function.
  - Provide background or context of the reason for the audits to be included in the plan.
  - Identify changes such as system changes, organizational restructure, or operational process changes having an impact on risk areas.
  - Discuss ways internal audit could be more valuable to the institution.
- Consulted with the UT System Chief Audit Executive to determine audit activities and obtain feedback on modification of internal audit plan.
- Evaluated the state and system required audit activities and timelines and its impact on the audit plan.
- Consulted with the audit team and assessed skills and experience for being able to conduct the planned audits.

Modifications were made to the FY 2014 Internal Audit plan as a result of the procedures performed above and assessment of internal audit staff model. The modified plan was presented to the Institutional Audit Committee and approved. Modifications included a deferral of audit projects for the next fiscal year, cancelled projects that could be considered for future years depending on risk assessment results, and changes in audit scope which resulted in an increase or decrease of original plan hours. The modified plan represented a reduction in total FY 2014 hours from 14,415 to 9,433.

The following audits were in-process at the end of FY 2014 and will be reported in the December Audit Committee meeting:

- 14:07 IRB Oversight Review
- 14:08A Charge Master Review (MSRDP) – Co-sourced with outside firm (Protiviti)
- 14:08B Charge Master Review (Hospitals & Clinics) – Co-sourced with Protiviti
- 14:09 Sample Off-site Clinic(s) Operational Review(s)
- 14:10A Denials Management Review (MSRDP) – Co-sourced with Protiviti
- 14:10B Denials Management Review (Hospitals & Clinics) – Co-sourced with Protiviti

The following FY 2014 audits from the modified plan were cancelled:

- 14:14 Review of Office of Communications, Marketing, Public Affairs – Leadership turnover
- 14:17 Time and Effort Reporting for Research Grants – Project on Office of Compliance FY 2015 plan

The following FY 2014 audits from the modified plan were deferred to FY 2015:

- 14:13 Change in management Office of VP for Technology Development – To be performed in conjunction with the Technology Development audit on the FY 2015 audit plan

- 14:22 PeopleSoft User Access Review – To be combined with the PeopleSoft HCM/Payroll Audit on the FY 2015 audit plan

IV. Consulting Services and Non-audit Services Completed

Activity	Impact
Performed reviews of complaints received through Medical Center's *EthicsLine.*	Provides the Medical Center with investigation resources.
Conducted facilitated risk assessment workshops and developed comprehensive risk assessment results documents	Collaborates with Medical Center management to provide an enterprise risk management approach for the Medical Center in addition to identifying auditable risk areas to be included in Internal Audit Plan.
Assisted in identifying controls for adequate Departmental Financial Review processes	Provides Medical Center employees with guidance on how to review and reconcile their departmental accounts to minimize errors and irregularities in the normal course of business activities.
UTS142.1 Testing	Provides validation for annual financial certification processes and monitoring controls.
Fraud Analysis	Provides independent consultation and evaluation tools to management for preventing, detecting and monitoring of fraudulent activities.
Archibus Implementation	Provides independent consultation and guidance of internal controls for process flows within Archibus application implementation.
Business Resumption and Disaster Recovery Planning	Provides independent consultation and guidance to help Medical Center address Emergency preparedness and Business Continuity risks.
Participation in the quarterly Executive Compliance Committee	Provides consultation and guidance on emerging issues in risk management and audit initiatives.
Participation in monthly Information Security/Privacy Steering Committee meetings	Provides consultation and guidance on emerging issues in areas of physical security initiatives, privacy and information security.
Participation in the following Committees or work groups: • Executive Wellness Committee • Business Services Committee • Financial Administrative Group • UT System Risk Assessment Work Group • Capital Process Improvement Committee	Participates in focused groups and provides consultation on process improvement, development of new processes, institutional initiatives, emerging issues in risk management, and audit initiatives.
Coordination of External Audits	Provides operational support for the following: State Auditor's Office single statewide audit (A-133 and Financial portions), Deloitte Financial Audit (Interim and Year-end), Deloitte Information Security Assessment and Effectiveness Review, US Department of Health and Human Services Office of Inspector General.

Consulting Services and Non-audit Services Completed, continued	
Activity	Impact
Assistance to External Audit Professional Organizations	Provides professional assistance or participation in the following associations: Association of Healthcare Internal Auditors (AHIA), Institute of Internal Auditors (IIA), Information Systems Audit and Control Association (ISACA), Association of College and University Auditors (ACUA).
Assistance to UT System Internal Audit function	Participates in focused groups and provides consultation and assistance in providing institution risk information, Internal Audit reporting, and quality related matters.

V. External Quality Assurance Review (Peer Review)

An External Quality Assurance Review was performed in FY 2014 by an independent outside firm (PwC). The letter accompanying the Quality Assurance Report is noted below.

July 7, 2014

Ms. Valla Wilson, Assistant Vice President and Chief Audit Executive
The UT Southwestern Medical Center
6363 Forest Park Rd, Dallas, TX 75235

We have completed an External Quality Assessment ("EQA") of The University of Texas Southwestern Medical Center ("UT Southwestern", 'UTSW", or "institution") Office of Internal Audit ("IA"). The EQA included an assessment of the level of conformance with the Institute of Internal Auditor's International Standards for the Professional Practice of Internal Auditing ("the IIA Standards"), the Generally Accepted Government Auditing Standards ("GAGAS"), as well as the relevant requirements of the Texas Internal Auditing Act ("TIAA"). Listed below are our observations:

- IIA Standards - Based on our work, overall IA generally conforms. We did identify process enhancement opportunities.
- GAGAS - Our assessment of GAGAS was limited, based on IA's disclosure that no internal audits were performed during our assessment period under GAGAS. Based on our work, we did not identify conformance observations. We did identify process enhancement opportunities.
- TIAA requirements – Other than the observations related to IIA Standards and GAGAS, no conformance observations were identified during our work. We did identify a process enhancement opportunity.

Our services were performed and this report was developed in accordance with our contract dated February 18, 2014 and are subject to the terms and conditions included therein. Our Services were performed in accordance with the Standards for Consulting Services established by the American Institute of Certified Public Accountants ("AICPA"). Accordingly, we are providing no opinion, attestation or other form of assurance with respect to our work and we did not verify or audit any information provided to us. Our work was limited to the specific procedures and analysis described herein and was based only on the information made available through May 23, 2014, when field work was substantially completed. Accordingly, changes in circumstances after this date could affect the findings outlined in this report. This information has been prepared solely for the use and benefit of, and pursuant to a client relationship exclusively with The University of Texas System Administration. PwC disclaims any contractual or other responsibility to others based on its use and, accordingly, this information may not be relied upon by anyone other than The University of Texas System Administration and UT Southwestern.

We would like to offer a sincere thank you to you and your staff, and the Audit Committee and management of UT Southwestern, for the time and attention they provided during this assessment. We appreciate the opportunity to serve The University of Texas System Administration on this important engagement.

Very truly yours,

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP, 1201 Louisiana, Suite 2900, Houston, TX 77002-5678
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VI. Internal Audit Plan for Fiscal Year 2015

FY 2015 Audit Plan Audit/Project	Budgeted Hours	% of Total
Financial		
Risk Based Audits		
Charge Capture/Reconciliation Audit (Hospitals and Clinics) +	600	
Charity and Uncompensated Care Audit	200	
Sponsored Programs Administration Review	300	
Patient Collections Audit (Hospitals and Clinics)	400	
Accounts Receivable - Billing Audit (Hospitals and Clinics)	400	
Clinical Trials Billing Audit	300	
Non-Risk Based Audits		
Deloitte Financial Audit Support	815	
Direct Reports' Travel & Entertainment Review	200	
Assistance to UT System for Presidential Travel & Entertainment Review	40	
Financial Subtotal	**3,255**	**21.9%**
Operational		
Risk Based Audits		
Pharmacy Review (Hospitals and Clinics)	450	
PeopleSoft HCM/Payroll Audit*	300	
Timekeeping Audit*	300	
Vendor Recall	250	
Sample Offsite Clinic(s) Operational Review(s)+	400	
Technology Development	300	
DaVita Joint Venture Review	250	
Carryover of FY14 Audits	400	
Consulting Projects		
ICD10 Readiness	200	
Operational Subtotal	**2,850**	**19.2%**
Compliance		
Risk Based Audits		
IACUC Process/Program Review (Compliance)*	400	
Animal Controlled Substances Audit	300	
HIPAA Privacy Compliance	300	
Document Retention Audit	300	
Non-Risk Based Audits		
UTS 142.1 Annual Monitoring Plan Review	100	
Proportional Funding of Benefits Review	200	
Compliance Subtotal	**1,600**	**10.8%**
Information Technology		
Risk Based Audits		
Disaster Recovery/Business Continuity	300	
Mobile Device Security	200	
Decentralized Application Reviews +	600	
Project Management/System Acquisition Methodology	200	
Cyclical Infrastructure Audits		
Database Layer	250	
Consulting Projects		
Archibus Facilities Management System	100	
Other System Development Consulting	300	
Compliance Audits		
TAC 202 Compliance (Biennial Requirement)	200	
Information Technology Subtotal	**2,150**	**14.5%**

Change in Management Audits		
Change in Management Review - AVP, Real Estate and Auxiliary Services	200	
Change in Management Reviews for key leaders (TBD)	200	
Change in Management Reviews for key leaders (TBD)	200	
Change in Management Reviews for key leaders (TBD)	200	
Change in Management Subtotal	**800**	**5.4%**
State/Federal Support		
State Auditor's Office (SAO) Support	250	
State/Federal Support Subtotal	**250**	**1.7%**
UT System Support		
Annual Internal Audit Report	100	
UT System Identified Risk-Based Review	300	
UT System Support Subtotal	**400**	**2.7%**
Projects/Special Reporting		
Audit Follow-Up	550	
Audit Committee Reporting	500	
FY16 Risk assessment and Audit Plan Development	400	
Hotline/Special Projects & Consulting Reserve	1,694	
Internal Audit Development	150	
Continuous Auditing/Monitoring	250	
Projects/Special Reporting Subtotal	**3,544**	**23.9%**
Total Hours	**14,849**	**100.0%**

VII. External Audit Services Procured in Fiscal Year 2014

The following is a list of audits completed by outside agencies at the Medical Center in FY2014.

- American Heart Association – Review of Administrative Controls and Expenditures
- Deloitte – Annual Financial Report Audit (FY 2013 Year-end Testing and FY 2014 Interim Testing)
- Deloitte – Review of Cancer Prevention Research Institute of Texas (CPRIT) Grant Processes and Expenditures (multiple years)
- Grant Thornton – Review of CPRIT Expense Reimbursement, Matching Funds, and Assets
- McAfee – Vendor Software License Audit
- Office of Civil Rights – HIPAA, HIV, and Limited English Proficiency Patient Rights Protections Review Office of the Inspector General (OIG), Office of Audit Services – Review of Policies & Procedures Related to Right Heart Catheterization and Heart Biopsies in the Same Operative Session
- State Auditor's Office (SAO) – Single Audit A-133 (Research & Development Cluster and Financial Audit)
- State Comptroller's Office – Post Payment Audit
- Weaver & Tidwell – Moncrief Cancer Center Foundation, Audit of Year-end Financial Statements
- Weaver & Tidwell – Moncrief Cancer Center, Audit of Year-end Financial Statements

In addition, the Medical Center procured internal audit services from Protiviti due to unfilled staff positions. The Office of Internal Audit co-sourced with Protiviti staff on two FY 2014 audits (Charge Master Review and Denials Management Review). Both audits were in-process as of August 31, 2014.

VIII. Reporting Suspected Fraud and Abuse

- Fraud Reporting - Section 7.10, General Appropriations Act (82nd Legislature), Article IX.
- Coordination of Investigations - Texas Government Code, Section 321.022.
  - UT Southwestern maintains a fraud, waste and abuse hotline webpage that links to the State Auditor's fraud hotline information and website for fraud reporting.