Audit & Compliance Committee

June 2016

June 9, 2016
3:30 p.m. - 5:00 p.m.

West Committee Room, McNamara Alumni Center
AUD - JUN 2016

1. 2016-17 Internal Audit Plan
   Docket Item Summary - Page 3
   2016-17 Internal Audit Plan - Page 4
   Presentation Materials - Page 18

2. Internal Audit Update
   Docket Item Summary - Page 42
   Internal Audit Update - Page 43

3. Update on Human Participant Research Protection Implementation Plan
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4. Information Items
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   Controller's Semi-Annual Report - Page 71
AGENDA ITEM: 2016-17 Internal Audit Plan

☐ Review  ☐ Review + Action  ☐ Action  ☒ Discussion

This is a report required by Board policy.

PRESENTERS: Gail Klatt, Associate Vice President

PURPOSE & KEY POINTS

The Audit & Compliance Committee is delegated the responsibility, via its Charter, to review the annual Internal Audit plan on behalf of the Board of Regents.

The recommended Internal Audit plan for FY 2017 is risk-based and continues to reflect the principles of the Integrated Framework of Internal Control. The plan includes 28 audits of University processes and units, and the review of several colleges and academic units. Audit coverage will also be provided over central business processes associated with the management and reporting of sponsored funding, as well as the protection of human research participants. Selection of activities for inclusion in the annual audit plan considered alignment with the Institutional Risk Profile and well balanced coverage across the University. Audit resources have also been reserved for administrative/special requests and investigative audit needs.
PURPOSE OF THE ANNUAL PLAN

The annual internal audit plan is intended to demonstrate:
- the breadth and depth of audit activities addressing financial, operational, compliance, strategic, and reputational risks of the University;
- accountability for our resources; and
- the progress in our efforts to continually improve the University's Internal Audit program.

It is our intent to convey a current sense of the University's internal control environment and the extent to which institutional risk mitigation is being assessed by regular audit activities, addressed proactively through advisory services, or investigated as a result of issues raised.

DEVELOPMENT OF THE ANNUAL PLAN

The development of the annual audit plan is based on information gathered through broad consultation across the University and a formal assessment of existing and emerging risks. We also do a scan to identify areas of emphasis at relevant federal agencies and use a survey of other research universities regarding the assessment of risks within their institutions.

External Risk Assessment / Scan of the National Landscape of Higher Education

Regulatory Agencies: The federal regulatory agencies that have significant involvement with University activities continue to be highly focused on the implementation of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards issued in December 2014, both internally within the agencies themselves, as well as by their grantees. Additional refinements to the Guidance are under consideration by the Office of Management and Budget. Audits of college and university grantees will be focused on subcontracting practices and oversight, compliance with select agent requirements and transfers, export controls, human research participant protections, and general cost compliance.

Research Universities: Our survey of other research universities found the following items consistently identified as risks warranting governing board attention: funding, student/campus safety, regulatory compliance, IT governance, cybersecurity, leadership and workforce succession planning, and institutional reputation.
Internal Risk Assessment

As part of the planning process, we held individual discussions with each member of the Board of Regents to identify areas of risks/concerns at the governance level for audit consideration. The risks most often identified in these discussions were Board governance practices, key leadership transitions, and impact of tuition principles/decisions on affordability and access. M Health was also raised as potentially raising risks for the University, as well as opportunities.

We also held discussions with 92 institutional officials from 38 units to solicit input on the University’s institutional risks and any specific areas of concern. Themes which emerged from these discussions included the risks associated with: 1) the local effort needed to adjust to changes resulting from the Enterprise Upgrade for Human Resources and the job family study, 2) the continued direction to cut administrative costs now impacting core academic activities, 3) the potential impact of unionization, and 4) adapting to changes arising from the Human Participant Protection Plan implementation.

Operational Risk Assessment

Finally, our annual planning process includes re-examining the audit universe to ensure that all university activities are considered when determining how audit resources will be allocated. We also consider new regulatory developments, new business processes, and institutional priorities and strategic initiatives.

The Office of Internal Audit continues to utilize a formalized risk assessment methodology in selecting processes/units/systems for inclusion in the annual audit plan. Relative risk assessment is necessary to provide a basis for the rational deployment of our limited resources across the institution. The risk factors that we considered in prioritizing institutional activities are:

- Impact on the University’s mission
- Impact on University finances
- Assessment of the activity’s control environment
- Level of compliance concerns
- Impact of information technology
- Complexity and/or diversity of the activity
- Changes in the organization or leadership

Our operational risk assessment resulted in a risk ranking of 180 individual auditable activities, of which 22 are considered to be high risk, 107 moderate risk, and 51 low risk. A rating of “high-risk” does not mean that the activity is perceived to have control problems, but rather reflects the criticality or centrality of the activity to the University’s mission.

OVERALL RISK ASSESSMENT AND IMPACT ON THE FY2017 AUDIT PLAN

In FY 2016 we devoted significant audit attention to centralized business processes to assess the impact of the Enterprise Upgrade on the University’s control environment. The proposed FY 2017 audit plan provides greater coverage of academic units in response to decanal
requests as well as to ensure that the control environments in these units remain stable in light of administrative cost reductions. The audit plan also continues to provide coverage in Athletics and units impacted by the Human Participant Protection implementation plan.

In selecting specific activities for inclusion in the audit plan, we recognize there are areas of high risk across the University that we have intentionally excluded because 1) the issues are well known and are being addressed by the administration, 2) the activity lacks the necessary maturity for meaningful auditing, or 3) the issues are receiving extensive external review. Such risks include those associated with M Health, Psychiatry, fetal tissue procurement, and the Healthcare Center of (IT) Excellence. We will continue to monitor these areas outside of the audit process for indications that audit coverage would be helpful.

**ALLOCATION OF AUDIT RESOURCES**

The audit plan is based on a planned staffing complement of 16.75 FTE professionals, which is our full complement.

Approximately 54% of the Office of Internal Audit’s resources are committed to the completion of planned audit projects. This year 6% of those resources will be needed to complete carry-over work from our FY 2016 audit plan. Five audit projects are currently in process and will be completed in FY 2017.

The remainder of our FY 2017 audit resources is reserved as follows:

- 11% has been reserved to accommodate requests from the President, the Board, or members of the senior leadership team. This has been supported by the Audit and Compliance Committee. The number of hours remains consistent from previous years.
- 5% has been reserved for investigations. The number of hours remains consistent from previous years.
- 4% has been reserved for follow-up procedures performed on behalf of the Audit and Compliance Committee. The number of hours remains consistent from previous years.
- 26% has been set aside for internal administrative functions, including our continuous improvement efforts. This remains fairly consistent with the previous year.
FY 2017 PLANNED ALLOCATION OF AUDIT RESOURCES

- Scheduled Audits: 54%
- Investigations: 5%
- Presidential/Executive Requests: 11%
- Follow Up: 4%
- Administration: 26%
To avoid duplication of work and additional burden on University staff, we continue to place reliance on audit related work performed by other service providers. We rely on the external audit work performed by Deloitte and Touche, LLP in the areas of investments, annual external financial reporting, and RUMINCO, the University's captive insurance company. We also rely on the audit work performed by external construction audit firms engaged by the University's Capital Planning and Project Management (CPPM) unit for construction projects that are delivered using the Design/Build or the Construction Manager at Risk delivery methods. We are in agreement with the scope of this audit work and receive and review copies of their reports.
FY 2017 AUDIT PLAN

Taking into consideration the risks identified externally as well as internally, and balancing all of the above with our available resources, the audit plan recommended for FY 2017 includes the following:

<table>
<thead>
<tr>
<th>Audits Planned for FY 17</th>
<th>Process/Unit</th>
<th>Risk Area(s) Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Risk Audits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Subjects (TBD)</td>
<td>Process (1)</td>
<td>Human Subject Research*, Research, AHC, Technology, Compliance</td>
</tr>
<tr>
<td>Sponsored Transactions (UG, subawards)</td>
<td>Process (1)</td>
<td>Federal Research Funding*, Financial Mgmt, Technology, Compliance, Higher Ed Operating Model*</td>
</tr>
<tr>
<td>Accounts Receivable Services</td>
<td>Process (1)</td>
<td>Financial Management, Technology, Compliance, Higher Education Operating Model*</td>
</tr>
<tr>
<td>ESUP Student Upgrade</td>
<td>Process (1)</td>
<td>Technology, Student Experience, Financial Management</td>
</tr>
<tr>
<td>Public Health Information Technology</td>
<td>Unit</td>
<td>IT Infrastructure*, Technology</td>
</tr>
<tr>
<td>Google Email &amp; Applications</td>
<td>System</td>
<td>IT Infrastructure*, Technology, Student Experience</td>
</tr>
<tr>
<td><strong>Moderate Risk Audits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community University Health Care Center</td>
<td>Unit</td>
<td>Financial Management, Compliance, Technology, AHC, External funding</td>
</tr>
<tr>
<td>Export Controls</td>
<td>Process (1)</td>
<td>Compliance, Research</td>
</tr>
<tr>
<td>Radiology/Ctr. for Magnetic Resonance Res.</td>
<td>Unit</td>
<td>Federal Research Funding*, Financial Management, Compliance, AHC, Technology, Research</td>
</tr>
<tr>
<td>College of Liberal Arts</td>
<td>Unit</td>
<td>Financial Management, Research, Compliance, Technology, Student Experience</td>
</tr>
<tr>
<td>College of Food, Ag, &amp; Nat. Resource Sciences</td>
<td>Unit</td>
<td>Financial Management, Research, Compliance, Technology, Student Experience, Federal Research Funding*</td>
</tr>
<tr>
<td>Math</td>
<td>Unit</td>
<td>Financial Management, Research, Compliance, Technology, Student Experience, Federal Research Funding*</td>
</tr>
<tr>
<td>College of Biological Sciences</td>
<td>Unit</td>
<td>Federal Research Funding*, Research, Financial Management, Compliance, Technology, Student Experience</td>
</tr>
<tr>
<td>UMD Housing</td>
<td>Unit</td>
<td>Campus Safety*, Financial Management, Student Experience, Technology</td>
</tr>
<tr>
<td>UMD Swenson College of Science/Engineering</td>
<td>Unit</td>
<td>Financial Management, Research, Compliance, Technology, Student Experience, Federal Research Funding*</td>
</tr>
<tr>
<td>UMD Natural Resources Research Institute</td>
<td>Unit</td>
<td>Federal Research Funding*, Financial Management, Research, Technology, Compliance, Research</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>Unit</td>
<td>Federal Research Funding*, Financial Management, Compliance, AHC, Technology, Research</td>
</tr>
<tr>
<td>Admissions</td>
<td>Process</td>
<td>Student Experience, Financial Management, Technology, Student Demographics/Enrollment Strategies*</td>
</tr>
<tr>
<td>NCAA Compliance Sport Audit</td>
<td>Unit</td>
<td>Athletics*, Compliance, Student Experience, Student-Athlete Health and Safety</td>
</tr>
<tr>
<td>Athletics Advising (McNamara Academic Ctr)</td>
<td>Unit</td>
<td>Athletics*, Compliance, Student Experience</td>
</tr>
<tr>
<td>Student Judicial</td>
<td>Process</td>
<td>Student Experience, Compliance</td>
</tr>
<tr>
<td>Athletics Information Technology</td>
<td>Unit</td>
<td>Athletics*, Technology, Compliance</td>
</tr>
<tr>
<td>ADA Technology Accessibility Compliance</td>
<td>Process</td>
<td>Equity &amp; Diversity, Technology, Student Experience, compliance</td>
</tr>
<tr>
<td>Auxiliary Services Information Technology</td>
<td>Unit</td>
<td>IT Infrastructure*, Technology</td>
</tr>
<tr>
<td>Destiny One (non-credit registration)</td>
<td>System</td>
<td>IT Infrastructure*, Technology, Student Experience, Financial Management</td>
</tr>
<tr>
<td><strong>Other Audits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of Faculty Retention/Set-Up/Award</td>
<td>Process (1)</td>
<td>Attracting and Retaining Talent*, Financial Management</td>
</tr>
<tr>
<td>Vikings Closeout Audit</td>
<td>Process</td>
<td>Financial Management, Facilities*</td>
</tr>
<tr>
<td>OIT Network Upgrade (non report)</td>
<td>System</td>
<td>Technology, IT Infrastructure*</td>
</tr>
<tr>
<td>Identity Management Upgrade (non report)</td>
<td>System</td>
<td>Data Privacy/Security*, Technology, IT Infrastructure*</td>
</tr>
<tr>
<td>Athletic Expense Review (non report)</td>
<td>Unit</td>
<td>Financial Management, Athletics*</td>
</tr>
</tbody>
</table>

* This risk is included on the Institutional Risk Profile (Appendix A)
(1) Testing in individual units is planned during this process audit
The proposed audit plan is comprised of 11 process audits (35%), 16 unit-based audits (52%), and 4 system audits (13%). Seven (64%) of the process audits will involve unit-level audit testing. Five of the process audits are considered high risk. The proposed audit plan also includes significant coverage of selected risks included on the Institutional Risk Profile.
The FY 2017 plan continues to provide well-balanced coverage across the University. The following chart shows the distribution of audit coverage by University component for FY 2017, based on the number of hours allocated to each component.

**FY 2017 AUDIT COVERAGE BY UNIVERSITY COMPONENTS**

- AHC 19%
- Provost 38%
- CIO 4%
- U Services 5%
- Finance 7%
- Executive 7%
- Human Resources 1%
- Research 8%
- System Campuses 11%
FY 2016 RESULTS

For FY 2016, we will have issued 22 audit reports which were the result of planned reviews and requests from management (See Appendix A).

In addition,
- Six audits are currently in the planning or fieldwork stages and will be completed in FY 2017.
- Nine audits were deferred to FY 2017.
- One audit was not completed due to limited audit resources

During the past fiscal year we conducted 10 investigations into financial or operational misconduct. Where appropriate, we have partnered with the University Police or the Office of the General Counsel to complete these reviews.

INDEPENDENCE

There were no incidences during the year in which the independence or scope of internal audit work was restricted in any way.

COORDINATION WITH EXTERNAL AUDITORS

The Office of Internal Audit continues to coordinate its audit plan with the University’s external auditors to ensure appropriate coverage is achieved through the internal and external audit plans and to leverage the collective efforts of both organizations. The Office of Internal Audit meets the professional standards required by external auditors to place reliance on internal audit work. We also rely on the work performed by Deloitte and Touche, LLP in the areas of investments, annual external financial reporting, and RUMINCO, the University’s captive insurance company.

COORDINATION WITH OTHER INTERNAL RESOURCES

The Office of Internal Audit coordinates its work with other internal units to maximize the quality of audit coverage provided as well as to promote prompt attention when University-wide trends are identified. We have established strong working relationships with the University’s compliance partners, the Office of Research Education and Oversight (now part of the Research Compliance Office), the Human Research Protection Program, the Department of Environmental Health and Safety, University Information Security, and the Office of the General Counsel, each of which work closely with us during audits involving complex regulatory issues.

The Office of Internal Audit interfaces regularly with the Institutional Compliance Officer and we serve on the Executive Compliance Oversight Committee. Input from the Compliance Officer is solicited during our annual audit planning. In addition, throughout the year we
report to and collaborate with the Compliance Officer on issues identified during our audits. We also share the results of employee surveys with the Compliance Officer. During fiscal year 2016, a total of 2,656 employee surveys were sent out as part of our audit process, with a 56% response rate. Along with the Office of Institutional Compliance, we serve as a triage office for managing U Report, the University’s confidential reporting line.

Audit results are also shared with central support units such as the Office of Information Technology, Sponsored Projects Administration, Payroll, Controller’s Office, Training Services, and Human Resources when policy non-compliance or when the need for process enhancements are identified. Best practices identified in local unit audits are also shared with these central unit process owners for consideration of broader adoption.

STAFF DEVELOPMENT, QUALIFICATIONS AND PROFESSIONAL INVOLVEMENT

The Office of Internal Audit is committed to providing educational opportunities to our staff in order to enhance our audit knowledge and abilities and to achieve our professional best. Ever-changing government regulations, new technologies, and new developments in auditing principles and methods dramatically affect not only what we audit, but also how we audit. We constantly strive to stay abreast of new developments and improve our audit proficiency in order to enhance the overall quality of our audits. To accomplish this, we pursue a variety of methods to continue our staff’s professional education.

Our departmental memberships with the Institute of Internal Auditors (IIA), the Association of College and University Auditors (ACUA), the Association of Certified Fraud Examiners (ACFE), the American Institute of Certified Public Accountants (AICPA), and the Information Systems Audit and Control Association (ISACA) provided staff members the opportunity to attend seminars and conferences that specifically address current issues and techniques in internal auditing. The interaction of our staff members with their peers through these professional organizations helps to keep us up-to-date on the latest auditing trends and issues affecting higher education.

All but two of the professional internal audit staff are professionally credentialed or hold advanced degrees. Specifically,

- Thirteen have professional certifications of Certified Internal Auditors, Certified Public Accountants, Certified Information Systems Auditors and/or Certified Fraud Examiners;
- Three are certified in Risk Management Assurance;
- Three have Master of Business Administration degrees;
- Two have Master of Accounting degrees;
- One has a Juris Doctor (law degree);
- Two have a Master of Public Policy degree; and
- Two are pursuing a professional certification.

In the first 10 months of FY 2016, the Office of Internal Audit provided over 1200 hours of formal and informal training (an average of 78 hours for each employee). These hours do not include the time associated with completing coursework funded by the University’s Regents Scholarship Program. We continue to provide the continuing professional development required to maintain the staff’s professional credentials. For FY 2017, 1350 hours have been budgeted for formal staff training, an average of 80 hours per employee.
PROFESSIONAL STANDARDS

The Office of Internal Audit conducts its work in accordance with the Institute of Internal Auditors’ Standards for the Professional Practice of Internal Auditing. All of the audit staff is also required to comply with the Institute’s Code of Conduct for Internal Auditors.

INTERNAL QUALITY ASSURANCE PROGRAM

We have established an internal quality assurance program within the Office of Internal Audit. This program is structured around the robust supervision of audit staff and their work products. In addition, internal practices and tools are routinely evaluated for their effectiveness and efficiency and changes are made when potential improvements are identified. Our quality assurance measures throughout the year confirmed our practices met the requirements of our professional Standards.

EXTERNAL QUALITY ASSURANCE REVIEW

Our professional standards require that our audit practice undergo an external quality assurance review every five years. Our most current external review was conducted in February 2015 and determined that 1) our work was in full compliance with the Standards, and 2) University management and the Board of Regents can appropriately rely on the assurance provided by the work performed by the Office. The review team also opined that they had seldom been as impressed with an internal audit activity as they were with the Office of Internal Audit and the quality and level of performance they observed over all aspects of our practice.

OFFICE OF INTERNAL AUDIT FY 2016 STAFFING

We experienced 16% turnover (three positions) in FY 2016. This is consistent with our normal turnover rate of 13%. Two of the departures involved retirements. We have successfully filled all of the positions and will begin FY 2017 at a full staff complement.

OFFICE OF INTERNAL AUDIT BUDGET STATUS

The Office of Internal Audit received additional funding for a 2.5% compensation increase, consistent with the administration’s pay plans. The Office’s overall budget was reduced by $16,000 (.8%). Additionally, we returned $400,000 from our reserve balances to central administration to support other institutional priorities.

We appreciate the continued financial and operational support we receive from the administration.
University of Minnesota Institutional Risk Profile

The institutional risk profile is used to identify those risks of greatest import to the Board of Regents at a governance level. This profile is a synthesis of the committee’s work in reviewing a broad range of risks identified by the administration over the last two years.

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
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<tbody>
<tr>
<td>Impact</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
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<table>
<thead>
<tr>
<th>Audit Coverage</th>
<th>FY 17</th>
<th>FY 16</th>
<th>FY 17</th>
<th>FY 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
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<tr>
<td>Attracting and Retaining Talent</td>
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<td>X</td>
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<td>Data Privacy/Security</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Student Demographics/Enrollment Strategies</td>
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<td>Federal Research Funding</td>
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<tr>
<td>Higher Education Operating Model</td>
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<td>X</td>
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<tr>
<td>Human Subject Research</td>
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<tr>
<td>Strategic Plan Implementation</td>
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<td>Student Preparedness</td>
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<td>Workforce Development Expectations</td>
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<tr>
<td>Campus Safety and Security</td>
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The following addresses audit coverage based on the previous institutional risk profile:

<table>
<thead>
<tr>
<th>Unit</th>
<th>FY 15</th>
<th>FY 14</th>
<th>FY 13</th>
<th>Unit</th>
<th>FY 15</th>
<th>FY 14</th>
<th>FY 13</th>
</tr>
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<tbody>
<tr>
<td>Research- Infrastructure</td>
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<td>x</td>
<td>Investments</td>
<td></td>
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<td>Individual Sponsored Projects</td>
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<td>x</td>
<td>Leadership/Succession</td>
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<td>AHC</td>
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<td>Student Experience</td>
<td>x</td>
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<td>x</td>
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<td>Athletics</td>
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<td>Associated Organizations</td>
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<tr>
<td>Financial Management</td>
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<td>x</td>
<td>Tech Transfer</td>
<td></td>
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<tr>
<td>Technology</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Campus Safety</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>Academic Quality</td>
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<td></td>
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<td>Strategic Decisions</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Quality of Faculty/Staff</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Asset Optimization</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
STATUS OF FY 2016 AUDIT PLAN

Audits Completed

High Risk
- Athletics Administration
- Athletics Finance and Operations
- Boynton Health Services
- Department of Medicine

Moderate Risk
- College of Science & Engineering Deans Office
- Clinical and Translational Science Institute
- College of Food, Ag & Natural Res. Sciences Deans Office
- UMD Athletics
- College of Pharmacy
- Athletics Sport Compliance (Basketball)
- College of Design
- Office of Information Technology Database Administration
- Law School
- Electrical and Computer Engineering
- Masonic Cancer Center
- UMD College of Education & Human Services Professions
- Incentive Compensation

System-Wide Audits/Reviews
- OLA Environment & Natural Resources Trust Fund
- Testing of University of MN Foundation Trans FY 15

Audit Effort Not Resulting in Audit Report
- Monitoring of Enterprise Upgrade Project

Audits Expected to be Completed in FY16

High Risk
- Purchasing Card Process
- Vendor Payment Process
- Payment Card Industry Compliance

Moderate Risk
- PeopleSoft IT: Gen Controls, Infrastructure & Governance
- School of Dentistry
- Office of Human Resources/ESUP Upgrade to HRMS System

Audits Started in FY16 but will be Completed in FY17

High Risk
- International Admissions
- Tuition Waivers

System-Wide Audits/Reviews
- Testing of University of MN Foundation Transactions FY 16

Audits Deferred and in 2017 Audit Plan

- Accounts Receivable Services
- Community University Health Care Center
- Epidemiology
- Auxiliary Services Information Technology
- Review of Faculty Retention, Set-Ups & Awards
- Human Subjects (TBD)
- ESUP Upgrade Student System
- UMD Housing
- UMD Natural Resources Research Institute

Audits Not Completed
- MN Drive
Topics

• Risk Assessment and Plan Development
• FY 2017 Audit Plan
• FY 2016 Audit Results
Office of Internal Audit Portfolio

- Audits
- Investigations/Special Projects
- Audit Advisory Services
Developing the Annual Plan

- External Risk Assessment
  - Survey of research-intensive universities
  - Review of regulatory agencies, externally conducted surveys, professional discussion groups, etc.

- Internal Risk Assessment
  - Discussions with administrative leadership
  - Discussions with Board members
Developing the Annual Plan

Operational Risk Assessment

• Assuring that all University activities have been accounted for, and included in a defined auditable activity

• Assessing each auditable activity against a set of defined risk factors
Operational Risk Factors

• Impact of activity on the University mission
• Impact of information technology
• Regulatory compliance issues
• Organizational change/turnover
• Complexity/diversity of operations
• Known or perceived control concerns
• Audit history
• Impact on University finances
• Assessment of activity’s control environment
Operational Risk Assessment

180 auditable activities

- 22 high-risk activities
- 107 moderate-risk activities
- 51 low-risk activities
Overall Risk Assessment

Audit Focus for 2017
  – Academic units
  – Athletics
  – Human participant research
FY 2017 Allocation of Resources

- Scheduled Audits - 54%
- Investigations - 5%
- Presidential/Executive Requests - 11%
- Follow Up - 4%
- Administration - 26%
FY 2017 Allocation of Resources

Comparison of Audit Resources for FY 2016 and FY 2017

Percent of Available Time

<table>
<thead>
<tr>
<th>Category</th>
<th>16/17 Budget</th>
<th>15/16 Actual</th>
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<td>Follow Up</td>
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</tr>
<tr>
<td>Administration</td>
<td>25</td>
<td>21</td>
<td>26</td>
</tr>
</tbody>
</table>
Deploying Audit Resources

We select activities for inclusion in the plan by considering and placing priority on coverage of:

- High-risk activities
- Major organizational components
- Institutional Risk Profile/ Risk Assessments
- Areas of strategic priority
- Management requests
FY 2017 Breakdown by Type of Audit

- Process: 35%
- Unit: 52%
- System: 13%

64% of the planned process audits will involve unit testing.
FY 2017 Audit Coverage by Major Component

- AHC 19%
- Provost 38%
- CIO 4%
- U Services 5%
- Finance 7%
- Executive 7%
- Human Resources 1%
- Research 8%
- System Campuses 11%
FY 2017 Audit Coverage by Major Component

**Provoest**
- College of Liberal Arts
- College of Biological Sciences
- Department of Math
- College of Food/Ag/Natural Science
- ESUP Student System Upgrade
- Admissions
- Athletic Advising (MAC)
- Student Judicial Process
- Destiny One Registration System

**AHC**
- CUHCC
- Epidemiology (w/ Provost)
- Radiology/CMRR (w/ Provost)
- School of Public Health IT (w/ Provost)

**System Campuses**
- UMD Swenson Science/Engineering
- UMD Housing
- UMD NRRI

**Executive**
- Athletics Sport Compliance
- Athletics Expense Review
- ADA Technology
- Athletics IT

**CIO**
- Google Email
- OIT Network
- Identity Management Upgrade

**Research**
- Export Controls
- Human Subjects
- Uniform Guidance/Subawards

**Finance**
- Accounts Receivable Services
- Sponsored Financial Reporting

**U Services**
- Auxiliary Services IT
- Vikings Contract Close Out
The institutional risk profile is used to identify those risks of greatest import to the Board of Regents at a governance level. This profile is a synthesis of the committee’s work in reviewing a broad range of risks identified by the administration over the last two years.

<table>
<thead>
<tr>
<th>Likelihood</th>
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<td></td>
<td>Campus Safety &amp; Security</td>
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<tr>
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<td></td>
<td>D</td>
<td>Athletics: Program Integrity &amp; Success of Business Model</td>
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<td></td>
<td>IT Infrastructure &amp; Costs</td>
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<td>Managing Brand &amp; Reputation</td>
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<td>Meeting Expectations on Workforce Development</td>
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<td>Moderate</td>
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<td>Effective Communication</td>
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<td>Autonomy</td>
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<td>Attracting &amp; Retaining Talent</td>
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<td>Data Privacy/Security</td>
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<td>Student Demographics &amp; Enrollment Strategies</td>
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<td>Facilities: Strategic Needs &amp; Aging Infrastructure</td>
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<td></td>
<td>Federal Research Funding</td>
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<td>Prioritization: Balancing Breadth &amp; Quality of Offerings</td>
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The institutional risk profile is used to identify those risks of greatest import to the Board of Regents at a governance level. This profile is a synthesis of the committee’s work in reviewing a broad range of risks identified by the administration over the last two years.
# Audit Coverage of Institutional Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>FY 17</th>
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<td>Athletics</td>
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<td>x</td>
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<td>IT Infrastructure &amp; Costs</td>
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<td>x</td>
<td>Brand and Reputation</td>
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<td>Human Subject Research</td>
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<td>Maximizing Multiple Campuses</td>
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<tr>
<td>Student Preparedness</td>
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<td>Perception of HE Value</td>
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<td>Workforce Development Expectations</td>
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<td>Commercialization of Intellectual Property</td>
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</tbody>
</table>

*Page 33 of 76*
The 2017 Audit Plan

• Provides reasonable audit coverage across all of the major components of the University.
• Addresses risks currently impacting the University.
• Addresses selective risk areas identified by the Audit and Compliance Committee as important.
FY 2016 Audit Results

Our Commitment to Accountability
Our Commitment to Accountability

The Office of Internal Audit is committed to its accountability for the professional conduct of its work.

• We conduct our work in accordance with the Standards for the Professional Practice of Internal Auditing and abide by our profession’s Code of Ethics.

• There were no restrictions on audit scope or interference with our independence during the year.
Quality Assurance Review

Conclusions

We underwent a quality assurance review in February 2015

- “University Management and the Board of Regents can appropriately rely on the assurance provided by the work performed by the Office of Internal Audit.”

- “Our team, which collectively has extensive experience performing quality assessments, has seldom been as impressed with an internal audit activity as we were with the Office of Internal Audit.”
Our Commitment to Accountability

The Office of Internal Audit is committed to its accountability for the productive use of the resources provided by the University.

In FY 2016:

- 22 audits completed
- 6 audits currently in process
- 9 audits were deferred to FY 2017
- 1 audit was not completed due to lack of resources
- 10 investigations conducted
Our Commitment to Accountability

The Office of Internal Audit is committed to its accountability for the professional competence of its staff.

All but two professional staff are professionally certified or hold advanced degrees.

- Thirteen are professionally certified as a CPA, CIA, CFE, or CISA
- Eight have master’s or JD degrees
- Two are pursuing professional certification
- The audit staff has on average 12 years of audit experience
Our Commitment to Accountability

The Office of Internal Audit is committed to its accountability for the quality of the audit services we provide.

- We routinely benchmark our practices/ performance against other audit functions.
- We request a post-audit evaluation of our services after each audit.
- We have rigorous internal quality assurance processes in place.
Questions?
AGENDA ITEM: Internal Audit Update

☐ Review  ☐ Review + Action  ☐ Action  X Discussion

This is a report required by Board policy.

PRESENTER: Gail Klatt, Associate Vice President

PURPOSE & KEY POINTS

The purpose of this item is to update the committee on Internal Audit activities, results, and observations to help the Committee fulfill its fiduciary responsibilities under its reserved authority for oversight of the internal audit function, as outlined in the committee charter.

- Since the last follow-up, at the February 2016 meeting, 43% of the outstanding recommendations rated as “essential” were implemented by University departments. This is consistent with the expected implementation rate of 40%. Seven units fully implemented all remaining “essential” recommendations.
- An updated control evaluation chart is included for each audit to show progress made on the “essential” items.
- Eight audit reports containing 51 recommendations rated as “essential” were issued in the last four months.

BACKGROUND INFORMATION

This report is prepared three times per year and is presented to the Audit & Compliance Committee in conformance with Board policy.
This report includes:
- Audit Observations/Information/Status of Critical Measures/Other Items
- Status of “Essential” Recommendations & Bar Charts Showing Progress Made
- Audit Activity Report
- Audit Reports Issued Since February 2016

Details for any of the items in this report are available on request. Individual reports were sent to the President, Provost, Vice Presidents, and Chancellors about these internal audit issues.

Audit Observations/Information

Status of Critical Measures

As part of our on-going efforts to provide the Audit and Compliance Committee with critical information in as concise a format as possible, we have developed the following three charts to present a “snap-shot” status report on work performed by the Office of Internal Audit.

The first chart, “Essential Recommendation Implementation”, provides our overall assessment of the success University departments had during the last quarter in implementing our essential recommendations. Readings in the yellow or red indicate implementation percentages less than, or significantly less than, our expected University-wide rate of 40%. Detailed information on this topic, both institution-wide and for each individual unit, is contained in the next section of this Update Report.

The second chart, entitled “Progress Towards Annual Audit Plan Completion”, is our assessment of how we are progressing towards completion of the FY 2016 Annual Audit Plan. Readings less than green could be influenced by a variety of factors (i.e. insufficient staff resources; increased time spent on non-scheduled audits or investigations).

The final chart, “Time Spent on Investigative Activities”, provides a status report on the amount of time consumed by investigative activities. Our annual plan provided an estimated budget for this type of work, and the chart will indicate if we expect that budget to be sufficient. Continued readings in the yellow or red may result in seeking Audit and Compliance Committee approval for modifying the Annual Audit Plan.
Since the February update we experienced turnover in three positions. Two employees (both with an average of 30 years of service) retired from the University, and one left because of spousal employment relocation. One of the retiring employees was a member of our management team, and we promoted from within to replace him. We were fortunate to recruit and replace all of our open positions; one via an internal transfer from within the University, and two with new college graduates from UMTC and UMD.

Under the current affiliation agreement with Fairview Health Services, the University’s Internal Audit Director serves as a member of the Corporate Board’s Audit Committee. In preparation for the reconstitution of the Board as part of the creation of M Health, the Audit Committee was disbanded after its last meeting in April. It is unknown if there will be any future involvement.
Status of “Essential” Recommendations as of May 27, 2016

<table>
<thead>
<tr>
<th>Report Date</th>
<th>Audit (P) Indicates a University process audit</th>
<th>Original Report Control Rating</th>
<th># of Essential Recommendations in the Report</th>
<th># of Essential Recommendations Remaining From Prior Quarter</th>
<th>Implemented</th>
<th>Current Quarter Results</th>
<th>Overall Progress Towards Implementation*</th>
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<tbody>
<tr>
<td>Oct-11 UMD School of Fine Arts</td>
<td>Adequate</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>Satisfactory (1)</td>
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<tr>
<td>May-13 Travel &amp; Employee Reimbursements (P)</td>
<td>Good</td>
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<td>1</td>
<td>1</td>
<td>1</td>
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<td>Good</td>
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<td>2</td>
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<td>1</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Jun-14 Parking &amp; Transportation Services</td>
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<td>10</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Jul-14 UMD University for Seniors</td>
<td>Good</td>
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<td>1</td>
<td>1</td>
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<td></td>
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</tr>
<tr>
<td>Jan-15 Server Room Security</td>
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<td>12</td>
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<td>9</td>
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<td>6</td>
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Total: 155 108 46 13 35 12 2

* The following bar charts provide details on progress made towards implementation

(1) UMD School of Fine Arts (GlenSheen) has completed the GlenSheen inventory, and the contents are now being appraised. The expected completion date is December 2016.

(2) The recommendation listed as partially implemented pertains to a state law (MN. Statute 137.31, subdivision 1) regarding small business set-aside. The Controller's Office has reviewed the law and concluded they are unable to comply with the letter of the law as it is written. They believe the law is vague, provides no guidance in terms of definitions, and contains language which no longer has meaning to the University's funding. They have reported the University has, however, established internal benchmarks and quantitative goals which fulfill the spirit of the law. Their focus moving forward is a combined effort with the Office of Business and Community Economic Development to achieve increased targeted supplier spend with the newly established goals.

Audits receiving first-time follow-up

<table>
<thead>
<tr>
<th>Report Date</th>
<th>Audit (P) Indicates a University process audit</th>
<th>Original Report Control Rating</th>
<th># of Essential Recommendations in the Report</th>
<th># of Essential Recommendations Remaining From Prior Quarter</th>
<th>Implemented</th>
<th>Current Quarter Results</th>
<th>Overall Progress Towards Implementation*</th>
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<td>Oct-15</td>
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<td>Oct-15</td>
<td>UMD Athletics</td>
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<td>Jan-16</td>
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Total: 155 108 46 13 35 12 2

Comparison of First-time to Prior Follow-up

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1st Time Implemented

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<td>13</td>
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1st Time Not Implemented

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<td>13</td>
<td>13</td>
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</tbody>
</table>

Audits > 2 years old (see the following report for details on unresolved issues)

<table>
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<tr>
<th>Report Date</th>
<th>Audit (P) Indicates a University process audit</th>
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<td>1</td>
<td>Satisfactory (1)</td>
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<td>Jun-14 Parking &amp; Transportation Services</td>
<td>Good</td>
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<td>3</td>
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<td>Apr-15 Dept. of Ophthalmology &amp; Visual Neurosciences</td>
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<td>May-15 Technology Vendor Due Diligence</td>
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<td>Sep-15</td>
<td>Critical &amp; Translational Science Institute</td>
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<td>Jan-16</td>
<td>College of Pharmacy</td>
<td>Good</td>
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<td>Jan-16</td>
<td>College of Design</td>
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<td>Feb-16</td>
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Total: 155 108 46 13 35 12 2

* The following bar charts provide details on progress made towards implementation

(1) UMD School of Fine Arts (GlenSheen) has completed the GlenSheen inventory, and the contents are now being appraised. The expected completion date is December 2016.

(2) The recommendation listed as partially implemented pertains to a state law (MN. Statute 137.31, subdivision 1) regarding small business set-asides. The Controller's Office has reviewed the law and concluded they are unable to comply with the letter of the law as it is written. They believe the law is vague, provides no guidance in terms of definitions, and contains language which no longer has meaning to the University’s funding. They have reported the University has, however, established internal benchmarks and quantitative goals which fulfill the spirit of the law. Their focus moving forward is a combined effort with the Office of Business and Community Economic Development to achieve increased targeted supplier spend with the newly established goals.

Total Not Fully Implemented (n=62)

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<thead>
<tr>
<th>Past Target Date (n=37)</th>
<th>Not Past Target Date (n=25)</th>
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"Essential" Recommendation Implementation Trends

<table>
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<tr>
<th>Month / Year of Follow-up Report</th>
<th># of Essential Recommendations Receiving Follow-up</th>
<th># of Recommendations Considered Fully Implemented</th>
<th>Implementation Percentage</th>
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<td>June 2016</td>
<td>108</td>
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<td>Feb. 2016</td>
<td>83</td>
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<tr>
<td>Sept. 2015</td>
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<td>June 2015</td>
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<td>Feb. 2015</td>
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<td>Sept. 2014</td>
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<tr>
<td>June 2014</td>
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<td>Feb. 2014</td>
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<td>Sept. 2013</td>
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<td>Average</td>
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<tr>
<td>Audit/Report Date</td>
<td>Status - Partially Implemented (P) or Not Implemented (N)</td>
<td>Senior Management Contact</td>
<td>Summary of the Issue/Risk Involved</td>
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<tr>
<td>UMD School of Fine Arts  &lt;br&gt;Oct-11  &lt;br&gt;# of Items 1</td>
<td>P  &lt;br&gt;William Payne Bilin Tsai</td>
<td>Glensheen management should work with Accounting Services to develop procedures for reporting the value of its collection.</td>
<td>Per the director of Glensheen: The process of hiring an appraiser has begun. Completion of the appraisal process itself can be expected by at least the end of the calendar year.</td>
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<tr>
<td>University-wide  &lt;br&gt;Purchasing process  &lt;br&gt;Feb-14  &lt;br&gt;# of Items 1</td>
<td>P  &lt;br&gt;Tim Bray Michael Volna</td>
<td>Purchasing Services and the Office for Business &amp; Community Economic Development should work with University senior administration to:  &lt;br&gt;- Establish appropriate institutional goals and metrics regarding purchases from Targeted Business Groups to ensure the institution is meeting the intent of the Regents Policy.  &lt;br&gt;- Implement steps to measure and ensure compliance with MN. Statute 137.31 subdivision 1.</td>
<td>Per the Director of Purchasing Services: Regarding MN State Statute 137.31, subdivision 1, we are unable to comply with the letter of the law as it is written. The law is vague, provides no guidance in terms of definitions and contains language which no longer has meaning to the University's funding. The University has, however, established internal benchmarks and quantitative goals which fulfill the spirit of the law. Our focus moving forward is a combined effort with the Office of Business and Community Economic Development (BCED) to achieve increased targeted supplier spend with the newly established goals. Purchasing Services and BCED have jointly agreed to establish a FY 2017 Targeted Business goal of 6% in the Goods and Services area. This would more than double the current targeted business participation. The goal in the Construction arena will continue to be 13%. In addition, the dollar threshold used for inclusion of the supplier diversity commitment form on RFP's was lowered to $50,000 from $500,000 effective 1-01-16. Information was shared with the Senior Leadership Group on April 13, 2016. Purchasing Services and BCED have also put together an outreach campaign to colleges and business units to review University goals in regard to targeted supplier spend, and provide training and tools to enable them to contribute to our goals for spend transactions less than $50,000. This plan was reviewed with the Senior Leadership Group in April.</td>
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<td>Identity Management  &lt;br&gt;Jun-14  &lt;br&gt;# of Items 1</td>
<td>P  &lt;br&gt;Bernard Gulachek</td>
<td>The University should implement processes to periodically evaluate whether logging and monitoring processes associated with high-risk University systems are occurring in a manner that complies with University's requirements. The evaluation process should be comprehensive and address all logging and monitoring issues identified in the bulleted list in this finding. The review should include University managed systems and systems obtained from the cloud. In order to evaluate cloud services the University will likely need to obtain independent evaluation reports (e.g., SSAE 16 SOC 2 reports) Where systems are found to be non-compliant remediation plans should be developed and processes should be established to ensure correction action is completed in a timely basis. Evaluation and corrective actions should focus first on the highest risk processes and systems.</td>
<td>Operational log management is both a policy requirement for systems meeting the Security High classification (as determined by the Data Security Classification policy) and a regulatory requirement for certain kinds of data in that high classification. While this finding now exceeds the 2 year mark, significant progress in implementing a new operational log management program has occurred. The Office of Information Technology (OIT) has completed many of the steps that it had outlined in its management action plan / response two years ago. All central IT services are using the new operational log management solution [Splunk] on their servers and databases. Additionally, one-third of the Academic Health Center’s systems that contain ‘Security High’ data are using operational log management solution. Completion of the remaining two-thirds of the AHC-IS’s systems with ‘Security High’ data is scheduled for Summer 2017. By centralizing log management, the correlation to existing logs will enhance security log analysis. OIT is working with system owners to enhance the log analysis capability for system and application logs. While the goal is to provide operational log management services for all ‘Security High’ systems across the University, the costs to the institution continue to be a challenge. The VP/CIO will continue to work with senior leadership to determine an affordable operational log management service level that meets the regulatory requirements and University policy.</td>
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</table>

**Total:**  3
The bar charts shown below are presented to provide pictorial displays of the progress units are making on implementing audit recommendations rated as "essential". The bar chart included in the original report is shown in the left column, along with updated bar charts showing the previous quarter and the current status of the "essential" recommendations only (those bars that have red segments). The chart in the center column displays the status as of February 2016, while the chart on the right represents the current status. Charts are not presented for investigations. Charts for those units having implemented all "essential" recommendations during the current quarter are shown at the end of this report.
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**UDM Athletics (October 2015)**

**No Previous Control Evaluation Chart**

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**Athletics Administration (December 2015)**

**No Previous Control Evaluation Chart**

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<th>Risk Assessment</th>
<th>Purchasing &amp; Disbursements</th>
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The icons represent the level of control:
- Green square: Adequate Control
- Yellow square: Significant Control Issue(s)
- Red square: Critical Control Issue(s)
Units with Charts that Fully Implemented their "Essential" Recommendations During the Past Quarter

Original Report Evaluation

Previous Quarter Evaluation

Current Quarter Evaluation

Travel & Employee Expense Reimbursement Process (May 2013)

Parking and Transportation Services (June 2014)
College of Design (January 2016)

NO PREVIOUS CONTROL EVALUATION CHART
Audit Activity Report

Scheduled Audits

- Completed audits of NCAA sport compliance (men’s and women’s basketball), OIT Database Administration, Law School, UMD College of Education and Human Service Professions (CEHSP), Department of Medicine, Athletics Finance and Operations, Masonic Cancer Center and the Department of Electrical and Computer Engineering. Details are shown on the following charts.

- Began/continued audits of: purchasing card program, vendor payment process, School of Dentistry, Office of Human Resources - OHR Operations, Payment Card Industry (PCI) compliance, Community University Health Care Center (CUHCC) and PeopleSoft IT General Controls and Governance.

Non-Scheduled Audits

- Continued a requested audit of UMD tuition waiver processes.
- Continued a review of international admissions processes.

Investigations

- Performed investigative work on six issues in accordance with the University Policy on Reporting and Addressing Concerns of Misconduct.

Special Projects

- Provided consulting services related to University payroll exception testing.
- Provided technology consulting in several areas including the University’s IT security policies and HIPAA security.
- Participated in a review of the institutional compliance program.
- Participated in a review of BioNet, the University’s centralized tissue procurement facility.
- Assisted Fairview with its audit of the AHC Information Exchange (AHC-IE)
- Reviewing TCF Stadium scheduling issues associated with Drum Corps International.

Other Audit Activities

- Participated in the following:
  - Senior Leadership Group
  - Operational Excellence Leadership Team
  - President's Policy Committee
  - Policy Advisory Committee
  - Board of Regents Policy Committee
  - Executive Compliance Oversight Committee
  - Institutional Conflict of Interest Committee
  - University of Minnesota Foundation Audit Committee
  - Fairview Health Systems Audit Committee
  - IT Leadership and Operational Excellence Committees
  - Use Case Categorization Scheme Committee
  - Senior Vice President Finance & Operations Search Committee
  - Standard Operating Procedures Advisory Committee
Audit Reports Issued Since February 2016

Operational and Compliance Audit - Basketball

The focus of this audit was on the activities of the Men's and Women's Basketball programs as well as the oversight provided by the Office of Athletic Compliance and Athletics Administration. Results of the audit work performed show a control environment and system of internal control that addresses most major business and compliance risks. Our review generated no recommendations for academic processes. However, improvement is needed in purchasing and disbursement processes, and greater emphasis needs to be placed on compliance with travel and expense policies, including the appropriate use of Enhancement funds. Athletics Human Resources processes including contract limitation monitoring, contract retention, and taxable benefits also need improvement.

OIT Database Administration

The OIT Database Team offers a professionally managed database service to the University community, and has a control environment that is generally effective and largely in alignment with recommended security configurations and University policy. Positive aspects of the Team’s control environment include: strong vulnerability monitoring, a highly-competent support staff, and some effective logging processes. However, a few of the OIT Database Team’s processes are still not in compliance with the University Information Security Policy and require further improvements to minimize risk to data confidentiality, integrity, and availability. Needed improvements include additional monitoring, authentication and access management controls. In addition, the Team needs additional backup and/or cross-trained staff.
Law School

<table>
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<tr>
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<th>Monitoring</th>
<th>Information &amp; Communication</th>
<th>Risk Assessment</th>
<th>Administration</th>
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Report # 1612 Issue Date May-16
# of Essential Recs. 8 Total # of Recs. 14
Overall Assessment Adequacy of MAP Needs Improvement Satisfactory

From the results of the audit work performed, we believe the Law School control environment and system of internal control needs improvement. The controls over payroll/human resources and disbursements need strengthening, and an assessment should be conducted to determine if the necessary resources have been allocated to these key functions. Law School has basic operational controls in place and information technology risks are mostly mitigated by some key operational controls on their most critical system, Clio. However, some information technology as well as compliance controls should be improved.

UMD College of Education and Human Service Professions (CEHSP)

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<th>Licensing / Accreditation</th>
<th>Cash Receipts / AR</th>
<th>Sponsored Projects</th>
<th>Payroll / HR</th>
<th>Purchasing / Disbursements</th>
<th>Safety / Minors</th>
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Report # 1613 Issue Date May-16
# of Essential Recs. 9 Total # of Recs. 33
Overall Assessment Adequacy of MAP Needs Improvement Satisfactory

Results of the audit work performed show that CEHSP has developed a control environment and system of internal control that addresses many major business and compliance risks. However, substantial improvement is needed to resolve risks related to information technology, and issues involving improving working relationships (particularly between the Dean’s Office and the Education department) and the overall work environment for the college need to be addressed.
Department of Medicine

Athletics Financial and Operational Review

This audit focused on Athletic contract oversight (Learfield, Nike, Verizon, Aramark), Athletics Ticket Office functions, payroll processes, purchasing processes, Athletics Facility billing procedures and Athletics Medicine procedures. From the results of the audit work performed, we believe Athletics needs to improve their control environment with an emphasis on oversight and procedures to address contract management and business processes. More attention is needed for Athletics to strengthen its foundation of compliance and control.
Masonic Cancer Center

Department of Electrical and Computer Engineering

Founded in 1991, The Masonic Cancer Center became a National Cancer Institute-designated comprehensive cancer center in 1998, one of only 45 in the US and two in Minnesota to hold that designation. From the results of the audit work performed, we believe the MCC has developed a control environment and a system of internal control that addresses most major business and compliance risks. MCC has basic operational controls in place; however, some compliance risks should be addressed related to clinical trial consent, salary cap compliance and IT change management processes.

Department of Electrical and Computer Engineering has developed a control environment and a system of internal control that addresses most major business and compliance risks. One of the essential recommendations addresses improvements needed in the oversight and monitoring of the relationship between the University of Minnesota Center for Electric Energy (UMCEE) and its industrial partners.
AGENDA ITEM:  Update on Human Participant Research Protection Implementation Plan

[ ] Review  [ ] Review + Action  [ ] Action  [X] Discussion

This is a report required by Board policy.

PRESENTERS:  Brian Herman, Vice President for Research

PURPOSE & KEY POINTS

The purpose of this item is to share and discuss progress made on the Board resolution, passed June 2015, related to the Human Participant Research Protection Program implementation plan. The work remains on schedule, and a detailed analysis of progress against the original external review panel recommendations is being maintained. Work areas remain engaged with key faculty stakeholders and consult their work broadly to ensure engagement and adoption of the changes.

On May 19, 2016, Vice President Brian Herman, Research, and Vice President Brooks Jackson, Health Sciences, testified before the Senate Higher Education Committee to respond to a report of the Office of the Legislative Auditor (OLA). The report indicated that the University, while engaged in a complex process, is making good progress. The OLA is encouraged by the work and the commitment of the faculty and staff involved in the process. It was noted that the work is on time and on target. The full audit report is available online HERE.

Progress since the May committee meeting is as follows:

- The Engaging Research Participant work group is drafting the work area’s final report, which adopts a systems approach, identifying expectations of researchers in engaging participants and the public as well as evaluating participant and public responses related to research. Work group recommendations focus on the informed consent process documents and the ongoing engagement of research participants. The work group is in the process of finalizing participant contact cards for study coordinators to give to participants and their family members at each visit, and a participant feedback survey that will provide real-time feedback and trends about participants’ experience to University leadership, the Community Oversight Board (COB) and the public. Feedback from participants and the public, primarily through the survey, will also help inform education and training for investigators and their study teams. The work group is also finalizing recommendations about the dissemination of research results to participants and the broader public.
The Community Oversight Board (COB) held its second quarterly meeting on May 12, 2016. Key agenda items included the Compass Point Report, the Department of Psychiatry Assessment Report and CTSI Management Plan, and the composition of the board.

Progress continues through changes to the IRB (Institutional Review Board) structure and process improvements. IRB member assignments for four of the eight planned biomedical panels are final and will start in July. Additional member orientation meetings and training sessions were held in May.

Revised policies, standard operating procedures, an education and training proposal and an investigator guide are under review regarding participants with impaired or fluctuating capacity to consent. These were developed in consultation with the Center for Bioethics and the University’s external advisor.

As always, a blog update will be published to accompany submission of this report for those who sign up for regular updates. The University continues to monitor emails at advancehrp@umn.edu for any additional feedback.

The dashboard included in the docket shows the full scope of work and this month’s updated status of each item. For complete details, go HERE.

BACKGROUND INFORMATION

On February 23, 2015, an external review panel issued a report containing 63 recommendations for improving the human subjects protection program at the University. The language of that report was strong in its statement that while the current program is in many respects adequate, the University must make changes if it wishes to have a leading program in human subjects protection. The external panel’s report is available here.

On March 12, 2015, President Kaler charged Brian Herman, Vice President for Research, and Brooks Jackson, Vice President for Health Sciences, with oversight of the implementation of the recommendations of an external review panel by establishing an Implementation Team (Team) of internal and external individuals with the qualifications and expertise to review the recommendations and develop a plan to implement them. At its March 2015 meeting, the Board approved immediate and longer-term action plans to implement the recommendations.

The Team was chaired by Dr. William Tremaine, Professor of Medicine, Mayo Clinic and Director, Mayo Clinic IRB. During the time of the Team’s work, two additional reports were made available: 1) a May 5, 2015 draft report from the Office of the Legislative Auditor, which presented findings from all industry-sponsored studies at the University from 2004-2014; and 2) Final IRB Investigation Report Into Fairview Concerns Regarding Psychiatry Research Studies at the University of Minnesota, referred to as the “Oakes report.” Team members considered the information from these reports in their recommendations. Report #2 above is publically available on the Advancing Human Subjects Research website.

The Team submitted a draft report to President Kaler on May 15, 2015. This report was made available for public comment on May 18, 2015; the comment period closed on June 1, 2015.

The report recommended significant and disruptive changes to the University’s human participant research protection program. These changes are intended to cultivate a culture of ethics, ensuring the primacy of the University and each investigator’s duty to keep the well-being of patients who become research participants at the center of policies and procedures, while ensuring the institution’s commitment to clinical research and the faculty.
Key components of the report were:

- Cultivating a culture of ethics
- Strengthening Institutional Review Board (IRB) membership and review process
- Scientific review
- Post-approval monitoring
- For-cause investigation
- Research with subjects who have impaired or fluctuating capacity to consent
- Department of Psychiatry
- Engaging research subjects
- Education and training of investigators
- Accounting metrics
- Managing Conflicts of Interest
- Community Oversight Board
- External advisor
- Required resources

The Team received over 60 comments to the draft report. The comments reflected concerns about undue burden and the proposed policy change regarding Conflict of Interest; suggestions for community engagement; concerns about changes to scientific review; and questions about the applicability to the Social and Behavioral IRB. The final report reflects those submissions.

At its June 2015 meeting, the Board reviewed and discussed the final work plan’s key recommendations and passed a resolution endorsing the final work plan. The Board also stated it would take an active role in providing ongoing oversight and monitoring of these activities by receiving regular progress reports through its Audit Committee at each of the committee’s meetings until the work plan has been fully implemented. Those progress reports are online at the Advancing HRP website.

At its September 2015 meeting, the Audit & Compliance Committee received an update about several recommendations from the external review and implementation plan that had been addressed and reported to the Regents and the Legislature over the summer. Those items included:

- Establishment of the Fairview University Research Oversight Committee (FUROC)
- Retaining an external advisor (Dr. David Strauss) from the external advisory panel to assess progress on the original recommendations
- Outsourcing review of Psychiatry clinical trials
- Hiring Compass Point to randomly review 100 psychiatric trials
- IRB meeting changes: quorum, number of meetings, number of protocol reviews per meeting
- Policy change: 72-hour hold practice

The December 2015 Audit & Compliance Committee meeting included updates from Vice President for Research Brian Herman; Professor Steve Miles; and Lynn Zentner, Director of the Office of Internal Compliance.

Continued monthly reporting to the Legislature included updates about:

- Status of IRB Membership, Research Compliance Office and For Cause Investigations final deliverables including review by David Strauss, external reviewer for the implementation.
- Development of four medical IRB rosters and nominees to serve.
• Updates about a more stringent Conflict of Interest policy and broad consultation of the changes.
• A national conference on December 2, 2015, hosted by the University’s Consortium on Law and Values entitled “Research with Human Participants.”
• Research Compliance Office structure and operations that became effective on October 2, 2015.
• Appointment of a new Community Oversight Board chair, Paul Mattessich.
• Development of new coursework by the Center for Bioethics that includes standards for research with human participants and the hiring of a new education and outreach specialist for researchers and IRB member training and communications.

At the February 2016 meeting, Paul Mattessich, Executive Director of Wilder Research and Chair of the Community Oversight Board, was introduced to the committee and discussed implementation of the new COB board. The following updates were also covered:

• The Clinical and Translational Science Institute (CTSI) continuing its evaluation of the Department of Psychiatry and has begun a gap analysis and curriculum design plan for human participation research training and education at the University in collaboration with the OVPR, IRB, and Center for Bioethics.
• Presented the results of a recent external consultant’s review of the Department of Psychiatry. CTSI hired the consultant to assess the status of clinical trials in the department early last fall and assist in developing a management plan. The consultant’s final report was received in January and made observations similar to previous reports on this topic. To address those observations, the University has increased monitoring of clinical research in the department, including assisting faculty in understanding and using GCP guidelines, and is moving forward on transferring the management of this clinical research to CTSI.
• HRPP beginning the first phase of implementing an electronic IRB. The eIRB, when fully implemented, will speed up reviews for researchers, add capacity, and ensure proper documentation.
• Continued consultation of the Conflict of Interest policy changes. This policy will be voted on at the April 2016 University Faculty Senate meeting.
• Plans to make the successful December conference entitled “Research with Human Participants” an annual event.
• The Scientific Review submitting their final report and move forward to discontinue departmental review and create a process in the Human Research Protection Program (HRPP) for this review, eliminating real or perceived conflict.
• Recruiting of membership for the Community Oversight Board. The board is diverse with members representing health care providers, patient advocates, the State, the University and the non-profit community.

At the May 2016 meeting, a full list of all the accomplishments since the June 2015 Board resolution was provided. The updates included the following:

**Department of Psychiatry**

• New department head, Dr. Sophia Vinogradov, starts July 31, 2016 and is already engaging with the University community.
• Department faculty have adopted new policies: requiring Good Clinical Practice (GCP) standards for all studies, implementation of a new checklist to ensure better collaboration with clinical staff, and a requirement that a treating clinician of a potential study participant cannot be involved in consent for a research study.
• The department has endorsed Clinical and Translational Science Institute (CTSI) management of all clinical trials and begun that transition.
A full-time CTSI research project manager, already embedded in Psychiatry, is working with investigators on all aspects of design and execution of clinical trials.

New accountability standards require that any problems identified with studies and not quickly corrected by the Principal Investigator are reported to the department head and then, if still not corrected, to the Vice Presidents of Health Sciences and Research.

The department continues to work with the Center on Bioethics on recruitment and other ethical issues.

**Internal Review Board (IRB)**
- Reconstituted to form eight medical committees, broadened membership to ensure adequate expertise, and implemented compensation for faculty participants.
- Revised the format of meeting minutes to ensure adequate documentation.
- Reviewed best practices of peer organizations.
- Began implementation of an electronic IRB to ensure better and faster review of study protocols.
- New monitors have been hired through the Post Approval Review function to increase and improve PAR monitoring.
- All psychiatric interventional drug trials were suspended and re-reviewed by an external IRB. Quorum IRB continues as the IRB of record for these trials.
- Implemented a policy stating the University will not recruit individuals or patients on a 72-hour hold.
- An external consulting firm, Compass Point Research, submitted a final report of their independent review of close to 100 IRB protocols for active studies. Overall, the report indicates that the University does not have a systemic issue with the conduct of clinical research.

**New Oversight Structure**
- Research Compliance Office (RCO) – Effective as of October 2015, RCO has responsibility for conducting for-cause investigations to ensure separation from the IRB.
- Fairview University Research Oversight Committee (FUROC) – This committee is composed of leaders of the University and Fairview Health Services to ensure better communication about and oversight of research in Fairview facilities and involving Fairview patients and staff. The committee is co-chair by Brooks Jackson, Vice President of Health Sciences and Dean of the Medical School, and Beth Thomas, Chief Medical Officer of Fairview.
- Community Oversight Board (COB) – The COB was created to allow greater community input into research involving human participants at the University on ethics, community engagement, policies, communication and dissemination of research finding. The board is chaired by Paul Mattessich of Wilder Research and has a diverse membership representing health care providers, patient advocates, the University, the non-profit community.
- External Advisor – Dr. David Strauss continues reviewing progress with each work team and spent time on campus in March consulting and discussing accomplishments.

**Education and Training**
- New “best clinical practices” training is in final stages of development and will be required in the Department of Psychiatry starting this summer.
- Needs assessment and gap analysis on Human Research Protections and Ethics training complete
- New model for human research protection education coordination and enforcement approved
Culture

- Convened a national conference in December 2015 entitled, “Research with Human Participants: The National Debates.” This will be an annual event and include an educational component.
- Created language describing the University’s core ethical commitments. This statement is being discussed and published throughout the University, particularly within clinical and research units.
## June 2016 Progress Dashboard

<table>
<thead>
<tr>
<th>Work plan Section</th>
<th>Status</th>
<th>Lead</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IRB Membership</strong></td>
<td>✓</td>
<td>Billings, Biros</td>
<td>Recruit membership; Form new committees; restructure biomedical; target membership to accurately reflect protocol submission; Set compensation structure and policy for medical and nonmedical IRBs</td>
</tr>
<tr>
<td><strong>FUROC</strong></td>
<td>✓</td>
<td>Herman</td>
<td>U establish committee jointly with Fairview</td>
</tr>
<tr>
<td><strong>For-Cause Investigations</strong></td>
<td>✓</td>
<td>Webb</td>
<td>Establish Research Compliance Office (RCO); Transition For Cause Investigations to RCO; establish more robust procedures specific to complainant and adverse event reporting</td>
</tr>
<tr>
<td><strong>Community Oversight Board</strong></td>
<td>✓</td>
<td>Herman</td>
<td>Establish board structure and guidelines; Finalize membership; appoint chair; Invite members; convene first meeting</td>
</tr>
<tr>
<td><strong>External Advisor</strong></td>
<td>✓</td>
<td>Herman</td>
<td>Hire external advisor (external review panel member); 2015 AAHRPP Accreditation; Compass Point compliance review.</td>
</tr>
<tr>
<td><strong>Scientific Review of Studies</strong></td>
<td>✓</td>
<td>Billings, Biros</td>
<td>Eliminate department reviews and move to Human Research Protection Program (HRPP) office; Define a new IRB process and policy in consultation with other required scientific reviews</td>
</tr>
<tr>
<td><strong>Cultivating a Culture of Ethics</strong></td>
<td>O</td>
<td>Aronson, Zentner, Wolf</td>
<td>Create language explaining the University’s commitment to research participant protection; Clear statements on key websites; Host a campus conversation or other forum on human research participant protection; Regular benchmark our program against our peers</td>
</tr>
<tr>
<td><strong>IRB Protocol Review Process</strong></td>
<td>O</td>
<td>Dykhuis</td>
<td>Implement new eIRB technology – IRB Renew; Implement Huron Toolkit IRB forms and procedures; Add new FTEs; Complete benchmarking visits</td>
</tr>
<tr>
<td><strong>Monitoring of Studies</strong></td>
<td>O</td>
<td>Dykhuis</td>
<td>New post-approval review FTEs; Reengineer post approval review function; Includes work with Compass Point to further refine methodology.</td>
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<tr>
<td><strong>Human Research Participants Who Have Impaired or Fluctuating</strong></td>
<td>O</td>
<td>Miles</td>
<td>Implement tool to assess capacity</td>
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<td>Work plan Section</td>
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<tr>
<td>Capacity to Consent</td>
<td>O</td>
<td>Dykuis</td>
<td>Implement LAR policy changes</td>
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<td>Implement 72-hour hold policy</td>
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<tr>
<td>Department of Psychiatry</td>
<td>O</td>
<td>Paller</td>
<td>Transition to Clinical &amp; Translational Science Institute (CTSI) management of trials</td>
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<td>Engage consultant for climate assessment plan. Enhance culture of inclusion and mutual trust.</td>
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<td>Engaging Research Participants</td>
<td>O</td>
<td>Eder</td>
<td>Create a research participant satisfaction survey and a plan to collect and analyze data</td>
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<td>Revise IRB forms to include a section expressing appreciation and a plan for sharing research results</td>
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<td>Create and publicize mechanisms for participants and families to provide confidential feedback and report concerns, develop a small handout</td>
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<td>Create and publicize procedures for handling concerns and for notifying reporter when they have been handled</td>
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<td>Create position of Community Liaison officer</td>
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<td>Create link to Community Oversight Board</td>
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<tr>
<td>Education and Training of Investigators</td>
<td>O</td>
<td>Ingbar, Schacker</td>
<td>Integrate and coordinate human research protection training</td>
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<td>Curriculum development</td>
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<td>Training delivery</td>
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<tr>
<td>Accountability Metrics</td>
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<td>Waldemar</td>
<td>Track and report accountability metrics</td>
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<tr>
<td>Conflict of Interest</td>
<td>O</td>
<td>Durfee</td>
<td>Implement updated COI policy</td>
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√ = Completed
O = In Progress/some items completed
✖ = Not Started

For more details see about progress and alignment with the external review panel recommendations, see the Advancing HRP website.
AGENDA ITEM: Information Items

☐ Review  ☑ Review + Action  ☐ Action  ☑ Discussion

This is a report required by Board policy.

PRESENTERS: Gail Klatt, Associate Vice President

PURPOSE & KEY POINTS

The purpose of this item is to present the semi-annual Controller's Report. This report provides information on recent activities in University financial operations that have strengthened financial reporting, enhanced internal controls, improved the management of financial risks, provided better services to the University community, and maximized the institution's financial resources.

Highlights include:

- A discussion of new accounting standards that will be adopted by the University for fiscal years 2016, 2017 and 2018, and the likely impact on the University's annual audited financial reports (if known).
- Results of a credit card data security (PCI DSS) compliance report that was recently issued by a third-party assessor.
- Changes being made to the University's property insurance program, and an estimate of the cost savings.
- Changes put in place for physical inventory of the University's capital equipment assets, with the estimated cost savings.
- A brief summary of the support being provided by the Controller's Office to the Athletics Financial Oversight Committee.

BACKGROUND INFORMATION

This report presents a summary of activities completed by the Controller’s Office in the last six months to assess and implement new accounting and reporting standards, enhance internal controls, better manage financial risks, improve services to the University community, and maximize the institution’s financial resources and financial operations.

I. Accounting and Financial Reporting Matters

The Governmental Accounting Standards Board (GASB) has issued three new accounting and reporting standards that will be effective for fiscal year 2016. The following provides a brief summary of each new standard, and where known, the likely impact.

New standards effective for FY 2016

- In February 2015, the GASB issued Statement No. 72, *Fair Value Measurement and Application*, addresses accounting and financial reporting issues related to fair value measurements. It will require measurement of certain assets and liabilities at fair value using a consistent and more detailed definition of fair value and accepted valuation techniques, as well as provide guidance towards the enhancement of related disclosures to all fair value measurements.

  At this time, the impact for the University will be a restatement of prior fiscal years presented (FY14 and FY15) for the change in accounting principle, resulting in the reclassification of certain investments (e.g., income-producing patents) to another asset classification based on the revised definition of an investment in GASB 72. Also, new fair value disclosures will be presented, including the fair value hierarchy classification of investments (e.g., Level 1, Level 2, and Level 3) and associated values, as well as private equities and hedge fund investments that are valued at NAV (net asset value per share).

- In June 2015, the GASB issued Statement No. 73 (GASB 73), *Accounting and Financial Reporting for Pensions and Related Assets That Are Not within the Scope of GASB Statement 68 (GASB 68), and Amendments to Certain Provisions of GASB Statements 67 (GASB 67) and 68*, establishes requirements for defined benefit pensions that were not within the scope of GASB 68, as well as for the assets accumulated for purposes of providing those pensions. In addition, it establishes requirements for defined contribution pensions that are not within the scope of GASB 68. The provisions of GASB 73 are effective for fiscal year ending June 30, 2016, except those provisions that address employers and governmental non-employer contributing entities for pensions that are not within the scope of GASB 68, which are effective for fiscal year ending June 30, 2017. At this time, management is not anticipating GASB 73 to have a material impact to the University’s financial statements.
In June 2015, the GASB issued Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*, which supersedes an existing standard (GASB 55) and amends another existing standard (GASB 62). GASB 76 will result in a reduction of the generally accepted accounting principles (GAAP) hierarchy to two categories of authoritative GAAP, and will address the use of authoritative and non-authoritative literature in the event that the accounting treatment for a transaction or other event is not specified within a source of authoritative GAAP. At this time, we expect there will be no impact on the University’s financial statements, as the University’s practice for applying accounting and financial reporting treatment already fits within the hierarchy of GAAP prescribed by GASB 76.

In December 2015, the GASB issued Statement No. 79 (GASB 79), *Certain External Investment Pools and Pool Participants*, which establishes criteria for an external investment pool to qualify for making the election to measure all of its investments at amortized cost for financial reporting purposes versus reporting at fair value. Additional footnote disclosures would be required if reported at amortized cost, including information about any limitations or restrictions on participant withdrawals. Certain provisions of GASB 79 are effective for fiscal year ending June 30, 2016, with the remaining provisions effective for the fiscal year ending June 30, 2017.

**New standards effective for FY 2017**

- In June 2015, the GASB issued Statement No. 74 (GASB 74), *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans (OPEB)*, which replaces the requirements of existing standards (GASB 25, 43, 50, and 57). The requirements of GASB 74 will improve financial reporting primarily through enhanced note disclosures and schedules of required supplementary information that will be presented by OPEB plans that are administered through trusts that meet the specified criteria. It also includes requirements to address financial reporting for assets accumulated for purposes of providing OPEB through defined benefit OPEB plans that are not administered through trusts or equivalent arrangements. The University has not yet begun analyzing the impact of this standard to our financial statements.

- In December 2015, the GASB issued Statement No. 78 (GASB 78), *Pensions Provided through Certain Multiple-Employer Defined Benefit Pension Plans*, which amends the scope and applicability of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions—an amendment of GASB Statement No. 27*, to exclude pensions provided to employees of state or local governmental employers through a cost-sharing multiple-employer defined benefit pension plan that meet certain criteria. For applicable pensions, GASB 78 establishes the requirements for recognition and measurement of pension expense, liabilities, note disclosures, and required supplementary information for these plans. This statement is effective for the fiscal year ending June 30, 2017.

- In January 2016, the GASB issued Statement No. 80 (GASB 80), *Blending Requirements for Certain Component Units—an amendment of GASB Statement No. 14*, which amends the blending requirements for the financial statement presentation of component units established in GASB Statement No. 14, *The Financial Reporting Entity, as amended*. The additional criterion requires blending of a component unit incorporated as a not-for-profit corporation in which the University would be a sole corporate member. This statement is effective for the fiscal year ending June 30, 2017.
In March 2016, the GASB issued Statement No. 82 (GASB 82), *Pension Issues—an amendment of GASB Statements No. 67, No. 68, and No. 73*, addresses issues related to three areas: 1) presentation of payroll-related measures in required supplementary information; 2) selection of assumptions and treatment of deviations from guidance in an Actuarial Standard of Practice for financial reporting purposes; and 3) classification of payments made by employers to satisfy employee (plan member) contributions requirements. The provisions related to areas #1 (payroll related measures) and #3 (classification of payments related to required contributions) are effective for fiscal year ending June 30, 2017, and area #2 (actuarial assumptions) are effective for the fiscal year ending June 30, 2018.

**New standards effective for FY 2018**

- In June 2015, the GASB issued Statement No. 75 (GASB 75), *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*, which replaces the requirements of two existing standards (GASB 45 and 57). It establishes new accounting and financial reporting requirements for governments whose employees are provided with OPEB, as well as for certain nonemployer governments that have a legal obligation to provide financial support for OPEB provided to the employees of other entities. This statement is effective for the fiscal year ending June 30, 2018.

- In March 2016, the GASB issued Statement No. 81 (GASB 81), *Irrevocable Split-Interest Agreements*, requires that if the University receives resources from an irrevocable split-interest agreement (type of giving agreement used by donors to provide resources to two or more beneficiaries) to recognize assets, liabilities, and deferred inflows of resources at the inception of the agreement. The University would also be required to recognize assets representing beneficial interests in such agreements when administered by a third-party if the University controls the present service capacity of the beneficial interests. This statement is effective for the fiscal year ending June 30, 2018.

**II. Activities to enhance internal controls, better manage financial risks, reduce costs, and improve services to the University community**

**Payment Card Program and Payment Card Industry Data Security Standards (PCI DSS) Compliance**

The University accepts payment cards (Visa, MasterCard, Discover and American Express) for payment of goods and services. On an annual basis, 110 departments at the University collectively process 3,150,000 transactions for a total of approximately $145,000,000 in annual revenue. A variety of processes are used including swipe terminal, mobile cellular terminal, e-Commerce/Internet, and point-of-sale systems. The ability to accept payment cards is a valuable tool for University Departments, but it also creates risk for the University. Payment card information represent valuable information that can be exploited for the purpose of creating fraudulent transactions or identity theft.

Payment card accounts are mainly governed by the contracts the University has with its banks and the card brands (e.g. VISA, Mastercard, American Express). These contracts require that the University handle and process the transactions in a prescribed manner, and they require compliance with the Payment Card Industry Data Security Standards (PCI DSS). The PCI DSS is a security standard...
developed and owned by the major payment card companies to help ensure the safe handling of sensitive information.

Merchants are required to comply with all PCI DSS requirements at all times, but the method of validating compliance varies by card brand and number of transactions processed. In late 2012, the University’s acquiring bank, Wells Fargo Merchant Services, clarified that for purposes of PCI DSS validation, the University is one entity, and based on the number of transactions processed annually, is considered a Level 2 merchant.

With the change in classification, the University is required to validate compliance as one entity using an external security assessor who is certified, or “qualified” by the PCI Security Standards Council. This Qualified Security Assessor (QSA) completes an annual on-site assessment of the University’s compliance with the PCI DSS requirements.

Assessments conducted in previous years identified areas in which departments and the University were not in compliance with PCI DSS. Individual merchants, Accounts Receivable Services, University Information Security, and OIT Service areas worked through remediation of findings that were identified in these assessments.

Through the remediation process, departments have:
- changed business processes to no longer accept mail, telephone or fax orders;
- changed business processes to use secure swipe terminals rather than less secure laptop or desktop computers;
- switched to enterprise solutions in lieu of an individual department system and merchant account;
- implemented technology that encrypts the credit card number at the swipe. These departments include most of the high-volume units including Athletics, Tickets and Events, Student Unions, Twin Cities Bookstores, UMD Stores, and UMD Dining Services. This has the effect of lowering the risk of processing payment card transactions and reducing the scope of systems and network components subject to PCI DSS review.

To meet a training requirement, the University began using security awareness training from SANS Institute called Securing the Human.

The University’s most recent assessment was conducted the week of January 25, 2016. The completed report was received in March 2016. This Report on Compliance showed all PCI DSS requirements to be in place or N/A. While this is an important achievement to be recognized, it is only one milestone in the life of the University’s payment card and compliance program and it is no guarantee that a breach will not occur. Compliance with PCI DSS is an everyday task. Threats, technology, and the requirements themselves are continually changing and the University and departments that accept payment cards must stay vigilant in order to minimize the risk of data breach and its associated costs.

Other payment card activities implemented within the last year include a terminal loan program, rollout of EMV (chip) capable terminals, and terminal destruction program.

A terminal loan program was implemented in FY2016. Departments may borrow a swipe terminal for one-time or short-term events. This provides the ability for departments to accept credit/debit
card payments, eliminates the need to establish a separate merchant account, and reduces the compliance burden on the department.

EMV, which stands for EuroPay MasterCard Visa, refers to an imbedded chip in consumer credit and debit cards. This is a more secure way to process transactions versus the magnetic stripe which contains static data and is easy to reproduce for fraudulent use. Along with this change in technology comes a change in merchant liability. As of October 1, 2015, if a customer presents an EMV chip card and it is not properly processed with EMV-capable equipment, the merchant may be liable for the loss in the event of card-present fraud. Departments utilizing swipe terminals reviewed their equipment and card processing methods and replaced outdated equipment.

A terminal destruction program was also implemented in FY2016. As departments upgraded payment card terminals, they turned in obsolete terminals for secure destruction. Over 75 terminals have been securely destroyed as they were replaced with EMV (chip) capable terminals. Over $1,000 in monthly rental fees have been eliminated as merchants completed a review of their equipment.

These payment card activities have provided enhanced controls, assisted the University in keeping pace with changing technologies and helped manage costs to departments, while enabling those units to generate external sales activity as a means to supplement University revenues.

**Property Insurance Program Cost Savings**

For many years, the University has purchased its property insurance through a consortium buying program offered by the Midwest Higher Education Compact (MHEC). MHEC is a quasi-public entity, created by joint compact among 12 midwestern states, including Minnesota. Over the years, the cost of property insurance through MHEC has experienced volatility, due to the University’s unique loss experience and the formulas MHEC uses to allocate premiums among the 40 or 50 higher education institutions that purchase through the consortium. This past year, the Office of Risk Management and Insurance proposed evaluating other options in the commercial insurance market for coverage. Based on that process, the University determined a 3 year contract with FM Global for property insurance is more cost-effective than the MHEC program.

Highlights of the new policy include the following:

- A three year policy, effective June 29, 2016.
- Annual premium savings for FY 17 of $800,000 - $1,100,000, compared to MHEC's announced premiums for FY 17.
- A guarantee of flat premium rates for the 3 year contract (rates are measured in cost per $100 of insured property value). Premiums will be adjusted for changes in property values.
- An additional 5% discount applied to FY 18 premiums, if coverage is entered into by June 29, 2016. This credit should offset much of the expected valuation increases for next year.
- An increase in overall property coverage, from $1.75 billion to $2 billion.
- A more advantageous deductible structure, which should save the University several hundred thousand dollars in years that have adverse claims experience.
Capital Equipment Inventory Process Savings

Regulations related to the University’s federal funding require the University to perform biennial physical inventories of all capitalized equipment. In the past 4 years the Controller’s Office has made changes to capitalization and accounting practices, which has reduced the number of capital assets requiring inventory by approximately 33,000 items (48%). Recognizing that this reduction would have the potential for significant process improvements and cost reductions, the Controller’s Office conducted an analysis of options and determined that it would be most cost-effective to contract with a third party for future capital asset inventory services. Effective July 1, 2016, the University has entered into a 4 year contract with HCA to perform capital asset inventories. The expected cost savings from this new arrangement are estimated to be approximately $201,000 for each two-year inventory cycle.

Athletics Financial Oversight

The University Controller is a member of the Athletics Financial Oversight Committee, which is providing oversight during the resolution of audit recommendations stemming from the December, 2015 internal audit report on Athletics finances. The Controller’s Office has committed significant talent and resources to support those efforts. Some examples of the support being provided are:

- Purchasing staff have been deployed to assist in developing and delivering travel and hospitality training to Athletics staff.
- Controller’s Office staff are assigned to revise travel and hospitality policies and procedures in ways that address gray areas or policy “pain points”.
- Business analyst support has been provided to assist Athletics with some technology needs, which will address weaknesses in their financial reporting for NCAA and EADA purposes.
- The University Controller is working with a group of finance professionals across the institution in the development of a certification process, to strengthen the dotted-line relationship between the University’s CFO and chief financial managers across the institution.