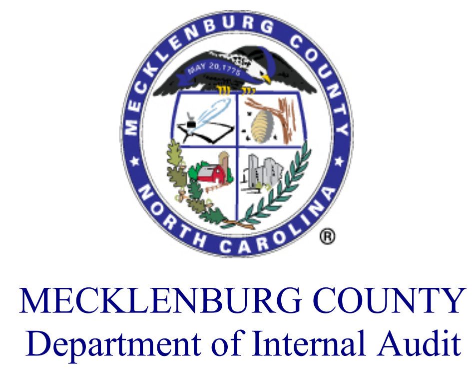
Mecklenburg County
Department of Internal Audit

Department of Public Health
Village HeartB.E.A.T. Program
Report 2261

December 16, 2022

Internal Audit's Mission	To support key stakeholders in cultivating an environment of accountability, transparency, and good governance.
Internal Audit Contacts	Terry Thompson, CIA, CRMA, Audit Director (980) 314-2889 or terry.thompson@mecklenburgcountync.gov Felicia Stokes, CIA, CISA, CRMA, CFE, Audit Manager (980) 314-2893 or felicia.stokes@mecklenburgcountync.gov
Staff Acknowledgements	Frank Crutchfield, CIA, CISA, CRMA, Auditor-in-Charge
Obtaining Copies of Internal Audit Reports	This report can be found in electronic format at https://www.mecknc.gov/audit/reports/pages/default.aspx



MECKLENBURG COUNTY
Department of Internal Audit

To: Dr. Raynard Washington, Director
Department of Public Health

From: Terry Thompson, Director
Department of Internal Audit

Date: December 16, 2022

Subject: Village HeartB.E.A.T. Program Audit Report 2261

The Department of Internal Audit has completed our audit of the Village HeartB.E.A.T. Program to determine whether internal controls effectively manage key business risks inherent to this program. Internal Audit interviewed key personnel, reviewed and evaluated policies, procedures, and other documents, observed operations, and tested various activities for the period of July 1, 2018 through March 31, 2022.

This audit was conducted in conformance with The Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

OVERALL EVALUATION

Overall, opportunities exist to improve the design and operation of several key control activities that manage the risks inherent to the Village HeartB.E.A.T. program to an acceptable level.

RISK OBSERVATION SUMMARY

The table below summarizes the risk observations identified during the audit, grouped by the associated risk factor, and defined in Appendix A. The criticality or significance of each risk factor, as well as Internal Audit's assessment of the design and operation of key controls to effectively mitigate the risks, are indicated by the color codes described in Appendix B.

RISK OBSERVATION SUMMARY			
Risk Factors and Observations	**Criticality**	**Design**	**Operation**
1. Policies and Procedures Risk	🔴	🔴	🔴
1.1 Formal Documentation			
2. Payment Accuracy Risk	🔴	🟡	🟡
2.1 Upfront Funding 2.2 Recordation 2.3 Supporting Documentation			
3. Documentation Risk	🟡	🟡	🟡
3.1 Document Retention			
4. Human Resource Risk	🟡	🟡	🟡
4.1 Training			
5. Time Reporting Risk	🟡	🟡	🟡
5.1 Ambassador Payroll			
6. Compliance Risk	🟡	🟡	🟡
6.1 Bimonthly Meetings			
7. Physical Security Risk	🟡	🟢	🟢
No risk observations noted			
8. Segregation of Duties Risk	🟡	🟢	🟢
No risk observations noted			
9. Integrity Risk	🟡	🟡	🟢
No risk observations noted			

The risk observations and management's risk mitigation strategies defined in Appendix C are discussed in detail in the attached document. Internal Audit will conduct a follow-up review to verify management's action plans have been implemented and are working as expected.

We appreciate the cooperation you and your staff provided during this audit. Please feel free to contact me at 980-314-2889 if you have any questions or concerns.

c: County Manager
Deputy County Managers
County Attorney
Deputy County Attorney
Board of County Commissioners
Audit Review Committee

BACKGROUND

The Village HeartB.E.A.T. Program (the Program) was launched in February 2013 within the Public Health Department's Office of Community Engagement (OCE). The Program's vision is to ensure that everyone in Mecklenburg County has equitable access to health and wellness education through partnerships and community engagement.

The objectives of the program are outlined in its name:

- **B**uilding the capacity of African American and Latino adults to address their own health needs and the capacity of the faith community to initiate and sustain needed lifestyle changes.
- **E**ducation on chronic disease prevention, treatment and control.
- **A**ccountability for success in every aspect of the program, including monitoring both individual and partner adherence to program objectives.
- **T**ogether, collaboratively work to problem solve with strong participant input in program design and execution.

There are two primary activities of the Program: educational training and annual wellness competition. Educational training content is centralized through the Theresa C Elder Leadership Academy (The Academy). The Academy is named after Theresa Clark Elders, the first African American Public Health Nurse in Charlotte, North Carolina. The Academy trains participants and faith-based organizations (FBO) throughout the year. The Program determines what training is to be provided to participants and subsequently sources the trainers. The OCE staff comprise the management team within this Academy. The Health Program Supervisor presides over this Academy with additional OCE staff supporting the Academy. Content offered is in line with the data obtained through the pre-competition biometric collection process which is a part of the annual competition process.

The second program activity is to facilitate an annual competition process. The Program offers a 14–16 week team-based wellness competition that involves more than 40 faith-based organizations and incorporates individual and group wellness activities. Team captains are required to meet twice a month with Program management to receive updates and address any questions or issues that team captains may have. In order to gauge participant progress, the Program requires participants to complete a pre- and post-competition biometric screening.

The Program partners and invests in local faith-based organizations within high-risk communities to provide these primary activities and adopt effective and sustainable policy, system, and environmental change (PSE) strategies. The faith-based organizations selected to participate in the Program are classified as either a hub or church based on their level of commitment, with hubs having a more formal partnership.

The following table provides a summary of the number of faith-based organizations that collaborated with the Program regarding educational activities by fiscal year.

Number of Churches and Hubs[1]			
Category	**FY20**	**FY21**	**FY22 (ending 3/30/2022)**
Hubs	7	15	19
Churches	59	45	50

Source: Data provided by the VHB Program

Organization

The Assistant Health Director of Population Health provides oversight for the Program while the Senior Health Program Manager oversees the day-to-day operations and staff. There are four positions that report to the Senior Health Program Manager.

In addition to Public Health staff, the Program employs the use of ambassadors who serve as advocates for the Program and are classified as either program-based or hub-based. Ambassadors provide outreach for different activities, such as National Night Out, local food distribution, and other special events. Program-based ambassadors receive training at a local community college, but there is no training provided for hub-based ambassadors. Ambassadors work in a part-time capacity with a maximum of 20 hours a week.

[1] Program staff was unable to provide the number of hubs and churches involved during FY19.

COUNTY MANAGER'S OVERALL RESPONSE

The County Manager concurs with all risk mitigation strategies and timeframes for implementation.

RISK OBSERVATIONS AND MITIGATION STRATEGIES

Risk Factor	Criticality	Design	Operation
1. Policies and Procedures Risk	●	●	●

Risk Observation

1.1 Formal Documentation—The Department did not have formal, documented policies and procedures for the Program. Failure to implement and utilize policies and procedures may lead to inefficient and ineffective execution of responsibilities. This condition may result in increased operating costs and failure to achieve operating objectives.

Recommendation

1.1 Internal Audit recommends management develop formal policies and procedures and train staff accordingly. The policies and procedures should include, at a minimum:

- Frequency of policy and procedure reviews and updates
- Documentation and retention requirements
- Staff roles and responsibilities
- Segregation of duties
- Time reporting requirements
- Essential operating activities required to process payments, e.g., invoice review, approval, processing, and reconciling, recordation, supporting documentation maintenance, and monitoring
- List of allowable expenses
- Applicable information technology systems

Management's Response

1.1 **Risk Mitigation Strategy:** Reduce **Implementation Date:** March 2023

Action Plan: The Office of Health Equity, formerly the Office of Community Engagement, will provide written policies and procedures for the following program areas by March 30, 2023. All program staff will be trained on the policies and procedures. Training will be documented.

- Documentation and retention requirements
- Staff roles and responsibilities
- Segregation of duties
- Time reporting requirements
- Invoice review, approval, processing and reconciling, recordation, supporting documentation maintenance and monitoring.

Risk Factor	Criticality	Design	Operation
2. Payment Accuracy Risk	● (red)	● (yellow)	● (yellow)

Risk Observations

2.1 Upfront Funding—The Program allowed faith-based organizations to receive 10% upfront funding of the total amount awarded. However, staff did not reconcile invoices and supporting documentation received from the organizations to the disbursed upfront funding in a more timely manner, e.g., monthly. Failure to reconcile upfront funding may result in overpayments or inability to detect fraud, which may damage the County's reputation.

2.2 Recordation—Program expenses are recorded in the general ledger using the unit code for the Office of Community Engagement instead of a specific code for the Program. As a result, Program management is unable to determine and manage disbursed Program funds which may result in errors or increase the potential for fraud.

2.3 Supporting Documentation—Program management did not require organizations to provide supporting documentation for each invoice line item. Thirty-five out of 65 or 54% of invoices sampled did not have the necessary supporting documentation. In addition, binders of invoices and supporting documentation were not scanned into the County's documentation management system or retained for three years as required by the 2021 North Carolina Records Retention and Disposition Schedule. As a result, management is unable to ensure vendors are not over paid or that fraud exists, which may result in damage to the County's reputation.

Recommendations

2.1 Internal Audit recommends management develop a formal process to manage upfront funding that includes (but is not limited to) requiring supporting documentation for purchases and timely review and reconciliation of the supporting documentation to funds disbursed.

2.2 Internal Audit recommends management collaborate with Finance to establish and use a unique general ledger activity code to track and manage disbursed Program funds.

2.3 Internal Audit recommends management verify supporting documentation is obtained and retained in the County's documentation management system for all invoiced line items. In addition, management should reemphasize to staff the importance of retaining documentation in accordance with the North Carolina Records Retention and Disposition Schedule.

Management's Responses

2.1 **Risk Mitigation Strategy:** Reduce **Implementation Date:** December 2022

Action Plan: Vendors/community partners will identify in the budget section of their scope of work or grant application the upfront item(s) they wish to procure. The Senior Health Manager for the Office of Health Equity shall approve upfront budget line items prior to the start of the

program. Upfront funding must also be approved by the Health Department Fiscal Compliance Manager. The vendor/community partner will have 90 days to provide supporting documentation (receipts, timesheets, contracts) for approved upfront funds. Invoices must be accompanied by supporting documentation and will be reconciled on a monthly basis. If a vendor does not provide supporting documentation, the upfront funding amount will be deducted from the contract/grant award total and the final payment(s) will be withheld pending receipt of necessary documentation. Any changes to a vendor/community partner's approved budget must have prior written approval from Health Department Executive Leadership.

2.2 **Risk Mitigation Strategy:** Reduce **Implementation Date:** December 2022

Action Plan: A Village HeartBEAT unit code (VHBT) has been created by the Finance Dept. for all Village HeartBEAT Program related purchases in the general ledger. Program staff will apply this code to budget lines to identify expenditures for the program.

2.3 **Risk Mitigation Strategy:** Reduce **Implementation Date:** March 2023

Action Plan: Health Department program staff will provide training to vendors/community partners regarding County expectations for supporting documentation prior to the funding award. All invoices will need to be accompanied by line-item supporting documentation and if such documentation is not provided, program staff will follow-up with the vendor/community partner. Supporting documentation will be scanned along with the invoice and sent to HSF invoice processing for payment. HSF invoice processing uploads invoices and supporting documentation into the County's document imaging system.

Risk Factor	Criticality	Design	Operation
3. Documentation Risk	●	●	●

Risk Observation

3.1 Document Retention—Program management did not consistently retain the Waiver & Release of Liability forms which allowed the Program to collect personal and demographic information, use images in Program materials, and release the County of liability related to participant injuries. Specifically, forms were not retained for 5 out of 68, or 7% of Program participants sampled. The failure to retain Program forms and supporting documentation may result in potential legal or liability issues.

Recommendation

3.1 Internal Audit recommends the Program reemphasis to staff the importance of retaining all required forms and verify all forms are obtained and retained.

Management's Response

3.1 **Risk Mitigation Strategy:** Reduce **Implementation Date:** December 2022

Action Plan: In addition to establishing formal program policy, program management will re-emphasize to all program staff the importance of retaining all required forms. All documentation related to waivers and release of liability will be retained in a shared One-Drive location.

Risk Factor	Criticality	Design	Operation
4. Human Resource Risk	●	●	●

Risk Observation

4.1 Training—Program management did not require hub-based ambassadors to attend training before starting work or team captains to attend the required annual orientation. Without proper training, management cannot ensure that hub-based ambassadors or team captains receive the information needed to efficiently and effectively execute their responsibilities.

Recommendation

4.1 Internal Audit recommends management ensure all ambassadors attend training before starting work, team captains attend annual orientation, and ensure documentation associated with this training and orientation activities (including agendas and attendance forms) is retained.

Management's Response

4.1 **Risk Mitigation Strategy:** Reduce **Implementation Date:** March 2023

Action Plan: Program staff will ensure that all ambassadors attend a training outlining roles and responsibilities and reporting requirements before starting work. Training will be mandatory for ambassadors. Team captains are volunteers and as such, they will be encouraged to attend annual orientation. However, if attendance is not possible due to availability or scheduling, orientation materials will be provided via e-mail. Staff will ensure documentation associated with training and orientation activities (including agendas and attendance forms) is retained.

Risk Factor	Criticality	Design	Operation
5. Time Reporting Risk	●	●	●

Risk Observation

5.1 Ambassador Payroll—Program management did not verify hours worked by four hub-based ambassadors as there was not a formal process in place. In addition, management did not adequately review hours worked by Career Match ambassadors and ensure supporting documentation was obtained and retained. As a result of this condition, inaccurate and/or fraudulent payments may be made to ambassadors.

Recommendation

5.1 Internal Audit recommends that management develop a process to verify hours worked including adequate supporting documentation.

Management's Response

5.1 **Risk Mitigation Strategy:** Reduce **Implementation Date:** March 2023

Action Plan: The Health Department Fiscal Compliance team will collaborate with the Office of Health Equity to develop a process to verify hours worked by ambassadors including adequate supporting documentation. This verification process will go hand-in-hand with the training of the faith institutions and the ambassadors so there is clear understanding and clarity around the expectations for supporting documentation.

Risk Factor	Criticality	Design	Operation
6. Compliance Risk	●	●	●

Risk Observation

6.1 Bimonthly Meetings—Program management could not provide evidence that required bi-monthly meetings for the period of September 2020 through March 2022 were conducted. For example, there was no evidence that bi-monthly Office of Community Engagement team meetings were conducted for 8 out of 19 or 42% of months sampled. In addition, for the period of October 2020 through March 2022, there was no evidence that bi-monthly Team Captain meetings were conducted for 5 out of 18 or 28% of months sampled. As a result of these conditions, management has not provided effective oversight of Program directives to effectively identify and address issues in a timely manner.

Recommendation

6.1 Internal Audit recommends that management revise the expectations associated with the frequency of these meetings as needed and ensure meetings are held and documented in accordance with Program expectations.

Management's Response

6.1 **Risk Mitigation Strategy:** Reduce **Implementation Date:** July 2023

Action Plan: With the assistance of the new Senior Health Manager for the Office of Health Equity, management will review the expectations for the frequency of meetings both internally and externally and will revise program expectations accordingly. However, the Department would also like to note that during the audit reference period, September 2020 until March 2022, the Department led the emergency pandemic response and management as well as staff took on significant additional responsibilities. Normal operations, including the frequency of meetings, were disrupted.

APPENDIX A—Risk Factor Definitions

Risk Factor	Definition
Compliance Risk	Failure to comply with established policies, procedures, and/or statutory requirements may result in unacceptable performance that impacts financial, operational, or customer objectives.
Documentation Risk	Failure to adequately collect, file, and retain key documentation may result in lack of accountability and/or evidence of information and support.
Human Resource Risk	Failure to attract, train, develop, deploy, and/or empower competent personnel may inhibit the organization's ability to execute, manage, and monitor key business activities.
Integrity Risk	Failure of employees, vendors, or other parties to carry out their activities in compliance with the law and ethical standards of the organization may result in fraud.
Payment Accuracy Risk	Failure to adequately execute disbursement processes may result in incorrect or duplicate vendor payments.
Physical Security Risk	Failure to adequately secure assets may allow unauthorized access to data files, programs, hardware, and other assets, and increase the risk of loss or impairment.
Policies and Procedures Risk	Failure to have formal, documented, clearly stated, and updated policies and procedures may result in poorly executed processes and/or increased operating costs.
Segregation of Duties Risk	Failure to adequately segregate duties may allow an employee or group of employees to perpetrate and conceal errors or irregularities without timely detection
Time Reporting Risk	Failure to accurately and timely report employee work hours may result in untimely or inaccurate employee payments.

APPENDIX B—Color Code Definitions

The criticality of a risk factor represents the level of potential exposure to the organization and/or to the achievement of process-level objectives before consideration of any controls in place (inherent risk).

Criticality	Significance and Priority of Action
🔴	The inherent risk poses or could pose a significant level of exposure to the organization and/or to the achievement of process level objectives. Therefore, management should take immediate action to address risk observations related to this risk factor.
🟡	The inherent risk poses or could pose a moderate level of exposure to the organization and/or to the achievement of process level objectives. Therefore, management should take prompt action to address risk observations related to this risk factor.
🟢	The inherent risk poses or could pose a minimal level of exposure to the organization and/or to the achievement of process level objectives. Risk observations related to this risk factor, however, may provide opportunities to further reduce the risk to a more desirable level.

The assessment of the design and operation of key controls indicates Internal Audit's judgment of the process and system design to mitigate risks to an acceptable level.

Assessment	Design of Key Controls	Operation of Key Controls
🔴	The process and system design do not appear to be adequate to manage the risk to an acceptable level.	The operation of the process' risk management capabilities is not consistently effective to manage the risk to an acceptable level.
🟡	The process and system design appear to be adequate to manage the risk to an acceptable level. Failure to consistently perform key risk management activities may, however, result in some exposure even if other tasks are completed as designed.	The operation of the process' risk management capabilities is only partially sufficient to manage the risk to an acceptable level.
🟢	The process and system design appear to be adequate to manage the risk to an acceptable level.	The operation of the process' risk management capabilities appears to be sufficient to manage the risk to an acceptable level.

APPENDIX C—Risk Mitigation Strategy Definitions

Risk Mitigation Strategy	Definition
Reduce	Risk response where actions are taken to reduce a risk or its consequences.
Accept	Risk response where no action is taken to affect the risk.
Transfer	Risk response where a portion of the risk is transferred to other parties.
Avoid	Risk response to eliminate the risk by avoiding or withdrawing from the activity giving rise to the risk.