UTSouthwestern
Medical Center™

Office of Institutional Compliance
and Audit Services

Change in Management Audit Department of Dermatology

Internal Audit Report 25-AS-0002

October 13, 2025

Executive Summary

The UT Southwestern Department of Dermatology delivers specialized patient care at four major medical centers and is internationally recognized for its expertise in a wide range of complex skin conditions and treatments. This audit was initiated following a series of leadership transitions within the Department of Dermatology, including the appointment of a new Chair in November 2023, a Department Administrator in July 2024, and a Financial Manager in February 2025. Leadership transitions present a critical opportunity to assess the current state of operations, validate the strength of internal controls, and verify that key processes remain compliant with regulatory requirements and aligned with institutional objectives and expectations.

The purpose of this review was to provide the incoming leadership with a clear understanding of the department's control environment, oversight mechanisms, and risk landscape. By evaluating monitoring practices, analyzing operational data, and assessing compliance across in-scope processes, the audit aimed to identify areas where controls may be ineffective, risks may be insufficiently mitigated, or improvement opportunities exist.

Engagement Results

The Office of Institutional Compliance & Audit Services (OICAS) conducted the Change in Management Audit - Department of Dermatology. Overall, the audit team recognized multiple strengths for the processes including management's openness to improvement, early initiation of data reconciliation efforts, recognition of process gaps, and proactive momentum toward standardizing operational procedures within the first year in the organization. However, some control gaps were identified that require management to enforce expectations and enhance monitoring and reconciliation practices.

A summary of observations is outlined below:

AREA	OPPORTUNITIES	RISK RATING
Vendor Management	• Vendor Listing • Vendor Payment Monitoring	LOW
Departmental Oversight	• Employee Listing Maintenance • Asset Management	LOW

Further details are outlined in the Detailed Observations section. Less significant issues were communicated to management.

Management Summary Response

Management agrees with the observations and Recommendations and has developed action plans to be implemented on or before December 19, 2025.

Appendix A outlines the objectives, scope, methodology, stakeholder list, and audit team for the engagement.

Appendix B outlines the Risk Rating Classifications and Definitions.

The courtesy and cooperation extended by the personnel in the Department of Dermatology are appreciated.

Natalie A. Ramello

Natalie A. Ramello, JD, CIA, CHC, CHPC, CHRC, CHIAP
Vice President, Chief Compliance & Audit Officer
Office of Institutional Compliance & Audit Services
October 13, 2025

DETAILED OBSERVATIONS

1. Vendor Management

Vendor management is crucial for ensuring effective oversight of vendor relationships and compliance with procurement policies. Gaps have been identified, including the lack of a comprehensive inventory of vendors and associated contracts as well as overall expense and transaction monitoring. While efforts are underway to establish formal expectations surrounding vendor listing and expenses, opportunities exist to enhance vendor monitoring practices, ensure adherence to UT Southwestern policies, and improve oversight of spending.

LOW

1.1 Vendor Listing	Recommendations	Management Action Plan

The department does not currently have a comprehensive list of active vendors and associated contracts (as applicable). It is important to note that reconciliation efforts are in progress as contracts are identified.
 	
Without a formal contract inventory for department-specific vendors, it is difficult to track existing agreements, monitor vendor relationships, and ensure cost effectiveness and appropriate oversight of contractual obligations.
	Management should continue to develop and maintain a formal, comprehensive vendor list that includes all active vendor relationships and contracts utilized by the department.
	
	This list should be routinely (e.g., quarterly, bi-annually, etc.) updated as new vendors relationships and contracts are executed or terminated, ensuring accurate tracking and oversight of vendor utilization.
		Action Plan Owners:
		    Jami Armbrester
		    Jason Carter
		
		Action Plan Executive:
		    Dr. Joseph Merola
		
		Due Date: 10/31/2025
		
		Management will:
		
		• *Complete the building of a comprehensive listing of all currently utilized vendors for the department by reconciling various sources (e.g., accounts payable (AP) system, contract management portal, OneCard, etc.).*
		
		• *Perform the reconciliation quarterly to ensure a complete vendor listing and to identify any vendors engaged without prior*

		notification to departmental leadership.
1.2 Vendor Payment Monitoring	**Recommendations**	**Management Action Plan**
Opportunity exists to enhance monitoring of the overall spend per vendor to ensure compliance with procurement procedures based on spend thresholds. According to the Procurement and Contract Management Handbook, payments ranging from $15,000 to $50,000 require informal quotes from at least three potential vendors, underscoring the importance of enhanced scrutiny and adherence to formal procurement procedures for higher-value spending. During the audit period, ten (10) vendors were identified with total expenditures exceeding $15,000: two (2) vendors from the OneCard report and eight (8) from expenditure reports. These transactions may warrant further departmental review to assess compliance with the Procurement and Contract Management Handbook. The department is actively working to ensure OneCard transactions align with expectations, particularly around clarifying which types of purchases are appropriate.	Establish a process to track cumulative vendor spend across all payment methods to ensure compliance with procurement thresholds and contractual obligations. Review vendors with total payments exceeding $15,000 to verify compliance with competitive procurement requirements, and initiate procurement actions where necessary. Upon creation of a comprehensive vendor listing, analyze spend patterns to validate appropriateness and cost-efficiency, and ensure alignment with institution procurement and contracting procedures. Provide refresher training and communicate expectations for OneCard cardholders based on the current review of historical OneCard transactions.	Action Plan Owners: Jami Armbrester Jason Carter Action Plan Executive: Dr. Joseph Merola Due Date: 10/31/2025 *Management will:* • *Incorporate cumulative spend monitoring by vendor into the monthly expense review process.* • *Review the identified potential exceptions and ensure the department is in compliance with procurement and contract requirements for vendors with a cumulative spend over $15,000.* • *Perform an evaluation of spend across all expense reporting (e.g., OneCard, AP, etc.) to ensure appropriate vendor utilization and cost effectiveness.* • *Provide targeted training to OneCard cardholders based on the current review of historical OneCard transactions.*

2. Departmental Oversight

Departmental oversight plays a vital role in fostering operational efficiency and compliance. While employee maintenance practices are generally effective, there are occasional inconsistencies in record-keeping, and documented standard operating procedures (SOPs) / expectations and asset management. By focusing on these aspects, the department can continue to enhance its oversight framework and support overall performance.

LOW		
2.1 Employee Listing Maintenance	**Recommendations**	**Management Action Plan**

Through reconciliation of various reports, it was identified that all reports do not reflect current state. Specifically:
 	
• One (1) individual who is listed as an approver within the expenditure reports was transferred out of the department on 11/1/2024 per the *Hci003 Turnovers Transfers* report. It is important to note that no approvals have occurred since the transfer occurred.
 	
• One (1) individual was identified as an active department contact within the department listing; however, the individual was terminated on 5/14/2025 per the *Hci003 Turnovers Transfers* report.
 	
• Three (3) individuals were identified as OneCard cardholders; however, they were not included within the department cardholder listing. Management confirmed the list was
	Management should update and maintain comprehensive lists of department approvers, contacts, and OneCard cardholders. The lists should be routinely (e.g., monthly, quarterly, etc.) reconciled with personnel rosters, expenditure reports, etc. to ensure proactive oversight is occurring and all roles are appropriate.	Action Plan Owners:
		    Jami Armbrester
		    Jason Carter
		
		Action Plan Executive:
		    Dr. Joseph Merola
		
		Due Date: 11/30/2025
		
		Management will:
		
		• *Update all trackers / lists to reflect current state.*
		
		• *Reconcile the trackers / lists at least quarterly, if not required to be updated to reflect a change in staffing (e.g., termination, hire, etc.).*

inaccurate, and it is appropriate for the individuals to be cardholders.

2.2 Asset Management	Recommendations	Management Action Plan

Controls need to be improved to ensure keys and controlled assets are no longer assigned to individuals who have left the department, either due to actual retention or inaccurate custodial records.
 	
• 101 department keys remained assigned to 85 individuals who were listed as terminated in the HCi057 Facilities Keys Details and/or the department roster.
• 30 controlled assets were still assigned to 11 individuals who had been terminated, as noted in the FDi029 Asset Management Custodian and/or department records.
 	
This increases the risk of unauthorized access to assets and equipment in the department.
	Management should review the identified exceptions and determine next steps (e.g., update institution listings, report key loss/replacement to Facilities Management etc.).
	
	Moving forward, management should review the keys and asset reports when employees leave or transfer out of the department to ensure the retrieval of all keys and assets.
	
	Management should review and reconcile the reports with personnel rosters routinely (e.g., monthly, quarterly, etc.) to ensure reports are properly updated.
		Action Plan Owners:
		    Jami Armbrester
		    Jason Carter
		
		Action Plan Executive:
		    Dr. Joseph Merola
		
		Due Date: 12/19/2025
		
		Management will:
		
		• *Review both the key and assets lists and update the institution's reporting (as necessary).*
		• *Utilize the keys and assets reports to ensure keys, assets, etc. are obtained prior to the departure of staff.*
		• *Reconcile the key and asset lists with current personnel roster at least quarterly to reflect any changes in staffing (e.g., termination, hire, etc.).*

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Appendix A

Objectives, Scope, and Methodology

The objective of the review was to perform a high-level current state review of the Department of Dermatology to ensure that internal controls remain strong and uncover improvement opportunities and potential risks that are not well controlled, not operating as intended, or not in compliance with regulatory requirements.

The audit scope period included activities of the Department of Dermatology from 05/01/2024 to 04/30/2025. The review included accounts payable (AP), asset control, compliance, finance / budget, human resources, payroll, and vendor management. The review did not include revenue cycle processes, research or medical practice operations, physician arrangements and associated payments, advanced practice provider (APP) utilization, or conflict of interest.

Procedures included but were not limited to the following:

- Interviewed key personnel and reviewed relevant organizational and departmental specific policies
- Evaluated the current monitoring practices to ensure there is clear accountability and effective oversight mechanisms in place to identify any gaps or areas of opportunity
- Performed data analysis across various processes to identify potential areas of opportunity to identify any gaps or areas of opportunity
- Evaluated the in-scope processes to ensure risks are effectively mitigated, ensure compliance with regulatory requirements and policies, and identify improvement opportunities.

The OICAS conducted the engagement in conformance with the Institute of Internal Auditors' Global Internal Audit Standards™.

Executive Sponsor:

Dr. Joseph Merola, Professor and Chair, Department of Dermatology

Key Stakeholders:

Jami Armbrester, Department Administrator, Dermatology
Angela Brodrick-Donohue, Director of Administrative Development and Support Services, Office of the Provost
Jason Carter, Manager, Financial Affairs, Dermatology
Sharon Leary, Assistant Vice President, Accounting and Fiscal Services

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Audit Team:

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Appendix B

Risk Classifications & Definitions

Each observation has been assigned a risk rating according to the perceived degree of risk that exists based upon the identified deficiency combined with the subsequent priority of action to be undertaken by management. The following chart is intended to provide information with respect to the applicable definitions, color-coded depictions, and terms utilized as part of our risk ranking process:

Degree of Risk & Priority of Action	
Priority	An issue identified by Internal Audit that, if not addressed immediately, has a high probability to directly impact achievement of a strategic or important operational objective of UT Southwestern or the UT System as a whole.
High	A finding identified by Internal Audit that is considered to have a high probability of adverse effects to UT Southwestern either as a whole or to a significant college / school / unit level. As such, immediate action is required by management to address the noted concern and reduce risks to the organization.
Medium	A finding identified by Internal Audit that is considered to have a medium probability of adverse effects to UT Southwestern either as a whole or to a college / school / unit level. As such, action is needed by management to address the noted concern and reduce the risk to a more desirable level.
Low	A finding identified by Internal Audit that is considered to have minimal probability of adverse effects to UT Southwestern either as a whole or to a college / school / unit level. As such, action should be taken by management to address the noted concern and reduce risks to the organization.

It is important to note that considerable professional judgment is required in determining the overall ratings. Accordingly, others could evaluate the results differently and draw different conclusions. It is also important to note that this report provides management with information about the condition of risks and internal controls at one point in time. Future changes in environmental factors and actions by personnel may significantly and adversely impact on these risks and controls in ways that this report did not and cannot anticipate.

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