17-100 Division of Anesthesiology, Critical Care and Pain Medicine Review

EXECUTIVE SUMMARY

The Division of Anesthesiology, Critical Care and Pain Medicine provides state-of-the-art anesthesia care, pain management, and life support for cancer patients in intensive care units. Total hospital and gross patient revenue for the Division in fiscal year 2016 was approximately $271 million, with a margin of approximately $25 million. The purpose of this review was to provide a general assessment of key financial and administrative functions within the Division, its three departments and its research center.

In summary, we found that significant improvements in controls and processes are needed, including but not limited to the following:

- **Financial Management** – management should continue their efforts to reconcile patient revenues in a timely manner, along with the resolution of missed charges related to drug administration. Controls and processes over procurement cards need to be implemented to ensure that transactions are allowable, adequately supported, reconciled, reviewed timely, and to ensure that card numbers are secured and not shared inappropriately.

- **Asset management** – corrective actions are necessary related to reporting of missing assets, tagging of assets, completing offsite authorizations, performing external transfers and protecting information technology assets that contain sensitive data.

- **Personnel Management** – improvements are needed so that departmental approvals for Kronos time records are consistently performed, and to ensure proper approvals, accurate recording and tracking of extramural leave occur.

We also identified other less significant opportunities for improvement related to annual conferences, Chairman's fund expenditures, controlled substances, material transfer agreements, shared project costs and financial incentives.

Further details are outlined in the Detailed Observations section below.

Management's Summary Response:
Management agrees with the observations and recommendations and has developed action plans to be implemented on or before September 1, 2017.

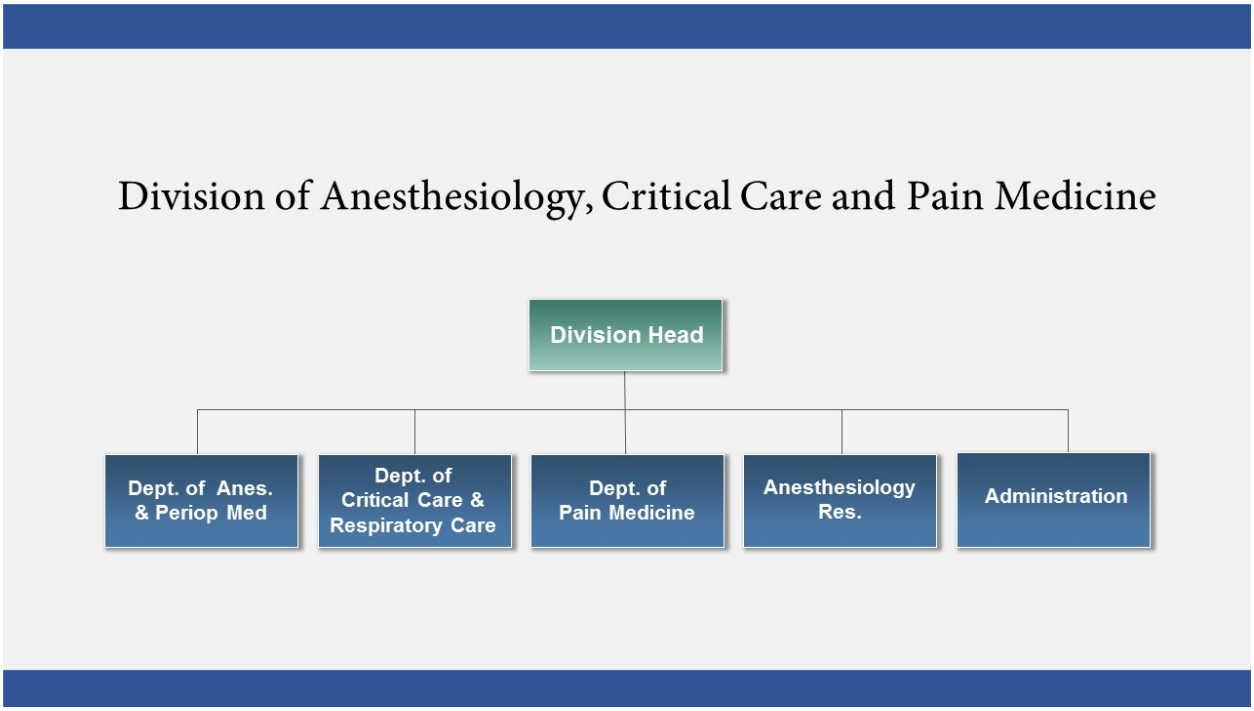
Appendix A outlines the methodology for this project.

The courtesy and cooperation extended by the personnel in the Division of Anesthesiology, Critical Care and Pain Medicine are sincerely appreciated.

Sherri Magnus

Sherri Magnus, CPA, CIA, CFE, CRMA
Vice President & Chief Audit Officer
March 17, 2017

BACKGROUND



The Division welcomed a new Division Head in October 2016, and in March 2017 will also have a new Division Administrator. For the audit period, the Division employed 393 full time equivalent (FTE) employees.The Division provides anesthesia services for 39 operating rooms and numerous other services in the out-of-Operating Room (OR) setting. For fiscal year 2016, this resulted in 38,628 OR anesthetics and 16,928 out-of-OR anesthetics. The Division provides medical staffing for the institution's 52 bed state-of-the-art combined Medical and Surgical intensive care units, respiratory care for the institution's patients, and acute and chronic pain services to our cancer patients and survivors.

FY 2016 Employee Data

Salary Plan	FTE
Administrative/Classified	293
Education	8
Faculty - Clinical	85.72
Faculty - Research	5.48
Total FTE	**393.05**

Source: Division of Anesthesiology, Critical Care & Pain Medicine

Research, another important activity for the Division, had total research expenditures for the period of approximately$5M. The Division ranked 18th[1] among all Departments of Anesthesiology in the United States in the amount of NIH funding received. In 2016, the Division's faculty and staff published over 80[1] articles in peer-reviewed journals.

[1] *As reported by the Division of Anesthesiology, Critical Care and Pain Medicine*

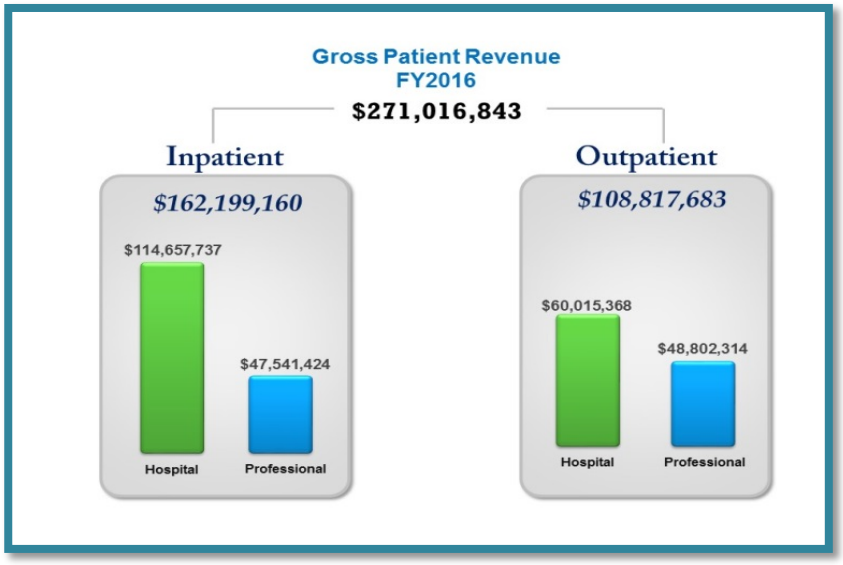
DETAILED OBSERVATIONS

Financial Management

Departments and Divisions are responsible for establishing appropriate controls over the Institution's financial resources. Key controls should include but are not limited to properly segregated duties, timely reconciliations for significant financial activities, adequate supporting documentation for transactions, and monitoring to ensure that transactions are accurate and complete.

Observation 1:

Perform Revenue Reconciliations Timely ***RANKING: Medium***



The Institution's Charge Submission and Reconciliation Policy requires that all professional and technical charges for services rendered be reconciled timely. Currently, the Division's charge capture processes need improvement to ensure this consistently occurs. In February 2017, the Division had recently completed the monthly reconciliation for September 2016, but none of the subsequent months have been reconciled. Given that gross patient revenues for fiscal year 2016 were $271 million, the reconciliation process is considered to be an important control for the Division.

When monthly reconciliations are not performed timely, there is an increased risk that patient revenue may be lost.

Recommendation:
Management should continue its efforts to bring the monthly revenue reconciliations up-to-date. In addition, management should implement a process to ensure that professional and technical charges are reconciled in a timely manner.

Management's Action Plan:
Responsible EVP: Thomas Buchholz, M.D.
Owner: Evangeline Austin/Juana Villarreal
Due Date: May 1, 2017

The Institution's Charge Submission and Reconciliation Policy requires that all professional and technical charges for services rendered be reconciled timely. The Division's charge capture processes for daily management are currently in place. As of February 2017, the Division completed September's reconciliation and management will ensure that all other months are reconciled by the due date below. A process has been implemented to ensure going forward that these reconciliations are completed by the designated due date (20th of each month).

Observation 2:
Improve Controls for Procurement Cards ***RANKING: Medium***

During the period September 2015 through August 2016, the Division's 19 procurement cardholders made 925 purchases totaling approximately $ 238,500. With such a high volume of cardholders (19 for the audit period, although subsequently reduced to 10) these risks are increased without sufficient monitoring in place. We reviewed $27,233 of the Division's procurement card transactions for the year and found the following:

- Two instances of card sharing between a cardholder and other employees
- Unallowable purchases in some instances (i.e. flowers for bereavement, online survey tool)
- Transactions with inadequate or missing supporting documentation, such as invoices
- Two instances where the full credit card number and three digit security code was included in supporting documentation
- Missing reconciliation packages for two cardholders
- Numerous instances of untimely review or no evidence of review of reconciliations
- Four transactions coded to the wrong general ledger account

Institutional guidelines require that purchases be allowable in conjunction with the fund type, have adequate supporting documentation and be coded to the correct general ledger account. Additionally, monthly reconciliations should be performed, documented and reviewed in a timely manner to ensure the proper expenditure of funds. When established guidelines are not followed, there is an increased risk of unallowable, unauthorized, or inappropriate purchases.

Recommendation:
Management should strengthen its controls over procurement cards as follows:

- Supervisory reviews should be enhanced to ensure that purchases are allowable, adequately supported and executed only by the authorized cardholder.
- Credit card numbers and security codes should be redacted in all relevant supporting documentation or excluded from support.
- A monitoring process should be implemented to ensure that reconciliations are performed, adequately documented and reviewed in a timely manner.
- A periodic review of the number of cards issued to Division and Department employees should be conducted to ensure all are properly monitored.
- Procurement card training should be provided to all cardholders.

Management's Action Plan:
Responsible Executive: Thomas Buchholz, M.D.
Owner: Ryan Thompson/Cindy Whittenberg
Due Date: April 1, 2017

- *On Monday, 2/13/2017, we implemented our process to ensure all ProCard expenses receive fund approval before the item(s) are charged to the ProCard. We are now using our Division's web-based PO request system to request ProCard purchases. The request is routed to the fund approver and then to the ProCard holder. There is a field for entering the chart field string that the charge will be allocated to during the reconciliation process. This will ensure the expense is transferred to the correct general ledger account. This was communicated in detail to all DACCPM admin support staff, including ProCard holders.*
- *ProCard holders have been reminded sharing ProCard is prohibited, no exception.*
- *We have reduced the number of Procard holders from 19 to 10.*
- *ProCard holders have been re-educated on reconciling every month even if there are not any transactions.*
- *Managers will review and reconcile transactions to ensure compliance with institutional policy.*
- *All signed reconciled documents must be uploaded by Procard holders to the division drive after all required signatures are completed on a monthly basis at the designated deadline (deadline set by Div. representative).*

Observation 3:
Continue Efforts to Resolve Missed Drug Charges ***RANKING: Medium***

During our review, management for the Department of Anesthesiology and Perioperative Medicine indicated that administration of the commonly used drug Propofol was not always being recorded correctly in the medical record after the implementation of OneConnect. Certain steps must be completed in OneConnect in order for a charge to occur. Specifically, when mixtures, time-based infusions and any other medication identified as an infusion are used, OneConnect is unable to determine how many packages were used to administer the medication. If New Bag is not selected, the patient will not be charged for subsequent new bags/vials/syringes. Total missed charges for Propofol and other 1-step drugs (mixtures/infusions) due to this issue were still being determined at the time of this report. Management is currently working with Pharmacy in monitoring these charges as well as education of staff.

Institutional policy requires that all charges be posted in an accurate and timely manner. When this does not occur, revenues may not be collected timely or may be lost.

Recommendation:
Department management should continue to coordinate with Pharmacy management to mitigate lost charges going forward. Department management should continue to educate staff on proper methods for recording administrations in the medical record. In addition, Pharmacy management should continue to monitor for potential lost charges and remediate errors timely.

Department Management's Action Plan:
Responsible EVP: Thomas Buchholz, M.D.
Owner: Ryan Thompson/Dr. Ken Sapire
Due Date: September 1, 2017

While the solutions to this workflow are not directly governed by anesthesia, we share the challenges along with Pharmacy. Education has occurred at faculty meetings and Grand Rounds for anesthesia providers on how to click "new bag" for every vial used per patient until a permanent solution is completed. Since the matter was first identified, we have seen a reduction in the amount of missed drug charges related to the new bag workflow. From Week 3 (11/28/16-12/04/16) to Week 13 (2/6/17-2/12/17) of monitoring missed drug charges, we have seen a 94% decrease. Management will continue to work with Pharmacy and the EPIC team to resolve revenue challenges related to these drug charges.

Pharmacy Management's Action Plan:
Responsible EVP: Thomas Buchholz, M.D.
Owner: Wendy Heck
Due Date: April 1, 2017

The Division of Pharmacy will continue to monitor possible missed charges and provide corrections if necessary. In addition, the Division of Pharmacy will collaborate with Anesthesia users to identify areas of focus for re-education or intervention.

Observation 4:
Secure Controlled Substances in MRI ***RANKING: Medium***

As previously noted during our 2013 risk assessment, controlled substances are sometimes left in unsecured locations or carried around by staff during their shift. Based upon our observations and discussions with Department of Anesthesiology and Perioperative Services management, this is still occurring within the MRI service area. Currently no Pixys machines are located in the area where these drugs could be stored and dispensed securely. As a result, the risks are increased that controlled substances may be lost or stolen when left unsecured.

Recommendation:
Department management should implement controls to safeguard controlled substances in the MRI area. This should include consideration of installing a Pixys machine so that the drugs could be stored and dispensed securely.

Management's Action Plan:
Responsible Executive: Thomas Buchholz, M.D.
Owner: Ryan Thompson/Gary Brydges
Due Date: September 1, 2017

Following extensive conversation between management and Pharmacy, a pyxis machine was installed in the MRI environment January 19th. A second pyxis machine was approved and Pharmacy is continuing to work on securing the contract. This will provide the necessary storage for drug trays in a secure location for both MRI suites.

Observation 5:
Strengthen Controls over Annual Conference ***RANKING: Low***

The Division's Department of Anesthesiology and Perioperative Services holds an annual Anesthesia Technology Conference at MD Anderson. The 2016 conference had an annual budget of approximately $12,000 and an average of 90 attendees. During our review, we noted the following opportunities for improvements related to the conference:

- Incompatible duties for registration fees (cash, checks, credit cards) including collection and deposit, recordkeeping and reconciliation are not adequately segregated among more than one employee. Conference registration fees totaled approximately $6,300.
- The manual registration process of collecting credit card information via the mail is not adequately secure to protect this information from unauthorized/inappropriate use and is therefore not compliant with Payment Card Industry (PCI) standards. Credit card payments represented 72% or approximately $4,500 in registration fees. While responsible employees indicated that credit card numbers were redacted after the cashier processed the transactions, our own observations indicated that the redaction was not being performed consistently.
- The Department has not obtained the required annual authorization by the Continuing Medical Education (CME) Advisory Committee and the Senior Vice President of Academic Affairs to sponsor the conference as required by policy ADM0148.

When duties are not adequately segregated, errors or irregularities may occur and go undetected. Additionally, when credit card information is not adequately secured as required, noncompliance with PCI standards and unauthorized use or theft may occur. Without the required annual authorization, a conference may not adhere to the institution's standards for CME.

Recommendation:
Department management should review the duties associated with the registration process and segregate them among more than one employee. In addition management should implement a more secure registration process so that credit card information is secure. Finally, management should request the required approval for the annual conference in accordance with policy.

Management's Action Plan:
Responsible Executive: Thomas Buchholz, M.D.
Owner: Ryan Thompson/Cindy Whittenberg
Due Date: July 1, 2017

- *Our corrective action will include creating an automated process for collecting all credit card information that will align us with Payment Card Industry (PCI) standards, including a process to securely redact credit card information received via mail or email.*
- *We have spoken with CME/Conference Management to assist with an electronic registration process.*
- *Additional education for impacted A&CC Admin Support employees has occurred surrounding segregation of duties and institutional policy. We are working towards creating a document that outlines the segregation of duties for these types of events. We must eliminate any irregularities and follow the agreed upon process.*
- *Reconciliation will occur with multiple layers to ensure oversight and transparency before submitting deposits.*
- *We will create our Departmental Policy that will be applied across Anesthesiology & PeriOp Med, Critical Care & Respiratory Care, and Pain Medicine.*

Observation 6:
Ensure Chairman Fund Expenditures Are Supported ***RANKING: Low***

At the request of Division management, we reviewed expenditures for the Division Head and Department Chairman's funds for compliance with fund guidelines. Results indicated the following:

- Eleven expenditures lacked a documented business purpose, and as a result we could not determine their allowability.
- Ten expenditures for meals (included in the above eleven) lacked documentation indicating the attendees.

When expenditures do not have adequate supporting documentation such as a documented business purpose or attendees, management has limited assurance that the expenditures were made to further the goals of the Division and the institution, or comply with applicable rules and regulations.

Recommendation:
Management should strengthen controls related to Chairman's funds to ensure that they are adequately supported, including a documented business purpose and attendees when applicable.

Management's Action Plan:
Responsible EVP: Thomas Buchholz, M.D.
Owners: Andrea Armstrong
Evangeline Austin
Brittan Sweetin
Ryan Thompson
Juana Villarreal
Cindy Whittenberg
Due Date: June 1, 2017

We will follow the below pre-approval process to ensure all Chair Fund Expenditures, specifically Business Entertainment and Employee Courtesies, include a business justification and list of proposed attendees/employees, before the items are ordered via CaterTrax or Resource One.

- *All Division of Anesthesiology, Critical Care and Pain Medicine (DACCPM) Business Entertainment and Employee Courtesy purchases will require management approval.*
  - *We will create a fillable pdf form that will be completed by the requestor and routed to the appropriate manager for approval. The form will include the business justification, list of attendees, if applicable, list of Employee Courtesy recipients, and the chart field string.*
  - *The manager will sign the form electronically and return it to the requestor.*
- *All DACCPM employees will use our web-based PO Request System for all Business Entertainment purchased via Resource One or CaterTrax and Employee Courtesies purchased via Resource One. The approved pdf form will be attached to the PO Request form and routed to the fund approver.*
- *The fund approver will be responsible for ensuring there is an adequate business justification and that the list of business entertainment attendees includes names, titles and institutional affiliations.*
  - *If there are 10 attendees or less, a list of names, titles and institutional affiliations will be provided;*
  - *If there are more than 10 attendees, a group function will be identified (i.e. committee name, task force, etc.).*
- *All admin support employees will be educated on the new process.*
- ***Caveat**: Research employees will not be required to submit their requests in the DACCPM PO Request System. They will complete the fillable pdf form and route it to their manager and fund approver if different from the manager.*

Asset Management

Each Division and its respective Departments are responsible for their capital and controlled assets throughout the property life cycle, including accounting and timely completion and accuracy of annual physical inventory. Each employee has the responsibility to use capital or controlled assets for state purposes only and to exercise reasonable care for its safekeeping. Information technology (IT) assets are used across the Institution to store and transmit sensitive, confidential data, so encryption and other security methods are critical in protecting this data against unauthorized use.

Observation 7:
Strengthen Asset Reporting, Tagging and Offsite Authorizations ***RANKING: Medium***

The Division had an inventory of 927 assets for the period. During our review, we noted multiple instances where asset controls should be strengthened:

- For the 32 missing assets identified during the fiscal year 2015 and 2016 inventories, no missing property forms were submitted to Materials Management.
- Of the assets noted as missing, 21 IT assets were not reported to the University of Texas Police Department or Information Security, as required by the Information Resources Security Manual. One was subsequently reported during the course of this review.
- One missing asset was not tagged as required by the Asset Control Manual. As a result, the equipment could not be scanned during the inventory process. The Division subsequently scanned the equipment during the course of this review.
- Offsite Authorization and Data Security agreements were not being consistently completed for assets remotely located.

When missing assets are not reported to the appropriate parties, necessary actions cannot be taken, including steps to mitigate the risks of inappropriate use of the computer's data, including protected health information (PHI). Additionally, when offsite agreements are not prepared and authorized, the Division's property officer may not be aware when property has been taken offsite or whether PHI is at risk.

Recommendation:
Management should strengthen controls related to asset reporting, so that all appropriate departments are notified of missing assets when identified. Additionally, controls should be established to ensure that assets are tagged as required. Finally, a process should be implemented to ensure that all offsite agreements are prepared and authorized annually as required.

Management's Action Plan:
Responsible Executive: Thomas Buchholz, M.D.
Owner: Juana Villarreal
Due Date: May 1, 2017

As part of our current process, the status of the inventory for each department is communicated to each property officers. In addition all Property officers are notified whenever an item is determined to be missing, this notification comes prior to the items formally being reported to the institution.

The division will reinstitute Asset Inventory Committee, this committee is made up of the Property Administrator, Property Officers and Department Inventory Representatives. This committee will organize the inventory effort across our division so that each department will have increased visibility on all aspects of the inventory process. As part of the committee each department representative will be fully trained on all the requirements of inventory, this includes but is not limited to; Scanning, Offsite Agreements, and the Missing Property Process. Along with the division inventory ordination each member of the committee will be required to take the Property Network Training provided by Asset Management.

In order to ensure that all items are tagged appropriately, division procurement staff will inspect each asset that is delivered to the division (previously done by IT). During this inspection they will verify that the device is tagged according to the institutions guidelines. In order to ensure that devices remain tagged properly we will institute a quarterly asset scan, this will provide an opportunity to not only verify proper tagging but also the assets location.

Observation 8:
Mitigate Risks Related to Transferred IT Assets ***RANKING: Medium***

The Institution's Asset Control Manual indicates that property is eligible for transfer to another State of Texas agency only when the property is no longer of use to the department. When computer assets are transferred, these should "wiped"[2] of all data before a transfer is made.

During our review, we found that three computer assets were transferred to another state agency in the custody of a former employee. While a completed property transfer form was on file in the department, the following gaps in the process occurred:

- Email communications indicate that the transfer was discussed with Materials Management at the time, but they did not have the transfer form on file. As a result, the inventory records did not reflect the transfer.
- No evidence was found to indicate that the computer assets were "wiped" prior to the transfer. We were unable to determine if sensitive data existed on the assets prior to the transfer.

[2] **Wiped** – computer's contents including files and data are completely erased from the hardware.

We confirmed with the state agency's internal auditor that the assets are on-site as indicated. When computer assets are transferred outside of the institution without following the proper procedures, necessary actions cannot be taken, including making the necessary changes to the inventory records and steps to mitigate the risks of inappropriate exposure or use of the assets' data.

Recommendation:
The Division should work with Institutional Compliance and Materials Management to determine the best approach in mitigating the risks associated with these assets and any data they hold. Immediate action should then be taken to resolve this matter.

Management's Action Plan:
Responsible Executive: Thomas Buchholz, M.D.
Owner: Juana Villarreal
Due Date: May 1, 2017

Observation states that Materials Management was contacted regarding the transfer of equipment to another state institution, it is also stated that no evidence was found to indicate that the computer assets were "wiped" prior to the transfer. There is no instructions in the Asset Management Policy that speak to the need to have a device "wiped" prior to it being transferred to another UT system component. At no point in our discussions with Materials Management were we instructed that the devices in questions needed to be "wiped".

In order to prevent this type of issue for occurring in the future, we will follow the institutional policy that states that an employee leaving the institution must check out with his/her one up. During this check out the one up will be responsible for verifying that the proper steps have been followed regarding the return or transfer on computer equipment.

If an employee is wanting to transfer any equipment internally or externally to another UT component they must receive approval from the Property Administrator, Property Officer and their Manager.

Observation 9:
Ensure Computers and Mobile Devices are Encrypted ***RANKING: Medium***

The Information Resources Security Operations Manual requires the protection of desktops, laptops, and mobile computing devices that view or store confidential information. We identified four computers and numerous mobile devices that did not contain sufficient protective measures. Without these device management protections, sensitive information could be accessible to unauthorized individuals.

Recommendation:
Management should coordinate with the Information Technology department to ensure all computers and mobile devices are protected.

Management's Action Plan:
Responsible Executive: Thomas Buchholz, M.D.
Owner: Juana Villarreal
Due Date: September 1, 2017

The responsibility to ensure that equipment is encrypted is that of Information Security. It is our viewpoint that no device should be delivered to our division without being properly encrypted before delivery. Going forward we would like to see an improved process from IS and IT to stop unencrypted devices from reaching the users in our division.

Our division will coordinate with IS and IT to ensure that all devices currently in use by our division have the proper encryption. Going forward we will regularly review the asset encryption reports that have been made available to us. Our recommendation on the frequency that these reports are reviewed is monthly, however we will defer to the recommendations of IS.

Personnel Management

Effective personnel management includes, but is not limited to, the accurate recording of faculty extramural leave and the timely approval of employee time records, including leave taken.

Observation 10:
Improve Extramural Leave Administration ***RANKING: Medium***

Extramural leave is granted annually to eligible faculty members to pursue outside professional activities or interests with or without personal financial gain. This leave may not exceed 30 working days in any fiscal year, without prior approval from the Provost, and must be recorded in Kronos. During our review, we noted the following opportunities for improvement in managing extramural leave:

- The process for approving extramural leave requests delegated approval of requests to a designated faculty member instead of the Chair, as required by Institutional Policy ACA 0051.
- 17 extramural leave days, utilized by various faculty, were not recorded in Kronos.
- Extramural leave was not consistently requested and approved via the agreed upon departmental method (paper form, OpenTempo, Lotus Notes), resulting in six trips that lacked approval documentation.
- Extramural leave was incorrectly calculated to include two days before and after business began, rather than the allowed one day before and after, resulting in six unrecorded Paid Time Off (PTO) days.
- Due to an unrecorded extramural day identified in Concur, one faculty member exceeded the allowable 30 day limit by one day, without prior approval.

When extramural leave is not managed properly, leave balances may be incorrect and the 30-day extramural limit may be exceeded.

Recommendation:
The Division should improve the administration of extramural leave. This should follow the approval process so that faculty leave is approved by the department chair as required. In addition, controls should be established to ensure that all extramural leave complies with institutional policies and is recorded in Kronos as well as the supporting leave records. Finally, the Division should coordinate with Human Resources to ensure that the six unrecorded PTO days are applied to the leave balances of the applicable faculty members.

Management's Action Plan:
Responsible Executive: Ethan Dmitrovsky, M.D.
Owner: Ryan Thompson/Cindy Whittenberg
Due Date: May 1, 2017

Anesthesiology Process:

- *To ensure appropriate approval from the Dept. Chair for all extramural leave, an email approval from Dr. Rahlfs will occur before any actions are entered into Concur. Documentation will include business justification of event, brochure, and meeting dates. The approval documentation and approval will be added to the Concur documentation. Dr. Lim will continue to post PTO and EXT in Open Tempo. This will facilitate clinical coverage is met. Only Dr. Rahlfs' approval will start the official extramural leave process.*
- *Administrative staff have been reeducated on the extramural leave policy surrounding travel days for international travel to ensure the one day before and after extramural leave is accurate. Faculty will receive additional education at the upcoming faculty meeting. This will be a continuous process as new providers and staff are hired.*
- *Kronos Corrections will be submitted.*

Critical Care Process:

- *Faculty emails Dr. Price and requests EXT. The email includes meetings dates, meeting brochure and business justification.*
- *Chair approves or denies via email.*
- *Chair approves EXT request in myHr Calendar (I am working with myHR to add Dr. Karen Chen and me as approvers for 203100 [Critical Care]). Dr. Price will continue to approve in the meantime.*
- *The approval email is saved as a pdf file and uploaded to the Concur Travel Authorization along with the meeting brochure.*
- *Kronos Corrections will be submitted.*

Observation 11:
Approve Timecards in a Timely Manner ***RANKING: Low***

Institutional Policy requires department managers to review and approve employee timecards weekly in Kronos. On average, the Division and its Departments have 430 employee timecards to approve each week. We reviewed timecard approvals for five randomly-selected weeks in fiscal year 2016 and found that approvals did not always occur by the required deadline As a result, 272 timecards were not approved by the departments during our sample weeks. When timecards lack management's review, it increases the risk that timecard errors may not be identified and corrected timely.

Recommendation:
Management should enhance controls to ensure that employee timecards are reviewed and approved in a timely manner.

Management's Action Plan:
Responsible Executive: Thomas Buchholz, M.D.
Owners: Tom Sachdev
Brittan Sweetin
Ryan Thompson
Juana Villarreal
Cindy Whittenberg
Due Date: May 1, 2017

- *We have created a spreadsheet identifying all designated time approvers.*
- *All timecards will be approved by 11:59PM every Tuesday, unless Kronos Security grants an extension for an institutional holiday, inclement weather, etc.*
- *We have created an overlap in approvers to ensure consistent approval of all time. If the primary approver is absent, the back-up approver will manage this process.*

Grants Management

Grants management relates to the administrative tasks required to comply with the financial, reporting, and program requirements of federal, state, and private sponsors, as well as institutional policies. It includes, but is not limited to, effort reporting, progress and financial reporting, material transfer agreements, shared cost allocations, and financial incentives for participants.

Observation 12:
Ensure Material Transfer Agreements Are In Place ***RANKING: Low***

Material transfer agreements (MTAs) are contracts between a provider and recipient which define the terms related to the transfer of research materials. The Division did not have an MTA in place for mouse skin samples sent to an out of state collaborator. Institutional policy requires an approved MTA to be in place prior to shipment of research materials. An MTA is necessary to ensure the institution's intellectual property rights are protected.

Recommendation:
The Division should ensure that MTAs are in place for all research materials transferred to and from the Institution, as required by policy.

Management's Action Plan:
Responsible Executive: Ethan Dmitrovsky, M.D.
Owner: Brittan Sweetin
Due Date: April 1, 2017

In order to prevent this occurrence from happening again, all MTA contracts have been moved to a central location in the Research Admin shared folder. All faculty and staff working with MTAs have been reminded that contract and proof of receipt/submission of material is required for each contract and to be kept in the central folder.

Observation 13:
Allocate Costs Shared by Projects ***RANKING: Low***

Commonly used lab supplies such as gloves and sodium chloride in a shared lab are not allocated to the related grants based on usage. Federal regulations require that such costs be allocated to a project in proportion to the associated activities, as required by federal regulations. When costs are not allocated accordingly, federal projects may incur costs not associated with the project.

Recommendation:
Management should develop and implement a reasonable cost allocation methodology for shared lab supplies.

Management's Action Plan:
Responsible Executive: Ethan Dmitrovsky, M.D.
Owner: Brittan Sweetin
Due Date: April 1, 2017

In general, this is a difficult area for labs and administrative personnel to manage and the Institutional compliance team has initiated a project to look at "shared allowability to look into other measures on how to meet the federal requirements. We will be compliant with the outcomes recommended by this group. Until that outcome is reached we will mitigate this risk in the following manner:

- *Consumable supplies such gloves, pipette tips, kim wipes, etc will be charged to the laboratory research funding model (LRFM) chartfield string and no longer charged to individual grants as is financially feasible.*
- *Common reagents - it is very difficult to determine usage of common reagents (ex. sodium chloride, acids, bases, etc) as these are purchased in bulk at a reduced rate and sharing across projects to help reduce product waste due to expiration dates. In order to mitigate this risk, replacement products will be purchased by the project estimated to use a majority of the product. This determination will be made by the Lab PI and laboratory staff. If financially feasible, expense transfers for commonly used reagents may be moved from grants to the LRFM close to the end of the fiscal year.*

Observation 14:
Implement Controls over Financial Incentives ***RANKING: Low***

Parking vouchers are provided as financial incentives to clinical trial participants when they visit the hospital. During the audit, we reviewed the controls surrounding these incentives. While we found that patient affidavits for valet parking are completed when the vouchers are distributed, the following issues were noted:

- Reconciliations between vouchers purchased, distributed, and on hand are not performed,
- Parking validation logs do not contain sufficient information to enable tracking, and
- Tasks associated with the vouchers reside with a single employee, and are not properly segregated.

We were unable to determine total of the vouchers that had been purchased or what the actual balance of vouchers should have been due to the lack of documentation. The balance on hand at the time of the audit was considered immaterial.

Ineffective controls over parking vouchers could result in loss, theft, or non-compliance with grant requirements.

Recommendation:
The Division should establish controls to ensure that vouchers are properly tracked, logs contain sufficient information to enable tracking, reconciliations are performed, and tasks are properly segregated among more than one employee.

Management's Action Plan:
Responsible Executive: Ethan Dmitrovsky, M.D.
Owner: Brittan Sweetin
Due Date: April 1, 2017

Controls have been established to ensure parking vouchers and balance of vouchers are fully documented and kept in a locked compartment. An inventory record for Vouchers received has been created and tracking numbers have been assigned to each voucher in order to track them more accurately. Additionally, the log for recording voucher distribution has been updated to include the voucher tracking number. Voucher logs and inventory will be randomly reviewed and reconciled by the Research Manager. Documentation of reconciliation and amount of remaining vouchers will be recorded in the inventory log.

Appendix A

Objective, Scope and Methodology:
The objective of this review was to provide a general assessment of the financial, administrative, and compliance controls within the Division and its Departments. Testing periods varied based upon the area or process reviewed; however, all selected transactions occurred between September 2015 and August 2016.

Our methodology included the following procedures:

- Interviewed key personnel and reviewed relevant organizational policies to understand financial and administrative processes within the Division and its Departments.
- Reviewed relevant documentation and conducted interviews to assess the Division's processes for ensuring accurate posting and timely reconciliation of professional and technical charges
- Reviewed grant administration processes related to effort reporting and certification; allowable expenditures; cost allocation; subrecipient monitoring; timely progress reports; and use of material transfer agreements
- Reviewed documentation to ensure proper invoicing for clinical trials
- Tested cash receipts for supporting documentation, segregation of duties, and timely deposit
- Reviewed the results of the Division's 2015 and 2016 physical inventories and assessed processes and controls over missing assets
- Reviewed IT assets reported as non-encrypted and validated current status
- Tested procurement card transactions and reconciliations for compliance with institutional guidelines
- Tested expenditures of Division Head and Chairman's funds for allowability and appropriateness
- Reviewed documentation to ensure required monthly certification of selected expenditure, payroll expense reviews, and reconciliation of grant accounts
- Reviewed grant and non-grant account activity to determine whether deficit balances were properly resolved
- Examined timekeeping and leave records to determine if institutional leave management guidelines were followed
- Reviewed user access lists and current HR data files to ensure OneConnect access was disabled for terminated employees

Our internal audit was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing* and *Government Auditing Standards*.

Number of Priority Findings to be monitored by UT System: None

A Priority Finding is defined as "*an issue identified by an internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.*"