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AUDIT AND ADVISORY SERVICES

School of Medicine
Departmental Review
Project #15-021

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University of California
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Audit and Advisory Services

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Interim Vice Dean
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SUBJECT: School of Medicine Departmental Review

As a planned internal audit for Fiscal Year 2015, UCSF Audit and Advisory Services ("AAS") conducted an assessment of administrative practices of selected departments within the School of Medicine. Our services were performed in accordance with the applicable International Standards for the Professional Practice of Internal Auditing as prescribed by the Institute of Internal Auditors (the "IIA Standards").

Our preliminary draft report was provided to management in February 2015. Management provided us with their final comments and responses to our findings and recommendations in March 2015. The observations and corrective actions have been discussed and agreed upon with department management and it is management's responsibility to implement the corrective actions stated in the report. In accordance with the University of California audit policy, AAS will periodically follow up to confirm that the agreed upon management corrective actions are completed within the dates specified in the final report.

This report is intended solely for the information and internal use of UCSF management and the Ethics, Compliance and Audit Board, and is not intended to be and should not be used by any other person or entity.

Sincerely,

Irene McGlynn
Director
UCSF Audit & Advisory Services

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MANAGEMENT SUMMARY

As a planned audit for fiscal year 2014-2015, Audit and Advisory Services (AAS) completed a review of departmental administrative practices in selected departments within UCSF's School of Medicine (SOM). The purpose of this review was to assess administrative practices and procedures implemented within the SOM departments for compliance with University policies and regulatory requirements.

To conduct the review, AAS selected five SOM Departments: Epidemiology and Biostatistics, Neurology, Ophthalmology, Pediatrics (specifically, the division of Hematology/Oncology) and Urology. The departmental administrative practices and procedures reviewed for each department were: general ledger verifications, sponsored award expense allowability, award monitoring adequacy, research subject approval, technology management, and cash controls. For each department, we reviewed general ledger verifications for a judgmental sample of sponsored and department projects to determine if they were completed timely. For the sample of sponsored projects we also reviewed relevant records to determine the completeness, accuracy and timeliness of financial and effort reporting. Additionally, we determined if the sponsored projects had current approvals from the Committee on Human Research or the Institutional Animal Care and Use Committee (as applicable). For a sample of expenses posted to sponsored projects from fiscal year 2013-2014, we examined source documentation to determine appropriateness, allowability, and compliance with related policies. Finally, we reviewed the processes within the department for encrypting laptops and managing cash.

Based on procedures performed, the departments reviewed were generally aware and complied with applicable University policies and regulatory requirements related to sponsored award expense allowability and monitoring, and research subject approval. We observed that the departments did not perform all monthly GL verifications timely or document them properly. Additionally, effort reports were not always certified before the end of the certification period. We also noted two departments had one laptop each that were not encrypted as required by the UCSF's Minimum Security Standards. Finally, one department did not have documentation to support that background check was completed for their cash handler.

More detailed information on the observations and management corrective actions can be found in the body of the report.

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I. BACKGROUND

As a planned audit for fiscal year 2014-2015, Audit and Advisory Services (AAS) completed a review of departmental administrative practices in selected departments within UCSF's School of Medicine (SOM). SOM departments are responsible for the oversight of financial, scientific and compliance aspects of their clinical, research and educational activities. These departments report into the SOM Dean's Office and the departments' oversight includes:

- Ensuring procurement activities comply with relevant policies and regulations;
- Ensuring expenditures incurred are within the authorized budget and recorded within the appropriate period;
- Maintaining sufficient records to support transactions and demonstrate compliance with contract terms, University policies and regulatory requirements;
- Reviewing management reports to monitor payroll and non-payroll expenditures;
- Verifying general ledgers and reconciling expenditures to ensure that they are allowable and reported accurately and timely;
- Certifying effort timely and monitoring Effort Reports for changes in certification status (and recertifying if required);
- Ensuring appropriate equipment management controls; and
- Implementing appropriate processes to help ensure compliance with UCSF cash policies and procedures.

II. PURPOSE AND SCOPE

The purpose of this review was to assess administrative practices and procedures implemented within the SOM departments for compliance with University policies and regulatory requirements. In conducting this review, we selected five SOM departments for review: Epidemiology and Biostatistics, Neurology, Ophthalmology, Pediatrics (specifically, the division of Hematology/Oncology) and Urology. These departments were chosen based upon a risk analysis of all departments in the SOM. Factors considered in the risk assessment were:

- BearBuy utilization for non-payroll expenses;
- Percentage of BearBuy transactions that were less than $500;
- Cost transfers as a percentage of total expenses;
- Late cost transfers as a percentage of total expenses;
- Amount of cash transactions;
- If the department was included in a recent AAS review; and
- Input from the SOM Dean's Office.

For the five SOM departments selected, the scope of our review included the following: general ledger verifications, sponsored award expense allowability, award monitoring adequacy, research subject approval, technology management, and cash controls.

To conduct our review, the following procedures were performed:

- Developed and distributed an Internal Control Questionnaire (ICQ) and Separation of Duties Matrix (SOD) to the administrative personnel of the SOM departments selected for review;
- Reviewed the ICQ and SOD completed by department administrative personnel;
- Obtained and reviewed three months of General Ledger (GL) verifications for a judgmental sample of sponsored and department projects;

- Reviewed interim financial reports provided to Principal Investigators (PIs) for the sample of sponsored projects;
- Reviewed a sample of expenses from fiscal year 2013-2014 charged to the sponsored projects selected above (including cost transfers and salaries for administrative personnel);
- Verified that the effort reports for Federal projects included in our sample were certified by Principle Investigators (PIs) timely;
- Reviewed approvals from the Committee on Human Research and the Institutional Animal Care and Use Committee (if applicable);
- Verified that laptops within the department were appropriately encrypted; and
- Reviewed the departments' practices for managing cash.

The scope of our review was limited to the specific departments and procedures described above. As such, work completed is not intended, nor can it be relied upon, to identify all instances of potential irregularities, errors, or control weaknesses that may occur in areas not covered in this review. Fieldwork was completed in December 2014.

III. CONCLUSION

Based on procedures performed, the departments reviewed were generally aware of and complied with applicable University policies and regulatory requirements related to sponsored award expense allowability and monitoring, and research subject approval. The departments have reasonable procedures to oversee the financial and compliance aspects of their projects and provide financial reports to PIs. The departments have implemented procedures to help ensure that expenditures are allowable and they maintain sufficient records to document expenditures posted to sponsored projects. Additionally, the departments maintained documentation to substantiate approval for the use of research subjects.

We observed that the departments did not perform monthly GL verifications timely or document them properly. Additionally, effort reports were not always certified before the end of the certification period. We also noted two departments had one laptop each that were not encrypted as required by the UCSF's Minimum Security Standards. Finally, one department did not have documentation to support that background check was completed for their cash handler.

IV. OBSERVATIONS AND MANAGEMENT CORRECTIVE ACTIONS

A. GL Verifications

GL verifications, designated by the Controller's Office as a key control, were not always completed timely or properly documented.

Nineteen out of 69 GL verifications (28%) were performed more than 30 days after the month-end close:

- Neurology: Four out of 12 GL verifications were performed more than 30 days after the month-end close (between 22 and 169 days late);
- Ophthalmology: Seven out of 15 GL verifications were performed more than 30 days after the month-end closed (between 11 and 180 days late);

- Urology: Eight out of 12 GL verifications were performed more than 30 days after the month-end close (between 9 and 109 days late).

Additionally, 13 GL verifications were not properly documented:

- Epidemiology and Biostatistics: Six out of 15 GL verifications were not dated;
- Pediatrics (specifically the division of Hematology/Oncology): Seven out of 15 GL verifications were not documented on a monthly basis. While the department stated that GL verifications were performed monthly, the forms used to evidence completion of the GL verifications were signed off and dated on a quarterly basis.

GL verification is a key control of UCSF. It is the responsibility of each department to verify that the financial transactions recorded in the GL are in accordance with University regulations. Additionally, transactions recorded against restricted funds must be in accordance with the terms of the award. Per UCSF policy, GL verifications must be performed monthly, within 30 days of the previous month-end close.

GL verification ensures expenditures are accurately reported and no misstatements are reflected. Absent this timely assurance, unallowable expenditures may be posted to sponsored awards or awards may not receive benefit of the incurred expenses. In turn, this may subject UCSF to repaying the expenses, and impair UCSF's reputation, adversely affecting the campus' ability to compete for future research funding.

Management Corrective Actions

The results of a previous AAS review[1] found that several departments, across the University, did not perform timely GL verifications. As a result of this observation, the Controller’s Office will implement a monitoring process, by June 30, 2015, to help ensure GL verifications are being completed monthly. The action by the Controller’s Office should address the control concerns of this observation.

By June 30, 2015, the Dean’s Office will coordinate with the Controller’s Office to ensure the monitoring process is effectively implemented in all SOM departments and that the risks noted above are being addressed. Additionally, the Dean’s Office should reiterate to departmental management the importance and expectations surrounding the completion of GL verifications, including timeliness of completion and expectations for documenting their reviews.

B. Effort Reporting

The departmental processes to resolve delinquent effort reports could be enhanced to ensure that these reports are completed before the end of the certification period.

[1] Contracts and Grants Accounting – End of Award Expenditures, Project 14-036, December 2014

We noted that the effort reports for two projects (out of 12 reviewed) were not fully certified timely. As the personnel working on these projects were in different departments from the home department of the project, no follow-up was performed on the effort reports for those personnel. The department management did not recognize that personnel outside their department were associated with these projects.

The two projects noted were:

- Project 117685A, Epidemiology & Biostatistics, personnel from Neurological Surgery (41 days past the certification deadline);
- Project 119430A, Ophthalmology, personnel from Proctor Foundation (47 days past the certification deadline).

All personnel paid from, or with effort committed to, a federal-sponsored project are required to certify effort reports on a semiannual basis (six-month period ending June 30 and December 31).

The Controller's Office notifies departments of the availability of Effort Reports, monitors compliance with policy and follows-up on delinquent effort reports. Departments monitor progress toward certification completion and ensure they are completed before the end of the certification period. Chairs and Deans follow-up on non-compliance issues, and if necessary, impose corrective measures.

Timely certification of effort reports is a condition of acceptance of federal funding when direct salary charges are contemplated and incurred or cost shared salary is proposed on an award. The effort report should be certified within 120 days of the end of the reporting period.

Management Corrective Actions

By June 30, 2015, the Ophthalmology and Epidemiology & Biostatistics departments will establish procedures to follow up on projects with personnel outside the department to ensure that the effort of personnel outside of their department is certified by the end of the certification period.

C. Laptop Encryption

The process to encrypt all laptop computers should be enhanced to ensure that restricted data is appropriately secured.

Generally, the departments had adequate processes to ensure that laptops deployed to end users were configured with appropriate encryption. However, we noted two laptops in the departments reviewed were unencrypted (one each in Neurology and Ophthalmology). The Neurology laptop was deployed without encryption due to an error on the part of a technician within Information Technology Field Services (ITFS). The Ophthalmology laptop was purchased without encryption and was not reported to the department. As such, it was deployed to the end user without the required encryption.

Per UCSF's Minimum Security Standards for Electronic Information Resources: All laptops used for UCSF business, whether UCSF-owned or non-UCSF-owned, must be encrypted. Given the prevalence of restricted data in the UCSF environment, ineffective management of information technology may result in the loss of research data or the unauthorized access to ePHI.

Management Corrective Actions

ITFS has since put into place an ongoing monitoring process to identify hardware connected to the UCSF network that has not been properly encrypted. As unencrypted hardware is identified, ITFS works with the department to encrypt the devices. Since our observation, ITFS has encrypted the laptop in Neurology and is working with Ophthalmology to encrypt their device.

D. Background Check and Fingerprinting

The processes to obtain required criminal background check and fingerprinting documentation for personnel transferring into critical positions should be reiterated to the departments.

At the time of our review, the Ophthalmology department could not locate documentation of the Cash Handler being fingerprinted. Per management, this employee transferred from another department where she held similar duties. However, fingerprinting and background check for the employee were not performed as part of the hiring process. The department had the employee fingerprinted in January 2015.

Per UCSF Administrative Policy Cashiering, 300-14, all employees whose duties include the handling of cash must be subjected to a background check for criminal convictions. Additionally, proof of completion of the background check must be maintained on file in the appropriate Human Resources Service Center.

Management Corrective Actions

By June 30, 2015, the Dean's Office will remind the departments that they need to obtain the required fingerprinting documentation and criminal background check for personnel hired into critical positions such as those with responsibility for cash and cash equivalents (including current employees transferring from other departments).

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