Fiscal Year 2020 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.

Table of Content

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 2020 Audits - Summary of Issues and Current Status

II. Internal Audit Plan for Fiscal Year 2020

FY 2020 Audit Plan	Project No.	Original Budget	Actual Hours Through 08/31/20	Remaining Budgeted Hours	Status
Assurance Engagements					
Controlled Substance Agreements Audit	20-1	450.0	440.5	9.5	Carryforward - Exit Conference Scheduled
Medical Devices Audit	20-2	450.0	445.0	5.0	Completed
Research Grants Audit	20-3	500.0	202.5	297.5	Carryforward - Fieldwork In-Progress
Accounts Payable Audit	20-4	400.0	391.5	8.5	Completed
Assurance Engagements Subtotal		**1,800.0**	**1,479.5**	**320.5**	
Advisory and Consulting Engagements					
Institutional Committees and Workgroups - Advisory Role	20-5	200.0	217.5	-17.5	Completed
Institutional Strategic Initiatives	20-6	100.0	97.0	3.0	Completed
Opioid Stewardship Committee - Advisory Role	20-7	40.0	5.5	34.5	Completed
Training provided by Internal Audit	20-8	200.0	89.5	110.5	Completed
Data Analytics	20-9	150.0	142.0	8.0	Completed
Advisory and Consulting Engagements Subtotal		**690.0**	**551.5**	**138.5**	
Required Engagements					
State Institution of Higher Education Contracting Assessment	20-10	50.0	30.5	19.5	Completed
Benefits Proportionality	20-11	175.0	173.5	1.5	Completed
Family Medicine Residency Program Grant Audit FYE 8/31/2019	20-12	100.0	110.0	-10.0	Completed
Financial Statement Audit Assistance	20-13	30.0	20.5	9.5	Completed
CPRIT Grant External Audit (assistance to management)	20-14	20.0	11.5	8.5	Completed
Required Engagements Subtotal		**375.0**	**346.0**	**29.0**	
Investigations					
Investigations - Assistance	20-15	50.0	52.0	-2.0	Completed
Investigations Subtotal		**50.0**	**52.0**	**-2.0**	
Reserve					
Reserve for TBD Engagements	TBD	300.0	0.0	300.0	N/A - No Reserve Hour Projects Requested for FY 2020
Reserve Subtotal		**300.0**	**0.0**	**300.0**	
Follow-Up					
Follow-up procedures conducted to verify the implementation status of past recommendations made	CATS/TM Reports	65.0	66.0	-1.0	Completed
Follow-Up Subtotal		**65.0**	**66.0**	**-1.0**	
Development - Operations					
Annual Risk Assessment and Audit Plan Development		200.0	199.5	0.5	Completed
Institutional Audit Committee Preparation and Participation		225.0	245.5	-20.5	Completed
Quality Initiatives		175.0	174.5	0.5	Completed - Internal Self-Assessment and External QAR
UT System & SAO Reports and Requests		50.0	70.5	-20.5	Completed
Automated Tools Skills Development and Maintenance		75.0	21.5	53.5	Completed
UT Health CAEs Monthly Collaborative Meetings		25.0	20.5	4.5	Completed
UT Health East Texas Monthly Collaborative Meetings		25.0	32.5	-7.5	Completed
Development - Operations Subtotal		**775.0**	**764.5**	**10.5**	
Development - Initiatives and Education					
System Audit Office initiatives participation		50.0	110.0	-60.0	Completed
Professional organization/association participation		50.0	49.0	1.0	Completed
Individual Continuing Professional Education (CPE) Training, including related travel		160.0	160.0	0.0	Completed
Development - Initiatives and Education Subtotal		**260.0**	**319.0**	**-59.0**	
Total Budgeted Hours		**4,315.0**	**3,578.5**	**736.5**	

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".

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 2020, 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 in the near term post-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.
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.
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.

Report Date	Report Title	High-Level Objective	Results
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 IDEA 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 2021

The FY 2021 Audit Plan was primarily developed based upon the results of the institution-wide risk assessment completed late in FY 2020, which focused on UTHSCT's critical strategic and operational objectives and related risks. To identify audits and projects for the plan, IA considered the level of risk for strategic and operational objectives and monitoring activities of the risks performed internally and externally. In addition, audits and projects externally required or requested by UTS or the Board of Regents were also included in the plan.

The audit plan was divided into the following categories:

- Assurance Engagements;
- Advisory and Consulting Engagements;
- Required Engagements;
- Investigations;
- Reserve;
- Follow-up;
- Development – Operations; and
- Development – Initiatives and Education.

Audits and projects were included in the plan based upon the level of risks and the audit resources available, but allocations were made to ensure an adequate level of coverage within each of the categories. Although the plan was developed to cover as many of the high risks as possible, there were some risks related to strategic or operational objectives which were ranked as "high" that were identified in the risk assessment process in which a project was not scheduled. Many of these "high" risk objectives for which a project was not scheduled were deemed to be mitigated by the secondary line of defense such as Compliance, Risk Management, functional teams, or committees. Specific "high" risks not covered by the plan were communicated to senior leaders and UTHSCT's Institutional Audit Committee (IAC). High risks not covered by the FY 2021 Audit Plan include the following subject areas:

High-risk Strategic or Operational Areas Not Covered in the FY 2021 Audit Plan	
Human Resources	Enrollment Management
Property Management	Legal
Medical Training	University Relations
Instruction	Revenue Cycle

The FY 2021 Audit Plan was approved by UTHSCT's IAC on June 25, 2020 and by the UTS Board of Regents' Audit, Compliance and Risk Management Committee and full board at the August 20, 2020 meeting.

Risk Assessment Process

As a basis for the FY 2021 Audit Plan, a risk assessment was completed to identify and evaluate risks relative to UTHSCT's critical strategic and operational objectives. This risk assessment methodology was

developed under the leadership of the UTS Audit Office and implemented System-wide. The process is designed to capture and evaluate critical strategic and operational risks for the organization utilizing a top-down approach.

The risk assessment approach consisted of the following procedures:

- Identified and considered UT System-wide risks;
- Reviewed important Institutional financial and operational documents, and industry data to become aware of recent Institutional performance and challenges in the industry in which the Institution operates;
- Identified the Institution's important strategic and operational priorities and defined objectives at-risk relative to these priorities;
- Collaborated with certain top organizational and operational leaders to evaluate and update strategic priorities and objectives and to score risks; and
- Conducted cross-functional risk assessments involving the areas of Information Security, Compliance, Legal and Security.

The risk assessment approach used is structured around the Three Lines Model that is endorsed by the Institute of Internal Auditors. This model provides a structured approach for various departments or areas within an organization to be responsible for managing the organization's risks. In summary, management is primarily responsible for risk. Risk assessing and risk managing functions such as Compliance, Information Security, Risk Management, Police, and Legal make up the secondary line of defense. Finally, Internal Audit is responsible for independently and objectively providing advice on how to strengthen risk management in the first and second lines of defense and to mitigate risk.

Fiscal Year 2021 Audit Plan

Code	FY 2021 Audit Plan	Budget	Percent of Total
	Assurance Engagements		
21-1	Stark Law Physician Contract Audit (Subsequent to the Master Services Agreement (MSA)) - Attorney-Client Privilege	450	
21-2	EPIC Post-Implementation Audit	500	
21-3	Employee Off-Boarding Audit	400	
21-4	Carryforward of Assurance Engagements	200	
	Assurance Engagements Subtotal	**1550**	**35.0%**
	Advisory and Consulting Engagements		
21-5	Institutional Committees and Workgroups - Advisory Role	50	
21-6	UTHSCT/UT Tyler Integration - Advisory Role	100	
21-7	UTHSCT & UT Health East Texas Clinical Operations Management Agreement (COMA) Review	100	
21-8	Institutional work from home procedural review	100	
21-9	Review of compliance with national guidelines for animal facilities	100	
21-10	EPIC Pre-Implementation Workgroup	50	
21-11	Institutional Strategic Initiatives	150	
21-12	Opioid Stewardship Committee - Advisory Role	40	
21-13	Training provided by Internal Audit	200	
21-14	Data Analytics	150	
	Advisory and Consulting Engagements Subtotal	**1040**	**23.5%**
	Required Engagements		
21-14	State Institution of Higher Education Contracting Assessment	50	
21-15	Family Medicine Residency Program Grant Audit FYE 8/31/2020	125	
21-16	Financial Statement Audit Assistance	50	
21-17	CPRIT Grant External Audit (assistance to management)	25	
	Required Engagements Subtotal	**250**	**5.6%**
	Investigations		
21-18	Investigations - Assistance	50	
	Investigations Subtotal	**50**	**1.1%**
	Reserve		
TBD	Reserve for TBD Engagements	300	
	Reserve Subtotal	**300**	**6.8%**
	Follow-Up		
CATS/TM Reports	Follow-up procedures conducted to verify the implementation status of past recommendations made	65	
	Follow-Up Subtotal	**65**	**1.5%**
	Development - Operations		
	Annual Risk Assessment and Audit Plan Development	250	
	Institutional Audit Committee Preparation and Participation	250	
	Quality Initiatives	100	
	UT System & SAO Reports and Requests	50	
	Automated Tools Skills Development and Maintenance	75	
	UT Health CAEs Monthly Collaborative Meetings	35	
	UT Health East Texas Monthly Collaborative Meetings	50	
	Development - Operations Subtotal	**810**	**18.3%**
	Development - Initiatives and Education		
	System Audit Office initiatives participation	100	
	Professional organization/association participation	100	
	Individual Continuing Professional Education (CPE) Training, including related travel	160	
	Development - Initiatives and Education Subtotal	**360**	**8.1%**
	Total Budgeted Hours	**4425**	**100.0%**

Information Security Standards

TAC §202.76(c) requires that "A review of the institution's information security program for compliance with these standards will be performed at least biennially, based on business risk management decisions, by individual(s) independent of the information security program and designated by the institution of higher education head or his or her designated representative(s)."

IA has included this required review as two (2) risk-based assurance engagements on the FY 2021 Audit Plan titled "EPIC Post-Implementation Audit" and "Employee Off-Boarding Audit".

Benefits Proportionality

Rider 8, page III-48, the General Appropriations Act (86th Legislature), requires each higher education institution to consider audits of benefits proportionality when developing their annual internal audit plans. IA assessed risks relating to benefits proportionality as part of the FY 2021 Annual Risk Assessment process. Based on that risk assessment and the previous audits conducted in this area, IA decided to exclude an audit of benefits proportionality for the FY 2021 Audit Plan. IA will continue to monitor these risks throughout the year and will also monitor for new audit requirements in the upcoming 87th Legislature.

Contracting Processes and Controls

Senate Bill 20 (84th Legislative Session) made several modifications and additions to the TGC and the 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 has included this required assessment as a required engagement on the FY 2021 Audit Plan.

VI. External Audit Services Procured in Fiscal Year 2020

IA did not engage in, or require any, external audit services for FY 2020.

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 2020 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.	Substantially 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	Substantially Implemented

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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 #3**: The Medical Device Inventory List maintained by Biomedical Services does not include fields to track whether each listed medical device interfaces with PHI, stores PHI, is connected to the network, has network capability, or can be accessed remotely by the Vendor. As noted in our testing results above, numerous medical devices were identified as being connected to the network and/or containing PHI. **Recommendation #3**: Biomedical Services, in collaboration with Information Security, update its Medical Device Inventory List to include information for each listed medical device to track whether it interfaces with PHI, stores PHI, is connected to the network, has network capability, and/or can be accessed remotely by the Vendor.	Fully Implemented

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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 #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.	Substantially Implemented

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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 #5**: There is a lack of communication and notification amongst the departments involved in the medical device processes at the Institution. Biomedical Services maintains a Medical Device Inventory List, the Accounting Department (Accounting) maintains a State Asset Listing (Fixed Assets), the Facilities Department (Facilities) has signature authority for the acquisition and disposal of items included on these lists, and both Information Security and Information Technology need to be made aware of medical devices added and removed from these lists to ensure the devices are properly set up, maintained, and removed. **Recommendation #5**: Biomedical Services, Accounting, Facilities, Information Security and Information Technology should collaborate to develop and implement a standardized process for ensuring the necessary communication and notification is provided to each department. This process should be captured within the policy in Recommendation #1 above. In addition, this group of departments should consider creating a committee for Medical Device Governance that meets periodically (e.g., monthly, quarterly, etc.) to ensure their on-going collaboration.	Fully Implemented

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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
20-2	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 #7**: The sample of medical devices selected from the facilities while onsite, in order to test for completeness of the medical devices captured on both the Medical Device Inventory List and the State Asset Listing, revealed medical devices that were missing a State Asset tag and/or could not be located on the State Asset Listing. **Recommendation #7**: Accounting should collaborate with Biomedical Services to ensure medical devices that exceed the State Asset threshold are properly tagged and are captured on the State Asset listing.	Fully Implemented

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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 #8**: Currently, Information Security's approval is not on the "Pre-Approval Review" section of the Capital Expenditure Request Form. Information Security's required approval on this section of the form would provide notification, and the acceptance, of a medical device being acquired by the Institution. **Recommendation #8**: Information Security should be added to the Capital Expenditure Request Form within the "Pre-Approval Review" section in order to ensure Information Security's approval prior to acquisition.	Fully Implemented
20-4	03/04/2020	Accounts Payable Audit	The objective of this audit was to review the Institution's processes and controls within Accounts Payable to ensure there are no duplicate payments submitted or duplicate vendors set up in the vendor master file.	**Observation #1**: Currently, UTHSCT does not have an Institutional policy and/or standard operating procedures on vendor management processes that addresses duplicate payments or duplicate vendors set up in the vendor master file. **Recommendation #1**: Finance Management develop and implement an Institutional policy and/or written procedures on vendor management processes to address duplicate payments and duplicate vendors set up in the vendor master file.	Fully Implemented

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Report No.	Report Date	Name of Report	High-level Audit Objective(s)	Observations/Findings and Recommendations	Status/Actions [1]
20-4	03/04/2020	Accounts Payable Audit	The objective of this audit was to review the Institution's processes and controls within Accounts Payable to ensure there are no duplicate payments submitted or duplicate vendors set up in the vendor master file.	**Observation #2**: The review of the vendor master file revealed duplicate vendors, based on Tax Identification Number, set up in the vendor master file. **Recommendation #2**: Finance Management address each of the duplicate vendor returns to reduce the risk to the Institution.	Fully Implemented
20-4	03/04/2020	Accounts Payable Audit	The objective of this audit was to review the Institution's processes and controls within Accounts Payable to ensure there are no duplicate payments submitted or duplicate vendors set up in the vendor master file.	**Observation #3**: The review of the vendor master file revealed many outdated vendors (e.g., had not had any activity in five (5) years or longer) still classified as "Active" that could be moved to an "Inactive" status. **Recommendation #3**: Finance Management, in collaboration with Information Technology, work to move these outdated vendors from an "Active" classification to "Inactive".	Fully Implemented

Exhibit B: FY 2020 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]
20-4	03/04/2020	Accounts Payable Audit	The objective of this audit was to review the Institution's processes and controls within Accounts Payable to ensure there are no duplicate payments submitted or duplicate vendors set up in the vendor master file.	**Observation #4**: The search for duplicate payments identified six (6) potential duplicate payments to individuals for patient refunds. Our testing of the six (6) flagged items, all of which were for a small dollar value, confirmed that these were in fact duplicate payments. **Recommendation #4**: Finance Management, in collaboration with the Institution's third-party revenue cycle contractor, develop a review procedure to help prevent duplicate payments for patient refunds and to ensure any duplicate payments made to patients for refunds are detected and remediated.	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.