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July 16, 2018

Mr. Framroze M. Virjee, President
California State University, Fullerton
800 N. State College Boulevard
Fullerton, CA 92834

Dear Mr. Virjee:

Subject: Audit Report 18-19, *Student Health Services*, California State University, Fullerton

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 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

The California State University
Audit and Advisory Services

STUDENT HEALTH SERVICES

California State University, Fullerton

Audit Report 18-19
June 4, 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 SHS as of April 27, 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 SHS provided by Health Services (HS); however, we identified a few areas needing improvement. HS did not always obtain Office of General Counsel (OGC) review and approval for contracts and agreements and did not have a current executed agreement for X-ray reading services. In addition, an agreement to access reference laboratory software was executed by an individual without the delegated authority to commit resources or obligate the university contractually. Further, administrative oversight of HS information systems related to formal risk assessment and user access review needed improvement.

We also found that the athletics sports medicine program (SMP) did not execute an agreement for the physician with medical oversight responsibility, did not perform periodic inspections of over-the-counter (OTC) medications, and had not obtained formal approval for SMP policies and procedures. In addition, the campus did not always update the system record of approving officials with delegation of fiscal authority. Further, HS retained some medical and other administrative records past the established record retention period and did not perform required annual reviews of keyholders and/or access badge cardholders with access to HS facilities.

Specific observations, recommendations, and management responses are detailed in the remainder of this report. Information security-related observations, recommendations, and management responses are detailed in Appendix A.

OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. CONTRACT ADMINISTRATION

OBSERVATION

The campus did not always obtain required review and approval for educational program agreements and did not execute an agreement for routinely procured X-ray services.

Specifically, we found that:

- For three active agreements and one recently expired agreement with outside universities, and for one internal memorandum of understanding with the school of nursing, the campus did not obtain OGC review and approval. Executive Order (EO) 943, *Policy on University Health Services,* requires such approval for educational program agreements that involve the provision of healthcare at HS facilities.

- An agreement to access reference laboratory software was signed by someone who did not have the authority to commit resources or otherwise obligate the university contractually.

- HS did not execute a contract with a radiology vendor for routinely procured X-ray reading services. We noted that at the time of the audit, HS was in the process of executing a contract with a new vendor to procure these services.

Proper review and approval of contractual agreements helps to reduce risk, can protect the university from adverse financial and legal obligations, and promotes compliance with campus and systemwide requirements. 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 healthcare at HS facilities, and remind appropriate campus staff of the requirements of EO 943 related to healthcare educational programs.

b. Obtain necessary campus approval for the agreement noted above that was not signed by someone with the authority to commit resources or otherwise obligate the university contractually, and remind appropriate HS staff of key university policies and procedures for contracts and procurement.

c. Finalize the agreement for the procurement of X-ray reading services noted above.

MANAGEMENT RESPONSE

We concur.

a. We will create a procedure to ensure that proper review and approval is obtained for all educational program agreements that include the provision of healthcare at HS facilities, and remind appropriate campus staff of the requirements of EO 943 related to healthcare educational programs. Anticipated completion date is September 1, 2018.

b. We will obtain necessary campus approval for the agreement noted above that was not signed by someone with the authority to commit resources or otherwise obligate the university contractually, and remind appropriate HS staff of key university policies and procedures for contracts and procurement. Anticipated completion date is October 31, 2018.

c. We will finalize the agreement for the procurement of X-ray reading services. Anticipated completion date is August 1, 2018.

2. ATHLETICS SPORTS MEDICINE PROGRAM

OBSERVATION

Administration of the SMP needed improvement.

We found that:

- Although the physician responsible for medical oversight of the SMP has been in place since at least academic year 2006/07, the campus did not have an executed agreement with the physician. Additionally, there was no formal designation from the campus president or designee to establish the physician's role, as required by EO 943.

- Boxes of OTC medication included numerous expired single-dose packets. Additionally, a written log documenting the routine inspection of OTC medications for removal of expired, deteriorated, or recalled medications was not maintained, as required by EO 943.

- SMP had not developed a quality assurance program (QAP) similar to the program used by the HS and required by EO 943. This QAP should address topics such as facility cleaning and maintenance, review of incident or injury reports and safety issues, security and confidentiality of health records, and periodic staff training and meetings.

- SMP policies and procedures had not been formally approved in writing by the physician responsible for medical oversight of the program, as required by EO 943.

Effective oversight of SMP activities can help to ensure that administrative responsibilities are addressed, promotes compliance, and reduces the campus exposure to potential litigation or regulatory sanctions.

RECOMMENDATION

We recommend that the campus:

a. Obtain formal designation from the campus president or designee for the physician with oversight responsibilities for SMP, and execute a contractual agreement that addresses the required elements outlined in EO 943.

b. Review all OTC medication in stock, including those stored in sports medicine kits, and remove all expired, deteriorated, or recalled medications. In addition, maintain proper documentation of routine medication inspections.

c. Develop and implement an appropriate QAP for SMP similar to the one used by the HS.

d. Obtain approval in writing for SMP policies and procedures from the physician responsible for medical oversight of the SMP.

MANAGEMENT RESPONSE

We concur.

a. We are in the process of obtaining a formal designation from the campus president or designee for the physician with oversight responsibilities for SMP and executing a contractual agreement that addresses the required elements outlined in EO 943. Anticipated completion date is July 1, 2018.

b. We have reviewed all OTC medication in stock, including those stored in sports medicine kits, and removed all expired, deteriorated, or recalled medications. In addition, we have revised proper documentation of routine medication inspections. Anticipated completion date is June 30, 2018.

c. We have revised and are implementing an appropriate QAP for SMP similar to the one used by the HS. Anticipated completion date is November 30, 2018.

d. We are in the process of obtaining an approval in writing for SMP policies and procedures from the physician responsible for medical oversight of the SMP. Anticipated completion date is November 30, 2018.

3. DELEGATION OF FISCAL AUTHORITY

OBSERVATION

The campus record of approving officials with delegation of fiscal authority was not current.

We reviewed a module in the campus PeopleSoft system, the Business Intelligence Delegation of Authority Dashboard, to assess whether the approving officials with delegation of authority over funds administered and expended by the HS were appropriate. We found a separate list of approving officials for each of the following areas: requisitions and expenditures, check

requests, budget, and hospitality-related expenditures. However, we found 11 instances in which employees who had separated from the campus or HS were not removed from the record of approving officials.

An accurate record of approving officials with delegated fiscal authority provides documented accountability and helps ensure that fiscal transactions are administered in accordance with campus and CSU policies and procedures.

RECOMMENDATION

We recommend that the campus review the Business Intelligence Delegation of Authority Dashboard and ensure that the record of approving officials with delegation of fiscal authority is accurate and appropriate.

MANAGEMENT RESPONSE

We concur. The CMS security team will ensure the delegation of authority is accurate and appropriate by reviewing all employee separations and department changes. Anticipated completion date is July 30, 2018.

4. GENERAL HS ADMINISTRATION

OBSERVATION

HS records management practices and administration over review of keyholders and/or access badge cardholders required improvement.

We reviewed HS records and record retention practices, and we found 13 boxes containing HS medical records and other administrative documents that had been retained past the required retention period and should have been destroyed. The destruction dates indicated on the boxes ranged from May 2009 to June 2017.

In addition, the HS director had not performed an annual review of keyholders and/or access badge cardholders with access to HS facilities as required by EO 943.

Proper record management practices, including proper retention and disposition of medical and related records, helps to ensure compliance with legal and regulatory requirements. Periodic management review of HS keyholders and/or access badge cardholders reduces the risk of inappropriate and/or unauthorized access to HS facilities.

RECOMMENDATION

We recommend that the campus:

a. Review and appropriately dispose of HS records that have met their record retention period, including the HS medical records and other administrative documents noted above.

b. Perform and document the review of HS keyholders and/or access badge cardholders annually, as required by EO 943.

MANAGEMENT RESPONSE

We concur.

a. We will review and appropriately dispose of HS records that have met their record retention period, including the HS medical records and other administrative documents.

b. We will perform and document the review of HS keyholders and/or access badge cardholders annually, as required by EO 943.

Anticipated completion date is November 30, 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 and Student 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 electronic medical records (EMR), including some vendor applications designed specifically for university health services. Regulation over these emerging technologies include Health Insurance Portability and Accountability Act of 1996 (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, Fullerton (CSU Fullerton), the HS department provides eligible students with primary care, preventive services, wellness education, mental health services, and specialty care including acupuncture, chiropractic care, optometry and orthopedics. In

addition, laboratory, X-ray, and pharmacy services are available onsite. The HS department is accredited by the AAAHC, and the pharmacy is licensed by the California State Board of Pharmacy. The HS uses Point and Click Solutions, an EMR system, and the pharmacy uses a pharmacy management system by ProPharm to manage prescriptions and track dispensed medications prescribed primarily by HS providers. Oversight and responsibility of HS is delegated to the associate vice president for student affairs, who reports to the vice president for student affairs.

SCOPE

We visited the CSU Fullerton campus from March 26, 2018, through April 27, 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 April 27, 2018.

Specifically, we reviewed and tested:

- Campus administration of SHS, including clear reporting lines and defined responsibilities, risk assessment, and current policies and procedures.
- HS 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 HS, 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 HS 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 HS 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 HS, pharmacy, and the athletics SMP, as well as testing of a limited number of medical staff credentials, EMRs, and revenue and expenditure transactions. Our review focused primarily on HS and athletics SMP 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 943, *Policy on University Health Services*
- EO 1000, *Delegation of Fiscal Authority and Responsibility*
- EO 1031, *Systemwide Records/Information Retention and Disposition Schedules Implementation*
- 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
- CSU Fullerton *Delegation of Authority for Contracting and Procurement*
- CSU Fullerton *Titan Athletics Training Policies & Procedures*

AUDIT TEAM

Audit Manager: Joanna McDonald
Senior Auditor: Marcos Chagollan

APPENDIX A – INFORMATION SECURITY

Information security-related observations are not publicly posted as they may contain information exempt from disclosure under the California Public Records Act (PRA), California Government Code §6254.19. To make a PRA request, please contact itaudits@calstate.edu.