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May 15, 2018

Dr. Karen S. Haynes, President  
California State University San Marcos  
333 S. Twin Oaks Valley Road  
San Marcos, CA 92096

Dear Dr. Haynes:

**Subject: Audit Report 18-16, Student Health Services, California State University San Marcos**

We have completed an audit of *Student Health Services* as part of our 2018 Audit Plan, and the final report is attached for your reference. The audit was conducted in accordance with the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing*.

I have reviewed the management response and have concluded that it appropriately addresses our recommendations. The management response has been incorporated into the final audit report, which has been posted to the Audit and Advisory Services' website. We will follow-up on the implementation of corrective actions outlined in the response and determine whether additional action is required.

Any observations not included in this report were discussed with your staff at the informal exit conference and may be subject to follow-up.

I wish to express my appreciation for the cooperation extended by the campus personnel over the course of this review.

Sincerely,



**Larry Mandel**  
Vice Chancellor and Chief Audit Officer

c: Timothy P. White, Chancellor

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## **STUDENT HEALTH SERVICES**

**California State University  
San Marcos**

**Audit Report 18-16  
April 18, 2018**

## EXECUTIVE SUMMARY

### OBJECTIVE

The objectives of the audit were to ascertain the effectiveness of campus operational, administrative, and financial controls over the administration of student health services (SHS) activities and to ensure compliance with relevant governmental regulations, Trustee policy, Office of the Chancellor directives, and campus procedures.

### CONCLUSION

We found the control environment for some of the areas reviewed to be in need of improvement.

Based upon the results of the work performed within the scope of the audit, except for the weaknesses described below, the operational, administrative, and financial controls for student health services as of March 2, 2018, taken as a whole, provided reasonable assurance that risks were being managed and objectives were met.

In general, we noted that the campus had an appropriate framework for the administration of health services at Student Health and Counseling Services (SHCS). We identified areas needing improvement, including instances in which SHCS contracts and agreements did not always include the required campus approvals or were not executed by individuals with the delegated authority to commit resources or obligate the university contractually. In addition, the pharmacy's internal controls did not provide assurance that inventory of controlled substances was accurate. Also, SHCS incorrectly charged students an additional fee for basic diagnostic X-ray services and used unallowed billing practices to recover some operational costs of providing family planning services to eligible students.

We also found that oversight responsibilities in the sports medicine program needed improvement, primarily with regard to security, credential review of volunteer community medical providers, and general administrative requirements. Further, the campus did not always enforce registration holds to ensure compliance with campus student immunization requirement policies and procedures, did not conduct a formal risk assessment for all SHCS information systems, and did not establish the required student health advisory committee that advises the campus president and SHCS.

Specific observations, recommendations, and management responses are detailed in the remainder of this report.

## OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

### 1. CONTRACT ADMINISTRATION

#### OBSERVATION

Administrative oversight of SHCS contracts and agreements, including proper review and approval by the Office of General Counsel (OGC) and campus procurement and support services, needed improvement.

Specifically, we found that:

- For two active educational program agreements in which SHCS participated with outside universities as a host for clinical rotation sites that involve the provision of health care at SHCS facilities, the campus did not obtain OGC approval as required by Executive Order (EO) 943, *Policy on University Health Services*.
- Two separate contractual agreements to provide offsite basic diagnostic X-ray services and procure clinical reference laboratory services were signed by someone who did not have the authority to commit resources or otherwise obligate the university contractually.
- A SHCS memorandum of understanding (MOU) with a campus auxiliary that allows eligible students from the American Language and Culture Institute Intensive Academic Program to access student health services expired in 2010 and has not been formally renewed through the established campus procurement and contract process.

Proper review and approval of contractual agreements helps to reduce risk, can protect the university from adverse financial and legal obligations, and promotes compliance. In addition, active monitoring helps to ensure that contracts and agreements are current and do not lapse.

#### RECOMMENDATION

We recommend that the campus:

- a. Ensure that proper review and approval is obtained for all educational program agreements that include the provision of health care to students, and remind appropriate campus staff of the requirements of EO 943 related to health care educational programs.
- b. Obtain necessary campus approval for the two agreements noted above that were not signed by someone with the authority to commit resources or otherwise obligate the university contractually, and remind appropriate SHCS staff of key university policies and procedures for procurement and contracts.
- c. The expired MOU noted above should be renewed to comply with the campus *Procurement & Support Services Policy*.

#### MANAGEMENT RESPONSE

We concur.

- a. The campus will ensure that proper review and approval is obtained for all educational program agreements that include the provision of health care to students and remind appropriate campus staff of the requirements of EO 943 related to health care educational programs.
- b. The campus will obtain necessary campus approval for the two agreements noted above that were not signed by someone with the authority to commit resources or otherwise obligate the university contractually and remind appropriate SHCS staff of key university policies and procedures for procurement and contracts.
- c. The expired MOU noted above will be renewed to comply with the campus *Procurement & Support Services Policy*.

Estimated completion date: October 18, 2018

## 2. INVENTORY CONTROLS

#### OBSERVATION

Internal controls surrounding the pharmacy's inventory of controlled substances needed improvement to provide assurance of accurate records.

We performed an actual count and reconciliation of the pharmacy's controlled substances to verify the inventory on-hand, and we found that:

- For two controlled substances, our actual counts did not reconcile to the independent count performed by a third-party vendor in June 2017. Specifically, our counts were over the reconciled vendor's count by 18 and 40 pills, respectively.

According to SHCS management, the vendor performs an annual inventory of the pharmacy formulary and uses a counting method of estimation, meaning that the number of pills in a container may be counted in even numbers and estimated rather than counted pill-by-pill. We noted that the vendor's method is not appropriate for controlled substances.

- The current pharmacy management system is outdated and unable to maintain a current inventory count. According to campus staff, the university is in the process of implementing an improved pharmacy management system that will be able to maintain a perpetual inventory, among other things. An adequate pharmacy management system can track the amount of medication on hand and automatically update the inventory as the medication is dispensed, purchased/replenished, and discarded.

Proper inventory controls, including reliable independent annual inventory counts and pharmacy management systems that are capable of maintaining reliable records over

pharmaceuticals, helps to reduce the risk of loss or theft and non-compliance with applicable regulations.

#### **RECOMMENDATION**

We recommend that the campus:

- a. Require and ensure that the third-party vendor who performs inventory of the pharmacy formulary confirms the pharmacy's pill-by-pill count of controlled substances. Additionally, determine whether the vendor's methods are appropriate for non-controlled substances, and communicate any necessary changes to the vendor.
- b. Ensure that the new pharmacy management system capabilities are fully implemented and utilized.
- c. Ensure that SHCS management uses the annual inventory count to conduct an independent review and reconciliations of pharmaceutical inventories, especially for controlled substances.

#### **MANAGEMENT RESPONSE**

We concur.

- a. The campus will require and ensure that the third-party vendor who performs inventory of the pharmacy formulary confirms the pharmacy's pill-by-pill count of controlled substances. Additionally, we will determine whether the vendor's methods are appropriate for non-controlled substances and communicate any necessary changes to the vendor.
- b. The campus will ensure that the new pharmacy management system capabilities are fully implemented and utilized.
- c. The campus will ensure that SHCS management uses the annual inventory count to conduct an independent review and reconciliations of pharmaceutical inventories, especially for controlled substances.

Estimated completion date: October 18, 2018

### **3. FEE ADMINISTRATION**

#### **OBSERVATION**

Administration of some basic health services fees and the billing of Family Planning, Access, Care and Treatment (Family PACT) did not always comply with EO 943, *Policy on University Health Services*, and Coded memorandum Academic Affairs (AA) 2015-08, *Clarifications to Executive Order 943*.

Specifically, we found that:

- SHCS was not providing onsite X-ray services but had a contract with an offsite third-party vendor for these services. SHCS incorrectly charged students an additional fee for basic diagnostic X-ray service, which is a basic health service that is already included in the mandatory student health fee. The SHCS is not allowed to charge an additional fee for basic services or for services that do not meet the specific criteria outlined in EO 943 Section III D-1.
- SHCS was providing family-planning services, including certain standard laboratory tests, to eligible students through Family PACT, at no additional charge. SHCS was directly billing Family PACT for two laboratory diagnostic tests (UA Dip and UCG, also known as urine analysis and urine pregnancy test), primarily to help recover some of their operational costs. However, AA-2015-08 specifically states that student health centers may not bill governmental or other agency programs more than the amount charged to the students paying user charges directly, and because the tests noted above are required to be provided to eligible students at no additional charge, billing Family PACT is not appropriate.

Proper fee administration over charges for basic services and Family PACT billings ensures compliance with California State University (CSU) requirements.

#### **RECOMMENDATION**

We recommend that the campus immediately discontinue charging students an additional fee for basic diagnostic X-ray services and billing Family PACT for the two laboratory diagnostic tests noted above and remind appropriate campus staff of the prohibited practices as noted above.

#### **MANAGEMENT RESPONSE**

We concur. The campus will immediately discontinue charging students an additional fee for basic diagnostic X-ray services and billing Family PACT for the two laboratory diagnostic tests noted above, and will remind appropriate campus staff of the prohibited practices as noted above.

Estimated completion date: October 18, 2018

## **4. ATHLETICS SPORTS MEDICINE PROGRAM**

#### **OBSERVATION**

Oversight responsibilities in the sports medicine program (SMP) related to security, review of community member medical providers (CMMP), and general SMP administration needed improvement.

We noted that security over the following SMP components required attention:

- Medical records were stored in an unlocked cabinet inside the sports office, which was accessible to athletic directors and management, who had a key to the office, and the cabinet key was not always properly secured.
- Mitigating controls such as password-protected send-and-receive functionality were not implemented on the dedicated fax machine used to transmit and receive confidential medical records. In addition, the sports office where the fax machine is located was accessible to athletic directors and management, who had a key to the office.
- Over-the-counter (OTC) medicine was stored inside the sports office in a cabinet that could not be locked. In addition, the sports office was accessible to athletic directors and management, who had a key to the office.
- Sports medicine kits were not always stored inside a lockable compartment when not in use.

We also found that current volunteer forms were not maintained for CMMPs, nor was there evidence that CMMPs had been subject to a periodic credential review, as required by campus human resources policy and EO 943.

In addition, SMP administration needed improvement. Specifically, we noted:

- One sports medicine kit contained expired OTC items, and the expiration dates on some containers were unclear. Additionally, a written log documenting the routine inspection of OTC items for removal of outdated/expired, deteriorated, or recalled medications was not maintained as required by EO 943.
- A quality assurance program similar to the program used by the campus SHCS and required by EO 943, to address, among other things, facility sanitation and safety issues, regular cleaning of instruments and equipment, and staff training, had not been developed or implemented for the SMP at the time of the audit.
- There were two unused user accounts within one information system used by the SMP, which can increase vulnerability of confidential medical records.
- Policies and procedures for the SMP had not been formally approved in writing by the physician responsible for medical oversight of the program, as required by EO 943.

Effective management over the SMP can help to ensure that proper safeguards and security exist over medical records, information systems, and sports medicine kits; that CMMPs are credentialed and reviewed; and that administrative responsibilities are addressed to promote compliance and reduce the campus exposure to potential litigation or regulatory sanctions.

## RECOMMENDATION

We recommend that the campus:

- a. Address the security concerns noted above by:
  - Reminding appropriate sports medicine staff of policies and procedures for maintaining and safeguarding medical records including, but not limited to, locking the medical records cabinet at all times when it is not in use and securing the cabinet key.
  - Implementing password-protected send-and-receive fax functionality or other appropriate mitigating controls to ensure faxed medical records transmitted and received are secured appropriately.
  - Installing a lock on the cabinet where OTC medications are stored and ensuring that keys are properly secured at all times.
  - Ensuring that sports medicine kits are always stored in a locked compartment and that keys are properly secured at all times.
- b. Implement a process to ensure that volunteer forms for CMMPs are renewed annually, including a periodic review of required credentials.
- c. Address SMP administration concerns noted above by:
  - Reviewing all sports medicine kits and removing all outdated, expired, deteriorated, or recalled medications, including the items noted above, and maintaining proper documentation of all routine inspections conducted.
  - Developing and implementing a quality assurance program for the sports medicine area similar to the one used by the campus SHCS.
  - Ensuring that user access to SMP information systems is appropriate, and removing the two unused user accounts noted above.
  - Finalizing the SMP policies and procedures, and obtaining approval in writing from the SHCS director.

## MANAGEMENT RESPONSE

We concur.

- a. We will address the security concerns by:
  - Reminding appropriate sports medicine staff of policies and procedures for maintaining and safeguarding medical records including, but not limited to, locking the medical records cabinet at all times when it is not in use and securing the cabinet key.

- Implementing password-protected send-and-receive fax functionality or other appropriate mitigating controls to ensure faxed medical records transmitted and received are secured appropriately.
  - Installing a lock on the cabinet where OTC medications are stored and ensuring that keys are properly secured at all times.
  - Ensuring that sports medicine kits are always stored in a locked compartment and that keys are properly secured at all times.
- b. We will implement a process to ensure that volunteer forms for CMMPs are renewed annually, including a periodic review of required credentials.
- c. We will address SMP administration concerns noted above by:
- Reviewing all sports medicine kits and removing all outdated, expired, deteriorated, or recalled medications, including the items noted above, and maintaining proper documentation of all routine inspections conducted.
  - Developing and implementing a quality assurance program for the sports medicine area similar to the one used by the campus SHCS.
  - Ensuring that user access to SMP information systems is appropriate and removing the two unused user accounts noted above.
  - Finalizing the SMP policies and procedures and obtaining approval in writing from the SHCS director.

Estimated completion date: October 18, 2018

## 5. IMMUNIZATION REQUIREMENTS

### OBSERVATION

The campus did not always enforce registration holds to ensure compliance with the campus *Student Immunization Requirement Policy and Procedures*.

In general, the campus policies and procedures on student immunization requirements states that matriculated students must provide proof of full immunization against measles, rubella, and hepatitis B within the first year of enrollment and requires the campus to maintain the immunization documents as a part of the student's health record. In addition, if a student does not provide proof of immunization by the established timeline, the campus is required to place a hold on the student's registration.

At the time of the audit, we found that the campus had implemented a rule-based process to enforce immunization registration holds within the PeopleSoft module that manages student enrollment and registration. We reviewed a sample of student registrations to verify whether

these rules were effective, and we found that the rules were not properly configured and resulted in immunization registration holds not being enforced for graduate, credentialed, and transfer students.

Proper implementation of immunization registration holds promotes compliance with campus policy and provides greater assurance that students have obtained required immunizations, and can reduce the risk related to the outbreak of diseases on campus.

#### **RECOMMENDATION**

We recommend that the campus verify that system-based rules are properly configured to ensure registration holds are enforced for all applicable students as required by the campus *Student Immunization Requirement Policy and Procedures*.

#### **MANAGEMENT RESPONSE**

We concur. The campus will verify that system-based rules are properly configured to ensure registration holds are enforced for all applicable students as required by the campus *Student Immunization Requirement Policy and Procedures*.

Estimated completion date: October 18, 2018

## **6. INFORMATION SYSTEMS RISK ASSESSMENT**

#### **OBSERVATION**

The campus had not conducted a formal assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information that was obtained and held in all SHCS information systems.

Specifically, we found that:

- A formal risk assessment of the SHCS's pharmacy management system had not been conducted because the system was implemented before the campus established the current risk assessment process. Moreover, the SHCS was in the process of implementing a new pharmacy management system to replace the current system.
- A formal risk assessment of the SHCS's point-and-click electronic medical records (EMR) system had not been finalized because verification of some components was pending.

According to EO 877, *Designation of Health Care Components for Purposes of the Health Care Portability and Accountability Act of 1996 (HIPAA)*, the individual entities within the CSU that are designated as health care components are required to comply fully with HIPAA, including the requirement to conduct a complete and accurate risk assessment.

Adequate assessment of the potential risks and vulnerabilities to electronic protected health information can help to safeguard the confidentiality of information collected from students and reduces campus exposure to potential regulatory sanctions.

**RECOMMENDATION**

We recommend that the campus conduct a risk assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information obtained and held by the pharmacy management system and finalize the risk assessment for the EMR system.

**MANAGEMENT RESPONSE**

We concur. The campus will conduct a risk assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information obtained and held by the pharmacy management system and finalize the risk assessment for the EMR system.

Estimated completion date: October 18, 2018

**7. STUDENT HEALTH ADVISORY COMMITTEE**

**OBSERVATION**

The campus did not have an established student health advisory committee (SHAC).

SHACs are required by EO 943, *Policy on University Health Services*, which states that each president or designee shall establish a student health advisory committee to serve as advisory to the president and to the SHCS on the scope of service, delivery, funding, and other critical issues relating to campus health services, among other specific requirements and responsibilities.

Establishing a SHAC can help to ensure that students' input on university health services is obtained and enables communication between the committee, the campus president, and the SHCS on critical health issues.

**RECOMMENDATION**

We recommend that the campus establish a SHAC.

**MANAGEMENT RESPONSE**

We concur. The campus will establish a SHAC.

Estimated completion date: October 18, 2018

## GENERAL INFORMATION

### BACKGROUND

The primary health entity on each CSU campus is the student health center (SHC). EO 943, *Policy on University Health Services*, outlines the health services that campuses may provide, funding sources for these services, and the conditions for adding additional services or increasing fees. The EO also addresses qualifications of health care providers, operational expectations for pharmacies, facility safety and cleanliness, medical records management, accreditation, and oversight responsibilities. Although the EO focuses primarily on the scope and activities of the SHCs, it includes sections that are applicable to other campus programs providing student health care, such as intercollegiate athletics, intramural sports, or kinesiology.

Health services are funded in part by two mandatory student fees: a health services fee covering basic health services and a health facilities fee to support the health center facility. Each SHC may provide augmented services and either impose a fee-for-service for each augmented service rendered or a fee that allows unlimited use of all augmented services provided by the SHC. It can also elect to not impose additional fees. These fees are described in EO 1102, *California State University Fee Policy*, and can be changed only after a student referendum or a consultation that allows meaningful input and feedback from appropriate campus constituents.

Each campus SHC and its pharmacy must obtain accreditation every three years from a nationally recognized and independent review agency, such as the Accreditation Association for Ambulatory Health Care (AAAHC). In addition, pharmacies are subject to periodic inspections by the California State Board of Pharmacy.

At the Office of the Chancellor, the student academic support department in the Academic Affairs division is responsible for monitoring systemwide SHC activities and ensuring that campus SHCs comply with CSU management and regulatory policies. In addition, a systemwide SHS advisory committee meets at least twice per year to provide recommendations to the chancellor regarding revisions to applicable EOs. The committee also identifies and implements corrective measures for issues identified in the systemwide survey and accreditation report reviews.

A majority of CSU campuses have implemented systems and applications that facilitate a transition to EMRs, including some vendor applications designed specifically for university health services. Regulation over these emerging technologies include HIPAA, which establishes national standards for electronic health care transactions, and the Health Information Technology for Economic and Clinical Health Act, which addresses the privacy and security concerns associated with the electronic transmission of health information. Although this audit assesses the security of medical records, it does not address HIPAA in depth, which generally is reviewed as a separate audit.

At California State University San Marcos (CSUSM), SHCS provides eligible students with primary care, preventive services, wellness education, and mental health services. These services include an onsite laboratory and pharmacy. In addition, X-ray services are available through an offsite contracted third-party provider. SHCS is accredited by the AAAHC, and the

pharmacy is licensed by the California State Board of Pharmacy. The SHCS uses Point and Click Solutions, an EMR system, and the pharmacy uses a pharmacy management system by Lagniappe to track dispensed medications prescribed primarily by SHCS providers. Oversight and responsibility of the SHCS is delegated to the SHCS director, who reports to the associate vice president for student engagement and equity and the vice president for student affairs.

## SCOPE

We visited the CSUSM campus from January 29, 2018, through March 2, 2018. Our audit and evaluation included the audit tests we considered necessary in determining whether operational, administrative, and financial controls are in place and operative. The audit focused on procedures in effect from July 1, 2016, through March 2, 2018.

Specifically, we reviewed and tested:

- Campus administration of SHS, including clear reporting lines and defined responsibilities, risk assessment, and current policies and procedures.
- SHCS accreditation status and management responsiveness to recommendations made by the accreditation team.
- Procedures to confirm credentials and qualifications of clinical staff and other employees providing patient care.
- The definition and provision of basic and augmented health services in the SHCS, including approval and eligibility for services.
- Health education programs for the student population.
- Administration of athletics medicine, including proper designation of responsible parties.
- Administration of pharmacy operations, including licensing and permit requirements, pharmacy formulary, dispensing, inventory, and physical security practices at the SHCS and other areas on campus.
- On a limited basis, medical records management, including practices to ensure security and confidentiality.
- Measures to ensure the security of student health facilities.
- Fiscal administration, including the establishment of and subsequent changes to the mandatory health services fee, methods to set and justify fees for augmented services, budgets and financial records, and revenue and expenditure transactions in health fee trust accounts.
- On a limited basis, review of the campus formal risk assessment of applicable SHCS information systems.
- On a limited basis, access to the automated systems to determine that they are adequately controlled and limited to authorized persons.

As a result of changing conditions and the degree of compliance with procedures, the effectiveness of controls changes over time. Specific limitations that may hinder the effectiveness of an otherwise adequate system of controls include, but are not limited to, resource constraints, faulty judgments, unintentional errors, circumvention by collusion, and

management overrides. Establishing controls that would prevent all these limitations would not be cost-effective; moreover, an audit may not always detect these limitations.

Our testing and methodology was designed to provide a review of key operational, administrative, and financial controls and included walkthroughs of the SHCS, pharmacy, and athletics sports medicine program, as well as testing of a limited number of medical staff credentials, electronic medical records, and revenue and expenditure transactions. Our review focused primarily on the SHCS and athletics sports medicine program and included a limited review of academic areas that may be offering health-related services as part of their training programs. Our review did not include counseling and psychological services or a detailed review of medical records and information technology systems.

## CRITERIA

Our audit was based upon standards as set forth in federal and state regulations; BOT policies; Office of the Chancellor policies, letters, and directives; campus procedures; and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors' *International Standards for the Professional Practice of Internal Auditing*.

This review emphasized, but was not limited to, compliance with:

- EO 803, *Immunization Requirements*
- EO 877, *Designation of Health Care Components for Purposes of the Health Care Portability and Accountability Act of 1996 (HIPAA)*
- EO 939, *Augmented Health Services Fee and Augmented Health Services Cancellation Fee; California State University, San Marcos*
- EO 943, *Policy on University Health Services*
- EO 1000, *Delegation of Fiscal Authority and Responsibility*
- EO 1069, *Risk Management and Public Safety*
- EO 1102, *CSU Student Fee Policy*
- Integrated California State University Administrative Manual §8000, *Information Security*
- AA-2015-08, *Clarifications to EO 943*
- Code of Federal Regulations §164.308, *Administrative Safeguards*
- Government Code §13402 and §13403
- California Penal Code §11160 and §11161
- AAAHC Accreditation Standards
- CSUSM *Procurement & Support Services Policy and Procedures*
- CSUSM *Student Immunization Requirement Policy and Procedures*
- CSUSM *Sports Medicine Policy and Procedures*
- CSUSM *Volunteer Guidelines*

## AUDIT TEAM

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Senior Auditor: Marcos Chagollan