NOTICE OF MEETING

NORTH BROWARD HOSPITAL DISTRICT

BOARD OF COMMISSIONERS

An Audit Committee meeting will be held on Wednesday, May 27, 2020, at 2:00 pm, via WebEx. The purpose of this committee meeting is to review and consider any matters within the committee’s jurisdiction.

NOTE: This public board meeting shall be conducted only through communications media technology in accordance with Fla. Exec. Order No. 2020-69 (March 20, 2020) and § 120.54(5)(b)2., Florida Statutes.

The meeting shall be open to the public who may attend by calling toll free: (650) 479-3208 and when prompted use the Meeting Access Code: 471 496 328. **If you are considering calling in to attend the meeting via WebEx, please ensure your phone is set to MUTE when not commenting to avoid an echo that would greatly interfere with the sound making communication inaudible.**

Any person who decides to appeal any decision of the District’s Board with respect to any matter considered at these meetings will need a record of the proceedings, and for such purpose, may need to ensure that a verbatim record of the proceedings is made which record includes testimony and evidence upon which the appeal is to be based.
AUDIT COMMITTEE MEETING
1:30 p.m., February 26, 2020

1. NOTICE

Official notice and agenda of this meeting is attached to the Minutes, as EXHIBIT I and EXHIBIT II, as presented for consideration of the Committee.

2. CALL TO ORDER 1:39 p.m.

3. COMMITTEE MEMBERS

Present: Commissioner Christopher T. Ure, Chair
Commissioner Nancy W. Gregoire, Vice Chair
James Petkas, External Audit Consultant
Scott Porter, External Audit Consultant

Absent: Commissioner Marie C. Waugh

Senior Leadership
Additionally Present: Ray T. Berry/Commissioner, Stacy L. Angier/Commissioner, Gino Santorio/Chief Executive Officer/President, Alan Goldsmith/Chief Administrative Officer, Alex Fernandez/Chief Financial Officer, Linda Epstein/Corporate General Counsel, Jerry Del Amo/Deputy, General Counsel

4. PUBLIC COMMENTS None.

5. APPROVAL OF MINUTES DATED JANUARY 15, 2020

MOTION It was moved by Mr. Porter seconded by Mr. Petkas, to:

Approve the Audit Committee meeting minutes, dated January 15, 2020.

Motion carried unanimously.

6. TOPIC OF DISCUSSION

6.1. Review Completed Audits

Interim Chief Internal Auditor, Anthony Almeda, gave a follow up report on findings that were made on two completed audits, as seen below.

340B Pharmacy Discount Audit

- Ineligible clinics listed on HRSA’s Office of Pharmacy Affairs website were removed.
• Identified that there was no 340B oversight committee established to ensure effective policy and governance.
• Over 11,000 340B medications were improperly dispensed to ineligible patients, leading to a possible million-dollar refund.
• 128 effective manufacturers were identified.

HRSA Health Care for the Homeless Grant Audit
• 11 recommendations implemented, followed up and effectively remediated.

Mr. Almeda gave a report on the findings for several new audits.

Procurement of Services and Medical Supplies (purchasing audit and procurement audit)
• Audit on vendor purchase orders above $50k
  o Emergency purchase orders audited
  o Electronic purchase orders audited
  o Manual purchase orders audited
  o RFP purchase orders audited

Patient Access, Operations and Admissions,
• Determine if internal controls were in place for patient registration and patient financial illegibility for pre-scheduled and walk-in encounters.
  o Collection of patient demographic
  o Verification of illegibility
  o Physician order management timeliness of medical necessity authorization
  o Patient liability
  o Calculations.

Discussion ensued on how the audit department conducted reports, who was involved, and what occurred once the findings were shared with management.

It was confirmed that a third-party Revenue Cycle firm was being sourced to assist with pending reports. Commissioner Ure requested that the scope of service related to what vendors were being asked to bid on, be presented at the next Audit Committee meeting.

Discussion ensued on the degree of the Audit Committee independence in engaging professional services. Ms. Epstein noted that the Audit Committee’s recommendations must have final Board approval. She believed it was referenced under the Charter and Bylaws but would confirm and report back.

Mr. Porter suggested that Mr. Almeda present internal audit department’s policy at the next meeting, prior to presenting the rest of his report. The remaining items were tabled.

**MOTION** It was moved by Mr. Porter, seconded by Mr. Petkas, that:
The report be tabled and brought back at the next Audit Committee Meeting after being fully vetted through the management review process.

Motion **carried** unanimously.

6.2. Discussion of Update on status of FY2020 Audit Plan

6.2.1. Update on Audits in Progress

Commissioner Ure suggested that the audit plan be tabled to the next meeting due to time constraints.

6.3. Discussion of follow up Quality Assurance Review and Fee by AMP

Mr. Almeda shared that he contacted Ms. Angela Poole, with AMP, to familiarize himself with her report. Discussion ensued on whether her contract included a follow up and if there would be an additional fee incurred, of up to $20k. Mr. Almeda confirmed he felt comfortable enough to do the follow up himself regarding recommendations to improve the audit charter.

Mr. Santorio clarified that part of the original scope of phase one, which was delivered on, was to provide a formal report that addressed recommendations for improvements to the District’s Audit Committee including the audit committee charter. Phase two would comprise of a follow-up to see if the recommendations were being complied.

The committee concluded that a follow up presentation was not necessary.

7. **ADJOURNMENT** 3:03 p.m.

**MOTION** It was **moved** by Commissioner Gregoire, **seconded** by Mr. Petkas, to:

**Adjourn the Audit Committee Meeting.**

Motion **carried** unanimously.

Respectfully submitted,
Commissioner Stacy L. Angier, Secretary/Treasurer
May 18, 2020

The Board of Commissioners
North Broward Hospital District
Fort Lauderdale, Florida

We are engaged to audit the financial statements of the North Broward Hospital District (the District), as of and for the year ended June 30, 2020. We would be glad to meet with you to discuss this information further at your request.

Our Responsibilities under U.S. Generally Accepted Auditing Standards, Government Auditing Standards and the Uniform Guidance.

As stated in our engagement letter signed on May 31, 2019, our responsibility, as described by professional standards, is to express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the financial statements does not relieve you or management of your responsibilities.

In planning and performing our audit, we will consider the District's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. We will also consider internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with the Uniform Guidance.

As part of obtaining reasonable assurance about whether the District's financial statements are free of material misstatement, we will perform tests of its compliance with certain provisions of laws, regulations, contracts, and grants. However, providing an opinion on compliance with those provisions is not an objective of our audit. Also in accordance with the Uniform Guidance and Chapter 10.550, Rules of the Auditor General State of Florida, we will examine, on a test basis, evidence about the District's compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) Compliance Supplement and Chapter 10.550, Rules of the Auditor General State of Florida applicable to each of its major programs for the purpose of expressing an opinion on the District's compliance with those requirements. While our audit will provide a reasonable basis for our opinion, it will not provide a legal determination on the District's compliance with those requirements. Generally accepted accounting principles provide for certain required supplementary information (RSI) to supplement the basic financial statements (as identified in the engagement letter). Our responsibility with respect to such supplementary information, which supplements the basic financial statements, is to apply certain limited procedures in accordance with generally accepted auditing standards. However, the RSI will not be audited and, because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance, we will not express an opinion or provide any assurance on the RSI.

We have been engaged to report on other supplementary information (as described in the engagement letter), which accompany the financial statements but is not RSI. Our responsibility for this supplementary information, as described by professional standards, is to evaluate the presentation of the supplementary information in relation to the financial statements as a whole and to report on whether the supplementary information is fairly stated, in all material respects, in relation to the financial statements as a whole.
Planned Scope, Timing of the Audit, and Other

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Material misstatements may result from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity. We will generally communicate our significant findings at the conclusion of the audit. However, some matters could be communicated sooner, particularly if significant difficulties are encountered during the audit where assistance is needed to overcome the difficulties or if the difficulties may lead to a modified opinion. We will also communicate any internal control related matters that are required to be communicated under professional standards.

We expect to begin our audit on approximately July 27, 2020. Phillip Grice will serve as the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it.

This information is intended solely for the use of the Board of Commissioners and management of the District and is not intended to be, and should not be, used by anyone other than these specified parties.

Very truly yours,

Warren Averett, LLC
Birmingham, Alabama
AUDIT SCHEDULE

- Planning weeks: May 11th and 18th
- Fieldwork scheduled to start July 27th for 5 weeks
- Target date for issuance - October Board meeting
COVID-19

- Working remotely for interim fieldwork due to COVID-19
- Warren Averett utilizes remote work technology on regular basis
- Utilizing FileZilla file share portal, WebEx screen sharing, and Citrix Receiver to review client files
- Warren Averett Connect – secure file sharing portal
- Communication barrier – overcome remote working challenges with regular conference calls with Warren Averett team members and Broward team, when necessary
PLANNING

- Preliminary analytics – financial comparisons with prior year balances and other analytics
- Establish materiality – testing threshold related to total assets and other factors
- Identify significant areas – materiality, fraud risk factors, volume of transactions, and other factors
- Perform process walkthroughs over significant audit areas
- Assess audit risk – Low, Moderate, High
- Inquiries of key personnel – identify entity changes
- Develop audit plan for all areas
INTERIM PROCEDURES

- Journal entry testing
- Disbursement testing
- Review of accounts receivable estimates
- Fixed asset testing
- Review of interim third-party payor settlements estimates
CONTROL TESTING

- Controls may be tested if they are determined to be suitably designed and properly implemented
- Testing controls for:
  - Accounts receivable
  - Accounts payable
  - Entity level controls
SIGNIFICANT AREAS - ASSETS

- Cash
- Investments
- Patient revenues and receivables
- Estimated third-party payor settlements
- Other revenues and receivables
- Capital assets
SIGNIFICANT AREAS = 96% OF TOTAL ASSETS

<table>
<thead>
<tr>
<th>Assets</th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$ 22,709</td>
<td>$ 121,223</td>
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<tr>
<td>Cash and investments externally restricted by donors</td>
<td>$ 16,634</td>
<td>$ 14,937</td>
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<td>Short-term investments</td>
<td>$ 512,727</td>
<td>$ 442,756</td>
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<tr>
<td>Assets whose use is limited required for current liabilities – Investments</td>
<td>$ 7,437</td>
<td>$ 6,262</td>
</tr>
<tr>
<td>Due from patients and others, net of allowance for uncollectibles of $236,279 ($248,968 in 2018)</td>
<td>$ 142,401</td>
<td>$ 154,812</td>
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<tr>
<td>Inventories</td>
<td>$ 35,233</td>
<td>$ 32,253</td>
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<tr>
<td>Estimated third-party payor settlements</td>
<td>$ 21,220</td>
<td>$ 5,888</td>
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<tr>
<td>Other current assets</td>
<td>$ 47,463</td>
<td>$ 47,834</td>
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<tr>
<td>Total current assets</td>
<td>$ 805,824</td>
<td>$ 825,965</td>
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<tr>
<td>Assets whose use is limited – Cash and investments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts designated for self-insurance</td>
<td>$ 38,698</td>
<td>$ 37,670</td>
</tr>
<tr>
<td>Project fund from debt issuance</td>
<td>$ 932</td>
<td>$ 26,981</td>
</tr>
<tr>
<td>Less amount required to meet current obligations</td>
<td>$ (7,437)</td>
<td>$ (6,262)</td>
</tr>
<tr>
<td>Assets whose use is limited, net</td>
<td>$ 32,193</td>
<td>$ 58,389</td>
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<tr>
<td>Investments</td>
<td>$ 228,167</td>
<td>$ 150,088</td>
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<tr>
<td>Capital assets, net</td>
<td>$ 560,493</td>
<td>$ 577,467</td>
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<tr>
<td>Net pension asset</td>
<td>$ 11,853</td>
<td>$ 1,580</td>
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<tr>
<td>Other assets</td>
<td>$ 24,278</td>
<td>$ 27,850</td>
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<tr>
<td>Total noncurrent assets</td>
<td>$ 824,786</td>
<td>$ 756,985</td>
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<tr>
<td>Total assets</td>
<td>$ 1,662,803</td>
<td>$ 1,641,339</td>
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SIGNIFICANT AREAS - LIABILITIES

- Expenses for goods and services, accounts payable and other liabilities
- Payroll and related liabilities
- Malpractice and other insurance liabilities
- Debt and debt service expenses
- Pension asset/liability
- Other postemployment benefit program liability

- Compliance with laws and regulations (not on balance sheet)
SIGNIFICANT AREAS = 100% OF TOTAL LIABILITIES

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>$</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current maturities of revenue bonds payable</td>
<td>5,025</td>
<td>4,030</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>115,353</td>
<td>122,357</td>
</tr>
<tr>
<td>Accrued salaries, benefits, and payroll taxes</td>
<td>29,390</td>
<td>31,225</td>
</tr>
<tr>
<td>Accrued personal leave</td>
<td>29,940</td>
<td>29,735</td>
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<tr>
<td>Current portion of lease obligations</td>
<td>1,749</td>
<td>108</td>
</tr>
<tr>
<td>Estimated third-party payor settlements</td>
<td>38,126</td>
<td>36,203</td>
</tr>
<tr>
<td>Current portion of self-insurance program liability</td>
<td>7,437</td>
<td>6,262</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td>227,020</td>
<td>229,920</td>
</tr>
<tr>
<td>Revenue bonds, net of current maturities</td>
<td>337,242</td>
<td>343,637</td>
</tr>
<tr>
<td>Lease obligations, net of current portion</td>
<td>5,903</td>
<td>237</td>
</tr>
<tr>
<td>Self-insurance program liability, net of current portion</td>
<td>23,883</td>
<td>26,148</td>
</tr>
<tr>
<td>Other postemployment benefit program liability</td>
<td>159,987</td>
<td>158,175</td>
</tr>
<tr>
<td>Total liabilities</td>
<td>754,035</td>
<td>758,117</td>
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</table>
RISK ASSESSMENT – IT ENVIRONMENT

- Information Technology General Controls Review
  - Assess risks associated with the IT Environment of Broward as it relates to overall risks in the organization and the financial statements
  - Review risks and controls in the following categories:
    1. Structure and Strategy
    2. Change Management
    3. Vendor Management
    4. System and Application Security
    5. Incident Management
    6. Backup Management
    7. Vulnerability Management
SINGLE AUDIT

- Single Audit Overview
- Schedule of Expenditures of Federal and State Awards
- Major Program Determination
  - Low-risk auditee status
  - Type A and B program thresholds
  - Program risk assessment process
- Audit Process – Compliance Supplement
  - Internal controls over compliance
  - Compliance testing
- Timing of Single Audit
- Issued Reports
Questions?
1. PURPOSE

The purpose of this policy is to establish clear standards of the internal auditor duties and set procedures for undertaking any special projects that go beyond the realm of consulting as addressed in the International Standards for the Professional Practice of Internal Auditing (Standards). This policy applies to all Broward Health-Auditing Staff and may aid in the understanding to all Broward Health facilities and employees.

Mission of the Internal Audit Department
The mission of the Internal Audit (IA) Department is to enhance and protect the organizational value by providing risk-based and objective assurance, advice, and insight in order to ensure that Broward Health operates in compliance with the law, rules and regulations, established internal controls, policies and procedures, applies sound management practices, and is fiscally accountable for the use of public funds.

2. KEY TERMS

Audit Plan: A description and schedule of internal audits to be performed over a certain period of time (usually based upon fiscal year) that includes areas to be audited, type and scope of work, and high-level objectives.

Audit Program: Procedures that govern the audit process.

Controls: The policies, procedures, practices, and organizational structures, designed to provide reasonable assurance that business objectives will be achieved and that undesired events will be prevented or detected and corrected.

Criteria: Standards, measures, or expectations used in making an evaluation and/or verification of an observation. They can be internal (policies and procedures), external (laws and regulatory requirements), and leading practices (industry best practice, professional guidance, key performance measures).

Executive Management: The highest level of management in an organization responsible for planning, leading and controlling a business.

Governance: Processes and structures implemented to communicate, manage, and monitor organizational activities.

Impact: The influence and effect of a risk.

Internal Audit: Internal audit (IA) is an independent, objective assurance and consulting activity designed to add value and improve an organization’s operations. It helps an organization accomplish its objectives by...
3. POLICY

Objectives

The objective of the Internal Audit Department (IA) is to conduct independent reviews and appraisals to evaluate and improve the effectiveness of governance, risk management, and internal control processes. This includes systematic assessments of Broward Health's (the "District") policies, procedures, and operations to provide management with an independent appraisal of the various operations and systems of internal control. The reviews also help to ensure that the District's resources are used efficiently and effectively. It is the intention of the Internal Audit Department to perform these services with due professional care and with minimal disruption to District operations.

The Internal Audit Department (IA) accomplishes its objectives through the conduct of operational, financial, compliance, and performance audits, selected as a result of a comprehensive risk analysis and assessment process.

The management of the District is responsible for establishing and maintaining internal controls to protect assets, discourage perpetuation of fraud, and encourage achievement of the organizational goals and objectives. Internal Audit is responsible for examining and evaluating the adequacy and effectiveness of those internal controls.
Independence and Objectivity

In order to maintain independence and objectivity, the Internal Audit function has no direct responsibility or any authority over the activities or operations that are subject to review. Internal Audit does not develop and implement operational policies and procedures, or systems of internal control, prepare records, or engage in activities that would normally be subject to Internal Audit review. However, the Internal Audit staff may be consulted when new systems or procedures are designed to ensure internal controls are adequately addressed.

Internal auditors must maintain an impartial, unbiased mental attitude, and avoid conflicts of interest in fact or appearance. Internal auditors must disclose any actual or potential impairment to independence or objectivity in relation to any audit engagement to the audit committee and Board of Commissioners.

Confidentiality

It is understood that certain information or items are confidential in nature and special arrangements may be required when examining and reporting on such items. Internal Audit will handle all information obtained during a review in the same prudent manner as the custodian of such information. Internal Audit respects the value and ownership of information they receive and will not disclose confidential information without appropriate authority unless there is a legal or professional obligation to do so.

The Internal Audit staff is expected to remain prudent with all information obtained during the course of an engagement. When discussing matters pertaining to an engagement or any other District matters, the Internal Audit staff must always remain discreet and be certain to limit those conversations exclusively to appropriate personnel. The Internal Audit staff has an obligation to never indiscreetly discuss any information obtained during the course of audit assignments.

Code of Ethics

The Internal Audit staff shall subscribe to the Code of Ethics established by the Institute of Internal Auditors (IIA), as well as adhere to Broward Health Code of Conduct and other Governmental related policies and regulations.

Standards of Conduct

In addition, the Internal Audit Department will adhere to the following IIA standards and standards of conduct:

- **Service** - Demonstrate commitment to fulfilling all responsibilities with an attitude of service toward Broward Health commissioners, management, and staff, while maintaining a sincere, respectful, dignified, and caring attitude.

- **Excellence** - Uphold a high standard of service and a commitment to quality in performing all projects.

- **Leadership** - Provide noteworthy examples which emphasize high ethical and moral standards.

- **Professionalism** - Conduct business in a manner that reflects favorably on the individual auditor, the Internal Audit Department, and the District. Exercise skill, integrity, maturity, and tact in all relations. Under no circumstances should the Auditor demonstrates a behavior that is condescending, and lack of respect to clients when gathering information. BH Internal Auditors will not use the office of internal audit to interrogate, and intimidate clients. Abhorrent attitude and behavior from an Auditor will be addressed by the Chief of Internal Audit, or BH Human Resources.

Professional Proficiency and Due Professional Care
Engagements must be performed with proficiency and due professional care. Internal auditors must possess the knowledge, skills, and other competencies needed to perform their individual responsibilities. If such knowledge, skills, and competencies are not present in the Department, the Chief Internal Auditor may source them by procuring outside services.

Professional proficiency is the responsibility of each auditor. Each member of the Internal Audit staff has a professional obligation to schedule and attend on-going continuing professional education forums to ensure they remain academically proficient and advance professionally. They should keep informed about improvements and current developments in internal auditing standards, procedures, and techniques. Continuing education may be obtained through membership and participation in professional societies; attendance at conferences, seminars, and college courses.

Each Internal Auditor will be responsible for updating and maintaining a file on the department's shared drive documenting their compliance with continuing education requirements. This file should include a spreadsheet tracking the hours of continuing education by subject areas as well as copies of the related certificates supporting completion of the required training.

The Chief Internal Auditor will assign each audit to the person who possesses the necessary knowledge, skills, and disciplines to conduct the audit properly.

The Chief Internal Auditor is responsible for providing appropriate audit supervision. Supervision is a continuing process, beginning with planning and ending with the conclusion of the audit assignment. The Chief Internal Auditor will document evidence of supervision and review on all audits.

Services Provided by the Internal Audit Department

Internal Audit's primary activity is the implementation of a program of regular audits and reviews of Broward Health's business operations. However, services may include special projects, investigations, and consultations as requested by management or necessitated by the identification of a risk area or possible adverse incident. Services provided by the Internal Audit Department may include:

a. Operational Audits/Reviews. Operational audits consist of critical reviews of operating processes and procedures, and internal controls that mitigate area-specific risks. These audits examine the use of resources to determine if they are being used in the most effective and efficient manner to fulfill the organization's mission and objectives.

b. Financial Audits/Reviews. These audits review accounting and financial transactions to determine if commitments, authorizations, and receipt and disbursement of funds are properly and accurately recorded and reported. This type of audit also determines if there are sufficient controls over cash and other assets and that adequate process controls exist over the acquisition and use of resources. Unlike external financial audits, internal financial audits do not prepare or express professional opinions on the fairness of financial statements.

c. Investigative Audits/Reviews. These audits may be conducted to determine existing internal control weaknesses, assist in determining the amount of loss, and recommending corrective measures to prevent subsequent re-occurrence of an alleged or identified incident. These types of investigations may encompass misuse of Broward Health's funds or assets, potential fraud, potential conflicts of interest, or gross misconduct. At the conclusion of the investigation Corporate Compliance and Legal should be notified and receive a draft copy of any report prior to its release.

d. Technology Audits/Reviews. Technology audits are usually comprised of control reviews of disaster recovery plans, system back-up procedures, and general security of data and of the physical facilities.
The purpose of these audits is to evaluate the accuracy, security, effectiveness, and efficiency of the organization's electronic and information processing systems.

e. Compliance Audits/Reviews. These audits determine the degree to which operational areas adhere to Broward Health's policies and procedures, as well as mandated Federal, State, or other regulatory requirements. Recommendations usually require improvements in processes and controls used to ensure compliance with regulations.

f. Consulting Engagements. Consulting engagements may be accepted based on request from management. The nature and scope of consulting engagements are agreed with the client, and are intended to add value and improve an organization's governance, risk management, and control processes without the internal auditor assuming management responsibility. See Policy GA-031-002 Internal Audit Assistance to Management.

Audit Plan

The Chief Internal Auditor is responsible for developing a risk based Audit Plan each fiscal year. The Audit Plan is a written document showing specific audits or projects to be performed by the Internal Audit staff. The Audit Plan is presented to the Audit Committee annually for approval.

The development of the Audit Plan includes an evaluation of the Enterprise Risk Assessment. The Risk Assessment includes a broad range of risks and associated controls. In addition, Internal Audit is responsible for identifying and evaluating exposures to business risks and the controls designed by management to reduce those risks. Factors considered in assessing risks may include:

a. Ongoing Factors - process complexity, established policies and procedures, operational changes, and potential financial impact;

b. Environmental Risk Factors - political environment, regulatory guidelines, financial markets, technology initiatives, and public image.

The Internal Audit Department may also conduct unplanned audits as warranted or requested. Prior to most audits, the Internal Auditor assigned to the engagement will discuss with management the general scope, purpose, and estimated time frame of the audit, as appropriate. Due to the nature of certain issues that may be the subject of investigative reviews, advance notification may not be considered appropriate. As unplanned projects are required, they are included in the overall Audit Plan for the year. Any substantial changes to the Audit Plan will be presented to the Audit Committee at subsequent meetings.

4. PROCEDURE

Audit Process

Although every audit project is unique, the audit process is similar for most engagements. Throughout the engagement, Internal Audit will determine ways to minimize risks and increase efficiencies within the area of review. Auditee involvement is critical at each stage of the audit process. An audit will result in a certain amount of time being diverted from area personnel's usual routine. One of the key objectives of the auditor is to minimize this time and avoid disrupting on-going activities.

Audits will be assigned to one or more auditors based upon the magnitude, special knowledge required, and/or time constraints. In the case of multiple auditors assigned, one will be designated as the auditor in charge. The individual is responsible for overseeing all aspects of the audit, and ensuring the completion of the assignment in a timely manner. The auditor in charge is responsible for keeping the Chief Internal Auditor informed of
significant opportunities for improvement and any expected delays in the completion of the assignment.

The auditor(s) should review any prior audit work papers and final report as one way of researching background information on the audit unit/area. The auditor should also utilize other sources of information that may be helpful to the review, such as, other audit staff with relevant experience, the Internet, IIA reference library, "Auditnet," industry and professional subscription and publications, etc. Depending upon any changes to the audit-able unit, audit recommendations from the final report of the prior audit should be noted and included in the development of the audit program for the current review.

Once sufficient background information has been reviewed, the scope, goals and objectives for the audit should be established and documented. The information gathered during this phase will also be useful in the planning phase of the audit.

1. Notify. The auditor will complete an audit announcement to be distributed to the process owners of the audit. It will only be sent after the Chief Internal Auditor reviews and approves the announcement and distribution list. The audit announcement will include:
   a. Audit objective and preliminary scope
   b. Audit documentation request
   c. Engagement team details
   d. Project timing and completion
   e. Request for information

The Internal Audit Department will notify and schedule a kickoff meeting with the manager and the senior managers of the process to be audited no earlier than 10 days after the audit announcement has been distributed. The purpose of the kickoff meeting is to identify the general scope and the objectives of the audit, how long the audit is expected to last, and what the responsibilities for all parties are in the audit process. Any factors that will impact the audit should be raised at this time.

2. Plan. Internal auditors must develop and document a plan for each engagement, including the engagement's objectives, scope, timing, and resource allocations. Internal auditors must develop and document work programs that achieve the engagement objectives. Work programs must include the procedures for identifying, analyzing, evaluating, and documenting information during the engagement. The work program must be approved prior to its implementation, and any adjustments must be approved promptly.

As part of the planning process, the auditor should assess the risks associated with the audit area. The Risk Assessment (RA) is one method of identifying and documenting each risk, or control objective, associated with a particular review; there after a separate document Audit Program is created which includes audit steps that are used to test controls and address those risks. The RA can also incorporate corresponding audit step – creating a hybrid between the RA and the audit program. The Auditor can use prior work papers and information from management to help identify risks. This information can also be obtained from familiarity with the area, observations, walk-through, and interviews with the staff in the area. A Planning Document should be prepared summarizing the information gathered through the planning process and the direction of the review. The Planning Memo should include, as applicable:

   a. Review Prior Audits - the auditor should note the date of the last review, any significant issues from prior reviews, and the current status of the issues identified in the prior review.

   b. Review Management Audit Requests - the auditor should note any requests made by
management, along with the names and titles of those members of management.

c. **Description of, or Significant Changes to the Subject Area** - the auditor should describe or note any changes to the area's/function process, i.e., policy and procedure changes, system changes, staffing changes, etc.

d. **Pre-Audit Observations** - the auditor should note specific issues that may require more research. These would be issues that were either told to the auditor or the auditor learned through the research conducted during the planning stage.

e. **Adjustments to Objectives and Scope** - the auditor should document any changes in the audit scope, based on information learned during the planning stage and any requests from management.

Using all of the information gathered and reviewed up to this point, the auditor should prepare an Audit Program. The Audit Program documents the specific steps that will be taken to complete the review. If a review of the area/function was previously performed, the auditor can start with the program from the prior review and make changes, as necessary, to document the requirements of the current review.

Upon completion of the Audit Program and Planning Document, the auditor will submit these documents to the Chief Internal Auditor for review and approval. The approved documents should be included in the work papers. For each segment of the audit, the Audit Program should include:

a. A statement of the objectives.

b. The work steps required to meet the objectives.

c. A space for referencing the related audit work papers and the initials of the auditor performing the work step.

3. **Test/Fieldwork.** Internal auditors must identify and analyze sufficient, reliable, relevant, and useful information to achieve the engagement's objectives. Testing may include interviews with the staff, review of procedures and manuals, review of compliance with the District's policies and governmental laws and regulations and assessing the adequacy of internal controls, as well as other procedures necessary to achieve audit objectives. Each audit will have unique aspects; therefore, the audit fieldwork and analysis performed on each audit assignment should be customized for that particular assignment. The following factors should be considered in conducting fieldwork:

a. Determine the most efficient and effective approach to review the audit area. If the audit step involves testing a sample of items, the auditor should first obtain independent verification of the population to ensure the population is as complete as possible. Then, from the population, a sample should be selected to test. The auditor should ensure that the sample is representative of the population by using a statistical or non-statistical sampling technique; for example: systematic, random, clustered, judgmental, convenience and bias in sampling.

b. In performing tests on sample items, the auditor should ensure that the same tests are performed on all sample items.

c. If the most efficient and effective methods involve walking through the process or interviewing, the auditor should schedule appointments with the necessary individuals. When arranging appointments, the auditor should accommodate the individual's schedule as much as possible, and keep interruption of the area/function to a minimum. The author should take sufficient notes during the walk-through or interview, and should type up those notes as soon as possible, upon return to the audit department.

d. Any questions or issues noted as a result of fieldwork and analysis should be conveyed to the
We agree/disagree/partially agree with the auditors' observations and/or recommendations.

- Respond directly to the observation and its recommendation(s) designated contact person. The "respond by" date on the audit inquiry should be reasonable, but should not be so prolonged as to hold up the audit. If the response is not received in a timely manner, the auditor should follow-up with the contact person to determine the reason for the delay. If further, unnecessary delay occurs, a second audit inquiry, stamped "Second Request," should be sent to the contact person and their supervisor. Non-response should be elevated to senior management for further resolution.

e. The auditor should follow-up, as necessary, to clarify audit inquiry responses received.

f. If during the course of the audit fieldwork and analysis, a concern is identified that is not properly addressed in the scope of the Audit Program, the auditor should discuss the concern with the Chief Internal Auditor. The auditor and the Chief Internal Auditor should decide how to best address the concern. If the concern is material in nature, it may be addressed either in the current audit by expanding the scope and developing a new step in the program, or in a completely separate audit.

g. After completing audit fieldwork and analysis for any section of the program, the auditor should inform management of any material issues noted in that section. Both positive successes and opportunities for improvement should be discussed.

h. All documentation that supports the auditor's work and conclusions throughout the review should be maintained. Once the auditor completes the audit fieldwork, the documentation should be organized, indexed, and maintained in an internal audit software (G-Drive, TeamMate).

At the conclusion of any on-site visit the auditor will have a meeting with the process owners to discuss any observations identified during the walk through and discuss the next steps in the audit process. The auditor will document the meeting to be saved with in their work papers.

4. Exit Meeting/Communicate. At the completion of all the fieldwork/testing the auditor will have an exit meeting with the process owners. This meeting must include any observations found and who will receive the draft report to provide management response. The auditor is to keep the department that is undergoing the audit updated on a regular basis of the progress of the audit and especially if there are any observations. There may be instances where the deficiencies can be addressed immediately. During the audit process, recommendations will first be verbally shared with management to gain consensus on the facts and circumstances. In lieu of initial verbal discussions, Internal Audit may also provide a written recommendation marked "Draft for Discussion Purposes Only."

5. Draft Report. After all the fieldwork/testing has been completed the auditor will write a draft report. A draft report should be watermarked "DRAFT" and include an executive summary, objectives and scope, background, conclusions and observations, and audit recommendations (see Policy GA-001-003 Internal Audit Report). When the Chief Internal Auditor has approved the draft report it will be distributed to the identified personnel from the exit meeting for review and management response.

6. Management Response. The process owners will receive the draft audit report after the exit meeting has taken place. The report should be reviewed to confirm the contents and respond to Part I. of the audit recommendations if needed. It is up to the audited department to determine who will provide the management response. The response should begin with the following statement:
   - We agree/disagree/partially agree with the auditors' observations and/or recommendations.

The following guidelines must be used in writing the Management Response:
   - Respond directly to the observation and its recommendation(s)
• Provide specific actions that management commits to take to correct the deficiency
• Make your response clear and concise
• Exclude information that is not pertinent to the finding or its corrective action plan
• Identify specific date the remediation will be completed, and personnel responsible for implementation

The time window for the management response is 10 business days. The auditor will include in the report a copy of management's written comments, or a summary of the comments received. In cases where a fully developed action plan requires further study and analysis, management may indicate this in their action plan.

7. Review/Final Report. After the management responses are received and added to the draft report a final version will be created by the auditor. The audit work papers, draft report, and the final report with management responses will be reviewed by the Chief Internal Auditor or designee. All identified audit documentation or report issues must be resolved prior to finalization of reports. The Chief Internal Auditor at their discretion will meet with executive management to discuss the audit and any identified observations prior to distribution.

8. Distribute. When approved by the Chief Internal Auditor the final report is then immediately released to the audited department, senior management, and other relevant parties as determined by the Chief Internal Auditor. It is also released to the Audit Committee as part of the agenda at the periodic meetings.

9. Monitoring Progress. The Internal Audit Department will monitor implementation of corrective actions included in Management Responses to the open action items related to Part I. Audit Observations on a continuous basis until the issues are resolved. Based on the significance of the item and nature of the remediation plan, Internal Audit may conduct a follow up audit/review of the area. The follow-up audit/review is intended to ensure that management has addressed all deficiencies and recommendations included in the audit report. It should take place soon after the agreed implementation deadline to which management has committed in the management response. During the review, Internal Audit tests the effective implementation of each audit recommendation. If recommendations have not been satisfactorily addressed, a second follow-up review is scheduled. This process continues with successive reviews until either the recommendation has been implemented or the circumstances giving rise to the concern have changed.

For less significant areas, Internal Audit will monitor and follow-up on the progress of implementation of all corrective actions relating to deficiencies and recommendations. Responsible managers are generally asked for an update on implementation of corrective action plans on at least a quarterly basis. Internal Audit may conduct walk-through or tests to validate the effective implementation of each audit recommendation as deemed necessary.

Each Internal Auditor in charge of a particular engagement is responsible for monitoring the progress of implementation of corrective actions in accordance with the process outlined and providing periodic updates to the Chief Internal Auditor and the Auditing Monitoring Committee. The Auditing Monitoring Committee will be reporting its results to the audit committee and the Board of Commissioners.

Audit Documentation

1. Evidential Matter. Evidential matter obtained during the course of fieldwork provides the documented basis for the auditor’s opinions, observations, and recommendations as expressed in the audit report. Auditors must obtain all evidence necessary for the effective completion of the audit. The decision on how much evidence is enough and what type to seek requires the exercise of the auditor’s judgment based on experience, education, reasoning, and intuition. A thorough knowledge of the concepts underlying audit evidence will help the auditor to improve the audit quality and efficiency.

The International Standards for the Professional Practice of Internal Auditing require that work papers possess certain attributes to provide a sound basis for audit observations and opinions and to be considered as
evidential matter. Those attributes are defined to be sufficient, competent, relevant, and useful as follows:

a. Sufficient information is factual, adequate, and convincing so that a prudent, informed person would reach the same conclusions as the auditor.

b. Competent information is reliable and best attainable through the use of appropriate audit techniques.

c. Relevant information supports audit findings and recommendations and is consistent with the objectives for the audit.

d. Useful information helps the organization meet its goals. It also provides a reference for the preparer when called upon to answer questions.

2. Types of Evidence. If the evidence supports the basic tests of sufficiency, competence, and relevance, it may be used to support the auditor’s observations. The following outlines the different types of evidence obtained during the course of an audit:


b. Testimonial evidence. From interview and statements from involved persons: Interview summaries should clearly indicate the date, time and person interviewed, and should include a clear concise summary of all the relevant information provided by the interviewee.

c. Documentary evidence. Consisting of legislation, reports, minutes, memorandum, contracts, extracts from accounting records, formal charts and specifications of documentation flows, systems design, operations and organization structure.

d. Analytical evidence. Secured by analysis of information collected by the auditor.

Documentation of Evidential Matter

Standards for the Professional Practice of Internal Auditing require that audit work papers reflect the details of the evidence upon which the auditor has relied. The Internal Audit staff must maintain adequate documentation of the audit, including the basis and extent of planning, work performed, and the results and observations of the audit.

WORK PAPER PROCEDURES

1. Work Papers – General

The work papers document a system, operation or process, and audit procedures performed. They should contain the records of preliminary planning, the audit program, audit testing, and the results of procedures that were performed.

2. Work Paper – File Structure

There are two types of working papers - permanent and current. The permanent work papers, known as the "Permanent Files," contain historical and relatively static descriptive material. The current work papers (or simply "work papers") contain records of audits as they are carried out.

a. Permanent Files. Permanent files are used only for data that can reasonably be expected to be needed in audits for two or more years and to remain unchanged. The material that may appropriately be included varies widely from audit to audit. Items that may be held in permanent files include flowcharts, system narratives, operating policies and procedures, long-term debt agreements, contracts, organizational charts, and regulatory material.

The Internal Audit staff is responsible for updating the permanent files during the planning stage of an audit. Current materials are to be clearly identified. Old materials should be identified and placed in a sub-folder label.
"old files" providing an audit trail of past practices and changes to those practices.

b. **Current Work Papers.** The current Work Papers should contain documentation related to the objectives and scope, the audit testing, observations, conclusions, and recommendations. At a minimum, the current work papers should include the following documentation:

- Preliminary Survey
- Planning Memo
- Audit Announcement
- Audit Program
- Internal Control Questionnaire/Documentation
- Test of Details
- Draft Reports
- Final Report

3. **Type of Work Papers**
The type of work papers may take various forms based on the subject matter, types of information, and source of information.

a. **Schedules and analyses.** Schedules are useful for identifying statistical trends, verifying the accuracy of data, developing projections or estimations, and determining if tasks or records have been properly completed. Each schedule or analysis included in the work papers should include an explanation of the purpose of the analysis and a summary of the results.

b. **Documents.** Copies or actual samples of various documents can be used as examples, for clarification, and as physical evidence to support a conclusion or prove the existence of a problem. These documents can be memos, computer printouts, forms, invoices, or any of numerous other items. Any copied document should serve a useful audit purpose. The following guidelines should be followed when including documents in the work papers:

- Indicate the person and/or file that the document came from.
- Fully explain the terms.
- Fully explain the terms and notations found on the document, as well as its use. These explanations may be made on an attached page or on the line of the document.
- Each document should be cross-referenced to either the page or separate analysis where it was discussed.
- No document should be included in the work papers without an explanation of why it was included.

c. **Process Narratives and Flowcharts.** In many audits, it is necessary to describe systems or processes as they relate to the area being audited. An explanation and description of such procedures or processes should be documented through the use of narratives or flowcharts or some combination of the two. The choice of which method to use depends on the relative efficiency of the method in relation to the complexities of the system being described. Narratives are often easier to use, and should be used, if the system or process can be described clearly and concisely. However, when narratives are not practical and a description of control points are difficult to integrate, flowcharting (or a combination of narratives and flowcharting) is an appropriate alternative. Flowcharts conveniently describe complex relationships because they reduce narrative explanations to a picture of the system. They are concise and may be easier to analyze than written descriptions. Process narratives should be sufficiently detailed to achieve audit objectives and to support analysis and testing of control procedures.
d. Providing a Record of Interviews and Observations. Often, relevant information may be obtained through interviews conducted with area personnel. Any verbal information that is likely to support a conclusion in the audit work papers should be documented. Interviews are useful in identifying problem areas, documenting controls, obtaining general knowledge of the audit subject, collecting data not in a documented form, and documenting the opinions, assessments, or rationale for actions from area personnel. Interview notes should contain only the facts and views presented by the person interviewed and should not include any of the auditor's opinions. The activity that an auditor observes can serve the same purposes as an interview. If an observation can be used to support a conclusion, it should also be documented. This is especially true when performing physical verifications. Documentation of interviews and observations should clearly outline the date, location, participants, and relevant information discussed or observed.

4. Quality of Work Papers

Proper work papers demonstrate professionalism and document the audit procedures that were performed. Audit work papers also need to support that due professional care was exercised and illustrates compliance with professional auditing standards. Comprehensive and well-organized work papers are characterized as follows:

a. Complete and Accurate. Work papers must be able to "stand alone." This means that a person external to the audit or not necessarily familiar with audit policies and procedures should be able to follow the work from planning through fieldwork to the report with no information besides what appears in the work papers. The information should be factual, objective and answer all questions stated in the work paper objective.

b. Concise. Work papers must be confined to those that serve a useful purpose. Items that are used in the audit should be evaluated as to their necessity in the work papers. Work papers are not retained if they are not required to support the conclusions drawn in the audit. Documents that support evidence of exceptions to policy and procedure should be included in the work papers.

c. Uniform. Where possible, work papers should be fairly uniform in appearance and types of content, such as purpose, testing procedures, findings, and conclusion. In addition, work papers should be sufficiently numbered and indexed.

d. Observation Documentation. Identified deviations must be adequately documented in the test work paper where the results are uncovered. There are five elements of an observation:

- **Condition**: The existing situation that is not in compliance with the criteria. This is a description of what was observed or the results of the test procedure.
- **Criteria**: The policies and procedures, laws, regulations, contracts, standards, measures, expected performance, and benchmarks against which performance is compared or evaluated. Criteria identify the required expectation and provide a context for evaluating evidence and understanding the observation.
- **Cause**: This is a description of the reason(s) why the exception occurred, which may also serve as the basis for recommendations for corrective actions.
- **Risk/Effect**: This identifies the real or potential impact of the observation and answers the question, "What effect did/could it have?" or "What is the risk?"
- **Recommendations**: This identifies suggested improvement actions and answers the question, "What should be done to mitigate the risk of the observation?"

General issue writing guidelines:
• Be factual, specific, objective and concise;
• Avoid extraneous information;
• Avoid negative terms or tone; and
• State consequences in realistic and relative terms (avoid taking it to the extreme).

5. Work Paper Techniques

An auditor makes frequent use of a variety of symbols / tick-marks to indicate work that has been done. A legend or key explaining the use of each tick-mark should be included with the work papers.

a. Tick Marks. When performing attribute testing, a tick-mark may be used to indicate an item meets the attribute. However, if an attribute is not met, a tick-mark with a unique explanation should be used. This allows for more easily distinguishing between exceptions and non-exceptions for reporting purposes.

b. Descriptive Headings. All working papers that are not self-explanatory should have a heading which includes the area under audit, title of work paper, and the date prepared. If it is not evident, the source of information and purpose of the working paper should also be noted.

Work Paper Organization

a. Indexing. Work papers must be well organized with a logical flow of the work. Work papers within each audit section should be arranged from the level of least detail to the most. That is, the audit program, followed by the lead schedule or summary page for the section (if applicable), with the detailed testing behind. For non-financial work papers, a summary memo, narrative, or flowchart may be presented first with examples of related documents or other more detailed information to follow.

b. Cross-Referencing. Cross-referencing within work papers should be complete and accurate. Work papers should be cross-referenced to the appropriate audit program, lead sheet, or other summary work paper.

c. Carry forward. The auditor should make full use of the work papers developed in prior audits. Flowcharts, system descriptions, and other data may still be valid. A copy of those work papers that remain useful should be made a part of the current working papers. Prior year sign-offs should not be deleted from the original document.

Control/Confidentiality of Work Papers

Access to work papers is limited to authorized personnel. In circumstances where requests for access to audit work papers and reports are made by parties either within or outside the District, approval must be obtained from the Chief Internal Auditor.

5. RELATED POLICIES

GA-031-002 Internal Audit Assistance to Management
GA-031-003 Internal Audit Report

6. REGULATION/STANDARDS

Institute of Internal Auditors (IIA)
Generally Accepted Auditing Standard (GAAS)
Generally Accepted Accounting Principles (GAAP)
7. REFERENCES
Broward Health's Internal Audit Charter

9. ATTACHMENTS
Audit Process Work Flow Diagram

Attachments

Audit Process Work Flow Diagram.pdf

Approval Signatures

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GA-031-002 Internal Audit Assistance to Management

1. PURPOSE

This policy applies to all Broward Health Auditing Staff and may aid in the understanding to all Broward Health facilities and employees. The purpose of this policy is to establish clear standards to Broward Health of the internal auditor duties and set procedures for undertaking any special projects that go beyond the realm of consulting as addressed in the International Standards for the Professional Practice of Internal Auditing (Standards).

2. KEY TERMS

Controls: The policies, procedures, practices, and organizational structures, designed to provide reasonable assurance that business objectives will be achieved and that undesired events will be prevented or detected and corrected.

Governance: Processes and structures implemented to communicate, manage, and monitor organizational activities.

Internal Audit: Internal audit (IA) is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Management: The person(s) responsible for achieving the objectives of the entity and who makes decisions by which those objectives are to be pursued.

3. POLICY

Internal auditors are often asked to perform duties beyond the internal audit role. Their expertise in governance, risk management, and control, coupled with an extensive knowledge of the organization, makes them a valuable resource to which management can turn for assistance. However, they must guard against assuming management responsibilities that could impair their independence and objectivity or take too much time away from internal audit's primary activity of carrying out the risk-based plan of independent, objective assurance and consulting.

The Internal Audit Department's primary activity is to conduct a "broad comprehensive program of evaluating the effectiveness of the company's governance, risk management, and control processes." An internal auditor
is to evaluate the reliability and integrity of financial and operating information; the effectiveness of governance, risk management, and controls; and adherence to policy and procedures. It is crucial to the success of internal auditing and to conformance with the Standards that any duties that may risk harming the department's independence or an internal auditor's objectivity be carefully evaluated before acceptance. Activities such as training line personnel; performing accounting duties; providing staff support in operational areas; and developing systems, procedures, and policies are the responsibility of management. Requests for such assistance must be referred to and approved by the chief internal auditor (CIA). Assignments of this nature with an expected duration of more than one week will be undertaken only after the CIA approves written objectives, time commitment, and terms of reference agreed to with client management. Upon completion of such an assignment, an internal auditor will generally not be assigned to an internal audit in the same area for a period of time (usually one year) to be stipulated by the CIA.

4. PROCEDURE

The audit process is defined in Broward Health policy GA-031-001.

5. RELATED POLICIES

GA-031-001 Broward Health Internal Audit Policy and Procedure

6. REGULATION/STANDARDS

International Standards for the Professional Practice of Internal Auditing.
Institute of Internal Auditors Code of Ethics.
Broward Health Code of Ethics.

7. REFERENCES

Broward Health's Internal Audit Charter.

Attachments

No Attachments

Approval Signatures

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GA-031-003 Internal Audit Report

1. PURPOSE

The purpose of this policy is to establish clear standards of the internal auditor duties and set procedures for the Internal Audit Report. It also provides guidelines regarding report writing and report characteristics. This policy applies to all Broward Health auditing staff and may aid in the understanding to all Broward Health facilities and employees.

2. KEY TERMS

**Application Controls**: Controls that relate to data and transactions within an application system to validate completeness and accuracy (See also: Application System, Controls).

**Application System**: Integrated computer programs designed for a specific purpose.

**Audit Plan**: A description and schedule of audits to be performed over a certain period of time that includes areas to be audited, type and scope of work, and high-level objectives.

**Audit Program**: Procedures that govern the audit process.

**Cause**: A description of the reason(s) why the exception occurred, which may also serve as the basis for recommendations for corrective actions.

**Condition**: The existing situation that is not in compliance with the criteria. This is a description of what was observed or the results of the test procedures.

**Controls**: The policies, procedures, practices, and organizational structures, designed to provide reasonable assurance that business objectives will be achieved and that undesired events will be prevented or detected and corrected.

**Criteria**: Standards, measures, or expectations used in making an evaluation and/or verification of an observation. They can be internal (policies and procedures), external (laws and regulatory requirements), and leading practices (industry best practice, professional guidance, key performance measures).

**Executive Management**: The highest level of management in an organization responsible for planning, leading and controlling a business.

**Governance**: Processes and structures implemented to communicate, manage, and monitor organizational activities.
Impact: The influence and effect of a risk.

Internal Audit: Internal audit (IA) is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

IA Charter: A document approved by the board of commishioners that defines responsibility, authority, and accountability for audit functions.

Key Control: A primary control or combination of controls that are essential for a business process and provide reasonable assurance that material errors will be prevented or detected in a timely basis.

Likelihood: The probability of a risk occurring (See also: Risk).

Management: The person(s) responsible for achieving the objectives of the entity and who makes decisions by which those objectives are to be pursued.

Mitigation Actions: The necessary steps, or action items, to reduce the likelihood and/or impact of a potential risk (See also: Impact, Likelihood, Risk).

Non-Key Control: If the potential impact of the financial statements upon its failure is deemed immaterial and if that failure cannot cause the entire process to fail.

Observations: Also may be referred to as findings. The auditor makes observations to evaluate the efficiency and effectiveness of the controls followed by the organization.

Process Owner: The person who has the authority to determine how a process operates, and the responsibility to make sure it continues to meet customer and business needs today and into the future.

Residual Risk: The risk remaining after management takes action to reduce the impact and likelihood of an adverse event, including control activates in responding to a risk.

Risk: A potential event or action that would have an adverse effect on the organization.

Work papers: Documents that summarize and record all the activities and evidence obtained during an audit or investigation.

3. POLICY

Timely and proficient communication of internal audit engagements can increase the effectiveness of governance and risk management, provide opportunities for process improvements, and influence positive change. Written internal audit reports provide a formal means of notifying senior management, the board, and other stakeholders of audit observations, related risk, and areas for improvement. The audit report presents the results of an audit or review within the organization and is the core deliverable of an Internal Audit Department. The report structure will contain the following elements:

- Title page
- Table of Contents
- Executive Summary
- Audit Objectives
- Audit Scope and Methodology
- Background
- Part I Observations, Recommendations, and Management Responses
4. PROCEDURE

Audit report general guidelines.

The draft report should go through one or two levels of internal review before its sent to the process owners. The Chief Internal Auditor must approve the draft report prior to it being sent out for management response. The final audit report must be approved by the Chief Internal Auditor prior to final distribution.

a. Title page. The title page of the report will include the following elements:
   - Title and date of report
   - Report number
   - Broward Health logo
   - Distribution List

b. Executive Summary. The executive summary is to provide a clear and concise overview of the audit observations and efficiently deliver critical information with a persuasive, well substantiated key message to stakeholders. A strong executive summary will assist the reader to understand the key points of the audit report. Some components of an executive summary include:
   - Introduction that provides basic information about the audit.
   - Audit report rating.
   - Brief description of the objectives and scope of the audit.
   - Summary of observations of the audited activity/process.
   - An acknowledgement of satisfactory performance, whenever possible.

The executive summary may include repeat observations from previous audits and information on action plans from previous audits that have not been completed. It should also include any scope limitations encountered during the audit. The executive summary should not exceed one and a half (1.5) pages.
c. **Audit Objectives.** This is a detailed description of what the audit set out to accomplish and is consistent with the approved audit plan.

d. **Audit Scope and Methodology.**

   - The audit scope is the organizational department being reviewed along with the time period covered by the audit.
   - Methodology is the processes or procedures the auditor performed to assess specific operations. It should include the amount of items tested along with the total amount in the scope period.

   It should also include any areas that have been excluded during the audit.

e. **Background Information.**

   The background should be a synopsis of the activity being audited or an explanation of the process for readers who are not familiar with the area being reviewed. It can also include a summary of the policies being tested and any federal and state regulations that affect the area being reviewed.

f. **Part I Observations, Recommendations, and Management Responses.**

   Part I observations is only for internal and external criteria used to make an observation. The observations are more than the results of testing and should include relevant details to understand the issue and demonstrate the observation is based on facts. The Part I audit observations include the following components:

   - **Condition:** The existing situation that is not in compliance with the criteria. This is a description of what was observed or the results of the test procedure.
   - **Criteria:** The policies and procedures, laws, regulations, contracts, standards, measures, expected performance, and benchmarks against which performance is compared or evaluated. Criteria identify the required expectation and provide a context for evaluating evidence and understanding the observation. The criteria used should only be internal or external.
   - **Cause:** This is a description of the reason(s) why the exception occurred within the system and the root cause. It can also serve as the basis for recommendations for corrective actions.
   - **Risk/Effect:** This identifies the real or potential impact of the observation and answers the question, "What effect did/could it have?" or "What is the risk?"
   - **Recommendations:** This identifies suggested improvement actions and answers the question, "What should be done to mitigate the risk of the observation?" It should be based on observations and include actions to correct the existing conditions.

   Each observation will have its own stand alone rating based on the observation rating system. They should be rated based on their significance relative to the project, individual risk, or to the organizations as a whole. The ranking with the highest risk should be listed first.

   **Management Response.**

   Management response is needed for all Part I observations. It is up to the audited department to determine who will provide the management response. After the exit meeting between the auditor and the process owners a draft report will be provided. The management response is due in 10 business days after the draft report and exit meeting is completed. The management response will include the following elements:

   - Planned actions to mitigate the observation
   - Person responsible to ensure the planned actions are completed
   - Target date action plan will be completed
The management response should start with; we agree/disagree/partially agree with the auditors' observations and/or recommendations. The following guidelines must be used by the process owners when writing the Management Response:

- Respond directly to the observation and its recommendation(s)
- Provide specific actions that management commits to take to correct the deficiency
- Make your response clear and concise
- Exclude information that is not pertinent to the finding or its corrective action plan
- Identify specific date the remediation will be completed, and personnel responsible for implementation

**g. Part II Additional Observations and Enhancement Opportunity**

Part II observations is used to communicate observations dealing with leading practice criteria (industry best practice, professional guidance, key performance measures) or other observations identified during the review. The part II audit observation should include:

- **Condition**: The existing situation that is not in compliance with the criteria. This is a description of what was observed or the results of the test procedure.
- **Criteria**: This is a description of the reason(s) why the exception occurred within the system and the root cause. The criteria use for Part II should only be leading practices.

No management response is needed for Part II observations and no risk rating will be provided.

**h. Part III. Appendix**

The audit rating description for the audit report and the risk rating for the individual observations will be listed here. The rating system is as follows:

**Audit report rating**: The audit report rating is for the complete area that was reviewed and will be discussed in the Executive Summary. When deciding the audit report rating the totality of the audit must be considered which will includes the number of observations being reported. The audit team will discuss the report with the Chief Internal Auditor and use the following system to assign a report rating:

<table>
<thead>
<tr>
<th>Audit Report Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong</strong></td>
<td>Internal controls are sufficient and appropriate to the organization. Risk is effectively managed. No exceptions to established policies and procedures were identified.</td>
</tr>
<tr>
<td><strong>Acceptable</strong></td>
<td>There have been some minor risk management weaknesses identified. Controls have modest weaknesses that are correctable in the normal course of business and/or minor improvements.</td>
</tr>
<tr>
<td><strong>Needs Improvement</strong></td>
<td>Risk may not be effectively managed. Weakness may include control exceptions or failures that could have adverse effects on the organizations if corrective actions are not taken. Controls not fully in place or applied consistently.</td>
</tr>
<tr>
<td><strong>Unsatisfactory</strong></td>
<td>There are significant deficiencies due to the absences of effective controls. Risks are not effectively managed and/or there is widespread lack of application and/or compliance.</td>
</tr>
</tbody>
</table>

**Observation risk rating**: This rating is used only for Part I. When internal and external criteria have observations they will receive a risk rating. The audit team along with the Chief Internal Auditor will review all observations and use the following system to assign a rating.
<table>
<thead>
<tr>
<th>Observation Risk Rating</th>
<th>Definition</th>
<th>Number of Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>High risk of an error or incident occurring that may contribute to the non-achievement of a control objective and/or is a key focus for business success/achievement of goals – immediate management action needs to be taken to address the identified conditions.</td>
<td></td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>Moderate risk of an error or incident occurring that may contribute to the non-achievement of a control objective and/or is important for business success/achievement of goals – management action is required to address the identified conditions.</td>
<td></td>
</tr>
<tr>
<td>Low Risk</td>
<td>Minor risk of an error or incident occurring that when addressed will strengthen the controls and assist in mitigating risk – management action is required to address the identified conditions.</td>
<td></td>
</tr>
</tbody>
</table>

i. General Information.

A list of the audit team, Chief Internal Auditor, and electronic signature of the Chief Internal Auditor.

j. Attachments.

Any attachments needed will be placed within this section. It can include charts, graphs, or other information not included in the background. Attachments should be referenced in the body of the report for the reader.

5. RELATED POLICIES

GA-031-001 BH IA Policy and Procedure

6. REGULATION/STANDARDS

Institute of Internal Auditors (IIA)

7. REFERENCES

Broward Health’s Internal Audit Charter

8. ATTACHMENTS

Internal Audit Report Template

Attachments

Report Template.docx

Approval Signatures

<table>
<thead>
<tr>
<th>Step Description</th>
<th>Approver</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Brian Kozik: SVP, COMPLIANCE &amp; PRIVACY</td>
<td>03/2020</td>
</tr>
<tr>
<td>Step Description</td>
<td>Approver</td>
<td>Date</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>Robert Colwell: SUPV, CLINICAL AUDIT</td>
<td>03/2020</td>
</tr>
</tbody>
</table>
Revenue Cycle:
Patient Access Operations & Admissions
Audit Report

Internal Audit Report No: 2020 A-223
Respectfully Submitted By:
Internal Audit Department Broward Health

Confidential
January 7, 2020
Re-Issued (New Format)
April 1, 2020

<table>
<thead>
<tr>
<th>Name</th>
<th>Organizational Role</th>
<th>Draft</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Committee</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gino Santorio</td>
<td>President/Chief Executive Officer BH</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Alan Goldsmith</td>
<td>Executive Vice President/Chief Administrative Officer</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Alex Fernandez</td>
<td>Senior Vice President/Chief Financial Officer</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Linda Epstein</td>
<td>General Council</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Heather Havericak</td>
<td>Chief Executive Officer, BHMC</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Randy Gross</td>
<td>Chief Executive Officer BHIP</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Jared Smith</td>
<td>Chief Executive Officer BHCS</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Alice Taylor</td>
<td>Chief Executive Officer BHN</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Onel Rodriguez</td>
<td>Chief Finance Officer BHMC</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Romaine Layne</td>
<td>Chief Finance Officer BHIP</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maureen Martin</td>
<td>Chief Finance Officer BHCS</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Kimberly Cole</td>
<td>Chief Finance Officer BHN</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Katherine Ross</td>
<td>Chief Information Officer, Information Technology</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Name</td>
<td>Organizational Role</td>
<td>Draft</td>
<td>Final</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Mary Hummel</td>
<td>Manager, Healthcare Information Security, Information Technology</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Kerry Emrith</td>
<td>Executive Director, Patient Access</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Table of Contents
1 Executive Summary ................................................................. 1
2 Audit Objective ........................................................................... 2
3 Audit Scope and Methodology ...................................................... 2
4 Background ................................................................................. 3
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6 Part II Additional Observations and Enhancement Opportunity ............. 8
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9 Attachments ................................................................................. 10
1 Executive Summary

The Internal Audit Department (IA) has conducted an audit of the Patient Access Department. This Audit was part of our fiscal year (FY) 2020 Audit Plan and meets the requirement of the Institute of Internal Audit (IIA) standards. The objectives of the audit were to determine whether internal controls are in place for patient registration and financial clearance processes for pre-scheduled and walk-in encounters. Audit procedures focused on Patient Access front-end processes for registering patients and verifying insurance, which have a direct impact on effective billing. The scope of the audit covered the period from July 1, 2018 through June 30, 2019 and included the Patient Access, Registration and Admitting Departments at all Broward Health Hospitals. This audit did not include a review of the unfunded to funded patient account process (M.O.P.E.D.).

Overall, the patient registration process for areas reviewed by Internal Audit are acceptable to support timely, accurate, and efficient billing. However, during our audit we did come across areas in which the process could be enhanced. This is based on the following observations:

Part I Observations:
Listed below are areas of improvement identified related to BH Policy and Procedures or Regulatory Agencies and require a management response.

1. Policy GA-003-138 Information Access Management. Terminated employees maintain access to Audit Logix. 31 out of 274 active accounts within Audit Logix are assigned to terminated employees.
2. Policy GA-032-034 Registration and Financial Clearance for Scheduled and Unscheduled Patients does not provide guidance on how non-collected copays and/or deductibles due at time of service are documented, tracked, or approved.
3. Policy GA-003-011 Data Security Monitors requires a quarterly access review. Quarterly access review has not been performed for Audit Logix.
   Reasonable efforts to ensure minimum amount of PHI disclosed to registration staff at BHIP needs enhancement.

Part II Additional Observations and Enhancements Opportunity:
Listed below is additional information and enhancement opportunities for informational purposes only and did not require a specific management response.

1. IA noted that BH revenue cycle score card includes only two of the seven Healthcare Financial Management Association’s (HFMA) suggested key performance indicators (KPI) for patient access.
2. As of November 2019, the Point of Service (POS) cash collection for FY 2020 at all BH hospitals is $1,157,578 less than the stated POS goal of $7,255,611.
3. POS cash collection. The amount of co-pays and deductibles that were due at the time of service and not collected is not tracked.

The Internal Audit Department would like to acknowledge the collaboration of the management and staff from the Patient Access Department. The audit team would also like to acknowledge
Broward Health Imperial Point (BHIP) for their exceptional documenting within Invision of relevant information.

2 Audit Objective

The objectives of the audit were to determine whether internal controls are in place for patient registration and financial clearance processes for pre-scheduled and walk-in encounters. This review entailed a timely and thorough review of the Patient Access business process by accessing the following information: collection of patient demographic information, verification of eligibility, physician order management, timely initiation of medical necessity authorizations when needed, patient liability transparency, calculation, and collection processes and retro-review of financial clearance functions. By reviewing the information listed above it will ensure the regulatory compliance guidelines are being followed and mitigate any potential financial loss.

3 Audit Scope and Methodology

The scope of our audit work was performed in accordance with the standards set forth by Federal and State regulations, identified BH policy, and the Institute of Internal Auditors (IIA). The scope of the audit covered the period from July 1, 2018 through June 30, 2019 and included the Patient Access, Registration and Admitting Departments at all Broward Health Hospitals.

This audit did not include a review of the unfunded to funded patient account process (M.O.P.E.D.).

To accomplish the audit objective, we performed the following procedures:

2. Reviewed Federal and State Regulations.
4. Verified required data entered by patient access was completed during registration.
5. Conducted on-site visits at all BH hospitals.
6. Conducted interviews of patient access staff.
7. Reviewed HFMA hospital best practice KPI guidelines for revenue cycle management.
8. Performed research of best practices for patient access.
9. Conducted testing on patient access required documentation by reviewing the documents in Electronic Documentation Management (EDM) and reviewing notes on the patient’s accounts in Invision.
11. Reviewed Audit Logix Account Management.
12. Performed research of best practices for patient access.
13. Conducted testing on patient access required documentation by reviewing the documents in Electronic Documentation Management (EDM) and reviewing notes on the patient’s accounts in Invision.
4 Background

The revenue cycle includes all the events that occur from the time a patient enters the healthcare system to the time their claim is paid or otherwise resolved. A service depends on patient access entering accurate and complete information from patient identification to insurance information to identifying financial needs. Given that patient satisfaction is now a component of quality measurement and reporting, healthcare organizations must assess the effectiveness of patient access points.

Patient Access Services within a hospital setting can encompasses many different roles and responsibilities. It is one of the most important and concentrated areas in health care. According to the National Association of Healthcare Access Management (NAHAM), patient access general responsibilities can include the following: customer service, positive identification of the patient, pre-admission services, scheduling, verification of pre-certification, obtain signatures on required documents, important messages from Medicare, collection of accurate and complete patient information, and point of service (POS) collections.

Patient access is responsible for the collection of co-pays and deductibles at the time of service. The patient access specialist (PAS) will call the member after verifying benefits and any deductible or co-pay due at the time of service to notify the patient prior to the procedure date. If the patient is unable to pay the amount due at the time of service, the PAS will discuss it with their manager to see if a lower amount can be paid on the day of service and a payment plan would be set up. There is a Center for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual that provides guidance on collecting deductibles and coinsurance of patient that have Medicare coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) implemented privacy rules of Protected Health Information (PHI). PHI under the U.S. law is any information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity (or a Business Associate of a Covered Entity), and can be linked to a specific individual. The privacy rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The HIPAA minimum necessary rule limits the sharing of PHI between parties. It requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information.

To effectively evaluate a hospitals revenue cycle sufficient KPIs should be developed. A KPI is a set of quantifiable measurements that a company uses to gauge or compare performance in terms of meeting their strategic and operational goals. These KPIs should be measured to evaluate and compare performance on business objectives. According to the HFMA, there are 29 KPIs for hospital revenue cycle benchmarking divided into five major groups. These five groups, Patient Access, Pre-Billing, Claims, Account Resolution, and Financial Management reflect the activities by the individual groups making up the revenue cycle process. The KPI has been developed by industry leaders led by HFMA. These KPIs are standard metrics that define the essentials of revenue cycle performance in clear, consistent, and unbiased terms. The HFMA KPI’s for patient
access has a total of seven different indicators. BH uses a revenue cycle score card to report on its progress of meeting its goals.

National Association of Healthcare Access Management (NAHAM) has 34 different KPIs that measure how well front-end departments and staff are doing across six Patient Access domains that include:

- Collections
- Conversions
- Patient Experience
- Critical Processes
- Productivity
- Accuracy

Patient access managers can use NAHAM KPIs to measure a facility's performance and then compare their score against industry benchmarks, thus measuring outcomes, not merely activities.

In discussing the HFMA KPI’s with Patient Access Management we were informed that beginning in March 2020, with the centralization of patient access, the KPI indicators related to pre-registration rate, verified encounters and, registered encounters standards mentioned as points of clarification in the audit, are now being monitored, manually, due to restrictions within the registration platform and the lack of integration with the Cerner scheduling and insurance verification system.

Audit Logix is an automated web-based reporting tool that is used to identify real time errors in the registration process and facilitate error identification and corrections before billing occurs. Daily PAS must sign-in to Audit Logix in order to access their registrations completed for that day to determine if there were any errors in the registration process. Audit Logix is configured with standard rules that apply to all hospitals, in addition to custom-made rules that are specific to each hospital, which are used to identify and flag any errors that occurred. Patient Access Supervisors review Audit Logix error reports to determine which flagged errors can be accepted and approved, or rejected and require additional documentation. Once an error is corrected, it is resubmitted through the Audit Logix workflow.

5 Part I Conditions, Recommendations and Management Responses.

Observations noted below are areas of improvement identified in reference to BH Policy, contractual deliverables, and Procedures or Regulatory Agencies guidelines and require a management response.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. During review of user access on the Audit Logix system, we noted terminated employees maintain access to Audit Logix.</strong></td>
<td><strong>Condition Details:</strong> 31 out of 274 active accounts within Audit Logix are assigned to terminated employees. Note: We would like to point out that none of the 31 terminated employees attempted to access Logix after terminating. <strong>Criteria:</strong></td>
</tr>
</tbody>
</table>
Access Modification

1. Upon termination of employment, contract, or service agreement, access is removed from systems on the Broward Health network in accordance with Broward Health policy, Information System Access via the Broward Health Network. For systems not on the Broward Health network, the supervising manager is responsible for ensuring the removal of access upon staff termination.

2. When authorized users change positions or responsibilities, their direct supervisors are responsible for ensuring the appropriate modification of access to systems on the Broward Health network in accordance with Broward Health policy, Information System Access via Broward Health Network. Likewise, for systems not on the Broward Health network, direct supervisors are responsible for ensuring that access is modified as appropriate for authorized users' job responsibilities in accordance with, Minimum Necessary Uses, Disclosures, and Requests.

**Cause:**
Terminated employees are typically removed at the Active Directory level which disables a user’s ability to access the internal network which, as a result, disables access to the applications reliant on network access. Audit Logix is a web-based tool and is accessible from the internet and does not require network credentials for access.

**Risk/Impact:**
Due to Audit Logix being accessible from the internet and not requiring a BH network account, any person with an active Audit Logix account can access the application which contains PHI.

In addition, depending on the level of access, an unauthorized person with access to Audit Logix can process information and make changes directly to the application.

**Recommendations:**
1. Users with access to Audit Logix should be reviewed against a current listing of terminated users as part of the quarterly access review.
2. When an employee separates with BH, access should be removed within Audit Logix, and a review should be performed to ensure the terminated employee did not access the application after their last day worked.

**Management Response:**

**Planned Actions:**
IT will remove all active accounts from Audit Logix that were identified as a terminated employee.

**Person Responsible:**
Mary Hummel, IT Security Manager

**Target date:**
Completed. IA confirmed all terminated users were disabled from Audit Logix on 2/3/2020.
2. **Policy GA-032-034 Registration and Financial Clearance for Scheduled and Unscheduled Patients** does not provide guidance on how non-collected copays and/or deductibles due at time of service are documented, tracked, or approved.

<table>
<thead>
<tr>
<th>Condition Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH policy GA-032-034 Registration and Financial Clearance for Scheduled and Unscheduled Patients section j (a) states “If the patient is unable to meet their financial liability in full, the Patient Access Specialist (PAS) must seek managerial approval for acceptance of a lesser payment or payment arrangement.” The policy does not provide guidelines for documentation of the managerial approval, such as e-mail or sign off when copays or deductibles are not collected in full at time of service. No written guidelines are in place of what criteria the manager is using when accepting a lesser payment or accepting a payment arrangement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH policy GA-032-034 Registration and Financial Clearance for Scheduled and Unscheduled Patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cause:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete policies that do not address tracking or include guideline on non-collection of copays and deductibles.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk/Impact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loss of revenue.</td>
</tr>
<tr>
<td>2. Possible non-compliance with established BH policies &amp; procedures.</td>
</tr>
<tr>
<td>3. Possible non-compliance with federal regulations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Policies and procedures should be reviewed to ensure they have guidelines in place showing documented managerial approval, such as e-mail or sign off when copays or deductibles are not collected in full at time of service.</td>
</tr>
<tr>
<td>2. Policies and procedures should be reviewed to ensure they include criteria the manager uses to decide when collecting less than the full amount due of copays or deductibles.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management Response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff members were seeking management approval and documenting the approval. However, the documentation of the approval was not was clearly outlined in the policies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Access Policies GA032-034 Registration and Financial Clearance and GA032-041 were revised to set the criteria and documentation of the approval process by staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Responsible:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerry Emrith, Executive Director Patient Access</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed 4/1/2020</td>
</tr>
</tbody>
</table>
3. Policy GA-003-011 Data Security Monitors requires a quarterly access review. Quarterly access review has not been performed for Audit Logix.

**Condition Details:**
Upon inquiry with IT personnel, it was noted that a user access review has not been recently performed for Audit Logix, and evidence of a review could not be produced.

**Criteria:**
BH policy GA-003-011 Data Security Monitors, a quarterly access review is to be performed by IT to ensure users with access to Audit Logix are current employees, and appropriately authorized based on their job title.

**Cause:**
A quarterly access review has not been scheduled for Audit Logix.

**Risk/Impact:**
1. Due to Audit Logix being accessible from the internet and not requiring a BH network account, any person with an active Audit Logix account can access the application which contains PHI.
2. Depending on the level of access, an unauthorized person with access to Audit Logix can process information and also make changes directly to the application and configurable rules.

**Recommendations:**
1. IT should schedule and perform a reoccurring (quarterly) departmental review of Audit Logix based on BH policy GA-003-011.
2. For any users identified during the review that should have their access removed, perform an analysis to determine if those users accessed Audit Logix after their termination date, and if so, to what extent.

**Management Response:**

**Planned Actions:**
1. AuditLogix has been added to the automated SSAR schedule.
2. The program runs 8 times a year by I.T., it compares the email address from Audit logix with Active Directory and Lawson.
3. An excel spreadsheet must be exported from Audit logix for this process.

**Person Responsible:**
Mary Hummel, IT Security Manager

**Target date:**
Completed. IA confirmed Audit Logix was added to the SSAR schedule on 1/24/2020

---

4. Reasonable efforts to ensure minimum amount of PHI disclosed to registration staff at BHIP needs enhancement.

**Condition Details:**
The authorization confirmation PAS at BHIP received a printed schedule daily to verify authorizations of scheduled diagnostic tests. Included in this printed schedule is patient names who are scheduled for physical therapy or wound care. The PAS is not routinely verifying authorizations for physical therapy or wound care and would not need to know who is coming to BHIP for appointments. This observation was corrected prior to the completion of the audit.

**Criteria:**
BH Policy GA-004-100 Minimum Necessary for Uses, Disclosures, and Requests. When using, requesting, or disclosing PHI BH will make reasonable efforts not to use, access, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose.

<table>
<thead>
<tr>
<th>Cause:</th>
<th>Limitation with how the schedule is printed and management may have been unaware of what information is printed.</th>
</tr>
</thead>
</table>
2. Non-compliance with BH policies. |
| Recommendations: | 1. The patient schedule should not all be printed in one report to ensure only BH staff that need access based on their roles can see PHI and ensure only minimum necessary PHI is seen. |
| Management Response: | The Cerner Schedule at BHIP was printing with appointments from all areas. |
| Planned Actions: | Worked with Cerner IT and a filter was developed which restricts the staff to only select/view the scheduled services for which they are required to work. This was tested and verified. |
| Person Responsible: | Kerry Emrith Executive Director, Patient Access |
| Target date: | 12.5.2019 (completed prior to report draft) |

### Part II Additional Observations and Enhancement Opportunity

Listed below is additional information and enhancement opportunities for informational purposes only and do not require a management response. During, and at the end of our audit, we provide enhancement opportunities that could enhance the efficiency or effectiveness of the processes audited. These are presented for Management consideration and should be prioritized in accordance with the organization’s strategic objectives and business priorities.

<table>
<thead>
<tr>
<th>No.</th>
<th>Opportunity for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>IA noted that BH revenue cycle score card includes only two of the seven HFMA suggested KPI for patient access.</td>
</tr>
<tr>
<td>2.</td>
<td>The 34 different NAHAM KPIs for front-end departments are not all measured at BH.</td>
</tr>
<tr>
<td>3.</td>
<td>As of November 2020, the POS cash collection for FY 2020 at all BH hospitals is $1,157,578 less than the stated POS goal of $7,255,611.</td>
</tr>
<tr>
<td>4.</td>
<td>The POS cash collection does not include the amount of co-pays and deductibles that were due at the time of service and was not collected.</td>
</tr>
</tbody>
</table>
In discussions with Patient Access Management regarding the lack of tracking and trending of Point of Service potential collections versus actual collections, we note that the lack of tracking is attributed to the fact that Patient Access does not have within our current systems, an up-front Payment Card Industry (PCI) data security cash collection tool. The process of POS cash collections is currently a paper process, comprised of cash receipts and journals reconciled manually daily. Notwithstanding this system limitation, the POS self-pay cash collections as a percentage of total patient payments, as the time of the audit, was at 38.6% compared to the industry standard of 35%. In addition, at the time of this audit response the percentage year to date as of February 2020 was 41.05%.

Patient Access Management would also like to highlight that currently leadership discussions are looking at integrated patient access management and PCI cash collection tools which, once obtained, will enable patient access tracking and trending of most, if not all, of the National Association of Access Management (NAHAM) and HFMA standards.

7 Part III APPENDIX

Audit report rating: The audit report rating is for the total area that was reviewed and will be discussed in the Executive Summary. The totality of the audit has been considered which included the number of observations being reported.

<table>
<thead>
<tr>
<th>Audit Report Rating</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong</td>
<td>Internal controls are sufficient and appropriate to the organization. Risk is effectively managed. No exceptions to established policies and procedures were identified.</td>
</tr>
<tr>
<td>Acceptable</td>
<td>There have been some minor risk management weaknesses identified. Controls have modest weaknesses that are correctable in the normal course of business and/or minor improvements.</td>
</tr>
<tr>
<td>Needs Improvement</td>
<td>Risk may not be effectively managed. Weakness may include control exceptions or failures that could have adverse effects on the organizations if corrective actions are not taken. Controls not fully in place or applied consistently.</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>There are significant deficiencies due to the absences of effective controls. Risks are not effectively managed and/or there is widespread lack of application and/or compliance.</td>
</tr>
</tbody>
</table>

Audit Condition Rating Criteria

Ratings have been assigned at the condition level to allow management and key stakeholders to better understand the significance of the internal audit report results and the impact on business operations. Ratings should also be used to assist management in prioritizing the implementation of management action plans, in understanding the level of effort required from the action plan and in enforcing accountability for action plan development and implementation. Condition-level ratings are assigned to each condition independently as described below.
<table>
<thead>
<tr>
<th>Audit Rating</th>
<th>Definition</th>
<th>Number of Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>High risk of an error or incident occurring that may contribute to the non-achievement of a control objective and/or is a key focus for business success/achievement of goals – immediate management action needs to be taken to address the identified conditions.</td>
<td>1</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>Moderate risk of an error or incident occurring that may contribute to the non-achievement of a control objective and/or is important for business success/achievement of goals – management action is required to address the identified conditions.</td>
<td>3</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Minor risk of an error or incident occurring that when addressed will strengthen the controls and assist in mitigating risk – management action is required to address the identified conditions.</td>
<td>0</td>
</tr>
</tbody>
</table>

8 General Information

| Audit Team: | Lead Auditor: Robert Colwell  
|            | Contributing Auditor: Ghania Khalil  
|            | Contributing Auditor (IT): Kevin Kull  
| Interim Chief Internal Auditor | Brian W. Kozik, CHC, CCEP, CHPC |

Brian W. Kozik  
Brian W. Kozik, CHC, CCEP, CHPC  
Interim Chief Internal Auditor

9 Attachments

Healthcare Financial Management Association’s KPI for Patient Access

Percentage of Patient Schedule Occupied (PA-1)  
Purpose: Identifies opportunity to maximize utilization of scheduled availability.  
Value: Measures available capacity.  
Equation:  
Number of patient slots occupied = Scheduling System  
Number of patient slots available = Scheduling System  
Points of Clarification:  
“Slots” Are Consistent In Size and Defined By the User  
- Represent available time for patient services  
Excludes:  
- Slots block for non-patient activities  
Number of Patient Slots Occupied  
Includes:
- Overbooked slots
- May exceed 100% (overbooking)

**Number of Patient Slots Available**
Includes:
- Actual number of available slots for use in reporting period
- Represent available time for patient services
Excludes:
- Slots block for non-patient activities

**Number of Patient Slots Occupied**
Includes:
- Overbooked slots
- May exceed 100% (overbooking)

**Pre-Registration Rate (PA-2)**
**Purpose:**
Trending indicator that patient access processes are timely and efficient.

**Value:**
Indicates revenue cycle efficiency and effectiveness.

**Equation:**
\[
\frac{\text{Number of patient encounters pre-registered}}{\text{Number of scheduled patient encounters}} = \frac{\text{Patient Financial System}}{\text{Patient Financial System}}
\]

1 Data can be drawn from scheduling systems integrated or a bolt-on to the PFS system

**Points of Clarification:**

**Pre-registered Patient Encounters**
Total number of monthly encounters pre-registered prior to scheduled service. A successful pre-registration is defined as completion of at least all demographic and insurance data fields, and preferably completion of all patient demographic, insurance and financial data fields required for registration as defined by organizational policy. Encounters may be preregistered in-person, over the phone, or electronically.

Includes:
- Outpatient encounters; an outpatient account is defined as one encounter; e.g. a recurring account counts as one account and one encounter
- Inpatient admissions and observation cases (if scheduled in advance)
- Urgent care appointments, if scheduled (provider option)
- Canceled pre-registrations
- Accounts created from any departmental schedule that qualify for pre-registration per provider policy

Excludes:
- Unscheduled pre-admits, walk-in’s, urgent care (if not scheduled) and Emergency encounters
Scheduled Patient Encounters
Total number of monthly scheduled encounters. A “scheduled encounter” is defined as an encounter scheduled prior to service.
Includes:
- Outpatient encounters - an outpatient account is defined as one encounter; e.g. recurring account counts as one account and one encounter
- Inpatient encounters and observation cases (if scheduled in advance
- Urgent care appointments, if scheduled (provider option)
- Canceled pre-registrations
Excludes:
- Unscheduled pre-admits, walk-in’s, urgent care (if not scheduled) and Emergency encounters

Insurance Verification Rate (PA-3)
Purpose:
Trending indicator that patient access functions are timely and efficient.
Value:
Indicates revenue cycle process efficiency and effectiveness.
Equation:
\[
\frac{\text{Number of verified encounters}}{\text{Number of registered encounters}} = \frac{\text{Patient Financial System}^1}{\text{Patient Financial System}}
\]
Points of Clarification:
Verified Encounters
Total of monthly scheduled encounters that have been verified prior to or at time of service AND unscheduled verified encounters prior to final billing. A successful verification is defined by the individual organization policy.
Includes:
- Outpatient encounters - an outpatient account is defined as one encounter; e.g. recurring account counts as one account and one encounter
- Inpatient encounters
- Unscheduled book of business, i.e. all walk-in patients, emergency department patients, urgent care patients

Registered Encounters
Total number of registered encounters reported in same reporting month as numerator. No type of registered encounter is to be excluded from the total - ALL encounters should be included.
Includes:
- Outpatient encounters - an outpatient account is defined as one encounter; e.g. recurring account counts as one account and one encounter
- Inpatient encounters

Service Authorization Rate - Inpatient and/or Observation (PA-4)
Purpose:
Trending indicator that measures what is actually authorized versus the total population that requires authorization.
Value:
Indicates revenue cycle process efficiency and effectiveness.

Equation:
\[
\frac{\text{Number of IP/OBS encounters authorized}}{\text{Number of IP/OBS encounters requiring authorization}} = \text{Patient Financial System}^{1}
\]

Points of Clarification:

**Authorized Encounters**
Total monthly number of inpatient (IP) and observation (OBS) encounters that have been authorized prior to claim release. “Authorization” is defined as medical necessity approval obtained from the third-party payer for services ordered. A retro-authorization should be counted if completed before claim is released to the payer.

**Encounters Requiring Authorization**
Total monthly number of inpatient and observation encounters that require authorization prior to service. “Authorization” is defined as medical necessity approval obtained from the third-party payer for services ordered. The denominator data should be calculated as the numerator (number of authorized encounters) and the number of encounters that were denied due to a lack of authorization.

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**Service Authorization Rate - Outpatient Encounter (PA-5)**

**Purpose:**
Trending indicator that measures what is actually authorized versus the total population that requires authorization.

**Value:**
Indicates revenue cycle process efficiency and effectiveness.

**Equation:**
\[
\frac{\text{Number of outpatient encounters authorized}}{\text{Number of outpatient encounters requiring authorization}} = \text{Patient Financial System}^{1}
\]

Points of Clarification:

**Encounters Authorized**
Total monthly number of outpatient (OP) encounters that have been authorized prior to claim release. “Authorization” is defined as medical necessity approval obtained from the third-party payer for services ordered. A retro-authorization should be counted if completed before claim is released to the payer. For the purposes of these keys, authorization and referral approval are considered the same activity.

Includes:
- Series accounts, initial encounter or subsequent encounter where a new authorization is required

Excludes:
- Inpatient and Observation encounters

**Encounters Requiring Authorization**
Total monthly number of outpatient encounters that require authorization prior to service. “Authorization” is defined as medical necessity approval obtained from the third-party payer for
services ordered. Data should be calculated as the numerator (number of authorized encounters) plus the number of encounters that were denied due to a lack of authorization.

Includes:
- Series accounts, initial encounter or subsequent encounter where a new authorization is required

Excludes:
- Inpatient and Observation encounters

**Conversion Rate of Uninsured Patient to Third-Party Funding Source (PA-6)**

**Purpose:**
Trending indicator of qualifying uninsured patients for a third-party funding source.

**Value:**
Indicates organization’s ability to successfully secure funding for uninsured patients and improve patient satisfaction.

**Equation:**

\[
\text{Conversion Rate} = \frac{\text{Total uninsured patients converted to third-party funding source}}{\text{Total uninsured discharges and encounters}}
\]

\[\text{Accounts Receivable}^1\]

^1 Includes vendor reports for outsourced accounts

**Points of Clarification:**

**Uninsured Patients (Discharges and Encounters) Converted to Third-Party Funding Source\(^1,2\)**
Total patient discharges and encounters approved in the reporting month

**Include:**
- Inpatients converted at any time
- Outpatients converted after discharge, including ED, should be counted
- Conversions of newborns from self-pay to Medicaid because mother has Medicaid
- Medicaid conversions where provider has received notification from Medicaid agency that coverage is in effect for the specified date of service

**Exclude:**
- Conversions awaiting Medicaid applications (pending approval status)

\(^1\) Conversion is counted once valid coverage is verified

- Must be a third-party funding source; conversions to Charity Care are not counted
- Third-Party funding sources may include COBRA, Medicaid, worker’s compensation, Third-Party liability (TPL), Supplemental Security Income (SSI), local government programs, etc.
- Qualifying assumptions:
  - Funding source was identified accurately at time-of-service
  - Funding source identified is new and not a registration error correction

\(^2\) All conversions approved in the reporting month are included in the numerator regardless of discharge date

**Uninsured Discharges and Encounters**
The total number of uninsured discharges and encounters in the reporting month.

**Point-Of-Service (POS) Cash Collections (PA-7)**

**Purpose:**
Trending indicator of point-of-service collection efforts.

**Value:**
Accelerates cash collections and may reduce collection costs.

**Equation:**

Patient POS payments = Accounts Receivable

Total self-pay cash collected Accounts Receivable

**Note:** Alternative data source is the general ledger transaction code applied to patient POS cash and the general ledger total for all patient (self-pay) cash collected during the month.

**Points of Clarification:**

**Patient Point-of-Service (POS) Payments**

Point-of-service payments are defined as:

1. Patient cash (self-pay cash) for a **current encounter** which is collected prior to, at the time of service, and up to seven days after discharge; and
2. Patient cash (self-pay cash) for a prior encounter which is collected prior to or at the time of a new service. **Note:** Payments on prior balances do not count as POS if received any time after the time of a new service; thus, the seven-day window does not apply to prior balances.

**Includes:**
- All posted POS payments, including undistributed payments (debit transactions only)
- Cash collected on prior encounters, including cash collected on bad debt accounts, at the current pre-service or time-of-service visit
- Pre-admit dollars captured in the month payment is posted rather than received
- Combined hospital/physician payments, if included in denominator²

**Excludes:**
- Refunds; cash refunded to the patient should not be considered
- Routine payment plan payments unless collected at time of service

² If reporting hospital data only, physician payments included only for Medicare recognized hospital-based status clinics; if only reporting physician/ambulatory payments, exclude hospital payments for non-physician/non-ambulatory payments. If reporting combined hospital and physician data, report all qualified POS collections. If reporting at the integrated delivery system level, all self-pay cash collected across the system is included.

**Self-Pay Cash Collected**

Total cash collected for patient responsibility for the reporting month

**Includes:**
- All patient cash collected for the month reported from patient cash account (debit transaction only)
- All posted self-pay payments, including undistributed payments
- Bad debt recoveries
- Loan payments
- Combined hospital/physician payments, if included in the numerator¹

¹ If only reporting hospital data, physician payments included only for Medicare recognized hospital-based status clinics; if only reporting physician/ambulatory payments, exclude hospital payments for non-physician/non-ambulatory payments. If reporting combined hospital and physician data, report all qualified POS collections. If reporting at the integrated delivery system level, all self-pay cash collected across the system is included.
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<th>Completion Date / Report Number</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Travel and Entertainment (T&amp;E) Expenses Review and Prior Year Follow-up</td>
<td>District Wide</td>
<td>Review Broward Health employee travel and entertainment expenses to ensure proper approval, recordation and reimbursement in accordance with BH policy.</td>
<td>To verify that T&amp;E expenses reimbursement comply with BH's policies. High risk of abuse.</td>
<td>C</td>
<td>1/30/2020 2020-A219</td>
<td>Risk Assessment / Yearly</td>
</tr>
<tr>
<td>Payment Card Industry (PCI) Compliance</td>
<td>All Facilities with Credit Card Machine and ports of hot-site</td>
<td>Ensure proper safe guards are in place at BH facilities to protect customer’s credit card information in accordance with payment card industry standards. Determine if BH IT ports susceptible to cyber treat and security system penetration.</td>
<td>Federal regulation and BH policy requirements</td>
<td>O</td>
<td></td>
<td>HIPAA requirement</td>
</tr>
<tr>
<td>Review Broward Health Payment Sources - Employed Physicians (Payroll), - Non-employed Physicians (CCP), - Accounts Payable (AP) - Healthcare Advisor Series (HAS) and contract data quality as required under CIA Focus Arrangement tracking review.</td>
<td>Accounts Payable (AP), Payroll Dept., &amp; CCP Vendor</td>
<td>Independent evaluation by IA to: 1. Ensure that Physicians (employed and non-employed) are paid according to contracts and the payments are not extended beyond the contract dates. 2. Review to make sure that payments are earned, reasonable and agreed to contract. 3. Determine if BH is appropriately monitoring physician contract's deliverables and quality WRVU. 4. Assure the existence of adequate controls in place that prevent or avoid wasteful, carelessness, and inefficient practices.</td>
<td>1. Ensure that payments are in compliance with Broward Health policies. 2. Failure of contract deliverables can result in decreased effectiveness of patient care. 3. Identify and recover overbillings. 4. Contract monitoring is a requirement of the CIA. 5. Lack of monitoring of contracted physicians may be perceive publicly as poor physician performance, a failure of BH to identify risk, and providing sub-par care. 6. To fulfill the requirements of the corporate integrity agreement levied by the OIG</td>
<td>C</td>
<td>January 2020 2020-A222</td>
<td>CIA Requirement / Yearly</td>
</tr>
<tr>
<td>Underpaid Claims - (Revenue Cycle)</td>
<td>CBO, PBO, Managed Care, Accounting, IT, IS</td>
<td>1. Review of current contracted fee schedule rates and payer down coding or underpayments resulting in lost revenue. 2. 24 month Historical Data review for compliance, efficiencies, best practices, waste, and fraud.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. Assessing the controls to ensure appropriate risk management.</td>
<td>C</td>
<td>1/7/2020 2020-A201</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Periodic Inventory Count &amp; Valuation of Medical Devices and Supplies</td>
<td>Accounting Services, Hospital Materials Management, Procurement.</td>
<td>Participate in the periodic physical inventory count &amp; valuation throughout the District facilities and perform price testing on selected inventory items to validate information provided by external company BIG.</td>
<td>Annual review of 3rd party inventory count and valuation to facilitate financial statement presentation</td>
<td>Due to virus and need to enter hospitals, this review will be deferred to FY’21 Plan.</td>
<td>BH Requirement</td>
<td></td>
</tr>
</tbody>
</table>
## INTERNAL AUDIT DEPARTMENT
### Fiscal Year 2020 AUDIT WORK PLAN

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</tr>
</thead>
<tbody>
<tr>
<td>Physician Referral Management Process (Revenue Cycle)</td>
<td>Facilities, CBO, PBO, Managed Care, Accounting, IT, IS</td>
<td>Review of all scheduling and Physician Referral and order management, required data elements, receipt prior to treatment, and proper documentation. Examine referral leakage that may equate to millions of dollars in forgone revenue. Review current workflow, policy, and process review for compliance, efficiencies, best practices, waste, and fraud.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.</td>
<td>B</td>
<td></td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Inpatient Concurrent/Admission Review Case Management/ Utilization Review and Two Midnight Rule (Revenue Cycle)</td>
<td>CBO, PBO, Managed Care, Accounting, IT, IS, BH facilities</td>
<td>Review of Concurrent/Admission inpatient stay authorization protocols as well as patient assessment, patient care and treatment plan documentation; attention to Medicare two midnight rule to patient hospitalization for billing. Assess the level of care status change and rollback policies and procedures for compliance, efficiencies, best practices, waste, and fraud.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. High risk process and immense potential to gain revenue via effectiveness and efficiencies.</td>
<td>Corporate Compliance completed a review of the 2MN rule.</td>
<td></td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Reimbursement rates (HMO's) for Commercial Insurances.</td>
<td>All BH Hospitals Contracting Accounts Payable</td>
<td>Review contracted reimbursement rates from Insurance companies and compare rates across BHs Hospitals. Ensure payments received are the agreed contracted amount. Ascertain whether the rates are indicative of the health care market.</td>
<td>Ensure revenue received is in accordance of the contracted rate. To compare reimbursement rates to actual cost Ensure reimbursement rates are the same all BH facilities.</td>
<td>B</td>
<td></td>
<td>Risk Assessment</td>
</tr>
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</tr>
<tr>
<td>Audit Information Technology (IT) Logical, Application, General Controls, Change Management Controls and Cyber security.</td>
<td>IT Dept.</td>
<td>Follow-up on deficiencies noted on outsourced Company Presidio. Perform review of IT patch documents, policy, and procedures relating logical and change management controls. Review whether newly implemented access controls, security controls (password changes) and productivity are in-balance. Review IT cyber security standards, guidelines, procedures, and implementation of the controls.</td>
<td>IT infrastructure impact on BH business as follow: - Logical access controls over applications, data and supporting infrastructure - Program change management controls</td>
<td>C</td>
<td>11/7/2019 2020-M221</td>
<td>BH Requirement</td>
</tr>
<tr>
<td>Audit IT General Controls</td>
<td>IT Dept.</td>
<td>Review whether IT General Controls are in place.</td>
<td>IT infrastructure impact on BH business as follow: - Logical access controls over applications, data and supporting infrastructure - Contingency Planning/Disaster Recovery</td>
<td>O</td>
<td>Report in progress</td>
<td>Ad Hoc</td>
</tr>
<tr>
<td>Uninsured Patient Processes (Revenue Cycle)</td>
<td>CBO, PBO, Managed Care, Accounting, IT, IS</td>
<td>Examine the process of servicing uninsured patient. All uninsured patient standard operating procedures and policies for inpatient stays, recurring treatment and scheduled outpatient procedures. 24 month uninsured patient balance, bad debt write off data for compliance, efficiencies, best practices, waste, and fraud.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance.</td>
<td>H</td>
<td>Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>Balance Score Card &amp; Corporate Departments Quality Metrics Review</td>
<td>District Wide</td>
<td>Determine if the performance metric used in BH strategic management to identify and improve the various internal functions and their resulting external outcomes is effective. Appraise the usefulness to measure and provide feedback to organization's managers and Board of Commissioners.</td>
<td>Ineffective performance metric may result in the inability to identify factors hindering the hospital performance and outline strategic changes tracked by future scorecards.</td>
<td>C</td>
<td>12/19/2020 2020-M225</td>
<td>Risk Assessment / Yearly</td>
</tr>
</tbody>
</table>
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<tr>
<td>Physician Credentialing Process</td>
<td>District Wide</td>
<td>Examine the credentialing process for physicians across BH facilities. Determine if the process is centralized to help eliminate repetitive work, improve revenue cycle, and lower credentialing costs for hospitals and practices. Flesh-out the benefits of credentialing by examine: 1. eliminate redundant work 2. facilitating delegated agreements decreases costs and delays 3. Improved data integrity.</td>
<td>To ensure that data integrity improves and impacts all participants, each participating hospital and facility must be able to access its providers’ data. The centralized platform must be able to sync to each participant’s downstream data systems, including EHR, billing systems, provider directories, etc.</td>
<td></td>
<td>Due to virus and need to enter hospitals, this review will be deferred to FY’21 Plan.</td>
<td>Corporate and Hospitals</td>
</tr>
<tr>
<td>Community Care Plan (CCP) deliverable</td>
<td>District Wide</td>
<td>BH moved the PPUC program to CCP. CCP, the health plan with a heart, is an entity owned by Broward Health (North Broward Hospital District) and Memorial Healthcare System (South Broward Hospital District). Fully accredited by the Accreditation Association for Ambulatory Health Care as a Health Plan, CCP serves enrollees enrolled in Medicaid, Children’s Medical Services Network and self-insured employee health plans. our purpose is to examine the CCP contract activities and determine whether the deliverables (scope of work) are being achieved.</td>
<td>There a risk that the Community Care Program (CCP) may not achieve the desired objectives if the contract deliverables are not met.</td>
<td></td>
<td>C</td>
<td>BH Sr. Management</td>
</tr>
<tr>
<td>Compliance Department Hotline/Focus Arrangement Quality Review</td>
<td>Compliance Department</td>
<td>Examine Compliance Department and responsible person audit process to ensure that remunerations are tracked to and from all parties, referral services logged and reviewed, leased space monitored, medical devices and equipment are paid in accordance with policy.</td>
<td>Federal regulation (Stark) and BH policy requirements</td>
<td></td>
<td>C</td>
<td>Risk Assessment</td>
</tr>
</tbody>
</table>

---

**Examine**

1. eliminate redundant work
2. facilitating delegated agreements decreases costs and delays
3. Improved data integrity.
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<tr>
<td>Financial Statement Line Items Review</td>
<td>Corporate</td>
<td>Select main drivers to the financial statement (Inpatients admission, surgeries supplies, etc.) and determine if the items are being posted to the trial balance and subsequent to the financial statement correctly. Examine financial accruals for major accounts for accuracy.</td>
<td>The risk relating to miscalculating profit is detrimental to the reputation of BH, and may lead to increase tax burden on Broward Health citizens. If profit reported is either too low/ too high, it will adversely effect BH statement of financial position.</td>
<td>Due to virus and need to enter hospitals, this review will be deferred to FY’21 Plan.</td>
<td></td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Physical Security Audit - System Wide</td>
<td>District Wide</td>
<td>Review the system wide security for control.</td>
<td>The risk relating to physical security and the protection of personnel, hardware, software, networks and data from physical actions and events that could cause serious loss or damage to broward health. This includes protection from fire, flood, natural disasters, burglary, theft, vandalism and terrorism.</td>
<td>H</td>
<td></td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Construction Audit</td>
<td>District Wide</td>
<td>Determining whether the Construction process is meeting contract deliverables (cost, scope and term), and examining expenditures relating to the Construction are manage adequately.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes</td>
<td>Due to virus and need to enter hospitals, this review will be deferred to FY’21 Plan.</td>
<td>On going review and attendance of constructio n meetings</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Pyxis System &amp; Operations</td>
<td>Corporate</td>
<td>BH uses the Pyxis system, which is an automated medication storage and distribution device that provides information for medication management that is readily accessible and meets patients needs in a timely manner. The system can also improve resource management by linking to the supply ordering and distribution system and eases the billing of pharmaceuticals by posting charges and credits to the patient account when medication is dispensed from or returned to the device.</td>
<td>The risk relates to system and process controls over the Pyxis system that may be ineffective which would impact the accuracy of our inventory management, and patient charge financial data that are reported in the financial statements.</td>
<td>Due to virus and need to enter hospitals, this review will be deferred to FY’21 Plan.</td>
<td></td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Physician Relocation Agreement Review</td>
<td>District Wide</td>
<td>In order to attract the highest quality managers, executives, and professionals, BH assists newly recruited employees with some of the major financial expenses relating to relocation.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes</td>
<td>C</td>
<td>Report to be completed A-234</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Audit/Project</td>
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<tr>
<td>BH Foundation Grants/ Donation/ Allotments/ Endowments and Expenses Review</td>
<td>BH Foundation</td>
<td>BH Foundation is a 501(c)(3) nonprofit organization whose mission is to improve the health of its community by providing resources to promote, support, and enhance the programs and initiatives of BH.</td>
<td>Donors' proceeds are not spent in accordance with their intended purposes.</td>
<td>O</td>
<td>Report in progress</td>
<td>Risk Assessment</td>
</tr>
</tbody>
</table>
| Payroll                                                                      | Finance              | Review the payroll process as it relates to employee onboarding, job change, terminations, overtime pay, payroll codes, payroll payment processes, payroll payment/disbursement, and logical access/segregation of duties. In addition, perform analytics round the following areas:  
  • Duplicate employee master file records;  
  • Duplicate payroll register payments;  
  • Excessive or unexpected overtime;  
  • Unreasonable on-call and call back pay; and  
  • Exempt employees with unexpected premium pay                                                                 | BH must have proper procedures in place or risk errors, fraud or regulatory penalties.                    | O                                                              | A-228                  | Risk Assessment      |
| Charge Capture & Reconciliation                                              | District Wide        | Review the Charge Reconciliation Process internal controls for high dollar acuity areas to validate the accuracy and timeliness of charge validation as it pertains to the Revenue Cycle policy.                | The failure to effectively capture charges, along with poor charge master coding, and lost or late charges, can decrease revenue for the organization. | Due to virus and need to enter hospitas, this review will be deferred to FY’21 Plan. | Risk Assessment       |
| Operating Room ("OR") and Cath Lab Inventory Management                      | All Hospitals        | Review the effectiveness and efficiency of controls over BH Inventory Management process for OR and Cath Lab. The areas of focus include, but are not limited to: governance, access to inventory and systems, ordering, receiving, segregation of duties, consignment, credits, cycle counts, par values including unit of measure, obsolete, wasted and expired inventory and preference cards. | Inventory Management has a direct impact on company's cash flow and profit margins.                       | Due to virus and need to enter hospitas, this review will be deferred to FY’21 Plan. | Risk Assessment       |
### Audit/Project

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</thead>
<tbody>
<tr>
<td>Operating Room (&quot;OR&quot;) Charge Capture &amp; Reconciliation</td>
<td>All Hospitals</td>
<td>Conduct an Implanted Device Charge Reconciliation to validate the accuracy and completeness of charge capture in a timely manner to enhance the charge capture process.</td>
<td>The failure to effectively capture charges, along with poor charge master coding, and lost or late charges, can decrease revenue for the organization.</td>
<td>Due to virus and need to enter hospitals, this review will be deferred to FY'21 Plan.</td>
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</tr>
<tr>
<td>Length of Stay (&quot;LOS&quot;) - Data Analytics</td>
<td>All Hospitals</td>
<td>Analyze the effectiveness and efficiency of process controls in place to manage LOS by performing the following data analytics: • Identifying patients whose LOS is greater than the Centers for Medicare &amp; Medicaid Services (&quot;CMS&quot;) average LOS for specific diagnosis code; and • Identifying LOS outlier trends based on various factors.</td>
<td>A decreased LOS is desired to avoid patient harm and lower costs.</td>
<td>Due to virus and need to enter hospitals, this review will be deferred to FY'21 Plan.</td>
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</tr>
<tr>
<td>Gold Coast Home Health Services Operations</td>
<td>Gold Coast</td>
<td>Gold Coast is a non-profit agency offering a full spectrum of services: home health, hospice, and palliative care.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes</td>
<td>H</td>
<td></td>
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### Broward County Contract and Grant Review

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</thead>
<tbody>
<tr>
<td>Broward County Contract and Grant Review</td>
<td>CHS, Accounting Services</td>
<td>Broward County Grant - Financial and testing of details</td>
<td>Requirement by Broward County based on contract</td>
<td>H</td>
<td>Broward County Requirement Yearly</td>
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### A-133 Sub-contractor Monitoring (Financial Management)

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<tr>
<td>A-133 Sub-contractor Monitoring (Financial Management)</td>
<td>CHS, Accounting Services</td>
<td>Homeless Grant (serviced by SBHD).</td>
<td>Review compliance with sub-contracts.</td>
<td>O</td>
<td>Broward County Requirement Yearly</td>
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<tr>
<td>HR. Compensation &amp; Benefits Follow-up</td>
<td>Corporate HR. &amp; Benefit</td>
<td>Examine HR. process and metrics that align with management: salary adjustment, bonus, valuation and time off benefits. Examine advertisement campaign and contract associated with employee benefit. Review HR. practices and policy for sexual harassment.</td>
<td>Valuation of HR. metrics, including the organization’s ability to mitigate risk of improper human resource management to reduce managerial prerogatives (privilege), and seriously damage the organization’s reputation and employment brand.</td>
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<td></td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Transaction posting* (Revenue Cycle)</td>
<td>CBO, PBO, Managed Care, Accounting, IT, IS</td>
<td>Thorough review of cash posting including patient payments, point of service payments, 835 electronic payment posting, manual insurance check and eon posting for compliance, efficiencies, best practices, waste, and fraud.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.</td>
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<td>Compliance 360 (C360) Data migration and Control Process review</td>
<td>Contract Dept.</td>
<td>Review a sample of Data migrated from MediTract to Compliance 360 system to ensure completion of data transfer. Ensure due diligence information is obtained, documents are attached, appropriate approvals are secured and contract checklist completed.</td>
<td>Review contract process to make sure that it is in compliance with BH Policies, CIA and IRO requirements</td>
<td></td>
<td>Report in progress</td>
<td>CIA Requirement Yearly</td>
</tr>
<tr>
<td>340B Pharmacy Medication Program Disbursement*</td>
<td>All BH Outpatient Pharmacies</td>
<td>To examine the 340B pharmacy program and ensure compliance with all 340B Program requirements.</td>
<td>Failure to comply may make the 340B covered entity to be removed from the 340B Program. Non compliance with the 340B program may make BH subject to fines. Ensure policies and procedures related to 340B Program are in place and followed.</td>
<td>C</td>
<td>11/25/2019 2020-A224</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Procurement - GOP Share back, &amp; Diversity Program</td>
<td>Procurement Accounting Service</td>
<td>Review GPO cost rebate and cash savings based on contract deliverables. Verify that there is adequate monitoring over contract deliverables and revenue.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.</td>
<td>Due to virus and need to enter hospitals, this review will be deferred to FY'21 Plan.</td>
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<tr>
<td>Accounts Payable Department</td>
<td>AP Department</td>
<td>To examine controls and process efficiency within the Accounts Payables Department. Also to review Accounts Payable payments to ensure the three way matching system - purchase order/requisition, invoice, and receiving report for accuracy and completeness.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.</td>
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<tr>
<td>Denial Recovery Operations (Revenue Cycle)</td>
<td>CBO, PBO, Managed Care, Accounting, IT, IS</td>
<td>Workflow analysis of Denial Recovery processes resulting in operational write off. 6 month historical OWO data review and regulatory compliance protocol review for compliance, efficiencies, best practices, waste, and fraud.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.</td>
<td>C</td>
<td>11/6/2019 2020-A201</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>Re-admission Rate/Discharge Planning (Revenue Cycle)</td>
<td>BH Hospitals</td>
<td>Examining process that: determine whether patient quality of returns to the hospital after discharge. help prevent readmissions and solving challenges of follow-up care and discharge planning. ensure a patient safe - discharge.</td>
<td>Hospital readmission rates can be a measurement of the effectiveness and providing responsible care. Excessively high readmission rates may result in reduced payments from CMS. Increased readmission rates may have a decline in public trust and adversely affect BH image. Due to virus and need to enter hospitals, this review will be deferred to FY'21 Plan.</td>
<td></td>
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<td>Risk Assessment</td>
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<tr>
<td>Fixed Assets Review - Follow-up</td>
<td>District Wide</td>
<td>To determine whether controls were implemented to ensure an effective Fixed Asset process. Follow up on the audit deficiencies noted in fiscal year 2019.</td>
<td>Internal Audit policy and IIA standard require that internal audit activity helps BH organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. Due to virus and need to enter hospitals, this review will be deferred to FY'21 Plan.</td>
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<td>Risk Assessment</td>
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<td>Health Resources and Service Administration (HRSA) Healthcare for the Homeless (HCA) Grant Follow-up</td>
<td>Community Health Services Grant Management</td>
<td>Ensure areas of noncompliance identified during the HRSA operational site visit conducted May 14-16, 2019 have been mitigate.</td>
<td>BH is required to make corrections to ensure compliance with HRSA grant requirement and to remain eligible to continue receiving funding from the HRSA HCA grant.</td>
<td>C</td>
<td>12/17/2019 2020-A229</td>
<td>Risk Assessment HRSA requirement</td>
</tr>
</tbody>
</table>