Fiscal Year 2021 Internal Audit Annual Report

UT HEALTH SCIENCE CENTER AT TYLER
OFFICE OF INTERNAL AUDIT
11937 US HIGHWAY 271
TYLER, TX 75708

Purpose of the Internal Audit Annual Report: To provide information on the assurance services, consulting services, and other activities of the internal audit function. In addition, the Internal Audit Annual Report assists oversight agencies in their planning and coordination efforts.

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I. Compliance with Texas Government Code, Section 2102.015: Posting the Internal Audit Plan, Internal Audit Report, and Other Audit Information on Internet Website

Texas Government Code, Section 2102.015 requires that state agencies, including institutions of higher education, post on their website:

- the agency's approved Internal Audit Plan, as provided by Texas Government Code Section 2102.008
- the agency's Annual Report, as required by Texas Government Code Section 2102.009

Texas Government Code, Section 2102.015, also requires entities to update the posting described above to include the following information on the website:

- a detailed summary of the weaknesses, deficiencies, wrongdoings, or other concerns, if any, raised by the Audit Plan or Annual Report
- a summary of the action taken by the agency to address the concerns, if any, that are raised by the Audit Plan or Annual Report

A state agency is not required to post information contained in the agency's Internal Audit Plan or Annual Report if the information meets an exception from public disclosure under Texas Government Code Chapter 552.

The UT Health Science Center at Tyler's (UTHSCT) Internal Audit Department (IA) complies with these requirements by posting fiscal year (FY) Audit Plans and Annual Internal Audit Reports on the Institution's external website in the "Reports to the State" section. Detailed summaries of weaknesses and deficiencies raised by the Audit Plan, along with the summary of actions taken to address the concerns, are included within the Annual Internal Audit reports.

Reference Exhibit B: FY 2021 Audits - Summary of Issues and Current Status

II. Internal Audit Plan for Fiscal Year 2021

FY 2021 Audit Plan	Project No.	Original Budget	Budget Adjustments	Revised Budget	Actual Hours Through 08/31/21	Remaining Budgeted Hours	Status
Assurance Engagements							
Stark Law Physician Contract Audit (Subsequent to the Master Services Agreement (MSA)) - Attorney-Client Privilege	21-1	450.0	0.0	450.0	439.0	11.0	Completed
EPIC Post-Implementation Audit	21-2	500.0	(500.0)	0.0	0.0	0.0	Removed - EPIC Implementation Delayed until FY22 - Moved to FY22 Audit Plan
Employee Off-Boarding Audit	21-3	400.0	0.0	400.0	392.0	8.0	Completed
Carryforward of Assurance Engagements	21-4	200.0	0.0	200.0	522.0	-322.0	Completed - 20-1 Controlled Substance Agreements Audit and 20-3 Research Grants Audit
Assurance Engagements Subtotal		**1,550.0**	**(500.0)**	**1,050.0**	**1,353.0**	**-303.0**	
Advisory and Consulting Engagements							
Institutional Committees and Workgroups -	21-5	50.0	50.0	100.0	109.5	-9.5	Completed
Consulting Ad-Hoc Project #1	21-5a	0.0	250.0	250.0	249.0	1.0	Completed
UTHSCT/UT Tyler Integration - Advisory Role	21-6	100.0	50.0	150.0	148.5	1.5	Completed
UTHSCT & UT Health East Texas Clinical Operations Management Agreement (COMA)	21-7	100.0	0.0	100.0	98.0	2.0	Completed
Institutional work from home procedural review	21-8	100.0	0.0	100.0	2.0	98.0	Removed - change in risk landscape
Review of compliance with national guidelines for	21-9	100.0	0.0	100.0	0.0	100.0	Removed - change in risk landscape
EPIC Pre-Implementation Workgroup	21-10	50.0	0.0	50.0	53.5	-3.5	Completed
Institutional Strategic Initiatives	21-11	150.0	50.0	200.0	196.5	3.5	Completed
Opioid Stewardship Committee - Advisory Role	21-12	40.0	0.0	40.0	13.5	26.5	Completed
Training provided by Internal Audit	21-13	200.0	0.0	200.0	199.5	0.5	Completed
Data Analytics	21-14	150.0	0.0	150.0	149.0	1.0	Completed
Advisory and Consulting Engagements Subtotal		**1,040.0**	**400.0**	**1,440.0**	**1,219.0**	**221.0**	
Required Engagements							
State Institution of Higher Education Contracting	21-15	50.0	0.0	50.0	47.0	3.0	Completed
Family Medicine Residency Program Grant Audit	21-16	125.0	0.0	125.0	119.0	6.0	Completed
Financial Statement Audit Assistance	21-17	50.0	0.0	50.0	46.0	4.0	Completed
CPRIT Grant External Audit (assistance to	21-18	25.0	0.0	25.0	0.0	25.0	N/A - Assistance not requested
Required Engagements Subtotal		**250.0**	**0.0**	**250.0**	**212.0**	**38.0**	
Investigations							
Investigations - Assistance	21-19	50.0	0.0	50.0	0.0	50.0	N/A - Assistance not requested
Investigations Subtotal		**50.0**	**0.0**	**50.0**	**0.0**	**50.0**	

FY 2021 Audit Plan	Project No.	Original Budget	Budget Adjustments	Revised Budget	Actual Hours Through 08/31/21	Remaining Budgeted Hours	Status
Reserve							
Reserve for TBD Engagements	TBD	300.0	(250.0)	50.0	0.0	50.0	Reduced for Ad-Hoc Consulting Project
Reserve Subtotal		**300.0**	**(250.0)**	**50.0**	**0.0**	**50.0**	
Follow-Up							
Follow-up procedures conducted to verify the implementation status of past recommendations	CATS/TM Reports	65.0	100.0	165.0	142.0	23.0	Completed
Follow-Up Subtotal		**65.0**	**100.0**	**165.0**	**142.0**	**23.0**	
Development - Operations							
Annual Risk Assessment and Audit Plan Development		250.0	0.0	250.0	248.5	1.5	Completed
Institutional Audit Committee Preparation and Participation		250.0	0.0	250.0	325.0	-75.0	Completed
Quality Initiatives		100.0	0.0	100.0	109.0	-9.0	Completed
UT System & SAO Reports and Requests		50.0	50.0	100.0	72.5	27.5	Completed - FY20 Internal Audit Annual Report & UTS Requests
Automated Tools Skills Development and Maintenance		75.0	0.0	75.0	52.5	22.5	Completed
UT Health CAEs Monthly Collaborative Meetings		35.0	0.0	35.0	22.5	12.5	Completed
UT Health East Texas Monthly Collaborative Meetings		50.0	0.0	50.0	46.0	4.0	Completed
Development - Operations Subtotal		**810.0**	**50.0**	**860.0**	**876.0**	**-16.0**	
Development - Initiatives and Education							
System Audit Office initiatives participation		100.0	50.0	150.0	140.0	10.0	Completed
Professional organization/association participation		100.0	100.0	200.0	278.0	-78.0	Completed
Individual Continuing Professional Education (CPE) Training, including related travel		160.0	50.0	210.0	209.5	0.5	Completed
Development - Initiatives and Education Subtotal		**360.0**	**200.0**	**560.0**	**627.5**	**-67.5**	
Total Budgeted Hours		**4,425.0**	**0.0**	**4,425.0**	**4,429.5**	**-4.5**	

Rider 8, page III-48 of the General Appropriation Act (86th Legislature)

Rider 8, page III-48, the General Appropriations Act (86th Legislature, Conference Committee Report), requires that higher education institutions conduct an internal audit of benefits proportional by fund, using a methodology prescribed by the State Auditor's Office. The rider requires that the audit examine FY 2017 through 2019 and be completed no later than August 31, 2020.

IA completed an Audit of Benefits Proportionality by fund for FY 2017 through 2019, using the methodology prescribed by the State Auditor's Office, as a project under the required engagements for the FY 2020 Audit Plan, titled "Benefits Proportionality". An audit of FY 2020 and FY 2021 Benefits Proportionality is included in the FY 2022 Audit Plan.

Texas Education Code, Section 51.9337

Senate Bill 20 (84th Legislative Session) made several modifications and additions to Texas Government Code (TGC) and Texas Education Code (TEC) related to purchasing and contracting. Effective September 1, 2015, TEC §51.9337(h) requires that, "*The chief auditor of an institution of higher education shall annually assess whether the institution has adopted the rules and policies required by this section and shall submit a report of findings to the state auditor*."

IA conducted this required assessment for FY 2021, and found the following:

Based on the review of current Institutional policies and procedures, UT System (UTS) Board of Regents' rules and regulations, and UTS policies and procedures, UTHSCT has generally adopted all the rules and policies required by TEC §51.9337. Review and revision of Institutional and UTS policies is an on-going process. These rules and policies will continue to be assessed annually to ensure continued compliance with TEC §51.9337.

III. Consulting Services and Non-Audit Services Completed

Report Date	Report Title	High-Level Objective	Results
No Formal Report	Institutional Committee and Workgroups – Advisory Role	To assist in an advisory role on committees/workgroups at the Institution. The committees/workgroups will be defined by leadership to continue to reflect the UT Health East Texas transaction.	Internal Audit served in an advisory capacity on several standing and ad-hoc committees during the year and completed various action items assigned during the committee meetings.

Report Date	Report Title	High-Level Objective	Results
No Formal Report	UTHSCT/UT Tyler Integration - Advisory Role	To assist in an advisory role on committees/workgroups at the Institution defined by leadership related to the upcoming UTHSCT and UT Tyler integration.	Internal Audit served in an advisory capacity on several integration committees during the year and completed various action items assigned during the committee meetings.
No Formal Report	UTHSCT & UT Health East Texas Clinical Operations Management Agreement (COMA) Review	To perform an annual review of UTHET's performance under the COMA to evaluate its compliance with the agreed upon Management Parameters.	Internal Audit performed an annual review of UTHET's performance under the COMA by evaluating its compliance with the agreed upon Management Parameters.
No Formal Report	Consulting Ad-Hoc Project #1	To perform a review, at management's request, of certain vendor invoices over a specified period of time for appropriateness and accuracy.	Internal Audit identified errors and inconsistencies in the vendor's invoices during the specified timeframe reviewed, resulting in cost savings for the Institution.
No Formal Report	EPIC Pre-Implementation Workgroup	To assist in an advisory role on Epic committees/workgroups at the Institution for the expected FY21 EPIC conversion.	Internal Audit served in an advisory capacity on Epic committees/workgroups and communications during the year.
No Formal Report	Institutional Strategic Initiatives	To assist in an advisory role on initiatives related to strategic advancement of controls at the Institution within specific areas that have been impacted by the UT Health East Texas transaction.	Internal Audit served in an advisory capacity on initiatives to assist the Institution within specific areas impacted by the UT Health East Texas transaction.

Report Date	Report Title	High-Level Objective	Results
No Formal Report	Opioid Stewardship Committee - Advisory Role	To assist in an advisory role on the Opioid Stewardship Committee which was comprised to review risks and controls related to Controlled Substances for the Institution.	Internal Audit served in an advisory capacity on the Opioid Stewardship Committee during the year and advised, as necessary, on tasks and subjects addressed by the Committee related to Controlled Substances for the Institution.
No Formal Report	Training provided by Internal Audit	To develop and deliver ad-hoc training to Institutional customers for emerging fraud related risks and to provide training to auditees post audit.	Internal Audit served in an advisory capacity to develop and deliver ad-hoc training to Institutional customers for emerging fraud related risks and to provide training to auditees post audit.
No Formal Report	Data Analytics	To develop and deliver ad-hoc financial/operational reports using data analytics software for Institutional clients as requested.	Internal Audit, with the assistance from the UTS Audit Office, developed and delivered ad-hoc financial/operational reports using IDEA software for Institutional clients as requested.
No Formal Report	Supply Inventory Recounts	To assist the Accounting department with the annual verification of departmental supply inventories for the purpose of financial statement asset valuation.	Supply inventory test recounts of assigned areas were substantially accurate.

IV. External Quality Assessment Review (QAR) (Peer Review)

Baker Tilly was engaged to conduct an independent validation of IA's self-assessment with the assistance of an internal audit executive from a peer institution, which was completed in August of 2020. The primary objective of the validation was to verify the assertions made in the self-assessment report concerning adequate fulfillment of the organization's expectation of the internal audit activity and its conformity to the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing*

and Code of Ethics, Generally Accepted Government Auditing Standards, and relevant requirements of the Texas Internal Auditing Act.

Based on Baker Tilly's independent validation of the self-assessment performed by IA, the internal audit function received an overall rating of "Generally Conforms" with the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing* and Code of Ethics. The IIA's *Quality Assessment Manual* suggests a scale of three ratings, "generally conforms," "partially conforms," and "does not conform." "Generally conforms" is the top rating and means that an internal audit activity has a charter, policies, and processes that are judged to be in conformance with the *Standards*. "Partially conforms" means deficiencies in practice are noted that are judged to deviate from the *Standards*, but these deficiencies did not preclude the IA activity from performing its responsibilities in an acceptable manner. "Does not conform" means deficiencies are judged to be so significant as to seriously impair or preclude the IA activity from performing adequately in all or in significant areas of its responsibilities.

Reference Exhibit A: External Quality Assessment Review Executive Summary

V. Internal Audit Plan for Fiscal Year 2022

The UT Tyler and UT Health Science Center at Tyler Internal Audit departments combined in February of 2021 to form a unified UT Tyler Internal Audit Department and developed one (1) FY 2022 Audit Plan that covers the newly aligned UT Tyler and Health Science Center as follows.

Project Name	Budget
Assurance Engagements	
Epic Post-Implementation Audit	500
Controlled Equipment Audit	400
Research Time and Effort Audit	400
Employee Off-Boarding Audit	400
Medical Devices Audit	400
Accounts Payable Audit	300
Cloud Security Audit	300
Assurance Engagements Subtotal	**2700**
Advisory and Consulting Engagements	
Executive Management Meetings, Consulting and Advisory Services, and Special Requests or Emerging Risks	400
Institutional Committees, Workgroups, Training, and Meetings	400
UTHSCT and UT Health East Texas Clinical Operations Management Agreement (COMA) Review	100
Data Analytics Program	500
IT Incident Response	100

Advisory and Consulting Engagements Subtotal	**1500**
Required Engagements	
State Institution of Higher Education Contracting Assessment	40
Family Medicine Residency Program Grant Audit FYE 8/31/2021	100
Financial Statement Audit Assistance	40
CPRIT Grant External Audit (assistance to management)	30
Benefits Proportionality Audit	350
Required Engagements Subtotal	**560**
Investigations	
Investigations	500
Investigations Subtotal	**500**
Reserve	
Reserve for Ad-Hoc Engagements	400
Reserve Subtotal	**400**
Follow-Up	
Implementation Status Tracking	300
Follow-Up Subtotal	**300**
Development - Operations	
Annual Risk Assessment and Audit Plan	400
Institutional Audit Committee	400
Quality Initiatives	300
External Reporting /Requests	200
Audit Management Software, IT Support, and Website Maintenance	300
Staff Meetings	300
CAE Update/Collaborative Meetings	150
Development - Operations Subtotal	**2050**
Development - Initiatives and Education	
System Audit Office Initiatives	150
Professional Organizations/Association Participation	300
Individual Continuing Professional Education (CPE)	350
Development - Initiatives and Education Subtotal	**800**
Total Budgeted Hours	**8810**

Other High-Level Risks:

Additional critical and high risks that were identified but not included in the FY 2022 Audit Plan are related to the following:

- Administration, accreditation, strategic planning and growth
- Compliance with regulations including purchasing, billing, and disclosure requirements
- Finance, human resources, and research
- Information technology and security
- Safe campus environment and travel
- Athletics and campus programs for minors

While related engagements are currently not part of the FY 2022 Annual Audit Plan, there are other mitigating activities underway that address the objectives at risk.

Risk Assessment Process:

The UT Tyler FY 2022 Audit Plan was prepared using a risk-based approach developed by the University of Texas System to ensure that areas and activities specific to UT Tyler with the greatest risk were identified for consideration to be audited.

The goals for this risk assessment approach were to start with an awareness of critical initiatives and objectives to ensure the risks assessed were the most relevant. The risk assessment approach was based on a top-down process that included conversations and requests for input with risk collaborators, executives, and managers from the various operating areas on campus to review the activities and associated risks in their areas. During the risk assessment, risks associated with information technology related to Title 1, Texas Administrative Code, Chapter 202; Benefits Proportionality; and compliance with contract processes and controls according to Texas Government Code, Section 2102.005(b) were considered. An emphasis was placed on collaboration with other functions that assess, handle, or manage risk. The risk assessment and subsequent Audit Plan were reviewed and approved by members of executive management and the Institutional Audit Committee.

VI. External Audit Services Procured in Fiscal Year 2021

Internal Audit did not engage in, or require any, external audit services for FY 2021.

VII. Reporting Suspected Fraud and Abuse

UTHCST has taken the following actions to implement the requirements of:

• Section 7.09, page IX-37, the General Appropriations Act (86th Legislature, Conference Committee Report): The Institution's website includes the State Auditor's Office fraud hotline information and a link to the State Auditor's website for fraud reporting. The information is linked from the Institution's home page via a link entitled, "Compliance". The Institution has also included information on how to report suspected fraud involving State funds to the State Auditor's Office in its Compliance and Ethics Hotline Reporting Policy (PolicyStat ID #5560494) in the Institutional Handbook of Operating Procedures (IHOP).

• TGC Section 321.022, Coordination of Investigations: UTS has implemented UTS Policy 118, Section 5, which includes a reference link to the TGC §321.022. This policy is applicable to all UTS institutions, including UTHSCT. The policy states that "the Chief Inquiry Officer for the U. T. System is the designated investigation coordinator responsible for tracking and coordinating investigations of allegations of misconduct, including Dishonest or Fraudulent Activity, at U.T. System Administration or involving an Institutional President." The UTHSCT President is knowledgeable about the policy requirements and his reporting responsibilities to the State Auditor.

Exhibit A: External Quality Assessment Review Executive Summary

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August 3, 2020

Stephen Ford, Jr., Associate Vice President, Chief Audit Executive
The University of Texas Health Science Center at Tyler

In June 2020, The University of Texas Health Science Center at Tyler (UTHSCT) internal audit (IA) function, the Office of Internal Audit (OIA), completed a self-assessment of internal audit activities in accordance with guidelines published by the Institute of Internal Auditors (IIA) for the performance of a quality assessment review (QAR). UTHSCT OIA engaged an independent review team consisting of internal audit professionals with extensive higher education and healthcare experience to perform an independent validation of OIA's QAR self-assessment. The primary objective of the validation was to verify the assertions made in the QAR report concerning IA's conformity to the IIA's *International Standards for the Professional Practice of Internal Auditing* (the IIA *Standards*) and Code of Ethics, Generally Accepted Government Auditing Standards (GAGAS), and the relevant requirements of the Texas Internal Auditing Act (TIAA).

The IIA's *Quality Assessment Manual* suggests a scale of three ratings, "generally conforms," "partially conforms," and "does not conform." "Generally conforms" is the top rating and means that an internal audit activity has a charter, policies, and processes that are judged to be in conformance with the *Standards*. "Partially conforms" means deficiencies in practice are noted that are judged to deviate from the *Standards*, but these deficiencies did not preclude the IA activity from performing its responsibilities in an acceptable manner. "Does not conform" means deficiencies are judged to be so significant as to seriously impair or preclude the IA activity from performing adequately in all or in significant areas of its responsibilities.

Based on our independent validation of the QAR performed by OIA, we agree with OIA's overall conclusion that the internal audit function **"Generally Conforms"** with the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing* and Code of Ethics, as well as with OIA's conclusions regarding GAGAS and TIAA requirements. Our review noted strengths as well as opportunities for enhancing the internal audit function.

This information has been prepared pursuant to a client relationship exclusively with, and solely for the use and benefit of, The University of Texas System Administration and UTHSCT and is subject to the terms and conditions of our related contract. Baker Tilly 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 The University of Texas Health Science Center at Tyler.

The review team appreciates the cooperation, time, and candid feedback of executive leadership, stakeholders, and OIA personnel.

Very truly yours,

Baker Tilly Virchow Krause, LLP

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Texas Government Code, Section 2102.015 requires state agencies and institutions of higher education to post to the institution's website:

- A "detailed summary of the weaknesses, deficiencies, wrongdoings, or other concerns raised by the audit plan or annual report."
- A "summary of the action taken by the agency to address concerns, if any, that are raised by the audit plan or annual report."

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-2	12/03/2019	Medical Devices Audit	The objective of this audit was to review the Institution's processes for protection of its information resources against network or data damage via insecure or unmanaged medical device exposure.	**Observation #1**: Currently, UTHSCT does not have an Institutional policy that addresses medical devices. **Recommendation #1**: Information Security, in collaboration with Information Technology, develop and implement an Institutional policy that addresses its medical device requirements and ensure all parties involved receive notification and guidance upon its implementation. The policy should be based upon best practices and consider addressing network segmentation for medical devices.	Fully Implemented
20-2	12/03/2019	Medical Devices Audit	The objective of this audit was to review the Institution's processes for protection of its information resources against network or data damage via insecure or unmanaged medical device exposure.	**Observation #2**: Currently, Biomedical Service's risk assessment for medical devices does not evaluate security controls such as device limitations, vulnerabilities, and impact for devices that interface with PHI or are network capable in order to establish risk ratings and risk criteria for each medical device that interfaces with PHI or has network capability. **Recommendation #2**: Biomedical Services, in collaboration with Information Security, develop and implement a risk assessment of medical devices considering device limitations, vulnerabilities, and impact of those devices that interface with PHI or are connected to the	Fully Implemented

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
				network and ensure this information is captured on the Medical Device Inventory List. The risk rating (e.g., Category I, II, III, etc.) and vulnerability classification of medical devices should be standardized for a consistent evaluation of risks for each device.	
20-2	12/03/2019	Medical Devices Audit	The objective of this audit was to review the Institution's processes for protection of its information resources against network or data damage via insecure or unmanaged medical device exposure.	**Observation #4**: Currently, Biomedical Services does not inform the Compliance Department (Compliance) or Information Security when a medical device, that interfaces with PHI, stores PHI, and/or has network capability, can't be located (e.g., has been misplaced, lost, or stolen) during its preventive maintenance checks. If the same medical device can't be located for two (2) consecutive checks, Biomedical Services categorizes the medical device as "Retired" on the Medical Device Inventory list. **Recommendation #4**: Biomedical Services should inform Compliance and Information Security when a medical device, that interfaces with PHI, stores PHI, and/or has network capability, can't be located (e.g., has been misplaced, lost, or stolen) during its preventive maintenance checks, prior to the medical device being categorized as "Retired", in accordance with the timeframe established by the policy in Recommendation #1 above.	Fully Implemented

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-2	12/03/2019	Medical Devices Audit	The objective of this audit was to review the Institution's processes for protection of its information resources against network or data damage via insecure or unmanaged medical device exposure.	**Observation #6**: It was noted during our testing that numerous medical devices have open ports, were not logically restricted, and/or were logically restricted with generic or manufacturer default usernames and passwords. **Recommendation #6**: Biomedical Services should ensure that all open ports on medical devices are not active or accessible; medical devices are logically restricted if possible; and generic or manufacturer default usernames and passwords are replaced on all medical devices. These requirements should be captured within the policy in Recommendation #1 above.	Incomplete\On-Going
20-1	10/21/2020	Controlled Substance Agreements	The objective of this audit was to evaluate the Institution's processes for executing and managing controlled substance agreements in accordance with its new policy.	**Observation #1**: UTHSCT is not able to provide a tracking report that identifies all patients who, in accordance with the terms of its policy, require a controlled substance agreement. Of the 165 patients selected from the current report, 52 did not require an agreement upon testing. **Recommendation #1**: UTHSCT implement processes that will allow its clinics, providers and leadership to readily and accurately identify all patients who require a controlled substance agreement, as per the language in its policy, in order to monitor which patients will need an agreement upon their next appointment.	Incomplete\On-Going

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Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-1	10/21/2020	Controlled Substance Agreements	The objective of this audit was to evaluate the Institution's processes for executing and managing controlled substance agreements in accordance with its new policy.	**Observation #2**: UTHSCT is not able to provide a tracking report that identifies all patients, accurately and completely, who currently have a signed controlled substance agreement in their EHR. **Recommendation #2**: UTHSCT implement processes that will allow its clinics, providers and leadership to readily and accurately identify all patients who are currently on a controlled substance agreement, in order to identify the patients that need to be in compliance with the 13 testing attributes listed above and to provide continuous monitoring for the attributes that are outstanding for the identified patients.	Incomplete\On-Going
20-1	10/21/2020	Controlled Substance Agreements	The objective of this audit was to evaluate the Institution's processes for executing and managing controlled substance agreements in accordance with its new policy.	**Observation #3:** As noted in the sample testing results above, 55 patients identified as needing a controlled substance agreement per Institutional policy, do not have an agreement on file. **Recommendation #3:** UTHSCT should execute a controlled substance agreement for each of the identified patients. In addition, Management should continue training efforts and share best practices amongst the clinics to ensure all clinics are aware of the controlled substance agreement requirements specified by Institutional policy and put into practice.	Incomplete\On-Going

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Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-1	10/21/2020	Controlled Substance Agreements	The objective of this audit was to evaluate the Institution's processes for executing and managing controlled substance agreements in accordance with its new policy.	**Observation #4**: Currently, UTHSCT is not able to provide a historical tracking report for PMP checks performed through DrFirst. In addition, PMP checks performed through DrFirst software are not captured in the patient's EHR for verification that the checks were performed. As a result, the PMP checks performed through DrFirst do not have an audit trail. **Recommendation #4**: UTHSCT implement a process for documenting the PMP checks performed in the EHR. As part of the EPIC implementation process, Management should work to ensure PMP checks performed through DrFirst are automatically captured in the EHR.	Incomplete\On-Going

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Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-3	12/10/2020	Research Grants Audit	The objective of this audit was to evaluate the adequacy of processes and controls for accurate time and effort (T&E) reporting for sponsored research	**Observation #1**: The current PA form is lacking key grant information such as effort percentages and salary cap levels. As a result, we noted inconsistent use of the PA form across the departments completing PA forms with grant accounts and an increased difficulty to reconcile individual effort percentages and salary cap levels. **Recommendation #1**: OSP should work with HR to update the Institution's current PA form to include key grant information. The Institution should also consider, in the event funding becomes available, technologies for PA automation.	Fully Implemented
20-3	12/10/2020	Research Grants Audit	The objective of this audit was to evaluate the adequacy of processes and controls for accurate time and effort (T&E) reporting for sponsored research	**Observation #2**: Currently, T&E certifications are completed by grant and not comprehensively per individual, unless the individual is over the salary cap level. As a result, it is difficult to track and review total effort for all grant personnel to ensure they do not exceed 100% effort. **Recommendation #2**: OSP should consider completing a comprehensive T&E certification per individual to aid in the tracking of total effort on an individual basis.	Incomplete\On-Going

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Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-3	12/10/2020	Research Grants Audit	The objective of this audit was to evaluate the adequacy of processes and controls for accurate time and effort (T&E) reporting for sponsored research	**Observation #3**: Currently, OSP is not conducting annual training as required by Institutional Policy #6317889. **Recommendation #3**: OSP, in coordination with HR, and in alignment with recommendation #1 above, should develop and provide training to all Grant Owners/PIs and the staff preparing these individuals' PAs on PA form policy and procedure requirements. This training should be provided to all new research employees in these areas going forward and continue on an annual basis.	Fully Implemented
20-3	12/10/2020	Research Grants Audit	The objective of this audit was to evaluate the adequacy of processes and controls for accurate time and effort (T&E) reporting for sponsored research	**Observation #4**: As noted in the audit results above, a number of T&E certifications had not been sent for completion at the time of our testing. In addition, it was noted that a high percentage of the T&E certifications were not reviewed in a timely manner and in one (1) instance the T&E certification included the PI's salary percentage instead of the effort percentage. **Recommendation #4**: OSP further strengthen its T&E certification tracking and review procedures to ensure accurate and timely completion of all T&E certifications.	Fully Implemented

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-3	12/10/2020	Research Grants Audit	The objective of this audit was to evaluate the adequacy of processes and controls for accurate time and effort (T&E) reporting for sponsored research	**Observation #5**: The following exceptions were noted in our testing of PA forms: • OSP did not have the final completed copy of the PA form, inclusive of all required signatures, for a number of our sample selections; • There were multiple instances where OSP did not have a copy of the PI's PA form on file; • 11 of the selected PA forms that OSP had on file were not completed in a timely manner; and • Multiple individual's PA forms were missing one (1) or more grants (it should be noted that the missing grants identified were allocated at 0% salary so no adverse effects on salaries were identified). These exceptions resulted in a number of incomplete T&E certifications. **Recommendation #5**: OSP, in coordination with HR, should develop a process to ensure they receive the final completed copy of all PA forms that include grant personnel timely. In addition, OSP should strengthen their PA review process to ensure all applicable grants are included on the PA form.	Fully Implemented

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-3	12/10/2020	Research Grants Audit	The objective of this audit was to evaluate the adequacy of processes and controls for accurate time and effort (T&E) reporting for sponsored research	**Observation #6**: Institutional Policy #6317889 states that "the minimum effort on any project for which salary costs are reimbursed will be 1%". It was noted that during our testing multiple PIs were allocated 0% effort to a grant. **Recommendation #6**: OSP should develop pre-award procedures to ensure that PIs are allocated an effort percentage in accordance with its policy.	Fully Implemented
20-3	12/10/2020	Research Grants Audit	The objective of this audit was to evaluate the adequacy of processes and controls for accurate time and effort (T&E) reporting for sponsored research	**Observation #7**: Currently, Institutional Policy #6317889 references outdated procedures and does not specify a timeline for T&E certification reviews and PA completion. **Recommendation #7**: UTHSCT should update its policy to address the following: • ECRT is no longer used for the T&E certification process; • T&E certifications are now completed on a quarterly basis; • Specify a timeline for T&E certification reviews and reconciliations; and • Specify a timeline for PA completion upon changes to grant funding sources.	Fully Implemented

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-3	12/10/2020	Research Grants Audit	The objective of this audit was to evaluate the adequacy of processes and controls for accurate time and effort (T&E) reporting for sponsored research	**Observation #8**: Currently, OSP has not obtained independent approvals by the Senior Vice President of Research for research personnel with effort assigned in excess of 90% as required by Institutional Policy #6317889. **Recommendation #8**: OSP should develop a process to ensure independent approval by the Dean of the School and Senior Vice President of Research for research personnel with effort assigned in excess of 90% is obtained.	Fully Implemented
21-3	2/05/2021	Employee Off-Boarding Audit	The objective of this audit was to assess the current processes and controls in place, post-implementation of the new Institutional policy, for the timely and accurate removal of UTHSCT employee access as the result of termination and/or transfer. This audit will meet the biennial Texas Administrative Code (TAC) §202.76 risk-based review of compliance with Texas information security standards.	**Observation #1**: Currently, Institutional policies relating to the employee off-boarding process do not specify a separate timeline for employees terminated for cause. **Recommendation #1**: UTHSCT should consider requiring immediate account deactivation and collection of Institutional equipment for employees terminated for cause.	Fully Implemented

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
21-3	2/05/2021	Employee Off-Boarding Audit	The objective of this audit was to assess the current processes and controls in place, post-implementation of the new Institutional policy, for the timely and accurate removal of UTHSCT employee access as the result of termination and/or transfer. This audit will meet the biennial Texas Administrative Code (TAC) §202.76 risk-based review of compliance with Texas information security standards.	**Observation #2**: As part of our testing, we noted untimely account deactivation and unreturned badges and/or keys for numerous terminated and transferred employees. It should be noted that the untimely account deactivations identified were as a result of untimely PA submissions by department managers. **Recommendation #2**: HR, in coordination with IT and the current off-boarding notification process, should develop a digital check-out form to be completed by the department manager to help ensure that all employee access is deactivated, and equipment is returned in a timely manner upon termination or transfer. HR should continue training efforts to help ensure that department managers are submitting PA forms in a timely manner.	Fully Implemented

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
21-3	2/05/2021	Employee Off-Boarding Audit	The objective of this audit was to assess the current processes and controls in place, post-implementation of the new Institutional policy, for the timely and accurate removal of UTHSCT employee access as the result of termination and/or transfer. This audit will meet the biennial Texas Administrative Code (TAC) §202.76 risk-based review of compliance with Texas information security standards.	**Observation #3**: Currently, UTHSCT does not have a complete inventory list of all system applications utilized at the Institution. **Recommendation #3**: IT should ensure that a complete and accurate system application inventory list is finalized and utilized as part of the employee off-boarding and transfer processes. In addition, IT should consider developing a role-based system access process, inclusive of all applications, to help ensure all system access is deactivated or modified as part of the employee off-boarding and transfer processes.	Incomplete\On-Going

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
21-3	2/05/2021	Employee Off-Boarding Audit	The objective of this audit was to assess the current processes and controls in place, post-implementation of the new Institutional policy, for the timely and accurate removal of UTHSCT employee access as the result of termination and/or transfer. This audit will meet the biennial Texas Administrative Code (TAC) §202.76 risk-based review of compliance with Texas information security standards.	**Observation #4**: Currently, UTHSCT does not have a consistent process in place to ensure that all applicable system access changes are completed and captured on an auditable log. **Recommendation #4**: IT should develop and implement a consistent process that will help ensure all applicable system access is deactivated or modified and can be tracked effectively.	Incomplete\On-Going

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
21-3	2/05/2021	Employee Off-Boarding Audit	The objective of this audit was to assess the current processes and controls in place, post-implementation of the new Institutional policy, for the timely and accurate removal of UTHSCT employee access as the result of termination and/or transfer. This audit will meet the biennial Texas Administrative Code (TAC) §202.76 risk-based review of compliance with Texas information security standards.	**Observation #5**: Currently, UTHSCT does not have a complete and accurate IT asset inventory. **Recommendation #5**: IT should ensure that a complete and accurate IT asset inventory is developed and utilized as part of the employee off-boarding and transfer processes.	Incomplete\On-Going

Exhibit B: FY 2021 Audits – Summary of Issues and Current Status

Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
21-3	2/05/2021	Employee Off-Boarding Audit	The objective of this audit was to assess the current processes and controls in place, post-implementation of the new Institutional policy, for the timely and accurate removal of UTHSCT employee access as the result of termination and/or transfer. This audit will meet the biennial Texas Administrative Code (TAC) §202.76 risk-based review of compliance with Texas information security standards.	**Observation #6**: Currently, UTHSCT does not have a formal notification process for interdepartmental transfers. **Recommendation #6**: HR, in coordination with IT, should develop a notification process for interdepartmental transfers so that all applicable departments are notified to ensure that employee access is deactivated or modified, and necessary equipment is returned in a timely manner upon transfer.	Fully Implemented

[1] Definitions of implementation status are as follows:

I. Fully Implemented: Successful development and use of a process, system, or policy to implement a prior recommendation.
II. Substantially Implemented: Successful development but inconsistent use of a process, system, or policy to implement a prior recommendation.
III. Incomplete/On-going: On-going development of a process, system, or policy to address a prior recommendation.
IV. Not Implemented: Lack of a formal process, system, or policy to address a prior recommendation.