Fiscal Year 2023 Internal Audit Annual Report

INTERNAL AUDIT DEPARTMENT
3900 UNIVERSITY BOULEVARD
TYLER, TEXAS 75799

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Purpose of the Internal Audit Annual Report

The purpose of this Internal Audit Annual Report is to provide information on the assurance services, consulting services, and other activities of the internal audit function. In addition, the annual report assists oversight agencies in their planning and coordination efforts. The Texas Internal Auditing Act, (Texas Government Code, Chapter 2102), requires that an annual report on internal audit activity be filed by November 1st of each year and submitted to the Governor, the Legislative Budget Board, the State Auditor's Office (SAO), and the entities' governing boards and chief executives. The report was prepared using the guidelines provided by the Texas State Auditor's Office. Additional information regarding The University of Texas at Tyler (UT Tyler) Internal Audit Department (IAD) can be found at the following website: http://www.uttyler.edu/internalaudit/.

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

Texas Government Code, Section 2102.015, requires state agencies and higher education institutions, as defined in the statute, to post certain information on their websites. Below is a summary of the provisions of that statute.

Within 30 days of approval, an entity should post the following information on its website:

- The approved fiscal year (FY) 2024 audit plan, as required by Texas Government Code, Section 2102.008
- The FY 2023 internal audit annual report, as required by Texas Government Code, Section 2102.009

The above reports are considered to be approved if they are approved by an entity's governing board or by the chief executive if the entity does not have a governing board.

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

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

Texas Government Code, Section 2102.015, also specifies that an entity "is not required to post information contained in the agency's internal audit plan or annual report if the information is excepted from public disclosure under Chapter 552 [of the Texas Government Code]."

The UT Tyler IAD complies with these requirements by posting the Fiscal Year (FY) 2023 Internal Audit Annual Report, FY 2024 Annual Audit Plan, and other audit information on its website at https://www.uttyler.edu/internal-audit/reports/ and https://www.uthct.edu/reports-to-the-state/. Each periodic internal audit report is submitted as required throughout the year.

Texas Government Code Section, 2102.015:
A summary table of audit report recommendations is included on the following pages to fulfill Texas Government Code Section, 2102.015 website posting requirements.

Reference Exhibit B: FY 2023 Audits - Summary of Issues and Current Status

II. Internal Audit Plan for Fiscal Year 2023

FY 2023 Audit Plan	Project No.	Original Budget	Budget Adjustments	Revised Budget	Actual Hours Through 8/31/23	Remaining Budgeted Hours	Status
Assurance Engagements							
Controlled Substance Agreements Audit	23-1	500.0	0.0	500.0	383.50	116.50	Exit Conference Completed - Awaiting Management Responses
Epic User Access Audit	23-2	500.0	0.0	500.0	542.95	-42.95	Completed
University Advancement Endowment Distributions Audit	23-3	500.0	0.0	500.0	495.25	4.75	Completed
Procurement Card Audit	23-4	450.0	0.0	450.0	457.25	-7.25	Completed
Incident Detection and Response Audit (Post-Incident and Response Health Check Review)	23-5	400.0	0.0	400.0	394.50	5.50	Exit Conference Completed - Awaiting Management Responses
Research Time & Effort Audit Carry-Forward	22-03CF	0.0	50.0	50.0	245.50	-195.50	Completed
Medical Devices Audit Carry-Forward	22-05CF	0.0	20.0	20.0	19.25	0.75	Completed
Nursing Shortage Reduction Program Audit Carry Forward	22-21CF	0.0	20.0	20.0	31.50	-11.50	Completed
Assurance Engagements Subtotal		**2,350.0**	**90.0**	**2,440.0**	**2,569.70**	**-129.70**	
Advisory and Consulting Engagements							
Consulting and Advisory Services, Executive Meetings, Meetings with Management, and Specific Management Requests related to Emerging Risks	23-6	450.0	-300.0	150.0	233.50	-83.50	Budget adjustment for addition of projects 23-22 and 23-23. Completed.
Institutional Committees, Workgroups, Trainings, and Meetings	23-7	400.0	0.0	400.0	556.45	-156.45	Completed
Consulting and Advisory Services related to any IT/IS Integration Efforts, as needed	23-8	400.0	-325.0	75.0	28.25	46.75	Budget adjustment for addition of projects 23-21 and 23-25 and additional hours for requested increased scope for project 23-9. Completed.
UTHSCT Clinical Operations Management Agreement (COMA)	23-9	100.0	50.0	150.0	140.50	9.50	Completed
Data Analytics Program	23-10	250.0	0.0	250.0	184.25	65.75	Completed
Grant Expenditure Procedure Review	23-11	150.0	0.0	150.0	154.75	-4.75	Completed
University Advancement Endowment Balances Review	23-12	200.0	0.0	200.0	216.00	-16.00	Completed
Cowan Center Review	23-13	200.0	0.0	200.0	134.00	66.00	Completed
Discovery Science Place Review	23-14	150.0	0.0	150.0	82.75	67.25	Completed
Meditract Contract Management Review	23-21	0.0	150.0	150.0	122.00	28.00	Completed
Check Deposit Process Review	23-22	0.0	150.0	150.0	114.50	35.50	Completed
Budget Override Consulting Review	23-23	0.0	150.0	150.0	156.60	-6.60	Completed
CPRIT Consulting Review (ACP)	23-24	0.0	300.0	300.0	290.50	9.50	Completed
CPRIT Phase II Consulting Services	23-25	0.0	125.0	125.0	122.50	2.50	Completed
Advisory and Consulting Engagements Subtotal		**2,300.0**	**300.0**	**2,600.0**	**2,536.55**	**63.45**	
Required Engagements							
State Institution of Higher Education Contracting Assessment	23-15	40.0	0.0	40.0	25.25	14.75	Completed
Family Medicine Residency Program Grant Audit FYE 8/31/2022	23-16	100.0	0.0	100.0	96.75	3.25	Completed
Financial Statement Audit Assistance	23-17	40.0	0.0	40.0	0.00	40.00	Completed - *Internal Audit Department Hours Not Requested
CPRIT Grant External Audit (assistance to management)	23-18	30.0	0.0	30.0	0.00	30.00	CPRIT Grant External Audit Completed - *Internal Audit Department Hours Not Requested
Required Engagements Subtotal		**210.0**	**0.0**	**210.0**	**122.00**	**88.00**	

The University of Texas at Tyler
Internal Audit Department
Internal Audit Annual Report for Fiscal Year Ended August 31, 2023

FY 2023 Audit Plan	Project No.	Original Budget	Budget Adjustments	Revised Budget	Actual Hours Through 8/31/23	Remaining Budgeted Hours	Status
Investigations							
Investigations	23-19	200.0	-40.0	160.0	140.00	20.00	Budget adjustment for addition of project 23-24. Completed
Investigations Subtotal		**200.0**	**(40.0)**	**160.0**	**140.00**	**20.00**	
Reserve							
Reserve for Ad-Hoc Engagements	TBD	350.0	-350.0	0.0	0.00	0.00	Budget adjustment is for carryforward of projects 22-05CF, 22-21CF, 22-03CF, and the addition of project 23-24. Completed
Reserve Subtotal		**350.0**	**(350.0)**	**0.0**	**0.00**	**0.00**	
Follow-Up							
Implementation Status Tracking	23-20	300.0	0.0	300.0	310.25	-10.25	Completed
Follow-Up Subtotal		**300.0**	**0.0**	**300.0**	**310.25**	**-10.25**	
Development - Operations							
Annual Risk Assessment and Audit Plan		400.0	0.0	400.0	361.75	38.25	Completed
Institutional Audit Committee		450.0	0.0	450.0	484.20	-34.20	Completed
Quality Initiatives		450.0	0.0	450.0	550.40	-100.40	2022 Self-Assessment Completed 2023 EQA Self-Assessment Completed
External Reporting/Requests		200.0	0.0	200.0	177.25	22.75	Completed
Audit Management Software, IT Support, and Website Maintenance		200.0	0.0	200.0	258.75	-58.75	Completed
Staff Meetings		350.0	0.0	350.0	390.95	-40.95	Completed
CAE Update/Collaborative Meetings		140.0	0.0	140.0	107.75	32.25	Completed
Development - Operations Subtotal		**2,190.0**	**0.0**	**2,190.0**	**2,331.05**	**-141.05**	
Development - Initiatives and Education							
System Audit Office Initiatives		250.0	0.0	250.0	249.35	0.65	Completed
Professional Organization/Association Participation		300.0	0.0	300.0	306.00	-6.00	Completed
Individual Continuing Professional Education (CPE)		350.0	0.0	350.0	353.25	-3.25	Completed
Audit Software Implementation		100.0	0.0	100.0	5.50	94.50	Implementation Date Moved to 2024
Development - Initiatives and Education Subtotal		**1,000.0**	**0.0**	**1,000.0**	**914.10**	**85.90**	
Total Budgeted Hours		**8,900.0**	**0.0**	**8,900.0**	**8,923.65**	**-23.65**	

Benefits Proportionality Audit Requirements:

Rider 8, page III-50, the General Appropriations Act (87th Legislature, Conference Committee Report), requires that higher education institutions conduct an internal audit of benefits proportional by fund, using a methodology prescribed by the State Auditor's Office. The rider requires that the audit examine FY 2019 through 2021 and be completed no later than August 31, 2022.

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

Senate Bill 20 / Texas Education Code, Section 51.9337:

Senate Bill 20 (84th Legislative Session) made several modifications and additions to Texas Government Code (TGC) and Texas Education Code (TEC) related to purchasing and contracting. Effective September 1, 2015, TEC §51.9337 requires that, "*The chief auditor of an institution of higher education shall annually assess whether the institution has adopted the rules and policies required by this section and shall submit a report of findings to the state auditor*." IAD conducted this required assessment for FY 2023 and found the following:

> Based on review of current Institutional policies and procedures, UT System policies and procedures, and the UT System Board of Regents' *Rules and Regulations*, UT Tyler has generally adopted all the rules and policies required by TEC §51.9337. Review and revision of these policies is an ongoing process. These rules and policies will continue to be assessed annually to ensure continued compliance with TEC §51.9337.

III. Consulting Services and Nonaudit Services Completed

Report Date	Report Title	High-Level Objective	Results
No Formal Report	Consulting and Advisory Services, Executive Meetings, Meetings with Management, and Specific Management Requests related to Emerging Risks	To participate in an advisory role on Executive Management meetings, to provide ad hoc consulting and advisory services, and for specific requests on emerging risks.	Internal Audit served in an advisory capacity on several Executive Management meetings, many of which were reflective of and incorporated the continued integration of various UT Tyler departments.

No Formal Report	Institutional Committees, Workgroups, Trainings, and Meetings	To assist in an advisory role on committees/workgroups at the Institution and provide and/or receive Institutional training as requested.	Internal Audit served in an advisory capacity on several standing and ad-hoc committees, workgroups, and trainings, many of which were reflective of and incorporated the continued integration of various UT Tyler departments.
No Formal Report	Consulting and Advisory Services related to any IT/IS Integration Efforts, as needed	To assist in an advisory role for any projects related to IT/IS integration efforts.	Internal Audit aided as an advisory in any projects that were related to IT/IS that focused on integration.
May 18, 2023	UTHSCT & UT Health East Texas Clinical Operations Management Agreement (COMA) Review	To perform an annual review of UTHET's performance under the COMA to evaluate its compliance with the agreed upon Management Parameters.	Internal Audit performed an annual review of UTHET's performance under the COMA by evaluating its compliance with the agreed upon Management Parameters.
No Formal Report	Data Analytics Program	To develop and deliver reports using data analytics software for Institutional clients as requested such as Procurement Cards, Balance Forwards, Journal Entry Approvals, and Duplicate Vendor/Payments.	Internal Audit, with the assistance of the UT System Audit Office, developed and delivered reports using data analytics software for Institutional clients as requested in an advisory capacity.
December 22, 2022	Grant Expenditure Procedure Review	To review controls related to training, processing, and oversight of expenditures for compliance with grant requirements.	Internal Audit reviewed controls related to training, processing, and oversight of non-salary expenditures for compliance with grant requirements.

March 16, 2023	University Advancement Endowment Balances Review	To review endowment expenditures and balances for compliance with UT System policies.	Internal Audit reviewed endowment expenditures and balances for compliance with UT System policies and evaluated annual spending in accordance with endowment terms.
November 22, 2022	Meditract Contract Review Management	To perform a limited review of the UT Tyler Health Science Center Campus (HSC) contract management system, Meditract, specifically the accuracy of the detailed information entered into and stored within Meditract for a sample of contracts selected by the IAD.	Internal Audit reviewed the current HSC policy and the resulting procedures along with ensuring all departments are utilizing Meditract 2.0 as the Institution's contract repository.
December 6, 2022	Check Deposit Process Review	To perform a limited review of the UT Tyler Main Campus controls for check deposit processing.	Internal Audit performed a limited review of controls for check deposit processing and identified limited controls for recording checks on the UT Tyler Main Campus.
February 21, 2023	CPRIT Consulting Review (Attorney-Client Privilege)	To evaluate policies and procedures related to specific CPRIT grants awarded to the HSC Campus and evaluate proper management and oversight with grant requirements.	Internal Audit evaluated and reviewed the policies and procedures related to specific CPRIT grants, as well as evaluated oversight of compliance with grant requirements, in order to provide recommendations based on the results.

March 31, 2023	Budget Override Consulting Review	To evaluate the current policies, processes, and controls in place related to budget overrides.	Internal Audit reviewed the current policies, processes, and controls in place related to budget overrides and referenced UT System Budget Rules and Procedures.

IV. External Quality Assurance Review (Peer Review)

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

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

Reference Exhibit A: External Quality Assessment Review Executive Summary

V. Internal Audit Plan for Fiscal Year 2024

The FY 2024 Audit Plan was primarily developed based upon the results of the institution-wide risk assessment completed in FY 2023, which focused on UT Tyler's critical strategic and operational objectives and related risks. To identify audits and projects for the plan, the IAD considered the level of risk for strategic and operational objectives and monitoring activities of the risks performed internally and externally. In addition, audits and projects externally required or requested by UT System or the Board of Regents were also included in the plan.

Fiscal Year 2024 Audit Plan

Project Name	Budget
Assurance Engagements	
Controlled Property Audit	500
Employee Off-Boarding Audit	500
Privileged Access Management - Domain Administrator Accounts	500
Epic Account Deactivation Review	300
Review of Employee Job Description Filing Processes	400
Assurance Engagements Subtotal	**2200**
Advisory and Consulting Engagements	
Ad Hoc Consulting and Advisory Services Requested by Management related to Emerging Risks	500
Executive Meetings, Meetings with Management, Institutional Committees	500
UTHSCT & UT Health East Texas Clinical Operations Management Agreement (COMA) Review	150
Data Analytics Program	300
Food Services Review	200
Student Housing Review	200
University Advancement Endowment Balances Review	200
Review of Historical Instances of Endowment Overspending	200
Consulting and Advisory Services related to any Research Department Integration Efforts, as identified by new leadership	200
Advisory and Consulting Engagements Subtotal	**2450**
Required Engagements	
State Institution of Higher Education Contracting Assessment	40
Family Medicine Residency Program Grant Audit FYE 8/31/2023	125
Financial Statement Audit Assistance	50
CPRIT Grant External Audit (assistance to management)	30
NCAA Agreed Upon Procedures (AUP)	30
Required Engagements Subtotal	**275**
Investigations	
Investigations	250
Investigations Subtotal	**250**
Reserve	
Reserve for Ad-Hoc Engagements	400
Reserve Subtotal	**400**
Follow-Up	
Implementation Status Tracking	300
Follow-Up Subtotal	**300**

V. Internal Audit Plan for Fiscal Year 2024, Continued

Project Name	Budget
Development - Operations	
Annual Risk Assessment and Audit Plan	400
Institutional Audit Committee	500
Quality Initiatives	400
External Reporting/Requests	200
Audit Management Software, IT Support, and Website Maintenance	250
Staff Meetings	350
CAE Update/Collaborative Meetings	150
Development - Operations Subtotal	**2250**
Development - Initiatives and Education	
System Audit Office Initiatives	250
Professional Organization/Association Participation	400
Individual Continuing Professional Education (CPE)	350
Institutional Trainings	225
Audit Software implementation	150
Development - Initiatives and Education Subtotal	**1375**
Total Budgeted Hours	**9500**

Other High-Level Risks:
Additional critical and high risks that were identified but not included in the FY 2024 Audit Plan are related to the following:

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

While related engagements are currently not part of the FY 2024 Annual Audit Plan, there are other mitigating activities underway that address the objectives at risk.

Risk Assessment Process:
The UT Tyler FY 2024 Audit Plan was prepared using a risk-based approach developed by The University of Texas System to ensure that areas and activities specific to UT Tyler with the greatest risk were identified for consideration to be audited.

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

VI. External Audit Services Procured in Fiscal Year 2023

External Audit Services during FY 2023, were provided as follows:

- Belt Harris Pechacek conducted an audit of the financial statements of The University of Texas at Tyler University Academy for the fiscal year ended August 31, 2022;
- Texas Higher Education Coordinating Board conducted a compliance audit of the Toward EXcellence, Access and Success (TEXAS) Grant for the fiscal year ended August 31, 2022;
- Texas Comptroller's Office conducted a Post Payment Audit on the Main Campus for the period from December 1, 2020, through November 30, 2021; and
- Texas Comptroller's Office conducted a Post Payment Audit on the HSC Campus for the fiscal year ended August 31, 2022.

VII. Reporting Suspected Fraud and Abuse

Actions taken by UT Tyler to comply with the following requirements are summarized below:

Sec. 7.09 General Appropriations Act (87th Legislature, Conference Committee Report)
A state agency or institution of higher education appropriated funds by this Act, shall use appropriated funds to assist with the detection and reporting of fraud involving state funds by:

1) *Providing information on the home page of the entity's website on how to report suspected fraud, waste, and abuse involving state resources directly to the State Auditor's Office. This shall include, at a minimum, the State Auditor's Office fraud hotline information and a link to the State Auditor's Office website for fraud reporting; and*
2) *Including in the agency or institution's policies information on how to report suspected fraud involving state funds to the State Auditor's Office.*

UT Tyler has a link for fraud reporting on the University's home page at https://www.uttyler.edu/ which provides information on how to report suspected fraud, waste, and abuse involving state resources directly to the State Auditor's Office (SAO). This includes the SAO's fraud hotline, a link to the SAO's website, and UT Tyler's policies for reporting suspected fraud. The Institution has also included information on how to report suspected fraud, waste, and abuse to the State Auditor's Office on the UT Tyler's Handbook of Operating Procedures (H.O.P.) 2.5.6 False Claims, Fraud, Waste, Abuse, and Other Misconduct.

Texas Government Code, Section 321.022. Coordination of Investigations

a) *If the administrative head of a department or entity that is subject to audit by the state auditor has reasonable cause to believe that money received from the state by the department or entity or by a client or contractor of the department or entity may have been lost, misappropriated, or misused, or that other fraudulent or unlawful conduct has occurred in relation to the operation of the department or entity, the administrative head shall report the reason and basis for the belief to the state auditor. The state auditor may investigate the report or may monitor any investigation conducted by the department or entity.*

b) *The state auditor, in consultation with state agencies and institutions, shall prescribe the form, content, and timing of a report required by this section.*

c) *All records of a communication by or to the state auditor relating to a report to the state* auditor under Subsection (a) are audit working papers of the state auditor.

UT System has implemented UTS Policy 118, Section 5, which includes a reference link to the TGC §321.022. This policy is applicable to all UT System institutions, including UT Tyler. The policy states that "the Systemwide Chief Inquiry Officer for the U. T. System is the designated investigation coordinator responsible for tracking and coordinating investigations conducted by U. T. System of allegations of misconduct, Dishonest or Fraudulent Activity, and allegations of misconduct against institutional presidents." The UT Tyler President is knowledgeable about the policy requirements and his reporting responsibilities to the State Auditor. UT Tyler reports such activities to the State Auditor's Office via the following website: https://sao.fraud.texas.gov/.

Reference Exhibit A: External Quality Assessment Review Executive Summary

June 16, 2020

Ms. Lou Ann Viergever, Executive Director of Audit and Consulting Services
The University of Texas at Tyler

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

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

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

This information has been prepared pursuant to a client relationship exclusively with, and solely for the use and benefit of, The University of Texas System Administration and UT Tyler and is subject to the terms and conditions of our related contract. Baker Tilly disclaims any contractual or other responsibility to others based on its use and, accordingly, this information may not be relied upon by anyone other than The University of Texas System Administration and The University of Texas at Tyler.

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

Very truly yours,

Baker Tilly Virchow Krause, LLP

bakertilly

August 3, 2020

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

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

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

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

Very truly yours,

Baker Tilly Virchow Krause, LLP

Exhibit B: FY 2023 Audits – Summary of Issues and Current Status

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

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

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
10/5/2022	Medical Devices Audit	Biomedical Services, in collaboration with Information Security, perform a detailed review for each of the Medical Devices to accurately and completely classify each Medical Device and update its Medical Device Inventory List to include this classification information (e.g., Category I, II, III, IV), as required by policy.	Biomedical Services will include Categories in the ISM Section of the Renovolive Database. Biomedical Services will work with IT/IS during Incoming Inspections and conduct an audit to adjust current inventory.	Completed
10/5/2022	Medical Devices Audit	HSC IT, in collaboration with Biomedical Services where necessary, should ensure all patient data is removed from medical devices that are decommissioned (retired), in accordance with HSC Policy.	Biomedical Services, Information Security, and Information Technology will review/update the referenced policy as needed and work through a process for ensuring the removal of PHI is documented and verified by Biomedical Services, Information Technology and Information Security.	Completed
10/5/2022	Medical Devices Audit	Management should perform a review of the identified policies that are past the specified review deadline and update as needed.	Policies are migrating from the HSC instance of Policy Stat to a different solution at UT Tyler Academic campus. The process of migrating policies should have also included a policy review. Once made available, the policy owners will ensure the referenced policies have been reviewed and updated as appropriate.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
10/5/2022	Medical Devices Audit	Accounting, with assistance from Biomedical Services as needed, should physically inspect medical devices to identify all medical devices that are missing a State Asset tag and to ensure all required medical devices that require a State Asset tag have a tag affixed and are present on the State Asset Listing.	We acknowledge that Accounting should be more involved in equipment received for tracking purposes, and the soon-to-be-formed "Medical Equipment Committee" will be key in our ability to improve in this area. While Tom is currently responsible for providing asset tags, this is sometimes challenging because departments have difficulty in determining which pieces of equipment require asset tags given the $5,000 state capital asset threshold – and of course, our ability to only have 1 accountant tracking all of this information is another challenge. Going forward, we can commit to updating our processes and cross training in Accounting to give this area more attention – but the "Medical Equipment Committee" will play a big role in our ability to succeed so we can have better participation and open communication between Accounting and the departments housing the equipment in question so we can properly identify and track equipment at initial purchase and annually.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
10/5/2022	Medical Devices Audit	Management should develop and implement a process regarding CER Forms to ensure all required approvals are obtained on the CER Form and all completed forms are stored in a central location. Once implemented, training must be provided to departments to ensure CER Forms are completed as required.	We agree that CERs should be completed and all approvals obtained before capital medical equipment is purchased, but we think this process needs to be adjusted so the Purchasing department is also aware of the requirement to ensure no unauthorized purchases slip through. To start, the CER should ideally be attached/completed prior to the requisition being entered so that the PO clearly shows approval prior to the purchase being completed. Essentially, Accounting has only been reviewing the CER at the beginning of the process (if received at all) and not at the end – making it difficult to ensure proper procedure was followed. Going forward, we can improve by coordinating between Purchasing and Accounting to require CER completion – and this is another item where the "Medical Equipment Committee" will be helpful to ensure there is a better understanding of the overall process at the department level.	Completed
10/5/2022	Medical Devices Audit	Inventory should be reviewed properly to ensure adequate records are maintained.	Biomedical Services is following the Renovo Medical Equipment Management Policy now. Per Renovo's (MEMP 4.0.G.1-22), all equipment will be checked every 6 months, during EOC rounding, or if there is a hospital policy surrounding Visual/Environmental Inspections.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
10/5/2022	Medical Devices Audit	Biomedical Services should inform Compliance, Accounting, and Information Security when a medical device that stores or interfaces with PHI can't be located (e.g., has been misplaced, lost, or stolen) during its preventative maintenance checks prior to the medical device being categorized as "Retired," in accordance with the Medical and Scientific Devices policy.	Agreed. This will now be included in the Environment of Care Reporting held monthly.	Completed
10/5/2022	Medical Devices Audit	Biomedical Services, in collaboration with HSC IT, should verify that medical devices are properly secure, and the number of PHI records stored on medical devices are accurately captured in accordance with policy.	Biomedical Services will work with IT to ensure all PHI records are documented accordingly and reported during Environment of Care.	Completed
10/5/2022	Medical Devices Audit	Until the implementation of the Medical Device's Classification (e.g., Category I, II, III, IV) on Biomedical Services Inventory List, in accordance with HSC policy, as identified in #1 above, Biomedical Services should update its “Specialization” column to accurately capture the device capabilities or remove the column to avoid inaccuracies.	Agreed. Renovo has included Categories I-IV in the ISM portion of the equipment tab of the database in accordance with the policy. We will work with IT/IS on Incoming Inspections.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
10/5/2022	Medical Devices Audit	In collaboration with leadership, this group of departments should work towards the formation of a committee for Medical Device Governance that meets periodically (e.g., monthly, quarterly, etc.) to ensure their on-going collaboration.	Agreed	Completed
10/5/2022	Medical Devices Audit	Management of IT, IS, Facilities, Accounting, and Biomedical Services should collaborate to implement a policy and to create and implement a deletion form for non-capital medical devices that are either retired, auctioned, or re-activated that formalizes the departments required to be involved in the process and the communication required amongst these departments. PHI removal, and an authorized signature from the attesting individual for the PHI removal, should be required items on the capital and non-capital deletion forms.	Biomedical Services, Information Security, and Information Technology will review/update the referenced policy as needed and work through a process for ensuring the removal of PHI is documented and verified by Biomedical Engineering, Information Technology and Information Security.	Completed
10/5/2022	Research Time & Effort Audit	ORSSP should expand the policies to include timeframes for notifying certifiers that the ECRT reports are available, in accordance with best practice.	Agreed. ORSSP will revise HOP policy 3.7.1 Grants, Contracts, and Sponsored Programs to include the time requirement for ORSSP to send notification to certifiers.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
10/5/2022	Research Time & Effort Audit	ORSSP should formally document the requirements for University Academy to follow the ORSSP guidelines.	Agreed. ORSSP will include documentation requirements in revised HOP 3.7.1 submitted to HOP Committee by October 31, 2022. Oversight of University Academy funding will be done moving forward by ORSSP as requested and per HOP 3.7.1 pertaining to routing and oversight of all external applications/awards. Correspondence will be sent to University Academy regarding this requirement by October 31, 2022.	Completed
10/5/2022	Research Time & Effort Audit	ORSSP should review employee personnel forms and related calculations to ensure they agree to the grant documents and include the salary caps, where applicable.	Agreed. ORSSP will review all employee personnel forms and related calculations to ensure they agree with grant documents and include the salary caps, where applicable. Effective Spring 2022, ORSSP has instituted "new award" meetings with the Principal Investigators and administrative/program staff when new or supplemental funding is received. Issues of pay, personnel forms, salary cap, changes in time and effort and how these changes are to be prepared and communicated are discussed. Employee personnel forms have been updated recently to ensure accuracy on the Health Science Center campus, the electronic Personnel Action (ePA) system has been modified by IT to make the "% effort" and "% distribution" fields mandatory for all grant award funds in PeopleSoft, as is the case on the academic campus. These forms will be carefully reviewed for accuracy by ORSSP personnel in preparation for all time and effort attestations.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
10/5/2022	Research Time & Effort Audit	ORSSP should verify the ECRT calculations are correct prior to notifying certifiers the reports are available.	Agreed. ORSSP staff will verify the ECRT calculations are correct prior to notifying certifiers the reports are available. A new budget modification process will be implemented so that ORSSP, PIs, and administrative staff have correct budget information prior to the creation of electronic personnel action forms (ePAs).	Completed
10/5/2022	Research Time & Effort Audit	ORSSP should follow up with certifiers to ensure all ECRTs have been certified as required.	Agreed. ORSSP will ensure follow-up with all individuals who have not certified via the eCRT system within 30 days of receipt. A process to ensure compliance within the 30 day certification period will be developed.	Completed
12/8/2022	Nursing Shortage Reduction Program - Regular Program Fiscal Year 2017 Audit	The School of Nursing Management, who were responsible for managing this award, through extensive collaboration with UT Tyler Executive Management, should prepare an agreed upon communication to THECB to inform them of this identified issue and to understand the next steps.	In September 2022, shortly after Internal Audit communicated that spending had occurred after the FY 17 NSRP Regular Program ending date, UT Tyler remitted $133,787.00 to THECB to repay these out of period expenditures. The Dean, School of Nursing will send a written communication to THECB immediately after issuance of this audit report, attaching a copy of this report to the transmittal. The transmittal will highlight the fact that spending after the award ending date was inadvertent due to a miscalculation of this date, that the funds have been returned, and that process improvements are being implemented to prevent similar circumstances going forward.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
12/8/2022	Nursing Shortage Reduction Program - Regular Program Fiscal Year 2017 Audit	The School of Nursing Management, who were responsible for managing this award, through extensive collaboration with UT Tyler Executive Management, should develop a process to monitor spending deadlines and work with Executive Management to develop oversight of the monitoring process. These procedures will help ensure future awards are fully expended.	School of Nursing leadership has already collaborated with administrative and sponsored program leaders to identify several tools and cross checks to monitor spending deadlines. In order to identify additional systematic processes and controls to ensure future awards are fully expended a School of Nursing representative will participate in the multidisciplinary process improvement project led by the University's Office of Planning, outlined directly below.	Completed
12/8/2022	Nursing Shortage Reduction Program - Regular Program Fiscal Year 2017 Audit	Executive Management should review the monitoring processes throughout UT Tyler to ensure appropriate oversight procedures are in place to monitor the expenditure of awarded funds, especially for awards that are not monitored by the Office of Research, Scholarship and Sponsored Programs, such as this award.	The SVP Finance, in collaboration with senior institutional leadership, has initiated a project led by the UT Tyler Office of Planning to identify a multidisciplinary approach to improving processes across the organization, with a goal of maximizing appropriate use of grant funds within the allowable periods. Additionally, the Provost has recommended that all institutional grants and contracts with deliverables and obligations have oversight by the Office of Research, Scholarship, and Sponsored Programs to supplement oversight by the principal investigator, academic unit, and budget and finance.	Completed
12/8/2022	Nursing Shortage Reduction Program - Regular Program Fiscal Year 2017 Audit	The School of Nursing Management, through extensive collaboration with UT Tyler Executive Management, should ensure that a primary point of contact is assigned for all NSRP awards and information is disseminated as required.	The Dean, School of Nursing, is now designated as UT Tyler's primary point of contact for THECB's Nursing Shortage Reduction Program. Several other UT Tyler leaders are also receiving THECB's communications about the NSRP program. The Dean, School of Nursing, is disseminating information and coordinating within the institution for all matters pertaining to the program.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
1/9/2023	Family Medicine Residency Program Annual Financial Report Audit for Fiscal Year Ended August 31, 2022	None		N/A
4/26/2023	Epic User Access Audit	HSC HR should work with UTHET HR to ensure Epic access for each of the identified terminated employees/contractors is removed. Further, HSC HR should continue to perform periodic manual checks utilizing the active Epic access data reports provided by Ardent, with continued efforts made to obtain this reporting from Ardent bi-weekly, to ensure Epic access is removed for all terminated HSC employees, as appropriate.	Agreed. HSC HR has submitted a ticket to Ardent, through its "Service Now" Help Desk, to have each of these individual's access removed and it is currently in progress. The process of an Epic account being terminated starts with the HSC sending an automated termination record on the daily interface from PeopleSoft to UTHET/Ardent. Terminations are sent for 14 consecutive days. Once the interface file is received by UTHET/Ardent, our understanding is that the list is provided to an account representative to term in Lawson. Once termed in Lawson, we are told that Epic access is termed via an automated process. HSC HR has continually requested regular audit files since previous audit and have only received one. We continue to analyze the data from this audit to find the root cause(s) of process failure to shore up all possible processes and welcome the collaboration of the Ardent Team in discussing automated solutions to this ongoing issue. Our proposed solution is to request completed task feedback via the Lawson to PS Interface to include additional field indicating date termed in Lawson. HSC IT will flag any discrepancies in termination for regular review and follow up to ensure any accounts that are missed in the Ardent Termination process are followed up on by both teams.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
4/26/2023	Epic User Access Audit	HSC IT and HSC HR should continue to work with Ardent/UTHET on enhancing deactivation procedures to ensure that Epic access for terminated HSC employees and contractors is removed timely. Until the deprovisioning process is automated by Ardent, which is currently being assessed, HSC HR should continue to perform periodic manual checks utilizing the active Epic access data reports provided by Ardent, with continued efforts made to obtain this reporting from Ardent bi-weekly, to ensure Epic access is removed for all terminated HSC employees, as appropriate.	Due to feed file timings and eForm approval timing, termination files need to be processed automatically to meet this standard. Once PeopleSoft termination is fully processed, it flows to Lawson overnight for fourteen days, and is manually processed after distributed and assigned to account representative for manual termination. We will continue to work with IT/Ardent IT to find an automated solution based on data analyzed from this audit. Using the above proposed solution to include termination dates as well as flag terminations not processed on the Lawson to PS interface, we can automate an alert to both HR teams indicating past the grace period for terminations on their end and to take necessary action.	Completed
4/26/2023	Epic User Access Audit	In collaboration with UTHET HR, HSC HR should periodically review the roles assigned within Epic for HSC employees/contractors and ensure all instances of inappropriate access is timely removed by UTHET HR.	Access was termed for affected employees that we believe were granted access during mass go-live account creation. Epic Access is currently granted for new and transferring employees based on hiring manager's request, Epic Training completion, and Epic Access team review of crosswalk.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
4/26/2023	Epic User Access Audit	The UT Tyler Compliance Department should perform a review of the identified policies, as part of the ongoing policy integration efforts being led by the Compliance Department, to ensure H.O.P. policy 1.1.1 specifies leadership's expectations for Clinical policies. In addition, the Compliance Department should ensure the policies are accessible via a link on the H.O.P., and that all the required review section dates are present, as per policy	The UT Tyler Compliance Department has reviewed the identified policies and assigned ownership of them as appropriate. The necessary changes have been made and will be posted to the UT Tyler Handbook of Operating Procedures.	Completed
4/26/2023	Epic User Access Audit	HSC IT, in coordination with Ardent/UTHET, should continue to pursue a process whereby HSC IT is able to view UTHET tickets processed for HSC employees.	The HSC is in the early stages of planning an integrated rollout of Service Now with UT Tyler. Once this project is complete, we (IT) will begin working to coordinate integration points/reports with Ardent and their instance of Service Now, which could provide us some insight into the Ardent/North campus ticketing process. This integration/reporting is dependent on 1) Ardent being willing to share HSC based tickets with North Campus and 2) Service Now's ability to provide data from Ardent to UT Tyler without automatically reassigning responsibility of the ticket to UT Tyler. Detailed needs assessment and design need to occur prior to integration with Ardent. If automated reporting is not an option, then we'll investigate manual reporting options.	In Process

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
4/26/2023	Epic User Access Audit	As referenced in Opportunity #1 and #2 above, until the UTHET Epic access deprovisioning process is automated by Ardent, which is currently being assessed, HSC HR should continue to perform periodic manual checks utilizing the active Epic access data reports provided by Ardent, with continued efforts made to obtain this reporting from Ardent bi-weekly, to ensure Epic access is removed for all terminated HSC employees, as appropriate.	We will continue to engage Ardent IT and HRIS resources to request a regular, automated audit file regarding Active Epic Access. HSC IT currently receives files from Epic with user account information, Epic User Interface. Our proposed solution is to request adding an Epic account term (disable) date to this interface to monitor account terminations and provide automated notices of any failures to the process.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
4/26/2023	Epic User Access Audit	In collaboration with UTHET HR, HSC HR should perform periodic reviews to ensure HSC employees do not have duplicate Lawson IDs.	Some duplicate IDs will continue due to the need to maintain Epic Access when moving from UTHET Tyler to North employment. Ardent still needs to process final pay and vacation for a departing employee which can take up to three weeks and requires a specific Term status to process appropriately. Since systems access requires an active status, we are unable to transfer Employee IDs across institutions. Currently HSC HR works with Ardent HR to ensure that everything transfers effectively and duplicate IDs are termed once payroll process is complete. We will work with Ardent HRIS and IT, as well as HSC IT, to come up with a regular audit framework. We do have occasional account duplications due to feed file failure. Our proposed solution would be to include Employee ID in Social Security Number field so it serves as a unique identifier in Lawson to avoid account duplication. Currently, we do not feed across employee SSN's per policy. Ardent HRIS assigns a randomly generated unique identifier for each "Add" account. By providing a unique identifier such as the PeopleSoft Employee ID, we can prevent duplicate account creation in cases of feed file failure.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
6/27/2023	Procurement Card Audit	Management should consider implementing a monitoring program to review unusual activity on a consistent schedule.	Management concurs with the recommendation. Implementation of a monitoring program will be conducted in a phased approach. In the first phase, we plan to launch a consistent internal review protocol for current cycle Procard transactions using existing UT Share/PeopleSoft queries for State compliance requirements. The second phase will follow training to use the UT System analytics software and reports to monitor those specific high-risk transactions noted by the audit team.	Completed
6/27/2023	Procurement Card Audit	Management should consider updating the UT Tyler Main campus "Procurement Card Program Policies and Procedures," located outside of the HOP, to ensure it accurately and completely reflects the current requirements for procurement card usage at UT Tyler.	Management concurs with the recommendation.	Completed
6/27/2023	Procurement Card Audit	Based on the results noted above, Management should specifically consider updating "Procurement Card Program Policies and Procedures" to capture that all purchases over $500 require a vendor hold search for all vendors, not solely for Texas based vendors, as is currently stated.	Management concurs with the recommendation.	Completed

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
6/27/2023	Procurement Card Audit	Due to the requirements of HOP 4.9.1, Management should consider addressing wireless communication devices in the "Procurement Card Program Policies and Procedures." This could include adding these to the Prohibited list and/or requiring an additional layer of approval.	Management concurs with the recommendation.	Completed
6/27/2023	Procurement Card Audit	Management should consider developing electronic training for all procurement cardholders and approvers to be completed annually along with the other required training at the Institution.	Management concurs with the recommendation. We are coordinating developing electronic Procurement credit card training with the Director of Human Resources using the most current learning management system.	In Process
8/3/2023	University Advancement Endowment Distributions Audit	University Advancement should request that the Endowment Compliance Officer be added to the routing in PeopleSoft for all appointment changes in an endowment cost center or account so endowment documents and training can be provided.	Advancement will initiate a dialogue with Budget, Payroll, and HR to determine an efficient solution to ensure that all appointment changes are communicated seamlessly to Advancement.	In Process

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
8/3/2023	University Advancement Endowment Distributions Audit	Endowment documents should be reviewed before funds are disbursed to ensure compliance with donor requests. If funds were used that were not in compliance with the donor agreement, funds should be transferred to correct the oversight.	Main Campus Management Response: We have a process in place that specifies that all endowments that do not have specific instructions on who should make the recommendation for the awards will be appropriately awarded by the scholarship office. In this case the specific "department head recommendation" requirement was not inputted into the Blackbaud management system to follow. This has since been updated to include this specific restriction. For 2023-2024 Aid year and going forward it is a requirement to have the department head recommend. Additionally, another review of all endowments will be done to confirm that no other endowments have atypical directives such as this and if they do those will be added into Blackbaud management system. There was an update to the original Memorandum of Understanding (MOU) that we had on file. The updated MOU contained the new directions that the funds should go pay the full tuition of one student instead of awarding the funds to multiple students at lower amounts. Our MOU records have since been updated for this endowment and we have already implemented this change and awarded one student for the 2023-2024 aid year.	In Process

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
8/3/2023	University Advancement Endowment Distributions Audit	Endowment documents should be reviewed before funds are disbursed to ensure compliance with donor requests. If funds were used that were not in compliance with the donor agreement, funds should be transferred to correct the oversight.	HSC Management Response: Scholarship funds received by the employee were tracked back and this situation was identified as an isolated incident that occurred when the employee switched disciplines in relation to a job move within the institution. Once the Texas Chest Foundation Endowment is replenished in September, Human Resources (HR) will work with Finance to reimburse the affected Nursing endowment. A committee of people review submissions electronically per process. Intake of application reviewed by HR Specialist and required items documented - > List of applicants emailed to Executive Director of HR for Review of good standing status and Director of HR for overall review -> HR Coordinator processes awards. HR will update the existing written procedures to include language that applications that qualify for Nursing endowments are processed in the same manner as Texas Chest Foundation.	In Process

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
8/3/2023	University Advancement Endowment Distributions Audit	University Advancement should request that the Endowment Compliance Officer be included in the PeopleSoft transfer routing to verify that transfers are appropriate and to ensure the department receiving the funds is provided with endowment documents and required training. The PeopleSoft roll-forward process can be used to automatically transfer ending balances back to the original cost center or account. University Advancement should discuss using this process with budget authorities and account owners who transfer funds. This process would further help to ensure the accuracy of the Endowment Compliance Annual Report and enable unspent transfers to automatically be returned to the originating cost center or account at year-end.	Advancement has been meeting with Academics and Finance to obtain a solution toward ensuring that we are aware of transfers and the accommodating account holders in real-time.	In Process

Report Date	Name of Report	Recommendation	Action Plan	Status/Actions
8/3/2023	University Advancement Endowment Distributions Audit	The Endowment Compliance Policy should be expanded to include monitoring of expenditures and transfers for compliance with endowment agreements.	We are addressing this monitoring issue with Academics and Finance. Once Advancement is included in the routing, we can begin the process of monitoring. This observation is contingent upon items #1 and #3 above occurring.	In Process
8/3/2023	University Advancement Endowment Distributions Audit	Human Resources on the HSC campus should develop a written policy and procedures for the application, selection, and awarding processes.	HR will update current written procedures to include responsibilities, clarify funding source selection per recent guidance surrounding the newly introduced clinical tuition reimbursement program and the use of existing endowments to fund applications. HR is also standardizing the application to bake in the need to review funding source and document on the application.	In Process