

**STUDENT HEALTH CENTER**  
**CALIFORNIA POLYTECHNIC STATE UNIVERSITY,**  
**SAN LUIS OBISPO**

**Report Number 00-33**  
**January 26, 2001**

---

**Members, Committee on Audit**

Frederick W. Pierce, IV, Chair  
Harold Goldwhite, Vice Chair  
Murray L. Galinson   Shailesh J. Mehta  
Neel I. Murarka   Stanley T. Wang

---

**Staff**

University Auditor: Larry Mandel  
Senior Director: Janice Mirza  
Audit Manager: Michelle Schlack

**BOARD OF TRUSTEES**



---

# CONTENTS

---

## INTRODUCTION

Purpose.....	1
Scope and Methodology.....	1
Background .....	3
Opinion.....	4
Executive Summary.....	4

---

## OBSERVATIONS, RECOMMENDATIONS, AND CAMPUS RESPONSES

Personnel Qualifications and Training.....	7
Program Administration .....	9
Memorandum of Understanding and Approval for Services.....	9
Written Policies and Procedures.....	11
Campus Health Services and Programs.....	12
Athletics Department – Credentialing.....	12
Athletics Department – Pharmacy Operations .....	13
Athletics Department – Medical Records .....	14
HIV Antibody Testing Contract.....	16
Pharmacy Operations .....	17
Inventory.....	17
Prescriptions.....	18
Medical Records .....	18
Data Access and Physical Security.....	20
Key Control and Building Security.....	20
Data Security.....	21

## **APPENDICES**

APPENDIX A:	Personnel Contacted
APPENDIX B:	Campus Response
APPENDIX C:	Chancellor's Acceptance

---

## **ABBREVIATIONS**

AAAHC	Accreditation Association of Ambulatory Health Care
CBA	Collective Bargaining Agreement
CME	Continuing Medical Education
CPR	Cardio Pulmonary Resuscitation
CSU	California State University
HCS	Health and Counseling Services
LAN	Local Area Network
MOU	Memorandum of Understanding
NCAA	National Collegiate Athletic Association
OTC	Over-the-Counter
REP	Resolution on Educational Policy
SAM	State Administrative Manual
SHC	Student Health Center
SOAP	Subjective Objective Assessment and Plan

---

## INTRODUCTION

---

### PURPOSE

The overall audit objective was to ascertain the effectiveness of existing policies and procedures related to the administration of the Student Health Center (SHC) and to determine the adequacy of controls over other campus areas providing student health services.

Within the overall audit objective, specific goals included determining whether:

- ▶ administration and management of the SHC provide an effective internal control environment; clear lines of organizational authority, delegations of authority and responsibility; formation of a Student Health Advisory Committee and documented policies and procedures;
- ▶ patient care quality and risks associated with health services are continually monitored and assessed;
- ▶ SHC and other employees providing patient care possess the necessary credentials and qualifications, and designations are maintained in favorable standing with licensing boards and medical associations;
- ▶ health services have been appropriately identified, approved, priced, and provided to all eligible personnel (including, but not limited to, students, university employees, visitors, etc.);
- ▶ ancillary services (e.g., laboratory, pharmacy, urgent care, diagnostic, etc.) are performed by qualified, licensed personnel and in compliance with state regulations and accreditation standards;
- ▶ pharmacy inventories are properly reported, safeguarded, and accounted for, and pharmacy security is maintained in accordance with CSU policy and state regulations;
- ▶ medical records are properly maintained, safeguarded, and retained in accordance with state and federal regulations and CSU policy, and automated medical records and other systems used by the SHC are adequately secured;
- ▶ sanitation and safety measures are adequately implemented and comply with CSU policy and state regulations;
- ▶ budgeting procedures adequately address SHC funding, ensure that Student Health Center fees are used for their designated purpose, and include procedures to monitor budget vs. actual expenses;
- ▶ cash receipts, dishonored checks and other debts are adequately controlled and properly accounted for, and cash disbursements are adequately controlled and made solely for the support of the SHC; and
- ▶ areas providing student health services are appropriately included in campus medical disaster planning and that adequate training is provided to all affected personnel.

---

### SCOPE AND METHODOLOGY

This review emphasized but was not limited to compliance with state laws, Board of Trustee policies, and Office of the Chancellor and campus policies, letters and directives. June 1999 to date was the primary period of review.

Our focus involved a wide variety of issues dealing with SHC operations and other areas providing student health services. Specifically, we reviewed and tested:

- ▶ use of a Student Health Advisory Committee for the development of new student health services and educational opportunities;
- ▶ procedures for monitoring the quality and effectiveness of patient care;
- ▶ processes to obtain and retain accreditation status;
- ▶ hiring, credentialing, and re-credentialing procedures;
- ▶ pharmacy operations, security, and inventory controls;
- ▶ procedures for maintaining and securing medical information;
- ▶ safety and sanitation procedures, including training of SHC and custodial staff;
- ▶ procedures for protecting the SHC and other health services facilities;
- ▶ budgeting procedures, fee authorization, and the management of trust accounts;
- ▶ procedures for controlling and processing cash receipts, refunds, dishonored checks, and other debts;
- ▶ procedures for controlling and processing cash disbursements; and
- ▶ data security, disaster recovery, and back-up procedures.

## BACKGROUND

As a result of a systemwide risk assessment conducted by the Office of the University Auditor during the last quarter of 1999, the Board of Trustees, at its January 2000 meeting, directed that *Student Health Centers* be reviewed.

The proposed scope of such audits, as presented in Attachment B, Agenda Item 3 of the January 25-26, 2000 meeting of the Committee on Audit, stated that the review would include all services rendered in or through student health facilities, including activities of doctors, nurses and other medical providers. Potential impacts include substandard medical care, inconsistent accessibility, erroneous dispensing of pharmaceuticals, inadequate health education, excessive costs and fees, and circumvention of state law/CSU policy. *Student Health Centers* was previously audited in 1986.

The *Policy of the Board of Trustees on Student Health Services* was adopted initially as a comprehensive systemwide policy in 1977. This original policy was revised in May 1988 and required that basic student health services, covering treatment for illnesses and injuries, family planning services, health education, and counseling for individual health problems, be available to all regularly enrolled students at no additional charge. In addition, the policy allowed campuses to offer additional elective, “augmented” services free of charge or for a fee.

In the early 1990’s, a dramatic change to the fiscal climate prompted a reevaluation of the existing policy. Several campuses reported an inability to provide these health services without additional revenue. Accordingly, in November 1992, the Board of Trustees delegated to the Chancellor the authority to approve exceptions to the fee restrictions of the policy. Such exceptions were permitted with the understanding that a task force would undertake a comprehensive review of the provision and financing of student health services.

The CSU Task Force on Student Health Services was charged with reviewing the scope of service, funding, delivery mechanisms, health insurance, medical liability, and facilities in CSU student health services. In May 1993, the Board of Trustees approved four task force recommendations (REP 05-93-03) which would (1) establish a revenue fund for health services fee revenues; (2) ensure continued availability of basic health services through charging mandatory fees if necessary; (3) reinforce and reiterate the role of student health advisory committees in campus health service decisions, and (4) retain a consultant to explore additional revenue sources, health insurance, and potential partnerships with health care organizations.

In July 1993, the Board of Trustees approved five additional recommendations (REP 07-93-05). The most significant recommendation required that all mandatory health services fees, both fee revenue and interest earned, shall be used only to support student health services operations, whether the campus participates in a systemwide health services revenue fund or chooses to deposit fees locally in the General Fund. Another major task force recommendation was that the Chancellor should implement trustee policy based on task force recommendations and the May 1988 revision of the *Policy of the Board of Trustees on Student Health Services* through an Executive Order. In August 1995, Executive Order No. 637, *CSU Policy on Student Health Services* was issued.

Throughout this report, we will refer to the program as the Student Health Center (SHC). At California Polytechnic State University, San Luis Obispo, the SHC is referred to as Health and Counseling Services (HCS), which has primary responsibility for campus student health services.

---

## **OPINION**

We visited the California Polytechnic State University, San Luis Obispo from August 21, 2000, through September 21, 2000, and audited the procedures in effect at that time.

In our opinion, the administration and management of the SHC program was adequate to ensure a viable student health function. Management at HCS placed great importance on providing quality health care and education to the student population as evidenced, in part, by the center's recent accreditation by the Accreditation Association of Ambulatory Health Care (AAAHC) and ongoing reviews/certifications by state agencies. Additional attention is warranted in the areas mentioned in the executive summary below.

---

## **EXECUTIVE SUMMARY**

The purpose of this section is to provide management with an overview of conditions requiring attention. Areas of review not mentioned in this section were found to be satisfactory. Numbers in brackets [ ] refer to page numbers in the report.

### **PERSONNEL QUALIFICATIONS AND TRAINING (7)**

Controls over the new hire and re-credentialing processes were not adequate. Adequate controls over these processes ensure compliance with CSU policy and quality services provided by qualified health care professionals.

### **PROGRAM ADMINISTRATION (9)**

#### **MEMORANDUM OF UNDERSTANDING AND APPROVAL FOR SERVICES (9)**

Services provided by Health and Counseling Services (HCS) were not always properly approved, charged for, or supported by appropriate documentation. Adequate documentation for services to other departments and proper approval of augmented services decrease the risk of misunderstandings and inconsistencies between current practice and the intentions of management and increase the amount of funds available for health services operations.

## **WRITTEN POLICIES AND PROCEDURES (11)**

Written policies and procedures were not developed for certain Health and Counseling Services (HCS) activities. Properly developing, documenting, and communicating policies and procedures improves internal controls.

## **CAMPUS HEALTH SERVICES AND PROGRAMS (12)**

### **ATHLETICS DEPARTMENT – CREDENTIALING (12)**

Controls over the hiring and credentialing of team physicians needed strengthening. Adequate controls in these processes reduce the risk that health services will be provided by unqualified personnel.

### **ATHLETICS DEPARTMENT – PHARMACY OPERATIONS (13)**

Pharmaceutical items maintained in the campus Athletics Department were not adequately inventoried and controlled. Adequate controls over medications decrease the risk of campus liability due to inappropriate activities.

### **ATHLETICS DEPARTMENT – MEDICAL RECORDS (14)**

Controls over student athlete medical information needed strengthening. Adequate controls over medical records decrease the risk of unauthorized disclosure of personal information and campus liability due to inappropriate activities.

### **HIV ANTIBODY TESTING CONTRACT (16)**

The contract with the County of San Luis Obispo and the Trustees of the CSU for Alternative Test Site (HIV Antibody Testing) was not current. Maintaining a current written agreement decreases misunderstandings and inconsistencies between existing contract language and the intentions of both the campus and County of San Luis Obispo management.

## **PHARMACY OPERATIONS (17)**

### **INVENTORY (17)**

Controls over Health and Counseling Services (HCS) prescription medications needed improvement. Maintaining adequate control over inventories of pharmaceutical items decreases the risk of loss or theft and could result in lower overall pharmacy costs.

### **PRESCRIPTIONS (18)**

The campus president did not approve the filling of written or oral prescriptions from off-campus providers. Obtaining appropriate approval from the campus president helps ensure that current practices are aligned with the intentions and risk evaluations of management.

### **MEDICAL RECORDS (18)**

Controls to ensure that medical charts contained required documentation needed improvement. Adequate controls over medical chart documentation decrease the risk of providing substandard patient care.

### **DATA ACCESS AND PHYSICAL SECURITY (20)**

#### **KEY CONTROL AND BUILDING SECURITY (20)**

Controls over key documentation and physical security needed improvement. Adequate controls over keys and building security decrease the risk of unauthorized disclosure of confidential data, lost or stolen medications and supplies, and non-compliance with CSU policy.

#### **DATA SECURITY (21)**

Data access and physical security controls over the Health and Counseling Services (HCS) NT server needed improvement. Maintenance of adequate system access and security controls prevents unauthorized access to restricted data and confidential patient information.

---

## OBSERVATIONS, RECOMMENDATIONS, AND CAMPUS RESPONSES

### PERSONNEL QUALIFICATIONS AND TRAINING

Controls over the new hire and re-credentialing processes were not adequate.

We noted that:

- ▶ Health and Counseling Services (HCS) internal credentialing and re-credentialing procedures for physician and provider (e.g., nursing and ancillary) staff did not include the following minimum qualifications and credentialing requirements:
  - verification of continuing medical education (CME) training at the time of hiring for physician and provider staff;
  - cardio pulmonary resuscitation (CPR) certification for physician and provider staff (excluding ancillary staff);
  - specialty board certification for temporary intermittent/on-call physicians;
  - evidence of specialty board certification for permanent, volunteer, and temporary intermittent physicians; and
  - written authorization from provider staff (excluding nurse practitioners) to verify hiring/credentialing information.
  
- ▶ Although required by HCS credentialing and re-credentialing procedures, monitoring controls were not in place to ensure physician files included properly completed Physician Privilege lists and evidence that physician licensure was verified with the appropriate medical board.
  
- ▶ Administrative personnel did not completely understand collective bargaining agreement (CBA) requirements regarding ongoing CME training for temporary intermittent/on-call physician and provider staff.
  
- ▶ As the result of the aforementioned control weaknesses, the following exceptions were noted in a review of ten physician and nine provider files:
  - Ten of ten physician files, and seven of eight provider files, did not contain evidence of CME verification at the time of hire.
  
  - Files for three part-time and one full-time provider did not contain evidence of CPR training/certification.
  
  - Five of seven applicable physicians attested to specialty board certification on their Physician Privilege list; however, there was no evidence of the certification on file, and one of seven applicable physicians did not attest to being specialty-board certified, and there was no evidence of this non-certification on file.

- Seven of nine provider files did not contain employee written authorization to verify credentialing information.
- Files for four volunteer and one part-time provider contained “approval” for physician privileges; however, a properly completed Physician Privilege list was not on file, and two part-time physician files did not contain a Physician Privilege list or management’s approval of assigned privileges.
- Two of ten physician files did not contain evidence that licensure was verified with the appropriate medical board.
- Two of ten physician files, and five of eight provider files, did not contain evidence of ongoing CME training.

Executive Order No. 637, *CSU Policy on Student Health Services*, dated August 1, 1995, prescribes the minimum qualifications and hiring requirements for professionals in student health services. Such criteria include, but are not limited to: possession of a valid professional California license, possession of a Drug Enforcement Agent number for prescribing physicians, compliance with continuing educations as required by the particular profession, appropriate CPR certification, and written authorization to allow verification of all information submitted.

Article 2.8 of the CBA between the CSU Board of Trustees and the California Federation of the Union of American Physicians and Dentists, for July 1, 1998, through June 30, 2001, states, in part, that the term “employee” as used in this Agreement refers to a bargaining unit member who is a full-time employee, a part-time employee, a probationary employee, a permanent employee, or a temporary employee. Article 23.4 states that the president may approve participation in professional development activities by eligible employees of up to 64 hours per fiscal year per full-time employee. Employees working less than full-time or in pay status less than a full fiscal year shall be eligible for a pro rata share of professional development time. Article 23.13 states that the CSU may require evidence of satisfactory completion of approved professional development activities.

Article 2.10 of the CBA between the CSU Board of Trustees and the California State Employees’ Association, for July 1, 1999, through June 30, 2001, states, in part, that the term “employee” as used in this Agreement refers to a bargaining unit member who is a full-time employee, a part-time employee, a probationary employee, a permanent employee, or a temporary employee. Article 22.34 states that an eligible employee may request approval to participate in continuing education activities in accordance with campus procedures. Article 22.35 states, in part, that the president may approve requests for participation in continuing education activities from eligible full-time employees for up to 32 hours per calendar year. Employees working less than full-time shall be eligible for continuing education on a pro rata share.

The 1999 *Accreditation Handbook for Ambulatory Health Care Standards*, Chapter 2, states that clinical privileges are granted for a specified period of time.

The director of Health and Counseling Services stated that completed CME was required for current licensure and re-licensure; therefore, notification of re-licensure appeared to be a method of tracking completion of CME. He further stated that failure to obtain other information (e.g., written authorization from provider staff to verify hiring information) was an oversight.

Inadequate documentation in employee files weakens internal controls over the hiring and re-credentialing process and increases the risk of providing health services by unqualified personnel.

### **Recommendation 1**

We recommend that the campus:

- a. strengthen processes to ensure that internal credentialing and re-credentialing procedures are appropriately aligned and comply with CSU policy and accreditation standards;
- b. implement appropriate monitoring controls to ensure that health care provider files contain required credentialing documentation per campus and CSU policies; and
- c. periodically consult with campus human resources or other subject-matter personnel regarding the applicability of CBA provisions (e.g., CME requirements) to all health care provider staff.

### **Campus Response**

We concur. The credentialing deficiencies primarily were found in the charts of on-call providers, who had not yet worked for the Health Services, or of volunteer/contract providers. Some elements of the credentialing process required information that was not available from the campus' employment application.

The credentialing form and policy/procedures are being revised to incorporate the auditor's findings. A quarterly quality assurance audit to review the completeness of all the files of each licensed provider whose professional license expired during that quarter will be the mechanism for monitoring the credentialing/recredentialing for providers. In addition, consultation between the Human Resources and Employment Equity and Health Services has already begun.

Anticipated Date of Completion: June 30, 2001

## **PROGRAM ADMINISTRATION**

### **MEMORANDUM OF UNDERSTANDING AND APPROVAL FOR SERVICES**

Services provided by Health and Counseling Services (HCS) were not always properly approved, charged for, or supported by appropriate documentation.

We noted that:

- ▶ the head of Medical Services performed a review/approval of student athlete physical evaluation forms prepared by off-campus providers and forwarded to HCS by the campus Athletics Department. This service and the department's respective roles and responsibilities had not been formally defined in a Memorandum of Understanding (MOU) or other similar agreement. Additionally, the Athletics Department was not charged for this service.
- ▶ the campus president had not approved the provision of dental services.

Executive Order No. 637, *CSU Policy on Student Health Services*, dated August 1, 1995, states in part, that the president is delegated the authority to approve any augmented services listed in Section II which include, but are not limited to, dental education/screening programs.

SAM §20050 states that the elements of a satisfactory system of internal accounting and administrative control include an established system of practices to be followed in performance of duties and functions in each of the state agencies.

The director of Health and Counseling Services stated that this process with the Athletics Department was in place before the current head of Medical Services assumed the position over ten years ago. He further stated that the need for a MOU and approval for the provision of dental services was an oversight.

The lack of adequate documentation for services provided to other departments and approval of augmented services increase the risk of misunderstandings and inconsistencies between current practice and the intentions of management and reduces the amount of funds available for health services operations.

## **Recommendation 2**

We recommend that the campus:

- a. re-evaluate the current practice of reviewing/approving student athlete physical evaluation forms provided by outside providers and, if necessary, develop a formal MOU for established services; and
- b. obtain campus president approval for dental services and develop formalized procedures to ensure presidential approval for any future augmented services.

## **Campus Response**

The review of physical examinations for Athletics has been discontinued. A Memorandum of Understanding between the Athletic Department and Health and Counseling Services is being developed. The development of a procedure for initiating new services has been completed and is being implemented with Dental Services.

Anticipated Date of Completion: June 30, 2001

## **WRITTEN POLICIES AND PROCEDURES**

Written policies and procedures were not developed for certain Health and Counseling Services (HCS) activities.

We noted that written procedures were not developed for the following areas:

- ▶ patient comments/suggestions and incidents;
- ▶ chargeback/billing and accounts receivable processing for employee services (e.g., asbestos physicals);
- ▶ visitor treatment of injuries and completion of accident forms;
- ▶ anonymous HIV testing and confidentiality of information; and
- ▶ reporting of violent crimes.

SAM §20050 states that a satisfactory system of internal administrative control shall include, but not be limited to, an established system of practices to be followed in performance of duties and functions. Further, the nonexistence of policy and procedural or operational manuals is a danger signal of a vulnerable control system.

The director of Health and Counseling Services stated that the lack of written procedures relative to chargeback/billing and accounts receivable for employee services, visitor treatment of injuries, anonymous HIV testing and confidentiality of information, and reporting of violent crimes was an oversight. He further stated that the comments/suggestions and incident process is currently under revision, so no written procedures are yet in place.

Failures to develop, document, and communicate policies and procedures compromise internal controls.

### **Recommendation 3**

We recommend that the campus develop and distribute formalized policies and procedures for the noted areas and implement appropriate monitoring controls to ensure procedures are updated and distributed to responsible personnel as appropriate.

### **Campus Response**

We concur. The campus will develop and distribute formalized policies and procedures for the areas noted. These policies will be reviewed biannually.

Anticipated Date of Completion: June 30, 2001

## CAMPUS HEALTH SERVICES AND PROGRAMS

### ATHLETICS DEPARTMENT – CREDENTIALING

Controls over the hiring and credentialing of team physicians needed strengthening.

We noted that team physicians were used to providing health services to athletes in addition to HCS providers. Although the team physicians were considered “volunteer” employees, there was no documentation on file to support this status for one of the two team physicians. We also noted that responsibility for obtaining this and other documentation (e.g., medical licensure, CPR certification, etc.) for the team physicians was not sufficiently defined and documented by the Athletics Department or other campus personnel.

Executive Order No. 637, *CSU Policy on Student Health Services*, dated August 1, 1995, prescribes the minimum qualifications and hiring requirements for professionals in Student Health Services. Such criteria include, but are not limited to: possession of a valid professional California license, possession of a Drug Enforcement Agent number for prescribing physicians, compliance with continuing education as required by the particular profession, appropriate CPR certification, and written authorization to allow verification of all information submitted.

The head athletic and assistant athletic trainers understood that volunteer status forms were obtained by Athletics Department administration.

Inadequate controls over the hiring and credentialing process increase the risk of providing health services by unqualified personnel.

#### **Recommendation 4**

We recommend that the campus:

- a. define and document the responsibilities for obtaining employment and credentialing documentation for team physicians; and
- b. establish formalized monitoring procedures to ensure ongoing compliance with procedures is maintained.

#### **Campus Response**

We concur. A Memorandum of Understanding between the Athletic Department and Health and Counseling Services is being developed. The Athletic Training Department will supply Health and Counseling Services with the names and credentialing process information for all physicians assisting in the Athletic Training Room. The physicians must meet the same standards that the physicians in the Health and Counseling Services Department meet. The physicians assisting in the athletic training room will also fill out a volunteer form through the Athletic Department. The

Athletic Training Room staff will discuss with the physicians the privileges that these physicians will be allowed and will be comfortable performing in the training room. These privileges will be documented and become part of the Athletic Training Room Policies and Procedures Manual.

Anticipated Date of Completion: August 17, 2001

## **ATHLETICS DEPARTMENT – PHARMACY OPERATIONS**

Pharmaceutical items maintained in the campus Athletics Department were not adequately inventoried and controlled.

We noted that:

- ▶ prescription medications (e.g., anti-inflammatories) were periodically administered to student athletes by the athletic trainers based on verbal instructions provided by one of the team physicians. Additionally, these items were not inventoried, nor were drug-distribution records created and maintained when the medications were administered to the student athlete.
- ▶ student assistants assigned to the training room administered non-prescription medications to student athletes. These items were housed in a cabinet in the assistant athletic trainer's office that was accessible for general use. Supplies of certain items (e.g., non-aspirin) were also maintained on a shelf in the training area for the student athletes' general and unsupervised use.
- ▶ expired over-the-counter (OTC) medications were noted in one of the cabinets housing these items, and unlabeled vials of non-aspirin were noted in one of the athletic trainer's travel bag.
- ▶ written policies and procedures were not established for the Athletics Department drug-distribution program.

The *1999-2000 NCAA Sports Medicine Handbook*, Guideline 1C, states, in part, that:

- ▶ certified athletic trainers should not be assigned duties that may be performed only by physicians or pharmacists. A team physician cannot delegate diagnosis, prescription drug control, or prescription dispensing duties to athletic trainers;
- ▶ drug-distribution records should be created and maintained where dispensing occurs in accordance with appropriate legal guidelines. The record should be current and easily accessible by medical personnel;
- ▶ all drug stock should be examined at regular intervals for removal of outdated, deteriorated, or recalled medications;
- ▶ all emergency and travel kits containing prescription and OTC drugs should be routinely inspected for drug quality and security; and

- ▶ individuals receiving medications should be properly informed about what they are taking and how they should take it. Drug allergies, chronic medical conditions, and concurrent medication use should be readily retrievable in the training room record.

SAM §20050 states that a satisfactory system of internal accounting and administrative control includes a plan of authorization and record-keeping procedures adequate to provide effective accounting controls over assets, liabilities, revenues, and expenditures.

The head athletic and assistant athletic trainers stated that the need for additional controls over pharmaceutical items was an oversight and that corrective action would be taken as appropriate.

Inadequate controls over medications increase the risk of campus liability due to inappropriate activities.

### **Recommendation 5**

We recommend that the campus re-evaluate the current practice of maintaining prescription and OTC medications in the athletics training room. In this regard and should this practice be approved by responsible management, we recommend that the campus:

- a. establish formalized policies and procedures for the storage, distribution, and inventory management of all supplies of prescription and OTC medications; and
- b. implement appropriate monitoring controls to ensure compliance with established policies and procedures is maintained.

### **Campus Response**

We concur. The Athletic Training Department is working on a written policies and procedures manual that will include guidelines on the handling of all over-the-counter medications. This will include an inventory sheet that is updated monthly, a dispensing record, and storage guidelines. The Athletic Training Department will no longer have prescription medications stored in the training room.

Anticipated Date of Completion: August 17, 2001

## **ATHLETICS DEPARTMENT – MEDICAL RECORDS**

Controls over student athlete medical information needed strengthening.

The following were noted during a review of the Athletics Department medical information management process:

- ▶ Student athlete medical information was maintained in two file cabinets that were not properly secured. We noted that the cabinet in the assistant athletic trainer's office did not have a locking mechanism, and the other cabinet in the main training area had a locking mechanism but no key.

- ▶ Student assistants working in the Athletics Department were not required to sign a Confidentiality Statement or other similar document to ensure proper protection of medical- related information.
- ▶ Written guidelines and procedures for medical records management had not been established to ensure effective record maintenance, retention, disclosure, and confidentiality requirements in accordance with CSU policy and state laws/regulations.

Executive Order No. 637, *CSU Policy on Student Health Services*, dated August 1, 1995, states, in part, that:

- ▶ medical records shall be maintained in a secure area;
- ▶ when not in use, medical records shall be stored in either locked files or in a locked room; and
- ▶ confidentiality of medical records shall be maintained in accordance with the California Information Practices Act and applicable state and federal laws.

The *Information Practices Act of 1977*, Civil Code §1798.1 (c) states, in order to protect the privacy of individuals, it is necessary that the maintenance and dissemination of personal information be subject to strict limits.

The *1999-2000 NCAA Sports Medicine Handbook*, Guideline 1B, states that a training record is a medical record, and therefore is subject to state and federal laws with regard to confidentiality and content.

The head athletic and assistant athletic trainers acknowledged the need for written policies and procedures for medical records management.

Inadequate control over medical records increases the risk of unauthorized disclosure of personal information and campus liability due to inappropriate activities.

### **Recommendation 6**

We recommend that the campus:

- a. review existing practices for storing medical information to ensure adequate safeguards and protection of confidential information;
- b. implement appropriate confidentiality forms for student assistants and other campus personnel with access to student athlete medical information; and
- c. establish written policies and procedures for athletics medical records management function.

### **Campus Response**

We concur. The Athletic Training Department is working on a written policies and procedures manual that will include guidelines for athletes and athletic training room staff regarding medical records. This will include a definition of what is considered part of the athlete's medical record

including a release of medical record form. There will be confidentiality agreement forms for all staff members with access to the records to sign. The medical records will be contained in three locked file cabinets.

Anticipated Date of Completion: August 17, 2001

## **HIV ANTIBODY TESTING CONTRACT**

The contract with the County of San Luis Obispo and the Trustees of the CSU for Alternative Test Site (HIV Antibody Testing) was not current.

Although the County of San Luis Obispo continued to provide services as stipulated by the agreement, the term of the agreement expired on September 23, 1997.

SAM §20050 states that the elements of a satisfactory system of internal administrative control include, but are not limited to, an established system of practices to be followed in performance of duties and functions.

The director of Health and Counseling Services (HCS) stated that he expected Contracts and Procurement to monitor the contract. However, the department thought that HCS was doing the same. He further stated that the county has continued to provide free supplies and training under the terms of the contract, so there was no external trigger indicating that the contract had expired.

Failure to maintain a current written agreement can result in misunderstandings and inconsistencies between existing contract language and the intentions of both the campus and County of San Luis Obispo management.

### **Recommendation 7**

We recommend that the campus update the HIV Antibody Testing agreement between the County of San Luis Obispo and the campus and implement monitoring controls to ensure that compliance with the contract terms is maintained and updates to the contract are performed in a timely manner.

### **Campus Response**

Health and Counseling Services is currently working with San Luis Obispo County to revise and update the HIV testing contract. If this process is not completed by June 30, 2001, Health and Counseling Services will discontinue anonymous testing until the contract is completed and signed. The contract renewal date has been entered in the Health Services' annual calendar.

Anticipated Date of Completion: June 30, 2001

## PHARMACY OPERATIONS

### INVENTORY

Controls over Health and Counseling Services (HCS) prescription medications needed improvement.

We noted that:

- ▶ although controlled substances and other prescription medications were maintained in locked cabinets in the Urgent Care area, the key to these cabinets was stored in an unlocked nearby facility; and
- ▶ although the pharmacist-in-charge implemented a perpetual inventory system to account for all narcotics, an effective inventory management system was not in place for other non-controlled prescription medications.

California State Business and Professions Code §4181(a) states, in part, that the clinic shall comply with all applicable laws and regulations of the State Department of Health Services relating to the drug distribution service to insure that inventories, security procedures, training, protocol development, record keeping, packaging, labeling, dispensing, and patient consultation occur in a manner that is consistent with the promotion and protection of the health and safety of the public.

SAM §20050 states that a satisfactory system of internal accounting and administrative control includes a plan of authorization and record-keeping procedures adequate to provide effective accounting controls over assets, liabilities, revenues, and expenditures.

The director of Health and Counseling Services stated that inventories maintained in the Urgent Care area had been in place for many years without known problems, and consideration of after-hours custodian access to the key was an oversight. He further stated that although annual inventories of prescription medications were performed, not implementing other inventory management controls was an oversight.

Not maintaining adequate control over inventories of pharmaceutical items increases the risk of loss or theft and could result in higher overall pharmacy costs.

### **Recommendation 8**

We recommend that the campus:

- a. strengthen procedures to ensure that access to controlled substances and other prescription medications is adequately controlled; and
- b. implement an effective inventory management system for non-controlled substances maintained in the HCS pharmacy, including periodic physical inventories and reconciliation to inventory records.

### **Campus Response**

We concur. Controlled substances and other prescription medications have been removed from the Urgent Care area and now are only in the pharmacy. We continue to explore the feasibility of having a box of non-controlled medications available for when the Health Center is open, but the Pharmacy is not. Until such a plan is developed and approved, prescription medication will only be available through the pharmacy (except for medication samples). In addition, inventory control procedures have been developed.

Anticipated Date of Completion: Complete

## **PRESCRIPTIONS**

The campus president did not approve the filling of written or oral prescriptions from off-campus providers.

Executive Order No. 637, *CSU Policy on Student Health Services*, dated August 1, 1995, states, in part, that with the written approval of the president, the director of the Student Health Center may implement a policy that permits the campus pharmacy to fill prescriptions written by off-campus physicians or other appropriate health care professionals.

The director of Health and Counseling Services stated that these services had been offered by the pharmacy for many years, pre-dating the August 1, 1995, executive order.

Internal controls over pharmacy operations are compromised, and liability increased, when the filling of prescriptions from off-campus providers is not properly approved.

**Subsequent to our visit, the campus provided evidence of the president's approval.**

## **MEDICAL RECORDS**

Controls to ensure that medical charts contained required documentation needed improvement.

The following were noted during a review of 25 randomly selected medical charts prepared from June 1, 2000, through August 31, 2000:

- ▶ In eight (32%) instances, the provider did not use the required Subjective Objective Assessment and Plan (SOAP) format to chart the patient visit.
- ▶ In seven (28%) instances, the Health Status Report was not properly completed to include the (students') parent health history information.
- ▶ In five (20%) instances, the provider had not documented instructions for follow-up visits or instructions to contact the provider for symptoms that persist, change, or worsen.

- ▶ In three (12%) instances, the Problem List was not properly completed (e.g., one list did not indicate the patient's most recent visit; two did not indicate prescribed medications).

The 1999 *Accreditation Handbook for Ambulatory Health Care Standards*, Chapter 6, states, in part, that entries in a patient's record for each visit shall include, but are not limited to: date, department, and provider name and profession, chief complaint or purpose of visit, clinical findings, diagnosis or impression, studies ordered, therapies administered, disposition, recommendations, and instructions given to the patient, and authentication and verification of contents by the practitioner.

SAM §20050 states that a satisfactory system of internal accounting and administrative control includes a plan of authorization and record-keeping procedures adequate to provide effective accounting controls over assets, liabilities, revenues, and expenditures.

The director of Health and Counseling Services stated there were discrepancies in the center's written policies regarding chart notes as the center had discontinued the requirement for SOAP notation format. He further stated that chart review occurs extensively, but had addressed delivery services more than the completeness of the medical record.

Inadequate controls over medical chart documentation increases the risk of providing substandard patient care.

### **Recommendation 9**

We recommend that the campus revise existing medical chart procedures to ensure alignment with current practice and management's expectations, and implement enhanced monitoring controls to ensure that chart deficiencies are timely identified and reported.

### **Campus Response**

We concur. A list of required elements in the charting of a visit is being developed by the Health and Counseling Services clinical staff. This list of elements will be included in the quarterly Quality Assurance Chart Audit (peer review). The Chart Audit results will be summarized and then reported to the Quality Assurance Committee as part of the quarterly summary of chart audits.

Anticipated Date of Completion: June 1, 2001

## DATA ACCESS AND PHYSICAL SECURITY

### KEY CONTROL AND BUILDING SECURITY

Controls over key documentation and physical security needed improvement.

We noted that:

- ▶ reserve keys to the Health and Counseling Services (HCS) pharmacy were maintained in a locker in the campus key department that was accessible by four facilities services' personnel;
- ▶ keys to the HCS building were issued to numerous individuals on the campus (e.g., facilities services, public safety) without approval from the director of Health and Counseling Services; and
- ▶ HCS does not perform a periodic physical verification of assigned keys to the campus key listing.

Executive Order No. 637, *CSU Policy of Student Health Services*, dated August 1, 1995, states, in part, that:

- ▶ pharmacy keys shall be issued only to licensed pharmacists. A pharmacy key may be maintained by the director of the Student Health Center. That key shall be kept in a sealed envelope and placed in a locked container and may only be used when emergencies arise and a licensed pharmacist is not present.
- ▶ access to the Student Health Center during after-hours shall be limited to health center personnel and other individuals authorized by the director of the Student Health Center.

SAM §20050 states that a satisfactory system of internal accounting and administrative control includes a plan of authorization and record-keeping procedures adequate to provide effective accounting controls over assets, liabilities, revenues, and expenditures.

The director of Health and Counseling Services stated that not exploring controls over spare pharmacy keys at the campus key department was an oversight. He further stated that the current practice of issuing numerous keys to the facility had been in place for many years, pre-dating the August 1, 1995, executive order.

Inadequate controls over keys and building security increases the risk of unauthorized access to the health services building, disclosure of confidential data, lost or stolen medications and supplies, and non-compliance with CSU policy.

### **Recommendation 10**

We recommend that the campus:

- a. establish formalized policies and procedures for the control, assignment, and documentation of pharmacy keys to ensure compliance with CSU policies and state/federal regulations;
- b. strengthen procedures to ensure that access to the health services facility by non-health center employees is properly approved; and
- c. establish procedures to periodically verify assigned keys to the campus key listing.

### **Campus Response**

We concur. The Director of Health and Counseling Services has reviewed the current list of key holders and retrieved keys from those who no longer need them. The Key Policy has been revised. The annual review of the key list has been added to our annual calendar.

Anticipated Date of Completion: Complete

### **DATA SECURITY**

Data access and physical security controls over the Health and Counseling Services (HCS) NT server needed improvement.

We noted that:

- ▶ the minimum password length was not set to industry standards;
- ▶ the lock-out feature to prevent user access after a pre-determined number of unsuccessful log-on attempts was not activated;
- ▶ keys to the cage door that allows access to the NT server were assigned to nine individuals of whom four were employed by the campus facilities services department; and
- ▶ written policies and procedures had not been developed for the HCS data security environment.

SAM §20050 and §4840 require, in part, that there be a plan that limits access to state agency assets to authorized personnel who require these assets in the performance of their assigned duties.

SAM §4841 requires state agencies to provide for the proper use and protection of its information assets by establishing appropriate policies and procedures for preserving the integrity and security of automated files and databases.

SAM §4989.7 requires state agencies to implement appropriate safeguards to secure workgroup computing configurations and their associated files. Management should protect computing configurations from theft and unauthorized use.

The director of Health and Counseling Services stated that the center was operating under the assumption that existing data security controls provided sufficient system security. He further stated that prior to the audit, the center did not view facilities services as a risk to the system and that not developing written policies and procedures for the data security function was an oversight.

Failure to provide adequate data and physical security jeopardizes the preservation/security of HCS information assets.

### **Recommendation 11**

We recommend that the campus:

- a. change the data security configuration on password requirements to include appropriate password lengths and time-out features;
- b. re-evaluate the key assignments to ensure appropriate protection of the HCS server; and
- c. establish formalized policies and procedures for HCS data security function.

### **Campus Response**

Data access and physical security controls over the Health and Counseling Services' NT server have been revised based on the recommendations made by the Chancellor's audit.

Anticipated Date of Completion: Complete

---

## **APPENDIX A: PERSONNEL CONTACTED**

<b><u>Name</u></b>	<b><u>Title</u></b>
Dr. Warren J. Baker	President
Richard Ascoli	Physician
Shirley Beaumonte	Insurance and Billing Coordinator
Martin Bragg	Director of Health and Counseling Services
Andrea Brauninger	Physician
Steven Briggs	Pharmacist-in-Charge
Burt Cochran	Head of Medical Services
Carlos Cordova	University Legal Counsel
Marjorie Davis	Clinical Laboratory Technologist
Robert Detweiler	Interim Vice President for Student Affairs
Thomas Eitriem	Buyer, Contract and Procurement Services
Judy Gordon	Instructional Support Assistant Counseling Services
Edie Griffin-Shaw	Key Distribution
Betty Kroeze	Head of Support Services
Lorlie Leetham	Assistant Director, Accounts and Payment Management
Barbara Melvin	Associate Director, Human Resources and Employment Equity
Lynn Ogden	Administrative Support Coordinator, Athletics
Marina Perez	Head of Nursing Services
Vivian Phillips	Assistant to Director of Health and Counseling Services
Joseph Risser	Risk Manager
Kathleen Ruiz	Licensed Vocational Nurse
Vanessa Scrimiger	Front Desk Supervisor
Krystal Slover	Assistant Athletic Trainer
Vicki Stover	Associate Vice President, Administration
Dorothy Tallman	Radiologic Technologist
Karen Webb	Associate Director, Budget and Analytic Business Services
Lori Williams	Health Records Technician
Steven Yoneda	Head Athletic Trainer



**California Polytechnic State University, San Luis Obispo  
Student Health Center  
Audit No. 00-33**

**Recommendation 1**

We recommend that the campus:

- a. strengthen processes to ensure that internal credentialing and re-credentialing procedures are appropriately aligned, and comply with CSU policy and accreditation standards;
- b. implement appropriate monitoring controls to ensure that health care provider files contain required credentialing documentation per campus and CSU policies; and
- c. periodically consult with campus human resources or other subject-matter personnel regarding the applicability of CBA provisions (e.g., CME requirements) to all health care provider staff.

**Campus Response**

We concur. The credentialing deficiencies primarily were found in the charts of on-call providers, who had not yet worked for the Health Services, or of volunteer/contract providers. Some elements of the credentialing process required information that was not available from the campus' employment application.

The credentialing form and policy/procedures are being revised to incorporate the auditor's findings. A quarterly quality assurance audit to review the completeness of all the files of each licensed provider whose professional license expired during that quarter will be the mechanism for monitoring the credentialing/recredentialing for providers. In addition, consultation between the Human Resources and Employment Equity and Health Services has already begun.

**Anticipated Date of Completion:** June 30, 2001

**Recommendation 2**

We recommend that the campus:

- a. re-evaluate the current practice of reviewing/approving student athlete physical evaluation forms provided by outside providers, and if necessary, develop a formal MOU for established services; and
- b. obtain campus president approval for dental services and develop formalized procedures to ensure presidential approval for any future augmented services.

**Campus Response**

The review of physical examinations for Athletics has been discontinued. A Memorandum of Understanding between the Athletic Department and Health and Counseling Services is being developed. The development of a procedure for initiating new services has been completed and is being implemented with Dental Services.

**Anticipated Date of Completion:** June 30, 2001

**Recommendation 3**

We recommend that the campus develop and distribute formalized policies and procedures for the noted areas, and implement appropriate monitoring controls to ensure procedures are updated and distributed to responsible personnel as appropriate.

**Campus Response**

We concur. The campus will develop and distribute formalized policies and procedures for the areas noted. These policies will be reviewed biannually.

**Anticipated Date of Completion:** June 30, 2001

**Recommendation 4**

We recommend that the campus:

- a. define and document the responsibilities for obtaining employment and credentialing documentation for team physicians; and
- b. establish formalized monitoring procedures to ensure ongoing compliance with procedures is maintained.

**Campus Response**

We concur. A Memorandum of Understanding between the Athletic Department and Health and Counseling Services is being developed. The Athletic Training Department will supply Health and Counseling Services with the names and credentialing process information for all physicians assisting in the Athletic Training Room. The physicians must meet the same standards that the physicians in the Health and Counseling Services Department meet. The physicians assisting in the athletic training room will also fill out a volunteer form through the Athletic Department. The Athletic Training Room staff will discuss with the physicians the privileges that these physicians will be allowed and will be comfortable performing in the training room. These privileges will be documented and become part of the Athletic Training Room Policies and Procedures Manual.

**Anticipated Date of Completion:** August 17, 2001

**Recommendation 5**

We recommend that the campus re-evaluate the current practice of maintaining prescription and OTC medications in the athletics training room. In this regard and should this practice be approved by responsible management, we recommend that the campus:

- a. establish formalized policies and procedures for the storage, distribution, and inventory management of all supplies of prescription and OTC medications; and
- b. implement appropriate monitoring controls to ensure compliance with established policies and procedures is maintained.

**Campus Response**

We concur. The Athletic Training Department is working on a written policies and procedures manual that will include guidelines on the handling of all over-the-counter medications. This will include an inventory sheet that is updated monthly, a dispensing record, and storage guidelines.

The Athletic Training Department will no longer have prescription medications stored in the training room.

**Anticipated Date of Completion:** August 17, 2001

**Recommendation 6**

We recommend that the campus:

- a. review existing practices for storing medical information to ensure adequate safeguards and protection of confidential information;
- b. implement appropriate confidentiality forms for student assistants and other campus personnel with access to student athlete medical information; and
- c. establish written policies and procedures for athletics medical records management function.

**Campus Response**

We concur. The Athletic Training Department is working on a written policies and procedures manual that will include guidelines for athletes and athletic training room staff regarding medical records. This will include a definition of what is considered part of the athlete's medical record including a release of medical record form. There will be confidentiality agreement forms for all staff members with access to the records to sign. The medical records will be contained in three-locked file cabinets.

**Anticipated Date of Completion:** August 17, 2001

**Recommendation 7**

We recommend that the campus update the HIV Antibody Testing agreement between the County of San Luis Obispo and the campus, and implement monitoring controls to ensure that compliance with the contract terms is maintained, and updates to the contract are performed in a timely manner.

**Campus Response**

Health and Counseling Services is currently working with San Luis Obispo County to revise and update the HIV testing contract. If this process is not completed by June 30, 2001, Health and Counseling Services will discontinue anonymous testing until the contract is completed and signed. The contract renewal date has been entered in the Health Services' annual calendar.

**Anticipated Date of Completion:** June 30, 2001

**Recommendation 8**

We recommend that the campus:

- a. strengthen procedures to ensure that access to controlled substances and other prescription medications is adequately controlled; and
- b. implement an effective inventory management system for non-controlled substances maintained in the HCS pharmacy, including periodic physical inventories and reconciliation to inventory records.

**Campus Response**

We concur. Controlled substances and other prescription medications have been removed from the Urgent Care area and now are only in the pharmacy. We continue to explore the feasibility of having a box of non-controlled medications available for when the Health Center is open, but the Pharmacy is not. Until such a plan is developed and approved, prescription medication will only be available through the pharmacy (except for medication samples). In addition, inventory control procedures have been developed.

**Anticipated Date of Completion:** Complete (supporting documentation will be forwarded upon acceptance of this report by the Chancellor)

**Recommendation 9**

We recommend that the campus revise existing medical chart procedures to ensure alignment with current practice and management's expectations, and implement enhanced monitoring controls to ensure that chart deficiencies are timely identified and reported.

**Campus Response**

We concur. A list of required elements in the charting of a visit is being developed by the Health and Counseling Services clinical staff. This list of elements will be included in the quarterly Quality Assurance Chart Audit (peer review). The Chart Audit results will be summarized and then reported to the Quality Assurance Committee as part of the quarterly summary of chart audits.

**Anticipated Date of Completion:** June 1, 2001

**Recommendation 10**

We recommend that the campus:

- a. establish formalized policies and procedures for the control, assignment, and documentation of pharmacy keys to ensure compliance with CSU policies and state/federal regulations;
- b. strengthen procedures to ensure that access to the health services facility by non-health center employees is properly approved; and
- c. establish procedures to periodically verify assigned keys to the campus key listing.

**Campus Response**

We concur. The Director of Health and Counseling Services has reviewed the current list of key holders and retrieved keys from those who no longer need them. The Key Policy has been revised. The annual review of the key list has been added to our annual calendar.

**Anticipated Date of Completion:** Complete (supporting documentation will be forwarded upon acceptance of this report by the Chancellor)

**Recommendation 11**

We recommend that the campus:

- a. change the data security configuration on password requirements to include appropriate password lengths and time-out features;
- b. re-evaluate the key assignments to ensure appropriate protection of the HCS server; and
- c. establish formalized policies and procedures for HCS data security function.

**Campus Response**

Data access and physical security controls over the Health and Counseling Services' NT server have been revised based on the recommendations made by the Chancellor's audit.

**Anticipated Date of Completion:** Complete (supporting documentation will be forwarded upon acceptance of this report by the Chancellor)

THE CALIFORNIA STATE UNIVERSITY  
OFFICE OF THE CHANCELLOR

BAKERSFIELD

CHANNEL ISLANDS

April 9, 2001

CHICO

MEMORANDUM

DOMINGUEZ HILLS

FRESNO

TO: Larry Mandel  
University Auditor

FULLERTON

FROM: Charles B. Reed 

HAYWARD

HUMBOLDT

SUBJECT: Draft Final Report Number 00-33 on *Student Health Center*,  
California Polytechnic State University, San Luis Obispo

LONG BEACH

LOS ANGELES

In response to your memorandum of April 9, 2001, I accept the response as submitted with the draft final report on Student Health Center, California Polytechnic State University, San Luis Obispo.

MARITIME ACADEMY

MONTEREY BAY

NORTHRIDGE

CBR/amd

POMONA

Enclosure

SACRAMENTO

cc: Dr. Warren J. Baker, President

SAN BERNARDINO

SAN DIEGO

SAN FRANCISCO

SAN JOSE

SAN LUIS OBISPO

SAN MARCOS

SONOMA

STANISLAUS