STUDENT HEALTH SERVICES
SAN JOSÉ STATE UNIVERSITY

Audit Report 13-59
December 9, 2013

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ABBREVIATIONS

BCP Business and Professions Code
CSU California State University
EMR Electronic Medical Records
EO Executive Order
HIPAA Health Insurance Portability and Accountability Act
ICSUAM Integrated California State University Administrative Manual
ISO Identity and Information Security Officer
IT Information Technology
OTC Over-the-Counter Medications
OAAS Office of Audit and Advisory Services
PD Presidential Directive
PNC Point and Click
SAM State Administrative Manual
SHAC Student Health Advisory Committee
SHC Student Health Center
SHS Student Health Services
SJSU San José State University
EXECUTIVE SUMMARY

As a result of a systemwide risk assessment conducted by the Office of Audit and Advisory Services (OAAS) during the last quarter of 2012, the Board of Trustees, at its January 2013 meeting, directed that Student Health Services (SHS) be reviewed. The OAAS last reviewed Student Health Centers in 2000.

We visited the San José State University (SJSU) campus from July 29, 2013, to September 6, 2013, and audited the procedures in effect at that time.

In our opinion, except for the effect of the weaknesses described below, the fiscal, operational, and administrative controls for SHS as of September 6, 2013, taken as a whole, were sufficient to meet the objectives stated in the “Purpose” section of this report. Areas of concern include: program administration, health programs, athletics medicine, pharmacy, medical records, fiscal management, and information and data security.

As a result of changing conditions and the degree of compliance with procedures, the effectiveness of controls changes over time. Specific limitations that may hinder the effectiveness of an otherwise adequate system of controls include, but are not limited to, resource constraints, faulty judgments, unintentional errors, circumvention by collusion, and management overrides. Establishing controls that would prevent all these limitations would not be cost-effective; moreover, an audit may not always detect these limitations.

The following summary provides 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.

PROGRAM ADMINISTRATION [9]

Responsibility for university health services provided in areas such as student affairs, academic affairs, and athletics, was not documented with a written designation or delegation of authority by the president. In addition, the Student Health Center (SHC) policies and procedures were not regularly reviewed and updated. Further, administration of the student health advisory committee (SHAC) needed improvement. For example, the presidential directive establishing the SHAC had not been updated since 1996 and included a reference to an outdated executive order. Also, the campus could not show evidence that the most recent SHC accreditation report had been sent to the campus president or designee.

HEALTH PROGRAMS [13]

The campus did not properly approve augmented health services.

ATHLETICS MEDICINE [14]

The campus had not developed a quality assurance program in the sports medicine area similar to the one used by the campus SHC. In addition, policies and procedures for athletics medicine had not been approved in writing by the physician responsible for medical oversight of the program. Also, team physicians in the athletics medicine department were not subject to a periodic medical credentials review and did not undergo a formal privileging process. Further, administration of medications within the
athletics medicine department needed improvement. For example, athletics medicine department staff were dispensing prescription medications without a pharmacist license or the appropriate clinical pharmacy permit.

PHARMACY [18]

Segregation of duties at the pharmacy was inadequate, as one individual performed all functions related to the provisioning of the pharmacy stock, including ordering, receiving, record updating, and periodic inventories. Also, the SHC did not have written authorization from the president or a designee for the filling of prescriptions from off-campus providers.

MEDICAL RECORDS [19]

The campus did not conduct an assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic health information obtained and held in the various areas of the campus.

FISCAL MANAGEMENT [20]

Administration of trust fund accounts utilized for student health services needed improvement. Specifically, trust fund agreements were not updated every three years as required by campus policy, and disbursements from trust funds were not always processed in compliance with funding designations and guidelines.

INFORMATION AND DATA SECURITY [21]

The campus did not have a documented plan that outlined the specific steps needed for recovery of data processing services in a local disaster affecting the SHC computer room. In addition, backup tapes for the systems maintained in the SHC computer room were not maintained at an off-site location, and the SHC computer room did not contain smoke detectors or water and heat sensors. Further, the campus had an excessive number of administrator profiles and one generic profile for the electronic medical records application.
INTRODUCTION

BACKGROUND

The Policy of the Board of Trustees on Student Health Services was initially adopted in 1977 as a comprehensive systemwide policy; since then, it has been periodically revised and updated to reflect the changing regulatory, financial, and student demographic environments. In 1993, a task force study recommended that system roles, responsibilities, and expectations be recorded in executive orders (EO) issued by the chancellor, and the policy has been communicated in that format since that time.

The most recent version, EO 943, Policy on University Health Services, dated April 28, 2005, outlines the health services the campuses may provide, including the conditions that must be met to justify adding additional services or funding sources. It also describes operational expectations for pharmacies, staffing, facility cleanliness and safety, medical records management, and accreditation. The EO focuses primarily on the scope and activities of the student health centers (SHC) but also includes sections that are applicable to other campus programs providing student health care, such as intercollegiate athletics, due to the SHC audits conducted in 2000.

The primary health entity on each California State University (CSU) campus, the SHC, is funded by two mandatory student fees, which are covered in EO 1054, California State University Fee Policy, dated January 14, 2011: a health services fee covering basic health services available to students, and a health facilities fee to support the health center facility. These fees can be changed only after a student referendum or a consultation that allows meaningful input and feedback from appropriate campus constituents.

Every three years, each campus SHC and its pharmacy are required to obtain accreditation from a nationally recognized, independent review agency such as the Accreditation Association for Ambulatory Health Care. Pharmacies are also subject to periodic inspections by the California State Board of Pharmacy.

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

A majority of CSU campuses have implemented systems and applications that facilitate a transition to electronic medical records (EMR), including some vendor applications designed specifically for university health services. Privacy concerns surrounding these emerging technologies have brought about new regulations, including the Health Insurance Portability and Accountability Act (HIPAA), which establishes national standards for electronic health care transactions, and the Technology for Economic and Clinical Health Act, a part of the American Recovery and Reinvestment Act of 2009 that addresses the privacy and security concerns associated with the electronic transmission of health information. Although this audit assesses the security of medical records, it does not address HIPAA in depth, as the
Office of Audit and Advisory Services (OAAS) reviewed the topic in 2010.

In 2000, the OAAS conducted an audit of SHC at ten campuses and issued a systemwide report. The report noted issues related to centralized oversight of student health activities, revisions to existing policies to clarify reporting and administrative expectations, credentialing of clinical staff in both the SHCs and athletics, and policies regarding the storage and dispensing of over-the-counter and prescription pharmaceuticals outside of campus pharmacies and in the athletics department. Recommendations from this audit were incorporated into EO 814, *Policy on University Health Services*, which was replaced by EO 943.
PURPOSE

Our overall audit objective was to ascertain the effectiveness of existing policies and procedures related to student health services (SHS) activities and to determine the adequacy of controls that ensure compliance with relevant governmental regulations, Trustee policy, Office of the Chancellor directives, and campus procedures.

Within the audit objective, specific goals included determining whether:

- Administration of SHS is well-defined and includes clear lines of organizational authority and responsibility and documented delegations of authority.
- Policies and procedures relating to SHS are current and comprehensive, and are effectively communicated to appropriate stakeholders.
- Management consistently monitors and assesses the risks associated with providing SHS.
- The SHC is appropriately accredited.
- SHC clinical staff and other employees providing patient care possess the necessary credentials and qualifications, and designations are maintained in favorable standing with appropriate licensing boards and medical associations.
- SHS are appropriately defined and approved and are consistently provided to all eligible students and personnel.
- Health education programs are appropriately developed and communicated.
- Athletics medicine activities are conducted in accordance with campus and CSU policies.
- Pharmacy operations in the SHC and other areas providing SHS have obtained the appropriate licenses.
- Pharmacy formularies are limited to medications that are necessary to provide quality health care and are representative of those medications most effective in terms of treatment.
- Pharmacy security is maintained in accordance with CSU policy and state regulations.
- Pharmacy inventories are properly reported, safeguarded, and accounted for, and prescription dispensing and destruction controls are in accordance with CSU policies and state regulations.
- Medical records, including electronic records, are properly maintained, safeguarded, and retained.
- The security of student health facilities is maintained in accordance with campus and CSU policy.
- Health services fees are approved, used for designated purposes, and properly accounted for in accordance with CSU policy and directives.

- Senior management demonstrates an awareness of security risks and monitors the computer environment to ensure the security of medical records systems.

- Methods used to enforce user authentication and appropriate access assignments for EMR systems are effective.

- Access to electronic medical records systems, programs, and data is appropriately restricted, and facilities are appropriately protected from fire and power outages.

- Medical records systems purchased from outside vendors are subject to CSU security provisions during procurement, and external access by vendors is controlled.

- Information technology assets supporting SHS are appropriately protected, and all assets are accounted for and have a nominated owner responsible for their protection.

- Senior management has a plan to recover all systems supporting the SHC following a major disaster.
SCOPE AND METHODOLOGY

The proposed scope of the audit as presented in Attachment A, Audit Agenda Item 2 of the January 22 and 23, 2013, meeting of the Committee on Audit stated that Student Health Services includes the provision of basic and augmented health services through campus student health facilities and pharmacy operations. Proposed audit scope would include, but was not limited to, a review of compliance with federal and state laws, Trustee policy, and chancellor’s office directives; establishment of a student health advisory committee; accreditation status; staffing, credentialing, and re-credentialing procedures; safety and sanitation procedures, including staff training; budgeting procedures; fee authorization, cash receipt and disbursement controls, and trust fund management; pharmacy operations, security, and inventory controls; and the integrity and security of medical records.

Our study and evaluation were conducted in accordance with the International Standards for the Professional Practice of Internal Auditing, issued by the Institute of Internal Auditors, and included the audit tests we considered necessary in determining that accounting and administrative controls are in place and operative. This review emphasized, but was not limited to, compliance with state and federal laws, Board of Trustee policies, and Office of the Chancellor policies, letters, and directives. The audit focused on procedures in effect from July 1, 2011, through September 6, 2013.

We focused primarily upon the internal administrative, compliance, and operational controls over SHS activities. Specifically, we reviewed and tested:

- Campus administration of SHS, including clear reporting lines and defined responsibilities, risk assessment, and current policies and procedures.
- SHC accreditation status and management responsiveness to recommendations made by the accreditation team.
- Procedures to confirm credentials and qualifications of clinical staff and other employees providing patient care.
- The definition and provision of basic and augmented health services in the SHC, including approval and eligibility for services.
- Health education programs for the student population.
- Administration of athletics medicine, including proper designation of responsible parties and the establishment of policies and procedures.
- Licensing and permit requirements for pharmacy operations at the SHC and other areas on campus, including athletics.
- Pharmacy formulary, dispensing, inventory, and physical security practices.
- Medical records management, including practices to ensure security and confidentiality.
INTRODUCTION

- Measures to ensure the security of student health facilities.
- The establishment of and subsequent changes to the mandatory health services fee, and methods to set and justify fees for augmented services.
- Budgets and financial records, including revenue and expenditure transactions in health fee trust accounts.
- Policies and procedures to ensure that information technology facilities, hardware, systems, and applications used for SHS are adequately secured, both physically and logically.
OBSERVATIONS, RECOMMENDATIONS, AND CAMPUS RESPONSES

PROGRAM ADMINISTRATION

GOVERNANCE

Responsibility for university health services provided in areas such as student affairs, academic affairs, and athletics was not documented with a written designation or delegation of authority by the president.

Executive Order (EO) 943, Policy on University Health Services, dated April 28, 2005, states that the president or a designee shall ensure appropriate oversight of all university health services. It further states that the president or a designee is responsible for ensuring appropriate oversight of all medical services provided to students participating in intercollegiate athletics.

The director of the student health center (SHC) and the director of sports medicine stated their belief that a written designation from the president indicating who was responsible for oversight was unnecessary.

A lack of clear accountability for university health services increases the risk that campus oversight will not include the entire range of health services available on the campus.

Recommendation 1

We recommend that the campus document responsibility for university health services provided in areas such as student affairs, academic affairs, and athletics with a written designation or delegation of authority from the president.

Campus Response

We concur. The campus will document the responsibility for university health services provided in areas such as student affairs, academic affairs, and athletics with a written designation or delegation of authority from the president. This will be completed by the end of March 2014.

POLICIES AND PROCEDURES

SHC policies and procedures were not regularly reviewed and updated.

We found that the last recorded updates to several key policies, including quality assurance and risk management, credentialing, and medical records management policies, were in 2010.

The Accreditation Association for Ambulatory Health Care Standards, Chapter 2, Governance, states that health organizations should adopt policies and procedures necessary for the orderly conduct of the organization, including the organization’s scope of clinical activities.
State Administrative Manual (SAM) §20050 states that elements of a satisfactory system of internal accounting and administrative controls includes an established system of practice to be followed in the performance of duties and functions in each of the state agencies.

EO 943, Policy on University Health Services, dated April 28, 2005, states that each campus department that has medical records shall biennially review its record management procedures.

The SHC director stated that policy reviews had been completed on a regular basis, but that due to oversight, the most recent review dates were not always recorded in the written policy and procedure documents.

Untimely review of policies and procedures increases the risk that critical policies will contain outdated or inaccurate information pertinent to student health administration and patient care.

**Recommendation 2**

We recommend that the campus regularly review and update SHC policies and procedures.

**Campus Response**

We concur. The campus will implement the procedure to regularly review and update SHC policies and procedures. This will be completed by the end of March 2014.

**STUDENT HEALTH ADVISORY COMMITTEE**

Administration of the student health advisory committee (SHAC) needed improvement.

We found that:

- The presidential directive (PD) establishing the SHAC had not been updated since 1996 and included a reference to an outdated EO.
- The SHAC had not established or obtained the president’s approval for its policies and operating procedures.
- The composition of the SHAC did not meet all of the PD’s requirements, as it did not include faculty members or a representative from university housing.
- The SHAC was not chaired by a student.
- SHAC members were not appointed in accordance with the PD, as student members were not appointed by the Associated Students, and faculty, staff, and administrative members were not appointed by the president.
The SHAC did not have a policy to ensure that proposals to add new or retain existing augmented services were submitted to the SHAC for consideration prior to review by the president, and these proposals were not always being presented to the SHAC.

EO 943, Policy on University Health Services, dated April 28, 2005, states that each president or designee shall establish a student health advisory committee to serve as advisory to the president and to the SHC on the scope of service, delivery, funding, and other critical issues relating to campus health services. It also states certain specific membership component requirements and states that a student shall chair the committee. In addition, the EO states that any proposals for augmented services shall be submitted to the committee for consideration prior to review of the proposal by the president.

San José State University (SJSU) PD 96-01, Student Health Advisory Committee, dated April 30, 1996, states that the SHAC shall consist of six students and five faculty, administrative, and staff members, and that one of the staff positions shall be a representative from university housing services. It further states that the student members shall be appointed by the associated students, and that faculty, staff, and administrative members shall be appointed by the president. The directive also states that the committee shall determine its own policies and operating procedures with final approval by the president.

The SHC director stated that he was unaware of the PD, and compliance with the provisions outlined in it would detract from the contemporary intent of the committee. He further stated that the augmented services had likely been vetted, but that the records had been misplaced due to a period of extensive leadership turnover at the SHC. He also stated his belief that absent a written directive from the president, he is the intended designee who should be informed of the committee input and decisions, and that he elevated the committee input to the appropriate management level. He further stated that while there was no official student chair for the committee, that the agendas presented at the meetings gave ample opportunity for the students to provide input.

Improper administration of the SHAC compromises student input into university health services and can cause communication between the committee and the campus president on critical health issues to be inadequate.

Recommendation 3

We recommend that the campus:

a. Update the PD establishing the SHAC, or issue another governing document regarding its administration.

b. Obtain the president’s approval for the SHAC’s policies and operating procedures.

c. Review the SHAC’s current membership, and revise it to meet the requirements of the existing or revised PD, or other governing document.

d. Appoint a student as chair of the SHAC.
e. Appoint SHAC members in accordance with the existing or revised PD, or other governing document.

f. Establish a policy that ensures that proposals to add new or retain existing augmented services are submitted to the SHAC for consideration prior to review by the president.

Campus Response

We concur. By the end of April 2014, the campus will complete compliance actions for the following specific recommendations:

a. Update the PD establishing the SHAC, or issue another governing document regarding its administration.

b. Obtain the president’s approval for the SHAC’s policies and operating procedures.

c. Review the SHAC’s current membership, and revise it to meet the requirements of the existing or revised PD, or other governing document.

d. Appoint a student as chair of the SHAC.

e. Appoint SHAC members in accordance with the existing or revised PD, or other governing document.

f. Establish a policy that ensures that proposals to add new or retain existing augmented services are submitted to the SHAC for consideration prior to review by the president.

ACCREDITATION REPORTS

The campus could not show evidence that the most recent SHC accreditation report had been sent to the campus president or designee.

EO 943, Policy on University Health Services, dated April 28, 2005, states that each SHC shall be evaluated and accredited by an appropriate, nationally recognized, independent review agency, and that the accrediting agency’s report shall be sent to the campus president or designee.

The SHC director stated that he forwarded the report to the vice president of student affairs in place at the time, and that the protocol would have been to allow that vice president to elevate the report.

Inadequate administration of required SHC accreditation reports undermines management’s ability to monitor the quality of health services provided at the SHC.

Recommendation 4

We recommend that the campus maintain evidence that SHC accreditation reports have been sent to the campus president or designee.


Campus Response

We concur. The campus will implement the procedure to maintain evidence that SHC accreditation reports have been sent to the campus president or designee. This will be completed by the end of March 2014.

HEALTH PROGRAMS

The campus did not properly approve augmented health services.

We found that the campus:

- Did not have documented approval from the president or designee for augmented services in place on the campus.

- Could not show evidence that augmented services were properly vetted before approval. For example, the campus could not show that student need or demand had justified the services or that the SHAC had been consulted about the services prior to their review by the campus president or designee.

EO 943, Policy on University Health Services, dated April 28, 2005, states that the president or designee is delegated the authority to approve any augmented service subject to certain conditions, including assurance that the services will not divert from the adequate provision of basic services; the SHC is equipped to provide the service; the medical qualifications and specializations of the staff are sufficient to provide the service; justification of student need or demand for the service has been made; the method for providing the service is the most effective in terms of both treatment and cost; and proposed services have been submitted for consideration to the student health advisory committee prior to review by the campus president or designee.

The SHC director stated that all augmented services were in place by the time that he and the medical chief-of-staff came to the SHC, and it was unclear how the services were approved before their hire. He further stated that even if initial approval was unclear, the services would not have been retained if they did not continue to meet the conditions for approval.

Insufficient documentation to support the proper approval of augmented services exposes the campus to questions regarding the appropriateness of services offered at the SHC.

Recommendation 5

We recommend that the campus:

a. Obtain documented presidential approval for augmented services.

b. Maintain evidence showing that augmented services have been properly vetted before approval.
Campus Response

We concur. By the end of April 2014, the campus will complete compliance actions for the following specific recommendations:

a. Obtain documented presidential approval for augmented services.
b. Maintain evidence showing that augmented services have been properly vetted before approval.

ATHLETICS MEDICINE

QUALITY ASSURANCE PROGRAM

The campus had not developed a quality assurance program in the sports medicine area similar to the one used by the campus SHC.

EO 943, Policy on University Health Services, dated April 28, 2005, states that intercollegiate athletic departments shall develop a quality assurance program similar to that used by the campus SHC.

The director of sports medicine stated that the athletics department thought that the requirement in the EO was unclear, making it difficult to gauge what would meet the requirement.

The lack of a quality assurance program in athletics medicine increases the risk that the campus will provide substandard care.

Recommendation 6

We recommend that the campus develop a quality assurance program in the intercollegiate athletics department’s sports medicine area.

Campus Response

We concur. The campus will develop a quality assurance program in the intercollegiate athletics department’s sports medicine area. This will be completed by the end of May 2014.

POLICIES AND PROCEDURES IN ATHLETICS MEDICINE

Policies and procedures for athletics medicine had not been approved in writing by the physician responsible for medical oversight of the program.

EO 943, Policy on University Health Services, dated April 28, 2005, states that athletics medicine policies and procedures, including any revisions, must be approved in writing by the physician responsible for medical oversight of the athletics medicine program.

The director of sports medicine stated that procedures had been reviewed, but written approval was not obtained due to oversight.
Lack of written approval of athletics medicine policies increases the risk that current practices will be misunderstood and exposes the campus to potential litigation.

**Recommendation 7**

We recommend that the campus obtain written approval of athletics medicine policies and procedures from the physician responsible for medical oversight of the program.

**Campus Response**

We concur. The campus will implement the procedure to obtain written approval of athletics medicine policies and procedures from the physician responsible for medical oversight of the program. This will be completed by the end of May 2014.

**CREDENTIALING AND PRIVILEGING**

Team physicians in the athletics medicine department were not subject to a periodic medical credentials review and did not undergo a formal privileging process.

EO 943, *Policy on University Health Services*, dated April 28, 2005, states that the president or designee, in conjunction with campus human resources, is responsible for credentialing and privileging providers of health care in the athletics department.

The director of sports medicine stated that the lack of formal credentialing was due to his misunderstanding of which campus parties were responsible for conducting the reviews. He further stated that the athletics department assumed that confirmation of the physicians’ qualifications was being conducted by either the SHC or human resources. In addition, he stated that he did not realize that privileging beyond a physician’s license was necessary.

Inadequate physician credentialing and privileging requirements exposes the campus to risks related to proper care of student athletes and exposes the university to potential litigation.

**Recommendation 8**

We recommend that the campus perform a periodic medical credentials review and a formal privileging process for team physicians in the athletics medicine department.

**Campus Response**

We concur. The campus will implement the procedure to perform a periodic medical credentials review and a formal privileging process for team physicians in the athletics medicine department. This will be completed by the end of May 2014.
MEDICATIONS AND PHARMACEUTICALS

Administration of medications within the athletics medicine department needed improvement.

We found that:

- Athletics medicine department staff were dispensing prescription medications without a pharmacist license or the appropriate clinical pharmacy permit.

- Of the six prescription records we reviewed, three (all written by the same physician) were filled even though they were missing critical information, such as the name of the medication or the amount to dispense. In addition, a prescription record could not be located to support the dispensing of two items that we selected from the medication log.

- A cabinet in one of the training facilities contained expired prescription medications.

- Medication inventory practices did not ensure adequate control of pharmaceutical stock, as they did not include an accounting for purchases since the last inventory or the reconciliation of variances between the records and the physical count.

EO 943, *Policy on University Health Services*, dated April 28, 2005, states that when pharmaceuticals, pre-packaged medications, over-the-counter items, samples, and other medications are stored outside the licensed pharmacy and are for the use of more than one licensed health care provider, the area must obtain and maintain a California State Board of Pharmacy Clinic Permit. It further states that campus health entities are held to the requirements under the business and professions codes regarding authorizing the purchase of drugs at wholesale and restricting the dispensing of drugs to a physician and a pharmacist. In addition, it states that inventories shall be conducted at least annually and that campus entities shall examine the drug stock at regular intervals to remove outdated, deteriorated, or recalled medications.

California Business and Professions Code (BPC) §4051, *Conduct Limited to Pharmacist*, states that it is unlawful for any person to manufacturer, compound, furnish, sell, or dispense any prescription unless he or she is a licensed pharmacist.

BPC §4181, *License Requirements; Policies and Procedures; Who May Dispense* states that the dispensing of drugs in a clinic shall be performed only by a physician, a pharmacist, or other person lawfully authorized to dispense drugs.

BPC § 4180, *Purchase of Drugs at Wholesale Only with a License* allows for student health centers to purchase drugs at wholesale for administration or dispensing and specifically denies this benefit to entities that have not obtained the proper license from the board of pharmacy.

*SJSU Sports Medicine Policies and Procedures*, dated 2013/14, states that prescription pharmaceuticals will only be prescribed by a team physician. It further states that both OTC and prescription pharmaceuticals will be subject to an inventory once per year. In addition, it states that
pharmaceutical stock will be checked monthly for expired medications, and that those will be disposed of by means that are compliant with federal and state laws.

The director of sports medicine stated his belief that the licenses of the athletics physicians who wrote prescriptions allowed trainers to dispense prescriptions based on the physicians’ direct orders. He further stated that trainers filled prescriptions that were incomplete due to human error and a misunderstanding of the requirements. He also stated that the expired prescription medications were missed in the inventory process due to human error. In addition, he stated his belief that inventory procedures were adequate.

Improper administration of medications in the athletics medicine department increases the risk of injury to student athletes and exposes the university to potential litigation and regulatory sanctions.

**Recommendation 9**

We recommend that the campus:

a. Allow only those with a pharmacist license and the appropriate clinical pharmacy permit to dispense prescription medications.

b. Properly complete prescription records to include the name of the medication and the amount to dispense, and prepare prescription records for all dispensed medications.

c. Remove expired prescription medications from cabinets in the training facilities.

d. Revise inventory procedures to ensure adequate control of pharmaceutical stock, including an accounting for purchases since the last inventory and a reconciliation of variances between the records and the physical count.

**Campus Response**

We concur. By the end of May 2014, the campus will complete compliance actions for the following specific recommendations:

a. Allow only those with a pharmacist license and the appropriate clinical pharmacy permit to dispense prescription medications.

b. Properly complete prescription records to include the name of the medication and the amount to dispense, and prepare prescription records for all dispensed medications.

c. Remove expired prescription medications from cabinets in the training facilities.

d. Revise inventory procedures to ensure adequate control of pharmaceutical stock, including an accounting for purchases since the last inventory and a reconciliation of variances between the records and the physical count.
PHARMACY

SEGREGATION OF DUTIES

Segregation of duties at the pharmacy was inadequate, as one individual performed all functions related to the provisioning of the pharmacy stock, including ordering, receiving, record updating, and periodic inventories.

State Administrative Manual (SAM) §20050 states that elements of a satisfactory system of internal accounting and administrative controls includes a plan of organization that provides segregation of duties appropriate for proper safeguarding of assets.

The SHC director stated that current ordering, receiving, and inventory procedures were intentionally modeled after industry and California State University (CSU) best practices. He further stated that he reviewed the maintenance of a perpetual inventory, available records of all itemized orders and receipts, the annual inventory by a third party, and regular inspection by the California Board of Pharmacy and concluded that procedures were adequate and professional.

Inadequate segregation of duties in the administration of prescriptions increases the risk of theft, loss and unauthorized usage.

Recommendation 10

We recommend that the campus implement appropriate segregation of duties in the provisioning of the pharmacy stock, including ordering, receiving, record updating, and periodic inventories.

Campus Response

We concur. The campus will implement the procedure to appropriately segregate the duties in the provisioning of the pharmacy stock, including ordering, receiving, record updating, and periodic inventories. This will be completed by the end of May 2014.

PRESCRIPTIONS

The SHC did not have written authorization from the president or a designee for the filling of prescriptions from off-campus providers.

EO 943, Policy on University Health Services, dated April 28, 2005, states that the SHC can implement a policy that permits the SHC pharmacy to fill prescriptions written by off-campus licensed health care professionals provided they obtain written approval for this from the campus president or designee.

The SHC director stated his belief that he was the designee expected to decide whether the SHC could fill prescriptions from off-campus providers. Inadequate approval of the filling of prescriptions from off-campus providers compromises pharmacy operations and increases the risk of liability.
Recommendation 11

We recommend that the campus obtain written authorization from the president or a designee for the filling of prescriptions from off-campus providers.

Campus Response

We concur. The campus will obtain written authorization from the president or a designee for the filling of prescriptions from off-campus providers. This will be completed by the end of February 2014.

MEDICAL RECORDS

The campus did not conduct an assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic health information obtained and held in the various areas of the campus.

EO 877, Designation of Health Care Components for Purposes of the Health Care Portability and Accountability Act of 1996 (HIPAA), dated April 14, 2003, states that the individual entities within the CSU that are designated as health care components will be required to comply fully with HIPAA.

Code of Federal Regulations §164.308, Administrative Safeguards, states that entities covered under HIPAA must conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity.

The identity and information security officer (ISO) stated that the formal risk assessment had not been conducted due to resource constraints and that management turnover had contributed to a delay in completing the assessment once the gap was identified.

Inadequate assessments of the potential risks and vulnerabilities to protected health information undermines the confidentiality of information collected from students and exposes the university to potential regulatory sanctions.

Recommendation 12

We recommend that the campus conduct a risk assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic health information obtained and held in the various areas of the campus.

Campus Response

We concur. The campus will conduct a risk assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic health information obtained and held in the various areas of the campus. This will be completed by the end of May 2014.
FISCAL MANAGEMENT

Administration of trust fund accounts used for student health services needed improvement.

We found that:

- Trust fund agreements were not updated every three years as required by campus policy. Specifically, all three of the trust fund accounts that were used for various health-services-related fees were operating under agreements established in 2002, until a recent update in July 2013.

- Disbursements from trust funds were not always processed in compliance with funding designations and guidelines. For example, the services trust account was charged for reimbursement of training event fees for one clinical staff employee, which was inconsistent with the stated authorized use of the fund. In addition, the account was charged for lab staff salaries in 2011, although the trust agreement indicated that only pharmacy salaries would be charged to the account.

EO 943, Policy on University Health Services, dated April 28, 2005, states that campuses may assess all students a mandatory student health services fee to provide basic services, and that all proceeds of the mandatory student health fee and interest earned shall be used to support SHC operations. It further states that each SHC may provide augmented services without imposing additional student fees subject to certain conditions, and that the fees collected for these services shall be separate from mandatory student health services fees and shall be charged to students in amounts not to exceed the actual cost of providing the services and/or materials.

SJSU trust fund agreement instructions state that fund agreements must be renewed every three years. Integrated California State University Administrative Manual (ICSUAM) §3103.01 Disbursements – General, dated January 1, 2012, states that the initiator of any disbursement must ensure that the expenditure is in compliance with any funding designations and/or guidelines.

SAM §19400.1, Trust and Agency Funds – Non-Treasury – Documentation states that each trust account shall be supported by documentation as to the type of trust, donor or source of trust moneys, purpose of the trust, and persons authorized to withdraw or expend funds. It further states that the documentation will be retained until the trust is dissolved.

The SHC director stated that the delay in updating the trust agreements was due to conflicting priorities and resource constraints, and transactional errors in the trust accounts were due to human error.

Inadequate administration of trust fund accounts utilized for student health services increases the risk of financial loss and potential improprieties.
Recommendation 13

We recommend that the campus:

a. Update trust fund agreements as needed, but at least within the time frame outlined in campus policy.

b. Process disbursements from trust funds only in compliance with funding designations and guidelines.

Campus Response

We concur. By the end of May 2014, the campus will complete compliance actions for the following specific recommendations:

a. Update trust fund agreements as needed, but at least within the time frame outlined in campus policy.

b. Process disbursements from trust funds only in compliance with funding designations and guidelines.

INFORMATION AND DATA SECURITY

DISASTER RECOVERY PLAN FOR THE STUDENT HEALTH CENTER

The campus did not have a documented plan that outlined the specific steps needed for recovery of data processing services in a local disaster affecting the SHC computer room.

EO 1014, California State University Business Continuity Program, dated October 8, 2007, states that the campus must keep all business continuity-related plans current, must test all plans for viability, and must reference all materials necessary to recover from a disaster.

ICSUAM §8085.0, Business Continuity and Disaster Recovery, dated April 19, 2010, states, in part, that campuses must ensure that information assets can continue to operate or be supplanted by backup systems so that minimal interruption of critical business services occurs in the event of a disaster.

The senior director of information technology (IT) for student affairs stated that administration of IT for the SHC was recently moved under the divisional IT group. He further stated that work had begun to integrate SHC operations with the campus IT infrastructure, and the process would include migrating SHC’s systems to a new campus off-site machine room facility currently being deployed in Stockton. In addition, he stated that as part of this effort, the division was working with the campus ISO to integrate all divisional disaster planning and recovery processes into a new campuswide process.
The absence of a current, tested, and easily executable disaster recovery plan for the recovery of SHC systems can result in unnecessary financial and non-financial losses in the event of a disaster and can create recovery delays that are outside of management expectations.

**Recommendation 14**

We recommend that the campus develop a documented plan that outlines the specific steps needed for recovery of data processing services in a local disaster affecting the SHC computer room.

**Campus Response**

We concur. The campus will develop a documented plan that outlines the specific steps needed for recovery of data processing services in a local disaster affecting the SHC computer room. This will be completed by the end of May 2014.

**BACKUP TAPES**

Backup tapes for the systems maintained in the SHC computer room were not maintained at an off-site location.

ICSUAM §8085, *Business Continuity and Disaster Recovery*, dated April 19, 2010, states that each campus must ensure that information assets can, in case of a catastrophic event, continue to operate and be appropriately accessible to users.

The senior director of IT for student affairs stated that as an interim measure, IT had integrated the SHC backup process with an existing backup process in place for the division’s enrollment services group. He further stated that as part of this integration, tapes from the SHC backup rotation would be included in the existing enrollment services off-site backup process, which uses Iron Mountain for off-site storage of monthly backups. He also stated that a longer-term plan was being developed as part of the campus off-site machine room initiative, which was expected to cover all divisional server backups, and that this process would be implemented once it was approved by the campus ISO.

Inadequate storage of SHC data backup tapes, at an off-site location, increases the risk of losing data in the event of a disaster, which could adversely affect SHC’s ability to recover data processing services.

**Recommendation 15**

We recommend that the campus store all backup tapes for the systems maintained in the SHC computer room at an off-site location.

**Campus Response**

We concur. The campus will store all backup tapes for the systems maintained in the SHC computer room at an off-site location. This will be completed by the end of April 2014.
COMPUTER ROOM ENVIRONMENT

The SHC computer room did not contain smoke detectors or water and heat sensors.

SAM §5330 states that physical security practices for each facility must be adequate to protect the most sensitive information technology application housed in that facility. Agencies must take appropriate physical security measures to provide for prevention, detection, and minimization of water damage.

The senior director of IT for student affairs stated that the campus was aware of the lack of adequate environmental controls in the computer room and that campus information technology services and the campus ISO were working to expedite the migration of all division machine room facilities to the new facilities. He further stated that SHC was expected to be one of the first such migrations to be carried out, as soon as the facilities were available.

Inadequate ability to detect and prevent water or flooding, excessive heat, or fire in the computer room can result in severe damage or loss of computing equipment.

Recommendation 16

We recommend that the campus install smoke detectors and water and heat sensors in the SHC computer room.

Campus Response

We concur. The campus will install smoke detectors and water and heat sensors in the SHC computer room. This will be completed by the end of March 2014.

MEDICAL RECORDS APPLICATION ACCESS

The campus had an excessive number of administrator profiles and one generic profile for the electronic medical records (EMR) application.

We reviewed the access list for Point and Click (PNC), the EMR application in use by the SHC, and found:

- A total of 16 administrative profiles for individuals who were employed by PNC.
- One generic profile called Treatment Nurse.

ICSUAM §8060, Access Control, dated April 19, 2010, states that access to campus information assets may be provided only to those having a need for specific access in order to accomplish an authorized task. It further states that authentication controls must be implemented for access to campus information assets and that they must be unique to each individual and may not be shared unless authorized by appropriate campus management.
The SHC senior operations officer stated that the excess PNC administrators on the access list were left over from the implementation stage, and the failure to remove their access once their tasks were completed was due to oversight. She further stated that the generic profile was created to run in the test platform of the application and has since been removed, along with the excess PNC administrators.

Inadequate control of access to campus information assets compromises the security and privacy of the information and exposes the campus to litigation and regulatory sanctions.

**Recommendation 17**

We recommend that the campus remove all excessive administrator profiles and the generic profile in the EMR application.

**Campus Response**

We concur. The campus will remove all excessive administrator profiles and the generic profile in the EMR application. This will be completed by the end of April 2014.
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Mohammad Qayoumi</td>
<td>President</td>
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<tr>
<td>Shawn Bibb</td>
<td>Vice President of Administration and Finance</td>
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<tr>
<td>Shawna Bryant</td>
<td>Assistant Athletic Trainer</td>
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<tr>
<td>Mike Cook</td>
<td>Identity and Information Security Officer</td>
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<tr>
<td>Peter Deutsch</td>
<td>Senior Director of Information Technology, Student Affairs</td>
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<tr>
<td>Roger Elrod</td>
<td>Director, Student Health Center (SHC)</td>
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<tr>
<td>Paula Hernandez</td>
<td>Senior Operations Officer, SHC</td>
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<tr>
<td>Hisashi Imura</td>
<td>Associate Head Athletic Trainer</td>
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<tr>
<td>Cecilia Manibo</td>
<td>Medical Chief of Staff</td>
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<td>Anthony Mays</td>
<td>Systems Information Technology Consultant</td>
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<tr>
<td>Carrie Medders</td>
<td>Senior Director, Human Resources Systems and Operations</td>
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<tr>
<td>Laurie Morgan</td>
<td>Associate Director, Wellness and Health Promotion</td>
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<tr>
<td>Ninh Pham-Hi</td>
<td>Director of Internal Control</td>
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<tr>
<td>Scott Shaw</td>
<td>Director of Sports Medicine</td>
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<tr>
<td>John Vo</td>
<td>Pharmacist</td>
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</tbody>
</table>
January 16, 2014

Mr. Larry Mandel  
University Auditor  
The California State University  
401 Golden Shore, 4th Floor  
Long Beach, CA 90802

Campus Response to Student Health Services Audit (#13-59) at San José State University.

Enclosed is San José State University’s response to the Student Health Services Audit (#13-59). The campus is committed to addressing the issues identified in this audit report.

Please let me know if I can provide you with additional information.

Shawn Bibb  
Vice President, Administration & Finance

Enclosure

cc: Mo Qayoumi, President
PROGRAM ADMINISTRATION

GOVERNANCE

Recommendation 1

We recommend that the campus document the responsibility for university health services provided in areas such as student affairs, academic affairs, and athletics with a written designation or delegation of authority from the president.

Campus Response

We concur. The campus will document the responsibility for university health services provided in areas such as student affairs, academic affairs, and athletics with a written designation or delegation of authority from the president.

To be completed by end of March 2014.

POLICIES AND PROCEDURES

Recommendation 2

We recommend that the campus regularly review and update SHC policies and procedures.

Campus Response

We concur. The campus will implement the procedure to regularly review and update SHC policies and procedures.

To be completed by end of March 2014.

STUDENT HEALTH ADVISORY COMMITTEE

Recommendation 3

We recommend that the campus:

a. Update the PD establishing the SHAC, or issue another governing document regarding its administration.

b. Obtain the president’s approval for the SHAC’s policies and operating procedures.
c. Review the SHAC's current membership, and revise it to meet the requirements of the existing or revised PD, or other governing document.

d. Appoint a student as chair of the SHAC.

e. Appoint SHAC members in accordance with the existing or revised PD, or other governing document.

f. Establish a policy that ensures that proposals to add new or retain existing augmented services are submitted to the SHAC for consideration prior to review by the president.

Campus Response

We concur. By end of April 2014, the campus will complete compliance actions for the following specific recommendations:

a. Update the PD establishing the SHAC, or issue another governing document regarding its administration.

b. Obtain the president's approval for the SHAC's policies and operating procedures.

c. Review the SHAC's current membership, and revise it to meet the requirements of the existing or revised PD, or other governing document.

d. Appoint a student as chair of the SHAC.

e. Appoint SHAC members in accordance with the existing or revised PD, or other governing document.

f. Establish a policy that ensures that proposals to add new or retain existing augmented services are submitted to the SHAC for consideration prior to review by the president.

ACCREDITATION REPORTS

Recommendation 4

We recommend that the campus maintain evidence that SHC accreditation reports have been sent to the campus president or designee.

Campus Response

We concur. The campus will implement the procedure to maintain evidence that SHC accreditation reports have been sent to the campus president or designee.

To be completed by end of March 2014.
HEALTH PROGRAMS

Recommendation 5

We recommend that the campus:

a. Obtain documented presidential approval for augmented services.
b. Maintain evidence showing that augmented services have been properly vetted before approval.

Campus Response

We concur. By end of April 2014, the campus will complete compliance actions for the following specific recommendations:

a. Obtain documented presidential approval for augmented services.
b. Maintain evidence showing that augmented services have been properly vetted before approval.

ATHLETICS MEDICINE

QUALITY ASSURANCE PROGRAM

Recommendation 6

We recommend that the campus develop a quality assurance program in the intercollegiate athletics department’s sports medicine area.

Campus Response

We concur. The campus will develop a quality assurance program in the intercollegiate athletics department’s sports medicine area.

To be completed by end of May 2014.

POLICIES AND PROCEDURES IN ATHLETICS MEDICINE

Recommendation 7

We recommend that the campus obtain written approval of athletics medicine policies and procedures from the physician responsible for medical oversight of the program.

Campus Response

We concur. The campus will implement the procedure to obtain written approval of athletics medicine policies and procedures from the physician responsible for medical oversight of the program.

To be completed by end of May 2014.
CREDEMIALING AND PRIVILEGING

Recommendation 8

We recommend that the campus perform a periodic medical credentials review and a formal privileging process for team physicians in the athletics medicine department.

Campus Response

We concur. The campus will implement the procedure to perform a periodic medical credentials review and a formal privileging process for team physicians in the athletics medicine department.

To be completed by end of May 2014.

MEDICATIONS AND PHARMACEUTICALS

Recommendation 9

We recommend that the campus:

a. Allow only those with a pharmacist license and the appropriate clinical pharmacy permit to dispense prescription medications.

b. Properly complete prescription records to include the name of the medication and the amount to dispense, and prepare prescription records for all dispensed medications.

c. Remove expired prescription medications from cabinets in the training facilities.

d. Revise inventory procedures ensure adequate control of pharmaceutical stock, including an accounting for purchases since the last inventory and a reconciliation of variances between the records and the physical count.

Campus Response

We concur. By end of May 2014, the campus will complete compliance actions for the following specific recommendations:

a. Allow only those with a pharmacist license and the appropriate clinical pharmacy permit to dispense prescription medications.

b. Properly complete prescription records to include the name of the medication and the amount to dispense, and prepare prescription records for all dispensed medications.

c. Remove expired prescription medications from cabinets in the training facilities.

d. Revise inventory procedures ensure adequate control of pharmaceutical stock, including an accounting for purchases since the last inventory and a reconciliation of variances between the records and the physical count.
PHARMACY

SEGREGATION OF DUTIES

Recommendation 10

We recommend that the campus implement appropriate segregation of duties in the provisioning of the pharmacy stock, including ordering, receiving, record updating, and periodic inventories.

Campus Response

We concur. The campus will implement the procedure to appropriately segregate the duties in the provisioning of the pharmacy stock, including ordering, receiving, record updating, and periodic inventories.

To be completed by end of May 2014.

PRESCRIPTIONS

Recommendation 11

We recommend that the campus obtain written authorization from the president or a designee for the filling of prescriptions from off-campus providers.

Campus Response

We concur. The campus will obtain written authorization from the president or a designee for the filling of prescriptions from off-campus providers.

To be completed by end of February 2014.

MEDICAL RECORDS

Recommendation 12

We recommend that the campus conduct a risk assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic health information obtained and held in the various areas of the campus.

Campus Response

We concur. The campus will conduct a risk assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic health information obtained and held in the various areas of the campus.

To be completed by end of May 2014.
FISCAL MANAGEMENT

Recommendation 13

We recommend that the campus:

a. Update trust fund agreements as needed, but at least within the time frame outlined in campus policy.

b. Process disbursements from trust funds only in compliance with funding designations and guidelines.

Campus Response

We concur. By end of May 2014, the campus will complete compliance actions for the following specific recommendations:

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INFORMATION AND DATA SECURITY

DISASTER RECOVERY PLAN FOR THE STUDENT HEALTH CENTER

Recommendation 14

We recommend that the campus develop a documented plan that outlines the specific steps needed for recovery of data processing services in a local disaster affecting the SHC computer room.

Campus Response

We concur. The campus will develop a documented plan that outlines the specific steps needed for recovery of data processing services in a local disaster affecting the SHC computer room.

To be completed by end of May 2014.

BACKUP TAPES

Recommendation 15

We recommend that the campus store all backup tapes for the systems maintained in the SHC computer room at an off-site location.
Campus Response

We concur. The campus will store all backup tapes for the systems maintained in the SHC computer room at an off-site location.

To be completed by end of April 2014.

COMPUTER ROOM ENVIRONMENT

Recommendation 16

We recommend that the campus install smoke detectors and water and heat sensors in the SHC computer room.

Campus Response

We concur. The campus will install smoke detectors and water and heat sensors in the SHC computer room.

To be completed by end of March 2014.

MEDICAL RECORDS APPLICATION ACCESS

Recommendation 17

We recommend that the campus remove all excessive administrator profiles and the generic profile in the EMR application.

Campus Response

We concur. The campus will remove all excessive administrator profiles and the generic profile in the EMR application.

To be completed by end of April 2014.
March 4, 2014

MEMORANDUM

TO: Mr. Larry Mandel
   Vice Chancellor and Chief Audit Officer

FROM: Timothy P. White
      Chancellor

SUBJECT: Draft Final Report 13-59 on Student Health Services, San José State University

In response to your memorandum of March 4, 2014, I accept the response as submitted with the draft final report on Student Health Services, San José State University.

TPW/AMD