UT SOUTHWESTERN
MEDICAL CENTER

Robert Rubel, CPA, CIA, CISA
Director

Office of Internal Audit

November 2, 2009

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

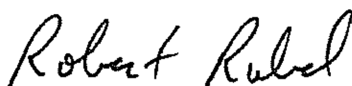
Dear Mr. Keel:

We have prepared this report on the activities of The University of Texas Southwestern Medical Center at Dallas' 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 2009 and 2010 audit plans, audits completed and recommendations. Our audit work for FY 2009 focused on key externally requested and Institutional risk based areas- 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,



Robert Rubel

cc: Michael Sparks, Governor's Office of Budget and Planning
Ed Osner, Legislative Budget Board
Internal Audit Coordinator, State Auditor's Office
Joey Longley, Sunset Advisory Commission

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The University of Texas Southwestern Medical Center at Dallas Internal Audit Annual Report for Fiscal Year 2009

November 2, 2009

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER AT DALLAS

INTERNAL AUDIT ANNUAL REPORT FOR FISCAL YEAR 2009

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I. Audit Plan for Fiscal Year 2009

FY 2009 Audit Plan Audit/Project	Hours
Financial Audits	
UT System Requested/Externally Required Audits	
FY08 Financial Statement Audit	1800
FY09 Financial Statement Audit	600
Presidential Travel and Entertainment Expenses	150
Joint Admission Medical Program (Biennial requirement)	100
National Pediatric Infectious Disease Foundation AFR	100
Risk Based Tier One Audits	
Payroll	400
Carryforward Audits	100
Financial Audits Subtotal	**3250**
Operational Audits	
UT System Requested/Externally Required Audits	
UTS 155: Policies and Procedures Regarding MSRDP/DSRDP/PRS Business Operations (if applicable)	450
UTS 155: Policies and Procedures Regarding MSRDP Business Operations (FSP-Allied Health)	150
Campus Security/Emergency Preparedness (Clery Act)	250
Risk Based Tier One Audits	
Physical Plant (Fuel Usage, Contract and Bidding Processes)	400
Contracts Management	250
MSRDP Billing Operations	500
MSRDP Charge Entry	500
Risk Based Tier Two Audits	
Internal Medicine	400
Core Lab Facilities/Recharge Centers	500
Expenditure Review – High Risk Areas	400
University Hospitals – Charge Entry	350
University Hospitals – Outpatient Imaging Services	500

Change in Management Audits	
Neuroscience	150
Radiation Oncology	150
Psychiatry	150
Neurology	150
Biochemistry	150
Carryforward Audits	500
Operational Audits Subtotal	**5000**
Compliance Audits	
UT System Requested/Externally Required	
Family Practice Residency Program Grants (THECB requirement)	100
Graduate Medical Education Grant (THECB requirement)	200
ATP/ARP Grants (if applicable)	100
Internal Audit Annual Report	60
UTS 166: Cash Handling and Cash Management Policy	500
Risk Based Tier One Audits	
Conflict of Interest	300
University Hospitals – Quality Indicators	200
Risk Based Tier Two Audits	
Epidemiology – Gulf War Syndrome Study	300
Animal Resource Center/IACUC	300
Research Compliance Billing	400
Export Controls/Intellectual Property	300
Medical Equipment – University Hospitals	250
Carryforward Audits	0
Compliance Audits Subtotal	**3010**
Information Technology Audits	
UT System Requested/Externally Required Audits	
TAC 202 Compliance Audit (Biennial requirement)	200
Risk Based Tier One Audits	
Telecommunications	300
Information Security	400
Risk Based Tier Two Audits	
EPIC Resolute Implementation Review	300
PeopleSoft Implementation Review	400
Record Retention	300
Carryforward Audits	0
Information Technology Subtotal	**1900**

Follow-up Audits	**600**
Projects	
Audit Projects	
UT System Requests	200
Special Requests - Audits	200
Consulting Projects	
Fraud Prevention and Analysis	500
LBB Performance Measures	200
Compliance Monitoring	400
Special Requests - Consulting	1000
Other Projects	
Requests for Information/Assistance	200
Quality Assurance Review	200
Training provided by IA	150
Internal Audit Committee	200
Internal Projects	300
Reserve for other Special Requests/Investigations	600
Projects Total	**4150**
Total Budgeted Hours	**18810**

Explanation of Deviations from Fiscal Year 2009 Audit Plan

As documented in the Audit Committee meeting minutes, the following items contributed to the deviations from the FY 2009 Audit Plan.

- Financial Audits - All audits were completed for this section.
- Operational Audits - *UT System Requested/Externally Required Audits* - Due external work performed in this area Campus Security/Emergency Preparedness (Clery Act) was moved to FY10 audit plan.
- Operational Audits - *Risk Based Tier One Audits* - Due to implementation of Epic Resolute, staff turnover, and training requirements of new staff MSRDP Billing Operations and MSRDP Charge Entry were moved to FY10 audit plan. All other priority audits were completed or in process.
- Operational Audits - *Risk Based Tier Two Audits* - Due to staff turnover, recruitment, and training requirements of new staff Internal Medicine was not performed. All other priority audits were completed or in process.
- Operational Audits - *Change in Management Audits* - All priority audits were completed for this section.
- Compliance Audits - *UT System Requested/Externally Required Audits* - All audits were completed for this section.

- Compliance Audits - *Risk Based Tier One* - Due to staff turnover, recruitment, and training requirements of new staff Conflict of Interest was not performed. Quality Indicators was moved to FY10 audit plan.
- Compliance Audits - *Risk Based Tier Two* - Due to staff turnover, recruitment, and training requirements of new staff Export Controls was not performed and Research Compliance Billing was moved to FY10. All other priority audits were completed for this section.
- Information Technology Audits - *UT System Requested/Externally Required Audits*- All audits were completed for this section.
- Information Technology Audits - *Risk Based Tier One* - All audits were completed for this section.
- Information Technology Audits - *Risk Based Tier Two* - Due to progress for completion for Epic Resolute and PeopleSoft implementation within the Medical Center Epic Resolute Implementation Review and PeopleSoft Implementation Review was moved to FY10 audit plan.
- Follow-up Audits - All planned follow-up audits were completed.
- Projects - All planned projects were completed.

II. External Quality Assurance Review

The University of Texas Medical Branch

OFFICE OF AUDIT SERVICES

June 18, 2009

Dr. Daniel K. Podolsky
President and Chair of the Internal Audit Committee
The University of Texas Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas, TX 75390

Dear Dr. Podolsky,

At the request of Robert Rubel, Director of Internal Audit and as directed by The Institute of Internal Auditors (IIA), the Texas Internal Auditing Act, and The University of Texas System Policy – UTS 129 Internal Audit Activities, we conducted an external quality assessment of the Office of Internal Audits (Internal Audits) at The University of Texas Southwestern Medical Center (UT Southwestern). Our review was conducted May 4-6, 2009, and covered departmental activities from September 2007 through the date of our work. Members of the review team were Michael C. Bowers, CPA, CIA, Associate Director for Business & Technology Audit Services, Massachusetts Institute of Technology; Richard Catalano, CPA, CIA, Director of Internal Audit Services, University of California – Davis; Kimberly K. Hagara, CPA, CIA, Associate Vice President, Audit Services, The University of Texas Medical Branch; and Valla Wilson, CIA, Director of Internal Audit – Duke Medicine, Duke University.

The principal objectives of the quality assurance review were to assess Internal Audit's conformity to The IIA's *International Standards for the Professional Practice of Internal Auditing (Standards)*, evaluate Internal Audit's effectiveness in carrying out its mission as set forth in its charter and expressed in the expectations of management, and identify opportunities to enhance its management and work processes, as well as its value to The University of Texas Southwestern Medical Center.

Background:
The Internal Audit Charter approved by the Institutional Audit Committee requires Internal Audit to conform with the standards established by the Institute of Internal Auditors (IIA) and the provisions of the Texas Internal Audit Act. The *IIA International Standards for the Professional Practice of Internal Auditing (IIA Standards)* require external assessments to be performed at least once every five years by a qualified, independent reviewer or review team from outside the organization. However, since one of the provisions of the Texas Internal Auditing Act is to conform with Generally Accepted Governmental Auditing Standards (GAGAS), Internal Audits undergoes an external assessment at least every three years. We conducted this review using the IIA Quality Assessment Manual, 5th edition, as a guide.

Objectives:
Our objectives were to assess the level of Internal Audits' compliance with the *IIA Standards* and identify opportunities to enhance its management and work processes, as well as its value to UT Southwestern.

Scope:
The scope of our review included:

- Review of self-assessment materials prepared by Internal Audit
- Review of the previous external quality assurance review issued in August 2005, self assessment of the implementation status of those recommendations, and UT System review conducted in July 2008
- Interviews with you, the chair of the Institutional Audit Committee and other Institutional Audit Committee members, the Chief Audit Executive of the University of Texas System and key

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administrators at UT Southwestern.

- Interviews with the Internal Audit Director and members of his staff
- Examination of a sample of work papers and reports produced by Internal Audit
- A comparison of Internal Audit's audit practices with the *IIA Standards.*

Overall Opinion

The rating system that was used for expressing an opinion for this review provides for three levels of conformance: generally conforms, partially conforms and does not conform. "*Generally Conforms*" means that Internal Audits has policies, procedures, and a charter that were judged to be in accordance with the *IIA Standards*; however, opportunities for improvement may exist. "*Partially Conforms*" means deficiencies, while they might impair, did not prohibit Internal Audits from carrying out its responsibilities. "*Does Not Conform*" means deficiencies in practice were found that were considered so significant as to seriously impair or prohibit Internal Audits in carrying out its responsibilities.

In our opinion, Internal Audits generally conforms with the *IIA Standards,* with the exception of Proficiency and Due Professional Care, which partially conforms. Additionally, we determined that the Office of Internal Audit generally conforms to the IIA Code of Ethics.

The following table contains our opinion of how Audit Services activities conform to each section of the *IIA Standards.*

Standard Type and Description	Opinion
Attribute Standards:	
1000 - Purpose, Authority, and Responsibility	Generally Conforms
1100 - Independence and Objectivity	Generally Conforms
1200 - Proficiency and Due Professional Care	Partially Conforms
1300 - Quality Assurance and Improvement Program	Generally Conforms
Performance Standards:	
2000 - Managing the Internal Audit Activity	Generally Conforms
2100 - Nature of Work	Generally Conforms
2200 - Engagement Planning	Generally Conforms
2300 - Performing the Engagement	Generally Conforms
2400 - Communicating Results	Generally Conforms
2500 - Monitoring Progress	Generally Conforms
2600 - Management's Acceptance of Risks	Generally Conforms
The Institute of Internal Auditors' *Code of Ethics*	Generally Conforms

It is our opinion that while overall Internal Audits is effective and appears to be meeting management's needs, there are significant opportunities for improvement in several areas: staff training and development, management development, specialized skill-sets, engagement management, and engagement documentation. Some of these opportunities were also identified in the 2005 External Quality Assurance Review, the 2008 Self Assessment Report and the 2008 UT System review.

The following recommendations are offered to address the assessment of partially conforms for the standard Proficiency and Due Professional Care:

Recommendation: Increase Continuing Professional Development

As articulated in the 2005 External Quality Assurance Review, 2008 Self Assessment Report and the 2008 UT

System review, the department lacks proficiency and resources with specialized skill sets in several critical areas including hospital operations and information technology. Also, over the past year, the department has experienced significant turnover at the staff level. The current recruiting model identifies talented individuals and hires individuals with various experience levels in either healthcare, auditing, or the culture of UT Southwestern, however, the post-recruitment processes may not adequately address the needs of a complex academic medical center. The department does not have a formal orientation process for training the new hires, instead relying on a traditional "on the job training" approach. Additionally, the current staff development plan and resource dedication do not appear to be adequately addressing the areas of hospital operations and information technology auditing. The fiscal year 2009 work plan dedicates approximately two FTEs to direct projects/audits in these critical areas. Additionally, other than the Director only one of the Managers holds the Certified Information System Auditor (CISA) designation with only a portion of her time allocated to information technology auditing.

Interviews with executive leadership indicated an expressed need for specialized skill sets in these areas with a willingness to provide funding for training or position enhancement. Additionally, during our staff interviews a common theme expressed was a desire for more "health care" training. It does not appear that an emphasis has been placed on industry specific training or that the new appointed "training director" is fully functioning in his role due to his limited time within the department. During our review of the departmental training records, we noted that most of the staff training is derived from local, short in duration seminars that although focus on many important topics do not adequately address in-depth healthcare topics. The Director should take the following actions to improve professional proficiency:

- *Identify specific training resources.* One solution would be to focus on identifying and attending multi-day, detailed training courses on specific topics, such as information technology (e.g. EPIC, PeopleSoft, etc.) or hospital operations (e.g. AHIA or HFMA), to gain knowledge and understanding of healthcare and IT processes, risks and controls . While this approach may be perceived as expensive in the short term, it provides the best access to knowledgeable individuals, potentially shortening the "learning curve" that will provide greater benefits to the institution in the long term.
- *Develop a training and development plan.* We encourage the Director to develop an annual formal training and development plan for the department. The plan should consider established skill sets, goals of the individual, department and institution, while also considering prospective needs in a complex, growing organization.
- *Implement Project Evaluations.* Employees should be given project evaluations at the conclusion of each project so that training opportunities and development needs are identified. The employees training and development plan should be updated as result of evaluation of performance.
- *Promote and encourage staff to get certifications.* Consideration should also be given to the establishment of certification goals, as currently only two Supervisors outside the management team are certified, one is a Certified Internal Auditor (CIA) and one is a Certified Public Accountant (CPA). Perhaps a one-time bonus or other reward could be given as an incentive for employees to obtain certifications such as the CPA, CIA or CISA.
- *Develop a new hire training program.* We encourage the Director to develop a formal orientation process that includes at a minimum a mentoring process, skill set gap analysis, as well as a clear training and development plan during their first evaluative period.

Recommendation: Management Development

Prior to September 2008, the departmental management team consisted of the Director and Associate Director. With the pending retirement of the Associate Director, Manager positions reporting directly to the Director were created. Two experienced Supervisors were promoted into these new roles. The Managers, similar to the Associate Director before, are responsible for the execution of the annual work plan and many of the departmental operations. This is done in an environment where the Director encourages and expects autonomy and ownership of the engagement/project by all staff members. While these are important development traits, when combined with the uncertainty of the new Manager Role, it appears to have caused

confusion in the roles of supervision, review and ownership of the individual engagements. Certain employees expressed a concern of the lack of clarity of roles and expectations, redundancies and inefficiencies in the audit process due to double reviews by both managers who have different approaches, work paper preferences, and report writing styles. To encourage management development, the Director should consider:

- *Establish roles and responsibilities.* Clear roles and responsibilities should be articulated and documented at the beginning of each engagement. The director should review the work of the managers to identify development needs.
- *Invest time in mentoring and coaching the managers.* The Director should consider establishing regular individual meetings with each manager to focus on coaching and mentoring to improve in areas such as project management and leadership skills. It is important to fully develop the new Managers to play a role in the management and strategic direction of the department.
- *Increase leadership opportunities.* The Director should identify leadership opportunities, both internally and externally to the department such as participation on certain committees or presentation opportunities. This is important for the Managers in developing their leadership and public relationship skills in representing the department so that they are recognized as a valuable resource by executive management. While we recognize that these efforts are ongoing by the Director and appreciate that the luxury of time has not passed to evaluate the final results of his effort; we remind the Director that this development is both formal and informal, as well as in and outside of the direct internal audit engagement efforts.

Although these areas of the standards were assessed as generally conforms, we believe opportunity exists to enhance the program in the following:

Recommendation: Engagement Management

Based on the QAR team's review and understanding of the work plan completion reports, engagement budget overruns, and engagement cycle time, there appears to be a need for improvement in the engagement management process. The 2005 External Quality Assurance Review Report makes a similar observation related to engagement cycle time. We noted that several of the 2009 audit engagements had significant budget overruns, while this can be attributable to either ineffective budgeting or engagement management, based on the objectives of the individual engagements and documented work performed it appears a lack of engagement management is the primary cause. Additionally, during our interviews, the staff indicated a need for more clarity and communication in who is responsible for the managing, monitoring and reviewing the engagement, particularly when the engagement team is comprised of multiple staffing levels. An additional observation by the staff related to the current report writing process, as articulated to the QAR team, is a need to determine who is responsible for authorship and limit the number of editors. The current process appears to results in inefficiencies due to personal preferences edits without substantial changes in content or context. The Director should take the following actions to improve engagement management:

- *Clarify managing and monitoring roles and responsibilities.* Clarify in the audit manual and through other communication channels the roles and responsibilities for different layers of the organization including who is responsible for the managing and monitoring engagements
- *Establish a clear report writing process.* Evaluate and document the reporting writing and editing process with the goal of defining who is the primary author and reducing staff frustrations and report issuance delays by limiting the number of editors.
- *Establish specific project meetings.* Improvement in the engagement management process could be achieved through the establishment of understanding meetings, regularly scheduled project status meetings, and pre-reporting meetings,.
- *Conduct a post-engagement review.* For those engagements with significant overruns meet and discuss the project to determine the root cause for project overrun. Consider developing a policy for departmental documentation requirements related to over-budgets projects

Recommendation: Engagement Evidence
While the QAR team believes that the work papers generally support the work of the department, it appears the department may be taking on a larger audit risk in each engagement than intended. The audit teams appear to rely more on interview and other less reliable evidence rather than re-performance or third party conformation. Reliance on audit evidence that is less objective than what otherwise may be available to support conclusions may lead to erroneous reports that do not address all risks of an area. While this was evident in review of general operational areas, it was also noted in technical operational areas of the institution. The more technical an area the greater the audit risk becomes as the understanding or ability to interpret data by the individual auditor diminishes. The Director should consider the following action to improve engagement evidence:

- *Develop departmental standards for audit evidence.* Provide formal guidance of the standards of audit evidence to the staff. Additionally, during the assignment of staff to an engagement, experience and technical expertise should be a primary consideration.

Recommendation: Follow-up Process
Currently, follow up on prior audit recommendation occurs annually and consists of an auditor contacting the management responsible for implementing corrective action. The existing process has some inherent risks including delay of action by management until a status is requested and not providing timely information to senior management on the status of action items. For example, if a recommendation is to be implemented by July 1, 2008 and you don't follow-up until May 1, 2009, senior management may not know that the action is 10 months past due. Additionally, we noted the follow-up for this year is being performed by the audit intern (not a member of the permanent staff). When interviewed, he indicated that he encounters issues of responsiveness and that in several instances he had to speak directly with a Vice President to obtain the needed information. While initial follow-up activities can be performed by staff auditors or perhaps interns, when there is non-responsiveness, this should be elevated to an Audit Manager with possible action by the Director. Additionally, having an intern contact a Vice President on a follow-up assignment may not be the best practice and has the risk of damaging working relationships with institutional leaders. The Director should:

- *Reevaluate the process for conducting follow-up.* Consideration should be given to quarterly or semi-annual follow-ups based on recommendation implementation dates. Additionally, it should be staffed by an individual with sufficient experience to appropriately represent the department with senior leadership and interpret to supporting information provided.

Recommendation: Independence
The 2005 External Quality Assurance Review noted that the Director of Internal Audit's administrative reporting relationship to the Executive Vice President for Business Affairs created a perceived impairment of Internal Audits within the Medical Center community. Although the reporting relationship has been addressed, it appears that the Director's continued close alignment with the Executive Vice President for Business Affairs, including attending the his weekly managers' meeting, monthly one-on-one meetings, and the Executive Vice President's review and agreement of all draft reports continues to foster a perception of an independence impairment. Additional steps should be taken to reduce the appearance of independence impairment, including considering not having the Director attend the weekly managers' meetings and having the Executive Vice President review and agree to only those draft reports related to his portfolio of responsibility.

Additional recommendations for enhancement of the internal audit function in the areas of follow-up, customer surveys; specific work paper documentation and strategic planning were also identified. The details of those recommendations have been communicated separately.

Identified Strengths and Best Practices
Although we have mentioned areas of improvement, we noted that the Internal Audit department is viewed as a valuable function by Senior Executive Management and the Audit Committee members. The following

strengths and best practices were identified during our interviews and review of documentation:

- Participate in organizational initiatives with providing consultation in addressing strategic and operational issues.
- Viewed as responsive to senior management needs with an extremely collegial and positive working relationship with executive and senior management.
- Viewed an institutional resource by executive and senior management resulting in Internal Audits' involvement in institutional committees and significant application system implementations
- Include the audit staff in the Risk Assessment process, allowing them to increase their exposure to management.
- Develop quality observations and valuable recommendations.
- Participate in institutional internal control activities by conducting training and facilitating control self assessment workshops
- Established an intern program associated with the UT Dallas School of Management Endorsed Internal Audit Program, allowing UT Southwestern Internal Audit to mentor and groom future auditors
- Maintain a detailed, current Audit Manual providing guidance to departmental staff
- Require Internal Audit staff to fully disclose conflicts of interest on an annual basis in the independence statement
- Established an internal quality assurance process for each engagement
- Provide training for new Institutional Audit Committee members
- Developed a Strategic Plan to improve and measure performance

GAGAS

Compliance with Generally Accepted Government Auditing Standards ("GAGAS") was not included in our review. As previously articulated, one of the provisions of the Texas Internal Auditing Act is to conform with Generally Accepted Governmental Auditing Standards (GAGAS) and although GAGAS is similar to *IIA Standards*, certain requirements are not the same. Differences occur in the amount and type of training required of staff and in allowable non-audit activities (e.g., consulting activities).

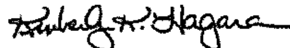
Recommendation: Internal Audits should perform an analysis of their compliance with GAGAS. This can be accomplished by either using the Texas State Agency Internal Audit Forum ("SAIAF") Master Peer Review Program, which includes the GAGAS requirements, to assess its compliance or performing a gap analysis. Additionally, Internal Audits should endure that future quality assessment reviews include assessing compliance with GAGAS.

We appreciate the cooperation and assistance provided to us throughout the course of our review by the President, members of the Institutional Audit Committee, other key administrators of the University and the management and staff of Internal Audit.

Sincerely,

Michael C. Bowers, CPA, CIA
Massachusetts Institute of Technology

Richard Catalano, CPA, CIA
University of California – Davis



Kimberly K. Hagara, CPA, CIA
The University of Texas Medical Branch

Valla Wilson, CIA
Duke University/Duke University Health System

III. List of Audits Completed

09:01 FY 2008 Financial Statement Audit

Report Number	09:01	Report Date	12.12.08	Name of Report	FY 2008 Financial Statement Audit
High Level Audit Objective	UT System requested				
Observations Findings Recommendations	**1. Monitoring Plan for Financial Subcertification** A Monitoring Plan should be established for the UT Southwestern financial subcertifications. The monitoring plan should be supported by a risk assessment focusing on high dollar/risk areas and document the Monitoring Party and the Responsible Party. The Monitoring plan should document the nature, scope and timing of accounts and departments to be reviewed during the year to ensure appropriate controls are in place for the year-end financial account subcertification. If there is a distributed responsibility, the Office of the Executive Vice President for Business Affairs should ensure the distributed areas complete their responsibilities. The timing of the subcertification letters should allow for year-end accounting months to be included prior to the AFR being due to the State Comptroller. The distribution of financial account subcertifications should include appropriate levels of management at UT Southwestern.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	A documented Monitoring plan for the sub-certification process may reduce the risk of non-compliance with UT System policy- An implemented Financial Monitoring Plan (UTS142 Policy on the Annual Financial Report - http://www.utsystem.edu/policy/policies/uts142_1.html) Leads to increased transparency of internal controls within financial reporting which in turn promotes better financial management decisions, improved disclosures, accountability and overall reliability of financial statements.

09:01 FY 2008 Financial Statement Audit, continued

Observations Findings Recommendations					
	2. University Hospitals-Credit Card Depository Account Reconciliations a. Management should review the methodologies being used to reconcile the credit card payments, record credit card payments and fees in the general ledger and determine procedures necessary to streamline the process, ensure compliance with generally accepted accounting principles, and identify reconciling items in the Cash Clearing accounts in a timely manner. b. Management should develop and implement written operational procedures regarding the reconciliation and journal entries of the credit card depository, credit card receivable, and the cash clearing accounts related to credit card payments.	Current Status	Fully Implemented	Fiscal or Other Impact	Clearing accounts that function correctly and have minimal balance or zero can then be used to identify and follow-up on potential errors that may include a review of charges to hospital credit card terminals to corresponding payments, use of incorrect accounts, etc. Operational procedures will increase efficiencies spent on managing and reconciling credit card depository and cash clearing accounts.
	3. Information Resources-Operational Procedures-University Hospitals Systems Data to University Hospitals Administration and Office of Accounting The Operational procedures to document the extraction, review and transfer of hospital systems financial operating data to University Hospitals Administration and the Office of Accounting should be updated. This will ensure transfer of data for consolidation at the Office of Accounting is timely, accurate and complete. The Director for Information Resources should approve the final versions.	Current Status	Fully Implemented	Fiscal or Other Impact	Outdated operational procedures for use in performing critical processes could potentially increase the possibilities of errors in the extraction, review, and transfer of hospital systems financial operating data.

09:01 FY 2008 Financial Statement Audit, continued

Observations Findings Recommendations					
	4. University Hospitals St. Paul Lab-Password Compliance for MySys and CoPath The IR Senior Business Analyst should review feasibility of strengthening the passwords in MySys and CoPath.	Current Status	Fully Implemented	Fiscal or Other Impact	http://inside.utsouthwestern.edu/irweb/infosec/policies/pol_200_07.pdf UT Southwestern Information Security Policy Number: 200-07 "Information Systems Password Management" emphasizes the need for strong compliant passwords for use of Information Systems within the Medical Center. A lack of compliant passwords increases the risk of unauthorized access to systems. Strong compliant passwords protect against unauthorized access.
	5. University Hospitals St. Paul Lab-Disaster Recovery Test for MySys and CoPath We recommend that the MySys and CoPath disaster recovery plan be tested in FY09. Disaster Recovery testing results should be coordinated and shared with the Information Resources Manager.	Current Status	Substantially Implemented	Fiscal or Other Impact	Proper testing of disaster recovery plans ensures successful operations of documented plans in event of crucial information system(s) failure.

09:01 FY 2008 Financial Statement Audit, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	6. Follow-up on Prior Audit Recommendations **08:01 Annual Financial Audit** 1a. Hospital Adjusting Journal Entries - We recommend hospital management: Create a policy that documents the purpose of the "other third party reserve" account and have the policy approved by executive management. The policy should establish two levels of approval.		1a. Fully Implemented		1a. Financial accounting policies increase transparency of executive management financial management activities/decisions. Prevention of significant journal vouchers, based on estimates, being entered into the financial statements without proper supporting documentation and authorization/approval.
	1b. Hospital Adjusting Journal Entries - We recommend hospital management: Attach supporting evidence to accounting journal vouchers and document necessary estimates or assumptions used in calculating the adjustment. Disclose to the Assistant Vice President of Accounting information about the use of estimates or significant adjustments made to the hospital year-end financial statements.		1b. Fully Implemented		1b. Supporting documentation is a key financial control to promote the validity, accuracy, completeness of a financial transaction (i.e. adjusting journal entries).
	2. Depository Cash Clearing Account - We recommend that unposted cash transactions be reconciled and reclassified to the appropriate general ledger account on a monthly basis. Management's review or reconciliations should be routinely documented and items noted for follow-up resolved in an expeditious manner.		2. Fully Implemented		2. Routine reconciliation assists management to prevent misstatements and irregularities. Promote accurate and timely financial information. Operational procedures will increase efficiencies spent on managing and reconciling credit card depository and cash clearing accounts.

09:01 FY 2008 Financial Statement Audit, continued

Observations Findings Recommendations	3. Update Payroll Policies and Procedures - We recommend that Payroll develop a plan to review and update their procedures on an annual basis to ensure consistency in the performance and evaluation of job duties and to maintain compliance with current internal	Current Status	3. Fully Implemented	Fiscal or Other Impact	3. Outdated operational procedures for use in performing critical processes could potentially increase the possibilities of errors in managing payroll data and increase the potential by-pass of built-in internal controls. Employees are better informed and can be held accountable for policy mandates.

09:02 FY09 Financial Statement Audit (Information Technology)

Report Number	09:02	Report Date		Name of Report	
High Level Audit Objective	See Results documented above in 09:01 Financial Statement Audit				
Observations Findings Recommendations		Current Status		Fiscal or Other Impact	

09:03 Presidential Travel and Entertainment Expenses

<table>
<tr><td>Report Number</td><td>09:03</td><td>Report Date</td><td>12.12.08</td><td>Name of Report</td><td>Presidential Travel and Entertainment Expenses</td></tr>
<tr><td>High Level Audit Objective</td><td colspan="5">The objectives of this audit were to: Determine the reliability and integrity of travel and entertainment expenses of the President; and, Determine compliance with applicable policies, procedures, laws, and regulations.</td></tr>
<tr><td>Observations
Findings
Recommendations</td><td colspan="2">1. Tracking and Inventory of Wine and Gift Items
We performed physical counts of wine inventory on November 5, 2008. Records had not been maintained to track the contents of the current wine inventory or to record gifts purchased. There is no method in place to track additions and usage of wine inventory or gifts. Also, an inventory by the Office of the President had not been performed for the wine stored at the two campus locations.
We recommend the following:
a. Written policies and procedures should be developed for physical control of the inventories, recording of inventory transactions, and performance of year-end counts.
b. Inventory logs should be maintained for wine stored on campus showing additions to and usage of wine.
c. Inventory logs should be maintained for donor gifts. The list should contain a description of the gift, the date that it was presented, and name of the donor.</td><td>Current Status</td><td>Fully implemented</td><td>Fiscal or Other Impact

Physical inventory controls improve visibility and accountability over inventory, which help improve storage and control excess or obsolete items.

Physical controls and accountability reduce the risk of:
• undetected theft or loss
• unexpected shortages of (critical) items
• unnecessary purchases of items already on hand</td></tr>
</table>

09:03 Presidential Travel and Entertainment Expenses, continued

Observations Findings Recommendations	Finding	Current Status	Status	Fiscal or Other Impact	Impact
Observations Findings Recommendations	**2. Enhance Supporting Documentation** We tested 33 travel, entertainment, and gift expenditures and determined through interview and observation that all expenditures were for valid business purposes. We noted a few items only had credit card statements for documentation. Medical Center policy allows reimbursement of expenditures from a credit card statement. Invoices, receipts, shipping lists, etc. provide additional detail on quantity and price of items purchased. We recommend that Medical Center policies be enhanced to require additional supporting documentation for reimbursement. Original invoices, print outs of receipts from on-line vendors, original itemized cash register receipts, should be included in the reimbursement request.	Current Status	Fully implemented	Fiscal or Other Impact	Additional documentation, in addition to credit card statements, assists the Office to maintain full support for its expenditures and transparency for its transactions.

09:04 Joint Admission Medical Program

Report Number	09:04	Report Date	11.13.08	Name of Report	Joint Admission Medical Program
High Level Audit Objective	Biennial requirement				
Observations Findings Recommendations	Our audit found that expenditures for the program were appropriate, and were used to promote the objectives of the Joint Admission Medical Program.	Current Status	No Recommendations	Fiscal or Other Impact	JAMP is a program administered by a council made up of representatives of the eight medical schools in the State of Texas. Funding is provided by the legislature to allow economically disadvantaged undergraduate students preparatory opportunities for pursuit of a medical degree.

09:05 National Pediatric Disease Foundation

Report Number	09:05	Report Date	01.12.09	Name of Report	National Pediatric Disease foundation	
High Level Audit Objective	The Office of Internal Audit agreed to provide consultation services to address the following objectives: • Perform year-end internal financial review for NPIDF to ensure its financial statements are materially accurate, reliable, and supported by the financial records of the NPIDF, • Provide documentation for consolidation into the AFR of UT Southwestern, as required by GASB 14, and • Completion of the Forms to satisfy filing requirements of the Internal Revenue Service for Exempt Organizations.					
Observations Findings Recommendations	Our review found that there are adequate financial controls in place within the National Pediatric Infectious Diseases Foundation to ensure a high level of accuracy and the financial reports reflect this accuracy.	Current Status	No Recommendations	Fiscal or Other Impact	The NPIDF actively strives to encourage continuous educational, clinical and scientific research within the field of pediatric infectious diseases. The NPIDF is funded by contributions from various individual donors as well as corporate donors and is governed by a three-member board appointed by UT Southwestern. Although the NPIDF is legally separate from the Medical Center, it is included in the UT Southwestern Annual Financial Report (AFR) as if it were part of UT Southwestern because it meets Governmental Accounting Standards Board (GASB) Statement 14 consolidation standards.	

09:06 Hourly Payroll Audit

Report Number	09:06	Report Date	04.08.09	Name of Report	Hourly Payroll Audit
High Level Audit Objective	The primary objective of this audit is to provide the president and Board of Regents with reasonable assurance that there are adequate and effective testing controls for Internal Audit to ensure the following: • Reliability and integrity of financial and operational information • Compliance with local, state, federal and contractual guidelines • Effectiveness and efficiency of operations				
Observations Findings Recommendations	**1. Kronos Clinical Time – NonExempt and Exempt Employees** Management should ensure adherence and consistency of the Ambulatory Services Policy 5.07. Any missing punches or corrections must be requested on the Time and Attendance Tracking form and approved by Clinic Managers. Any exceptions to the time and attendance policy should require written senior management approval. Changes and/or corrections to Kronos time sheets should not be allowed without authorized attendance tracking forms. Aston management should provide the Aston Senior Administrative Assistant with an effective reporting mechanism to expeditiously escalate potential deviations or inappropriate overrides with regard to the time and attendance guidelines for these time sensitive issues.	Current Status		Fiscal or Other Impact	

09:06 Payroll, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	Clinic Managers should be held accountable for entering accurate time into Kronos and reviewing the entries of their timekeepers before submission. A refresher or ongoing training for new clinic department managers and Kronos time editors should be provided on all updated policies and procedures. Also, Human Resources and Aston management should consider updating policies and procedures to include the four hour rule and provide examples of practical application of such rule to exempt and non-exempt employee time tracking systems.	Current Status	Substantially Implemented	Fiscal or Other Impact	To promote consistent application for enforcement, accountability, and clarity in the interpretation of local policies and procedures regarding attendance and time keeping policies and procedures. To increase consistent application for all updated policies and decrease potential increase for noncompliance with the Ambulatory Services Policy 5.07 and Fair Labor Standards Act.
	2. Late Agency Invoices Hospitals' management should enhance its monitoring procedures to ensure all hospital units/departments are submitting agency contract labor invoices in a timely manner to Accounts Payable.	Current Status	Fully Implemented	Fiscal or Other Impact	Monitoring procedures will decrease the potential for distortion within the accounting cycle, underreporting of hours and expenses, and erroneous accounting estimates. Poor management decisions due to misleading productivity results based on understated FTEs/per adjusted bed or units and overstated revenues.

09:06 Payroll, continued

<table>
<tr><td rowspan="2">Observations
Findings
Recommendations</td><td>3. Agency Per Diem Contract Labor – Time, Invoices and Productivity
Management should enhance their review of agency per diem contract labor and develop policies and procedures that ensure:
Custody procedures are adhered to by maintaining the original authorized agency timesheets
All per diem contract labor activity is accounted for daily, i.e., clock-in and out of Kronos daily to maintain accuracy of accounting accruals and productivity.
All agency timesheets are compared, before authorizing with a signature, to:
Kronos time detail or internal sign-in and out sheets
Schedules
Assignment sheets
Charges captured</td><td>Current Status</td><td>Fully Implemented</td><td>Fiscal or Other Impact</td><td>To eliminate the potential for falsified timesheets or overstated hours by removing contract labor access to authorized timesheets after they have been approved. Proper accounting, custody, and monitoring procedures of contracted labor ensures accuracy and validity to represented time records.</td></tr>
<tr><td>4. Nursing Staff Overtime Hours
Senior Management needs to establish written policies and procedures and a monitoring program that sets a top limit of hours that an employee can work in a pay period, requiring management approval prior to exceeding that limit to ensure a safe work environment.</td><td>Current Status</td><td>Incomplete/Ongoing</td><td>Fiscal or Other Impact</td><td>Work environment and patient safety may be jeopardized by nursing staff consistently working excessive hours in a pay period.</td></tr>
</table>

09:06 Payroll, continued

Observations Findings Recommendations	**5. Payment for Contract Services – Travel Expenses** Enhance internal controls by re-educating and clarifying processes regarding State of Texas Travel Guide, dollar limits and proper supporting documentation for all travel expenditure reimbursements, i.e., hotel, meals, auto rental, and per diems. Management should ensure payments to agencies are in accordance with the contract and/or the Texas Administrative Code, Title 34 and the State of Texas Travel Guidance.	Current Status	Fully Implemented	Fiscal or Other Impact	Supporting documentation for travel expenditures assists to corroborate travel reimbursements and provides transparency for transactions in compliance with State of Texas travel policies/guidance.

09:08 UTS 155: Policies & Procedures Regarding MSRDP Business Operations

Report Number	09:08	Report Date	08.03.09	Name of Report	UTS 155 Policies & Procedures Regarding MSRDP Business Operations
High Level Audit Objective	The primary objective of this audit is to provide the president and Board of Regents with reasonable assurance that there are adequate and effective testing controls for MSRDP business operations to ensure the following: • Reliability and integrity of financial and operational information • Safeguarding of assets • Compliance with laws, regulations, and contracts • Implementation of prior years audit recommendations				
Observations Findings Recommendations	Results of our expenditure testing found that controls were adequate and working as designed. No recommendations were made for FY 2008.	Current Status	No recommendations	Fiscal or Other Impact	Compliance with UTS 155.

09:09 UTS 155: Policies & Procedures Regarding FSP Business Operations

<table>
<tr><th>Report Number</th><th>09:09</th><th>Report Date</th><th>04.08.09</th><th>Name of Report</th><th colspan="2">UTS 155: Policies & Procedures Regarding FSP Business Operations</th></tr>
<tr><td>High Level Audit Objective</td><td colspan="6">The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that the overall environment in which FSP is currently operating has adequate and effective controls.</td></tr>
<tr><td>Observations
Findings
Recommendations</td><td colspan="2">Internal Audit recommends that the FSP use current monthly figures for both the billing and collection costs, as well as the net charges, so that there is a consistency in approach to the calculation of the ratio. Internal Audit further recommends that FSP cease using estimates of billing expenses in its calculations.</td><td>Current Status</td><td>Fully Implemented</td><td>Fiscal or Other Impact</td><td>The failure to calculate prescribed ratios on a monthly basis, deprives the Plan Board of information that could help them analyze trends and compare performance with prior year financials.

Using ratios that do not use estimates or annualize data as part of the Billing and Collection Cost to Net Charges ratio increases the reliability of financial and operational information. This provides the Plan Board with information that could help them analyze trends and compare performance with prior year financials.</td></tr>
</table>

09:10 UTSW University Police

Report Number	09:10	Report Date	09.03.09	Name of Report	UTSW University Police
High Level Audit Objective	The primary objective of this audit is to evaluate the adequacy and effectiveness of financial controls to manage risks within the University Police Department.				
Observations Findings Recommendations	**1. Review and reconcile firearm inventory records** We recommend that UP contact Inventory Control to update inventory records and ensure accuracy in the Inventory Control system for the items identified. Additionally, given the importance for control over firearms assigned, the UP should reconcile its firearm records annually, maintaining adequate separation of duties.	Current Status	Fully implemented.	Fiscal or Other Impact	Compliance with State Property Accounting (SPA) guidelines which require that all firearms be listed as controlled items on the Institution's SPA Inventory Listing submitted to the State Comptroller of Public Accounts.
	2. Consistently include provision in the Chief's annual appointment letter Use of a University vehicle to support availability to the University at all times should be stated in the Chief of Police's annual appointment letter.	Current Status	Fully implemented	Fiscal or Other Impact	Compliance with UTS157 which defines an authorized driver as "An employee of The University of Texas System ("University") who is eligible to operate a University-owned vehicle for official University business is an Authorized Driver."

09:10 UTSW University Police, continued

Observations Findings Recommendations					
	3. Ensure separation of duties for expenditure approval authorizations We recommend that the UP review and clearly define authorization roles with respect to department approval processes to ensure adequate separation of duties are maintained for UP transactions. Approval cycles should be based on level of risk associated to each transaction type. Specifically, for standard transactions, the Chief of Police should delegate approval authority to the Assistant Chief of Police rather than the first level approvers.	Current Status	Incomplete/ongoing	Fiscal or Other Impact	Segregation of duties is critical to effective internal control. It reduces the risk of both erroneous and inappropriate actions.
	4. Enhance Lost and Found record reconciliation process We recommend that UP management conduct a monthly review and reconciliation of lost and found records to ensure accuracy and consistency. The reviewer/reconciler should investigate and resolve any discrepancies and then sign the reconciliation documentation to approve its accuracy and consistency. The reviewer/reconciler should not be involved in initial documentation of lost and found property records. The University Police Department should revise General Order 506 to ensure consistent written procedures exist for updating of the statuses of Lost and Found records.	Current Status	Incomplete/ongoing	Fiscal or Other Impact	Reconciliation helps to prevent or detect misstatements, irregularities, loss, and misappropriations in a timely manner.

09:10 UTSW University Police, continued

Observations Findings Recommendations					
	5. Improve petty cash fund record-keeping procedures We recommend that the University Police Department revise procedures to ensure consistency with UT System Policy 166 and UTSW policies. The Petty Cash custodian should review the policy to ensure understanding of requirements and review UT System and UTSW policy for changes during the annual review of department procedures.	Current Status	Fully implemented	Fiscal or Other Impact	Compliance with UTS 166.
	6. Improve fuel usage tracking and fuel point controls to safeguard resources We recommend that Physical Plant implement stronger controls for fuel usage reporting and protection of University resources. The Physical Plant should evaluate cost effectiveness of repair or replacement of the Phoenix 8000 fuel point control system. A formal reconciliation process should be implemented to identify variances between fuel purchased and documented use. Any variances should be investigated and explained in a formal report to Physical Plant management. Consider the effectiveness and cost of implementing other fuel dispensing controls and deterrents such as locks on the fuel nozzles (to be unlocked by a fuel attendant), cameras, and locking the fuel point after normal working hours.	Current Status	Substantially Implemented	Fiscal or Other Impact	Monitoring and supervision are essential risk management functions to ensure the propriety of fuel use.

09:18 University Hospitals Charge Entry

Report Number	09.18	Report Date	08.11.09	Name of Report	University Hospitals Charge Entry
High Level Audit Objective	The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that there are adequate and effective charge entry controls for the UH pharmacies to ensure the following: 1) Reliability and integrity of financial and operational information • Evaluate charge entry process controls for pharmacy operations (refer to 3) • Document and analyze volume of charge transactions; select a charge sampling approach based on location, IR system, manual vs. automated, and dollar amount; select sample charge transactions for completeness, accuracy, and timeliness of entry • Evaluate and test charge reconciliation controls 2) Determine compliance with Federal, State, UT System, and Medical Center rules, regulations, policies and procedures. Identify Pharmacy Operation Policies and Procedures and review for adequacy 3) Effectiveness and efficiency of operations – Flowchart the complete charge entry process for Medical Center Pharmacy Operations and document key controls in process 4) Safeguarding of Assets – Review policies and practices related to charge capture and transmission for billing				
Observations Findings Recommendations	**1. Documenting Charge Entry Processes** We recommend that the UH Pharmacy revise the "UH Pharmacy Policy & Procedure Manual" to ensure consistent input batch control processes and charge entry matching to EpicRx records. This may ensure effective batch input process control and completeness of charge entry.	Current Status	Fully Implemented	Fiscal or Other Impact	Documented procedures allow accountability for effective performance, training for back-up coverage of critical activities, and performance measurement.
	2. Completeness of EpicRx Charges to Siemens Patient Accounting System We recommend that Pharmacy and PFS document a process for monthly review of EpicRx dispenses to Siemens Patient Accounting system changes. The process should include a coordinated effort to monitor quantities of matches and errors along with actions taken to resolve issues discovered to ensure billing services are complete.	Current Status	Fully Implemented	Fiscal or Other Impact	Monitoring and Supervision are essential risk management functions to ensure completeness of dispenses to charges between systems in order to mitigate the potential for unbilled charges resulting in lost revenue or non-payment for dispensed medications.

09:18 University Hospitals Charge Entry, continued

Observations Findings Recommendations					
	3. Charge Document Retention We recommend that the pharmacy document and implement a process which explains, directs, and coordinates compliance with UTSW Record Retention Schedule direction to retain charge documents for 1 year.	Current Status	Fully Implemented	Fiscal or Other Impact	The failure to keep the original document(s) increases potential noncompliance with state record retention requirements. Retaining the original charge sheet satisfies university and state document retention requirements and may improve data entry accuracy.
	4. Anesthesia Charge Entry Record for Patient Medications The Anesthesiology Departments and Pharmacy should investigate alternatives to the current intraoperative Anesthesia Record to accommodate more legibly recording patient medications used during surgery and to ensure timely and accurate charge capture by the OR pharmacy.	Current Status	Fully Implemented	Fiscal or Other Impact	Illegible intra-operative Anesthesia Records may result in inaccurate drug entry into EpicRx. An easier to read intra-operative Anesthesia Record form may improve accuracy, reduce non-compliance risks, and improve revenue capture.
	5. Ingenix Charge Master Review – Open Recommendations We recommend implementation of the remaining charge master recommendations from the July 2008 Ingenix Chargemaster Review be addressed.	Current Status	Fully Implemented	Fiscal or Other Impact	Implementation of the "Ingenix University Hospitals Chargemaster Review" recommendations strengthens controls over billing accuracy and regulatory compliance.

09:18 University Hospitals Charge Entry, continued

Observations Findings Recommendations	**6. Business Manager** We recommend that the University Hospital Pharmacy request a Business Manager position to address accounting, finance, inventory, metrics and reconciliation matters in the department.	Current Status	Incomplete/Ongoing Agency is currently trying to fill the position of Business Manager.	Fiscal or Other Impact	Division of duties may better allow the Pharmacist to focus on patient care and the business manager to focus on business responsibilities of the pharmacy.

09:19 University Hospitals Outpatient Imaging Services

Report Number	09:19	Report Date	08.11.09	Name of Report	University Hospitals Charge Entry
High Level Audit Objective	The primary objective of this audit is to provide reasonable assurance that there are adequate financial controls over Outpatient Imaging Services to safeguard assets and support effective revenue management.				
Observations Findings Recommendations	**1. Monitor, Review and Reconcile Cash Receipts** To minimize the potential for misappropriation of funds due to the manual cash receipting process and the lack of separation of duties in the cashier function, we recommend that compensating controls be implemented to include the monitoring, review and reconciliation of patient payment supporting documentation to payments posted (recorded) to the system and to payments deposited in the bank on a periodic basis. Adjustments to the process of monitoring, reviewing and reconciliation of cash receipts may be needed to accommodate the future Epic system implementation at the hospitals.	Current Status	Incomplete/Ongoing A reporting structure will be developed to document the reconciliation which will be reviewed by management.	Fiscal or Other Impact	Monitoring, segregation of duties and reconciliation of patient payment supporting documentation to payments posted (recorded) to the system and to payments deposited to the bank, are key internal control functions that greatly decreases misappropriation of Medical Center funds to go undetected.

09:19 University Hospitals Outpatient Imaging Services, continued

Observations Findings Recommendations					
	2. Identify and Manage Revenue by Outpatient Clinic We recommend Imaging Services management identify and manage revenue for each of the five Outpatient Imaging Services Clinics: Aston, Breast, PET, Rogers, and the Outpatient Building. We also recommend utilization of this information to improve overall management decision making to achieve operational goals.	Current Status	Incomplete/Ongoing The Imaging Director and Finance Manager will work with the Accounting Department to get a revenue report by clinic.	Fiscal or Other Impact	Clearly defined financial management objectives/analysis for revenue of each outpatient clinic is a crucial decision making tool.
	3. Clearly Define and Communicate Procedures for the Management of Charge Capture and Patient Billing Information We recommend Imaging Services review clinical processes over the management of charge and patient billing information to ensure consistency and adequacy of review. Additionally, written procedures should be developed to communicate the purpose and clearly define the steps to adequately complete the processes. At a minimum, the review of clinical processes and written procedures should include the Suspended Charge Report, Charge Reconciliation Report, Daily Registration Audit, and End of Day Procedures to promote accurate patient billing.	Current Status	Incomplete/Ongoing Tools have been developed and implemented for review and management of daily procedures. Department is in process of revising Suspended Charge Report, and will identify any other key control reports or processes and ensure that each clinic has consistent processes.	Fiscal or Other Impact	Written procedures allows for consistent and effective management of patient charges and patient information across each of the five Outpatient Imaging Services Clinics.

09:20 Department of Neuroscience

<table>
<tr><th>Report Number</th><th>09:20</th><th>Report Date</th><th>01.20.09</th><th>Name of Report</th><th colspan="2">Department of Neuroscience</th></tr>
<tr><td>High Level Audit Objective</td><td colspan="6">The primary objective of this audit was to provide the president and Board of Regents with reasonable assurance that there are adequate and effective controls for the Department of Neuroscience. Our audit objectives included the following:
1. Departmental Internal Controls
a. Evaluate the effectiveness of the policies, procedures, and internal controls currently in place with respect to department operations
b. Review the monthly departmental financial review process for timeliness and accuracy
c. Review controls related to security of critical data and training requirements
d. Ensure adequate controls for the use and safeguards of controlled substances in the lab
e. Ensure there are adequate controls in place over equipment inventory
2. Expenditures/Cost Recovery/Cash Receipting
a. Review the travel, entertainment, maintenance and operation expenditures
b. Review the department's cash handling procedures for cost recovery
c. Review the cash receipting controls for compliance with UTS166-Cash Management and Cash Handling Policy
3. Research/Grants Compliance – Review the processes involved with grants and contracts management for compliance with federal, state, UTS policies and local provisions</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="2">1. Departmental Internal Controls
a. We recommend that for the Department of Neuroscience:
1. Policies and procedures be strengthened by clearly documenting the major functions and written job descriptions that document staff duties and responsibilities as they relate to the operations of the department.
2. A departmental risk assessment be conducted alongside evaluation of management controls and their effectiveness
3. All key departmental personnel should attend internal control training.</td><td>Current Status</td><td>Fully Implemented</td><td>Fiscal or Other Impact</td><td>A strong management control environment decreases the potential for instances of fraud, waste and mismanagement which eventually could lead to public mistrust and lost opportunities for the Medical Center. Management control reviews help determine whether controls are adequate and are working as intended and whether new controls are needed.

Updated and well documented policies and procedures serve employees on job responsibilities and management directives.</td></tr>
</table>

09:20 Department of Neuroscience, continued

Observations Findings Recommendations					
	4. Deficiencies or violations noted in the Fire and Life Safety review be addressed timely. b. Management should formally develop department policies and procedures that clearly define its reporting, adjusting, and monthly financial review responsibilities by staff and subsequent monitoring activities by management. This should ensure that incompatible duties are not performed by the same employee. c. We recommend personnel complete or renew information security agreements and that all key departmental personnel attend the HIPAA/Information security training.	Current Status	Fully Implemented	Fiscal or Other Impact	Medical Center trainings increase department compliance and assist Medical center employees in understanding their roles and responsibilities as they relate to the goals of the Department and the Medical Center.
	2. Expenditures/Cost Recovery/Cash Receipting To ensure proper oversight functions and comply with UTS 166, and Accounting and Fiscal Services Cash Management Procedure ACC.CM 21, we recommend: a. Expenditures – We recommend charges for ARC for animal care per diem have a documented review and proper supporting calculations. b. Cost Recovery 1. Supervision of animal cost recovery processes should be qualified and continuous to ensure objectives are achieved and internal controls are maintained	Current Status	Fully Implemented	Fiscal or Other Impact	Unreconciled accounting transactions and operational activities cannot provide reasonable assurance to the effectiveness, completeness and accuracy of the Department transactions. Compliance with UTS 166.

09:20 Department of Neuroscience, continued

<table>
<tr>
<th>Observations
Findings
Recommendations</th>
<td>2. Management should ensure all departmental transactions related to animal cost recovery are properly recorded, approved, reconciled timely, and unreconciled items are investigated and resolved on a monthly basis.
3. All reports, logs and reporting tools necessary to routinely monitor animal cost recovery financial activities (i.e. animal inventory, expenditures, invoicing, cash receipts, subledgers, etc.) and those transaction reviews be clearly documented.
c. Cash receipting – Management ensure that all mail is opened in the presence of two people and initials are recorded that the mail has been opened. When opening mail, create and maintain a cash receipts log (i.e. listing of checks and other payments received). Require the person performing the review or reconciliation to initial and date the activity record, log or reconciliation as evidence of management review.</td>
<th>Current Status</th>
<td>Fully Implemented</td>
<th>Fiscal or Other Impact</th>
<td></td>
</tr>
</table>

09:21 Department of Radiation Oncology

<table>
<tr><th>Report Number</th><th>09:21</th><th>Report Date</th><th>04.08.09</th><th>Name of Report</th><th colspan="3">Department of Radiation Oncology</th></tr>
<tr><td>High Level Audit Objective</td><td colspan="7">The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that there are adequate and effective controls for the Department of Radiation Oncology to ensure the following:
1. Existence of adequate managerial controls applied to department revenues, expenditures, and patient billing procedures.
2. Existence of current and effective policies, procedures and internal controls.</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="3">1. Departmental Revenues, Expenditures, and Patient Billings
Internal Audit recommends the department immediately request a stamp from the Cash Management office. The endorsement stamps must include the following:

For Deposit Only
Pay to the Order of Bank of America
111000025
The University of Texas Southwestern Medical Center
At Dallas
Acct #</td><td>Current Status</td><td>Fully Implemented</td><td>Fiscal or Other Impact</td><td>Compliance UTS 166.</td></tr>
</table>

09:22 Department of Psychiatry

<table>
<tr><th>Report Number</th><th>09:22</th><th>Report Date</th><th>04.06.09</th><th>Name of Report</th><th colspan="3">Department of Psychiatry</th></tr>
<tr><td>High Level Audit Objective</td><td colspan="7">The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that there are adequate and effective management controls used within the department to ensure the following:
• Compliance with established policies, procedures, and internal controls
• Effectiveness of patient revenue collection and reconciliation process
• Safeguarding of assets</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="3">1. Effectiveness of Patient Revenue Collection and Reconciliation Process

a. After Hours Patient Processing
We found the department of Psychiatry does not have a consistent process directing providers and staff on how to handle patients seen after hours. To ensure after hour patients are processed consistently throughout the Department, we advise Psychiatry to work with Aston Administration and Billing Compliance, within the next 30 days, to develop and document a policy and processes that will train faculty and staff on how to handle patients seen after hours. The process should ensure the following:

• All patients are charged correctly according to the fee schedule
• All patient payments are collected on the date of service
• Every patient received a receipt
• Deposits are made in a timely manner
• Charges are entered with the appropriate batch
• Clinic activities are reconciled daily</td><td>Current Status</td><td>Fully Implemented</td><td>Fiscal or Other Impact</td><td>Lack of a comprehensive policy or procedures directing providers and staff on how to process after hour patients can potentially result in inefficiencies and inconsistent application of Department and Medical Center directives.</td></tr>
</table>

09:22 Department of Psychiatry, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	b. Cash Receipt Process Policies Internal Audit recommends Psychiatry develop a formal policy and procedure for cash handling to be consistently applied by all its divisions and include the following: • There should be a segregation of receiving (i.e. opening of mail, receipt of payment, etc.) and depositing cash and checks from posting transactions to departmental records • A log should be maintained of cash and checks received and a receipt provided to the payer without exception • All checks received should be immediately restrictively endorsed upon receipt • Deposits should be made daily or secured appropriately for short term only • Detailed listings should be reviewed appropriately and reconciled on a routine (daily, weekly, monthly) basis to ensure proper recording as deemed necessary by the department		Fully Implemented		A policy directing providers and staff on how to process after hour patients would facilitate consistent practices across divisions of Department. A formal Psychiatry department policy and procedure will help ensure consistent application and practices throughout Psychiatry divisions. Compliance with UTS 166.

09:26 THECB Medical Residency Program Contracts

Report Number	09:26	Report Date	03.03.09	Name of Report	THECB Medical Residency Program Contracts
High Level Audit Objective	The Office of Internal Audit reviewed the THECB Medical Residency Program contracts to address the following objectives: 1. Ensure that the THECB funds are being maintained in accordance with the contract guidelines • Confirm Income and Expenditure reports (Annual Financial Reports) include all expenses • Verify expenditures comply with contract terms 2. Ensure accuracy of financial reporting • Confirm amounts stated on the Income and Expenditure reports (Annual Financial Reports) can be traced back to the Medical Center Accounting records • Verify that the accounting records contain supporting documentation for expenditures				
Observations Findings Recommendations	We found that the policies, procedures, and internal controls relating to the THECB funded contracts are adequate to ensure proper accountability for the expenditures. We noted no material weakness involving internal controls over administrative and financial systems. The THECB funded programs were in compliance with prescribed rules and policies, and the financial data in the Medical Center accounting system was accurate and complete.	Current Status	No Recommendations	Fiscal or Other Impact	Financial controls assists management to use accurate, timely financial information.

09:30 UTS 166: Cash Management and Cash Handling Policy

Report Number	09:30	Report Date	04.06.09	Name of Report	UTS166 Cash Management and Cash Handling Policy
High Level Audit Objective	The primary objectives of this audit are to provide the President and Board of Regents with reasonable assurance that the Medical Center is in compliance with UTS166. Specific audit objectives are: • Evaluating the effectiveness of the policies and internal controls currently in place • Analyzing completeness and timeliness of daily deposits • Follow-up on prior audit recommendations to ensure recommendations have been adequately implemented				
Observations Findings Recommendations	**1. Medical Center Departments - Cash Receipt Procedures** Recommendation per 0802 Report To fully communicate Medical Center and UT System (UTS166) requirements relating to cash receipt handling, the University Hospitals, clinics, and administrative cash receipt locations should train cash handling personnel on cash handling policies and procedures. This includes distributing policies and procedures, and specific training on cash receipts obtained via the mail. This training will be used as a tool for verification and accountability that appropriate activities are in place to avoid errors or misappropriations and to promote consistency of cash handling activities performed throughout the Medical Center.	Current Status	Fully Implemented	Fiscal or Other Impact	The lack of written policies and procedures increases the risk that errors, omissions, and irregularities may occur and go undetected. Accordingly, internal control policies and procedures over cash receipts (i.e. through the mail, etc.) will reduce the risk of loss of funds, define employee responsibility in the cash handling process and assist management in its financial reconciliation responsibilities. Compliance with UTS 166.

09:30 UTS 166: Cash Management and Cash Handling Policy, continued

<table>
<tr>
<td>Observations
Findings
Recommendations</td>
<td>2. Cash Management – Automated Teller Machines
We recommend that the Cash Management office develop formal operating policies and procedures for administrative cash controls to ensure best practices for managing Medical Center ATM's. These policies and procedures should be included in a regularly updated operations manual. The manual should clearly define the steps required for each transaction, explain how to handle exceptions, and delineate lines of authority. The policies and procedures should document management's commitment to protection of ATM assets by outlining its administrative controls as follows:
1. Segregation of Duties – Cash Management should assign duties so no one person controls any transaction alone from beginning to end.
2. Dual Control – Dual custody requires that a minimum of two people are required to access ATM's and are equally accountable for their protection.
a. Dual custody and control procedures should be tested to ensure only collusion could bypass internal control procedures.
b. Logs should record entrance and exits to the ATM and be reviewed periodically for completeness and appropriate access granted.
3. Rotation of personnel – Employee job functions should be periodically rotated unannounced. The rotation should be of sufficient duration (i.e. rotate responsibilities quarterly). Cross training of personnel also provides flexibility and backup for key function areas.</td>
<td>Current Status</td>
<td>Fully Implemented</td>
<td>Fiscal or Other Impact</td>
<td>Administrative controls establish lines of authority and responsibility. Without document ed policies, the department lacks the ability to hold personnel responsible to a consistent standard of performance. Without sound controls, the system lacks the ability to effectively manage the risks associated with its use.

Policies and procedures let all employees know what is expected of them, how they should perform their job duties, and what the consequences are if they do not perform them as required.

Compliance with UTS 166.</td>
</tr>
</table>

09:37 University Hospitals Medical Equipment

Report Number	09:37	Report Date	03.31.09	Name of Report	University Hospitals Medical Equipment
High Level Audit Objective	The primary objective of this audit is to provide the President and board of Regents with reasonable assurance that there are adequate and effective controls for medical equipment to ensure the following: • Reliability, accuracy and safeguarding of equipment inventory • Adequate and effective equipment maintenance such as preventative maintenance, calibration, etc.				
Observations Findings Recommendations	**1. Adhere to Manufacturer's Preventive Maintenance (PM) Specifications** We recommend the following be conducted to provide management with the assurance that preventive maintenance for equipment is conducted according to the manufacturer's specifications: a. Conduct quarterly or 1000 hour preventive maintenance for the Fresenius 2008H hemodialysis machines. b. Adjust hemodialysis preventive maintenance procedures and policies to at least meet the manufacturer's specifications. A review of preventive maintenance procedures, policies and manufacturer's specifications for all equipment should be conducted to promote consistency and compliance.	Current Status	Fully Implemented	Fiscal or Other Impact	In the case that patient injury or death occurs, lack of following at least the manufacturer's minimum preventive maintenance guidelines could increase potential liability for the Medical Center by 1) creating the appearance of negligence for not following standard manufacturer's guidelines and 2) absolving the manufacturer of their share of liability as their recommendation for preventive maintenance was not followed.

09:37 University Hospitals Medical Equipment, continued

Observations Findings Recommendations		Current Status		Fiscal or Other Impact	
	c. Any change or revision made to policies should be accompanied by a review and documented approval by the Environment of Care Committee. Manufacturer's specifications should be provided to the Environment of Care Committee to support the change or revision as necessary. d. The Medical Equipment Management Plan should be updated to ensure that preventive maintenance for all medical equipment is performed at least as often as specified by the manufacturer.	Current Status	Fully Implemented	Fiscal or Other Impact	
	2. Perform and Document Risk Assessments We recommend Biomedical Engineering perform and document risk assessments using the risk assessment form in the Medical Equipment Management Plan Section E.10.6.3. Risk assessment results and scores should be included in the biomedical equipment database system. Management and Technicians should use the equipment risk assessment information to enhance decision-making.	Current Status	Substantially Implemented	Fiscal or Other Impact	By documenting risk assessment results for each medical equipment item, there is assurance that each equipment item has been thoroughly evaluated and subsequently assigned the appropriate preventative maintenance schedule, which contributes to better patient safety.

09:37 University Hospitals Medical Equipment, continued

Observations Findings Recommendations	Current Status	Fiscal or Other Impact
3. Enhance Communication to Management We recommend that the Department of Biomedical Engineering: a. Develop and utilize an Equipment Failure Log in accordance with the Medical Equipment Management Plan guidelines. This equipment failure log should be used as a key communication tool between the Department of Biomedical Engineering and the Environment of Care Committee. b. Information supporting the statistics in the "Equipment Summary Report" should be documented, tracked and provided to management in a more useful format which clearly defines all values presented. A formal review of these reports should be performed and discussed by Senior Management and the Environment of Care Committee.	Fully Implemented	Formal utilization of an Equipment Failure Log provides management key information on the viability of equipment used in the everyday care of University Hospitals patients. Patient safety is at risk if medical equipment information is not adequately presented, monitored and assessed.

09:37 University Hospitals Medical Equipment, continued

Observations Findings Recommendations	4. **Review and Monitor Documentation of Preventive Maintenance Procedures** We recommend that a formal system of monitoring and review be developed to promote consistency, accuracy, and completeness of PM documentation. Such a system should include: a. Document PM procedure numbers in the equipment history b. Ensure documented PM procedure intervals agree with Policy c. Ensure that PM procedures are updated to reflect complete and adequate information. Consider including procedure checklist factors identified in the Medical Equipment Management Plan EC.6.10.4 Maintenance Requirements.	Current Status	Fully Implemented	Fiscal or Other Impact	Without consistent guidelines, there is a risk that PM procedures may not be adequately communicated, resulting in the potential misinterpretation of requirements by technicians and employees and risk to patient safety.

09:37 University Hospitals Medical Equipment, continued

Observations Findings Recommendations	Current Status	Fiscal or Other Impact
5. Review and Monitor Inventory Records The Department of Biomedical Engineering should develop a formal review and monitoring process to ensure accurate PM system information including: • Up-to-date hospital equipment inventory to accurately reflect equipment status and PM schedules • Items with outstanding PM dates should be reviewed and prioritized. PM should be performed to ensure compliance for all equipment.	Fully Implemented	Up-to-date hospital medical equipment inventory combined with a detailed review of items that appear to be significantly past due for preventative maintenance can provide management with the assurance that equipment inventory preventative maintenance schedule is current and routinely performed as scheduled. As a result, the quality of patient safety is enhanced by providing patients with the sound assurance that medical equipment is adequately maintained and safe.

09:37 University Hospitals Medical Equipment, continued

Observations Findings Recommendations	6. **Document Biomedical Technician Training** We recommend the Department of Biomedical Engineering enhance its documentation of employee training to provide management with the assurance that the training objectives outlined in the Medical Equipment Management Plan are met. Documentation should include: a. Documentation of the completion of the Competency Assessments as part of the Annual Review, including signatures and dates by both the technician and the supervisor. b. Ongoing, consistent tracking of technician training with adequate supporting documentation. Each technician's training history should be reviewed for additional training needs during the Annual Review.	Current Status	Fully Implemented	Fiscal or Other Impact	Potential risk to patient safety as technicians may not be adequately trained to maintain certain pieces of medical equipment.

09:39 Texas Administrative Code (TAC) 202 Compliance

Report Number	09:39	Report Date	05.12.09	Name of Report	Texas Administrative Code (TAC) 202 Compliance
High Level Audit Objective	The primary objective of this audit is to provide the President and Board of Regents with reasonable assurance that the University of Texas Southwestern Medical Center at Dallas (Medical Center) is in compliance with Information Security standards set forth in TAC 202, Subchapter C Security Standards for Institutions of Higher Education				
Observations Findings Recommendations	**1. Information Resources Security Policies** **a. Segregation of Production and Testing Environments** To better ensure compliance with TAC RULE §202.75 IR Security Safeguards, Section (6) regarding segregation of production and testing environments, we recommend that the IS Program, Security Manual Policy No: 200-06 "SECURITY CONTROLS FOR INFORMATION SYSTEMS" section on PRODUCTION VS TESTING ENVIRONMENTS – items #22-25 be moved under Policy No: 200-17 "INFORMATION SYSTEMS ADMINISTRATION" section on CHANGE MANAGEMENT – items #31-33. Policy 200-17 is used in the System Administrator training courses and receives much more visibility.	Current Status	Fully Implemented	Fiscal or Other Impact	Compliance with TAC 202.

09:39 Texas Administrative Code (TAC) 202 Compliance, continued

Observations Findings Recommendations	Current Status	Fiscal or Other Impact
2. Follow-up on Prior Audit Recommendations Audit standards require that we follow up on prior audit recommendations. Internal Audit Report 07:03 – "TAC 202 Compliance" issued October 31, 2006 had four recommendations. We found three recommendations were implemented and one recommendation had a target completion date of December 2009.	Substantially Implemented	Compliance with TAC 202.

09:40 Telecommunications

Report Number	09:40	Report Date	08.13.09	Name of Report	Telecommunications

High Level Audit Objective

The objective of this audit is to provide the President and Board of Regents with reasonable assurance that there are adequate and effective controls for Information Resources Telecommunications regarding the following:

1. Determine if Telecommunications internal controls are adequate to ensure continuous availability of the telephone system (resiliency)
   a. How is the telephone system resiliency structured?
   b. What is the long range plan for the telephone system resiliency?
   c. Routine maintenance/monitoring
      i. Who monitors the telephone system?
      ii. Who fixes or changes telephone switches?
      iii. Assess the quality of repair/maintenance people. Is staffing adequate?
      iv. Are there any plans to replace switches on a regular basis?
      v. What are the future plans for upgrades and improvements?

09:40 Telecommunications, continued

<table>
<tr><td>High Level Audit Objective</td><td colspan="5">2. Determine if Telecommunications procedures are adequate for timely recovery of telephone system functions in the event of disruption (disaster recovery)
a. Disaster Recovery
i. Document built in measures that protect the phone system in the event of disaster
ii. Interview IR Disaster Recovery staff for operational perspective on how Disaster Recovery plan works
1. Is there a plan for alternate means of data transmission of the computer network if it is interrupted?
2. Does the business resumption plan include arrangements for emergency telecommunications?
iii. Is there a scheduled test for disaster recovery plan response?
b. Backup of Phone Data
i. What are the backup procedures for the servers that support the phone system?</td></tr>
<tr><td>Observations Findings Recommendations</td><td>1. Disaster Recovery
We recommend that Telecommunications complete the divisional "disaster recovery plan – department survey" and the "system recovery template" for incorporation into the data center "Information Resources Administration Recovery Plan".</td><td>Current Status</td><td>Incomplete/ongoing

Telecommunications is committed to implementing the audit recommendations by December 31, 2009.</td><td>Fiscal or Other Impact</td><td>Documented Telecommunications disaster recovery procedures would promote consistency in approach to handling of phone outages and restoration of phone equipment during a crisis.</td></tr>
</table>

09:40 Telecommunications, continued

Observations Findings Recommendations	**2. Follow-up on Prior Audit Recommendations** Audit standards require that we follow up on prior audit recommendations. Internal Audit Report 07:28 – "Compliance Monitoring II" issued December 12, 2007 had one recommendation pertaining to Telecommunications. The one recommendation (item B2) was regarding the Department of Information Resources Internal Controls Training – "We recommend that Information Resources management endure that key employees have received Internal Controls training." We determined this recommendation was implemented.	Current Status	Fully Implemented	Fiscal or Other Impact	Medical Center Internal Controls training requirements.

This completes the List of Audits Completed for FY 2009.

IV. List of Consulting and Non-audit Services Completed

P9:06.01 Mini Warehouse Storage Facility

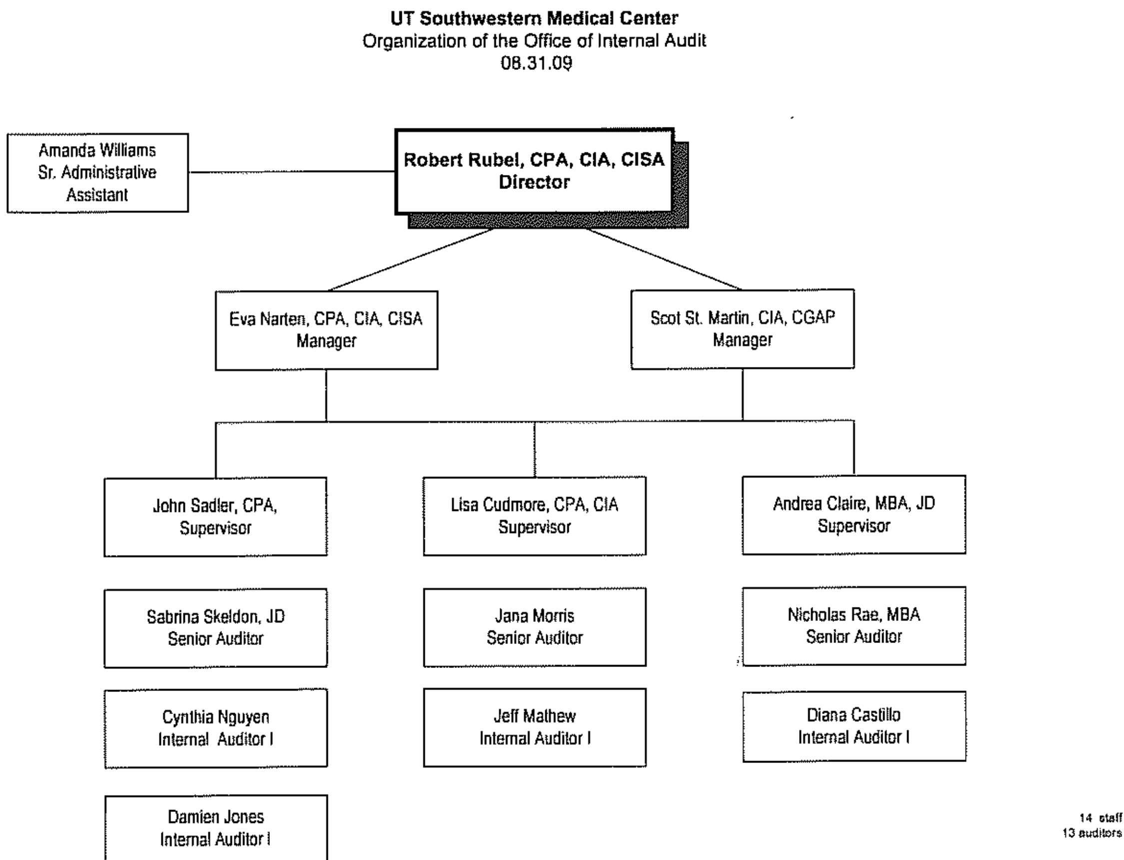
Report Number	P9:06.01	Report Date	05.11.09	Name of Report	Mini Warehouse Storage Facility
High Level Audit Objective	The objective of this review was to analyze business operations for the mini warehouse storage facility and evaluate current contracted management services provided by G&C Holdings for the property.				
Observations Findings Recommendations	**1. Review Services Contract** We recommend Real Estate Services review the contract for management services and build in performance standards (i.e. rent occupation percentage) as the primary measure for monthly payment rather than application of set fees. Because the primary customers are UT Southwestern departments, the contract should include clearly defined and outlined liabilities and obligations to related Medical Center and State of Texas rules and regulations. The contract should clearly define performance standards and measurable outcomes, as well as how the contract's performance will be evaluated. To further reduce costs, management should consider the cost/benefit of continuing the third-party contract(s) versus employing a UT Southwestern hourly employee to assist Real Estate Service.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Cost savings opportunity for the Medical Center.

P9:06.01 Mini Warehouse Storage Facility, continued

Observations Findings Recommendations	Current Status	Fiscal or Other Impact
2. Enhance Control Environment for Database and Computers In collaboration with Information Security, we recommend Real Estate Services enhance security for all desktop/laptop computers and its related hardware/software. We also recommend that controlled access to financial/operational records should be maintained and monitored by the Medical Center. Real Estate Services should enhance data security for the desktop and laptop computers. All database management procedures should be documented within related third party contract. Finally, as part of financial reconciliation procedures management should develop routine procedures to monitor history records/logs (clear audit trail) for activities performed within the WinSen database. Procedures to reconcile WinSen database activity to Real Estate Services system data should be clearly defined and documented as part of departmental policies.	Substantially Implemented	In the event of a loss or theft of the customers' credit card information, all customers would have to be notified of the breach, which could lead to poor publicity for the Medical Center. Weaknesses in financial controls that include unrestricted access to financial data can place the Medical Center at a higher risk for occurrence of misappropriations, errors, etc. to go undetected and unresolved.

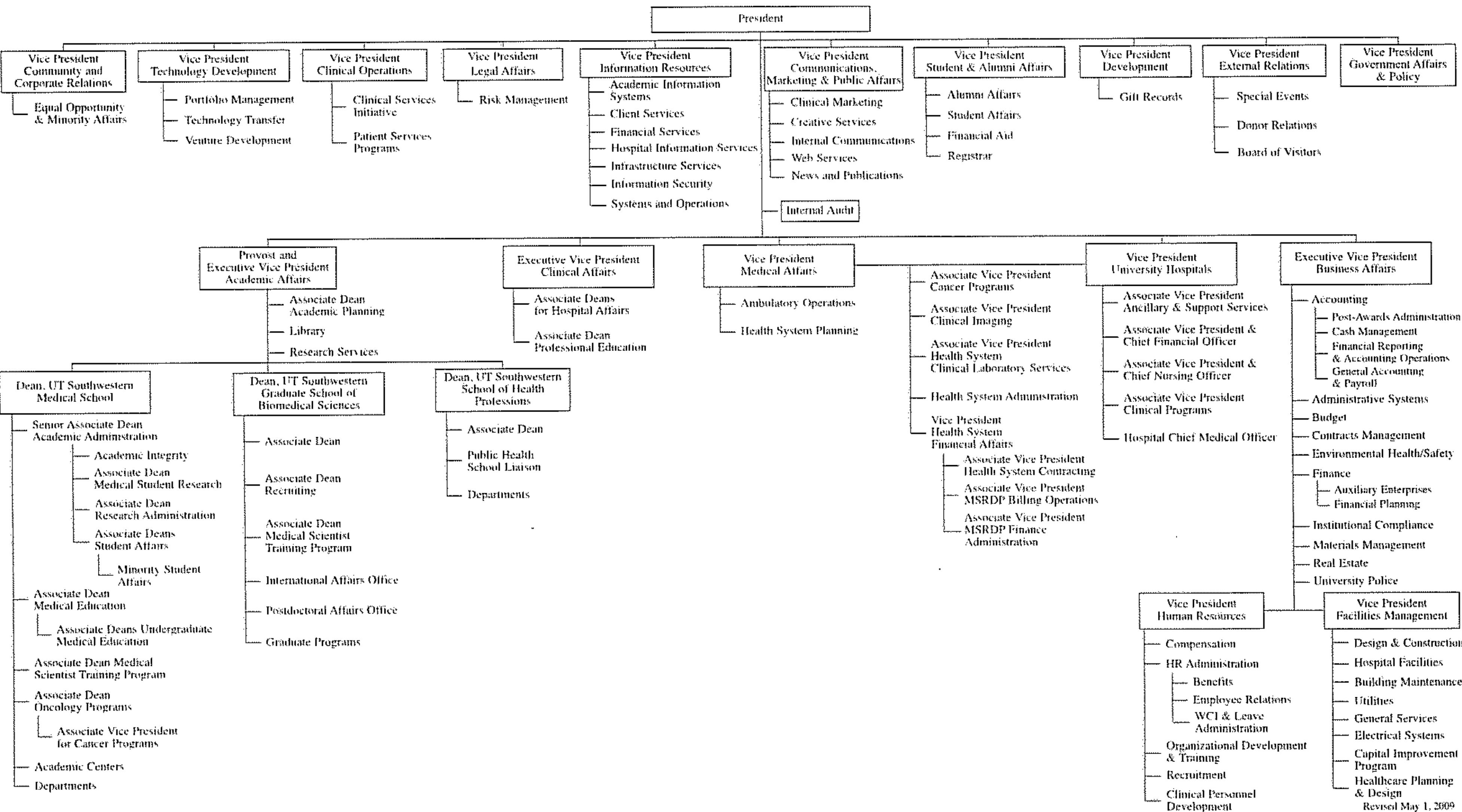
This completes the List of Consulting and Non-audit Services Completed for FY 2009.

V. Organizational Chart



UT Southwestern Medical Center's Internal Audit Department reports to the UT Southwestern Internal Audit committee on a quarterly basis.

The University of Texas Southwestern Medical Center at Dallas
Organizational Chart



VI. Report on Other Internal Audit Activities

Activity	Impact
Performed reviews of complaints received through Medical Center's *EthicsLine*.	Provides the Medical Center with investigation resources.
Conducted internal control training and facilitated control self assessment workshop	Provides Medical Center employees with guidance on internal controls, risk assessment, and how to implement controls to reduce errors and irregularities.
Conducted training for Medical Center employees on how to reconcile their departmental accounts	Provides Medical Center employees with guidance on how to reconcile their departmental accounts to minimize errors and irregularities in the normal course of business activities.
Fraud Analysis	Provides independent consultation and evaluation tools to management for monitoring and detection of fraudulent activities.
Institutional Compliance Committee	Provides continual assessment of the Medical Center compliance function to determine the effectiveness of the program, and to ensure Medical Center officials are knowledgeable about compliance risks, activities, and findings.
ERP Selection Committee	Provides independent consultation and guidance of internal controls for process flows within PeopleSoft applications implementation.
Business Resumption and Disaster Recovery Planning	Provides independent consultation and guidance to help Medical Center address Emergency preparedness and Business Continuity risks.
Security and Confidentiality Committee for HIPAA implementation	Provides consultation and guidance in the development of standards and procedures for the security of patient information per HIPAA guidelines for each institution.
Billing Compliance Committee	Provides independent consultation and guidance to help billing compliance activities address institutional risks.
Billing Oversight Committee	Addresses contemporary billing issues, e.g., AR statistics, collection reports, Medicaid issues, and management initiatives such as fee schedule analysis.
Coordination of External Audits	Provides operational support to the State Auditor's Office A-133 audit and Statewide Audit and financial audit

VII. Internal Audit Plan for Fiscal Year 2010

Risk Assessment Reference	Audit #	FY 2010 Audit Plan Audit/Project	Budgeted Hours	% of Total	Priority Hours	% of Total	✓ Priority	Description
		Financial Audits						
		UT System Requested/Externally Required Audits						
Inst. - Fin. Mgt.	10:01.01	FY2009 Financial Statement Audit - Financial	600		600		✓	Perform FY09 Financial Statement Audit to include Payroll coverage.
Inst. - Fin. Mgt.	10:01.02	FY2009 Financial Statement Audit - IT	400		400		✓	Perform FY09 IT control review.
Inst. - Fin. Mgt.	10:01.03	FY2009 Financial Statement Audit - Fraud	100		100		✓	Perform FY09 financial statement related fraud review.
Inst. - Fin. Mgt.	10:02.01	FY2010 Financial Statement Audit (Interim)	400		400		✓	Perform FY10 Financial Statement Audit preliminary financial internal control work.
Inst. - Fin. Mgt.	10:02.02	FY2010 Financial Statement Audit IT (Interim)	200		200		✓	Perform FY10 Financial Statement Audit preliminary information technology control work.
	10:03	Presidential Housing, Travel and Entertainment Expenses	150		150		✓	Review budgeting for charitable giving, expense reporting (excluding travel paid for by third party and institutional entertainment), and approval of expenditures and reasonably following state guidelines.

Research - Grants Mgt.	10:04	Time & Effort Reporting/American Recovery and Reinvestment Act (ARRA)	400		400		✓	Review funds received as part of the ARRA for compliance. If coverage provided by SAO, will perform audit on the appropriateness of and compliance with contract terms for Time & Effort Reporting.
	10:05	National Pediatric Infectious Disease Foundation AFR	100		100		✓	Review National Pediatric Infectious Disease Foundation AFR for consolidation into Medical Center AFR.
		Carryforward Audits	100		100		✓	
		Financial Audits Subtotal	**2450**	**14%**	**2450**	**17%**		
		Operational Audits *Risk Based Tier One Audits*						
Patient Care - Chg. Capture	10:06	MSRDP Billing Operations	600		600		✓	Review processes for refund checks, examining internal controls and audit logs post-Epic Resolute implementation. Review departmental maintenance of work queues for adequacy of controls to ensure that denials are managed timely in order to receive cash flow.
Patient Care - Chg. Capture	10:07	MSRDP Charge Entry	500		500		✓	Review charge entry controls and processes from date of service to closing of encounter to charge entry in Epic Resolute.

Inst. - Purch. & Ware.	10:08	University Hospitals - Procurement and Contract Monitoring	600	600	✓	Review controls and processes over monitoring of contracts (bidding, vender relationships, value and needs analysis, contract performance) and over hospital purchasing processes post-PeopleSoft implementation
Inst. - Plant Op. Main.	10:09	Construction Project Management	400	400	✓	Review controls and processes of Physical Plant to manage both large capital projects and small remodeling projects. Review follow-up on external audit findings of construction projects.
		Risk Based Tier Two Audits				
Patient Care - Care&Tr.Svcs.	10:10	University Hospitals - Simmons Comprehensive Cancer Center	500	500	✓	Review Cancer Center processes post-hospital based transition for adequate controls
Inst. - Gov. & Lead.	10:11	Governance: Policies & Procedures	350	350	✓	Review controls over the development, approval and communication of institutional policies & procedures.
Inst. - Asset/Risk Mgt.	10:12	Emergency Preparedness	400	0		Review coordination and communication of Medical Center emergency preparedness processes.
		Change in Management Audits				
Research - Grants Mgt.	10:13	Grants Management	150	150	✓	Perform review over department operations.
	10:14	Other	300	0	☐	Perform review over

							department operations.
	Carryforward Audits	200		200			
	Operational Audits Subtotal	**4000**	**24%**	**3300**	**23%**		
	Compliance Audits *UT System Requested/Externally Required Audits*						
10:15	FY09 SAO A-133 Federal Audit Assistance	50		50		✓	Provide assistance to the State Auditor's Office .
10:16	FY09 SAO Statewide Financial Audit Assistance	200		200		✓	Provide assistance to the State Auditor's Office - Financial Audit Review.
10:17	UTS155: Policies and Procedures Regarding Practice Plan Operations - MSRDP	300		300		✓	Review compliance with UTS155: Policies and Procedures Regarding MSRDP Business Operations. Perform UT System required procedures to complete Practice Plan Governance Audit.
10:18	UTS155: Policies and Procedures Regarding Practice Plan Operations - FSP School of Health Professions	200		200		✓	Review compliance with UTS155: Policies and Procedures Regarding MSRDP Business Operations.
10:19	Family Practice Residency Program Grants (THECB requirement)	150		150		✓	Review Family Practice Residency Program Grants (THECB requirement).
10:20	Graduate Medical Education Grant	200		200		✓	Review Graduate Medical Education Grant (THECB

		(THECB requirement)						requirement).
	10:21	Ethics-related objectives, programs and activities - IIA *Standards 2110.A2*	250		250		✓	Evaluate the design, implementation and effectiveness of the Medical Center's ethics-related objectives, programs and activities.
		Risk Based Tier One Audits						
Patient Care - Hosp. Gov.	10:22	University Hospitals - Quality Indicators	400		400		✓	Review procedures for determination, compilation, analysis, reporting, and monitoring of University Hospital quality indicators
		Risk Based Tier Two Audits						
Patient Care - Chg. Cap./Billing Ops.	10:23	Physician Billing Compliance	400		400		✓	Review physician compliance program for adequacy of controls
Research - Grants Mgt.	10:24	Clinical Trials Billing	300		300		✓	Review clinical trial billing procedures for adequate controls to safeguard against fraudulent claims. Review cash controls over human research subject payments.
		Carryforward Audits	100		100		✓	
		Compliance Audits Subtotal	**2550**	**15%**	**2550**	**18%**		
		Information Technology						

		Audits *UT System Requested/Externally Required Audits*						
	10:25	Information Technology Governance Audit - IIA *Standards 2110.A2*	250		250		✓	Assess whether the information technology governance of the organization sustains and supports the organization's strategies and objectives
	10:26	IT Exchange Program	100		100		✓	Collaboration with the Office of Internal Audit at the University of Texas at Dallas
		Risk Based Tier Two Audits						
IT - Clinical Apps Epic	10:27	Epic Resolute Implementation	600		600		✓	Review controls and procedures post-Epic Resolute implementation.
IT - Admin. Applications	10:28	PeopleSoft Implementation	800		600		✓	Review controls and procedures post-Phase I implementation. Review progress of Phase II implementation. Also provide other assistance and monitoring.
IT - Clinical Apps (Other)	10:29	University Hospitals - Sunquest MiSys Lab System Implementation	500		0			Review upgrade and implementation of Sunquest MiSys in labs and the Seay building for adequate controls.
		Carryforward Audits	100		100		✓	
		Information Technology Subtotal	**2350**	**14%**	**1650**	**11%**		

10:30	***Follow-up Audits***	**600**	4%	**500**	3%		
	Projects						
	Audit Projects						
	UT System Requests	200		100		✓	
	Special Requests - Audits	500		400		✓	
	Consulting Projects						
	Fraud Prevention and Analysis	500		400		✓	Continue to assess and review management's fraud management and monitoring processes/programs. Produce quarterly reports on activities.
	Special Requests - Consulting	1000		700		✓	Review LBB performance measures and other requests.
	Other Projects						
	Requests for Information/Assistance	200		200		✓	
	Internal Audit Annual Report	60		60		✓	
	Quality Assurance Review	300		300		✓	Continued review to ensure compliance with IIA, Yellow Book, and Texas Internal Auditing Act
	Annual Audit Plan and Risk Assessment	300		300		✓	Prepare annual risk assessment and audit plan
	Training Provided by IA	150		100		✓	Provide training services for internal control activities and other classes
	Internal Audit Committee	400		400		✓	Prepare report of activities for the various audit committees
	Internal Projects	400		300		✓	Develop internal controls

						module, TeamMate maintenance, computer maintenance
Reserve for other Special Requests/Investigations	1000		800		✓	Review ethics line and other special requests.
Projects Subtotal	**5010**	**30%**	**4060**	**28%**		
Total Hours	**16960**	**100%**	**14510**	**100%**		
			Percentage Priority of Budgeted Hours	**100%**		
			Percentage Priority Hours to Total Budgeted Hours	**86%**		

Note: Total Priority hours should be at least 80% of Total Budgeted Hours

VIII. External Audit Services

The following is a list of audits completed by outside agencies at the Medical Center in FY2009.

- State Auditor's Office FY2008 Federal A-133 Audit
- State Auditor's Office FY2008 Statewide Financial Audit
- State Auditor's Office FY2008 SACS Accreditation Review
- Weaver and Tidwell, LLP's FY2008 Moncrief Cancer Center Audit
- Weaver and Tidwell, LLP's FY2008 Moncrief Cancer Foundation Audit
- KPMG's FY2008 UT Southwestern Health Systems (UTSHS) audit
- FY2008 UT System Financial Audit

IX. Reporting Suspected Fraud and Abuse

- Fraud Reporting - Article IX, Section 17.05, the General Appropriations Act (81st Legislature)
- Reporting Requirements - Article XII, Section 5(c), the General Appropriations Act (81st Legislature).

In Process - We are currently finalizing UTSW web-site for full compliance of requirements. Implementation Date- Mid November 2009