UT SOUTHWESTERN
MEDICAL CENTER

Robert Rubel, CPA, CIA, CISA
Director

Office of Internal Audit

November 1, 2011

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

Dear Mr. Keel:

We have prepared this report on the activities of The University of Texas Southwestern Medical Center's Office of Internal Audit in compliance with the requirements established in the Texas Internal Auditing Act (Texas Government Code, Section 2102). This report provides information on our FY 2011 and 2012 audit plans, audits completed and recommendations. Our audit work for FY 2011 focused on key externally requested and Institutional risk-based areas including patient care, research, information technology, compliance, core business processes, and other areas based on risk.

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

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

Sincerely,

Robert Rubel

Robert Rubel

cc: Jonathan Hurst, Governor's Office of Budget and Planning
Ed Osner, Legislative Budget Board
Internal Audit Coordinator, State Auditor's Office
Ken Levine, Sunset Advisory Commission

The University of Texas
Southwestern Medical Center
Internal Audit Annual Report for Fiscal Year 2011

November 1, 2011

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER

INTERNAL AUDIT ANNUAL REPORT FOR FISCAL YEAR 2011

TABLE OF CONTENTS

I. Audit Plan for Fiscal Year 2011

FY 2011 Audit Plan Audit/Project	Hours
Financial Audits	
UT System Requested/Externally Required Audits	
FY2010 Financial Statement Audit - Financial	800
FY2010 Financial Statement Audit - IT	600
FY2010 Financial Statement Audit (Interim)	300
Presidential Housing, Travel and Entertainment Expenses	150
Joint Admission Medical Program (Biennial Requirement)	150
National Pediatric Infectious Disease Foundation AFR	200
Risk Based Tier One Audits	
Human Resources – Benefits & Leave Management	600
Buy Card Management	300
Carryforward Audits	100
Financial Audits Subtotal	3200
Operational Audits	
Risk Based Tier One Audits	
Patient Payments (Time of Service)	600
Research Laboratory Oversight	600
MSRDP Contract Administration (Non-priority)	400
Risk Based Tier Two Audits	
Animal Resource Center (Non-priority)	400
Pathology Labs/Veripath	600
CVIR/Cath Lab	600
Change in Management Audits (Non-priority)	400
Carryforward Audits	150
Operational Audits Subtotal	3750

Compliance Audits	
UT System Requested/Externally Required Audits	
UT System Requested/Externally Required Audits	
THECB Medical and Graduate Medical Education Programs	300
FY11 Practice Plan Medical Billing Compliance - UT System Assistance	200
Institutional Compliance Program	300
Effort Reporting	600
Risk Based Tier Two Audits	
Clinical Trials Billing	600
Carryforward Audits	100
Compliance Audits Subtotal	2100
Information Technology Audits	
UT System Requested/Externally Required Audits	
Information Security	600
TAC 202 Compliance Audit (Biennial Requirement)	200
Campus Wireless	300
Risk Based Tier Two Audits	
Electronic Medical Records	600
EPIC Interfaces	600
Carryforward Audits	100
Information Technology Audits Subtotal	2400
Follow-up Audits	
Follow-up Audits	
Follow-up Audits	600
Follow-up Audits Subtotal	600

Projects	
External Assistance	
UT System Requests	200
FY10 SAO A-133 & Statewide Financial Audit	500
Audit Projects	
PeopleSoft Modules	1400
FY10 LBB Performance Measures	200
Consulting Projects	
Reserve for Special Requests/Investigations	1200
Other Projects	
Continuous Monitoring	800
Requests for Information/Assistance	400
Internal Audit Annual Report	100
FY12 Annual Audit Plan & Risk Assessment	400
Internal Audit Committee	400
Projects Subtotal	5600
Total Budgeted Hours	17550

Explanation of Deviations from Fiscal Year 2011 Audit Plan

Deviations from the FY 2011 Audit Plan were due to staff turnover and budget reductions and were approved by the audit committee. Priority audits not completed for FY 2011 include: 11:09 Research Laboratory Oversight, 11:19 Clinical Trials Billing Compliance. Based on risk, these audits were carried forward to the FY 2012 audit plan as Research Compliance and Clinical Trials Billing Compliance.

II. External Quality Assurance Review

UTMB
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

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III. List of Audits Completed

11:01 FY 2010 Financial Statement Audit

Report Number	11:01	Report Date	12.10.10	Name of Report	FY 2010 Financial Statement Audit		
High Level Audit Objective	UT System requested						
Observations Findings Recommendations	**1. EPIC Resolute Change Management** Management should follow through with current plans to implement the Data Courier data migration system for Epic in February of 2011. Implementation will improve change management controls and the likelihood that only authorized changes are implemented. Management should: a. Implement controls to segregate building, review, testing and implementation of change activities. b. Devise a process to monitor and track changes until Data Courier is implemented. c. Create and keep documentation for UAT "to test/verify that the change is working according to the original specification and that all requirements have been met." d. Redesign the Change Control Status Report form to facilitate documentation of the approvals.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will improve change management controls and the likelihood that only authorized changes are implemented.		

11:01 FY 2010 Financial Statement Audit, continued

Observations Findings Recommendations	e. Devise a method to allow linking, or tracing, of changes to related documentation. Potential solutions include using the Epic Rule ID, a 3rd party tool, or vendor options or resources. f. Implement a script to migrate changes and ensure that migrations are performed by someone other than the analyst who built the change.	Current Status		Fiscal or Other Impact	
Observations Findings Recommendations	**2. Documentations of Processes and Procedures to Comply with the Monitoring Requirement defined in UTS 142.1 – Policy for the Annual Financial Report ("UTS 142.1"), Section 2.3 "Monitoring Plan"** Management should continue to define and document standardized monitoring processes and procedures to allow for increased coverage of high risk areas, random testing of low risk departments and compliance with the reporting requirements defined UTS 142.1, Section 2.3, and those stated in the Institution's Monitoring Plan.	Current Status	Fully Implemented	Fiscal or Other Impact	Controls over financial risk areas have been enhanced.

11:01 FY 2010 Financial Statement Audit, continued

Observations Findings Recommendations	**Appendix Item 2. University Hospitals St. Paul Lab - Disaster Recovery Test for MySys and Co path** We recommend that the Sunquest (MySys) and Copath disaster recovery plan be tested. Disaster Recovery testing results should be coordinated and shared with the Information Resources Manager.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will ensure system recovery plan is working in case of disaster.

11:03 Presidential Housing, Travel and Entertainment Expenses

<table>
<tr><td>Report Number</td><td>11:03</td><td>Report Date</td><td>11.18.10</td><td>Name of Report</td><td colspan="3">Presidential Housing, Travel and Entertainment Expenses</td></tr>
<tr><td>High Level Audit Objective</td><td colspan="6">To provide reasonable assurance that there are adequate and effective controls to ensure the following:
Reliability and integrity of financial and operational information
Travel and entertainment transactions have appropriate supporting documentation and approvals, and are recorded accurately
Quarterly reports are complete, accurate, and submitted to UT System in a timely manner
Compliance with laws, regulations, and contracts
Expenses are in compliance with all travel and entertainment policies and procedures
Expenses must meet requirements of UT System Board of Regents' Rules and Regulations, Series 20205</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="2">1. Test of Expenditures
All transactions tested were reasonable and appropriate.

2. Quarterly Reporting
The sampled expenditures evaluated during transaction testing were traced to the quarterly reports without exception.</td><td>Current Status</td><td>No Recommendations</td><td>Fiscal or Other Impact</td><td>Adequate controls are in place within the Office of the President to ensure processing of housing, travel, and entertainment expenditures in compliance with State and University rules. Policies and procedures for housing, travel, and entertainment reimbursements were followed and expenditures appeared reasonable and appropriate.</td></tr>
</table>

11:04 Joint Admission Medical Program

Report Number	11:04	Report Date	12.02.10	Name of Report	Joint Admission Medical Program		
High Level Audit Objective	Per the JAMP Council Agreement, an Internal or Independent Auditor's opinion on the appropriateness of the expenditures for the JSMP Program is required every even year for the prior two fiscal years. The audit objective is to provide assurance the Medical School is in compliance with JAMP policies and procedures as well as with laws and regulations that could have a significant impact on operations and reports.						
Observations Findings Recommendations	**1. Admissions Office Procedures for Managing the JAMP Account** The Admissions Office should document procedures that detail the Medical Center's internal processes for completing JAMP account monitoring activities and supporting schedule preparation. The procedures should include JAMP related job duties and titles/personnel responsible for satisfying the monitoring and reporting requirements. Job duties should include deadlines of required internal and external (JAMP Council Requirements) reports. These duties should be updated periodically to reflect any changes.		Current Status	Fully Implemented	Fiscal or Other Impact	Formal operating procedures have been enhanced to include reporting requirements.	
	2. Testing of Compliance We tested transactions to determine compliance with the related JAMP guidelines. **3. Reporting** We reviewed procedures to determine if FY09 and FY10 financial reports were being prepared timely and appropriately.		Current Status	No Recommendations	Fiscal or Other Impact	The audit resulted in no finding of noncompliance with the JAMP Agreement or JAMP Expenditure Guidelines.	

11:05 National Pediatric Infectious Disease Foundation FY 2010 AFR

<table>
<tr><td>Report Number</td><td>11:05</td><td>Report Date</td><td>01.20.11</td><td>Name of Report</td><td colspan="3">National Pediatric Infectious Disease Foundation FY 2010 AFR</td></tr>
<tr><td>High Level Audit Objective</td><td colspan="6">The Office of Internal Audit performed the NPIDF engagement to assist the Medical Center to fulfill the objectives of providing and reporting accurate and reliable financial and operating information. The following engagement objectives were deemed necessary to provide this assistance:
1. Financial statement audit
• Determine if the financial statements are materially accurate, reliable, and supported by financial records of the NPIDF
• Review financial transactions of the NPIDF for proper support
2. Assist in providing the necessary NPIDF financial information for consolidation into the Medical Center's AFR as required by GASB Statement 14
• Provide reconciliation and supporting documentation requested by Fiscal Reports to consolidate the NPIDF financial activity into the Medical Center's AFR
3. Assist NPIDF Management to complete the necessary forms to satisfy filing requirements of the Internal Revenue Service for Exempt Organizations
• Draft and monitor the completion of the Form 990 and supplemental schedules for NPIDF tax filing due January 15, 2011</td></tr>
<tr><td>Observations Findings Recommendations</td><td colspan="2">1. Financial Statement Review
a. Determine if financial statements are materially accurate, reliable, and supported by financial records of the NPIDF.
b. Tested financial transactions of NPIDF</td><td>Current Status</td><td>No Recommendations</td><td>Fiscal or Other Impact</td><td>Noted no material misstatements in the financial statements of NPIDF as of and for the fiscal year ended August 31,2010. Noted no material misstatements in the financial statements of NPIDF as of and for the fiscal year ended August 31,2010.</td></tr>
</table>

11:05 National Pediatric Infectious Disease Foundation FY 2010 AFR, continued

Observations Findings Recommendations	**2. Assisted in the NPIDF financial report consolidation into the AFR of the Medical Center as required by GASB** We provided financial information from NPIDF records to Fiscal Reports to consolidate the NPIDF financial statements into the Medical Center's AFR. The information provided included a reconciliation of the NPIDF disbursements (donations) to the Medical Center accounts. Additionally, the NPIDF financial statements and the NPIDF August 2010 bank statement were provided.	Current Status	No Recommendations	Fiscal or Other Impact	The NPIDF financial information has been properly included in the consolidated financial results of the Medical Center and has been properly reported on the Form 990 within the required timeline.

11:05 National Pediatric Infectious Disease Foundation FY 2010 AFR

Observations Findings Recommendations	**3. Assisted in the completion of the necessary forms to satisfy filing requirements of the Internal Revenue Service for Exempt Organizations** The NPIDF was terminated on August 2, 2010 with a certificate of termination filed and approved by the Office of the Secretary of State. We drafted the final Form 990 and corresponding schedules that are required for tax exempt organizations. The NPIDF was classified as a tax exempt organization under section 501 (c) 3 of the Internal Revenue Code. The information documented in the Form 990 and supplemental schedules includes the NPIDF purpose, its structure and general information regarding its financial transactions throughout the year. Several schedules are required to be prepared in accordance with the Form 990's instructions and include additional information such as the compensation of officers. The Form 990 and the corresponding schedules denoted above were filed by January 15, 2011.	Current Status	No Recommendations	Fiscal or Other Impact	The NPIDF financial information has been properly included in the consolidated financial results of the Medical Center and has been properly reported on the Form 990 within the required timeline.

11:06 Human Resources Benefits & Leave Management

Report Number	11:06	Report Date	04.12.11	Name of Report	Human Resources Benefits & Leave Management
High Level Audit Objective	The primary objective of this audit is to provide reasonable assurance that there are adequate and effective controls for Human Resources Benefits and Leave Administration to ensure the following: • Reliability and integrity of financial and operational information o Control environment is adequate to ensure the proper authorization, accuracy, and appropriate documentation of employee benefit transactions. o Adequate processes for tracking, recording, and approving leave balances reported to Human Resources (i.e., FLEA, FTBA, etc.). • Compliance with laws, regulations, and contracts o Employee benefits deductions/contributions are in compliance with each benefits plan's requirements, as well as with Federal and State regulations. o Employee leave (i.e., FMLA, LOA, VSL, etc.) is managed in compliance with UT System, and other applicable guidelines • Effectiveness and efficiency of operations • Policies and procedures related to the operations of Employee Benefits and WCI & Leave Administration are accurate, complete, and current				
	1. Absence of a Dependent Eligibility Documentation Process Internal Audit recommends the following: 1. Develop and document detailed desktop procedures to identify and collect dependent eligibility documentation and a time frame in which to provide it. The UT System Special Dependent Application Process, Policy 231 could serve as a guide. 2. Perform periodic reviews of the policy to ensure that it continues to meet UT System requirements.	Current Status	Fully Implemented	Fiscal or Other Impact	Dependent eligibility documentation process has been strengthened.

11:06 Human Resources Benefits & Leave Management

Observations Findings Recommendations	**2. Missing Special Dependent Documentation** Internal Audit recommends that HR seek resolution of the current exception noted and continue collection of required special dependent documentation during annual enrollment. Identify all employees receiving health benefits for special dependents. Review those employee's files to determine if all required documentation for special dependent eligibility is present. Notify any employees receiving special dependent benefits, but with missing required documentation, to meet documentation requirements of proof or face discontinuance of dependent health benefits.	Current Status	Fully Implemented	Fiscal or Other Impact	Special dependent documentation has been reviewed and resolved.
	3. Missing Required Voluntary Retirement Plan Documentation Internal Audit recommends the following: a. Develop a process for periodic review of 403 (b) participants' voluntary retirement files to identify which ones are missing TSA Disclosure forms. b. Develop a system for contacting employees whose TSA Disclosure forms are missing, obtaining signed forms from those employees, and tracking progress in obtaining the forms.	Current Status	Fully Implemented	Fiscal or Other Impact	A periodic review process has been implemented.

11:06 Human Resources Benefits & Leave Management, continued

Observations Findings Recommendations	**4. HRIS Contingency Related Documentation Noncurrent** HRIS should complete revision of their documentation to reflect changes for Media Control, Data Backup and Storage, and Contingency Planning. HRIS should then test the plans as specified in the Information Systems Administration Security Manual.	Current Status	Fully Implemented	Fiscal or Other Impact	HRIS contingency related documentation has been updated to address disaster recovery.

11:07 Buy Card Audit

Report Number	11:07	Report Date	09.30.11	Name of Report	Buy Card Audit		
High Level Audit Objective	The primary objective of this audit was to provide reasonable assurance that there are adequate and effective controls for the Buy Card Program to achieve its objectives. The audit measured the appropriateness, accuracy and compliance with purchasing guidelines.						
Observations Findings Recommendations	**Compliance with Guidelines** Examined purchase approval and management review processes, analyzed transactions and conducted on-site inspections.		Current Status	No Recommendations	Fiscal or Other Impact	Internal Controls are adequate and effective to provide reasonable assurance that Buy Card Program objectives are being achieved.	

11:08 Patient Payments at Time of Service

Report Number	11:08	Report Date	07.21.11	Name of Report	Patient Payments at Time of Service
High Level Audit Objective	The primary objective of this audit was to provide reasonable assurance that Ambulatory Operations and University Hospitals have adequate and effective controls in place to ensure the following: Reliability and integrity of financial and operational information • Ensure daily reconciliation of patient payments to daily patient encounters. Safeguarding of assets • Evaluate procedures for safeguarding cash from theft and misappropriation. Compliance with laws, regulations, and contracts • Ensure compliance with UTS 166 Cash Handling and Management procedures. • Ensure compliance with Medical Center Accounting & Fiscal Services, Cash Manual Effectiveness and efficiency of operations • Evaluate process for protecting patients' credit card/checking account information • Evaluate process for ensuring timely deposits				
Observations Findings Recommendations	**1. University Hospital Cash Handling** We recommend strict adherence to the UTS 166 and the Medical Center Cash Manual in the establishment of proper internal controls. These procedures should be consistent at all University Hospital locations.	Current Status	Fully Implemented	Fiscal or Other Impact	The Cash Manual has been updated and re-distributed to responsible parties.

11:08 Patient Payments at Time of Service, continued

Observations Findings Recommendations	**2. Cash Handling Training** We recommend that: a. Cash Management distribute the training module to the Associate Vice President for Physician and Clinic Financial Affairs and the University Hospitals Controller for manual assignment of Cash Manual training through the My Learning application to current cash handlers. b. Cash Management revise policies or procedures to include the following: i. The Associate Vice President for Physician and Clinic Financial Affairs and the University Hospitals Controller are responsible for ensuring all current and future cash handlers complete the required cash handling training on a yearly basis. ii. The Associate Vice President for Physician and Clinic Financial Affairs and the University Hospitals Controller are responsible for maintaining a record of all employees with cash handling responsibilities that includes the date of the Medical Center Cash Manual training. Furthermore, in the future, University Hospitals, Ambulatory Operations and Medical Center Accounting should work in conjunction with Information Resources to automate the assignment of Cash Manual training within the PeopleSoft My Learning application.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation of enhancements to controls over training will help ensure compliance with cash handling requirements.

11:08 Patient Payments at Time of Service, continued

Observations Findings Recommendations	**3. Cash Vault Reconciliation** We recommend development of a cash vault audit methodology that includes reconciling the contents of the St. Paul and Zale Lipshy cashier vaults against the daily reconciliations prepared by the cashiers on a periodic basis. Also, documentation of the audit should be maintained throughout the year as evidence of management's review.	Current Status	Fully Implemented	Fiscal or Other Impact	Cash vault reconciliation procedures have been improved. Patient Access Services has revised the policy and procedure to include unannounced cash counts of cash vaults.
	4. Change Fund Administration We recommend charge funds be issued by University Hospital Finance in the appropriate tamper proof cash bags to the individuals performing the cash handling responsibilities instead of the department managers. Individual cash bags should be issued with an identifier to assist University Hospital Finance with developing a random cash fund audit methodology, and implementing the methodology throughout the year. Furthermore, University Hospital Finance should reconcile all change fund accounts and resolve immediately any discrepancies noted between department and accounting records.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will enhance controls surrounding the change fund administration process.

11:12 Pathology Laboratory Information Systems

Report Number	11:12	Report Date	05.09.11	Name of Report	Pathology Laboratory Information Systems		
High Level Audit Objective	The audit objective was to assess the adequacy of the control design to mitigate risks related to information and charge capture across pathology information systems.						
Observations Findings Recommendations	**1. Chargemaster maintenance procedures are not adequate to ensure accuracy of codes, appropriate billing, and timely resolution of identified issues.** We recommend identification and documentation of all chargemaster issues resulting from the 2006 consulting review, Sunquest conversion, and existing issues. Documentation should also include an action plan and timeline which should be reported to Pathology executive management on a monthly basis for proper tracking and assurance of timely resolution. The Pathology Billing Compliance Plan should also be revised to reflect changes in chargemaster review procedures.			Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will enhance control design.

11:12 Pathology Laboratory Information Systems, continued

Observations Findings Recommendations	**2. Reconciliation of laboratory charges from order to billing is not performed on a comprehensive basis across pathology Information systems resulting in a risk of under-billing multiple laboratory services.** Reconciliation procedures should be developed and documented to ensure the accurate and complete capture of charges across various information systems. Given the nature of Pathology operations, consideration should be given to reconciliation at the laboratory level for review and approval. Reconciliation should be documented and enforced through establishment of charge reconciliation policies and procedures with approval by management. Furthermore, laboratory managers should be educated on appropriate charge reconciliation procedures.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will enhance control design.
	3. Billing errors identified by The Office of Billing Compliance have not been adequately resolved resulting in a risk of submitting incorrectly coded claims. We recommend prompt resolution of billing errors identified accompanied by a detailed action plan and timeline to be reported to Pathology executive management and the Billing Compliance Advisory Committee on a monthly basis. Coordination with Information Resources and the Billing Compliance Office should be performed to ensure errors and causes for errors are addressed.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will enhance control design.

11:12 Pathology Laboratory Information Systems, continued

Observations Findings Recommendations	**4. The Billing Middleware (BMW) access database lacks controls to ensure integrity and security of information critical to Pathology billing** We recommend the following to ensure the integrity and security of information: a. Implementation of security controls to prevent unauthorized access or alteration of programs and data. b. Implementation of program change controls and role-based access to appropriately segregate duties and ensure integrity of programs and data. c. System procedures should be documented detailing BMW design and data maintenance processes. Procures should be communicated to staff for their education and understanding of the BMW.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will enhance control design.
	5. Methods for reporting errors from the BMW error queue have not been established to resolve root causes and prevent recurrence of errors. We recommend the development of mechanisms to quantify and report errors to allow for comprehensive review and identification of root causes. Reports should be provided to management on a monthly basis for review and include action plans for timely resolution.		Incomplete/Ongoing		Implementation will enhance control design.

11:12 Pathology Laboratory Information Systems, continued

Observations Findings Recommendations	**6. Fee schedules in Epic Resolute are manually overridden to match client fee schedules maintained in the BMW without documented validation or review.** We recommend the documentation of validation and review of all manual entry of client fees and price overriding in Epic Resolute to ensure accuracy of client billing, supported by development of policies and procedures approved by Pathology management.	Current Status	Fully Implemented	Fiscal or Other Impact	Controls for review of manually overridden fee schedules in Epic Resolute have been strengthened.
	7. Reviews of accuracy and completeness for certain manual charges entered into Epic Resolute are not documented. We recommend establishment of processes to review and validate the accuracy and completeness of all manual charge entry, evidenced by documentation and approval by Pathology management.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will enhance control design.

11:12 Pathology Laboratory Information Systems, continued

Observations Findings Recommendations	**8. The various information systems used for specific laboratory operations lack controls to prevent unauthorized access and inappropriate program or data changes.** To enhance IT controls for the various laboratory information systems, the following is recommended: a. HistoTrac – Evaluation of software licensing requirements to ensure compliance and that user IDs are uniquely assigned to allow for proper tracking of user activity. Furthermore, processes should be established to communicate the termination of external users to appropriately remove access. b. FileMaker Pro – Implementation of a test environment to ensure appropriate segregation of duties in the change management process. c. Microsoft Access Database – At a minimum, movement of master files to a more secure location within the restricted drive, accessible only by those with absolute necessity for their assigned job duties.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Implementation will enhance control design.

11:13 Cardiovascular Interventional Radiology

Report Number	11:13	Report Date	02.09.11	Name of Report	Cardiovascular Interventional Radiology		
High Level Audit Objective	The audit objective is to assess the adequacy and effectiveness of controls and risk management for Cardiovascular Interventional Radiology revenue cycle operations and inventory processes to ensure the following: • Reliability and integrity of financial and operational information • Safeguarding of inventory • Effectiveness and efficiency of operations						
Observations Findings Recommendations	**1. Electrophysiology Catheter Recycling Processes** We recommend increased internal controls to ensure the accuracy and accountability of catheters purchased, used, returned for recycling or reprocessing. These processes and controls should include: 1. Increased management of catheter inventory, specifically the segregation of repurchasing responsibilities from physical inventory counts and recording of inventory adjustments. 2. Increased management oversight through development of reconciliation procedures to trace catheters purchased, used, returned and subsequently repurchased. 3. Accurate accounting for all rebate checks received.		Current Status	Fully Implemented	Fiscal or Other Impact	Controls over recycling have been strengthened.	

11:13 Cardiovascular Interventional Radiology, continued

Observations Findings Recommendations	4. Rerouting of rebate checks for delivery to the Purchasing Department as opposed to directly to the department. 5. Development of policies and procedures defining new recycling processes, requirements, and expectations. New policies and procedures should be communicated to all staff through formal documentation accompanied by training as necessary.	Current Status		Fiscal or Other Impact	
	2. Inventory – Segregation of Duties We recommend segregation between inventory and charge entry responsibilities accompanied by the development and documentation of monitoring activities to ensure that, on a reasonable basis, inventory deductions correlate to inventory used and to provide greater attestation to the accuracy of inventory reporting. Results of monitoring activities should be reported to management on a periodic basis and supported by written inventory management policies and procedures, communicated to staff with training as necessary.	Current Status	Fully Implemented	Fiscal or Other Impact	Segregation of duties over inventory has been enhanced.

11:13 Cardiovascular Interventional Radiology, continued

Observations Findings Recommendations	**3. Quarterly Inventory Adjustments** We recommend development of quarterly inventory policies and procedures to include documentation of reporting requirements and establishment of variance investigation and resolution procedures to provide assurance that inventory counts are accurate and adjustments are reasonable. Authority to adjust inventory should be limited to personnel with necessary access. Additionally, a reporting and approval structure should be established to ensure that all adjustments are properly reconciled and subsequently approved by management.	Current Status	Fully Implemented	Fiscal or Other Impact	Inventory policies have been strengthened.
	4. Monitoring of Charges We recommend management develop and document its monitoring methodologies to adequately cover risks associated with charge entry. Such methodologies should include defining the population, sample selection, frequency and criteria to effectively monitor technical and supply charges. Results should also be documented to provide evidence and support for reviews. Subsequently, results should be reported to management in order to effectively investigate root causes and implement effective resolution strategies. Revision to or development of new policies and procedures should be performed and approved by management.	Current Status	Fully Implemented	Fiscal or Other Impact	Charge reconciliation controls have been improved.

11:15 Texas Higher Education Coordinating Board (THECB) Medical and Graduate Medical Programs

Report Number	11:15	Report Date	02.08.11	Name of Report	THECB Medical and Graduate Medical Programs
High Level Audit Objective	Internal Audit (IA) performed the engagement to satisfy the audit requirements of the THECB and provide reasonable assurance that there are adequate and effective controls related to the administration of the Family Practice and Primary Care grants conducted in Dallas and Austin. The following audit objectives were identified: 1. Compliance a. Verify the residents identified within the grant were participants in the programs for the award year (FY 10). b. Determine if the reported Family Practice and Primary Care grant expenditures are in compliance with policies and procedures of the Medical Center, THECB grant guidelines and contract terms. c. Determine if the grant agreements between the residency programs and the THECB for FY10 had been properly executed by the required parties. d. Determine if Family Practice Residency Program is performing the required financial monitoring activities timely in accordance with the Family Practice Residency Program Guidelines. 2. Income and Expenditure Report Review – Determine if the financial reports provided by the Medical Center to the THECB represent accurate, complete, and timely information related to the grant. 3. Follow up on prior audit recommendations.				
Observations Findings Recommendations	Adequate and effective administrative controls exist over the Family Practice and Primary Care grants to provide assurance that program objectives are being achieved and the THECB requirements are being met.	Current Status	No Recommendations	Fiscal or Other Impact	Program objectives are being achieved and the THECB requirements are being met.

11:20 Information Security

Report Number	11:20	Report Date	05.18.11	Name of Report	Information Security		
High Level Audit Objective	Per UTS, the primary objective of this audit is to determine if the ISPI assessment accurately reflects the institution's strengths with regard to information security in the areas of foundation, practices and compliance.						
Observations Findings Recommendations	**1. Network segmentation/VLANs – Metric A-5.3** **2. PCI Data Security Compliance – Metric C-6** Scores reported are not accurate for two of the three specific metrics reviewed: A-5.3 Network Segmentation/Virtual Local Area Networks (VLANs), and C-6 Payment Card Industry Data Security Standard (PCI DSS) Compliance Status.		Current Status	Substantially Implemented	Fiscal or Other Impact	Ensure compliance with PCI requirements.	

11:21 Texas Administrative Code (TAC) 202 Compliance

Report Number	11:21	Report Date	03.11.11	Name of Report	Texas Administrative Code (TAC) 202 Compliance		
High Level Audit Objective	The primary objective of this audit is to provide reasonable assurance that the University of Texas Southwestern Medical Center at Dallas is in compliance with information security standards set forth in the Texas Administrative Code, Title 1 Administration, Part 10 Department of Information Resources, Chapter 202 Information Security Standards, Subchapter C Security Standards for Institutions of Higher Education.						
bservations Findings Recommendations	**1. Disaster Recovery Plan** a. Proceed with plans to obtain the key supporting information for critical systems. Revise and enhance the DRP where appropriate in consideration of the supporting information. b. Implement procedures to conduct a mock recovery exercise at the ARDC to test recovery of all critical systems supported by the Data Hall on an annual basis. c. Procedures should be implemented for an appropriate senior management committee to periodically, but at least annually, review and re-approve the "Critical Systems Recovery List" to ensure it is accurate and reflects all changes to the environment. Decisions as to system criticality and recovery priority can best be resolved by a steering committee comprised of designated executive management from the major operating divisions of the institution. There are currently three standing committees and one special project committee involved with IT decisions: the Clinical Information Services Steering Committee, the Information Security and Privacy Steering Committee, the Information Systems Acquisition Advisory Committee and the Administrative Systems Steering Committee. Due to the possible fragmentation in the focus of these committees,	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Ensure system recovery in event of disaster.	

11:21 Texas Administrative Code (TAC) 202 Compliance, continued

	management should consider whether a steering committee with an institution-wide IT focus and membership is needed to provide effective IT governance in this area. d. Obtain completed recovery plans from the system administrators for these four systems as soon as possible.	Current Status		Fiscal or Other Impact	
Observations Findings Recommendations	**2. Data Encryption and Data Leakage Protection** a. Configure the Zix SecureMail gateway to automatically encrypt all outbound email containing PI. b. Configure the Microsoft Exchange mail server to restrict auto-forwarding of email. c. The Information Security and Privacy Committee should re-visit and reassess the risk of potential data leakage this issue presents, particularly in light of the current environment and upcoming requirements for meaningful use certification, the PCI Data Security Standard, HIPPA, HiTech, and other state regulations. d. Enhance guidance posted on the UT Southwestern web page to address the appropriate security controls for iPads and other smart phones connecting to Medical Center email systems. At a minimum, these should include passwords or PINs (with strength requirements) to prevent access to stored information, as well as security software to enable users to remotely wipe the device if lost. Finally, enhance the "Information Security Agreement" or require users to sign a separate	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Enhance controls over data security.

11:21 Texas Administrative Code (TAC) 202 Compliance, continued

Observations Findings Recommendations	agreement acknowledging requirements for use of stated controls when connecting to UT Southwestern email systems with iPads and smart phones.	Current Status		Fiscal or Other Impact	
	3. Use of Production Data in the EPIC Test Environment Redact or de-identify the sensitive portions of the production data comprising patient records before using in a test environment.	Current Status	Fully Implemented	Fiscal or Other Impact	Testing procedures have been documented.
	4. Policy and Procedure Updates Review and revise policies to ensure compliance with TAC 202. Establish a schedule for review to ensure annual reviews and revisions of policies occur.	Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Ensure compliance with TAC 202.

11:22 Campus Wireless

Report Number	11:22	Report Date	08.16.11	Name of Report	Campus Wireless		
High Level Audit Objective	The audit objective was to assess the effectiveness of the Medical Center's wireless network access controls and related policies and procedures.						
Observations Findings Recommendations	**1. Wireless Policy, Training and Risk Awareness** Infrastructure Services should enhance training documentation. The Medical Center's Record Retention Schedule should be followed by maintaining the specified documentation of training completion. Internal Audit encourages management to utilize the PeopleSoft My Learning application as a tool to enhance training documentation.		Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Enhanced training documentation could help ensure compliance with wireless policy.	
	2. Wireless Architecture a. A recommendation was made regarding administration of the wireless controller. b. One recommendation was made regarding monitoring procedures.		Current Status	Incomplete/Ongoing	Fiscal or Other Impact	Strengthen security controls of the wireless network.	

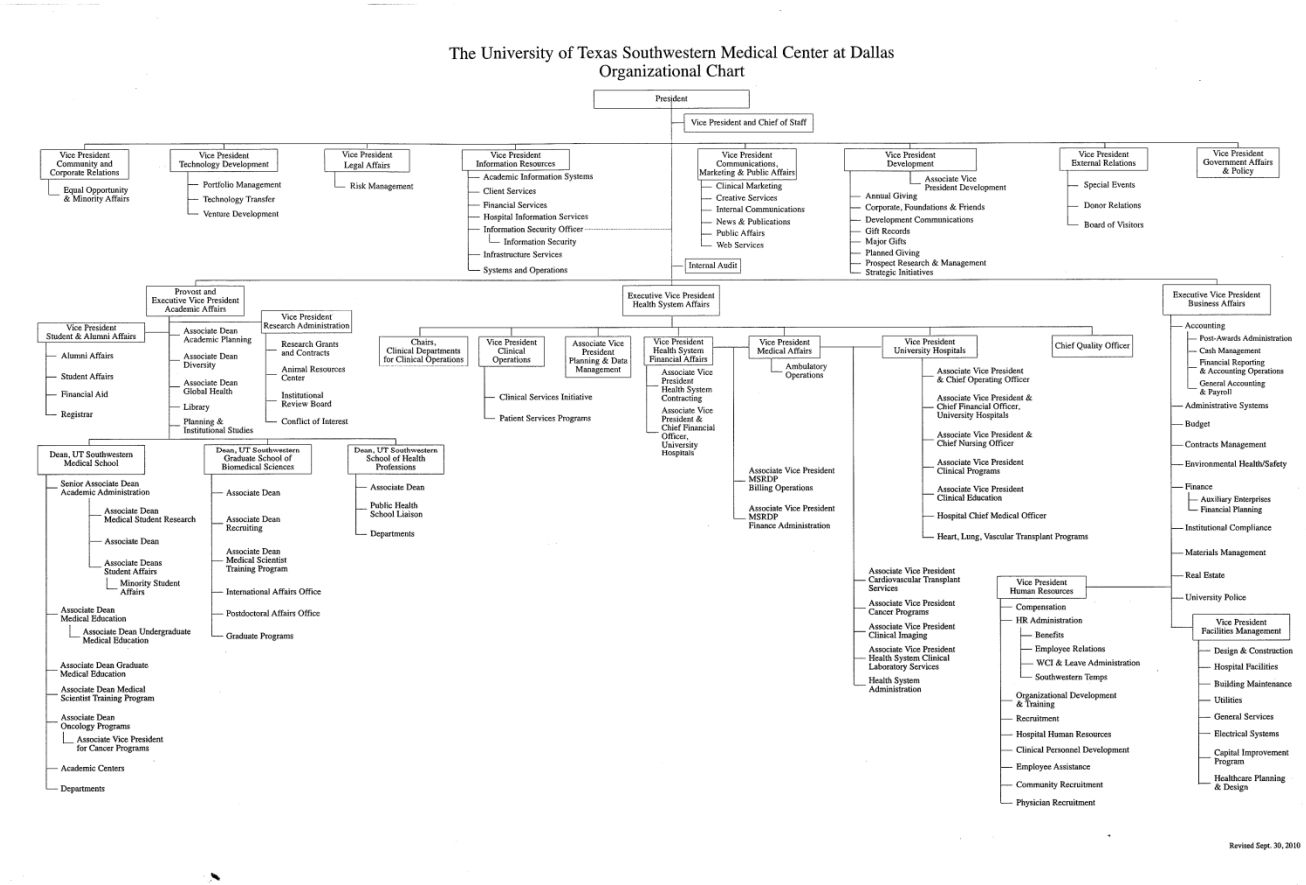
This marks the end for the List of Audits Completed for FY 2011.

IV. List of Consulting and Non-audit Services Completed

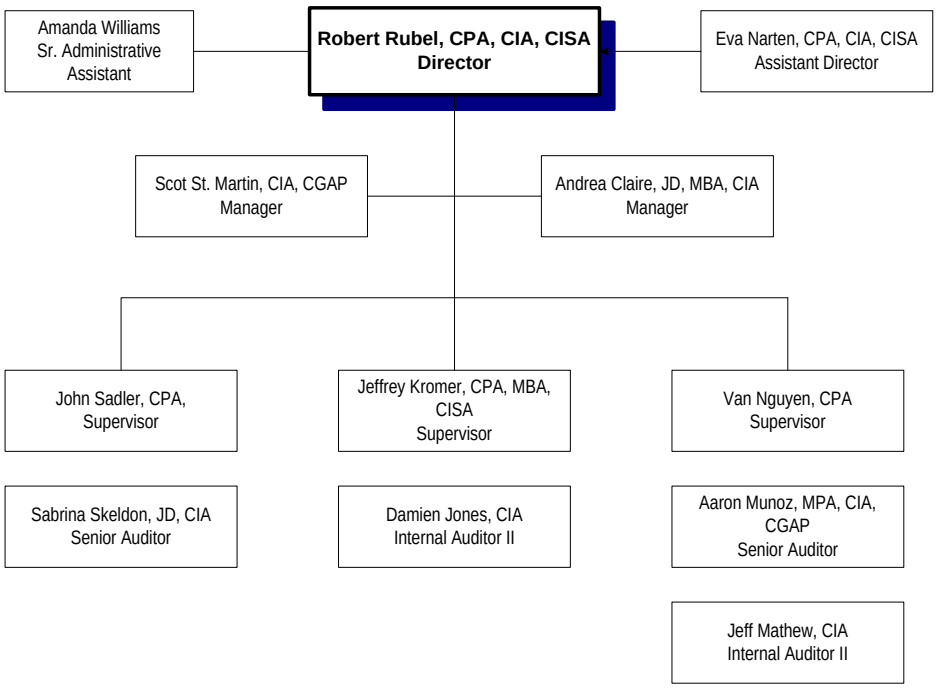
	[redacted]	[redacted]	[redacted]	[redacted]
High Level Audit Objective	N/A			

This marks the end for the List of Consulting and Non-audit Services Completed for FY 2011.

V. Organizational Charts



UT Southwestern Medical Center
Organization of the Office of Internal Audit
Effective 10/31/2011



11 staff
10 auditors

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

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.
Assisted Budget Office with review of LBB Performance Measures Data prior to reporting.	Provides review of information submitted for reporting performance measures information to LBB.
Assisted in assessing construction-related risks for the New University Hospital.	Provides assurance of control environment to address construction-related risks.
Conducted facilitated risk assessment workshops	Collaborates with Medical Center management to provide an enterprise risk management process for the Medical Center
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.
External Quality Assurance Reviews	Internal Audit Management participated in the following external quality assurance reviews for: • The University of Texas Health Science Center at San Antonio • American Heart Association
PeopleSoft Implementation	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 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 financial audit and Deloitte Financial Audit Interim Financial and IT support, the Deloitte Information Security Assessment and Effectiveness Review, UT System Medical Billing/MD Audit Guiding Principles Audit, and US Department of Health and Human Services Office of Inspector General - Review of Administrative and Clerical Costs at UT Southwestern Medical Center.
Assistance to External Audit Organizations	Provides assistance to Association of Healthcare Internal Auditors and the Institute of Internal Auditors and the Association of College and University Auditors.

VII. Internal Audit Plan for Fiscal Year 2012

UT Southwestern Medical Center

INSTITUTION TOTAL FY 2012 BUDGETED EXPENDITURE AMOUNT: $1.5 Billion

TOTAL NUMBER OF FY 2012 BUDGETED AUDITOR POSITIONS (GROSS OF VACANCIES) = 11

Fiscal Year 2012 Audit Plan

Audit/Project	Budgeted Priority Hours	% of Total
Financial Audits		
UT System Requested/Externally Required Audits		
FY2011 UTS Fin. Statement Audit - Financial/IT (YE) (Deloitte assistance)	650	
FY2012 UTS Fin. Statement Audit - Financial (Interim)	550	
Presidential Housing, Travel & Entertainment Expenses	200	
Financial Audits Subtotal	**1400**	**13%**
Operational Audits		
Risk Based Tier One Audits		
MSRDP - Contract Administration	500	
Risk Based Tier Two Audits		
Hazardous materials disposal and handling	500	
Change in Management Audits		
Business Office	150	
Accounting	150	
Carryforward Audits		
Misc.	100	
Operational Audits Subtotal	**1400**	**13%**
Compliance Audits		
UT System Requested/Externally Required Audits		
Assistance to the SAO (including A-133)	300	
Dependent Eligibility Audit	300	
THECB and Other Required Grant Audits	300	
UTS 155: Policies and Procedures Regarding Practice Plan Operations - FSP School of Health Professions and MSRDP	450	
Research Compliance	400	
FY 11 LBB Performance Measures	200	
Risk Based Tier One Audits		
HITECH funds compliance	400	
Risk Based Tier Two Audits		
Clinical Trials Billing	400	

Willed Body	300	
Reserve for Special Requests /Investigations	400	
Carryforward Audits		
Misc.	200	
Compliance Audits Subtotal	**3650**	**33%**
Information Technology Audits		
UT System Requested/Externally Required Audits		
Follow-up: Deloitte IT Security Review	300	
Risk Based Tier One Audits		
Epic security administration	400	
PeopleSoft Financials - post-implementation review of roles and responsibilities	300	
Consulting		
PeopleSoft Conversion	600	
Continuous Auditing	300	
Carryforward Audits		
Misc.	100	
Information Technology Audits Subtotal	**2000**	**18%**
Follow-up Audits	**750**	**7%**
Projects		
Quality Assurance Review (Internal/External)	600	
Requests for Information/Assistance	300	
Internal Audit Annual Report	100	
FY13 Annual Audit Plan & Risk Assessment	400	
Internal Audit Committee	400	
Projects Subtotal	**1800**	**16%**
Total Audit Plan Hours	**11000**	**100%**

Note: Total Hours should equal the total number of priority hours on Appendix A. The % should be 100%.

Explanation of High Risks Not Covered from Fiscal Year 2012 Audit Plan

High risk areas identified during the FY 2012 risk assessment have been mitigated or addressed with previous audit or compliance coverage.

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 FY2010 Federal A-133 Audit
- State Auditor's Office FY2010 Statewide Financial Audit & Follow-up
- Deloitte FY2011 - UT System Financial Audit - IT
- Deloitte FY2011 - UT System Financial Audit - Financial
- Deloitte Information Security Assessment and Effectiveness Review
- Medical Billing/MD Audit Guiding Principles Audit - UT System 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).