

UNIVERSITY OF MICHIGAN

REGENTS COMMUNICATION

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Regents

November 20, 2014

Item for Information

Subject: Report of University Internal Audits

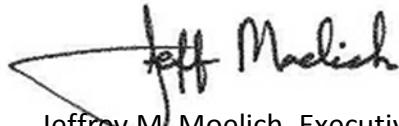
Attached is the report of activities completed by the Office of University Audits for the period **July 2 through September 30, 2014.**

Included in the report are a:

- Summary of each audit report issued during the period, including Management's Corrective Action Plans. These audits were presented at the Regents' Finance, Audit, and Investment committee meeting in October.
- Summary of each follow-up review memo issued during the period, including the actions completed by management. Follow-up reviews are designed to provide assurance that Management's Corrective Action Plans have been implemented, are working as intended, and are sustainable.
- Table of open audit issues as of **September 30, 2014**, including estimated completion dates.

If you have any questions or would like additional information, please contact me at 647-7500 or by e-mail at jmoelich@umich.edu.

Respectfully submitted,



Jeffrey M. Moelich, Executive Director
University Audits



Board of Regents

Internal Audit Reports – July 3 through September 30, 2014

November 20, 2014

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Reports Issued

Administrative Services Transformation Shared Services Vendor Selection and Payment

2014-812

Report issued July 2014

A. Executive Summary

1. Overall Conclusion

We did not identify any evidence of bias or personal gain on the part of any U-M employees involved in selection of The Hackett Group or Accenture LLP as consultants to the Administrative Services Transformation Shared Services project (“AST,” “Shared Services” or the “Project”). Though we did find that University requirements were not followed in all instances.

We did not find any evidence that the former Associate Vice President for Finance, a partner at Accenture prior to joining the University, exerted undue influence or otherwise directed the selection of Accenture. In response to questions from University Audits, Accenture and Hackett Group executives responsible for leading the consulting work at U-M stated that no incentive payments or other items of personal benefit were provided to anyone employed by or associated with the University of Michigan Shared Services project. The executives clearly indicated such payments are strictly prohibited by both firms’ business codes of conduct. We also verified that incentive and other compensation payments paid by U-M to certain Business and Finance executives responsible for the AST Shared Services project were properly authorized and were not tied to AST project decisions or outcomes.

In conjunction with our review, University Audits identified several opportunities for improvement:

- Transparency and disclosure of additional project work outside the original competitively bid scope of work
- Documentation of management plans for potential conflict of interest and conflict of commitment situations
- Clarification of the Executive Vice President and Chief Financial Officer’s (EVPCFO) delegation of authority related to procurement contracts and amendments
- Timely disclosure, via the Board of Regents reporting mechanism, of non-competitive purchase awards

2. Context and Key Risk Considerations

Administrative Services Transformation Background

During the economic downturn of 2009, former Provost Sullivan established several task forces to develop recommendations on ways the University could position itself to deal

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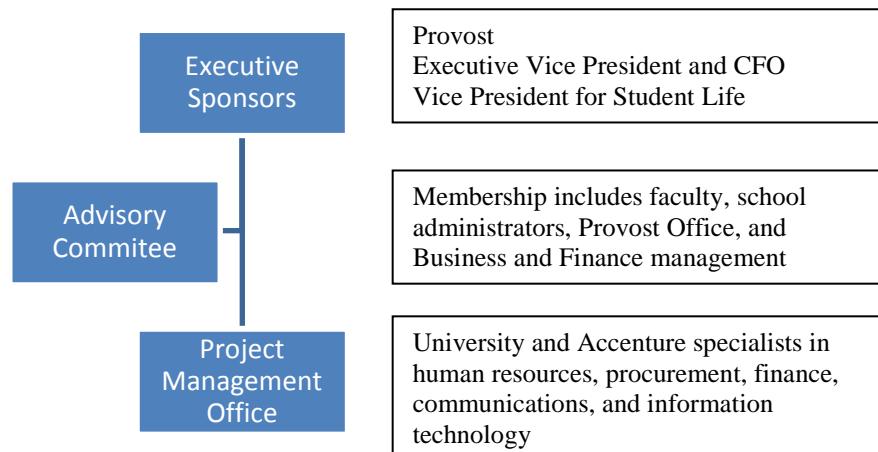
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with increasing financial challenges. Task force recommendations were used to shape long-term University-wide cost reduction and revenue enhancement plans.

In the fall of 2009, the University hired The Hackett Group to conduct a benchmarking study of select administrative areas. The study sought to compare U-M staffing levels and total cost of administrative services for central units, schools, and business units against peer institutions. The benchmarking study was completed in the spring of 2010. As a result of the benchmarking study and task force recommendations, the University decided to pursue an administrative services transformation strategy for certain finance and human resources activities.

In the fall of 2010, the University established an AST sourcing committee comprised of representatives from Procurement Services, Human Resources, Information and Technology Services, Finance, and the Office of the Provost. The committee requested proposals to evaluate opportunities to improve certain administrative service operations from qualified management consulting firms. The work was bid in two sections, one for strategic sourcing consulting and one for shared services consulting. No one individual made the vendor selection decision; the selections were based on the committee consensus evaluation and recommendations to the Executive Sponsors. Accenture LLP was awarded the contract for the shared services consulting, which included the business case and implementation roadmap (phase 1), project design (phase 2), and project implementation (phase 3). Global eProcure was awarded the strategic sourcing contract.

AST Project Organization



The AST Advisory Committee is charged with 1) reviewing planned future state process and organization models for the delivery of finance and human resource initiatives; 2) providing guidance to the project team and consultants throughout the design phase; and 3) providing input on the continuing assessment and implementation of strategic sourcing initiatives.

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Accenture and Hackett Group Consulting Activities

The tables below show the consulting contract awards and amounts invoiced by Accenture and The Hackett Group related to AST and other projects over the past five years.

Services	Dates	Contract Amount	Total Invoiced Through 4/28/2014
The Hackett Group			
Hackett Administrative Benchmarking	8/3/2009-1/31/2010	\$292,000	\$298,463
Accenture			
AST Shared Services Center - Master Contract	2/1/2011 - 4/28/2014	\$526,340	\$526,340
AST - Communication with Stakeholders (change order 3)		\$49,501	\$49,501
AST - Design of Shared Service Center (change order 5)		\$1,544,789	\$1,544,789
AST- Implementation of Shared Service Center (change order 6)		\$10,184,855	\$6,528,683
<i>Subtotal, AST- Shared Service Center Original Scope</i>		<i>\$12,305,485</i>	<i>\$8,649,313</i>
Health Plan Negotiation Analysis (change order 1)		\$88,300	\$88,300
Analysis of Accounts Payable (change order 2)		\$210,824	\$210,804
Improvements for Fleming Shared Service Center (change order 4)		\$49,764	\$49,764
Design ServiceNow Tool Phases (change order 7)		\$78,648	\$76,953
ServiceNow Tool Mapping (change order 8)		\$580,848	\$304,140
<i>Subtotal, AST Contract Spend</i>		<i>\$13,313,869</i>	<i>\$9,379,274</i>
IT Rationalization	2/4/2010-1/31/2013	\$9,833,474	\$9,143,682
UMHS Financial System (Hyperion)	9/13/2010-8/31/2011	\$1,320,873	\$1,324,312
UMHS Epic System Implementation	Time and materials per agreed rate schedule		\$437,132
<i>Subtotal, Non AST Projects</i>		<i>\$11,154,347</i>	<i>\$10,905,126</i>
Total for all Accenture Projects		\$24,468,216	\$20,284,400

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Procurement Policies and Procedures

Procurement Services provides University procurement oversight and ensures purchases are made in accordance with all applicable Regental By-laws, and federal and state regulations. Procurement Services is charged with maintaining an open and competitive process for procurement of goods and services. They also administer expenditures of all University funds for goods and services in conformance with University policies and procedures.

University Reporting Relationships

The Director of Procurement Services reports to the Associate Vice President (AVP) for Finance, who in turn reports to the Executive Vice President and Chief Financial Officer (EVPCFO). Other direct reports to the EVPCFO are the Chief Investment Officer, AVP for Facilities and Operations, AVP and Chief Human Resources Officer, Senior Advisor to the EVPCFO, and AVP and Chief Information Officer. The EVPCFO leads the Business and Finance function and reports to the University President.

Applicable U-M Procurement Policies

- University policy requires all goods and services over \$5,000 be competitively bid to ensure favorable terms, pricing, and service delivery. Single or sole sourcing should only occur under exceptional and limited circumstances, and must be approved in advance by Procurement Services.
- The authority to sign documents or bind the University to commit funds for goods and services, including consulting agreements, is granted by the Board of Regents to the EVPCFO. The EVPCFO in turn has delegated authority to the AVP for Finance, who in turn has delegated authority to the Director of Procurement Services. Procurement Services is the agent authorized to make commitments against University funds for these purposes.
- It is the responsibility of each faculty and staff member of the University, as well as Procurement Services, to assure that the University does not knowingly enter into any purchase commitment that could result in a conflict of interest situation. Care must be taken to avoid the intent or appearance of unethical or compromising practice in relationships, actions, and communications.
- Before vendor payments are made, knowledgeable management must verify that goods and services have been received and are acceptable, invoice pricing is consistent with contract terms, and the transaction is correctly recorded in the financial system.

3. Audit Objectives

The former Executive Vice President and Chief Financial Officer requested that University Audits perform a limited review and evaluation of the Administrative Services Transformation Shared Services vendor selection and contracting process.

The objectives were to perform a limited scope review to determine whether the vendor selection, contracting, and payment of consultants for the AST Shared Services

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project followed established University requirements.

4. Audit Scope and Identified Risks

The scope of the audit did not include the strategic sourcing portion of AST project. The scope of the audit was determined based on an assessment of the risks associated with the governance and consulting contract management activities of the Administrative Services Transformation - Shared Services project. This process included input from Executive Sponsors, AST management, and interested parties from other University functions.

University Audits examined proposal bid documents, contract and accounts payable documentation, and related records. We interviewed AST project leadership, individuals involved in the AST procurement decision-making process, and executive leaders from The Hackett Group and Accenture LLP. We also performed a limited review of the procurement of other consulting services that were awarded to Accenture and the Hackett group over the past five years.

The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity.

Key Activities Audited						
Sub-Activities Audited	Shared Services Consulting			Other Services Consulting		
	AST General Controls	Procurement- Shared Services Consulting	Shared Services Contract Management	Procurement- IT Rationalization Consulting	Procurement- UMHS Software Implementation	Procurement- Benchmarking Services
	Governance and leadership	Compliance with U-M policy	Contract language	Request for proposal	Request for proposal	Vendor selection sole source (Issue 4)
	Project phase management	Request for proposal	Delegated authority (Issue 3)	Bid process	Bid process	Pricing
	Conflict of interest (Issue 2)	Bid process	Change orders (Issue 1)	Vendor selection	Vendor selection	Non-competitive purchase reporting (Issue 4)
	Incentive compensation	Vendor selection	Project deliverables Budget and payment approval			

Legend: Overall risk conclusion for each sub-activity

High Risk

Medium Risk

No Issues Reported

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Contract Change Orders – Approval	High
<p>Issue: Using contract change orders, the Associate Vice President for Finance did not obtain competitive bids for additional projects awarded to Accenture that were outside of the original scope of the AST Shared Services project. The additional work was also not included in the quarterly report of non-competitive purchases provided to the Board of Regents.</p> <p>Risk: A lack of contract award transparency may not provide the best service or value to the University.</p> <p>Support:</p> <ul style="list-style-type: none">• Regental By-laws require that Procurement Services solicit bids for purchases of goods and services over \$5,000 (Standard Practice Guide section 507.01, <i>General Policies and Procedures</i>).• The Associate Vice President for Finance offered additional project work to the Accenture project team during a period in which the AST Shared Services project was temporarily on-hold pending approval for the next phase of work from the Project Executive Sponsors. Without an active project, University leadership was concerned that Accenture might reassign the U-M project team to other engagements. The Associate Vice President for Finance and the Director of Procurement Services believed that it would have cost more money to train and prepare new Accenture associates once approval to resume the work was obtained.• Using change orders, the Associate Vice President for Finance assigned additional work to Accenture that was outside of the original scope of the AST Shared Services work. Management asserts the additional work was related in nature to the project and was not required to be competitively bid. The additional work included:<ul style="list-style-type: none">○ An analysis of Accounts Payable○ Health Plan Negotiations – Insight and Benchmarking○ Design of ServiceNow Tool Phases (case management tool for SSC)○ ServiceNow Tool Mapping○ Improvements to the Fleming Shared Services Center• As of this report, the change orders have totaled nearly \$1 million.• Change orders are intended to be used for work that adds, changes, or deletes from the original scope of work of the contract. Review of the project scope documents and consultation with the Office of the General Counsel revealed that although some of the additional projects were related and supplemental to the AST Shared Services project, at least one (\$88K) was not. Two of the projects, although related to AST Shared Services, used additional Accenture resources that were not assigned to the AST project. <p>Recommendation: The additional work authorized by the change order should be reported to the Board of Regents via the quarterly report of purchases exceeding \$5,000 that were not</p>	

1. Contract Change Orders – Approval	High
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competitively bid. For future change orders:

- Include language in the Request for Proposal that indicates additional in-scope work may be negotiated without further bidding,
- Follow a competitive bidding process for any additional work,
- Or, at a minimum, use the University's established non-competitive purchase approval process. The reason for not competitively bidding the work should be documented and approved by the EVPCFO and Project Executive Sponsors, prior to the start of work.

Management Action Plan: Management agrees that contract change orders need to follow University guidelines regarding competitive bid requirements and that Requests for Proposals should clearly identify the possibility of additional work. While we did believe that it was in the University's best interest to keep the Accenture/U-M team intact, Procurement Services and the AVP for Finance also believed that the language allowing these change orders was included in the Request for Proposal (e.g., section 1.0, page 4 of RFP states: "The university expects to enter into an agreement with the successful bidder(s) for an initial three year term with an option to extend for additional related services as mutually agreed upon between the University and the consultant"). They also believed that the change orders were related to the scope of the RFP, which included "reducing administrative costs." Procurement Services will be more precise in future RFP language and assess each change order to ensure that the language in the RFP fully supports the added services.

Action Plan Owner: Associate Vice President for Finance

Expected Completion Date: Immediately

2. Conflict of Interest/Conflict of Commitment - Management Plans	Medium
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Issue: The Office of the Executive Vice President and Chief Financial Officer did not document management plans for potential conflict of interest and conflict of commitment (COI/COC) situations disclosed by and discussed with senior Business and Finance (B&F) staff.

Risk: Because B&F senior staff are key decision makers, conflicts of interest and conflicts of commitment (either in actuality or in appearance) could lead to situations that are not advantageous to the University. Lack of compliance with the B&F COI/COC policy by the B&F senior staff may also undermine the significance of the policy to other B&F staff members.

Support:

[U-M Standard Practice Guide \(SPG\)](#)

SPG Section 201.65-1, *Conflicts of Interest and Conflicts of Commitment*, defines a potential conflict of interest as a financial interest or activity outside the University that has the possibility (either in actuality or in appearance) of compromising a faculty or staff member's judgment, influencing decisions or behaviors with respect to use of University resources or other matters of interest to the University, or resulting in personal gain or advancement at the expense of the University. A potential conflict of commitment exists when a faculty or staff member's external

2. Conflict of Interest/Conflict of Commitment - Management Plans	Medium
relationships or activities have the possibility (either in actuality or in appearance) of interfering or competing with the University's missions or with that individual's ability or willingness to perform the full range of responsibilities associated with his or her position. Further, the SPG requires that all actual or potential conflicts of interest or commitment must be disclosed, evaluated; and, if found to be significant, eliminated or managed.	

B&F Policy

Consistent with the requirements of SPG Section 201.65-1, the EVPCFO established a COI/COC policy for B&F. The policy applies to all B&F employees and provides guidance for managing conflicts in five areas:

1. Time Conflicts
2. Relationship Conflicts
3. University Resource Conflicts
4. Gift Conflicts
5. Political Activity Conflicts

Deployment of B&F COI/COC Policy

While it appears actual and potential COI and COC situations were disclosed by the B&F senior staff and were discussed with the EVPCFO, management plans were not documented.

Recommendation: Strengthen the process to manage potential conflicts of interest and commitment for B&F senior staff reporting to the Office of the EVPCFO. Employee disclosures, evaluation of the disclosures, and resulting management plans (if any) should be documented and retained in accordance with the B&F COI/COC policy. Consider the potential appearance of a conflict in deciding whether to create a management plan. Per COI/COC policy, this should include implementation of an annual process to obtain and evaluate employee disclosures of potential conflicts (either in actuality or in appearance). In the absence of any potential conflict disclosures, consider requiring staff members to sign an attestation indicating they have no potential conflicts. It may be helpful to link this process to a current annual process (e.g., annual performance reviews) to serve as an annual reminder.

Management Action Plan: Management agrees with the recommendations and has already begun development of a more rigorous, standardized process and format for documenting, storing and tracking COI/COC management plans, as well as, implementation of an additional annual COI/COC disclosure process.

Action Plan Owner: Executive Vice President and Chief Financial Officer

Expected Completion Date: October 2014

3. Contract Change Orders - Delegated Authority	Medium
Issue: In practice, the Associate Vice President for Finance's signature authority mirrors the signature authority of the EVPCFO. This could be interpreted as being inconsistent with the	

3. Contract Change Orders - Delegated Authority	Medium
<i>Delegation of Authority to Bind the University to External Agreements on Business and Financial Matters (SPG Section 601.24).</i>	

Risk: Signing a contract or change order without authority increases the risk of taking on obligations without senior management knowledge or intention, which may not be in the best interests of the University.

Support:

- Standard Practice Guide Section 601.24, *Delegation of Authority to Bind the University to External Agreements on Business and Financial Matters* represents the legal power to act in the name of the Board of Regents of the University of Michigan or to bind the University of Michigan to an obligation or promise.
- The EVPCFO signed the Accenture Master contract of \$526,340 on behalf of University on January 23, 2011.
- As outlined in Table 1 (of SPG Section 601.24) – U-M Business and Finance Authority Delegations, the EVPCFO delegated to the Associate Vice President for Finance the authority to sign contract amendments up to 25% of the original amendment amount. Twenty-five percent of the \$526,340 Accenture Master contract is \$131,585.
- The Associate Vice President for Finance signed two of the change orders (Change Order 2 - Analysis of Accounts Payable for \$210,824 and Change Order 8 - ServiceNow Tool Mapping for \$580,848). This could be interpreted as exceeding his 25% delegation of authority for contract amendments.
- See Issue #1 above for further discussion of concerns related to these change orders.

Recommendation: SPG Section 601.24 should be reviewed and updated to reflect intended business practices. Once updated, as necessary, Procurement Services should raise awareness of signature authority limits in its operations, especially related to contract amendments and change orders. Develop a checklist or some other job aid to ensure the appropriate authorized signature is obtained as part of contract and change order execution.

Management Action Plan: Management agrees that some of the delegations when read together, could be viewed as inconsistent rather than supplementary. Management also agrees that the table and the business practices it is meant to reflect should be reviewed periodically and updated as necessary. Management will work with the Office of General Counsel and University Audits to do a comprehensive review of the delegation table, update the table, and then develop a communication/education plan to increase awareness and set expectations of achieving the highest possible compliance.

Action Plan Owner: Associate Vice President for Finance

Expected Completion Date: October 2014

4. Non-Competitive Purchasing	Medium
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Issue: The Associate Vice President for Finance did not follow competitive bidding or sole source justification requirements in contracting with The Hackett Group for benchmarking services. In addition, the contract was not identified by Procurement Services as a non-competitive award and was not promptly reported to the Board of Regents.

Risk: By not competitively bidding or following University exception and reporting processes there is a lack of transparency and a risk the award may not provide the best service or value.

Support:

- At the time, the Associate Vice President for Finance was new to the University and may not have been familiar with purchasing requirements.
- The University, as a governmental agency, contracted with The Hackett Group under pricing and terms of a national contract arrangement through the National Association of State Auditors, Comptrollers, and Treasurers (NASACT). The Associate Vice President for Finance approved the \$300,000 contract.
- A sole source justification form was approved by the Associate Vice President for Finance on July 20, 2009, 11 days after the contract was executed.
- We were unable to determine if the Associate Vice President for Finance negotiated the contract without Procurement Services assistance. Subsequently, and well after the contract end date of March 2010, the sole source reporting oversight was detected and corrected by Procurement Services leadership and reported to the Board of Regents on April 21, 2011.

Recommendation: Strengthen processes to ensure compliance with competitive purchasing and sole source justification requirements:

- Educate applicable University staff, especially new management who are not familiar with University policies, about the requirement for competitive vendor selection and sole source justification processes.
- Develop monitoring reports in MPathways to detect missing sole source indicators to ensure complete and accurate reporting of non-competitive awards.

Management Action Plan: Management agrees with the recommendations to strengthen processes related to ensuring compliance with competitive purchasing and sole source justifications. Education and communication will be especially important during and immediately after transition of personnel in Finance/Procurement and business officers in schools, college, auxiliaries, and other units. It is important to note that for the financial process benchmarking work, it was well understood by the EVPCFO and others that the Hackett group was, and still is, the only vendor with a pre-existing large database of benchmarked data for transaction costs in finance/HR across industry. All other vendors would have to create custom benchmarks. So, in this case, it was a process/paperwork delay/error and not a missed opportunity to competitively bid a contract for better terms.

Action Plan Owner: Associate Vice President for Finance

4. Non-Competitive Purchasing	Medium
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Expected Completion Date: October 2014

Bentley Historical Library

2014-201

Report issued July 2014

A. Executive Summary

1. Overall Conclusion

The audit identified several areas of improvement related to control of the Bentley Historical Library (Bentley) operations. In response, management has committed to timely remediation of all issues, including discontinuing outside business activities conducted in the Bentley Conservation Lab.

The Bentley faces significant challenges managing the University Archives. As outlined in Standard Practice Guide (SPG) Section 601.08, *University Archives and Records*, University records are the shared responsibility of U-M units in cooperation with the Bentley. However, records retention is a matter of choice at the University and many units do not consistently transfer records to the archives. Although the Bentley proactively reaches out to schools, colleges, and units, the outreach efforts have resulted in mixed success and are difficult to sustain due to limited resources. As a result, parts of institutional memory and history may not be fully preserved. In July 2012, a Records Management Task Force put forth a business case that explored concerns and challenges related to University records management¹. However, many of the task force recommendations have yet to be implemented.

Bentley should supplement its outreach efforts by working with central administrative offices to provide University units with an easy to understand Records Management Schedule that explains the types of records that are valuable to Bentley, records that units can destroy, and records that units must retain until they are deemed inactive and are no longer needed.

Bentley management could identify control weaknesses and opportunities for improvement by a more careful completion of the annual Internal Controls gap analysis .

2. Context and Key Risk Considerations

The Bentley was established in 1935 and has traditionally been supported almost entirely through the Office of the Provost, with nearly all of its funding coming from the General Fund. In recent years, successful fundraising from individuals and foundations

¹ <http://cio.umich.edu/records/Records-Management-Business-Case-July-2012.pdf>

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has made it possible to build an endowment to support acquisitions and programming. The Bentley also has an Executive Committee appointed by the Board of Regents, which oversees library policies and advises the Director.

The Bentley has a professional staff of 20, a fiscal year 2013 General Fund budget of \$1.57 million, and approximately \$10.5 million in endowments that support a wide range of critical functions, including conservation, preservation of the historic Detroit Observatory, researcher travel, and graduate student fellowships.

Several longtime leaders and other key staff have retired from Bentley in the past two years, and more retirements are anticipated. Clearly defining and documenting responsibilities during this transition period will be critical to maintain segregation of duties and adequate oversight. Management is considering succession planning to ensure that the Bentley retains people with the right skill sets to meet the demands of anticipated growth. Employees taking on new roles and additional responsibilities are working with Financial Operations and Financial Analysis to understand, analyze, and interpret key financial reports as well as recharges billed to other U-M units.

Since taking office in September 2013, the Bentley Director engaged an external consulting group to streamline overall Bentley operations and foster a team environment by improving communication between the divisions. Development opportunities include the following potential initiatives:

- Establishment of a metrics driven environment to measure services provided
- Increased use of the archive and the Detroit Observatory
- Prioritization of archival needs and organization of content to use storage space efficiently
- Education of the broader University population about available resources
- Identification and acquisition of necessary physical, financial, and technological resources for continued growth of the archives
- Exploration of opportunities to collaborate with the Office of University Development
- Engagement of students through internships and research experiences

The Bentley is hiring a Development Officer to raise additional funds from donors and external organizations, and is transitioning to MiWorkspace.

The Bentley is also considering implementing Aeon, an automated request and workflow management software, specifically designed for archives, to enhance researcher experience, automate reading room circulation functions, incorporate item tracking features with audit trails to enhance security, and easily generate statistical reports about the collection and its usage. Aeon is currently used by the University Library's Special Collections Library.

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3. Audit Scope and Identified Risks

The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity. The scope of the audit was determined based on an assessment of the risks associated with the activities of the Bentley Historical Library. This process included input from unit management and interested parties from other University functions.

Key Activities Audited						
Digital Curation	University Archives and Records	Michigan Historical Collections	Reference Services	Administrative and Fiscal Responsibilities	Cash and Asset Management, and Information Technology	
Sub-activities Audited	Policies and procedures	Policies and procedures	Policies and procedures	Core activities	Procurement, time and travel expenses (10)	Cash handling and credit cards (12)
	Access control	Records appraisal	Gifts and deposits	Staff training and qualification	International activities	Asset administration
	Digital inventory	Inventory and collections backlog (9)	Inventory and collections backlog Restricted gifts	Restricted materials	Budget and Statement of Activity	Information technology management (8)
	Vendor contract review (4)	Security and climate controls (3), (6)		Remote requests and statistics	HR, payroll, COI/COC, Hotline (11)	
	Website archiving	Restricted records	Conservation lab and insurance (1)	Reading Room activities	Executive Committee	
	Outreach and growth management	Oral history tapes and transcripts		Detroit Observatory and fine art (2), (7)	Gap analysis and financial reports	
		Records center storage and disposal		Loan process	Disaster recovery (5)	
					Succession planning	
					Gifts and endowments	

Legend: Overall risk conclusion for each sub-activity

High Risk

Medium Risk

No Issues Reported

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4. Audit Objectives

The objectives of the audit were to:

- Determine the appropriateness, adequacy, and implementation of policies, procedures, and processes for:
 - Administration, preservation, and management of digital and digitized materials
 - Acquiring and preserving records of the University and related materials
 - Acquiring and preserving materials related to the history of Michigan and the activities of its citizens and its institutions
 - Assisting researchers and facilitating access to collections
- Determine if Bentley has appropriate administrative and fiscal controls in accordance with regulatory, University, and department guidelines
- Determine adequacy of controls over cash, assets, and information technology management
- Assess if resources are used in an economical and efficient manner

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. External Work Performed by Conservation Lab Staff	High
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Issue: Management has not clearly determined whether to treat after-hours services provided by Conservation Lab employees to external clients using Bentley facilities as a vendor relationship or as part of Bentley operations.

Risk: Both U-M and individual Bentley employees could be liable for damage to privately owned articles provided by external clients for conservation work.

Non-exempt employees might claim overtime pay in back-wages under the Fair Labor Standards Act (FLSA). Lab staff might also claim worker's compensation for any injuries suffered while performing external work.

Private benefit may jeopardize U-M's tax-exempt status under section 501(c)(3) of the Internal Revenue Code.

External work performed during regular Bentley business hours may conflict with the employees' regular duties.

Revenue due to the Bentley may be underreported.

Support: The Conservation Lab has been providing after-hours document conservation services for at least 25 years to external individuals and organizations such as historical societies and universities. The previous Head Conservator, who retired in 2012, continues to assist and share

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in the revenue from this external work.

Charges for the conservation work are determined by the lab staff. Invoices list both the Bentley's and the Head Conservator's personal contact information. Clients pay by personal checks made out to the Head Conservator, who divides the proceeds among the lab staff. A record of the total revenues is not maintained.

35% of the revenue from external work is remitted to the Bentley as a surcharge covering the cost of conservation supplies used in performing the work. The Head Conservator periodically writes a check to the Bentley for the total surcharge and provides copies of the invoices. A handwritten record maintained by the lab indicates they remitted approximately \$80,000 in surcharges between 1986 and 2013.

No documentation is available to verify that staff had disclosed these activities as potential conflicts of interest or commitment.

Recommendation: The Conservation Lab should cease providing services to external clients until a sound business structure is established, documented, reviewed, and approved by Bentley management in consultation with the appropriate administrative offices (Office of the General Counsel, Tax Department, University Human Resources, and Risk Management) to ensure the work is conducted in a risk appropriate manner.

Management Action Plan: All external work performed by the Conservation Lab Staff is terminated as of June 1, 2014.

Action Plan Owner: Bentley Director and Division Head of Michigan Historical Collections

Expected Completion Date: Completed

Auditor's Comment: Management notified external clients this work would be ending. Conclusion of the work will be confirmed during audit follow-up.

2. Detroit Observatory	Medium
Issue: The fire alarm system in the Detroit Observatory does not produce sufficient audiovisual warnings to notify occupants to evacuate.	

Management has not planned long-term solutions to recurring maintenance problems and has not developed contingency plans for repairing the Observatory telescopes.

Risk: Visitor, student, and staff safety could be compromised. The Observatory building may be subject to further damage and deterioration as short-term repairs fail. Adequate funds may not be available for conservation and repair of the Fitz and Meridian telescopes.

Support: Smoke detectors in the Observatory do not sound an alarm in the building. A

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response tone at the security panel is barely audible on the second floor and completely inaudible in the dome. Occupational Safety and Environmental Health (OSEH) Fire Safety has recommended that Bentley determine the feasibility and cost of upgrading to wireless devices with audible alarms.

Repair and restoration of the Observatory requires expertise that is currently not available within the University. Damage to the building from factors such as water seepage and mold could impair functional use of the telescopes. Because proceeds from the Observatory endowment fund for maintenance have been limited, repairs have resulted in short-term fixes rather than long-term solutions.

In 2008, Risk Management recommended purchasing insurance for the telescopes in addition to Property Insurance Coverage provided by the University. However, this coverage was never obtained.

Management is considering strategic initiatives to increase foot traffic. The Observatory is not included in the Bentley's disaster recovery plan (DRP).

Recommendation: Work with OSEH to install appropriate fire controls so that visitors, students, and staff can be quickly evacuated in case of an emergency. In keeping with management's strategic goals, develop plans and proposals for long-term maintenance repair and restoration. Work with Risk Management to determine the feasibility and cost of purchasing insurance for the telescopes. While this may not cover total loss, it could cover damage due to wind, water, vandalism, or accident and provide funds for conservation and repair of these unique instruments.

Management Action Plan: Bentley Director, Acting-Associate Director, and the Program Coordinator for the Detroit Observatory are to determine the feasibility and cost of audible alarms; a long-term solution for maintenance of and disaster recovery of the Observatory will be explored; and insurance coverage for the telescopes will be explored with Risk Management. The exploration of strategic initiatives to increase foot traffic is ongoing and has included a U-M Business School case study.

Action Plan Owner: Bentley Director and Acting-Associate Director

Expected Completion Date: September 2014

3. Security of Facilities	Medium
Issue: The Bentley does not consistently obtain positive verification that departing staff members have returned assigned building keys.	

Risk: Unauthorized individuals may obtain access to sensitive areas compromising the safety of valuable archives, staff, and visitors.

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Support: The employee off-boarding process requires Bentley to collect building keys for return or reassignment. However, some employees have returned keys directly to the Key Office. Bentley marks those keys as returned, but does not confirm this has actually taken place.

According to Key Office records, 24 keys to various Bentley locations are still assigned to six former Bentley employees. Some keys may have been reassigned to other employees.

Recommendation: The Bentley should reconcile the quantity and ownership of keys in their possession with the Key Office. If discrepancies exist, consider appropriate steps such as rekeying. Going forward, management should collect keys directly from departing employees and maintain an internal record of key assignments for all Bentley facilities. Bentley can also consider retrofitting the stack entrance doors with M-Card access readers to monitor access.

Management Action Plan: Bentley Acting-Associate Director will undertake an inventory of keys in the possession of current staff member and aim to reconcile with inventory of Key Office to the extent possible, including the Key Office's records on keys held by former Bentley employees. Bentley Acting-Associate Director will in the future collect keys directly from departing employees and maintain an internal record of key assignments for all Bentley facilities. Bentley Director is also already working with the Division of Public Safety and Security on a thorough review of safety and security.

Action Plan Owner: Bentley Acting-Associate Director and Bentley Director

Expected Completion Date: July 2014

4. Contract Oversight	Medium
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Issue: Management does not proactively verify that vendors processing archival materials carry appropriate, contractually mandated insurance coverage.

Risk: Vendors may be underinsured, forcing the University to absorb additional loss.

The vendor may not have added the Regents of the University of Michigan as additional insured, thereby not protecting the University's interests against liabilities arising due to the external service provider's negligence.

Support: The Bentley contracts with external parties to digitize audiovisual materials and archive University websites, both key components of the Bentley's Digital Curation activities. Contracts with two of the three service providers require the provider to carry specific insurance coverage, list the Regents of the University of Michigan as additional insured, and provide a certificate documenting the insurance coverage.

During the period audited, vendors carried appropriate insurance. However, evidence of the coverage had not been obtained and confirmed during the contracting process and subsequent

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renewals, and the coverage did not designate the Regents as additional insured.

Recommendation: For all existing contracts and new agreements, the Bentley should consult with Risk Management and Procurement and work with vendors to confirm that contract terms including insurance are appropriately met.

Management Action Plan: Bentley Acting-Associate Director, Bentley Director, and the Division Head of Digital Curation Services are already beginning the process of consulting with Risk Management and Procurement on all existing contracts and new agreements going forward, and will work with vendors to confirm that contract terms are appropriately met.

Action Plan Owner: Bentley Acting-Associate Director, Bentley Director, and Division Head of Digital Curation Services

Expected Completion Date: September 2014

5. Disaster Recovery Plan	Medium
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Issue: The disaster recovery plan (DRP) is not complete and up to date, and it has not been tested.

Risk: The Bentley may not be able to respond quickly and efficiently to emergencies, increasing danger to staff and patrons as well as Bentley holdings.

Support: As an archive for the University and the state of Michigan, the Bentley houses unique and valuable documents and artifacts requiring special care in the event of fire, flood, or other disaster.

The Bentley began developing a DRP in 2006. Key individuals who worked on the plan are no longer employed at the University.

The draft DRP does not address all facilities such as the Detroit Observatory and off-site storage locations housing parts of the archive, and does not contain current emergency contact information or roles and responsibilities.

Portions of the DRP were updated during the audit, but significant work remains to be done.

Recommendation: The Bentley should review and update the disaster recovery plan to incorporate all operations, conduct appropriate training, and test and update the plan regularly.

Management Action Plan: Bentley Director, Acting-Associate Director, Division Head of Digital Curation Services, Conservation Lab staff, and the Program Coordinator for the Detroit Observatory are updating and expanding the disaster recovery plan. The Bentley will also update the existing plan to incorporate all operations including the Observatory and off-site

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storage locations, conduct appropriate training, and test and update the plan periodically.

Action Plan Owner: Bentley Acting-Associate Director

Expected Completion Date: September 2014

6. Environmental Controls in Archives	Medium
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Issue: Management does not monitor environmental conditions in all parts of the collection and has not remedied significant environmental deviations from desired standards.

Risk: Fluctuations in temperature and humidity increase the rate of deterioration of archival materials.

Lack of a fire suppression system increases the likelihood of loss in the event of a fire.

Support: As an archive for the University and the state of Michigan, Bentley houses unique and valuable documents and artifacts requiring special care and storage conditions. Holdings include more than 50,000 linear feet of archives and manuscripts, 90,000 printed volumes, and over 10,000 maps.

Management's target temperature is 65-68 degrees Fahrenheit, and target humidity is 40-45%. However, temperature and humidity fluctuations in the main Bentley stacks exceed management's target ranges. According to environmental reports, in October 2013 humidity readings ranged from 24% to 68%, and temperatures ranged from 59 to 75 degrees. Similar fluctuations in humidity and temperature were observed during February and June 2013.

Management has tried to resolve this issue with Facilities Maintenance, but no structural changes have been implemented as a long-term fix. Facilities Maintenance has indicated that reengineering may be required; however, no follow-up has taken place.

Temperature and humidity readings in the two off-site storage facilities are not measured, and one of the locations lacks central air conditioning and fire suppression.

Recommendation: The Bentley should work with Facilities Maintenance to develop and implement sustainable solutions to manage the temperature and humidity within acceptable archive-appropriate tolerances. Management should also reexamine the Bentley's current off-site storage facilities, and either implement archive-appropriate environmental controls or relocate those holdings to the main stacks.

Management Action Plan: Solutions will be sought through Facilities Maintenance for optimal temperature and humidity controls for all Bentley facilities.

Action Plan Owner: Bentley Acting-Associate Director

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Expected Completion Date: September 2014

7. Insurance for Fine Art	Medium
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Issue: Insurance needs for fine art in the Bentley's collections have not been evaluated.

Risk: Funds may not be available to restore or replace damaged items. Damaged collections may deteriorate further if not repaired promptly.

Support: The Bentley archives contain valuable items such as original photographs, architectural drawings, paintings, and autographs. For insurance purposes, these may be considered fine art, requiring separate coverage from standard University property insurance.

In response to a 2006 audit of Special Collections, Bentley management indicated they would work with Risk Management to insure their most valuable artwork and fine furnishings. However, this coverage was never obtained.

When loaning such valuable items to other institutions, the Bentley requires that institution to insure them for a dollar amount estimated by Bentley management. When loaning 37 original architectural drawings and photographs to Cranbrook Educational Community in 2013, management valued each item at \$5,000.

Although fine art items loaned to other University units are insured while in transit, some exclusions and special conditions may apply.

Recommendation: The Bentley should work with Risk Management to identify and assess valuable collections and purchase additional insurance when appropriate. As holdings change, revise coverage accordingly.

Management Action Plan: Risk Management has already reached out to Bentley to undertake an evaluation of and plan for the insurance of fine art in possession of the Bentley. University Library's Special Collections will be consulted for its experience in insuring its holdings. The Bentley is very interested in exploring both the concept and possible funding models for digitization as an approach to insuring the collections.

Action Plan Owner: Bentley Acting-Associate Director, Division Head of Digital Curation Services, and Acting-Division Head of University Archives and Records Program

Expected Completion Date: September 2014

8. Security of Donor Information	Medium
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Issue: Private personal information (PPI) of donors is stored in a departmental system that has not undergone security assessment. Management has not fully reviewed the placement and

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safeguarding of sensitive data within the Bentley's information systems.

Risk: Compromise of donor information could result in notification and remediation costs to Bentley, and discourage future donations.

Support: SPG Section 601.27, *Information Security Policy*, requires each unit to develop, maintain, and implement an information security plan, conduct risk assessments, and track critical and sensitive information assets.

The Bentley's accession management system records all items as they enter the archive. The system also maintains personal information about roughly 500 monetary donors and 11,000 material donors, which is used to produce mailing lists for soliciting membership renewals and distributing the library's annual report and other items.

All monetary gifts are also processed through the Development Office Donor Alumni Relationship Tool (DART) system.

ITS reviewed of the accession management system screen shots to confirm the data is PPI.

Recommendation: The Bentley should work with Information and Infrastructure Assurance to complete a security assessment of the accession management system. Management should also investigate further opportunities for using DART to manage solicitations and mailing lists, which might allow the removal of donor contact details from the accession management system.

Management Action Plan: The Bentley has already started its review of all data systems with the aim of using DART for as many of these as feasible. ITS and DART operators will be consulted.

Action Plan Owner: Division Head of Digital Curation Services and Bentley Development Director

Expected Completion Date: September 2014

9. Collections Backlog Management	Medium
Issue: The Bentley does not regularly monitor the processing of new items for inclusion in the collection.	

Risk: Researchers may not discover relevant historical documents that have not been processed.

Donor intent may not be realized.

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Undesirable items (e.g., low-value or duplicate) may be unknowingly retained resulting in inefficient use of storage space.

Support: During initial accession, staff assigns processing priority as low, medium, or high to collections in the Bentley Electronic Accession Locator (BEAL) system. BEAL reports indicate that there are high, medium, low, and un-prioritized materials from as early as 2001 that have not been processed for inclusion in the University Archive and Michigan Historical Collections.

Recommendation: Management should develop a plan to manage and monitor the accession process to minimize the collection backlog.

Management Action Plan: Division heads of Michigan Historical Collections and University Archives will review the backlog to update and identify with more precision what all constitutes the backlog. Based on the review, Bentley will develop a plan to manage and monitor the accession process.

Action Plan Owner: Division Head of Digital Curation Services and Acting-Division Head of University Archives and Records Program

Expected Completion Date: September 2014

10. Time Reports and Travel Expenses	Medium
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Issue: Time reports and travel expenses are not reviewed and approved by a higher administrative authority as required by University policies.

Risk: Bentley may not be paying employees appropriately.

Employee paid leave, if applied inequitably, could result in a perception of unfair treatment.

Funds may not be used for intended purposes.

Support: SPG Section 518.01, *Payroll Controls*, requires that individuals approving time be in a position of higher administrative authority and have sufficient knowledge to attest that hours reported are true and accurate. Time reported by the Administrative Secretary is reviewed and approved by the Secretary, which is a subordinate position. Time for all other bi-weekly and monthly Bentley employees is approved by the Administrative Secretary, who does not always have direct knowledge of the work performed.

SPG Section 507.10-1, *Travel and Business Hosting Expense Policies and Procedures for Concur Users*, requires that a supervisor or higher administrative authority approve a travel and business hosting expense before reimbursement is issued. The Bentley Director's expenses are appropriately approved by the Provost's Office. However, expense reports from staff as well as the Associate Director are reviewed and approved by the Administrative Secretary.

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Procurement requires that new expense approvers take the full approver course (TEE102) at least once. Thereafter, approver training is required every three years, with the option of the full course or the condensed refresher course (TEE103). Expense reports of the Administrative Secretary have been reviewed and approved by either the Director or the Associate Director, who have not completed these courses.

Recommendation: Time reports should be reviewed and approved by supervisors who are knowledgeable of the work performed by their direct reports. Travel expenses should be reviewed and approved by a higher administrative authority prior to reimbursement. All Bentley expense reviewers and approvers must complete the required training.

Management Action Plan: Bentley administration and division heads will undertake appropriate training as a first step in a new practice of having time and expense reports reviewed and approved by supervisors who are knowledgeable of the work performed by their direct reports.

Action Plan Owner: Bentley Acting-Associate Director

Expected Completion Date: September 2014

11. Conflict of Interest and Conflict of Commitment	Medium
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Issue: Management does not have an effective process to identify and manage conflict of interest (COI) and conflicts of commitment (COC).

Risk: Staff may engage in outside activities that may interfere with their University obligations.

Support: SPG Section 201.65-1, *Conflicts of Interest and Conflicts of Commitment*, requires that faculty and staff disclose all actual or potential conflicts as they arise or are identified, and requires management take appropriate actions to mitigate the associated risks.

No COI/COC disclosure forms were available for review.

The Bentley does not currently have a designated unit representative to manage the COI/COC process.

Recommendation: Bentley employees should disclose any relationships, interests, or activities that can potentially compete with their responsibilities. Management should then determine if a conflict exists. If further management or elimination of a conflict is required, develop a plan in consultation with the staff member, and monitor to ensure the plan is followed.

Management should periodically remind staff about the need to promptly disclose activities and situations that could create potential conflicts and address them appropriately.

Management Action Plan: Bentley Acting-Associate Director will assume the role of COI/COC unit representative. Bentley administration will schedule an annual workshop to review COI and COC. Each staff member will be required to complete a COI/COC disclosure form on an annual basis.

Action Plan Owner: Bentley Acting-Associate Director

Expected Completion Date: September 2014

12. Cash Handling	Medium
Issue: The same person who receives checks also records the transactions, reconciles the transactions, and deposits the checks. Bentley staff and management have not completed appropriate training related to cash handling and credit card processing.	
Risk: Checks could be diverted or posted to the wrong account without detection. Credit card transactions may be processed incorrectly, and safety of cardholder information could be compromised.	
Support: SPG Section 519.03, <i>Cash Management Policies</i> , specifies that there be adequate segregation of duties between personnel who receive funds, deposit funds, and reconcile transactions. All checks from the Friends of the Library and the Friends of the Observatory are received, recorded, reconciled, and deposited by the Bentley Secretary.	
Of the \$28,000 received by check in fiscal year 2013, approximately \$19,000 was received from the Friends of the Library and the Friends of the Observatory respectively. Going forward, Bentley plans to implement strategic fundraising activities to increase donor contributions.	
Individuals who handle cash but do not deposit are required to complete course TME103 once. Individuals who prepare deposits or allocate deposited funds to chartfields are required to complete course TME101 bi-annually. Individuals who process credit cards must complete course TME102 annually.	
None of the employees who handle cash are current on their cash handling training. Approximately twenty staff may handle different parts of the cash handling process while performing reference desk functions.	
Five of the six employees currently handling credit cards have not completed the TME102 Merchant Certification course. In fiscal year 2013, Bentley received approximately \$23,000 in credit card payments, mostly for photocopies, and photo orders.	
Recommendation: Bentley should separate duties that will allow for different people to	

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control different parts of the cash handling processes (e.g., receive, deposit, and reconcile), and require employees authorized to handle cash and credit card information to complete the required courses according to their job responsibilities.

Management Action Plan: All appropriate staff will take all appropriate training in order to achieve full compliance with best practices for cash and credit card handling. Bentley will also segregate cash handling duties appropriately.

Action Plan Owner: Bentley Acting-Associate Director and Division Head of Reference

Expected Completion Date: September 2014

Center for Global and Intercultural Studies

2013-215

Report issued July 2014

A. Executive Summary

1. Overall Conclusion

The Center for Global and Intercultural Study (CGIS) has solid practices in place for administering study abroad programs. Other units across the University recognize this as evidenced by their frequent requests for CGIS assistance. CGIS budgeting and financial planning processes for study abroad programs are also well established.

This audit is closed.

CGIS is exposed to unique and varying challenges associated with operating in the global landscape. One such challenge is safeguarding legal protection of the University in foreign countries. As CGIS frequently adjusts program offerings, it was noted during the audit that CGIS should strengthen coordination with the Office of the General Counsel to obtain guidance on establishing and modifying study abroad programs. In addition, University Audits recommended that CGIS continue collaboration with other University departments in efforts to improve international payment processes.

CGIS is committed to improving the underlying processes supporting the global programs they administer. Management completed the action plans identified to address issues noted during the audit. University Audits recently completed a follow-up review to assess the progress in addressing the audit recommendations. All management action plans were implemented and a summary of the completed corrective actions is included along with the issues later in this report.

2. Context and Key Risk Considerations

The Center for Global and Intercultural Study was founded to provide a wide variety of global engagement and learning opportunities. Although CGIS is focused on

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providing study abroad support to the College of Literature, Science, and the Arts (LSA) and is one of LSA's reporting units, the Center serves undergraduate students throughout the University of Michigan. CGIS offers over 70 programs in over 30 countries, from short-term summer internships to yearlong study abroad. The Center was established in July 2009 to provide a wide variety of global engagement and learning opportunities to the University community. CGIS programming serves students with diverse academic interests at sites on every continent. CGIS staff supports student participation in four different program areas: Michigan Global Academic Programs, Global Intercultural Experience for Undergraduates, Spring/Summer Language Study, and Global Course Connections. CGIS also offers administrative and academic support to departments and units across campus hoping to launch their own individual programs.

U-M endorses global education as an integral part of the undergraduate curriculum. As a result, there are many different options available to U-M students. Some colleges and schools administer global and intercultural programs specifically for their enrolled students; however, CGIS programs are open to students across the Ann Arbor campus. Some programs are also open to UM-Flint and UM-Dearborn students. Schools and colleges outside of LSA also often consult CGIS when determining how they can best administer their own study abroad programs. CGIS assists as resources allow.

Partner institutions, both in Ann Arbor and around the world, are a valuable part of the CGIS mission to provide a wide variety of intercultural learning opportunities. CGIS manages over 30 exchange agreements to offer opportunities for student exchange and faculty research in support of common missions of U-M and its partner institutions.

3. Audit Scope and Identified Risks

The scope of the audit was determined based on an assessment of the risks associated with the activities conducted by CGIS. This process included input from CGIS management and interested parties from other University functions. The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity.

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Key Activities Audited								
	Program Administration	Financing Sources	Financial Aid	Fiscal Responsibilities	Compliance (incl. HR)	Procurement / Accounts Payable	Payroll	Cash Handling
Sub-activities Audited	Administration process	Lump sum advances	Financial aid process	Management tools	Conflict of interest/ commitment (COI/COC)	Expense reporting	Overtime payments	Cash handling process
	Travel abroad policy compliance	Travel advances	Emergency loans	Budget process	Internal control certification	Training compliance	Temporary employee pay	Training compliance
	Travel warnings and restrictions	Imprest cash funds		Statement of Activity (SOA) reconciliation	Policy compliance	Expense approval and P-Card monthly limits	Retroactive adjustments	Cash deposit process
		International bank accounts		Written procedures	Compliance with international laws and practices	Split transactions	Gross Pay Register (GPR) reconciliation	
				Training compliance		Spending analysis		
				Endowment management		Payments to international service providers		

Legend: Overall risk conclusion for each sub-activity

High Risk	Medium Risk	No Issues Reported
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4. Audit Objectives

The objectives of this audit were to:

- Validate that study abroad programs are administered in the best interest of students and in compliance with University policies.
- Confirm that processes relating to financing sources are compliant with University policy.
- Assess the adequacy of procedures to budget, administer, and monitor financial aid.
- Review CGIS policies, procedures, control environment, and training documentation for appropriateness.
- Evaluate overall compliance with University policies and procedures.

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- Determine the effectiveness of purchasing controls, including expense reporting and approval.
- Verify the existence and adequacy of employee timekeeping controls.
- Confirm that appropriate cash controls are in place.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Payments to International Service Providers	Medium
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Issue: In some cases, CGIS had no documented contract or agreement with international vendors.

Risk: Without a contract or agreement, the University does not have documentation of the goods or services expected for payment provided, which could make it difficult to ascertain whether the goods or services were received. Unpaid vendors may cancel or delay programs or program components. This could create logistical issues and negatively impact students' study abroad experience. Without documented, agreed upon contract terms, the University may unknowingly be noncompliant with payment terms.

Support:

- CGIS had contracts for most vendors; however, there were no contracts or agreements for several vendors of legacy/longstanding programs. In some cases, a letter from the LSA Dean served as a document approving the payment instead of a contract.
- Several payments to international vendors took several months to process. Generally CGIS works to process payments within 30 days.

Recommendation: Identify international vendors without contracts and work with Procurement Services, the Office of General Counsel (OGC), and other necessary University departments to resolve it in a timely manner. Going forward, continue to document agreed-upon terms and conditions of service with newly established international vendors, so that the information can be used to confirm payment of invoices.

Management Action Plan: Since no consistent process or requirements were in place for paying foreign providers, payments took much longer than was reasonable to be approved. CGIS routinely reviewed and processed invoices as soon as they were received. Some additional time was added due to processing necessary by other units. The Associate Director participated on a working group with representatives from Procurement, the Office of General Counsel, and the Provost's Office. One of the main goals of this working group was to identify when an agreement or contract was necessary and who (OGC, Procurement, or both) should approve such agreements and/or contracts. Internally, CGIS created a checklist for new programs that reminded us to verify with OGC/Procurement whether a contract or agreement would be necessary for a new program.

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This group also assessed the issues of timely payments as well as situations where our office did not have contracts with vendors. As determined by the initial working group meeting, one of our ultimate goals was to identify a process that could allow payments to international vendors to be processed in a much timelier manner.

Until the working group made an official recommendation, we had a policy in place that our Dean signed off on any vendor invoices in which a contract did not exist. Although this was not a permanent solution, this allowed invoices to be paid much more quickly in recent months.

Follow-Up Status: The Vice Provost for Global and Engaged Education convened a working group to streamline the review, approval, and payment processes for vendors supplying goods and services related to U-M sponsored education abroad programs. Members of the working group included representatives from the Office of General Counsel, Center for Global and Intercultural Study, Office of the Provost, and Procurement Services.

The working group mapped the current process for service agreements and payments and proposed a standard approach to help units to facilitate the payment process and to use the best contractual language pertinent to a given program. According to the group's recommendations, not all agreements are required to undergo a review by the Office of General Counsel. Further, when an itemization of services or invoice exists rather than a contract, units are not required to create such a contract, given that the department and its unit-level approver have conducted an appropriate review of the program and the associated risks. The guidelines were summarized and posted on the Global Michigan website.

The newly designed approach is a pilot process and will likely adjust as a more complete list of agreement types is compiled. **Closed.**

2. Consultation with the Office of General Counsel for Program Setup	Medium
Issue: CGIS did not consistently seek upfront guidance from the Office of General Counsel when considering and establishing new programs.	
Risk: Without appropriate legal guidance, CGIS may be unaware of international labor laws, employment practices, or other legal requirements that could result in violations, penalties, or legal liability and have negative impact on the University's reputation.	
Support: CGIS consulted with OGC on some legal matters; however, CGIS did not reach out to OGC every time a new program was set up or an existing program expands to include new locations. CGIS frequently adjusts its program offerings to provide a variety of experiences and in response to student demand. With CGIS programs in over 30 countries, coordination with OGC is important to understand legal requirements and customs for each country.	
Recommendation: Include an initial consultation with OGC as part of the "site visit" checklist	

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whenever a new program is established or an existing one is modified or expanded.

Management Action Plan: OGC could not advise on potential areas of risk until they knew what was being proposed between CGIS and a provider, as the scope was too large. As CGIS further developed a program, it consulted with OGC as needed. CGIS connected with OGC through the process to develop a contract or agreement for new programs or locations. The expectation was that OGC would provide any feedback or concerns during this review process. In some instances, additional information was necessary before OGC could provide any feedback on potential legal concerns. CGIS addressed this observation as part of the action plan for the observation relating to payments to international service providers.

Follow-Up Status: Consistency in seeking upfront guidance from the Office of General Counsel was addressed by the Vice Provost for Global and Engaged Education and the working group. The type of contract now dictates the extent of the involvement required from the Office of General Counsel, whether it is feedback received while the new program is being established or when the contract is actually signed. **Closed.**

Life Sciences Institute

2014-502

Report issued September 2014

A. Executive Summary

1. Overall Conclusion

Over the past decade, the Life Sciences Institute (LSI or Institute) has been instrumental in faculty recruitment and the advancement of life sciences research and education at the University. The collaborative and interdisciplinary nature of the Institute supports a highly productive scientific faculty. The Institute has a strong control environment and governance model, which are supported by an organizational structure that is efficient, lean, and effectively uses shared services for many operational needs. Sponsored research grants, which make up over half of its operations, are well managed. LSI has accomplished these positive results in an era of declining federal funds, growing regulatory complexity, and continued University-wide cost-saving measures.

A dynamic scientific research environment creates challenges in managing the Institute's significant investment in infrastructure. Overall, LSI has robust practices in managing its facilities and operations, however, LSI management needs to focus attention on improving lab equipment record keeping, and approving/tracking asset transfers to other institutions and locations within U-M. To safeguard valuable laboratory technology and research data, unit IT operations should more proactively address known security risks and work to assess IT risks on a continuous basis.

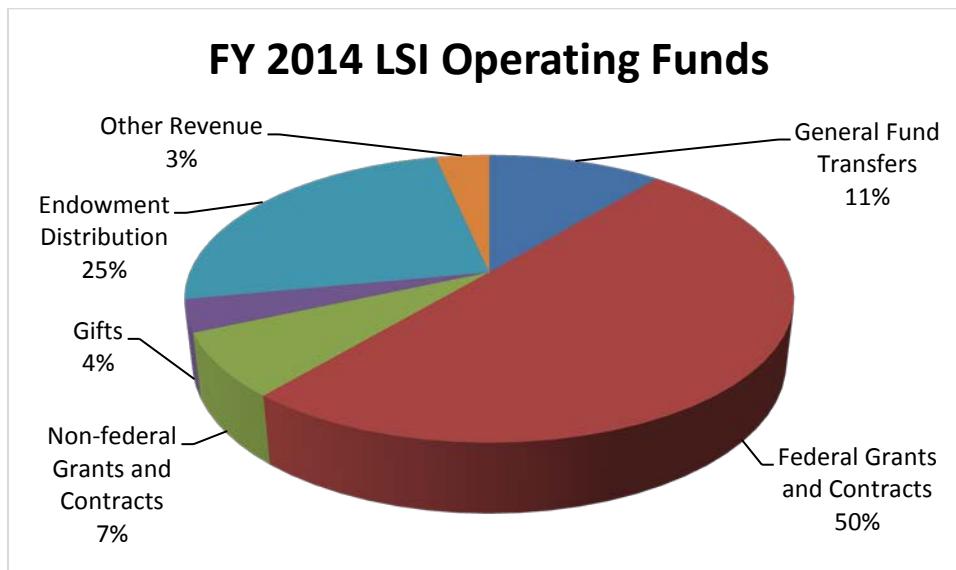
University Audits identified several other opportunities for improvement that are detailed in this report. Management has indicated a strong commitment to addressing identified risks and is already implementing corrective actions.

2. Context and Key Risk Considerations

LSI is comprised of faculty and staff from a wide range of life science disciplines including biology, chemistry, pharmacology, bioinformatics, medicine, physiology, genetics, and biochemistry. The University established LSI in 1999 for the purpose of research, service, and teaching in the life sciences and related disciplines. There are four research centers located in LSI:

- Center for Chemical Genomics
- Center for Structural Biology
- Center for Stem Cell Biology
- Center for the Development of New Medicines

As part of the establishment of the Institute, the University provided an initial \$120 million quasi-endowment, which was supplemented with an additional investment of \$30 million in fiscal year 2014. The current market value of the quasi-endowment is \$230 million. The quasi-endowment generates ongoing investment income distributions for the Institute's general operations. In fiscal year 2014, LSI had operational funding of approximately \$33 million. A breakout of the source of funds follows:



To support academic integration across the University, the Institute is a separate academic unit with a direct reporting relationship to the Office of the President and administrative oversight by the Office of the Provost. The Institute's Executive Committee is comprised of U-M faculty and senior administrators. In addition, two groups advise the Institute: the Scientific Advisory Board and the Leadership Council. The Institute supports 25 faculty members that lead a research staff of approximately 400, including 120 graduate and undergraduate students. LSI employs professional

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staffs dedicated to information technology, facilities management, grants and finance, human resources, fundraising, and communications that provide operational support to the research community.

In prior audits, University Audits identified some common risk considerations for centers and institutes. Key risk considerations in developing our audit program included:

- Governance structure
- Oversight and guidance from the “home unit”
- Faculty researchers’ experience with business management responsibilities
- Strategic and business planning
- Policies and procedures
- Administrative structure and internal control environment
- Faculty and staff training on University requirements

3. Audit Scope and Identified Risks

The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity. The scope of the audit was determined based on an assessment of the risks associated with the activities of LSI. This process included input from LSI management and interested parties from other University functions.

Sub-activities Audited	Key Activities Audited					
	Grant Management	Fiscal Responsibilities	Human Resources	Equipment	Procurement	Lab Safety
Sub-activities Audited	Grant compliance	Management reporting	Conflict of interest/ commitment	Equipment management	Expense report approvals (4)	Compliance and inspection follow-up
	Effort reporting	Budgeting	Temporary employees	Record keeping (1)	Concur training (4)	
	Subcontract oversight and monitoring	Statement of Activity (SOA) reconciliation	Policies and procedures	Asset disposition (1)	P-Card usage (4)	
		Discretionary funds	On-boarding and off-boarding		Vendor purchases	
		Internal controls certification (4)	Employment of minors			

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	Recharge Services	Information Technology	Cash Handling	Governance
Sub-activities Audited	Approval and monitoring Pricing Billing process (3)	Security plans and risk assessment (RECON) (2) Access management Vulnerability scans	Separation of duties (4) Training	Compliance with bylaws Executive committee

Legend: Overall risk conclusion for each sub-activity

High Risk	Medium Risk	No Issues Reported
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4. Audit Objectives

The objectives of the audit were to:

- Validate compliance of grants with University and sponsor requirements, including effectiveness of the controls for effort reporting.
- Assess the department's policies, procedures, and control environment associated with fiscal responsibilities.
- Evaluate compliance with the University Human Resources policy, including management of potential conflicts of interest or commitment.
- Validate effectiveness of the controls around asset management, including tagging, tracking, and disposing.
- Assess effectiveness of purchasing controls. Review documentation to confirm travel expenses are reasonable, authorized, and consistent with University and sponsor requirements.
- Validate that the corrective actions recommended during the OSEH review were addressed.
- Determine whether the recharges are accurate and timely.
- Confirm that University processes for safeguarding sensitive data and mission-critical systems within LSI are followed.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Equipment Transfer	High
Issue: LSI does not always effectively monitor, track, or seek University authorization for equipment transfers.	

Risk: The University may lose valuable equipment or not be properly compensated for equipment

1. Equipment Transfer	High
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moved to another institution. Transfer of equipment to overseas locations may trigger taxation and export requirements. Equipment maintenance and safety inspections may be impaired if asset location is unknown.

Support:

- In some instances, LSI has allowed faculty departing to other institutions to take LSI purchased equipment without authorization by Property Disposition. At least 12 pieces of equipment have left the University since 2010 without sufficient authority and process.
- Standard Practice Guide (SPG) Section 520.01, *Acquisition, Use and Disposition of Property (Exclusive of Real Property)*, requires all University of Michigan property and scrap material to be sold or disposed of by Property Disposition.
- When assets are transferred to other locations within the University, LSI does not regularly update equipment location records, as required by SPG Section 520.01

Recommendation: Educate principal investigators and department administrators on the need to manage and accurately account for equipment at all times in accordance with University policy. Add specific steps as part of LSI off-boarding procedures to ensure all University property assigned to the departing individual is accounted for adequately and equipment disposition follows University policy and procedure. At the time of any transfers within the University, Financial Operations should be contacted with a description of the equipment, Department ID to which the asset currently belongs, Department ID to which the asset is being transferred and the Tag Number or Asset ID.

Management Action Plan: LSI acknowledges that there had been a lack of knowledge regarding this process. In the months prior to the audit, Property Disposition had communicated with LSI the proper steps, which are now implemented at LSI. Since that time, we have had one faculty member transition to another U-M department and proper notification was made to Financial Operations and confirmed prior to the physical transfer. LSI will also work very closely with Property Control staff to increase the accuracy of tagging assets and asset information in the asset management database. We have had equipment that was not tagged by Property Control and single equipment items that had been assigned multiple asset tag IDs in the system. In the future, LSI will be proactive and contact Property Control management when such issues arise and are not resolved in a timely manner. LSI is also willing to assist Property Disposition in the physical tagging of equipment within LSI if that would be beneficial given the scope of their program.

Action Plan Owner: Director of Operations

Expected Completion Date: March 2015

2. Risk Evaluation of Computers on Open Networks (RECON) and Security Plan

High

Issue: LSI has not performed an IT risk assessment (RECON) since 2007 and has not updated its security plan since 2008. In addition, LSI did not address the gaps identified in the security plan and RECON at the time of the last assessment in 2008.

Risk: Undetected gaps in system controls or gaps that are not addressed may compromise the information security of the Institute and the University.

Support: SPG Section 601.27, *Information Security Policy*, requires each unit to develop, maintain, and implement an information security plan, conduct IT risk assessments, and track critical and sensitive information assets. Information and Infrastructure Assurance (IIA) recommends that units complete IT security risk assessments for their sensitive and critical information assets within a four-year cycle. LSI completed the RECON in 2007 and has not revisited it since. Similarly, LSI created a security plan in 2008 with a planned review in 2010, which has not taken place. There were three high risk issues identified in 2007 RECON that involved the following areas:

- Data security
- Business continuity
- Network security

The LSI IT staff experienced management transition since the last RECON, and the new manager was not aware of the results of the prior RECON or the periodic reporting requirements and available resources. LSI mitigated the data security risk by migrating the LSI's file server from Novell Netware to an industry standard Microsoft Windows fileserver. LSI has partially mitigated the identified business continuity and network security risks with short-term solutions and is working on permanent solutions.

Recommendation: To ensure a secure technology environment, LSI should:

- Update the RECON and security plans to reflect current operations and security requirements, and update them at least every four years or after any substantive system changes.
- Keep up-to-date on University IT requirements by engaging in user group and list serves geared towards campus IT staff. Some examples include but are not limited to: Frontline Notify (FLN), U-M Collaboration Forum, M+Box Updates, Computer Showcase Sneak Peek, umich-postmasters, Mobile Developer Community, Macintosh Special Interest Group (MacSIG), Unix.admins, Windows Administrators, drupal-people, and www-sig.
- Ongoing responsibilities and unresolved risks should be clearly documented and communicated.

Management Action Plan: A RECON on the LSI's End User Computing Infrastructure was completed in June 2014 for fiscal year 2014. Several high priority and high benefit items identified in this recent RECON, such as policy, training, contingency planning, data classification, login banners and session timeouts, are being acted upon now as set forth in the Risk Treatment Plan task list accompanying the RECON. Additional items, including those identified in the prior LSI

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2. Risk Evaluation of Computers on Open Networks (RECON) and Security Plan

High

RECON conducted in 2007, such as business continuity, disaster recovery and firewall assessment, are part of ongoing efforts requiring additional attention, coordination, and input from Information Technology Services, policy creation and/or unit leadership direction. We believe our immediate steps and plans will reduce our overall risk level in this area to at least medium in the near future. Further, RECONs of all mission critical systems or systems containing sensitive data will be conducted at least every four years or if a system that has undergone a previous RECON changes significantly. Finally, the LSI's Security Plan was updated and completed in August 2014 and will be reviewed and updated yearly and as RECONs are completed.

Action Plan Owner: IT Manager

Expected Completion Date: June 2015 (and ongoing as applicable)

3. Internal and External Services

Medium

Issue: LSI does not bill external customers in a timely way for services provided by the Center for Chemical Genomics (CCG). The Center does not accurately price for services that include reagents.

Risk: Untimely billing may result in noncompliance with University and Financial Operations accounting requirements. Incomplete supply pricing information may result in inaccurate recharge rate calculations, revenue loss, and potential tax implications.

Support: In fiscal year 2014, the Institute had recharge revenue of \$711,954. Currently, there are four recharge services that LSI provides:

- Protein Crystallography/Crystallization
- High Throughput Protein (HTP)
- Services provided by CCG (accounted for 51% of the recharge revenue)
- Glass washing

LSI provides these services to external and internal customers, with the exception of glass washing, which is provided to internal departments only.

Since there may be several phases of the services provided by CCG, the Center sometimes does not bill customers until all phases of the service are complete, although they may be independent of each other. For instance, it may take seven to nine months to complete these services. The Center purchases reagents from the U-M Biomedical Research store and other vendors to fulfill certain customer orders. The cost paid for the reagents may vary significantly depending on the timing of the purchase and reagent type. CCG does not consistently maintain detailed reagent costing records; therefore, CCG is not always accurately pricing services that include reagents.

Recommendation: LSI should set external billing schedules and send invoices to customers at a predetermined frequency (Office of Financial Analysis recommends monthly). LSI should use consistent recharge rates for any materials that they use when providing the service (e.g.,

3. Internal and External Services	Medium
reagents). LSI should work with the Office of Financial Analysis, Tax Department, and Office of Research and Sponsored Projects (ORSP) to develop the appropriate pricing methodology. LSI should also educate staff and faculty on the requirements associated with the recharges, including timely billing, tax implications, and consistent pricing.	

Management Action Plan: LSI Finance will meet with center managers to discuss monthly billing for any accrued costs and will establish procedures to send invoices to General Receivables on a monthly basis. LSI Finance will also work with the center managers to create standard material billing tables to be reviewed with the Office of Financial Analysis.

Action Plan Owner: Director of Finance and Research Administration

Expected Completion Date: January 2015

4. Internal Controls Gap Analysis and Certification Process	Medium
<p>Issue: The gap analysis process is not sufficiently comprehensive, resulting in inaccurate and incomplete department responses on the Annual Unit Certification of Financial Results and Internal Controls.</p> <p>Risk: Control gaps may go undetected and unresolved. LSI may make decisions based on inaccurate information.</p> <p>Support: The gap analysis process is an integral part of the Annual Unit Certification of Financial Results and Internal Controls. The gap analysis involves reviewing key internal control points for each financial related process and determining whether the appropriate controls are in place. If the control is not in place, a corrective action plan should be developed to ensure the control gap is remediated in a timely manner. The gap analysis helps inform the certifier, if there are any control gaps, so they can accurately attest to the internal control environment in their organization. At LSI, each manager is responsible for performing the gap analysis and sub-certifying the financial results and internal controls for their areas of responsibility. The LSI Chief Operating Officer then reviews the results and the LSI Director approves them by signing off on the certification form. While the certification form indicated compliance with the requirements, the following exceptions were noted:</p> <ul style="list-style-type: none">• LSI made cash deposits of \$105,113 in fiscal year 2014. The main source of deposits were reimbursements for student travel paid by LSI on their behalf. The following control weaknesses were identified:<ul style="list-style-type: none">○ Cash handling duties were not segregated and the same individual had the opportunity to receive, deposit, and reconcile cash.○ There was no requirement to log cash that LSI received.○ Check copies were retained (bank account and other personal information was not blacked out).○ Cash was not always kept in a secure manner until deposit.	

- LSI made cash deposits of \$105,113 in fiscal year 2014. The main source of deposits were reimbursements for student travel paid by LSI on their behalf. The following control weaknesses were identified:
 - Cash handling duties were not segregated and the same individual had the opportunity to receive, deposit, and reconcile cash.
 - There was no requirement to log cash that LSI received.
 - Check copies were retained (bank account and other personal information was not blacked out).
 - Cash was not always kept in a secure manner until deposit.

4. Internal Controls Gap Analysis and Certification Process	Medium
<ul style="list-style-type: none">• During the review of eight expense reports in Concur system we noted the following:<ul style="list-style-type: none">○ An unauthorized faculty member approved one of the eight expense reports. The report contained a non-business expense.○ One of the eight reports did not go through the full chain of required approvals. One of the required approvers had not completed approver's training.○ One of the three authorized approvers did not complete the required Concur Approvers training (TEE 102).• LSI has 30 active P-Cards with monthly spending limits that range from \$2,000 to \$15,000. Although LSI did adjust the limits for two P-Cards during the most recent Internal Controls Certification process, there is no formal process to periodically review the limits and adjust them in accordance with spending needs. Based on historical spending patterns, the monthly P-Card spending limit was set too high on 10 out of 30 department sponsored P-Cards.	

Recommendation: LSI should perform the gap analysis at a more detailed sub-certifier level. Monitoring of internal controls should be performed consistently throughout the year and not only at the time of the certification. LSI should strengthen the controls around these processes:

- Document procedures for the expense report approval process, including a list of authorized approvers and delegates, if needed.
- Reinforce the department's awareness of the University policies associated with expense reporting.
- Confirm that the approvers and delegates are up-to-date with the training requirements. Periodically monitor the expense reporting approval process (e.g., review system reports).
- Implement a process to periodically review limits of P-Cards and adjust the spending limits accordingly (at least, annually).
- Assign different stages of the cash handling process to different individuals and update the written procedures accordingly.
- Create a log document to track the receipt of the deposits.
- Refrain from retaining check copies or permanently black out or delete personal account information so it cannot be misused.
- Lock cash deposits in a secured cabinet until there is an opportunity to make a deposit on the next business day.

Management Action Plan: LSI management will ensure appropriate managers understand and complete the gap analysis process, so they can accurately attest to their department's financial results and internal controls. On an annual basis, as part of the Internal Control Certification process, system reports are run to review and identify potential errors or discrepancies in policies and procedures surrounding expense reporting and P-Cards. Some adjustments were made during the last review in September 2013. LSI procedures will be updated to review system travel and expense reports, ensure required training is completed, and to review P-Card spending limits, on a quarterly basis. LSI written procedures will be updated to document the full chain of required approvals.

4. Internal Controls Gap Analysis and Certification Process	Medium
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LSI recognizes that procedures surrounding cash handling should be followed regularly. A second depositor has completed training to deposit checks to the accounts that the first depositor reconciles. Staff has been reminded that all checks must be received and logged by the Business Manager, and a third staff person will reconcile the deposits to the cash log. Additional procedures for protecting personal information on checks and for securing cash until deposit will also be reviewed with staff.

Action Plan Owner: Director of Finance and Research Administration

Expected Completion Date: January 2015

MiChart Revenue Cycle	2014-112
Report issued July 2014	

A. Executive Summary

1. Overall Conclusion

University Audits and UMHS (U-M Health System) Compliance Office recently conducted an audit of the UMHS MiChart Revenue Cycle, which is part of a multi-year health system project to provide unified electronic health records and integrated business process workflows. The MiChart project is an essential part of complying with the federal Health Information Technology for Economic and Clinical Health (HITECH) Act. Several software vendors are part of this implementation, with Epic as the primary system vendor.

Comprehensive system implementations by their nature can cause significant disruption to existing processes and controls. Despite some initial delayed billing and collections, the UMHS Revenue Cycle is well into optimizing revenue cycle business processes.

Management attributes increasing revenues and improved collection rates to MiChart efficiencies. Charge capture, revenues, collections, claim payment denials, and accounts receivable are well tracked and monitored. Data common across the MiChart platforms (procedure master data files) are well maintained and kept up-to-date. However, several workflows and processes need strengthening to reduce unintended errors, misstatements, and potential misappropriation. Based on the results of the audit, revenue cycle processes that require specific management attention include:

- Complete reconciliation of payments to MiChart patient account records
- Separated duties, especially in cash handling, reconciliations, refunds, and write-offs
- Improved controls over review and approval of patient account write-offs and refunds
- Improved training and secondary review of physician coding and the use of

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modifiers

- Continued attention to patient privacy, especially when sharing data with other University offices as part of normal business processes

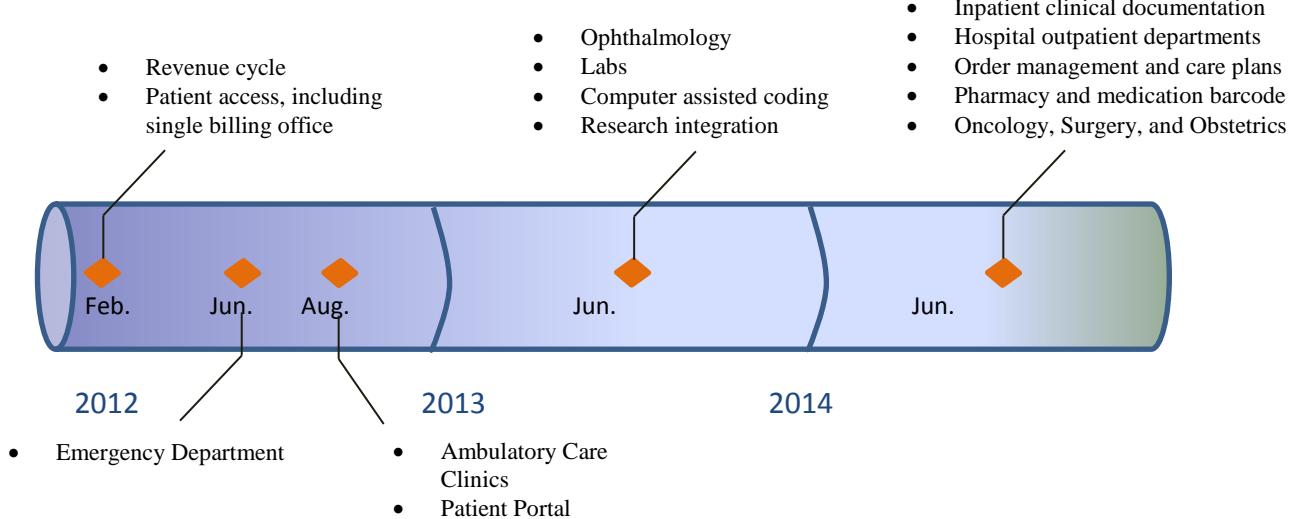
Throughout the audit, management was responsive and has adopted our recommendations or has action plans well underway. Because of the integrated nature of the MiChart platform, the recommended improvements should carry through subsequent implementation phases.

2. Context and Key Risk Considerations

The MiChart implementation is a multi-year clinical transformation project across the U-M Health System tasked with providing a unified electronic patient care and clinical business environment. The MiChart project uses several software vendors; Epic Systems Corporation has the largest role in the project. Epic is the primary provider of integrated patient care and billing software for major medical centers in the United States.

MiChart is being implemented in phases, which started in February 2012. The implementation is well underway and will last for several more years. Major implementation milestones to date include:

Major Implementation Milestones



The advantages of a comprehensive electronic health record and integrated orders and billing system are numerous:

- Enables quick access to patient records for more coordinated and efficient care
- Helps providers more effectively diagnose patients, reduce medical errors, and provide safer care
- Reduces cost through decreased paperwork, improved safety, and reduced duplication of testing

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As with all large-scale systematic change, there are risks of compromised data integrity, incomplete controls, unintended errors, and unauthorized data access and other security concerns.

University Audits completed this audit in cooperation with the UMHS Compliance Office, who provided expertise in coding and other aspects of the charge capture process.

3. Audit Scope and Identified Risks

This audit focused on the MiChart revenue cycle. The revenue cycle refers to all the administrative and clinical functions that contribute to the capture, management, and collection of patient services revenue. Audit areas included:

<u>University Audits Review</u>	<u>UMHS Compliance Office Review</u>
<ul style="list-style-type: none">Patient collection and accounts receivable managementPatient account write-offsPatient refundsRevenue monitoring and tracking, including claim payment denials management	<ul style="list-style-type: none">Physician outpatient codingCharge routing and charge lagMaintenance of charge master data files (EAP-Epic All Procedures)

The scope of the audit was determined based on an assessment of the risks associated with MiChart revenue cycle activities in the health system. This process included input from UMHS Revenue Cycle staff, UMHS Compliance Office staff, PwC (the University's external auditors), and interested parties from other University functions. The following table lists the key activities audited, along with the overall audit issues identified for each sub-activity.

Sub-activities Audited	Key Activities Audited					
	Refunds	Write-offs	Accounts Receivable	Cash Accounting	Revenue Monitoring	UMHS Compliance Office Review
Policies and procedures	Policies and procedures (Issue #4)	Patient account collections	Segregation of duties (Issue #3)	Write-off analysis	Physician coding (Issue #6)	
Segregation of duties (Issue #3)	Segregation of duties (Issue #3)	Claim payment denials management	Reconciliations (Issue #2)	Claim payment denials	Use of coding modifier 25 (Issue #7)	
Credit balances (Issue #5)	Authorization limits (Issue #4)	Aging of unpaid balances	Undistributed cash (Issue #2)	Charity care and bad debt	Charge routing and charge lag	

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	Refund payment support	Approval process (Issue #4)		Insufficient funds checks management (Issue #2)	Charge lag	Procedure master file
	Voided refund payments (Issue #5)	Monitoring process (Issue #4)			Collection rates and A/R aging	
	HIPAA compliance (Issue #1)	Write-off discounts (Issue #4)				

Legend: Overall risk conclusion for each sub-activity

High Risk	Medium Risk	No Issues Reported
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4. Audit Objectives

This audit was jointly managed and staffed by University Audits and UMHS Compliance. The key audit objectives by team are listed below:

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- Review and assess UMHS write-offs to determine if controls and practices are consistent and sufficient to prevent or detect errors and minimize lost profits
- Determine if accounts receivable controls are sufficient to reduce the risk of lost or misdirected revenues
- Assess the adequacy of cash accounting controls to manage processes, prevent or detect inappropriate activity, and maximize revenues
- Evaluate the effectiveness of oversight controls to monitor and report anomalies in the revenue stream
- Determine if the patient refund process is sufficiently controlled to prevent errors and misappropriation
- Assess the adequacy of existing controls to ensure claim payment denials are effectively pursued to minimize the amount of unpaid claims

UMHS Compliance

- Assess the accuracy and completeness of physician coding for select outpatient surgical procedures
- Assess whether medical documentation supports the use of coding modifier 25
- Evaluate the effectiveness of charge master file updating and maintenance
- Review the accuracy of charge routing and charge lag reporting

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Protected Health Information

High

Issue: The patient refund process was not fully compliant with Health Insurance Portability and Accountability Act (HIPAA) standards. In addition, patient refund information is stored and accessible to any University employee with access to University payment vouchers.

Risk: Failure to comply with HIPAA may result in civil and criminal penalties.

Support:

- U-M Financial Operations Accounts Payable (A/P) processes patient refunds for UMHS departments and campus units. As part of the accounts payable process, patient refund data is stored in M-Pathways and accessible to many U-M employees who do not have general training on how to handle protected health information (PHI).
- UMHS Revenue Cycle and Dental School staff were using noncompliant methods (M+Google and M+Box) to transmit patient refund information to Accounts Payable for processing. After University Audits communicated the finding, UMHS Revenue Cycle management quickly converted to a secure file transfer system. Treasurer's Office staff confirmed that the Dental School moved to a secure transfer file in June 2014.

Recommendations:

- A) Discontinue the practice of sending refund check information to A/P using non-HIPAA compliant file transfer systems. The UMHS Compliance Office should determine minimum necessary information needed for patient refunds and work with A/P and Information and Infrastructure Assurance (IIA) to develop the most appropriate method for storing data on U-M databases.
- B) UMHS Revenue Cycle staff has documented patient refund procedures; however, they need to update patient refund procedures to reflect recently revised processes for transmitting PHI to A/P.

Management Action Plans:

- A) The School of Dentistry Senior Compliance Specialist worked with the UMHS Compliance Office and A/P to ensure patient refund data is transmitted to A/P via a HIPAA compliant system. A/P management in consultation with UMHS Compliance Office staff will determine minimum necessary data requirements for processing patient refunds and communicate that information to interested parties, including Revenue Cycle Office, School of Dentistry, and University Health Services.
- B) Management will ensure staff updates refund procedures to reflect current practices. Management will also ensure staff periodically reviews procedures to keep them up-to-date.

Action Plan Owners:

- A) UMHS Chief Compliance Officer, School of Dentistry Senior Compliance Specialist, and Executive Director of the Shared Services Center
- B) Chief Officer, UMHS Revenue Cycle

1. Protected Health Information	High
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Expected Completion Dates:

- A) December 2014
- B) September 2014

Auditor's Note: A/P will transition to the Shared Services Center in August 2014. Their long-term goal is to move all refunds to M+Box as a shared process when M+Box becomes HIPAA compliant. In December 2014, University Audits will follow-up with Shared Services management to evaluate how refund processes are working in the shared services environment.

2. Reconciliations	High
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Issue: UMHS Revenue Cycle staff is unable to fully reconcile payments to patient accounts recorded in MiChart.

Risk: Weaknesses and inefficiencies in reconciling payment activity between MiChart and UMHS financial records may prevent administrators from accurately evaluating business performance and ultimately lead to mistakes in the University's balance sheet. Additionally, there is a risk that UMHS may be unable to detect duplicate batches, diversions of funds, and missing payments from insurance payors.

Support: In February 2012, UMHS blended Hospital Billing and Professional Billing into a consolidated billing system to create a single patient statement. Merging the professional and hospital billing platforms resulted in difficulties reconciling payments because reconciliation processes had not been fully developed before the consolidation.

- Payments received via the Health System's primary lockbox are reconciled at a high level; however, lockbox payments are not directly tied to activity recorded in MiChart. For example, insurance payments received through the lockbox are not traced to individual patient activity. As of March 2014, reconcilers estimated that there was a \$655,000 difference between payments recorded in UMHS financial records and cash posted in MiChart billing records. Staff attributes some of the difficulties of reconciling to Revenue Cycle's practice of posting certain payments based on insurance company electronic notice, but before UMHS physically receives the actual funds. Currently, these receivables are relieved based on the check date recorded in insurance payor A/R systems rather than on the deposit date or the date UMHS actually received payment.
- In March 2014, there was almost \$58 million in Hospital and Professional Billing Unknown Patient Payment accounts. This amount represents payments that have been posted to patient accounts, but not reconciled to UMHS financial records or matched and distributed to departmental earnings. Reconciliation staff titled the account "Unknown" because they cannot determine which charge units generated the revenue.

2. Reconciliations	High
<ul style="list-style-type: none">• Staff has been unable to reconcile and post some of the credit card payments received through the U-M Patient Portal because they lack sufficient information to determine charging units.• Staff has difficulties posting insufficient funds (NSF) checks to patient accounts. As of March 2014, almost \$63,000 in NSF payments had not been reconciled to a patient account.	

Recommendation: Obtain professional expertise in Epic payment posting and reconciliation processes to develop an effective reconciliation process. Determine resources necessary to complete reconciliations accurately and promptly.

Management Action Plan: Due to the significant changes the Revenue Cycle experienced with the MiChart implementation, management had anticipated a need to obtain assistance from an external consultant to review processes and ensure optimization of the Epic system. McKinnis Consulting Services (formerly MultiCare Consulting Services) was engaged via an RFP process in 2012 and they will focus on enhancing processes to reconcile payments and refunds recorded in UMHS financial records to patient activity recorded in the MiChart patient management system. McKinnis is working with Revenue Cycle Integrated Payment Posting and Analytics teams and UMHS Financial Services to develop reconciliation processes. As part of the engagement, management will work with McKinnis to determine personnel, skill sets, and other resources needed to perform reconciliations and keep them up-to-date. Proper segregation of duties will be taken into consideration.

Action Plan Owner: Chief Officer Revenue Cycle

Expected Completion Date: December 2014

3. Segregation of Duties	High
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Issue: Key revenue cycle operations are not segregated in a manner that will prevent a single employee from being able to execute a complete transaction without the involvement of others.

Risk: An employee may be able to both perpetrate and conceal errors or fraud in the normal course of business without detection.

Support: Incompatible duties that need to be segregated in an accounts receivable system are custody of assets, authorization, or approval of transactions affecting those assets, and recording and reporting of related transactions. Examples of conflicting responsibilities noted during the audit include:

- Users can approve write-off transactions they initiate; there is a small likelihood higher-level managers will review transactions when write-off amounts are within the users' established thresholds

3. Segregation of Duties	High
<ul style="list-style-type: none">• Individuals who post cash can also initiate and approve patient refunds without a secondary review by Patient Customer Service staff• Individuals responsible for reconciling refunds and payments can also initiate refunds and edit patient account information• Reimbursement managers, whose primary responsibility is working with charge units to resolve billing problems, can write-off patient balances without further approval or review• Individuals responsible for sending refund files to Accounts Payable also:<ul style="list-style-type: none">○ Initiate and approve refund transactions○ Edit payment designation handling codes, which control where checks are sent○ Handle insurance and other refund checks○ Mail checks○ Investigate refund payments that fail to upload to patient accounts	

Additionally,

- Line items on patient and insurance refund files, including payment handling codes that indicate where checks should be sent, can be manipulated (i.e., system-generated line items can be altered or deleted, new line items can be added).
- The MiChart billing system does not automatically restrict users from writing off personal account activity.

Recommendation: Assess roles assigned to staff in the MiChart system to verify roles are compatible with job responsibilities (i.e., reconcilers should not be able to write-off patient accounts without management approval).

- Separate responsibilities associated with approving transactions for payment, preparing check requests, and mailing checks. Assign the following responsibilities to someone independent of the refund process:
 - Sign-in and logging of refund checks delivered to revenue cycle operations
 - Verification that refund checks were mailed or voided
 - Investigation of refunds that fail to load to patient accounts
- Flag transactions initiated and approved by the same individual and delegate appropriate managers to review these transactions.
- Develop compensating controls to mitigate responsibilities that cannot be segregated properly.

Management Action Plan: Management will review roles assigned to staff involved in the refund process to ensure there is a proper segregation of duties. Management will also assess MiChart roles for conflicting access rights and remove those role assignments, where possible, or otherwise develop compensating controls. Management will explore ways to ensure one individual cannot both initiate and approve the same transaction.

Action Plan Owner: Chief Officer Revenue Cycle

3. Segregation of Duties**High****Expected Completion Date:** December 2014**4. Write-off Approval and Review****High**

Issue: Since the implementation of MiChart, review and approval of accounts receivable write-offs have been inconsistent. Preventive and detective controls over the write-off process are not fully developed.

Risk: Without systematic review and approval processes, there is a potential the U-M Health System may forego revenue when insurance and self-pay patient account balances are improperly reduced and written off.

Support:

- Write-off activity was:

WRITE-OFFS	Fiscal year 2013	Fiscal year 2014 through Apr. 2014
Professional Billing	\$21.9M	\$32.1M
Hospital Billing	\$24.1M	\$21.4M
- A/R management uses differing methodologies to approve and monitor write-offs, including:
 - Management approval via MiChart work queues
 - Written approval where the approval documentation is maintained by the employee
 - Verbal approval (approvals are not documented)
 - Management review after-the-fact
- Inconsistencies exist in how A/R management monitors write-off activity in their areas:
 - Hospital billing management receives detailed monthly reports showing write-off activity by user.
 - Professional billing management does not receive write-off reports.
 - Managers vary in the level of review from comprehensive reviews of all transactions that exceed staff thresholds to less detailed spot-checks of a sample of transactions for quality assessment purposes.
- Management does not review all write-off activity; in most circumstances, managers are reviewing write-off codes that are relevant to their area, and are not reviewing all write-offs performed by their staff.
- There are no system-wide restrictions or preventive controls; all users with the ability to perform write-offs may write off to any code and there are no system controls to restrict the amount users may write-off.
- Staff manually process write-off discounts as a percent of total charges; however, there are no built-in system controls to verify dollar amounts written off are calculated at the approved rate.
- Management has not reviewed and adjusted write-off thresholds since hospital and

4. Write-off Approval and Review	High
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professional billing platforms merged.

Recommendation: Develop robust write-off approval and review procedures, standardizing processes across all areas, and expand processes to include higher-administrative authority reviews of all write-off transactions initiated and approved by the same individual.

- Document write-off processes and make them available to relevant personnel.
- Develop detailed reports to document and facilitate management's review of professional billing write-off activity.
- Review and optimize system access and work flow to provide system-driven restrictions and controls, where possible.
- Analyze write-off trends to detect inappropriate activity.

Management Action Plan: With the assistance of McKinnis Consulting Services and with an anticipation of the need to update processes with the new system, management recently developed and implemented a new write-off policy, incorporating new thresholds and approval processes. The Revenue Cycle Analytical team will soon provide monthly write-off activity reports to professional billing management and start analyzing professional and hospital billing write-off activity for unexpected trends and other anomalies.

Action Plan Owner: Chief Officer Revenue Cycle

Expected Completion Date: September 2014

5. Refund Practices	Medium
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Issue: The patient refund process does not have sufficient controls to detect errors, such as duplicate refunds.

Risk: Unauthorized and duplicate refunds may be processed and misappropriated without detection. Payments are not always promptly and properly applied to patient accounts, resulting in additional attempts to collect payments, patient and insurance payor dissatisfaction, potentially higher volume of write-offs, and understated collection rates. Refund checks that should be voided may be mistakenly remitted to the State of Michigan as unclaimed property.

Support:

- Refund activity was:

REFUNDS	Fiscal year 2013	Fiscal year 2014 through Apr. 2014
Professional Billing	\$4.2M	\$3.9M
Hospital Billing	\$21.9M	\$10.2M

- Despite controls built into the Accounts Payable system, duplicate refunds with identical or nearly identical invoice numbers can be processed.

5. Refund Practices	Medium
<ul style="list-style-type: none">Revenue Cycle staff does not always have sufficient information to match refund checks to patient accounts. In these situations, staff usually holds uncashed checks in office file cabinets without voiding them.Due to time constraints, Revenue Cycle staff does not investigate refunds that fail to post to patient account records.Staff has documented refund practices, but the document is in draft format and has not yet been reviewed and approved by management. University Audits reviewed the draft document and noted that it contains processes for generating, reviewing, and sending self-pay refund files to Accounts Payable, but does not address insurance refunds, failed uploads, and voiding refund checks.	

Recommendation: Enhance refund processes to prevent and detect duplication and other errors:

- Develop independent queries using tools such as Business Objects or ACL software to strengthen controls over identifying duplicate refund payments.
- Consider discontinuing the practice of deactivating temporary invoice numbers after refund information has been uploaded to patient records. Keeping temporary invoice numbers active will reduce the number of failed uploads, help keep records up-to-date with most recent refund and void activity processed on patient accounts, and facilitate staff investigations of potential duplicate payments. Instruct staff how to reference patient records using deactivated temporary invoice numbers.
- Develop and implement processes for voiding refund checks.
 - Include processes for handling checks remaining on-hand (i.e., print the word VOID across the face of the check using a permanent marker).
 - Document processes.
- Assign and train appropriate employees to act as backup for individuals who create and manage weekly refund files.

Management Action Plan: Refund practices will be enhanced to include check voiding processes and an internal methodology to detect and investigate potential duplicate refund payments. Management will:

- Investigate the feasibility of keeping temporary invoice numbers active
- Ensure relevant staff can tie temporary invoice numbers to patient account records
- Initiate a process to investigate failed uploads, keeping separation of duty guidelines in mind
- Develop backup processes to ensure refund files are sent to Accounts Payable as scheduled
- Ensure refund processes are documented and updated as necessary

Action Plan Owner: Chief Officer Revenue Cycle

Expected Completion Date: December 2014

6. Physician Coding	Medium
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Issue: Providers and charge unit billing staff do not always bill the correct procedure codes or verify that patient medical records contain sufficient documentation to support claims.

Risk: Billing errors and insufficient documentation put the University at risk for unintentional billing fraud and increase the likelihood of lost revenues.

Support: Based on a sample of 199 claims, 15 claims had incorrect codes or inadequate documentation to support the claim. This is an error rate of over 7.5%.

UMHS Compliance Office review of supporting documentation and billing claims for a judgmental sample of 199 claims (with service dates between April and June 2013) for eight different minor outpatient surgical procedures resulted in:

- 10 claims without adequate physician notation or other documentation to support the claim
- 5 claims billed using incorrect procedure codes

Recommendation: To decrease the risk of lost revenues, review the frequency and effectiveness of:

- Periodic provider audits to detect coding and documentation deficiencies and identify educational opportunities
- Education on documentation standards and correct code usage to clinicians, physicians, billing staff, and other personnel who contribute to claims processing

Claims identified with errors have been sent to Revenue Cycle management for refund and rebilling consideration.

Management Action Plan: Billing staff will investigate errors noted during the audit and make corrections in accordance with UMHS billing guidelines. Revenue Cycle management will work with the Chief Medical Officer for Billing and Compliance to evaluate coding review processes performed by Revenue Cycle staff and determine what adjustments need to be made to current processes (i.e., sample size, sample selection methodology, frequency or timing of review) to make them more effective.

Action Plan Owners: Chief Officer Revenue Cycle Management and Chief Medical Officer for Billing and Compliance

Expected Completion Date: December 2014

7. Use of Coding Modifier 25	Medium
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Issue: Charge units do not always correctly add-on Modifier 25 to patient claims in the MiChart billing system.

7. Use of Coding Modifier 25

Medium

Risk: Over- or under-billing and other billing errors put the University at risk for unintentional billing fraud and increase the likelihood of lost revenues.

Support: Adding coding Modifier 25 to patient health claims indicates that on the day of a procedure, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service, beyond the usual pre- and post-operative care associated with the original procedure or service performed. Adding Modifier 25 to a claim implies that documentation supports medical necessity and payment of both the procedure and the E/M service.

UMHS Compliance Office staff performed a retrospective audit using a judgmental sample of 151 outpatient procedures, with service dates between April and June 2013 and stratified over eight different minor surgical procedure billing codes. This sample was a subset of the claims selected for the physician coding test. The review resulted in a finding of:

- 10 claims in which E/M services with Modifier 25 add-ons were billed, but should not have, based on Centers for Medicare and Medicaid Services (CMS) documentation standards
- 6 claims that did not, but should have had , Modifier 25 added to the claim
- 5 claims that should have billed a separate E/M service and add-on Modifier 25, but were not

Recommendation: Perform secondary reviews and targeted audits on a regular basis to assess whether staff appropriately added-on Modifier 25 to claims. Additionally, develop mandatory training courses and create templates and other job aids to help providers and other individuals in the charge unit who are responsible for billing identify and understand situations in which modifiers should or should not be added to claims.

Regarding the billing errors UMHS Compliance Office auditors identified during this review, Revenue Cycle billing staff should initiate refunds and rebill claims as appropriate.

Management Action Plan: Billing errors noted during the audit will be investigated and corrected in accordance with UMHS billing practices. Revenue Cycle management will work with the Chief Medical Officer for Billing and Compliance to evaluate coding review processes performed by Revenue Cycle staff and determine what adjustments need to be made to the processes (i.e., sample size, sample selection methodology, frequency or timing of review) to make them more effective.

Action Plan Owners: Chief Officer Revenue Cycle and Chief Medical Officer for Billing and Compliance

Expected Completion Date: December 2014

Museum of Zoology

2014-208

Report issued September 2014

A. Executive Summary

1. Overall Conclusion

Opportunities exist to standardize functions, specifically those surrounding compliance with the import and export of specimens and samples. Creating a registrar position would capitalize on these opportunities. The Registrar could act as a central administrative point to oversee compliance and streamline processes. This position could potentially serve as a compliance monitor for other College of Literature, Science, and the Arts (LSA) museums. The implementation of a new collection management software solution and the relocation of the collection from the Ruthven Museums Building to the Varsity Drive facility provide some opportunity to centralize and standardize some processes.

The University of Michigan Museum of Zoology (UMMZ) is experiencing changes in administration, leadership, and facilities. Documenting collection management procedures for each division will help to confirm that processes are completed in a consistent, predictable, and efficient manner. Documentation is critical for succession planning and to confirm the transfer of knowledge from collection managers who, in some cases, have held that position upwards of 30 to 40 years.

2. Context and Key Risk Considerations

UMMZ is a center of research, education, and public outreach. Since 1837, UMMZ's core concern has been the preservation and maintenance of museum specimen collections. The UMMZ collections are unique, and much of it is irreplaceable and priceless. The breadth of the collection is global, represents many extinct species and fauna, and spans almost 200 years. The majority of the collection includes specimens that are either maintained in a dry state or preserved in ethanol (wet collection). The collection is respected internationally as one of the largest resources for research and scholarly publications. UMMZ houses roughly 15 million specimens that span across six divisions: birds, fishes, insects, mammals, mollusks, and reptiles and amphibians. There is a curator and collection manager for each division. In some cases, the division may not have an active curator so the responsibility is taken by the Museum Director.

In 2012, the large majority of the wet collection for UMMZ was moved from the Ruthven Museums Building to a new off-campus storage facility on Varsity Drive in order to comply with safety codes for storage of flammable material. The new facility includes state-of-the-art shelving and research areas. In 2013, further renovations of the Varsity Drive facility to relocate the dry research museum collections, associated lab spaces, and some offices were approved. Construction is scheduled to be completed in

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the winter of 2015 and relocation will occur shortly afterwards.

Since 2010, LSA has been engaged in a comprehensive review of collection management practices led by the LSA Museum Steering Committee. Based on this continued review, the recommendation was made to implement and support a single collection management software solution for all LSA Museums (i.e., Museum of Anthropological Archaeology, Kelsey Museum of Archaeology, Herbarium, Museum of Natural History, Museum of Paleontology, and Museum of Zoology). Discussions and testing are underway to identify the best solution for the museums.

3. Audit Scope and Identified Risks

The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity. The scope of the audit was determined based on an assessment of the risks associated with the activities of UMMZ. This process included input from leadership within LSA, the Department of Ecology and Evolutionary Biology (EEB), and interested parties from other University functions.

		Key Activities Audited				
		Accession and Deaccession Process	Inventory Management	Safety and Security	Regulatory Compliance	Research
Sub-activities Audited	Accession and deaccession approvals	Managing and tracking specimens	Physical access (see issue 4)	Orientation and training (see issue 2)	Research administration	
	System security and access - software	Lost specimens/inventory	Occupational Safety and Environmental Health (see issue 2)	Compliance monitoring	Research expenditures	
	Importing/exporting specimens (see issue 1)	Inventory reconciliation	Emergency procedures	Zoological permits	Subrecipient monitoring	
	Documented procedures (see issue 3)	Insurance (see issue 5)	Continuity of operations/disaster recovery	Intellectual property	Effort reporting	
		Loans	Research laboratories	Compliance Hotline	COI/COC management	

Legend: Overall risk conclusion for each sub-activity

High Risk

Medium Risk

No Issues Reported

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4. Audit Objectives

The objectives of this audit were to:

- Determine whether the processes for the accession and deaccession of specimens/samples are adequate.
- Determine whether the processes for managing and tracking specimens/samples are adequate.
- Assess whether safety and security measures are sufficient.
- Determine whether existing controls confirm compliance with applicable laws and regulations.
- Assess whether controls for research administration are appropriate.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Import and Export Permits	High
<p>Issue: UMMZ does not centrally monitor permits for imports and exports.</p> <p>Risk:</p> <ul style="list-style-type: none">• The University can incur penalties and fines associated with the illegal importing of research specimens upwards of \$10,000 per violation.• Individuals may incur criminal or civil penalties, including jail and/or fines.• Research could be invalidated and specimens could be seized.• The quality and growth of the UMMZ collection may be compromised.• Use of improperly acquired specimens could damage the University's reputation. <p>Support:</p> <ul style="list-style-type: none">• The United States and many foreign countries have enacted wildlife laws and ratified international treaties to protect wild animals, plants, and their habitats. These laws, treaties, and regulations require permits to help conserve protected resources.• It is the responsibility of research faculty to obtain the appropriate permits for incoming research specimens that are not a part of the museum collection. These faculty import specimens with no approval or oversight. When research is complete, these specimens are often given to the collection manager to be accessioned into the collection. There are times when faculty submit specimens without proper permit documentation years after the research has been conducted. These specimens are rejected by the collection managers, as proper documentation is required to be accessioned into the collection. Researchers cannot publish research done on specimens or samples that lack the proper permit documentation.• Collection managers are responsible for obtaining and maintaining permit documentation associated with specimens in the collection. They also have to report activity to the permitting agencies on an annual basis. Collection managers have experienced an increase in workload due to increased regulations and restrictions associated with import/export	

1. Import and Export Permits	High
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laws. In some cases, the number of specimens accessioned into the collection has reduced considerably due to difficulty in dealing with the process.

- Relieving the burden of managing permits would allow collection managers to focus more on cataloguing, maintaining, and expanding the collection.

Recommendation: Establish a process to oversee and monitor the acquisition of permits in compliance with regulations. A solution discussed with management included establishing a registrar position to serve as the compliance expert and monitor compliance with import/export regulations and other applicable laws. With collections of this size and complexity, a registrar position is common. Additionally, a registrar could standardize forms and processes. For example, forms to track transfers, gifts, and loans could be standardized museum-wide.

Ideally, the collection managers would have a dual reporting relationship, administratively to the curator and functionally to the registrar. The Registrar would potentially:

- Develop and implement a process to monitor compliance for faculty
- Educate faculty, staff, and students on regulations and guidelines for import/export and other compliance areas
- Act as a central administrative point for incoming and outgoing specimens/samples
- Manage the purchase and renewal of zoological permits
- Report activities to federal agencies as required on an annual basis
- Manage loans and transfers of specimens from the collection
- Assist in standardizing forms, templates, and processes museum-wide
- Monitor high-priced assets and obtain appropriate insurance coverage

The relocation of collections to the Varsity Drive facility would be an effective time to implement a process to monitor compliance. The co-location of museums may provide opportunities for a Registrar to assist with all museums that will be located at the Varsity Drive facility.

Management Action Plan: UMMZ curators and collection managers and researchers formally associated with UMMZ currently follow guidelines for the collection and the import/export of specimens as described in the 2011 “University of Michigan Museum of Zoology Policies and Procedures” document reviewed and approved by the LSA Executive Committee in 2012. Our policies do not currently include central compliance oversight.

The Department of Ecology and Evolutionary Biology (EEB) will work with LSA to identify the appropriate financial resources to create the position of Registrar for UMMZ. We envision the registrar will oversee and facilitate permit (collecting and import/export) compliance.

The standardization of forms will take place automatically once we adopt a new database management system.

Action Plan Owners: EEB Chair, Associate Chair for Museum Collections – Zoology, Interim Associate Chair for Museum Collections – Zoology, EEB Department Administrator

1. Import and Export Permits	High
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Expected Completion Date:

- Proposal for registrar – March 2015
- Standardization of forms – upon acquisition of a new database system, estimated to take 1-3 years

2. Handling of Hazardous Materials	Medium
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Issue: Individuals exposed to hazardous materials have not completed Occupational Safety & Environmental Health (OSEH) lab safety training. Additionally, a process has not been established for the safe transport of specimens preserved in alcohol by collection managers or other UMMZ staff.

Risk: Individuals may get injured and/or damage the collection.

Support:

- UMMZ uses some hazardous materials in the preservation process. Collection managers conduct training and orientation for faculty and staff. However, there are no unit procedures to identify, notify, and track that appropriate individuals have completed the required OSEH training.
- About five million specimens from the UMMZ's wet collection are preserved in ethanol inside various containers. Ethanol is highly flammable, corrosive, and can cause a number of health issues. The wet collection was moved to the Varsity Drive facility to comply with fire codes. Much of the office space, research space, and dry collections are still located at Ruthven.
- When small amounts of wet specimens are needed for research at Ruthven, staff transport them in jars of ethanol from Varsity Drive to Ruthven Museum in their personal vehicles. There is a process in place to transport large numbers of specimens via LSA Facilities. This is rarely used because large numbers of specimens are not typically needed for research.

Recommendation:

- All staff, students, and faculty handling hazardous materials should complete the OSEH lab safety training. OSEH lab safety training should be incorporated into the onboarding process, documented in the chemical hygiene plan, and tracked to confirm that training is completed. All staff, students, and faculty should complete the training every three years.
- Consult with OSEH, the Office of Risk Management, the Office of General Counsel (OGC), and LSA Facilities to identify a safe way to transport small quantities of specimens, without the use of personal vehicles. Establish and document the approved procedures for transporting specimens. Identify and implement methods to periodically monitor compliance with established processes. The OSEH Hazardous Material Management Team should be consulted to identify guidance and training related to specimens packaging.

Management Action Plan: Training: Currently, collection managers keep chemical hygiene plan

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2. Handling of Hazardous Materials	Medium
document binders. Effective fall term 2014, they will keep documentation on completion of OSEH lab safety training for staff, students, and researchers who work in their collection spaces. Their training will be kept up to date by being refreshed every three years. We will follow the OSEH guidelines for the training of faculty, staff, students, and visitors, and no one will be allowed to work in collection space without this training. We will coordinate with OSEH, particularly regarding training of individuals involved with packing and transporting specimens. Keys to collections space will not be distributed to anyone who has not had this training. When we move to the Varsity Drive facility, proof of training will be required before key card access is given.	

Transport of Specimens: The “timely” transport of specimens in alcohol to and from Central Campus and Varsity Drive is a current problem for us. In the past, we have used LSA Movers but they are not available on short-term notice. We have four options:

- 1) Package specimens for shipment before transporting them. This involves unnecessary handling of fragile specimens and is an undesirable solution.
- 2) Discuss with LSA Movers possible solutions that could include a standing order for specimen transport on a weekly basis.
- 3) Identify an alternative transport service. OSEH has identified two potential carriers:
 - a. Rightaway Delivery: <http://www.rightawaydelivery.com/rightaway-delivery.html>
 - b. Metro Delivery: <http://www.metrodelivery.com/>
- 4) Petition LSA for a dedicated and properly licensed University vehicle to transport specimens.

EEB will request support from LSA for either options three or four, with option four being our preference. We believe the best person to transport specimens is a collection manager who has specialized training in handling the materials.

Action Plan Owners: EEB Chair, Associate Chair for Museum Collections – Zoology, Interim Associate Chair for Museum Collections – Zoology, EEB Department Administrator

Expected Completion Date:

- OSEH training – effective immediately
- Transport of specimens – June 2015

3. Documentation of Procedures	Medium
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Issue: Key procedures are not consistently documented.

Risk:

- If UMMZ curators, collection managers, or staff left the University, specialized knowledge about that division may not be transferred effectively to their successor.
- Individuals may potentially misuse or mismanage collection specimens.

3. Documentation of Procedures	Medium
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Support:

- Some divisions have comprehensive curation manuals, and others have minimal documentation.
- Divisions use different software programs to manage collection data. In some cases, the software is outdated and would be difficult to use due to a lack of documentation if the collection manager left the University. Although there is an initiative to get all LSA museums on the same collections management software, it will not be fully implemented for at least three years. It is important to the continuity of the collections that key collection management procedures be documented.

Recommendation: Document key procedures for each division, especially in areas where UMMZ guidance is absent or not current. Documentation should be periodically reviewed and updated.

At a minimum, document procedures for:

- Collection management software (steps to access information, where it is located, how it is organized, backups, and record retention)
- Organization and storage of specimens and other materials
- Specimen preparation, care, and maintenance
- Cataloguing and tracking
- Permitting and Shipping

Given that some collection managers may be retiring within the next few years, it is essential to provide an overlap of employment so that specialized knowledge is transferred effectively. This also provides a good opportunity for the outgoing collection manager to document procedures as they are going through the training process.

Management Action Plan: Collection managers for each division will work on curation manuals over academic year 2014-2015. We have developed an M+Box site for this activity. Collection managers will use a prototype to develop their divisional manuals. We note that databases for all collections are routinely backed up on an LSA server. When completed, curation manuals will be added to the administrative area of the UMMZ website and hard copies maintained along with museum policy documents in the museum office and collection spaces. A policy to provide periodic review of all policies and procedures will be developed that will ensure these documents are reviewed on an annual or biannual basis.

Action Plan Owners: EEB Chair, Associate Chair for Museum Collections – Zoology, Interim Associate Chair for Museum Collections – Zoology, EEB Department Administrator

Expected Completion Date: June 2015

4. Management of Keys	Medium
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Issue: Individuals do not always return physical keys when they are no longer needed.

4. Management of Keys	Medium
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Risk:

- Unauthorized access to facilities, confidential and research data, and hazardous materials could result in theft or property damage, leading to irreparable damage to research projects and/or the collection.
- Unauthorized access may result in personal injury.

Support:

- There are currently over 1,000 actively issued keys (only tracked since 1992) that provide access to UMMZ office and research areas in the Ruthven Museums Building. Many of the keys are assigned to individuals who are no longer with the University. External entry to the Ruthven Museums Building is managed via electronic card access, while internal rooms remain controlled by physical keys.
- It is the key holder's responsibility to return the key to the Key Office. There is no departmental confirmation that staff members have returned keys.
- The Varsity Drive location access will be managed via card swipe access so the risk of physical keys in the new facility will decrease substantially. Key card access is granted and removed directly by UMMZ administration.

Recommendation: Create a process to determine whether keys issued for UMMZ access are returned upon termination, transfer, or retirement. Such a confirmation could be included in UMMZ off-boarding procedures. Consider the following when implementing the process:

- Sensitivity of areas
- Rekeying sensitive areas
- Periodic reconciliations of keys

To manage Varsity Drive access, keys should be periodically reconciled to ensure access is removed for individuals no longer requiring access to the facilities.

Management Action Plan: UMMZ will be moving to Varsity Drive in academic year 2016-2017 where access to the building and to the collections space will be via key-card. Currently, keys and card access are approved by the Museum Administrative Specialist, who maintains records of all such authorizations and removes card access when individuals leave the unit. This will continue after the move to the Varsity Drive. Although keys are issued by the Key Office and ultimate responsibility for returning them rests with the individual key holder, we will institute a procedure whereby the Administrative Specialist will monitor individuals with physical keys and contact them when they leave the unit to ensure that keys are turned in. We note that after-hours key-card access to Ruthven is up to date. Exterior doors to Ruthven were recently rekeyed, so old door keys no longer work. With the upcoming move of faculty and students from Ruthven to the new Biological Sciences Building (BSB), EEB plans a key exchange process, whereby the department will obtain keys for BSB rooms from the Key Office and only provide them to personnel in exchange for old keys. Old keys will be returned to the Key Office.

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4. Management of Keys	Medium
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Action Plan Owners: EEB Chair, Associate Chair for Museum Collections – Zoology, Interim Associate Chair for Museum Collections – Zoology, EEB Department Administrator

Expected Completion Date: Upon completion of move to Varsity Drive, estimated to be in academic year 2016-2017

5. Management of Artwork	Medium
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Issue: UMMZ has not maintained artwork properly. The art has not been evaluated for insurance requirements.

Risk: Artwork may be damaged or destroyed.

Support:

- Some divisions have artwork that may have substantial monetary or historical value. The majority of artwork identified during the audit was paintings of fauna relevant to that collection that were donated.
- Paintings and original artworks have not been appraised or insured.
- Staff members are not trained on how to store and maintain art.

Recommendation: Inventory artwork and document the location. Assess the value of the art and whether or not it is relevant to the collection to determine if it should be retained or sold. If art is retained, consult with the U-M Museum of Art should to determine how to effectively maintain the art. Coordinate with Risk Management to identify appropriate insurance coverage.

Management Action Plan: The UMMZ Scientific Illustrator is currently conducting an inventory of our artwork. Upon completion of the inventory, we will seek advice on our holdings from the Bentley Historical Library. Illustrations and other artwork appropriate for the Bentley will be donated to the Library. We will also seek advice from the Bentley and Risk Management to determine value and proper preservation procedures for artwork retained by the museum.

Action Plan Owner: EEB Chair, Associate Chair for Museum Collections – Zoology, Interim Associate Chair for Museum Collections – Zoology, EEB Department Administrator

Expected Completion Date: September 2016

NCAA Compliance Review

2014-402

Report issued July 2014

A. Executive Summary

1. Overall Conclusion

The Compliance Services Office (CSO) has adequate controls for monitoring compliance to NCAA guidelines. During the review, University Audits observed no NCAA violations.

2. Audit Scope and Identified Risks

As a member of the National Collegiate Athletic Association (NCAA), the University of Michigan is required to comply with NCAA rules and regulations. At U-M, the Compliance Services Office (CSO) has the primary responsibility to oversee conformity with these requirements. University Audits completes an annual NCAA Compliance Review to provide assurance that CSO monitoring processes are effective.

The annual reviews performed by University Audits include all varsity sports over a five-year cycle, with higher profile sports receiving reviews that are more frequent.

Procedures also include a review of select external camps and booster clubs to determine whether processes for tracking financial activity are adequate. The review completed this year included: Football, Men's Basketball, Women's Basketball, Men's Gymnastics, Women's Gymnastics, Women's Golf, Wrestling, and Men's Lacrosse. The following table lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity.

Key Activities Audited						
Sub-activities Audited	Rules Education	Playing and Practice Seasons	Coaching Staff Limits	Financial Aid	Eligibility	Recruiting
Rule interpretations and updates	Rule interpretations and updates	CARA (Countable Athletically Related Activities) process	Coaching staff limits	Squad lists and CAi data	Obtain certified eligibility lists (CEL)	On campus – official visits
	Intranet review	Timely submission of CARA logs		Individual limit testing	Initial eligibility	Contracts and evaluations
	Evaluation of rules education meetings	CARA testing		Team financial aid limit review	Continuing eligibility	
		Practice visits			Transfer eligibility	
		Playing and practice season				

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		Key Activities Audited					
		Camps	Boosters	Complimentary Tickets	Athletic Performance Program	Grade Changes	Gift Cards
Sub-activities Audited	Women's Field Hockey	U-M Club of Greater Chicago	Basketball Comp tickets	Athletic performance program	Monitoring of grade changes	Gift card controls	
	Football	U-M Club of Grand Rapids	Ice Hockey comp tickets				
	Ice Hockey	U-M Women's Athletic Association	Football comp tickets				
	Women's Softball		Post season comp tickets				
	Men's Soccer						
	Camp Administrator						

Legend: Overall risk conclusion for each sub-activity

High Risk	Medium Risk	No Issues Reported
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Note: No medium or high risk issues were identified during the audit. Low risk issues were communicated directly to unit management and are not included in the report.

3. Audit Objectives and Detailed Procedures

The section below outlines the specific objective(s) and detailed procedures for each compliance area reviewed. Unless specifically noted, procedures were performed only for the selected sports and for the 2013/2014 academic year.

Rules Education

- Confirmed that the “rules education program” includes student-athletes, coaches, non-coaching Intercollegiate Athletics (Athletics) employees, and other representatives of the University’s athletics interests (e.g., boosters).
- Reviewed selected CSO rules education information provided on the intranet site for meetings held during fall 2013 and winter 2014 to ensure coverage of key NCAA rules and regulations, including topics such as financial aid, recruiting, and eligibility.

Playing and Practice Seasons

Countable Athletically Related Activities (CARA) are tracked and monitored through the CSO’s compliance monitoring software, JumpForward. This process requires all sports

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to report weekly activities for each of their athletes. JumpForward then identifies a random sample of athletes who will receive an email requesting anonymous verification of the hours reported by the coach.

To complete the review of playing and practice seasons, University Audits:

- Confirmed each of the selected sports reported their CARA activity in JumpForward within the CSO's established timeframes for the full academic year.
- Confirmed that all athletes in the CSO's random sample had logged in to JumpForward and confirmed the schedule.
- Verified compliance with NCAA weekly hour limits and day-off requirements and confirmed adequate follow-up with student-athletes based on their responses. For football, the entire season was included. For men's basketball, four weeks of the playing season and four weeks of the off season were reviewed. For all other selected sports, one playing season week and one off-season week were reviewed.
- Verified compliance with restrictions on start and (where applicable) length of playing seasons.

Coaching Staff Limits

- Verified compliance with NCAA coaching limits by reviewing the coaching staff lists.
- Confirmed that non-countable staff (volunteer and other non-coaching positions) signed the agreement that details permissible and non-permissible activities.

Financial Aid

- For the entire student-athlete population, used data analysis software to compare financial aid amounts in M-Pathways to the data reported to the NCAA. Specifically:
 - Verified that total financial aid and athletic-based financial aid reported in the University's system for the fall 2013 and winter 2014 terms was within NCAA limits.
 - Confirmed the financial aid amounts in the University's system were not greater than the amounts actually reported to the Big Ten on the squad lists.
- For the sampled sports, verified compliance with NCAA team limits.

Eligibility

- **Initial Eligibility** - For a sample of incoming student-athletes, confirmed each student-athlete:
 - Had initial eligibility reports or other documentation from the NCAA Eligibility Center
 - Had their certification of initial eligibility completed prior to the student-

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- athlete's initial competition
 - Was enrolled in a full-time program leading to a degree
- **Continuing Eligibility** - For a sample of continuing student-athletes, confirmed each student-athlete:
 - Was enrolled in a full-time program leading to a degree
 - Was within the NCAA prescribed number of seasons of eligibility
 - Met specific NCAA and Big Ten progress toward degree and minimum grade point average requirements
- **Transfer Eligibility** - For a sample of incoming transfer student-athletes, confirmed each student-athlete:
 - Met the one-year residency requirement or qualified for a waiver
 - Had a copy of the releases from previous institutions on file
 - Met eligibility determinations for practice and competition

Recruiting

- **On-Campus** - Reviewed documentation for a sample of prospects from the selected sports who made an official visit to the University and confirmed:
 - The visit took place after the first day of classes of the prospect's senior year in high school
 - The file contained academic documentation and test scores or NCAA Eligibility Center verifications
 - The visit lasted no more than 48 hours
 - Lodging, meals, and entertainment were compliant with NCAA regulations
 - Official Visit and Code of Conduct forms were accurately completed
- **Off-Campus** - For a sample of prospects from the selected sports, reviewed a report from JumpForward that details all contacts and evaluations. Confirmed that the contacts and evaluations for the prospect did not exceed NCAA limits and occurred during allowable periods.

Camps and Clinics

- Reviewed compensation documentation submitted to Athletics to confirm that compensation for coaches and student-athletes is reasonably consistent with other counselors of like teaching ability and camp experience.
- Confirmed that free or reduced admissions were recorded with an explanation on Athletics forms and compliant with NCAA regulations.
- Reviewed bank statements and supporting documentation to ensure transactions are reasonable, have a clear business purpose, and appear to be related to the operations of the camp.
- Confirmed reasonableness of amounts reported on the Athletics Financial Disclosure form, based on documentation provided.

Recommendations to improve business operations for the camps were shared with the camp owners and sport administrators at the time of the review as well as in a separate

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memorandum addressed to the Camp Administrator, the CSO, and Athletics management.

Boosters

- Reviewed each booster club's Statement of Disclosure and financial records and assessed their processes for managing and tracking financial activity. Each booster club received a memorandum with suggested process improvements in their area as applicable; no compliance issues were observed.

Complimentary Tickets

- For one regular season game for football, men's basketball, and ice hockey:
 - Reviewed the complimentary ticket reconciliation form and supporting documentation for completeness.
 - Confirmed compliance with NCAA limits on student-athlete guest complimentary tickets.
 - Confirmed compliance with NCAA limits on complimentary tickets to high school, college preparatory, and two-year college coaches.
 - Confirmed compliance with NCAA limits on complimentary tickets provided to prospective student-athletes.
 - Reviewed the staff complimentary ticket sign-up sheet for completeness.
- For one postseason game for football, men's basketball, and ice hockey confirmed that:
 - Student-athlete guests were clearly authorized.
 - NCAA limits on number of tickets were adhered to.
 - Complete supporting documentation was available.

Recommendations to improve the complimentary ticket reconciliation process were shared with the CSO and Athletics Management in a separate memorandum.

Academic Performance Program

Performed a high-level review of the Athletics Office and the Registrar's Office processes to gather, analyze, reconcile, and submit documentation required for the Academic Performance Program.

Grade Changes

Performed a high-level review of grade change processes for student-athletes and related monitoring and oversight.

Gift Card/Awards Policy

Performed a review of controls over gift cards/awards provided to student-athletes, including approval by appropriate individuals and reconciliation processes that include confirmation of adequate support documentation.

A. **Executive Summary**

1. Overall Conclusion

The Office of Technology Transfer (OTT) effectively manages and controls their core processes. In response to the audit recommendations, management will update and document procedures in key areas including continuity of operations planning, critical software, and the patent maintenance fees payment process. Management will also allocate time and resources to develop more efficient business processes in two areas, Office of Research and Sponsored Projects (ORSP) grant closeouts and maintenance of inventor records.

2. Context and Key Risk Considerations

The Office of Technology Transfer is responsible for transferring technology based on University intellectual property (IP) to the marketplace. IP covers a wide range of items including software, drugs, medical devices, materials, and chemicals. OTT provides patent protection, establishes licensing agreements, and distributes royalties from licensed products. The Venture Center, a unit within OTT, offers a range of services for entrepreneurs and investors seeking start-up opportunities with U-M technology. OTT works closely with other U-M units engaged in business support, such as the Business Engagement Center, as well as external organizations, such as Ann Arbor SPARK.

OTT reports to the U-M Office of Research (UMOR) and is located in the North Campus Research Complex (NCRC). The office has 28 full-time employees and has maintained constant staffing levels over the past several years as the number of inventions and start-ups have increased. In fiscal year 2013, OTT had 128 issued patents, handled 108 license/option agreements, helped launch nine new start-up companies, and received and redistributed \$14.4 million in royalties and equity sales.

OTT is highly regarded by peer institutions. Staff are active in the Association of University Technology Managers, a national organization supporting academic IP, and have held leadership positions in that organization. OTT uses TechTracS, a third-party software used by many technology transfer offices, to manage the IP process from invention reporting to revenue distribution from license agreements.

3. Audit Scope and Identified Risk Levels

The scope of the audit was determined based on an assessment of the risks associated with the activities of OTT. This process included input from OTT management, UMOR management, and other interested parties from the University. The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-process.

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Key Activities Audited							
	Disclosure/ Assessment of Invention	Protection Process: patents, copyrights, and trademarks	Licensing and Marketing	Royalties and Revenue	Start-Up Support	COI/COC Management	Information Technology
Sub-Activities Audited	Pre-disclosure process	Pending patent applications	Existence of rights	Royalty distribution and recordkeeping	Commercializatio n	Policy	Continuity of operations/ disaster recovery (issue 1)
	Invention report management	Third party billings (issue 2)	Agreements/ legal templates	Recordkeeping – payments and equity	Coordination with internal/ external units	Reporting process - inventors	Backups and data storage
	Inventor outreach and education	Public disclosure management	Technology valuation	Management of future patent expenses	Venture Accelerator - space and asset management	Reporting process - start-ups	IT services – OTT and start-ups
	Invention evaluation process	Copyrights - risk of infringement	Metrics/ statistics	Abandoned patents	Financial oversight	Identifying potential conflicts	IT security
Legend: Overall risk conclusion for each sub-activity							
High Risk		Medium Risk		No Issues Reported			

4. Audit Objectives

The objectives of the audit were to:

- Identify stakeholder roles in the University's support for entrepreneurship and assess whether coordination is established and effective.
- Confirm whether sufficient controls exist so that the invention reporting process is comprehensive and confidential.
- Confirm whether an effective market analysis is conducted for the assessment of potential inventions.
- Evaluate whether the process to file, review, manage, and monitor patents is comprehensive and effective.
- Determine if the licensing process is appropriate, effective, and that strong controls are in place.
- Determine whether royalties and revenue are distributed accurately and according to established policy.
- Evaluate whether the assistance provided to start-up companies is sufficient to

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- promote their success and viability.
- Determine if conflict of interest and commitment policies are effectively communicated and properly managed.
- Identify information technology and recovery controls and determine whether they appear appropriate.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Documentation of Key Procedures	Medium
<p>Issue: Key procedures for continuity of operations and IT infrastructure have not been documented.</p> <p>Risk: In an emergency, critical time could be lost determining appropriate actions, increasing data loss and reducing recoverability of systems. Accurate job training may not be available for new employees. Lack of documented procedures could result in knowledge gaps between employees that manage different parts of the technology transfer process.</p> <p>Support:</p> <ul style="list-style-type: none">• There are no formal emergency plans for continuity of operations procedures. Although leadership has general ideas about the plans that would be put into place, documented emergency response, crisis management, and business continuity plans dramatically shorten the time needed to resume operations following a disaster or other significant incident.• The office completed a Risk Evaluation of Computers on Open Networks (RECON) of the TechTracS software in 2009. This software is critical to maintain OTT operations. The RECON demonstrated that limited documentation was available for the system, but due to other prioritized work and planning for the MiWorkspace rollout, the documentation has not been completed. <p>Recommendation:</p> <ul style="list-style-type: none">• Develop, test, and implement a complete continuity of operations plan as required by Standard Practice Guide Section 601.12, <i>Institutional Data Resource Management Policy</i>. The plan should include disaster recovery (short-term actions) and continuity procedures (long-term actions).• Complete the recommended documentation from the RECON, much of which also supports IT disaster recovery needs.• Review all documentation on a periodic basis to ensure it is updated as necessary to remain current. <p>Management Action Plan: We are currently reviewing and updating our 2009 Business Continuity Plan including staff contacts and responsibilities, particularly with regard to our</p>	

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current location in the NCRC.

We will formally document procedures that outline our Emergency Mode Operations, such as a short-term TechTracS or file server outage. This will include steps to restore servers, server location, and backup administrators. In a software emergency, the TechTracS vendor is responsible to provide support. Additional documentation includes a plan to increase the level of security in the overall computing environment and a detailed computer backup policy. Much of this information will address the documentation needs of the 2009 RECON. We will work with ITS to determine responsibility for the remaining documentation in light of the MiWorkspace rollout.

Action Plan Owners: OTT Operations Manager, ITS Systems Administrator Senior

Expected Completion Date: December 2014

2. Work Procedure Efficiencies	Medium
Issue: Some OTT processes may be overly manual or time-intensive.	
Risk: Re-keying data or completing excessively complex tasks is an inefficient use of staff time and increases the risk of error.	
Support: <ul style="list-style-type: none">• TechTracS maintains an inventor record that includes department and school or college appointment information. This information is currently downloaded from M-Pathways. The process requires manual checks to verify correct information, particularly for inventors with multiple current or historic appointments. New inventors who do not yet have a record in TechTracS must be manually input.• There is currently a manual process for OTT to communicate with the Office of Research and Sponsored Projects to ensure that any IP created under sponsored activity is reported to the sponsor. This involves checking information in TechTracS, eResearch, and iEdison, a website used to report IP under federal grants.• The process to review and resolve discrepancies in patent maintenance fee invoices is inefficient. This manual process is time intensive, uses many queries that are not well defined, and requires extensive coordination between the accounting and patent administrative staff. Invoices may be up to \$300,000 per quarter, and one completed discrepancy review resulted in a credit of \$85,000.	

Recommendation:

- Work with Information and Technology Services to identify ways to automatically upload employee records from M-Pathways to TechTracS. Focus on missing inventor appointments (which otherwise have to be manually input at the time of revenue distribution); review for duplicates or inaccurate data in inventor records.
- Develop a more efficient method to communicate IP to ORSP for their grant closeout

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process.

- Work with all employees involved with patent maintenance fee payments to map the process, identifying data hand-offs, reviews performed, resources required, duplicative steps, and other related processes. Determine process improvements to streamline the review and reduce the time spent reconciling. Document the final process.

Management Action Plan: We will investigate the feasibility of an automated data feed of the current inventor appointments into TechTracS or an automated download into a FileMaker lookup table. In the interim, we have implemented use of a new module in TechTracS, which efficiently links multiple appointments to a single inventor going forward. Historic records will need to be individually reviewed, as the time needed to link these through the module would be very extensive with minimal benefit. We will work to clean-up inventor records in TechTracS to ensure both current and historical appointment information is accurate and accessible.

We will develop a process to provide ORSP with the Invention Reports and patent information necessary to facilitate ORSP project closeout, which includes communication of IP to the sponsor. This may involve a periodic Excel spreadsheet export from TechTracS so ORSP staff can look up IP by grant numbers, or providing ORSP direct read-only access to iEdison.

OTT has streamlined several procedures related to Computer Packages Inc. (CPI), which manages ongoing patent maintenance fees. The process was reviewed in entirety and several changes were made, including streamlining the queries used to reconcile TechTracS data to the CPI invoices. This has resulted in automating much of what had been a manual, time-intensive process. Additionally, OTT has begun using CPI's interactive website to communicate pay or docket instructions as needed, instead of on a quarterly basis, which has reduced the amount of late term corrections. As the new process is finalized, it will be documented.

Action Plan Owners: Operations Manager, Senior Software Licensing Specialist, Patent Administrator

Expected Completion Dates:

- TechTracS inventor record clean-up – December 2014 (solution) and July 2015 (implementation of automated procedures if determined to be feasible)
- Communication process with ORSP – September 2014

Revised CPI billing reconciliation procedures – December 2014

Payment Programs for Research Subject Incentives

2012-501

Report issued September 2014

Preface

University Audits changed our audit report format in May 2013. However, audit fieldwork for this audit was completed and a draft report was originally created in September 2012. Since

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that time, University leadership has spent significant time reviewing issue #1, IRS Form 1099 Tax Reporting Compliance to determine the best course of action and how to implement that plan. During these discussions there were many staffing changes that occurred in University leadership, units involved in corrective actions, and in the audited units. These changes often started new conversations on appropriate actions. Due to these factors, the reporting phase was significantly delayed. Because all groups have been working with the original report format, the report was not converted to the new format.

Executive Summary

The University has two processes for issuing payments to human research subjects: a centrally maintained system managed by the Human Subjects Incentive Program (HSIP) under the Treasurer's Office and a long-standing process managed through the Institute of Social Research (ISR). ISR's payments comprise about half of the total payments to research subjects.

ISR's process did not permit the University to demonstrate full compliance with Internal Revenue Service (IRS) tax reporting requirements. ISR payment information was not compiled with other University payment data to identify individuals who have received more than \$600 in a calendar year who therefore must receive an IRS form 1099 for those earnings. Rather than processing ISR's payments through HSIP, Finance leadership agreed that ISR can continue to use their process, provided new service level agreements are developed. These agreements will establish a procedure so that ISR payment data can be aggregated with both HSIP and Accounts Payable in order to determine whether form 1099 reporting is required. This will allow the University to demonstrate full tax compliance with IRS regulations. This is a higher risk approach and will be reevaluated by University Audits after it has been in place for some time.

Procurement Services (Procurement), the Treasurer's Office, and the Tax Department (Tax) are also researching the current, limited use of third-party vendors, such as Amazon, to recruit and pay human research subjects outside the University's systems. The use of these services also prevents subject payment information from being aggregated with University data to identify individuals who should receive a 1099. Further, users of this service inappropriately enter into a contract on behalf of the University.

Management, in both ISR and the HSIP Office, has also taken steps to address other audit observations. A database developed by ISR for processing their research incentive payments will be evaluated by the University's Information and Infrastructure Assurance Office for IT risks and vulnerabilities, cash handling controls have been strengthened, and payment data records will be improved. The HSIP Office has strengthened documentation for employee exit checklists, payment transfer information, and procedures with support units. They have also enhanced training for users and identified new system compliance monitoring opportunities.

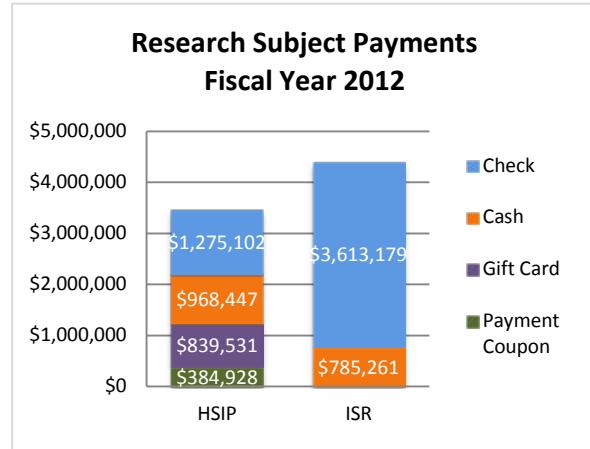
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Introduction

Research subject incentives (subject fees or subject payments) are provided as compensation to people who participate in certain research projects.

The University encourages participation in research by authorizing payments to human subjects as compensation for their time or the effort involved. All research involving human subjects, including proposed compensation, must be approved in advance through the Institutional Review Board (IRB). The University is required to prepare a federal tax form 1099 for individuals who receive \$600 or more in non-employee compensation during a calendar year, including subject payments.



In the past, subject payment programs were inconsistently organized across the University, and sometimes within study teams of the same school. In early 2007, the Associate Vice President for Research and the Associate Vice President for Finance sought to develop a centrally-managed process that would efficiently and effectively coordinate subject payment processing for the benefit of the entire campus. The goal was also to improve internal controls and strengthen processes by consolidating payment information into one source for ease of tax reporting, reducing the imprest cash funds on campus used to issue subject payments, and promoting data security and confidentiality.

A cross-functional team was created in 2007 to develop such a program, which included members from various University schools and colleges, Procurement, Tax, the IRB, the Office of the Vice President for Research, and ISR. As part of the process, the team reviewed the subject payment system ISR had previously developed for its research units and spoke with ISR personnel to discuss those related procedures. Needs of the larger campus community were also discussed.

The team's work led to development of the Human Subject Incentive Program (HSIP). HSIP started in May 2009 with a few pilot departments and expanded until every University unit in Ann Arbor, Dearborn, and Flint had converted to the centralized process by December 2010, with the exception of the ISR. The program is managed by a dedicated team in the Treasurer's Office. HSIP is now the central point for distributing subject incentive payments, whether by check, cash, or reloadable gift cards. In addition, HSIP tracks and manages all subject payment information and provides annual reports to Procurement for federal tax form 1099 reporting.

ISR has continued to maintain a separate process for subject payments under a service level agreement with Finance. In fiscal year 2012, ISR processed over 56% of the University's \$8 million of human subject payments.

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The chart² at the right shows the breakdown of total subject payments by type across the two University subject payment systems for fiscal year 2012. Fiscal year 2012 was the period evaluated during this audit.

Purpose and Scope

The scope of the audit was to evaluate the adequacy and effectiveness of controls over payments made to human research subjects. Both the HSIP and ISR processes were evaluated, including 1099 tax reporting compliance and data security. We also reviewed customer satisfaction from users of both systems, and how the respective process owners (the HSIP Office and the ISR Business Office) monitor their procedures.

Our work included interviews with researchers and administrators who are users of the processes, meetings with the IRB to understand their policies and guidelines for subject payments, and interviews with key personnel from departments that support the processes (Tax, Procurement, Central Imaging, and Information and Technology Services). Data for subject payments was also analyzed from the general ledger and available documentation provided by HSIP and ISR. In addition, we reviewed records to determine if researchers working with human subjects maintained current PEERRS certifications³.

Risk and Control Discussion

Form 1099 Tax Reporting Compliance

Discussion: A critical driver for the creation of the HSIP subject payment process was the need to comply with federal tax form 1099 reporting requirements and to be able to identify all individuals who received \$600 or more from University sources during a calendar year. HSIP uses a tiered structure⁴ that was approved by Tax to determine when social security numbers (SSNs) must be collected by research teams. HSIP, being a central data repository, has a process in place where payment information (with no information that could tie a participant to a particular study) is provided to Procurement, combined with other non-salary payments, and 1099 forms are issued when required.

ISR was given authorization to maintain their separate process through a 2007 service level agreement (SLA, since expired) with Finance; provided their subject payment information was sent to Procurement for analysis and determination of required 1099 tax reporting. ISR and Procurement were unable to establish a reliable means for sharing this data. Procurement

² The ISR figure for cash is comprised of \$769,560 in cash (with one project comprising nearly \$300K of this figure) and \$15,701 from gift cards. Gift cards are not a common incentive for ISR studies.

³ The Program for Education and Evaluation in Responsible Research and Scholarship, or PEERRS, is a web-based education and certification program at U-M. All U-M researchers working with human subjects are required to complete specific certifications in PEERRS.

⁴ The Tax Office partnered with HSIP to approve a tiered approach to collecting SSNs for research participants to comply with IRS form 1099 reporting requirements. A chart informs researchers whether their study requires the collection of this data. Studies where the total payments per participant per year would be less than \$100 generally do not require collection of SSN data.

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contends they have made multiple efforts to reach out to ISR but have received no response. Without the payment information from ISR to aggregate with other University payments, Tax believes it is not possible for the University to demonstrate form 1099 tax reporting compliance.

Recommendation: Provide annual reporting of subject payments to Procurement as agreed in the SLA with Finance, which is necessary for the University to fully demonstrate form 1099 tax compliance. Follow the tiered structure used by the remainder of the research community to determine when SSNs are required to be collected.

Management Response: We are working with Procurement to create new SLAs, which are now in the review stage. As part of this discussion we worked with Tax to develop a unique reporting threshold of the tiered structure due to the special characteristics of ISR studies. We are also developing and documenting procedures to provide the necessary information for tax compliance.

Individuals Responsible: ISR Managing Director, Director of Project Management Office

Target Dates: September 2014

Auditor's Note: Following audit fieldwork, there were substantial discussions as to the most appropriate corrective action to address this observation. Three options were presented: 1) accept the risk of the inability to demonstrate full tax compliance, 2) take actions necessary to facilitate coordination between ISR and both HSIP and Accounts Payable, and 3) consider consolidating ISR's human subject payment process into HSIP. ISR has elected to maintain their own system instead of participating in HSIP, and both ISR and Finance are aware that this is a higher risk scenario. However, management and key stakeholders agreed that the new SLA and associated data sharing procedures would facilitate the necessary coordination between ISR and both HSIP and Accounts Payable to demonstrate complete tax compliance. During the follow-up, University Audits will verify that the new SLA was developed and that procedures were created to provide the information necessary for the University to demonstrate complete tax compliance. Given the higher risk, a separate audit will evaluate the new process after it has been operating for some time. Noncompliance would result in presentation of the same three potential actions plans.

Internal Control and Operational Efficiency

Discussion: Based on review of the ISR subject payment process, University Audits identified the following internal control concerns and opportunities to improve operational efficiency:

- **Collection of Payment Data:** The process used by ISR does not centralize all subject payment records. If a sponsor requires more stringent data security, a study team will typically keep cash payment records in their possession. Therefore, to collect and aggregate all payment activity annually, the Business Office must go to individual study teams, request payment information, and key the data into a

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spreadsheet for purposes of aggregation. This is an extremely manual and inefficient process that also increases the risk of data entry errors.

Recommendation: To more efficiently obtain cash payment records, a standardized template to capture required details (e.g., subject name, date, payment amount) should be developed and required for use by the study groups. In cases where the sponsor requires heightened confidentiality, use of a consistent template would allow the Business Office to more efficiently collect and aggregate the information, as required (i.e., for internal reporting, sponsor-initiated audits).

Management Response: Imprest cash subject payments typically constitute approximately 1% of all respondent incentives at ISR. While we have established criteria for the collection of cash payment details, we agree a standardized template could prove to be an added value to our process and we will create this document in collaboration with our relevant research staff after the terms of the new SLA have been established.

- **Subject Incentive Cash Fund:** The ISR Business Office maintains a \$200,000 cash fund for subject payments, which is adequately secured in the Business Office vault. Standard Practice Guide Section 507.02, *Imprest Cash Funds*, provides guidance that funds should turn over at least four times a year. Review of the activity for fiscal year 2012 showed the fund turned over less than twice in that time frame. However, Accounts Payable confirmed the fund did turn over four times in fiscal year 2013, although the balance did not change. This suggests the account may have been over-funded for fiscal year 2012. In addition, the fund is reconciled monthly by an individual with regular access to the funds, and there is no consistent independent or supervised count.

Recommendation: Analyze actual payment activity to determine the optimum cash fund balance to meet the minimum turnover rate and review the fund balance periodically for continued appropriateness. Promptly reduce the fund after significant projects cease. The need for timely temporary adjustments should be discussed with Procurement and included in the SLA. Finally, document that the fund is independently counted and verified on a monthly basis.

Management Response: Study team needs fluctuate greatly and require a quick turn-around. In our experience, it takes up to two weeks to be issued a check through the Accounts Payable Office, and an additional one to two weeks to order and receive cash in the correct denominations. This time period involves pre-Procurement activity, communications, and review in addition to transactions managed through the Accounts Payable office. This type of delay would have considerable impact on meeting our sponsor deadlines and deliverables. The auditor's suggestion that the cash fund should turn over four times a year would equate to roughly a \$100,000 cash fund. Based on our analysis of the last 16 months (July 2011 – October 2012), a \$100,000 fund would

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not have been sufficient for 6 of the 16 months. However, we did work with Accounts Payable to reduce the amount of cash held in two smaller imprest cash accounts (not used for subject fees).

In response to the auditor's suggestion we have instituted a regular supervised count of the cash fund. Since June 2012 when the auditors made this observation, the Accounting Supervisor and an accountant, who has no access to cash otherwise, have jointly performed the monthly count. The Accountant and the Supervisor initial and date the count documentation beginning in January 2014.

- **Cash Handling:** Some ISR study team participants who handle cash have not taken the University's MyLinc cash handling training. In addition, requirements of the training are not consistently enforced in ISR's cash handling practices. For example, one study team lacked appropriate segregation of duties related to check handling (one person requested checks, picked up checks, distributed checks, and reconciled checks). This team, when interviewed, was not familiar with the Office of Internal Controls' gap analysis, which would have identified the control deficiency and had not taken the cash handling training.

Recommendation: The ISR Business Office should periodically monitor MyLinc training records to determine whether all employees with cash handling responsibilities have completed the cash handling training. Reinforce requirements and procedures conveyed in the training with cash handlers on an ongoing basis and also as new requests for cash/check custodians are received. Ensure that the ISR's respondent pay gap analysis is completed by individuals with sufficient knowledge to accurately describe study team practices. Confirm that study teams using cash or checks have a plan for ensuring proper controls, including segregation of duties.

Management Response: In response to discussions with the audit team and to our own annual review of internal controls, ISR has strengthened our cash handling controls. In April 2012, during the preparation of our fiscal year 2012 Internal Controls documents, we learned that a report had been created in Business Objects to monitor whether employees had taken the MyLinc cash handling course. Since that time, we have been regularly monitoring the report and contacting employees who handle subject payments to request that they complete the course. We have also improved our procedures for imprest cash and check writing to communicate to new users they must take the training course. ISR agrees there is a need for strict compliance and will take steps to incorporate additional monitors for ensuring cash handling training, including system generated reports and in-person attestations when ISR staff come to the Business Office to obtain respondent payment funds.

Auditor's Note: ISR provided documentation to support their new quarterly review of the Business Objects reports. They have updated their Imprest Cash Fund Request and Authorization form to require study team members to individually confirm that members

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*with access to the funds have completed the cash handling training. The need for and importance of the training is also verbally communicated by the Business Office staff when working with study teams. **This item is closed.***

- **User-Developed Applications (UDAs):** The ISR subject payment process is dependent on an Access database developed internally by a former ISR employee. The database is a check-writing system that interfaces with the bank to manage the multi-million dollars' worth of checks issued annually. University units using UDAs assume risks that are normally managed and controlled by ITS, such as data integrity, application availability, and security of the data. There is minimal documentation about the database that would be useful for ongoing maintenance or in the event of database failure.

Recommendation: Information and Infrastructure Assurance can provide assistance in preparing a RECON, a risk assessment methodology that will help ensure ISR has addressed such risks as application availability and data security. Update and/or create documentation explaining the technical details of the database including how the database functions, relationships in the database, and how backups are conducted. The documentation should also address data integrity (i.e., edit checks and other front end controls) and update procedures.

Management Response: While we do have written documents covering our Access database, we agree that such documentation needs revision. We will make our technical written documentation more comprehensive in covering all components, including those identified in the auditors' recommendation. These documents will be maintained by the ISR Business Office Management Information Systems personnel, in collaboration with ISR IT staff.

Individual Responsible: ISR Director of Business Operations

Target Dates:

- Standardized template for cash payments May 2014, or after the SLA is completed
- Joint count and sign-off of the cash fund revised process effective January 2014
- Updated documentation for the Access database by May 2014

Auditor's Note: The updated documentation will be reviewed for completeness and adequacy during the audit follow-up.

HSIP Procedures

Discussion: The HSIP Office has well-documented and thorough internal operating procedures; however, in a few places the documentation needs to be updated:

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- **Employee Exit Checklists:** Although HSIP procedures appropriately require access roles to be removed when employees leave HSIP, an exit checklist is not in place to ensure all steps are completed. University Audits reviewed staff with access to HSIP documents and identified two former HSIP staff that still had access. The HSIP Manager immediately removed access for the former employees.

Recommendation: Develop and implement an exit or off-boarding checklist to ensure all necessary steps, including the prompt removal of system access, are completed promptly when staff leave the HSIP Office.

Management Response: To complement the existing hiring and termination checklists in place in the Treasurer's Office, supplemental checklists have been developed for HSIP-specific system access. The updated checklist was used twice during off-boarding of an HSIP staff member.

Auditor's Note: Completed termination checklists were reviewed to confirm that HSIP access roles were removed timely. This item is closed.

- **Security of Payment Information Transfers:** With the implementation of Google mail and upgrades to the HSIP system, the process for receiving and uploading subject payment documentation from study teams for secure storage has changed. Study teams are now able to directly upload their documentation to M-Pathways. While the direct upload process has improved operating efficiency, some study teams continue to transmit the payment information via campus e-mail, which is not secure⁵.

Recommendation: Educate study teams on acceptable and secure methods to transmit subject payment information. Use a consistent process to "reject" documentation submitted by improper methods.

Management Response: Procedures for receipt and storage of payment documentation, as well as scanning of electronic HSIP documentation, have been added to the HSIP procedures manual. All HSIP staff are trained to immediately delete any e-mails containing subject information and send a message to the original sender informing them of correct procedures.

Auditor's Note: Updated HSIP processes were reviewed to confirm the appropriate data transfer procedures are stressed with study teams. The information is more prominently discussed during training and HSIP teams use canned responses in Google e-mail to consistently respond to study team members who attempt to transmit subject data via

⁵ The HSIP Office is now using Google mail, therefore sensitive regulated data should not be sent via e-mail regardless of the e-mail used by the study team transmitting the payment information.

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e-mail. HSIP staff have seen a significant decrease in attempts to transmit subject data using e-mail. This item is closed.

- **Documentation of Procedures for Support Units:** The analysis of subject payments and preparation of form 1099s are done outside the HSIP Office with the aid of supporting units. HSIP payment data is transferred at the end of the calendar year to Accounts Payable where staff aggregate this information with other U-M payments. The HSIP data contains only information related to the payment, and does not include any information about the nature of the research. Accounts Payable also prepares the 1099 file to send to the Internal Revenue Service (IRS). Information and Technology Services (ITS) staff perform the actual transfer of data to the IRS. There are no written expectations or procedures for those units related to HSIP data.

Recommendation: Document and communicate specific expectations and procedures for units that handle HSIP data. These should address data privacy, transmittal, and storage, along with the Treasurer's Office Data Confidentiality Statement. Also include specific expectations for each unit's responsibilities so all groups are clear on their roles.

Management Response: The procedures were developed and vetted with AP and ITS, and include dates on which data needs to be transferred, data security expectations, the Treasurer's Office Data Confidentiality Statement, and roles and responsibilities for each unit involved. We consulted with Information and Infrastructure Assurance (IIA) for the mechanics of the data transfer process to ensure subject information will be protected.

Individual Responsible: HSIP Program Manager, Manager of Procurement Business Operations, ITS Manager

Target Dates: All procedures fully documented by October 2012. The 1099 data transfer process was successfully completed starting in calendar year 2012.

Auditor's Note: The completed documentation was reviewed to confirm it included key criteria such as data privacy and storage standards. It adequately addresses the initial observation.

This item is closed.

Enhancing Training for University Users

Discussion: The HSIP process is documented and explained for University users through a variety of methods. The HSIP Office conducts regular training sessions that are open to new and existing users. The HSIP website contains resources for payment requesters and approvers, templates for developing unit-level HSIP process documentation, links to the HSIP internal control matrix from the Office of Internal Controls, and a FAQ page. University Audits reviewed all available training information and suggests the following improvements:

- Campus mail is noted as an acceptable method for transporting subject payment documentation. This is because some research teams may not have access to a fax or

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computer. However, there is no warning that campus mail should never be used for documentation that includes social security numbers.

- The distinction between subject payments and subject reimbursements is not covered during training. Subject reimbursements, such as for meals or parking, should be paid to subjects via PeoplePay with a non-PO. During the course of the audit, University Audits became aware that the distinction between subject payments and reimbursements is not always clear to the study teams.
- The HSIP Office has developed many subject payment Business Objects reports in addition to the three reports referenced in the Office of Internal Controls' gap analysis tool for subject payments. These additional reports could be helpful for units in reconciling or monitoring subject payment data. University Audits found that many HSIP users are maintaining copies of their payment documentation, which is unnecessary as HSIP was designed to be the central data repository for all subject payment documentation. One reason study teams maintain copies of subject payment documentation could be that they are unaware of the many different reports available.
- Some study teams who use cash as subject payments have not taken the University's online cash handling training. The training was not referenced on the HSIP website nor in the HSIP training.

Recommendation: Update training information for the study teams, both on the HSIP website and in the live training. Indicate subject payment documentation should not be transmitted using e-mail. Campus mail should never be used for documentation that includes social security numbers. Offer alternative means of submittal to study teams with no access to fax or computer such as hand delivery, U.S. mail, or use of tamper-proof envelopes. Give examples of the differences between subject payments and reimbursements and stress that research staff using cash as payment methods take the cash handling training. Finally, educate HSIP users about the various reporting options and stress that it is unnecessary for units to maintain copies of their payment documentation.

Management Response: Training information has been updated, both on the HSIP website and in the live training materials (slide presentation and handouts). These updates include:

- A documentation submission procedure, which includes the inability to accept subject information via e-mail and also offers alternatives to campus mail. This document is online as well as part of the live training.
- Documentation outlining the difference between incentives and reimbursements.
- Links to the MyLinc cash handling course have been added to the website and training slides now include recommendations to take that training.
- A guidance document has been created detailing the HSIP reports available in Data Warehouse/Business Objects. This document is available on the HSIP website and also in the live training materials. We will review the HSIP reports currently restricted to internal department use and determine which could have benefits to users in the units. Those reports will be added in the Public Folders of Business Objects and referenced during training.

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- A dedicated training slide concerning document retention has been added to the live training materials, and this information is also included in the Documentation Submissions procedure.

Individual Responsible: HSIP Program Manager

Target Date: October 2012

Auditor's Note: The updated training information was reviewed and sufficiently addresses the initial observation. The slides and handouts, along with verbal class directions, more fully cover information regarding safe transmittal of data, distinctions between payments and reimbursements, and reporting options. This item is closed.

Updating of University Policy

Discussion: Two Standard Practice Guide Sections (SPG) reference research subject incentives. SPG, Section 501.07-1, *Research Subject Incentives* was issued in October 2009 when HSIP became the centrally-supported process. An older version, SPG Section 501.07, *Research Subject Fees*, remains in effect partly because ISR continues to maintain an independent subject payment system. SPG Section 501.07 also references methods that are no longer permitted or used for subject payments, such as P-Cards.

Recommendation: If required, SPG Section 501.7 should be revised to include only approved payment methods for research incentive payments.

Management Response: Based on Finance's final decision regarding ISR and HSIP's dual payment systems, we will begin discussions on the necessity of the separate SPG and either update or remove it.

Individual Responsible: HSIP Program Manager

Target Date: October 2014

System Compliance Monitoring Opportunities

Discussion: The subject payment systems can be made more robust by including a link to other systems for compliance checks. These can be in the form of hard-stops or after-the-fact monitoring. The suggestions below are opportunities to incorporate compliance monitoring for consideration in planning for future upgrades of the HSIP system. These include:

- Monitoring for principal investigators/research team members listed as their own study subjects without proper authorization from the IRB
- Validation of the specific payment type used (e.g., cash, checks) versus the IRB approved method
- Improved verification of the maximum IRB approved payment amount, which currently relies on manually updated records in eResearch
- Verification of the IRB approved maximum number of participants

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- Confirmation that the principal investigator or researcher has up-to-date PEERRS certification

Recommendation: Work with ITS, the IRB, or other stakeholders to discuss the potential benefits, costs, and feasibility of incorporating additional levels of compliance checks into the system.

Management Response: The suggestions were reviewed with the IRB in order to discuss the feasibility of implementation, prioritize desired features, and plan for implementation. In summary,

- Since study teams already must include on their eResearch application if employees of the team will be included in the study population, we do not feel this aspect would benefit significantly from additional validation from the HSIP system.
- The validation of the specific payment type used is a desired enhancement and the HSIP Program Manager will work with ITS to implement this change in a future HSIP system release.
- Currently, study teams can enter a specific number or a range of payment amount in eResearch. The current HSIP system can, if a specific number is entered, validate this amount to payment requests. However, requiring study teams to only enter specific numbers would create an inordinate number of amendments to the IRB approvals.
- The HSIP system currently tracks number of payments per study, not individual participants. Most payments do not have a unique participant identifier, and thus the HSIP system cannot recognize when multiple payments are associated with the same person. Changes would require significant and difficult updates to the system. However, since the IRB allows for overruns of the maximum number of subjects in certain circumstances without approval, and there are current mechanisms to validate the number of participants during IRB approval renewals, this is considered a lower risk item.
- PEERRS certification is required for all study teams before final IRB approval is given on a new grant. Other University monitoring processes alert study teams members about recertification timeframes. It is not necessary to add HSIP as an additional monitoring tool.

Individuals Responsible: HSIP Program Manager, ITS Manager

Target Date: August 2014 with the next HSIP system release, for payment type validation.

Auditor's Note: The HSIP system release was moved to production on Tuesday, August 19, 2014. The new enhancement will alert the HSIP Office if a researcher requests a payment type that is different from the IRB approved payment type. This will allow the HSIP Office to review and determine if it is acceptable (e.g., researcher requests cash to purchase specific vendor gift cards, which the IRB approved) or unacceptable (e.g. researcher requests checks when IRB

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approved cash only). University Audits will verify that the HSIP Office receives and responds appropriately to these instances during the follow-up.

Third-Party Vendors

Discussion: Some research teams outsource survey components of their study to third-party vendors. These vendors conduct the surveys, pay the subjects, and provide text files with aggregate data to the research team on the survey results. The use of human subjects in these studies is appropriately approved by the IRB, but the payment information for the individual subject never becomes part of the University's records. These vendors have been used by units across campus, including ISR.

University Audits reviewed one vendor, Mechanical Turk (MTurk) by Amazon, in detail. MTurk is the most frequently used third party vendor. The participating research team signs an agreement with Amazon that states “you certify that you... have the authority to enter into this agreement and bind yourself or the company you represent.” Only Procurement has been delegated the authority to bind the University into purchasing agreements, and there is no Procurement contract with Amazon.

The use of MTurk also prevents subject payment information from being added to the HSIP data download for tax analysis and 1099 reporting. The participation agreement is clear that the “requester” (the individual using MTurk’s survey services) has responsibility for managing tax compliance but there is no mechanism for the data to be collected and reported to the appropriate University offices.

Because MTurk and other similar services are used to outsource an entire research component, and not just the payment processing, they have never been considered part of either HSIP or ISR’s payment process. However, interest in their use has been growing. They are, per policy, in violation of SPG Section 501.7-1, *Research Subject Incentives*, as only HSIP should be used to pay research subjects.

Third-party vendor payments for research services are not consistently coded by units across the University, therefore accurate figures are not available. Initial analysis shows that payments to these types of vendors could be upward of \$54,000 for fiscal year 2012. However, inquiries made by HSIP leadership indicate interest in these services is growing.

Recommendation: The Treasurer’s Office, Tax, and Procurement should work together to define acceptable use of third-party vendors for conducting survey research. Develop policy to document appropriate and approved use of these services. Monitor the “survey” account code, where such payments are typically charged, to identify units using third-party vendors and determine compliance with the final approved process.

Management Response: Upon learning of the gaps in tax reporting and the practice of non-authorized individuals binding the University to a purchasing agreement, the HSIP Office has been working with University Audits, Tax, and Procurement to address this matter

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expeditiously. We solicited information from units where the MTurk system is used to conduct research to ascertain the business need for using such third parties. The HSIP Office will continue to work with Tax and Procurement to determine if Amazon can provide participant payment data to comply with tax reporting requirements. If Amazon is unable to provide the information, the HSIP Office will work with Procurement to identify vendors that either assume the tax reporting responsibility or will provide tax reporting information to the University.

Individual Responsible: HSIP Program Manager

Target Date: December 2014

Summary

Overall, research teams at the University are satisfied with the systems used to process research subject incentive payments. Both HSIP and ISR process users praised the customer service they received from their respective offices. Monitoring customer feedback is important to both process owners, whether through a formal survey tool, via electronic correspondence, or hands-on training. Users of the HSIP system were enthusiastic in their satisfaction for the system over prior payment methods. Auditors noted that HSIP payment data reports were easily and quickly produced by the HSIP Office. ISR staff are commended for their deeply ingrained culture of protecting subject confidentiality.

Several opportunities to improve internal controls, strengthen policies, improve efficiencies, and better align third-party vendors with U-M processes for research subject payments were identified during the audit. HSIP committed to timely corrective actions to remediate all items. ISR has also taken steps to improve internal controls and gain efficiency. Importantly, they will coordinate with Procurement to provide the annual subject payment data necessary for the University to demonstrate compliance with federal tax form 1099 reporting requirements.

University Audits will request a status update in the third quarter of fiscal year 2015 and conduct a formal follow-up in the fourth quarter of fiscal year 2015. At that time we will assess the remaining action plans provided by management.

School of Education

2014-209

Report issued September 2014

A. Executive Summary

1. Overall Conclusion

School of Education (SOE or School) management has established internal control procedures surrounding the School's key financial, operational, and compliance activities. The controls are generally effective; however, several enhancement opportunities were identified during the audit. Management has committed to the timely remediation of all observations, including a review and update of their website to reflect current conditions and practices.

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Prior to the audit, management began the process of reviewing affiliation agreements and partnership agreements involving the exchange of services with school districts, schools, and certain external agencies. SOE is coordinating these efforts with the Office of the General Counsel to facilitate a legal and technical review of the agreements, and any revisions, to protect SOE and University interests.

Management has agreed to work with the Bentley Historical Library to explore more efficient ways of managing and archiving paper records, records in non-standard format (e.g., photographs, film, audio tape, electronic materials), and digital records such as email. Transferring valuable records and publications of continuing value to the archive will help preserve and enrich the institutional knowledge associated with SOE.

To address potential safety concerns with aged facilities, we recommend that management request an ADA (Americans with Disabilities Act of 1990) compliance review from Architecture, Engineering, and Construction (AEC) to determine if SOE building facilities such as stairways, ramps, and restrooms are up to code, and then take appropriate action based on the feedback.

2. Context and Key Risk Considerations

The U.S. News & World Report consistently lists the School of Education among the top schools in their annual graduate school rankings. SOE is currently ranked #8 in the rankings. Founded in 1921, the School is composed of five academic programs that offer Bachelor's, Master's, and Doctoral degrees.

SOE operates with a budget of approximately \$30 million. Currently SOE is undergoing a school-wide phased renovation project that will require a shift in space usage on an interim basis in fiscal years 2015 and 2016. Construction work on the over \$10 million project addresses updates to the fire alarm system, HVAC, bathrooms, and certain high-traffic areas in the building. SOE has also requested funds to update the current wireless infrastructure throughout the building.

SOE has migrated about 90% of their staff and 30% of their faculty to MiWorkspace. Management has also sent out correspondences encouraging all remaining faculty and staff to schedule their transition date. Some priorities established by SOE management to help direct academic leadership, set their scholarly course, and shape the School's budget include the following:

- Give active attention to diversity
- Investigate and improve education through research
- Develop and support quality teaching
- Create effective partnerships that actively engages schools and communities
- Establish new funding streams to service the goals established by the School

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3. Audit Scope and Identified Risks

The scope of the audit was determined based on an assessment of the risks associated with the activities conducted by the School of Education. This process included input from School of Education management and interested parties from other University functions. The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity.

Key Activities Audited								
	Grants Management	Field Placement and Accreditation	Admissions, Advising, and Grade Changes	Committee Activities	Facilities Management and University Vehicles	Fiscal Responsibilities	Human Resources	Information Technology
Sub-activities Audited	Federal and non-federal grants	School selection	Policies and procedures	Faculty appointments and promotions	Safety and ADA compliance	Management tools	Conflict of interest/commitment (7)	Risk assessment (RECON) (3)
	School-wide competitive grants	Verification of student background	Admissions review and approval	Tenure appointments and promotions	Building keys and M-Card access (6)	Budget process	Temporary employment	
	Emergency grants	Student training and feedback	Academic advising	New academic programs and curriculum changes	Records management	Internal control certification	Retroactive pay	
		Affiliation agreements (1)	Degree audits		University vehicles	Discretionary and RESIN funds (5)	Supplemental pay	
		Memoranda of understanding	Grade changes (4)			Cash handling training compliance	Joint appointment agreements (8)	
		Interactions with USNWR				Credit card processing	Compliance hotline (2)	

Legend: Overall risk conclusion for each sub-activity		
High Risk	Medium Risk	No Issues Reported

4. Audit Objectives

The objectives of this audit were to:

- Validate compliance with University and sponsor requirements.
- Evaluate processes to monitor student's qualification for and progression towards student teaching, determine if external party agreements are authorized and managed properly, and verify adequate oversight over the accreditation process.
- Evaluate procedures to manage the admissions, advising, and grade change processes.
- Evaluate governance activities performed by various School of Education

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- committees.
- Verify adequate oversight over the Facilities Office and University vehicles obtained from Parking and Transportation Services.
 - Determine if the School of Education has appropriate fiscal controls in accordance with regulatory, University, and department guidelines.
 - Evaluate overall compliance with University human resources policies and procedures, including joint appointments and the Compliance Hotline.
 - Determine adequacy of controls over information technology management.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Affiliation Agreements	Medium
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Issue: Management does not consistently establish and properly authorize affiliation agreements with schools/school districts that train student teachers.

Risks:

- Roles and responsibilities of the University and the school may not be defined, thereby exposing the University to attorney fees, court costs, or litigation expenses of other parties if there is a dispute. Student teachers and principal student interns may not be covered for expenses or damages sustained because of actions or claims against them resulting from accidental injury/death or destruction of property, while acting within the scope of their assignment.
- Terms and conditions in the agreement may not be in conformance with current regulatory and University requirements, consequently not protecting the University's policy, programmatic, financial, or strategic interests.
- Language used in the agreement may not adequately convey the intent of the University and the school or school district. Terms and conditions may be inconsistent across agreements.

Support:

- During the 2013-2014 academic year, the Teacher Education (TE) program placed approximately 167 elementary teaching interns and 200 secondary teaching interns in 29 school districts and 3 independent schools.
 - Affiliation agreements for 11 of the 29 school districts were missing.
 - One affiliation agreement was not signed by the independent school representative.
 - Affiliation agreements for 2 school districts were not signed by SOE or Provost Office representatives with appropriate signature authority.
 - The affiliation agreements recommend varying limits of insurance coverage requirements for the University and the school/school district. SOE does not verify that schools obtain and maintain the required levels of insurance

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coverage.

- The Education Studies (ES) program does not have an agreement with any of the schools where they place students to obtain Principal Certification. During the 2013-2014 academic year, the ES program placed approximately 5 students in 2 schools and plans to expand this program going forward.

Recommendation: SOE should consult with the Office of General Counsel to determine when agreements are necessary and the information/stipulations that should be included. Consider developing agreement templates that could be reviewed by OGC to be used in agreements on an ongoing basis. The templates should be reviewed periodically to ensure they remain current. Identify and document expectations regarding signature of these agreements so that agreements are signed with appropriate signature authority.

Management Action Plan: The Associate Dean for Research and Community Engagement (ADRCE) is submitting the Affiliation Agreement to the Office of General Counsel. Once returned, the Teacher Education program will do a systematic review of known academic year 2014-2015 placements and send out new Affiliation Agreements to relevant schools and districts. We may need a different approach with our multi-faceted school partners (i.e., Ann Arbor, P-CCS, Ypsilanti, Detroit). The TE Program Director will consult with the ADRCE to determine the best approach for these districts. The TE Program Director and Clinical Experience Coordinators will review each semester to determine if there are new districts to whom we need to send the agreement. Signed agreements will be reviewed each year by the TE Program Director, and any with a signature date five (5) or more years old, will be updated by sending new agreement.

Action Plan Owners: Associate Dean for Research and Community Engagement and Teacher Education Program Director

Expected Completion Date: February 2015

2. Fire Alarm System	Medium
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Issue: The current fire alarm system is not audible in certain sections of the SOE building to warn occupants about fire emergencies.

Risk: Occupants may not be able to evacuate the building in a safe and timely manner.

Support:

- In audit testing discussions, SOE staff indicated that the fire alarm is not audible in certain sections of the building. Management is aware of the locations where the current fire alarm system is not audible. Management asserts that the current fire alarm system appropriately notifies the University's Department of Public Safety and Security (DPSS) when the fire alarm is triggered in case of an emergency. If the fire alarm is triggered a second time and/or if DPSS receives communication of the fire, the

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dispatcher will also notify the Ann Arbor Fire Department.

- As part of the ongoing renovation, SOE is installing a new fire alarm system in the south end and north end sections of the building to address the drawbacks in the current system. The south end fire alarm system is scheduled to be operational after the first phase of the renovation is completed in September 2014. The north end fire alarm system will not be operational until September 2015; however, the current fire alarm system will remain operational in this part of the building during the interim period. In the event of an emergency, both the south end and the north end fire alarm systems will operate and respond as one single unit. SOE also plans to install a new public address system as part of the current renovation to warn occupants in case of any emergencies.

Recommendation: Management should implement the following compensating controls until the new fire alarm system becomes operational for the entire SOE building in September 2015:

- Explore options (e.g., wireless system) to temporarily install other State of Michigan approved fire alarm systems in strategic locations.
- Schedule an audibility test with Occupational Safety and Environmental Health (OSEH) during each phase of the new fire alarm system installation and validate that test results meet minimum established thresholds in conjunction with AEC.
- Designate floor marshals and educate them about their duties and responsibilities in case of an emergency. Conduct periodic meetings so that floor marshals become familiar with each other, encourage discussion of building safety issues as they arise, and keep the floor marshal contact list up to date.

Management Action Plan: The SOE Facilities Manager will oversee the corrective actions needed to comply with the recommendations provided above.

Floor marshals will be selected at our first 2014-15 all staff meeting, which will be held on Thursday, September 18, 2014. Training will follow. The Facilities Manager will hold monthly meetings with the floor marshals to discuss building safety issues as they arise.

The floor marshal contact list will be maintained in the SOE Facilities office/mailroom.

Action Plan Owner: Facilities Manager

Expected Completion Date: December 2014

3. Risk Evaluation of Computers on Open Networks (RECON) – Security Issues	Medium
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Issue: SOE has not completed corrective actions for all recommendations made to address high or severe risk security issues identified by the last IT RECON, which was conducted in 2011.

Risk: Failure to implement IT security control recommendations could increase security risks in the unit and lead to a security incident.

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Support:

- In 2011, Information and Infrastructure Assurance (IIA) performed the following seven IT risk assessments as part of the RECON:
 - One for each of the five academic programs
 - One for all of the SOE administrative offices
 - One for a research project (MTLT – Mathematics Teaching and Learning to Teach) identified as representative of the SOE research environment
- The RECON assessments indicated that the current overall risk profile was in the high or severe potential threat range for all seven areas reviewed. There were high or severe risks identified in all areas. IIA recommends the overall risk profile not to exceed the medium range.
- SOE Technology Services developed a risk treatment plan in fiscal year 2011 to identify action items they planned to implement to address high-risk security issues identified by the RECON. To date, SOE has fully or partially addressed 11 of the 23 action items. In addition, at least 6 of the remaining action items will be taken care of with the transition to MiWorkspace in fall 2014.

Recommendation: Work with IIA to schedule a RECON of the current SOE IT environment to reassess and determine action items to be implemented in light of the transition to MiWorkspace and establish project timelines for completion of all the adopted recommendations.

Management Action Plan: The School of Education Director of Information Technology has requested a new RECON be conducted for SOE to determine which action items are still relevant to SOE and which action items will be managed by Information and Technology Services (ITS).

The Director of Information Technology will manage and lead all action items remaining in SOE based on the new RECON.

Action Plan Owner: Director of Information Technology

Expected Completion Date: February 2015

4. Graduate and Undergraduate Grade Changes	Medium
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Issue: SOE leadership has not documented and communicated graduate and undergraduate grade change policies to all academic departments. There is a lack of clarity of expectations regarding review of grade changes.

Risk: Departments could be approving grade changes made by faculty resulting in an inefficient use of staff time and increasing the risk of error, depending on the access level of the approver.

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Support:

- Audit discussions revealed different expectations among SOE leadership regarding the review of undergraduate grade changes made by faculty.
- SOE leadership asserts that no grade changes made by faculty need additional review and approval.
- The Program Director of the Teacher Education department was under the impression that all undergraduate changes made by faculty are reviewed and approved prior to posting. However, the grade change rules table obtained from the Registrar's Office indicates that:
 - Some undergraduate grades can post immediately without prior authorization.
 - Some graduate grade changes require authorization while others can post without authorization.
- SOE faculty members posted 55 grade changes from spring 2013 through spring 2014. Five of 8 undergraduate grade changes were posted immediately without additional authorization, and all 47 graduate grade changes were posted immediately without additional authorization.
- SOE has not validated that the system rules set up in the grade change table process grade changes input by faculty according to SOE leadership expectations.

Recommendation: Develop, document, and communicate graduate and undergraduate grade change policies to all academic departments to ensure a fair and transparent process. Work with the Office of the Registrar to validate that graduate and undergraduate system grade change rules are consistent with the newly documented policies. Request updates to system grade change rules to resolve any discrepancies.

Management Action Plan: The Associate Dean for Academic Affairs, in consultation with the chairs of the academic programs, will oversee the development of a SOE graduate and undergraduate grade change policy that is in compliance with overarching University policies. The Teacher Education Program Director and the Director of Student Affairs will work with the Office of the Registrar to ensure that all grade changes are processed in accordance with the new policies.

Action Plan Owner: Associate Dean for Academic Affairs

Expected Completion Date: February 2015

5. Equipment Tracking – Research Incentive and Discretionary Funds	Medium
Issue: SOE does not have a process to track non-capital equipment and other property, including tangible, non-consumable items purchased using research incentive (RESIN) funds and discretionary funds.	

Risk:

- SOE may not be able to account for all equipment, especially high-risk consumable items

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such as ProBooks, Google Tablets, micro rechargers, projectors, iPods, iPads, and educational software that belong to the University.

- SOE may not be able to verify that faculty members returned all equipment that belongs to the University prior to their departure.
- University-owned non-capital equipment and tangible non-consumable items may be inappropriately removed from the University without detection.

Support:

- In fiscal year 2014, SOE awarded approximately \$200,000 in RESIN funding and \$90,000 in discretionary funding to faculty members. The Principal Investigator (PI) receives RESIN funds that are a calculated allocation of the indirect costs recovered. RESIN funds are incentive funds provided through the Dean's Office. Discretionary funds awarded by SOE are a commitment that the Dean has made to the faculty members.
- Per SOE policy, all equipment purchased using RESIN funds is the property of the University. Per the Provost's Office Policy on the use of Faculty Research and Discretionary Accounts, all equipment and tangible non-consumable items are University property.
- A review of 5 RESIN accounts and 5 discretionary accounts revealed that faculty members have purchased a variety of computer equipment and educational software using these funds. SOE did not have a list of all equipment purchased using RESIN funds by a faculty member who recently departed the University, and SOE is unable to confirm the whereabouts of these non-consumable items.
- Reconciliation of these fund accounts will move to Shared Services in 2015.

Recommendation: SOE should implement a process to track all equipment purchased using RESIN and discretionary funds.

Management Action Plan: All faculty and staff are encouraged to place their technology orders through the SOE Office of Information Technology. The Director of Information Technology will maintain an equipment-tracking database.

The Office of Financial Management and Planning staff will also track all equipment purchased on general, designated, and gift funds through an equipment tracking spreadsheet maintained by their office. The spreadsheet will track the items purchased and the account code used.

The Director of Information Technology and the Director of Financial Planning and Management will compare reports on a monthly basis and will investigate any discrepancies.

Beginning in 2015, with the shift to Shared Services, the Office of Financial Management and Planning will create a Business Objects report listing items purchased from the account codes that have been identified for equipment purchases.

Action Plan Owners: Director of Information Technology and Director of Financial Planning and

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Management

Expected Completion Date: February 2015

6. Building Keys and M-Cards	Medium
<p>Issue: SOE does not obtain positive verification that departing staff members, faculty, and graduate student employees have returned assigned building and storage cabinet keys. SOE does not revoke key card access for all departing faculty, staff, and graduate student employees.</p>	
<p>Risk: Unauthorized individuals may obtain access to locations containing research data, student data, and University assets kept in administrative offices shared by staff and students.</p>	
<p>Support:</p>	
<ul style="list-style-type: none">• The SOE Office of Facilities approves key and key card requests for faculty, staff, and graduate student employees. Some key cards provide access to the SOE building outside of the regular 7 AM to 9 PM working hours.• Procedures referenced in both the Faculty Transition Guidelines document and in the Gap Analysis document completed as part of the Annual Unit Internal Controls Certification Process indicate that SOE will collect keys from departing faculty, staff, and graduate student employees. However, SOE does not collect keys nor do they verify that departing faculty, staff, and graduate student employees return keys directly to the University Key Office.• The SOE Office of Facilities receives no notification when faculty members, staff, and graduate student employees who may have key card access leave SOE.• The SOE Office of Facilities provides keys to drawers, desks, and storage file cabinets to anyone who works in the SOE building. Many departments use storage file cabinets to store student admission records and data related to grants and research projects. These keys are not consistently collected when faculty, staff, and graduate student employees leave SOE.	
<p>Recommendation: The SOE Office of Facilities should reconcile the quantity and ownership of active keys for SOE with the Key Office. If discrepancies exist, consider appropriate steps up to and including rekeying. The Office of Facilities should revoke key card access for all faculty members, staff, and graduate student employees who no longer work at SOE. Reconciling a list of all current faculty members, staff, and graduate employees against everyone who has key card access in the system will help identify individuals whose key card access needs to be revoked.</p>	
<p>Going forward, consider developing an off-boarding checklist to facilitate proper processing of faculty and staff transfers and terminations. Management should collect keys directly from departing employees and maintain an internal record of all key assignments. The SOE Office of Human Resources should notify the SOE Office of Facilities to revoke key card access when</p>	

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faculty, staff, and graduate student employees depart.

Management Action Plan: The SOE Facilities Manager will oversee and implement the recommendations listed above.

The Facilities Manager will work with the Key Office to review the current outstanding key list.

Action Plan Owner: Facilities Manager

Expected Completion Date: February 2015

7. Conflict of Interest and Conflict of Commitment	Medium
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Issue: Management does not have an effective process to consistently implement the conflict of interest (COI) and conflict of commitment (COC) policy.

Risk:

- Staff and faculty may engage in outside activities that may interfere with their University obligations.
- Staff and faculty may have outside interests that affect or appear to affect their professional judgment in carrying out University responsibilities.

Support:

- In accordance with Standard Practice Guide Section 201.65, *Conflicts of Interest and Conflicts of Commitment*, SOE has developed their own COI and COC policy for faculty and staff.
- New SOE staff and faculty do not complete the COI/COC and Confidentiality Statement forms upon hire. New staff members sign and return the COI/COC and Confidentiality Statement forms during their first annual performance review and every year thereafter. Management agrees that it is good practice for faculty and staff to complete the COI/COC and Confidentiality Statement upon hire and renew annually.
- COI and COC requirements for temporary employees and graduate student employees are not addressed in either of SOE's COI/COC policies for faculty or staff. Temporary employees and graduate student employees do not complete the COI/COC and Confidentiality Statement either upon hire or annually.
- Faculty members annually renew their COI/COC and Confidentiality Statements at different times during the year.

Recommendation: Going forward, management should require all new staff, faculty, and temporary employees to sign and return the COI/COC and Confidentiality Statement forms upon hire and every year thereafter. Consider aligning the faculty COI/COC and Confidentiality Statement renewal process with the Faculty Annual Review (FAR) process to ensure that all faculty members sign and complete the forms annually as per policy. Document the COI/COC policy for temporary and graduate student employees.

Management Action Plan: The SOE Office of Human Resources now includes the COI/COC policy and forms as part of the new hire onboarding paperwork. This includes new faculty, staff, lecturers, graduate student employees, and temporary hires.

Beginning this fall, graduate student employees will receive the staff COI/COC policy and associated paperwork. This practice will be reviewed by the Dean and leadership team to determine whether this will continue or if graduate student employees should fall under the faculty policy or have their own.

Faculty will begin an annual renewal process during the 2014-15 Faculty Annual Review process.

Action Plan Owners: Director of Human Resources and Academic Human Resources Manager

Expected Completion Date: February 2015

8. Joint Appointments	Medium
Issue: All joint appointment agreements do not contain consistent guidelines that address key issues and define the roles and responsibilities of the schools/colleges and the faculty.	
Risk: Lack of clearly defined roles and responsibilities may result in confusion, frustration, delays, and conflicts for both the faculty with joint appointments and for the schools and colleges.	
Support: <ul style="list-style-type: none">• Guidelines developed by the Office of the Provost in 2008 recommend that an MOU be created for all new inter- and intra-school joint appointments, and be reviewed by their office no later than six months from the start of the joint appointment. The guidelines suggest clearly defining key aspects of a joint appointment, such as promotion and tenure, dispute resolution, workload, and which unit will function as the administrative home. The Provost's Office has developed templates for faculty with and without tenure to assist units with developing the MOUs.• Thirty SOE faculty members hold joint appointments with other University schools such as Business, Public Policy, and Literature, Science, and the Arts. For 7 of 8 joint appointments reviewed, the offer letter contained the terms of the joint appointment. However, the offer letters contained varying degrees of detail about the joint appointments and did not include all the terms/components detailed in the MOU templates. A recent joint appointment agreement has been drafted using a MOU, but did not include the faculty's signature.	

Recommendation: Consult the Provost's Office to determine if existing joint appointment agreements need to be updated. Going forward, SOE should generate an MOU for all new joint

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appointments at the assistant, associate, and full professor level for tenure track and instructional faculty using the templates provided by the Provost's Office.

The MOU can include unit-specific concerns along with components detailed in the templates, and should be signed by authorized representatives (e.g., Chair, Dean) of all the schools and colleges and the faculty member. All parties involved should sign a written agreement to address any changes in the terms of the joint appointment.

Management Action Plan: SOE will consult the Provost's Office to determine if existing joint appointment agreements need updating. The HR Academic Manager and Chief Administrative Officer (CAO) will work with other schools and colleges to make sure the Provost's MOU template is used for all future joint appointments.

Action Plan Owners: HR Academic Manager and Chief Administrative Officer

Expected Completion Date: February 2015

Social Media

2013-307

Report issued August 2014

A. Executive Summary

1. Overall Conclusion

The Office of the Vice President for Global Communications (OVPGC) is developing an effective control environment over centrally managed social media at U-M. Monitoring and brand protection are particular strengths in U-M's approach to social media.

OVPGC is effectively using appropriate tools to evaluate social media use. They review content placement to assess the effectiveness of chosen social media use to see how it should change in the future. OVPGC does a good job of controlling access to the central U-M social media accounts.

Social media platforms may be relatively new, but the strategic implementation of successful communications is not. In the last two years, OVPGC created a department to manage social media, hired two full-time staff and three interns, established a senior director level role, and implemented control processes. During this period, management processes, goals for campus-wide training, monitoring, best practice guidelines, a risk assessment, and brand protection processes have been created.

OVPGC works with the Office of the General Counsel (OGC) to facilitate brand protection. The University of Michigan brand is an outgrowth of the University's mission and emphasizes academic prestige, a public ethos and history, tradition and culture. U-M's use of social media takes deliberate action to reflect these values.

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As social media matures, it will become more important for U-M to strategize and proceduralize institutional use of social media resources because these tools are used increasingly to represent the University of Michigan brand to the University community and the public. Several key controls over social media are not fully developed. OVPGC can improve control by providing centralized guidance and training to the University community on the secure use of social media. The new Director of Social Media is addressing strategy and control over U-M's social media resources.

Although a number of key processes have been implemented to manage social media, OVPGC does not have all active risk management processes in place. Program management and evaluation should be included in OVPGC's oversight of University social media. OVPGC currently provides guidance on standards and best practices, however, processes need to exist to manage new and existing social media programs to ensure that they adhere to enterprise strategy, governance, and management objectives and policies. This may require more centralized control from OVPGC, including the ability to access and manage all U-M social media instances.

OVPGC established the Communicator's Forum group to share information with communications professionals across U-M and tap into the expertise that exists on campus related to marketing, design, writing, and digital media through bimonthly meetings and presentations. This is an important vehicle for the education and awareness of campus-wide social media issues as well as the sharing of acceptable use strategies and general information regarding U-M social media practice with all social media primary users across campus.

Because of the immediacy of social media, the ability to incorporate controls that keep errors or irregularities from occurring is limited. Controlling social media, therefore, requires a strong policy, training, and awareness to ensure that students, faculty, staff, contractors, and users understand acceptable use of social media at U-M. This need not be onerous, because instead of developing new policies specific to each new technology, the University can develop and implement security policies and end user training that is broadly applicable. Cooperation is vital since social media governance requires the active involvement of Information and Technology Services (ITS) and the Chief Information Officer.

2. Context and Key Risk Considerations

Social media is defined as using Internet-based applications to facilitate interaction among people in which they create, share, and/or exchange information and ideas in virtual communities and networks. U-M's central social media presence includes instances of collaborative projects, blogs and microblogs, content communities, and social networking sites.

In 2014, one in every four people in the world will log into a social network at least once a month. Students, faculty, and staff entering the workforce today are well-versed in

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social media. However, they often lack security awareness. As the use of social media matures, the business community is defining good business practices for managing social media. However, at this time there are no specific University guidelines in this area. OPGC and ITS can both positively impact the security environment through awareness, training, and the definition of best practices for use of social media.

There are two separate aspects to social media.

1. U-M can directly control some areas of social media. OPGC is the content owner for the University's official Facebook, Twitter, Instagram, Pinterest, Tumblr, Vines, and YouTube instances. Although these are applications housed by third parties, U-M has the responsibility for creating, administering, maintaining, monitoring, and moderating these official U-M social media sites.
2. U-M does not control other areas of social media that can greatly impact the University. Although not managed by the University, personal use of social media by the University community can negatively affect U-M through improper security, data leakage, or system compromise potentially resulting in disclosure of sensitive information, violation of legal and regulatory requirements, and damage of reputation. Additionally, like other web-based applications, access to social media sites can allow the introduction of inbound malware and enable phishing attacks.

The personal nature of social media makes its use different from traditional communication channels. Using social media, anyone with an Internet-attached device can participate with virtual anonymity and without specific accountability in public or private information or disinformation sharing. This creates risk because social media tools are used to represent the University of Michigan's brand, interact with the community, and provide rapid notification to the community in emergencies.

Certain risks are specific to social media, and are the focus of OPGC monitoring and best practice/awareness efforts:

- Use of personal accounts to communicate work related information
- Misrepresentation of the University brand reputation, messaging, and standards
- Unidentified portrayals or impersonation of University departments, schools, or personnel
- Disclosure of proprietary and/or confidential information
- Legal, regulatory, and compliance violations

Risk exists because an organization like U-M cannot control all aspects of social media that can negatively impact the University and because social media technologies can be hacked, hijacked, and leveraged by unscrupulous individuals. Cyber-criminals are increasingly turning to social networks because they are more difficult to monitor and control than conventional communication mechanisms.

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Education, awareness, training, and monitoring are the primary mechanisms for controlling social media. This is especially true in those areas of social media where the University lacks direct control such as personal use by faculty, staff, and students.

3. Audit Scope and Identified Risks

The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity. The scope of the audit was determined based on an assessment of the risks associated with the activities conducted by OVPGC. This process included input from unit management and interested parties from other University functions.

		Key Activities Audited					
		Strategy and Governance	Environment	Training	Staffing	Processes	Technology
Sub Activities Audited	Governance infrastructure	Monitoring	Awareness	Staffing	Alignment with business processes (issue 1)	Technology infrastructure	
	Mission	Regulatory and legal environment	Training programs (issue 3)	Social media support	Management and evaluation	Incident response	
	Controls	User guidelines (issue 2)		Central roles	Brand protection	Content filtering	
	Risk management				Access management	Monitoring	
	Risk assessment				Compliance	Security	
	Data classification				Emergency response		

Legend: Overall risk conclusion for each sub-activity

High Risk	Medium Risk	No Issues Reported
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4. Audit Objectives

The objective of this social media audit was to provide management with an independent assessment regarding the effectiveness of controls over the enterprise's social media policies and processes. The following detailed objectives were reviewed:

- Determine if the University has an appropriate governance structure over the use of social media.
- Assess whether the University has defined an overall strategy for use of social media aligned with the University mission.
- Determine if a central inventory (i.e., master listing) exists of all official U-M social media sites/instances including presences maintained by schools, colleges, and departments and who is responsible for each instance.
- Validate that the risk associated with social media is identified, evaluated, and aligned with enterprise risk profiles.

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- Determine if an overall strategy, governance structure, policy, and supporting standards exist to support social media.
- Determine if the organization has implemented effective social media usage policies.
- Ascertain how faculty, staff, students, and related parties are trained and made aware of their responsibilities relating to social media.
- Verify that staffing levels are adequate to support additional responsibilities resulting from social media projects.
- Determine if processes exist to manage new and existing social media programs to adhere to enterprise strategy, governance and management objectives, and policies.
- Assess how the U-M brand is protected from negative publicity or adverse reputational issues.
- Validate processes to provide a consistent incident response for significant reputational damage caused by misuse of any of U-M's authorized social media presences.
- Determine if U-M IT infrastructure supports risks introduced by social media.
- Determine if incident response plans for social media risks have been included in an Information Security Response Plan.
- Determine if content filtering technology is used to restrict or limit access to social media sites.
- Ensure that use of social media technology is actively monitored and its effect on the IT architecture and technology are regularly evaluated.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Social Media Strategy	Medium
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Issue: An overall social media strategy combining central and departmental social media strategy and including an integrated strategy for social media security has not been collected and documented at U-M.

Risk: Incomplete or inconsistent social media strategy can lessen the likelihood of accomplishing key University objectives provided by social media.

Support: At U-M, social media strategy is just one part of an overall communications strategy. The Vice President of Global Communications works closely with the OVPGC lead team, including the Director of Social Media and the Director of Digital Media, to plan to communicate the U-M brand message.

U-M, like the vast majority of organizations active in the social media arena, does not have a formal process associated with deploying social networking tools.

1. Social Media Strategy	Medium
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Beginning in January 2014, OVPGC developed a multi-pronged strategy and tactical plan in conjunction with the arrival of the new Social Media Director that clearly outlines the University's strategy and tactics through fiscal year 2015.

The identification and construction of system and network of access is a program goal listed in the 2014/15 planning document.

U-M's decentralized nature makes coordinating social media strategy difficult. However, guidance is being provided to help primary social media users develop their own strategy locally.

Recommendation: U-M should work with those responsible for social media locally in the schools, colleges, and departments at the University to create and implement an overall strategic plan for social media addressing deployment and management of social media platforms centrally and locally.

The strategic plan should describe how the University plans use social media and include a long-term adoption plan for policies, procedures, and solutions that will align the goals for social media use with University strategic objectives. OVPGC should perform a risk assessment to learn how new platforms, tools, and strategies will affect the University's risk profile.

OVPGC's strategic and tactical plans should address use policies, monitoring, and provisions for employee education, data protection, ownership of intellectual property and social identities, and remediating issues with social media.

OVPGC should continue to develop and implement a security strategy for system and network access. This security strategy can be included in an overall social media strategy.

Management Action Plan:

1. Complete the inventory and individual assessment of all primary social media channels which currently represent the University of Michigan.
2. Build concrete network of social media representatives responsible for content management of each identified channel.
3. Conduct regular meetings of social media representatives.
4. Formalize policy for social media account creation, and educate users on the availability of UMSocial for guidance and consultation.
5. Create and adopt among social media representatives, public affairs and other key stakeholders a plan for unified message role out in instances of specialized campaigns, announcements, and emergency response.

Action Plan Owner: Director of Social Media

Expected Completion Date: July 1, 2015

2. Acceptable Use Guidelines	Medium
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Issue: Up-to-date acceptable use guidance for faculty, staff, and students covering social media does not exist at U-M across campus.

Risk: Misuse of social media can result in violation of legal and regulatory requirements related to HIPAA, FERPA, or NCAA compliance.

Support: The University has not updated acceptable use policy for faculty, staff, and students since the advent of widespread use of social media.

Both the UMHS and athletics programs actively promote acceptable use guidelines.

Good business practice addresses social media use by integrating existing policy for social media use. Management can easily extend existing policies on acceptable use, communications, and human resources to cover social media.

The central U-M social media office has issued multiple white papers on social media best practices and acceptable use. OVPGC has distributed this guidance to social media primary users across campus.

Recommendation: OVPGC should work with ITS, OGC, and other concerned areas to update acceptable use guidance for faculty, students, and staff to include use of social media. Guidance should address how the University and those with whom it interacts on social media can meet compliance requirements, and adhere to existing policy addressing adult language, hate speech, inappropriate content, malicious links, and other risky content and activity.

Acceptable use guidelines should address faculty, staff, and student personal use of social media and use of social media for business purposes.

Members of the University community should sign an acceptable use agreement including notification of acceptance of proper use policies upon hiring. Those representing the University on social media sites should sign-off on these policies. The University should treat contractors similarly to staff.

Management Action Plan: An entire section is dedicated to acceptable use, creation, and implementation of social channels along with best practices and procedures on the new social media website that launched March 13, 2014. Additional work in updating and sharing standardized guidelines will be ongoing as the responsibility of the new Social Media Director.

1. Update acceptable use policy for faculty, staff, and students to include social media.
2. Educate faculty, staff, and students on the potential risks of social media as related to HIPAA, FERPA, and NCAA legal and regulatory requirements.
3. Create an active channel of communication between UMSocial, ITS, and OGC.
4. Author acceptable use agreement template to be distributed and/or adopted for new employee orientation, student orientation, training, etc.
5. Continue development of pertinent resources on socialmedia.umich.edu.

2. Acceptable Use Guidelines	Medium
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Action Plan Owner: Director of Social Media

Expected Completion Date: January 1, 2015

3. Training and Awareness	Medium
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Issue: A broad-based training and awareness program for faculty, staff, and students addressing the use of and/or response to social media is lacking.

Risk: Untrained users are more prone to exposing the University to risks when using social channels.

Support: There are a number of different constituencies using U-M social media. Social media is becoming common to many jobs at the University. Educating employees about how to use social media tools helps ensure they are doing so securely. Education and training for employees is a key component to managing loss of information. The Communicator's Forum is a good start toward building training and awareness, but training needs to be much broader.

Anyone with access to a central University social media account has been trained to engage effectively and securely.

Training of faculty, staff, and students in social media use, appropriate content, disclosure of information, and etiquette best practices is necessary.

Recommendation: OVPGC should coordinate with other University primary social media providers, ITS, University Human Resources, and Admissions to create training and leverage training opportunities. Training should address both circumstances where individuals are representing the University and when they use social media applications personally. Along with training on secure use of social media, faculty and staff should be trained on how to respond quickly and effectively during a crisis.

OVPGC should educate the University community about how their social media use could affect the University.

Management Action Plan: OVPGC is already working with Undergraduate Admissions, Student Life, New Student Orientation, and University Human Resources to provide social media training and educational opportunities.

1. Incorporate social awareness slide into new employee orientation, and other presentations across campus, such as Department of Public Safety and Security safety video.
2. Create Brown Bag series on social media topics available to staff and faculty.
3. Identify opportunities to partner with skilled faculty and staff using social media and conducting relevant research to host live chats and opportunities for education and

3. Training and Awareness	Medium
engagement. 4. Provide regular updates from the UMSocial website that highlight new developments, research and topics in social media. 5. Set standard for presentation of personal and unaffiliated individuals through social media, including username and biographical protocol.	

Action Plan Owner: Director of Social Media

Expected Completion Date: January 1, 2015

Sponsored Programs Office of Contract Administration

2014-502

Report issued September 2014

A. Executive Summary

1. Overall Conclusion

University Audits recently conducted an audit of the Office of Contract Administration (OCA). OCA is responsible for reviewing and approving contracts and grants associated with sponsored projects, and preparing and administering related subcontracts. Based on our review, OCA is reviewing and approving agreements effectively and efficiently. Over the past couple of years, OCA has significantly improved workflow processes and has an average contract approval turn-around time of 2.4 days.

The OCA subcontracting activity has recently transitioned from a manual process to an electronic workflow within the University electronic research administration tool (eResearch). University Audits identified several areas of improvement needed in the subcontracting process:

- There is limited definition and clarity surrounding roles and responsibilities for the monitoring of subrecipient activities. There is currently limited University training or guidance available to Principal Investigators (PIs) for subrecipient monitoring. This issue was previously identified in a subrecipient monitoring audit conducted in 2008.
- Controls around subrecipient payment processing related to invoice review and coordination with Accounts Payable (AP) need strengthening.
- Federal pre-award requirements are not consistently followed in the areas of subrecipient eligibility and communication of sponsor requirements. Subcontract templates have not been reviewed and approved by the Office of General Counsel.

Over 60% of the University's annual sponsored research spend of \$1.3 billion is federally funded. New federal guidance effective December 2014 will expand institutional

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responsibility around subrecipient monitoring. Strengthening the current control environment will better prepare the University for the new federal funding requirements.

2. Context and Key Risk Considerations

The OCA is a unit within Sponsored Programs, which reports to the Associate Vice President for Finance. Sponsored Programs manages post-award grant and contract activities of the U-M research enterprise and other sponsored activities to ensure compliance with applicable federal, state, and local laws as well as sponsor regulations. The University receives over \$1.3 billion annually in revenues from various government agencies and private sources for sponsored programs.

OCA is staffed by the Grants and Contracts Associate Director and four contract administrators. Two senior contract administrators draft and negotiate subcontracts and amendments, while two intermediate contract administrators manage the subcontracts after they are activated including invoicing and project close out activities. There are also two Procurement employees housed in OCA who are responsible for processing purchase orders related to subcontracts and other sponsored project payments outside normal procurement functions.

Per Regents' Bylaw 3.07, *Approval and Execution of University Documents* and Standard Practice Guide (SPG) Section 601.24, *Delegation of Authority to Bind the University to External Agreements on Business and Financial Matters*, the Office of Contract Administrations Associate Director has delegated signature authority from the Executive Vice President and Chief Financial Officer to review and sign, on behalf of the University:

- All contracts for sponsored programs up to \$750,000. This includes all contracts, awards, grants, cooperative agreements, and any amendments related to these agreements.
- Training grants and fellowship programs or fellowship programs exceeding \$250,000 in the fiscal year.

For the 15-month period ended March 31, 2014, the Grants and Contracts Associate Director reviewed and approved or sent on for higher level approval 4,313 agreements, including amendments. This includes contracts, grants, and amendments for externally funded sponsored projects.

In addition to the prime contracting activity, there are currently almost 1,000 active subcontracts at the University, all are created and administered by OCA. Although the subcontract workflow was recently transitioned to eResearch, many agreements still require ink signatures. During fiscal year 2013, the University disbursed roughly \$96 million to subcontract subrecipients.

All contracts and grants for U-M are managed through eResearch, the system for electronic research administration. As of the beginning of calendar year 2013, the

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eResearch Proposal Management system (eRPM) houses all new subcontracts. Prior to this, the contract administration process was a very paper-intensive and manual process. There are several efforts underway to improve eResearch processes, including implementing electronic signature approvals for University agreements.

As defined by the Federal Office of Management and Budget (OMB) Circular A-133, a subrecipient relationship exists when funding from a pass-through entity is provided to perform a portion of the scope of work or objectives of the pass-through entity's award agreement with an awarding agency. Federal regulations require that the pass-through entity monitor the financial and programmatic activities of subrecipients. The management and oversight of subrecipient activity is the responsibility of the PI and the institution.

3. Audit Scope and Identified Risk Levels

This focus of this audit was to review the primary functions of OCA, including the approval function and management of subcontracts. The scope of the audit was determined based on an assessment of the risks associated with the activities of Contract Administration. This process included input from the Office of Research and Sponsored Projects and the Sponsored Programs office management, as well as interested parties from other University functions. The table below lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity.

Key Activities Audited	Key Activities Audited			
	Contract/Grant Review and Approval	Subcontract Process Review	Subcontract Process Testing	Roles, Responsibilities, Policy, and Training
Assessment of legal and financial risk	Determining subrecipient eligibility (see issue 2)	Confirming eligibility requirements were reviewed and validated (see issue 2)	Defined roles and responsibilities (see issue 1)	
Contract approval process	Subcontract templates (see issue 4)	Verifying subcontract templates were used	Policy and procedure (see issue 1)	
Preparation for changes in the legal and regulatory environment	Compliance requirements (see issue 3)	Guidance and expectations were communicated to subrecipient	Training and awareness (see Issue 1)	
	Subrecipient monitoring (see issue 1)	Invoice was approved by PI or qualified individual		

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Key Activities Audited			
Contract/Grant Review and Approval	Subcontract Process Review	Subcontract Process Testing	Roles, Responsibilities, Policy, and Training
	Review, approval, and processing of invoices (see issue 5)	Subrecipients met A-133 requirements	

Legend: Overall risk conclusion for each sub-activity

High Risk	Medium Risk	No Issues Reported
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4. Audit Objectives

The objectives of the audit were to determine whether:

- The contract/grant review and approval process for OCA is effective, efficient, and consistently applied.
- The process for outgoing subcontracts is effectively managed and well controlled and consistent with sponsor requirements
- Individuals involved with contract and grant activities have been informed of responsibilities and been provided initial and ongoing training

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Subrecipient Monitoring Roles and Responsibilities	Medium
Issue: Although high-level responsibilities have been assigned to the PI, the expectations to monitor recipients of federally sponsored subcontracts have not been clearly defined, communicated, and documented. Additionally, there is a lack of guidance for subrecipient monitoring.	

Risk:

- Disallowance of funds and nonperformance of duty for sponsored contracts and awards.
- A lack of specified roles and responsibilities may lead to duplicated effort and inefficiencies. Documented roles and procedures ensure continuity of operations.
- Payments may be made to subrecipients that have not provided sufficient documentation to ensure that cost and spending requirements were met.

Support:

- Limited guidance and training for PIs was identified as an issue in the subrecipient monitoring audit conducted by University Audits in 2008.
- There is no central resource that provides guidance on how to effectively monitor programmatic and financial activities of subrecipients, such as standard operating

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procedures or training.

- The only institutional policy or guidance that speaks to the PI's responsibility to monitor subrecipient activity is *SPG Section 500.1 Fiscal Responsibilities*, "The PI is the individual with the ultimate responsibility for the administrative and programmatic aspects of the project including ensuring funds are spent in accordance with University and sponsor guidelines."
- Thirteen peer institutions, including the Big Ten, were reviewed and all have a separate policy or guidance detailing institutional and PI responsibilities as well as procedures for subrecipient monitoring. UM does not provide any comparable guidance.
- OCA does not have any documented standard operating procedures or job descriptions.
- Prior to routing invoices to PIs, there is no central review to determine whether sufficient detail exists so that the PI can confirm that cost and spending requirements were met. The only review currently done is a confirmation that the invoice is within the appropriate project dates.
- PIs do not always sign off on subrecipient invoices. They are often signed by department or research administrators.

Recommendation:

- Develop a policy to clarify institutional responsibilities for subrecipient monitoring and management of subawards. Provide written guidance and procedures to assist PIs with subrecipient monitoring. Review written guidance and procedures regularly so that they remain current and relevant. Communicate this to the University community on an ongoing basis.
- Document standard operating procedures for OCA, including the administration of subcontracts. Update these procedures on a regular basis so they remain current and relevant.
- Federal subcontract spending should receive monitoring similar to what is currently provided for direct federal spending at the University. The Office of Contract Administration or the Office of Sponsored Programs should review invoices for compliance with federal payment requirements prior to invoice payment. Create invoicing standards for subcontractors to follow to facilitate the review process. The review should include verification that invoices have enough detail to confirm that cost and spending requirements were met. Create a checklist so that the review process is consistent and complete including:
 - Expenses are itemized
 - Payroll information has sufficient detail to assess spending and adherence with any applicable federal salary caps
 - Expenses are incurred within the appropriate time period
 - Only direct costs are included and indirect costs are correctly applied

Management Action Plan: As part of our ongoing planning to comply with the upcoming changes required by the Federal Uniform Guidance requirements regarding subrecipient monitoring, we believe this issue will be fully addressed as we develop changes to our existing

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processes. Once developed, it is our intention to review these new processes with University Audits to ensure overall agreement before implementation.

Action Plan Owner: Grants and Contracts Associate Director

Expected Completion Date: January 2015

2. Subrecipient Eligibility Requirements	Medium
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Issue: The University does not always assess subrecipient eligibility and financial viability prior to awarding subcontracts.

Risk:

- There is a potential for federal audit findings resulting in disallowance of federal funds.
- The quality of research and deliverables may be compromised.

Support:

- If portions of a federal award are subcontracted to another institution, federal regulations require the contract recipient to review audit reports and financial statements of subrecipients to assess the subcontractor's eligibility to perform the work. The purpose of the review is to assess the subrecipients ability to adhere to federal cost and spending compliance requirements. The University has the responsibility to monitor subrecipients compliance throughout the contract period.
- Before a subcontract becomes active, OCA requires an institutional official signature and requests an Office of Management and Budget Circular A-133 (OMB A-133) audit report from non-profit organizations, and sometimes audited financial statements from for-profit organizations. The OMB A-133 report is a federally required annual audit report on internal controls and compliance for non-profit organizations that receive more than \$500,000 a year in federal funds. If the OMB A-133 report or audited financial statements are not obtained, which is common, it does not stop OCA from creating the subcontract.
- On an annual basis, OCA does attempt to follow up with subrecipient institutions to obtain missing audit reports. Work proceeds, even if the subrecipient is nonresponsive.
- We tested 20 subcontracts (14 non-profit and six for-profit) and determined:
 - Current OMB A-133 reports were not obtained for one non-profit subrecipient with awards in 2011 and 2013 (there was a 2010 report on file).
 - Financials statements were obtained for one out of the six for-profit firms; however, they were written in Chinese and were not translated. OCA staff acknowledged they do not have sufficient technical knowledge to assess the financial reports. As a result, little assessment is done other than to verify bottom line profit or loss.

Recommendation:

- For non-profit organizations, implement a process to utilize the Federal Audit

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Clearinghouse to collect the most recent A-133 audit report prior to subcontract approval and throughout the subcontract period.

- For for-profit organizations, collect audited financial statements and other materials to assess subrecipient eligibility prior to subcontract approval and throughout the subcontract period.
- Provide written guidance and training for reviewers so that the eligibility and assessment process is consistent and relevant:
 - Review audit report for any findings or concerns. Obtain assurance that the organization has corrected any findings that affect the subcontract.
 - Assess the overall size of operations and financial viability of the organization. Determine whether the organization has sufficient resources to administer, given the size and scope of the subcontract.
 - For for-profit organizations, obtain a list of other federally funded awards made to that organization to gauge the entities experience and demonstrated ability to administer federal contracts.
 - Consider requiring detailed invoicing from for-profit organizations to support effective monitoring of federal cost and spending requirements throughout the contract period.
 - Consider obtaining Dun & Bradstreet credit rating reports for companies that do not have an established relationship with the University. (see Issue 4 below second support bullet for further discussion of Dun & Bradstreet).
 - Create or expand current checklists to guide and facilitate review process.

Management Action Plan: The Management Action Plan stated in Issue #1 applies here as well. We believe the revisions to our processes necessitated by the Uniform Guidance requirements will address this issue and will be vetted with University Audits.

Action Plan Owner: Grants and Contracts Associate Director

Expected Completion Date: January 2015

3. Pre-award Compliance Requirements	Medium
<p>Issue: The University is not always in compliance with federal requirements to capture subrecipient DUNS numbers for all federal awards (grants and cooperative agreements) and to communicate the CFDA numbers to the subrecipient at the time of the subaward.</p>	

Risk: Noncompliance with federal laws and regulation could result in an OMB A-133 audit report finding and/or loss of federal funding.

Support:

- OCA staff stated they do not always capture DUNS numbers of the subrecipients of federal awards. They also stated they do not always communicate the CFDA number and title to the subrecipient of federal awards. Testing supported these statements.

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- According to OMB Circular A-133 compliance supplement, DUNS numbers should be obtained for all federal awards. Dun & Bradstreet provides a DUNS number, a unique nine digit identification number, for each physical location of a business. The DUNS number helps to identify information associated with the business including business name, physical and mailing address, financial data, payment experiences, government data, and more. OCA identified that DUNS numbers were not being captured for all awards prior to audit finding.
- According to OMB Circular A-133 compliance supplement, CFDA numbers should be communicated to the subrecipient at the time of the subaward. CFDA is a government-wide compendium of federal programs, projects, services, and activities that provide assistance or benefits to the American public. It contains detailed program descriptions for all federal programs available to the University. OCA identified that CFDA numbers were not included in all subawards prior to audit finding.

Recommendation:

- Require all subrecipients to provide a DUNS number as part of their subaward application.
- At the time of the subaward, communicate federal award information to the subrecipient including the CFDA title and number.
- Expand checklists and standard operating procedures to include these steps.

Management Action Plan: The requirements to capture DUNS and CFDA numbers in Federal subawards have been reiterated to all OCA staff and will be double-checked prior to executing the subawards to ensure their inclusion in the document.

Action Plan Owner: Grants and Contracts Associate Director

Expected Completion Date: August 2014

4. Nonfederal Subcontract Templates	Medium
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Issue: Subcontract templates are not reviewed and approved by the Office of General Counsel (OGC).

Risk:

- Subcontract language may not reflect current risks and legal considerations faced by the University.
- The University may enter into an agreement that results in a financial loss or reputational harm.

Support: OCA uses several templates to draft subcontracts. The template used the most is for organizations that are partnered with the Federal Demonstration Partnership (FDP). The FDP is an association of federal agencies and research institutions working to streamline administration of federally sponsored research. The FDP provides helpful templates that are

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thoroughly vetted by its members. The FDP templates are used for federal awards. The remaining templates have not been shared with OGC. OCA would benefit by sharing these subcontract templates with OGC for review and approval as they have insight into the nuances of contract language and changes in the legal environment.

Recommendation: Meet with OGC on a scheduled basis to discuss subcontract templates and any changes in the legal/regulatory environment that may have an impact. Assign the responsibility to a staff member to update templates periodically.

Management Action Plan: We will reach out to OGC and request an annual review of our subaward templates to ensure they capture the essential elements of a sound legal agreement.

Action Plan Owner: Grants and Contracts Associate Director

Expected Completion Date: November 2014

5. Invoice Numbering System	Medium
<p>Issue: Some invoice numbers assigned by Accounts Payable (AP) to subcontract invoices create unnecessary rework including incorrect identification of invoices that appear to be duplicate, but actually are valid individual invoices.</p> <p>Risk: The resolution of potential duplicate invoices causes unnecessary effort and impedes the payment process to subrecipients.</p> <p>Support: Many subcontractors use an invoice-numbering scheme that starts at invoice number "1" for each unique subcontract within their organization. When AP receives the invoices, the invoice number assigned by the subcontractor is entered in the system. The payables system will identify this as a duplicate if an invoice with the same number has already been paid to that organization on another subcontract. For example, if U-M has two projects with an organization, the first invoices on both projects will be numbered "1." These false positives are forwarded to OCA staff for resolution. When OCA staff receive the invoices they add the subrecipients unique grant number after the invoice number and send it back to AP for successful reprocessing. On average, there are approximately 10 of these false positives per week.</p>	

Recommendation: Meet with AP to develop a unique numbering system for subcontract invoice processing. Periodically meet to resolve workflow and rework issues related to invoicing.

Management Action Plan: We will work with AP, and possibly ITS, to overcome what we believe is a system limitation with MPathways.

Action Plan Owner: Grants and Contracts Associate Director

Expected Completion Date: January 2015

Student Domestic Travel – Sponsored Teams and Groups

2013-110

Report issued July 2014

A. Executive Summary

1. Overall Conclusion

U-M is committed to providing students with fulfilling and unique educational experiences, and some of these experiences involve travel. A large amount of travel is conducted by student teams and groups including sports teams, student organizations, and teams created by schools or colleges. The University sponsors much of this travel, whether it is as part of a course, components of a degree program, University athletic competitions, or travel for student organizations.

A policy on domestic travel does not exist nor does a central source for guidance for individuals traveling domestically. Valuable instruction exists in some units and programs, but in other cases, units are duplicating effort by recreating travel steps. Additionally, there is no coordinated mechanism for experienced travelers or administrators to share best practices or identify process improvements surrounding the domestic travel process with the University community. There is currently no central process that requires registration or communication of domestic travel plans, making it difficult to identify the amount of travel conducted or the location of travelers.

As the level of domestic student travel continues to grow, so too does the financial and reputational risk associated with this travel. A coordinated effort towards the development of best practices and guidance for domestic travel would be very valuable to University travelers. These best practices and guidelines could also be helpful to those taking trips for non-University travel. Prevalent areas of concern for travelers include struggles with planning and preparation, emergency response, and safety.

A substantial effort has been made toward addressing the risk associated with international travel. The increased visibility of the International Travel Oversight Committee, creation of Standard Practice Guide (SPG) Section 601.31, *International Travel* requiring the registration of international travel for University business in the Travel Registry, and continued work of the Council on Global Engagement all speak to these efforts. The opportunity exists to build upon these existing platforms to provide similar guidance and direction to University faculty, staff, and students traveling domestically. It may be possible to streamline some existing procedures to function for both types of travel. In areas where this is not possible, the University could leverage lessons learned to develop procedures specific to domestic travel.

Some best practices for domestic travel were noted, based on our testing, review of sampled units, and interviews with central administration:

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- Pre-departure orientation, including:
 - Safety, sexual harassment, use of vehicles, emergency procedures, insurance, critical information to carry, and alcohol and drugs
 - Awareness of how to handle potential mental or physical health issues
 - Expectations of students involved in travel
- Pre- and post-trip checklists
- List of student names, emergency contact information, and insurance
- Budgets and itineraries for trips
- Stored value payment cards (another procurement option available for travelers)
- Use of the Travel Registry
- Travel selection process is unbiased and transparent
- Understanding of the resources available, such as:
 - U-M Police Department
 - Risk Management
 - Center for Campus Involvement
 - Dean of Students Critical Incident Team
- Awareness of Clery Act reporting and expectations
- Understanding the difference between University business travel and leisure/personal travel and the implications of combining the two
- Debrief process that includes discussion of trips success and best practices

2. Context and Key Risk Considerations

This audit was conducted as part of University Audits' effort to review student safety on a regular basis. The appropriate management of student travel is frequently noted as a concern in discussions with executive leadership and unit management. The breadth of travel being conducted by students is extensive. Some units have a comprehensive travel process that has been augmented throughout the years based on their travel experiences. Other units should make continued efforts towards improving the travel process.

Students may participate in University-related domestic travel in various manners:

- Required part of a course (i.e., faculty-led trips)
- elective trips as part of a course
- Internships or practical experiential training
- Intercollegiate Athletic competition
- University band performance
- Co-curricular activity (including Club Sports, Sponsored Student Organization⁶ events, activity organized by University schools, colleges, and units)
- Community service related travel (e.g., Alternative Spring Break, Detroit Service

⁶ Sponsored Student Organizations (SSOs) are organizations that have a substantial relationship with a sponsoring University unit. Their mission must align with the University and sponsoring unit and they are accountable to the University for legal compliance and fiscal responsibility.

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The University unit or department that supports the student team or group may manage travel directly or may advise as the group plans the travel.

3. Audit Scope and Identified Risks

The scope of the audit included a review of University guidance for domestic travel conducted while on University business and a review of sponsored student groups conducting domestic travel. This process included input from central administration and leadership of sampled units. Units were selected to attain a representative sample of travel by University students. While students were the focus of the audit, procedures and practices available to all travelers were reviewed. Opportunities to improve the internal control structure surrounding the departmental travel process were communicated to sampled clients.

The travel process for each sampled unit was reviewed in order to understand the unit procedures, identify areas of concern, and note any best practices. Travel conducted by units ranged from two individuals driving in a personal vehicle to hundreds of students organized on buses. Informal or impromptu trips were not reviewed; however, student leadership and unit administrators were interviewed to identify concerns and struggles they deal with regularly. Five units were selected for an in-depth review of their travel process: 1) Solar Car Team, 2) Alternative Spring Break – Ginsberg Center, 3) Women's Tennis Team – Athletics, 4) Michigan Marching Band, and 5) UM-Flint Honors Program.

The following table lists the key activities audited, along with the overall risks of the audit findings. The unit procedures noted below were tested in each of the sampled units.

Key Activities Audited						
Sub Activities Audited	University Guidance	Planning and Administration	Funding	Safety/ Liability	Procurement/ Cash Handling	Vehicles
SPG/policies (see issue 2)	SPG/policies (see issue 2)	Policies and procedures	Source of funding	Tracking student travel (see issue 2)	Method of procurement	Safety and security
	Guidance available to travelers	Orientation and training (see issue 2)	Spending restrictions	Emergency procedures (see issue 2)	Concur	Incident response
	Security and liability	Travel arrangements	Reporting requirements for sponsored funds	Medical/mental health (see issue 2)	Approval for expenses	Policies and procedures
	Process owner/ process improvement (see issue 1)	Approval		Emergency contacts		Gross Pay Register

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Key Activities Audited					
University Guidance	Planning and Administration	Funding	Safety/Liability	Procurement/Cash Handling	Vehicles
Benchmarking/industry best practices Coordination among central administrative and academic units	Participant selection process		Privacy		Temporary employees

Legend: Overall risk conclusion for each sub-activity

High Risk Medium Risk No Issues Reported

4. Audit Objectives

The objectives of the audit were focused in two areas:

University guidance:

- Assess the level of guidance, resources, and expectations provided to domestic travelers, specifically student teams and groups, from the University and its central units.

Unit procedures:

- Determine whether pre-travel planning and administration is effective and adheres to relevant policies. Verify all travelers are informed of best practices, guidelines, and key travel concerns.
- Verify that all travel funds, specifically sponsored funds, are effectively managed for travel.
- Confirm that the safety of travelers is effectively managed and policies and procedures are followed. Verify liability to the University is identified and effectively managed.
- Determine whether adequate controls exist over the purchasing function and travel expenditures.
- Determine whether vehicles are responsibly and effectively managed.
- Determine if a post-trip debrief process exists and if it is effective and adheres to relevant policies.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Process Owner

High

Issue: There is no central oversight of University sponsored or related domestic travel.

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Risk:

- Inefficiencies related to duplication of effort may occur.
- Incomplete, inconsistent, or inaccurate information may be given to travelers.
- Travelers may not be aware of and prepared for potential risks and emergencies, which may impact student safety.

Support:

- Oversight of domestic travel is conducted at the unit level. Additionally, units are duplicating effort by creating steps that could be provided centrally.
- The Center for Campus Involvement focuses on providing guidance for Sponsored Student Organizations (SSO).

Recommendation: Establish a central domestic travel oversight process, including owner(s) with sufficient authority to oversee University related domestic travel. Consider following a model similar to the International Travel Oversight Committee by assembling a team of experienced travelers and administrators. Include experts and stakeholders with knowledge of the related risks and underlying processes. The newly created Council on Engaged and Civic Education may be a good resource in these efforts.

Management Action Plan: The Vice Provost for Global and Engaged Education will lead the effort necessary to address this issue. Detailed actions are included in one combined action plan, as noted below.

2. Policy and Guidance	High
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Issue: Institutional and departmental responsibilities regarding domestic travel have not been clearly defined or documented.

Risk: While traveling domestically, individuals may cause financial or reputational damage to the University or physical harm to themselves.

Support:

- University-wide procedures and best practices have not been identified for administering domestic travel.
- Little to no guidance is provided to student domestic travelers not associated with an SSO.
- Neither SPG 507.10-1, *Travel and Business Hosting Expense Policies and Procedures for Concur Users* nor SPG 601.31, *International Travel Policy* address domestic travel.
- Some units have a very solid travel process that has been developed over years of travel and access to resources while other units are still developing and fine-tuning steps.

During the audit, the following control weaknesses were identified:

- Orientation and Training: Units are not consistently educating travelers on best practices before trips.
 - Available orientation and training varies based on unit resources. Sampled units

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- with more experience and resources had more formal orientation or training for travelers. Orientation and training in some sampled units were minimal or nonexistent.
- Audit interviews demonstrated that students are interested in additional resources including best practices for domestic travel, specifically for safety.
 - Maintaining Mental Health Information: Some units are collecting mental health information on travelers during the planning stages of domestic travel.
 - Mental health data is covered by the Family Educational Rights and Privacy Act (FERPA) and should be treated sensitively.
 - Under FERPA, U-M is required to provide certain privacy protections for education records.
 - Maintaining mental health information may have legal implications (e.g., perceived discrimination). The Student Life Health Advisory Team is available to assist units with these efforts.
 - Rather than requesting mental health information, units should focus on awareness and pre-departure preparedness with the goal of developing a plan for training and educating all students, unique to the travel climate and situation.
 - Similar considerations may also be necessary for obtaining and maintaining other health information.
 - Emergency Procedures: In the event of an emergency, travelers may not know how to respond or may be unaware of procedures to follow.
 - Existing and documented emergency procedures reviewed during audit testing varied. Some sampled units did not have documented emergency procedures.
 - Tracking University Related Domestic Travel: Domestic travel locations and emergency contact information are not always tracked making it difficult to reach travelers in emergency situations.
 - The majority of informal travel is not tracked.
 - Units that tracked domestic travel most effectively used the Travel Registry.

Recommendation:

- Create a policy addressing domestic travel.
- Develop a process for identifying and communicating domestic travel best practices and guidance:
 - Develop and share University-wide pre-departure training and orientation procedures. Provide guidance and/or training for unit administrators to effectively manage domestic travel. Consider requiring training for students traveling domestically on University-sponsored travel.
 - Include guidance on how to cope with and manage stressors unique to the travel climate and situation for all student travelers.
 - Identify any baseline procedures that should be followed in an emergency. Provide

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- guidance to units on how to document relevant information and give instruction in the event of an emergency during domestic travel.
- Identify and communicate key resources that should be contacted in the event of an emergency.
- Promote the use of the Travel Registry to track domestic travel.

Combined Management Action Plan: The Vice Provost of Global and Engaged Education will identify and engage stakeholders in Academic Affairs and Student Life of all three campuses to discuss needs, risks, and concerns related to University sponsored student group domestic travel. The Office of the Vice Provost for Global and Engaged education will identify project planning and management actions necessary to enact process ownership and develop guidance. An advisory group will be formed to review the resulting plan and consult with the Vice Provost for Global and Engaged Education. The plan will also be reviewed by the Council for Engaged and Civic Education along with other identified stakeholders. In developing the plan for University sponsored domestic travel, current policy, structure, guidance, and best practices already in place for University sponsored international travel will be considered. Specific items that will be reviewed include the International Travel Oversight Committee, Global Michigan portal, Travel Registry, and other existing best practices.

Action Plan Owner: Vice Provost for Global and Engaged Education

Expected Completion Date: Plan/Steps identified – December 31, 2014; Initial structure and/or guidelines developed – June 30, 2015

University of Michigan-Flint Department of Public Safety

2014-204

Report issued July 2014

A. Executive Summary

1. Overall Conclusion

The University of Michigan-Flint Department of Public Safety (DPS or the Department) has effective controls in place and controls are working as intended. While the audit did not identify any high-risk issues, there are some opportunities for improvement. In response to the audit, UM-Flint management has committed to strengthen controls related to the UM-Flint Department of Public Safety Oversight Committee. Further, DPS leadership has already begun to make improvements related to control of the property room management, segregation of duties, managing potential conflicts of interest, and cash handling training.

2. Context and Key Risk Considerations

DPS provides the Flint campus with a full range of law enforcement services. A new Department Director was appointed in February 2012 and reports to the Assistant Vice Chancellor for Business and Finance. The DPS staff includes Police Officers licensed by the state, Security Officers, Communications Officers, Student Patrol Officers, and three

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Administrators to handle the business office. In addition to law enforcement duties, the Department provides escort services, motorist assistance, manages the campus lost and found office, and is an integral part of the University's Emergency Alert System.

Safety and security is a key component of the campus strategy to grow by increasing the number of international and non-commuter students. This is particularly critical given the city of Flint's consistent ranking as one of the most dangerous cities in the United States. The Department uses a variety of tactics to address safety and security concerns, including introducing student patrols to the campus, having officers patrol on bicycles, and implementing programs such as "pop with a cop" to help support communication between the campus community and DPS.

UM-Flint has established a committee to provide oversight as required by Michigan Public Act 120. The Committee is empowered to review grievances and functions as a check on DPS power.

With the new director for UM-Flint DPS and a new police chief in Ann Arbor, there is a strong desire for increased cooperation and collaboration between the campuses. During the audit, we noted several instances of Flint DPS moving toward more cooperation including UM-Flint officers working Ann Arbor events, joint training sessions, and Flint DPS seeking guidance on safety concerns from Ann Arbor.

An area of frustration for the officers interviewed during the planning stage was the inadequacy of the facilities for DPS. The current location is not large enough to house the entire unit, the locker room is inadequate, and the locker room doubles as the report writing room. Additionally, the dispatch office is in a separate location and may not be sufficiently secure. Upgrading DPS facilities was included in the UM-Flint Campus Master Plan Update of 2011. On-going discussions are held with the Assistant Vice Chancellor to review options and keep the upgrade project moving forward.

3. Audit Scope and Identified Risks

The table below lists the key activities audited, along with the audit issues identified for each sub-activity. The scope of the audit was determined based on an assessment of the risks associated with the activities of DPS. This process included input from the UM-Flint Vice Chancellor for Business and Finance and interested parties from other University functions. During the planning phase of the audit, discussions with the Vice Chancellor's Office and DPS senior staff highlighted the importance of providing a safe, secure campus while maintaining an excellent relationship with U-M-Flint faculty, staff, and students. Based on those meetings and the small volume of purchases and cash handling, the audit focused on mission-specific areas including safety and security concerns, Clery Act compliance, officer training, property room and evidence handling, and the policies and training related to officers' use of force.

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Key Activities Audited						
	Training and Education	Payroll and Timekeeping	Clergy Act	Asset Management and Procurement	Oversight Committee	Weapons and Use of Force
Sub-activities Audited	Track training and compliance	Monitoring and oversight	Consulting report recommendations	Capital purchases > \$5,000	Oversight committee policies and procedures (1)	Weapons handling policies and procedures
	Coordination with Ann Arbor	Approval and accuracy	Annual letter to CSAs	PO & capital purchases	State law and University policy (2)	Use of force policies and procedures
	Campus coverage during training	Temporary employees	Management oversight	Flint central business office		On-boarding/off-boarding
	Education programs	Overtime and supplemental pay	Crime data and non-campus locations reporting	Personal use of DPS assets		Use of force reporting
	Annual campus-wide training	Gross payroll reconciliation	Legal and expert guidance assistance	Retired assets		
		Campus security jobs	Record retention	P-card procedures and oversight		

Key Activities Audited (Continued)					
	Safety and Security	Conflict of Interest	Budget/Financial Oversight	Property Room	Cash Handling
Sub-activities Audited	Multi-Hazard mitigation plan	Secondary employment	Reviewing and approving budgets	Physical inventory of the property room (3)	Cash handling (4 and 5)
	Key controls	Communicating COI/COC	Monitoring budgets and major variances	Disposal of property and evidence	
		Reported conflicts and management plans (6)	Reconciling SOA	University ID/MCards	

Legend: Overall risk conclusion for each sub-activity

High Risk	Medium Risk	No Issues Reported
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4. Audit Objectives

The objectives of the audit were to:

- Review UM-Flint's multi-hazard mitigation plan (prepared by Green Oak Solutions) to assess implementation progress on the high priority recommendations.
- Assess the controls over payroll including overtime and supplemental pay.
- Review recommendations from the recent Clergy audit (conducted by Stafford

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Associates) and assess DPS's remediation of the recommendations.

- Review controls over procurement and managing of assets. Validate assets are monitored and that obsolete or expended assets are properly disposed.
- Review controls over the Oversight Committee, validate the Committee complies with UM-Flint and statutory requirements, and verify that faculty, staff, and students are knowledgeable about the Committee and grievance procedures.
- Review controls over department weapon systems, (lethal and non-lethal weapons) and compliance to “use of force” policy.
- Review training records to assess compliance with departmental policy and validate that all members of the department have received all required training.
- Assess the process for communicating the Conflict of Interest/Conflict of Commitment (COI/COC) policy and management of COI/COC disclosures and management plans.
- Assess controls over budget and financial activity including preparation, monitoring, and approving transactions.
- Assess the controls for inventorying, tracking, releasing, and disposing of evidence, and found or forfeited property.
- Assess the controls over cash handling.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Effectiveness of the Oversight Committee	Medium
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Issue: The Oversight Committee is not providing an effective check and balance to DPS.

Risk: Lack of effective oversight may lead to conflicts between the campus community and DPS, and reputational damage to the Department.

Support:

- UM-Flint has an Oversight Committee staffed in accordance with the requirements of Michigan Public Act 120.
- UM-Flint guidelines call for the Oversight Committee to meet at least quarterly. However, the Oversight Committee has not met during the last four years.
- Flint guidelines state grievances should be reported promptly to the Committee. However, there has been confusion over what types of issues should be handled by the Committee. As a result, the Committee has not reviewed any cases in the last eight years, even though there have been cases that may have been appropriate for review during that period.
- The possibility that an incident could happen that may cause irreparable damage to UM-Flint was brought to the attention of University Audits several times during the audit planning meetings. Having an effective, engaged, and transparent oversight process may alleviate some of the risk.
- DPS has done an excellent job of engaging the campus community with educational

1. Effectiveness of the Oversight Committee	Medium
<p>programs, bike patrols that help officers more closely engage with the campus, and by establishing student patrols. An effective Oversight Committee adds one more element to maintaining a good working relationship.</p> <ul style="list-style-type: none">• There is no process for the Oversight Committee to meet periodically with DPS.	

Recommendation:

- The Committee should comply with the guidelines for quarterly meetings. Additionally, there should be an established procedure for periodic meetings between DPS and the Oversight Committee.
- Clarify the roles and responsibilities of the Committee, including what constitutes reviewable grievances and complaints.
- Establish a process for communicating potential issues to the Committee on a regular basis. Document who should provide the updates and the frequency of the communication.
- Document an escalation process for the Committee if they have issues or concerns that are not being addressed.
- Establish a process for updating the guidelines and getting approval for the updates from the Office of General Counsel.

Management Action Plan:

- Human Resources together with the Vice Chancellor for Business and Finance Office (Vice Chancellor's Office) will clarify and document the Oversight Committee's role and responsibilities.
- Directors of DPS and HR will establish and document a process for communication with the Oversight Committee including periodic meetings with DPS.
- Guidelines, including an escalation process, will be updated and sent to OGC for review.

Action Plan Owner: HR Director, DPS Director, Vice Chancellor's Office

Expected Completion Date: December 2014

2. Information about the Oversight Committee	Medium
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Issue: There is minimal information for the campus community on how to communicate issues and grievances to the Oversight Committee.

Risk: Lack of knowledge may result in unreported and unresolved grievances, potentially leading to negative opinions about the Department.

Support:

- There is only one link to the information about the Oversight Committee. The link is on the DPS website.
- The link provides information about the structure of the Committee, provides a complaint

2. Information about the Oversight Committee	Medium
form, and directs individuals to contact Human Resources (HR) for additional information or to file a complaint but does not provide information about committee members, committee procedures, or election information.	

Recommendation:

- Provide more detail on the Oversight Committee. The information should include:
 - Names of the committee members
 - Procedures for the Oversight Committee
 - Public Act 120 (establishing the Committee)
 - Committee election information
 - How to report a grievance
- Establish a link on the HR website for the Committee

Management Action Plan:

- HR has added a link to their website to highlight the Oversight Committee.
- HR together with the Vice Chancellor's Office will revise the information provided to the campus community about the Oversight Committee.

Action Plan Owner: HR Director and Vice Chancellor's Office

Expected Completion Date: December 2014

3. Physical Inventory of the Property Room	Medium
Issue: The physical inventory process of the property room is not effectively managed.	

Risk:

- There is potential for undiscovered theft or loss of property or evidence.
- Missing evidence or lack of an audit trail may complicate or damage court cases.
- An expanding inventory may lead to increased mishandling issues.

Support: DPS has implemented a program to reduce larceny by collecting property left unattended on the campus. Overall, the program has been successful, but one consequence has been an expanding number of items processed through the DPS property room. The property room is used to store these items and items confiscated as evidence in police matters. The room is locked and secure, with limited distribution of keys. Our review identified several opportunities for improvement of the physical inventory process:

Periodic Count of Items On-Hand

- The DPS policy is to take an annual physical inventory of items in the property room. The Department has only taken two full physical inventories and two cash inventories in four years. The officer with responsibility for the property room is also completing the inventories. Per DPS policy, the same person should not handle both functions.

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3. Physical Inventory of the Property Room	Medium
<ul style="list-style-type: none">The inventory documents are hand-written, illegible, and would not be an effective tool for researching missing evidence or property or valuing the property and evidence being held.	

Database

- The Department has a new database to assist in managing the property room. The information being entered into the database would not be sufficient to complete an inventory. Examples of some entries included “marijuana” and “purple purse”. The person conducting the inventory would have to pull additional reporting to have sufficient details for completing an inventory.

Recommendation:

- Complete annual inventories using the printed database report.
- Segregate the duties for managing the property room and taking physical inventory.
- Revise procedures for entering found property and evidence into the database so entries contain sufficient information for completing an inventory.

Management Action Plan:

- DPS will send the Associate Clerk and a DPS Officer to property room training.
- Responsibilities will be revised and documented to have the Associate Clerk responsible for the property room and one DPS officer responsible for oversight. The officer responsible for oversight will conduct the annual inventory.
- Inventory procedures will be updated to include using the printed database report for inventories and providing sufficient detail about evidence and found property entered into the database.

Action Plan Owner: DPS Director

Expected Completion Date: December 2014

4. Segregation of Duties	Medium
<p>Issue: DPS does not segregate duties for some financial transactions, which may allow one employee to execute a complete transaction without checks and balances from other employees. In addition, department management does not provide detail oversight of financial transactions, which increases the risk.</p>	

Risk:

- There is potential for fraud or mismanagement of department funds or resources.
- Unauthorized or prohibited expenditures could go undetected.

Support: The DPS Business Office is a small group comprised of three employees that handle payroll, budgets, purchasing, training, and the property room.

4. Segregation of Duties	Medium
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The Associate Business Administrator is responsible for:

- POs and requisitions for business purchases
- Preparing, reviewing, and approving journal entries
- Processing all checks (with the exception of parking permit fees), cash reconciliation, and making deposits
- Reconciling the Statements of Activity and Gross Payroll Register

The Department has a thorough high-level overview of the budget completed monthly with the Director and the Associate Business Administrator. The goal is to validate the Department is meeting their budget commitments and to justify variances. What is lacking is a segregation of duties for the various financial functions.

The UM-Flint Financial Services & Budget Office provides additional backend controls. They monitor all Concur reports and the monthly budget reports to look for anomalies and questionable transactions.

Recommendation:

- Segregate duties so one person is not handling transactions in their entirety. For example, separate the cash handling functions so one person receives the checks, one person prepares the cash reconciliation, and the third completes the deposit. Ensure all employees involved with handling cash take the appropriate My LINC courses.
- Perform reasonableness tests on monthly oversight reports, e.g. Statements of Activity, to validate the information is reasonable and meets expectations. Use categories and thresholds to manage the amount of information management will need to review.

Management Action Plan:

DPS will revise the process for handling cash to include:

- Associate Clerk will receive all checks, stamp them for deposit only, and log them.
- Log will be given to the Intermediate Administrative Assistant and checks to the Associate Business Administrator.
- Associate Business Administrator will complete the deposit.
- Intermediate Administrative Assistant will reconcile deposit(s) to the log and monthly financial reports.
- Director and Associate Business Administrator will review Statements of Activity reports for reasonableness. Director will initial the reports to indicate information was reviewed.

Action Plan Owner: DPS Director

Expected Completion Date: December 2014

5. My LINC Training	Medium
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5. My LINC Training	Medium
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Issue: Employees handling cash and making deposits have not completed required training.

Risk:

- Individuals handling cash may not be compliant with University policy.
- Individuals may mishandle cash or cash equivalents.

Support: Based on discussions with the Director and the Associate Business Administrator, DPS was unaware of the My LINC courses for cash handling and deposits.

Per discussion with the UM-Flint Financial Services and Budget Office, department administrators are informed of the need to take the My LINC courses on a regular basis.

Segregation of duties and training related to job responsibilities should have been identified during the Annual Unit Internal Controls review. A separate management advisory memo was prepared for the Financial Services & Budget Office and Vice Chancellor's Office to highlight opportunities to strengthen controls over this process.

Recommendation: Employees should take all required training based on job responsibilities. A supervisor should monitor certification and refresher course training needs and requirements.

Management Action Plan: All DPS employees handling cash and/or making deposits will take the appropriate MyLINC training courses.

Action Plan Owner: DPS Director

Expected Completion Date: December 2014

6. Management Plans	Medium
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Issue: The Department does not have management plans in place for employees with identified conflicts of interest or commitment (COI/COC).

Risk: Because management plans are not documented:

- Employees may not fully understand the expectations related to their COI/COC.
- Management cannot effectively monitor and manage disclosed COI/COC because they have not documented expectations.

Support:

- Although COC/COI are being managed, the Department was unaware of the need to document the management plans. Per HR, expectations regarding COI/COC and documented management plans is part of manager orientation.
- The Director did manage an employee with a conflict of commitment, even though there was no documented plan in place. He used the disciplinary process, which included the

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6. Management Plans	Medium
Police Officers Association of Michigan (POAM) and HR involvement, and the employee is no longer with the Department.	
<ul style="list-style-type: none">The POAM contract requires an officer to receive an eight-hour break prior to their scheduled shift. For DPS employees engaged in part-time employment, this may represent a conflict and should be addressed in a management plan. This would specifically apply to the two officers currently working as volunteer firefighters.	

Recommendation: Document COI/COC management plans for all identified conflicts. Seek HR's assistance if there are any questions on wording for the plans.

Management Action Plan: DPS will prepare management plans for all identified conflicts.

Action Plan Owner: DPS Director

Expected Completion Date: December 2014

University Library **2014-217**
Report issued July 2014

A. Executive Summary

1. Overall Conclusion

The University Library (“Library”) is a highly regarded research library, both nationally and internationally, and is one of the ten largest research libraries in the United States. While the breadth and depth of the library collection is extensive with over 12 million volumes, adequate and appropriate storage for all physical materials is an issue. The main off-site storage location, Buhr, was considered a state-of-the-art facility when it was remodeled 30 years ago, but is now unable to provide adequate storage due in part to the inability to achieve ideal temperature and humidity settings for collection preservation. While Library management is aware of the shortcomings in existing storage space, there is no comprehensive long-term solution.

The Library’s six Associate University Librarians oversee day-to-day functions and employees located in 20 libraries across the Ann Arbor campus. This presents challenges to the communication and standardization of crucial processes, including biannual equipment inventory, disaster response and recovery, information technology, and building access. The complexity of the organizational structure has made it difficult for Library Finance to consistently implement and enforce finance policies including cash handling, procurement, and payment card industry (PCI) compliance.

The Library follows best practices to ensure continuous operation of their digital services. Leveraging ITS and local data centers, they incorporate redundant systems and cooling as well as failover capability.

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Librarians and staff were actively engaged and openly communicative about risks throughout the audit. Leadership was receptive to the audit issues and committed to addressing them.

2. Context and Key Risk Considerations

The Library includes the Art, Architecture & Engineering Library, Digital Media Commons, Fine Arts Library, Hatcher Graduate Library, Music Library, Shapiro Library, Museums Library, and Taubman Health Sciences Library. Also included in the Library are the Buhr Remote Shelving Facility and South State Street storage locations.

The value of the Library's collection is believed to exceed \$1 billion. The 2012 insured value of Special Collections alone was \$236 million and the Map Collection is estimated at \$35 million. Over four million people visit the Library each year. The Library has safeguards in place for the collection with increased security for Special Collections.

The Library balances continuing demand for print media with increasing demand for digital media. Each year the Library purchases approximately two linear miles of printed material. U-M is a founding member and the administrative home of HathiTrust, a 90-member partnership with a Digital Library containing over 11 million volumes.

3. Audit Scope and Identified Risks

The following table lists the key activities audited, along with the overall risks of the audit issues identified for each sub-activity. The scope of the audit was determined based on an assessment of the risks associated with the activities of the Library. This process included input from Library management and interested parties from other University functions.

The following risk areas are out of scope for this audit:

- Michigan Publishing
- Recharge activity
- Grant Management

Sub-activities Audited	Key Activities Audited					
	Cash and Credit Card Controls	Collections Management and Security		Digital Curation	Monetary Gifts	Financial Management
Sub-activities Audited	Central management	Strategic planning	Collection storage	Licensing agreement review, approval, and tracking	Gift processing	Statement of Activity reconciliations
	Cash and checks	Collection Safety	Material disposal		Restricted fund use and review of donor intent	Gross Pay Register reconciliations
	Credit cards	Book purchasing trips	Shared collection agreements			Segregation of duties
	Imprest cash funds	Gifts of material	Purchasing, receiving, and cataloging purchases			Coordination with financial staff housed in other units

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	Key Activities Audited				
	Payroll	Building Safety, Student Access and Equipment	Other	Information Technology	Procurement
Sub Activities Audited	Temporary student employment	Building access	Disaster response and recovery plan	Security	P-Card
	Time tracking and approval	Access to specialized technology and equipment	International travel	Support management	Travel and hosting
	Other compensation	Equipment inventory	University Compliance Hotline	Change management	Purchasing methodology
	Pay rate verification		Conflict of interest/conflict of commitment		

Legend: Overall risk conclusion for each sub-activity

High Risk	Medium Risk	No Issues Reported
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4. Audit Objectives

The objectives of the audit were to:

- Verify the effectiveness of controls and procedures over cash handling, credit card transactions, and imprest cash funds.
- Determine whether purchases adhere to University purchasing guidelines.
- Confirm the adequacy of processes for managing, tracking, storing, and disposing of collections and borrowed materials.
- Verify appropriate policies, procedures, and process are in place for digital media curation.
- Confirm monetary gifts are processed in compliance with University policies.
- Determine whether there are adequate procedures to ensure restricted gifts are expended according to donor intent.
- Determine whether financial reporting and management oversight are sufficient to support Library financial operations.
- Assess controls over payroll functions for completeness and accuracy.
- Confirm procedures are in place to ensure the safety of employees, visitors, and Library assets.
- Assess the Library Disaster Response and Recovery Plan.
- Determine whether controls are in place to track and monitor when staff travel internationally with their electronic devices.
- Determine availability and staff awareness of Compliance Hotline information.
- Verify that Library Human Resources has adequately communicated the Library's COI/COC policy to faculty and staff, and management plans are on file when appropriate.
- Determine the effectiveness of select IT security controls including computer management, network protection, anti-malware, server hosting, and audit

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logging.

- Ascertain the effectiveness of IT performance management controls.
- Determine whether IT change management processes are effective.

B. Audit Issues and Management Action Plans

This section of the report provides details of the high and medium risk issues identified during the audit. See Appendix 1 for risk definitions.

1. Storage of Collections	High
<p>Issue: The size of both the general collection and Special Collections exceeds available storage. Additionally, Special Collections is overcrowded and available storage is inadequate for long-term preservation of these materials.</p> <p>Risk: The Collections may be irreparably damaged. The loss of rare items in Special Collections materials is due to inadequate preservation. Decentralized storage increases the turnaround time for patron requests for material stored off-site and items may be damaged during transfer between buildings. Security risk increases due to the transportation between off-site storage and the Special Collections reading room.</p> <p>Support:</p> <ul style="list-style-type: none">• The Library purchases two linear miles of materials annually; however, there is no long-term strategy to manage storage of these materials.• Rare books are stored with general collection materials in the Library's main off-site storage location, Buhr. These items should be included in Special Collections-specific storage, but Specials Collections storage is already 20% over capacity.• Guidelines for special collections facilities published by the Society of American Archivists in 2009 states that ideal temperature for storage of collections to ensure long-term preservation is 50-60 degrees Fahrenheit with humidity between 30%-40%. However, Buhr targets are 65 degrees Fahrenheit and 45% humidity, which it is rarely able to achieve. According to analysis by U-M's Architecture, Engineering, and Construction unit, the shell of the building was not designed to support lower temperatures and humidity. Additionally, the climate control machinery cannot achieve these lower set points, and if it could, it would result in high costs due to the additional energy necessary to cool the building and harm to the fabric of the building.• Overflow storage at off-site locations is overcrowded and sub-standard for long-term preservation. Part of the Altman collection is stored in small rooms in the Finance area in Buhr which are not configured with temperature and humidity controls suitable for collections.• When a patron requests Special Collections materials stored at Buhr, the item is transported via a University mail truck from Buhr through the Hatcher receiving area and to the Special Collections reading room on Hatcher's eighth floor. Movement of these rare materials between locations and excessive handling may accelerate their wear.• Special Collections has additional storage on the seventh floor of Hatcher but staff share	

1. Storage of Collections	High
space with the collections, which can effect the humidity in the storage area. Additionally, the seventh floor has banks of windows that had to be covered because the collections can be damaged by sunlight. When Hatcher South was built the windows were blocked with particle board, which show signs of water damage. Special Collections has also been told by Conservation and Preservation that there is “more than likely” mold on the window facing side of the window coverings. The seventh floor has dedicated humidity control to raise the humidity in winter to around 40% (in order to prevent vellum and leather bindings from warping out of shape and cracking); even with the particle board coverings the windows are not sufficiently insulated for higher humidity in winter, and condensation forms on the glass.	

Recommendation: Review storage of all materials for appropriateness. Move materials to appropriate storage as necessary. Consider temporary storage needs for Special Collections Material. Establish a long-term storage solution for all collection materials.

Management Action Plan: Library Administration agrees with the recommendations. We have been in active conversation with the Provost regarding our need for long-term, archival quality storage, for a variety of purposes. As noted in our most recent budget request, we will develop a more detailed proposal that projects our future needs.

At the same time, we will continue discussion with the Provost regarding short-term measures that include space being prepared at 725 State Circle. We will review the location of Special Collections materials, and where appropriate, will make adjustments that reduce the need for movement between campus buildings. We will implement a “shelter in place” program for rare books currently housed in the Buhr stacks, changing their status until space becomes available for physical transfer to dedicated Special Collections storage.

Action Plan Owners: Associate University Librarian for Operations and the Associate University Librarian for Collections

Expected Completion Date: Initial review of longer-term needs and options by June 2015; some temporary storage by December 2014; status change for rare books by December 2016

2. Collections Inventory	Medium
Issue: The University Library does not have an accurate inventory of their collections. Risk: Items may not be available upon request, which may impede research. Lost, stolen, mis-shelved items may not be identified. Future purchases will not consider information lost resulting in gaps in the collection. Items at high risk of theft may not be identified and appropriate actions to mitigate the loss may not be put in place. Inconsistent and ineffective processes for the ordering, receiving, and cataloging of materials may result in misappropriation of materials not being identified.	

2. Collections Inventory	Medium
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Support:

- Items are identified as "missing" in the Library's online catalog when they have been requested by a patron and the material could not be located. In fiscal year 2014, 2,848 items were identified as "missing". While it is possible items may simply be mis-shelved, shelf checks to identify mis-shelved materials are not occurring consistently in all units.
- In discussion with Associate University Librarians and other Library staff, they are aware of thefts. For instance, the Asia Library has stopped purchasing martial arts related material because they are stolen frequently.
- When an item is taken out of circulation and sent for disposal the item is identified as "sent for withdrawal" in the online catalog. When the item is then sent to the third-party responsible for disposing of these materials the status of the item is updated to "withdrawn" in the online catalog. As of April 30, 2014, 3,566 items dating from calendar years 2006-2013 still had "sent for withdrawal" status. It is unknown what happened to these items.
- Orders may be delivered directly to the purchaser with a "confirmatory invoice" being sent to the Print Order Unit to enter in the online catalog. However, there is no reconciliation of items purchased via P-Card to these "confirmatory invoices".
- While progress has been made on the backlog of general collection and Special Collections items, some items in Special Collections remain unprocessed decades after receipt.
- Processing of materials occurs in several Library units; however, these processes have not been standardized for all units. While significant procedures have been documented for the ordering, receiving, and cataloging of materials, these procedures may not be accessible to all Library units performing the same function. Additionally, training and oversight to ensure consistency is not in place.

Recommendation:

- Periodically perform shelf checks to identify mis-shelved material. Relocate mis-shelved materials to the correct shelf space. Unit management should verify staff are performing shelf checks.
- A review of items in the "sent for withdrawal" status should be conducted. The current status of each item should be updated in the online catalog.
- Management should periodically review available reporting to verify item status is accurately reflected in the online catalog including following up on materials identified as in receiving for extended periods, and items received but never cataloged. Collection materials purchased with P-Cards should be identified and reconciled to the online catalog to verify the materials were accurately recorded timely.
- Status codes in the online catalog (e.g., missing, lost, sent for withdrawal, withdrawn) and their proper usage should be defined and documented and communicated to employees with access to change status codes in the online catalog. Management should periodically review status reporting and follow up on anomalies to ensure ongoing consistency in code usage in the future.

2. Collections Inventory	Medium
<ul style="list-style-type: none">• Communicate processes and procedures to appropriate employees in all applicable units. Include the appropriate process and procedure documentation in the onboarding of new employees. Management should periodically review work performed to verify it is compliant with documented procedures.	

Management Action Plan: Inventory control for a research collection exceeding eight million print volumes requires close attention to costs and benefits. We currently conduct annual shelf-readings in all libraries except Buhr. For clarification, we will create and distribute a new chart of each library's shelf-reading schedule and frequency. We do not shelf-read regularly at Buhr since this is a staff-mediated collection, but we will begin periodic review of heavy use areas.

We have developed a process for verifying and updating the status of items "sent for withdrawal" but not "withdrawn." We have identified and will over the next few months address the sources of this type of error. More generally we will review our current procedures, documentation and training in order to assure greater consistency across the library with regard to recording and updating the status of an item.

Outstanding orders are claimed from our vendors on a regular schedule, and are later reviewed and cancelled if unavailable.

We will conduct a library-wide inventory of unprocessed materials, will assess options for cataloging (i.e., options, costs, funding sources), and will track progress on our backlogs.

We will review and revise our procedures with regard to confirmatory orders to provide additional oversight for receipt and item status updating.

Action Plan Owners: Associate University Librarian for Operations and the Associate University Librarian for Collections

Expected Completion Date: December 2014 for improved overall procedures and documentation; ongoing for processing uncatalogued collections

3. Cash Handling	Medium
Issue: Management is not providing adequate oversight for cash handling.	
Risk: Misappropriation of financial assets may go undetected. Personal information may not be safeguarded.	
Support: The Library has six locations that collect cash and/or checks. The units are decentralized and operate individually. There is no central oversight of all units, and cash handling procedures are not consistent across units. During the fiscal year 2104 Unit Internal Control Certification Process, the department reported partial compliance for cash handling and reporting, noting that	

3. Cash Handling	Medium
some units needed a review and refresher in cash handling. The Library Finance manager reported that she does not go out and review operations in the decentralized units and made recommendations during the gap analysis that visits are needed to educate the units. A review of the units disclosed multiple control weaknesses that are outlined in a separate management advisory memorandum. During the course of audit fieldwork, Library Finance initiated changes in some unit depository practices and made efforts to educate units on expected internal controls over cash handling.	

Recommendation:

- Develop an education plan so units are aware of expected internal controls over cash and check handling, including imprest cash funds.
- Ensure all staff and students are properly trained. Review Business Objects reports to monitor training activity.
- Develop departmental procedures that are consistently applied throughout all units
- Include all cash collection sites in the next Unit Internal Control Certification Process and use the gap analysis to thoroughly review cash controls at each unit.

Management Action Plan: Action has already been taken towards achieving compliance across all Library units (not including MPublishing departments that are out of scope for this audit). Activity is ongoing and will continue over the next several months. To date, the following action has been taken:

- Meetings have been held with each cash handling unit where cash handling duties have been discussed and reviewed with appropriate managers. During the audit, responsibility for completing cash deposits transferred from Library Finance to the units directly for Hatcher, Shapiro, Art, Architecture & Engineering Library, and Operations (Vending).
- All units handling cash have been instructed to deposit weekly or whenever they accumulate \$500 or more in cash and checks. We are working with the Treasurer's Office to make sure the deposit frequency meets University standards. A cash-handling workbook was developed and distributed to the units who recently took over completing their own cash/check activity. The workbook allows them to track daily receipts and distribute funds to the area to which they belong (i.e., EBM, Lost Books, Fines, DMC Sales, Alumni Cards, Carrels, Copy Cards, Gifts, Lockers, and POD). The workbook also assists them with preparation of the weekly deposit. Units have been instructed to forward copies of their cash receipts to Finance weekly or monthly for monitoring and backup documentation for the monthly reconciliation process. The workbook is to be forwarded to Finance for preparation of journal entries to transfer the monthly receipts and credit card fees to the appropriate fund areas. Cash handlers, cash receipt preparers, and supervisor/managers (refunds, review/approval of cash receipts) have been identified in the units. Cash receipt preparers have taken the appropriate training. Library Finance is currently reviewing all other identified users to confirm that appropriate training has been completed or is up to date.

3. Cash Handling	Medium
Library Finance is in the process of hiring a new Finance Director. It is hoped a new Director will be in place by the end of September 2014. A draft action plan for department-wide procedures will be prepared for the new Finance Director so that he/she can review the plan, conduct the necessary review with staff and units, and finalize for implementation by December 31, 2014. The new Finance Director will establish the expected implementation completion dates.	

Action Plan Owner: Finance Director

Expected Completion Date: To be determined as indicated above

4. PCI Compliance	Medium
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Issue: The Library does not comply with the Payment Card Industry (PCI) Data Security Standard and Treasurer's Office standards.

Risk: If credit card data were exposed by a security breach, the Library could face payment card issuer and industry fines along with losing the ability to perform credit card transactions.

Support: The Library has eleven active Merchant Accounts. We reviewed activity in nine merchant accounts and determined Library merchant activity is not aligned with University policy and consistent procedures for merchant activity do not exist in the units. Specific operational details are outlined in a separate management advisory memorandum.

Recommendation:

- Work with Treasurer's Office to bring merchant activity into compliance with University standards.
- Ensure all staff and students are properly trained. Review BusinessObjects reports to monitor training activity.
- Develop departmental procedures that are consistently applied throughout all units

Management Action Plan: Action has already been started toward getting Library units into compliance (not including MPublishing departments that are out of scope for this audit). Activity is ongoing and will continue over the next several months. To date, the following action has been taken:

- Staff authorized to process credit card transactions and merchant contacts have been identified, and we are currently working to make sure they are all listed in the M-Pathways Merchant Management Report.
- Supervisors/Managers of authorized staff have been notified of the necessary training required for current users.
- The Merchant Services Policy has been delivered to each unit.
- In May 2014, each unit was requested to provide updates to the Merchant Services Policy. Library Finance is currently reviewing unit responses to confirm each unit has an updated Merchant Services Policy.
- In May 2014, Library Finance reviewed the Merchant Services policy and highlighted the

4. PCI Compliance	Medium
most pertinent information for individuals to review, then created an Acknowledgement form for each individual to attest to receiving and understanding the requirements of the Merchant Services Policy.	
<ul style="list-style-type: none">• Library Finance is currently reviewing unit responses to confirm that all appropriate users have signed the Acknowledgement attesting to their receipt and understanding, and that they have completed the necessary training.	

Library Finance is in the process of hiring a new Finance Director. It is hoped a new Director will be in place by the end of September 2014.

A draft action plan for department-wide procedures will be prepared for the new Finance Director so that he/she can review the plan, conduct the necessary review with staff and units, and finalize for implementation by December 31, 2014. The new Director will establish the expected implementation completion dates.

Action Plan Owner: Finance Director

Expected Completion Date: To be determined as indicated above

5. Verification of Equipment Inventory	Medium
Issue: The Library does not maintain an accurate equipment inventory report with Property Control for equipment valued over \$5,000. No process exists for monitoring equipment inventory valued below \$5,000 that is borrowed by students.	

Risk: Items at high risk of theft may not be identified, and appropriate actions to mitigate the loss may not be put in place.

Support:

- Library Finance is receiving and coordinating the verification of the equipment inventory reports from Property Control. However, it would be more efficient for Library Operations to coordinate the verification process because they work closer with the units having equipment.
- The Associate University Librarian for Operations reviewed the current equipment inventory report and stated that information on the list is out-of-date.
- Two pieces of audio equipment acquired in 2006 for a combined value of \$342,000 do not have University asset tags and are not listed on the Property Control equipment inventory report.
- Students may borrow Library equipment such as video or still camera kits, lighting kits, and tripods. Students usually borrow a combination of kits valuing as much as \$2,700. The equipment is recorded in the on-line catalog system when checked out, but a periodic independent inventory is not performed. Total value of all equipment available for student borrowing is approximately \$25,000.

5. Verification of Equipment Inventory	Medium
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Recommendation: Move responsibility for verification and update of the equipment inventory report from Library Finance to Library Operations. During the verification process, instruct units to identify and notify Property Control of equipment not tagged or listed on the report. Implement an inventory verification process for equipment items valued at below \$5,000 that are used by students. Consider using the Division of Public Safety and Security (DPSS) process to register items valued under \$5,000.

Management Action Plan: Library Operations will review with all Senior Managers the current inventory report (and ongoing, on an annual basis) to verify that what is there is correct, to see if anything is missing, and to ask that they regularly identify any new equipment that should be added (even if it is a gift or grant-funded).

We will add the Digital Media Commons 2006 equipment that is currently missing from the inventory, institute an inventory control audit for the material checked out for student use, and talk with DPSS about registering those devices.

Action Plan Owner: Associate University Librarian for Operations

Expected Completion Date: August 2014

6. Statement of Activity Reconciliations	Medium
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Issue: Library Finance does not complete Statement of Activity (SOA) reconciliations monthly.

Risk: Inaccurate or improper charges may not be detected. Information that management uses for decision making could contain errors, which may result in inaccurate fiscal decisions and ineffective monitoring of financial standing.

Support:

- University Financial Operations requires all units to reconcile their SOA transactions monthly; however, per Library Finance management as of April 2014, SOA reconciliations are completed with a six-month lag.
- Library Finance staff stated that they do not get notified of additional gift funds that are added to established gift accounts.
- Library Finance staff do not consistently get supporting documentation for any purchases from the units (e.g., those made with gift funds and those over \$1k requiring Associate University Librarian approval).

Recommendation: SOA reconciliations will be effected by the implementation of AST (Administrative Services Transformation); however, prior to the transition, reconciliations should be brought up-to-date and Library Finance should design an interim process to ensure timely completion. This process should include the following:

6. Statement of Activity Reconciliations	Medium
<ul style="list-style-type: none"> • Complete backlog of reconciliations. • Based on activity in accounts, risks, and available resources determine a required frequency for performing each reconciliation (e.g., monthly, quarterly). • Document the expected reconciliation frequency for each account. • Implement a monthly monitoring process to confirm that all reconciliations are completed, reviewed, and approved within their assigned frequency. • Establish a protocol with expectations for units on what supporting documentation is needed and when it should be sent to Library Finance. • Work with Library Development to ensure all new gift fund information is received timely. 	

Management Action Plan: SOA reconciliations are completed, at a minimum, quarterly. We do a general review of transactions monthly and a more formal review, with AULs and/or the representative, quarterly. Action has already been started towards getting Library units into compliance. Activity is ongoing and will continue over the next several months.

We will have a draft action plan prepared for the new Finance Director so that he/she can review the plan, conduct the necessary review with staff and units in the Library, and finalize the action plan for implementation by December 31, 2014. The new Finance Director will establish the expected implementation completion dates.

It is expected that most issues can be complete by January 2015. However, some may require additional time. Phase III of the AST initiative is expected to occur in March 2015. Several aspects of the new process have not yet been identified. Until the new processes are documented and training has been made available to units, Library Finance and most other units will be unable to document the new reconciliation process fully.

Action Plan Owner: Finance Director

Expected Completion Date: To be determined as indicated above

7. Disaster Response and Recovery Plan	Medium
<p>Issue: The Library has not implemented their Disaster Response and Recovery Plan. In addition, Library collections are housed in facilities that are not managed by the Library. There is no memo of understanding (MOU) covering responsibilities and expectations.</p>	

Risk: Library Collections could be damaged or lost in the event of a disaster.

Support: University Library created a Disaster Response and Recovery Plan for their collections.

- Distribution of the plan is not properly maintained.
- Training and emergency drills are not being completed in the units.
- Prevention steps such as walk-throughs of collections and buildings are not completed in the units.

7. Disaster Response and Recovery Plan	Medium
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- Post-event documentation and evaluation is not performed.
- Fire extinguishers in leased storage space are not inspected.

The Library houses collections in buildings that are managed by schools.

- Music Library is housed in a portion of the Moore Building, managed by School of Music, Theatre & Dance.
- The Fine Arts Library is housed in a portion of the Tappan Building that is managed by the College of Literature, Science, and the Arts (LSA).
- The Museum Library is housed in a portion of the Ruthven Museum Building that is managed by LSA.

Recommendation: Ensure proper distribution of the Disaster Response and Recovery Plan to all units and individuals. Create an education and awareness program so that designated individuals are aware of the plan and the pertinent steps. Ensure all parts of the plan are implemented as written or amend the plan as needed. Consider entering into MOUs with LSA and the School of Music, Theatre & Dance to clarify and document responsibilities and expectations for facilities and the protection of collections. Risk Management should have access to inventory information for recovery activity. Contact DPSS Emergency Management as a resource for coordination of activities.

Management Action Plan: We will annually update both the Disaster Response and Recovery Plan and the Library Emergency Plan. We will also:

- Create a regular annual “refresher” course for library staff to go over the key elements of the plan
- Distribute the updated plans now to all Senior Managers, and create a formal, posted distribution list that is kept up-to-date for revisions
- Conduct and document regular preventive walkthroughs in all buildings on a regular basis (this is currently done irregularly, depending on building)

The update and refreshers will be done under the guidance of both Head of Conservation and Preservation, and Manager of University Library Facilities and chair of the Library Safety and Security Committee.

We will initiate a formal process for post-event documentation and evaluation, including a written report for each incident within two weeks of the incident.

Fire extinguisher inspection in our leased building has been put in place, and will be initiated for a newly leased space to open at State Circle.

Although we feel certain there were initial agreements drawn up decades ago regarding the libraries housed in other department buildings (Museums, Music, Fine Arts, and Herbarium) we have not seen those agreements and are sure they will need to be updated, so will do so.

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7. Disaster Response and Recovery Plan

Medium

Action Plan Owner: Associate University Librarian for Operations

Expected Completion Date: August 2014

8. Building Access

Medium

Issue: Building access for retired and terminated employees is not consistently removed.

Risk: Library assets are at risk of theft. Confidential Library records are at risk for inappropriate access.

Support: Auditors reviewed building access reports provided by the Library Facilities Manager. Auditors judgmentally selected individual names to check and found several Library employees that are retired or terminated who still have building access. Of the 12 former employees noted, one left in 2010, three left in 2011, five left in 2012, and one left in 2013. Library Human Resources has an on/off boarding process that includes notification to the Library Facilities team of new and departing employees. The University Key Office has delegated all access responsibilities to the Library. The notification from Library Human Resources regarding off-boarding is not always implemented by Library Facilities.

Recommendation: Library Facilities should review all current building access reports for accuracy and remove inappropriate access. Going forward, Library Facilities should evaluate their on/off boarding process for building access in coordination with the Library Human Resources office to identify and close any gaps in the process.

Management Action Plan: Update of the current access is completed. We are refreshing the procedure for notification from Library Human Resources to Library Facilities of departing staff so that Library Facilities will update the access system immediately. We have a backup for Hatcher: as we remove people from the building staff email we will make sure they are also removed from the access system. We have revised procedures for adding (and removing) temporary access to the building for selected individuals (e.g., contractor foreman). We are instituting an annual review of the access reports as well as periodic spot checking.

Action Plan Owners: Associate University Librarian for Operations and the Head of Library Facilities

Expected Completion Date: July 2014

9. International Travel Safety

Medium

Issue: Library staff that travel internationally do not consistently register their travel with the U-M Travel Registry as required by Standard Practice Guide Section 601.31, *International Travel Policy*. Library Management does not offer guidance to international travelers about safe computing before, during, and after traveling.

9. International Travel Safety	Medium
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Risk: Computing devices may be compromised and sensitive U-M data could be exposed. Staff may not be aware of resources available in the event of an emergency abroad.

Support:

- As part of the Library travel request procedure, staff are asked to register their travel with the University Travel Registry. Library management has not established a follow-up procedure to ensure compliance. The University Travel Registry is the official and authoritative source of travel information that forms the basis for the University's emergency response protocols and communications strategy when responding to an emergency or critical incident abroad or as a point of contact in the event of a situation here at home. A review of the Travel Registry and the Concur Travel and Expense database showed that all international travel is not documented in the University Travel Registry.
- Library staff are traveling to locations that the Information and Infrastructure Assurance (IIA) considers high risk, specifically China. Library management does not provide any formal guidance about safe computing. The IIA web site offers guidance for securing University data and mobile devices before, during, and after international travel.

Recommendation: Provide guidance to Library staff traveling internationally that includes the University Travel Registry and safe computing with mobile devices. Direct staff to follow IIA safe computing guidance. Develop controls to track and monitor when staff travel internationally to encourage use of the Travel Registry when appropriate.

Management Action Plan: Library Administration agrees with the recommendations. We will modify our online travel request and approval form to indicate that registering with the UM Travel Registry and review of the IIA guidance for safe computing are mandatory for our travelers, and for staff to verify that they registered their travel before their travel is approved. Human Resources staff will work with IT staff to see how these changes can be made and if the Library online travel request system can interface with the University Travel Registry. We will communicate this requirement to the Library community.

Action Plan Owner: Human Resources Director

Expected Completion Date: November 2014

10. Pay Rate Verification	Medium
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Issue: Pay rate and appointment data are not validated.

Risk: Excessive expense may be incurred if inaccurate pay and appointment information are not identified.

Support: The Library experiences significant turnover in non-exempt employees each year, in

10. Pay Rate Verification	Medium
part, due to the number of students the Library employs. At least monthly, Library Human Resources sends Gross Pay Registers (GPR) to unit supervisors with the expectation that they are reviewed and reconciled by the person with knowledge of employee work hours and pay rates. Per discussion with unit supervisors, they do not consistently reconcile the GPR to exempt staff and faculty pay rate and appointment data.	

Recommendation:

- Document expectation and procedures for GPR reconciliations.
- Communicate these expectations to supervisors responsible for completing the reconciliations.
- Periodically select a sample of GPR reconciliations to review. Verify the reconciliations were completed accurately and within time specifications.
- University Payroll should be considered as a resource should additional information be necessary.

Management Action Plan: Library Administration agrees with the recommendations. We plan to map our current process of GPR reconciliations, create a standard procedure and expectations, and communicate them with supervisors who perform GPR reconciliations. We will create an audit process to audit a sample of GPR reconciliations twice a year.

Action Plan Owner: Human Resources Director

Expected Completion Date: December 2014

11. Information Technology Change Management	Medium
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Issue: Library IT ("LIT") does not standardize the change management process.

Risk: Service level expectations may not be achievable. Undocumented changes can introduce problems and prolong unexpected outages.

Support:

- Each LIT team manages their own IT change process differently.
- Some LIT teams have a standard IT change processes, however they are not documented.
- Per the LIT teams, documented procedures are out-of-date or are not uniformly applied.

Recommendation: LIT should develop a change management policy and processes that align with standard best practices (NIST, ISO 27001, COBIT) or leverage ITS change management methodologies and document existing procedures.

Management Action Plan: LIT is currently conducting a comprehensive review of internal structure and processes, with the goal of updating policies and procedures for change management in alignment with standard best practices and unit needs.

11. Information Technology Change Management	Medium
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Action Plan Owner: Associate University Librarian for Library Information Technology

Expected Completion Date: May 2015

12. Information Technology Support Management	Medium
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Issue: LIT does not provide a measurable end user support function and is not designed to optimize the customer relationship.

Risk: Unresolved support requests can disrupt Library operations. IT support decisions are not supported by data. Inconsistent customer service levels result in poor overall service.

Support:

- The LIT support web page:
 - Lists 14 different email support contacts.
 - Did not set an expectation for when a response would be received for urgent support problems. (This has since been resolved.)
- Not all LIT functional areas use a ticketing system to track support requests.
- No mechanism is available to measure the effectiveness of overall end user support.
 - Each LIT team has separate support tracking processes (email or separate non-integrated issue tracking products such as Footprints and Jira).

Recommendation: LIT should develop a central IT service management process that puts emphasis on customer service and can adequately track support requests in order to capture metrics that can help management make informed decisions.

Management Action Plan: LIT is currently conducting a comprehensive review of internal structure and processes, with the goal of updating policies and procedures for service provisioning, response, and tracking in alignment with standard best practices and unit needs.

Action Plan Owner: Associate University Librarian for Library Information Technology

Expected Completion Date: May 2015

Follow-up Reports Issued

Center for Learning and Teaching

Report issued March 2014

2013-222

Follow-up report issued September 2014

University Audits completed an audit of the Center for Learning and Teaching (CRLT) and issued an audit report in March 2014. The audit noted opportunities to improve processes and

University Audits

Summary of reports issued – July 2 through September 30, 2014

procedures related to visitor safety, cash handling, Compliance Hotline awareness, and conflict of interest/conflict of commitment. A follow-up review has been completed to determine if the following items have been satisfactorily completed. The corrective actions taken by CRLT management are summarized below. **This audit is closed.**

- **Visitor Safety:** CRLT did not have a process to contact and promptly notify visitors attending CRLT events of any emergencies or adverse situations. Management set up an emergency contact group in Blackboard Connect, the service U-M uses for emergency notification, to disseminate notifications to CRLT staff by phone, text message, or email. Management is developing a policy memorandum that will designate CRLT program staff who host events as responsible for obtaining emergency contacts from their program attendees and for notifying them of any alerts received via the Blackboard Connect system. Management plans to share the policy with CRLT staff during their September 30, 2014, team meeting. **Closed.**
- **Compliance Hotline Awareness:** CRLT staff members were not aware of the University Compliance Hotline and other compliance resources related to core CRLT functions such as classroom teaching, hosting visitors, and rights of student employees. Management has included Compliance Hotline information as part of CRLT's new employee orientation package, and plans to annually communicate information about the hotline and other compliance resources to staff either electronically or during departmental meetings. **Closed.**
- **Segregation of Duties – Cash Handling:** CRLT cash handling duties had not been segregated appropriately, and employees authorized to handle cash had not completed the required U-M training courses. CRLT has realigned staff responsibilities to create a proper separation of duties and updated their documentation. CRLT management will review and approve any cash activity where separation was not possible due to lack of staff. CRLT staff authorized to receive, record, and deposit cash have completed the appropriate training courses. **Closed.**
- **Conflict of Interest/Conflict of Commitment (COI/COC):** CRLT had a process for disclosing and documenting potential conflicts that was not documented, and management was not reviewing the determinations made by the Compliance Coordinator about those potential conflicts. Management has developed COI/COC procedures for CRLT that document individual responsibilities, definitions of key terms, examples of COI/COC scenarios, steps in the disclosure process, record keeping, the dispute process, education and training, and ongoing review of disclosed conflicts by CRLT management. Management plans to remind staff annually about the need to disclose any outside activities and relationships that may need to be managed

Department of Family Medicine

2013-211

Report issued April 2013

Follow-up report issued August 2014

University Audits completed an audit of the Medical School, Department of Family Medicine (DFM) and issued an audit report in April 2013. The audit focused on a review of key operational processes and the internal control structure in DFM. A follow-up review was conducted in December 2013 and determined that controls were put in place to address issues regarding the physician compensation model and procurement practices. The audit remained open for management to continue to strengthen controls for the Japanese Executive Physical Program (JEPP). **This audit remains open.**

DFM offers comprehensive executive physicals to Japanese executives and their families. JEPP staff bill the executive's company a set fee based on the services requested. Implementation of a new billing platform in 2012 (MiChart) created challenges for managing the billing for JEPP. In some cases, the incorrect party was billed for the services provided. Monitoring reports were difficult to obtain for reconciliation purposes and billing errors were not detected.

The DFM Finance Manager worked with UMHS Revenue Cycle staff to obtain the necessary reports to perform reviews and reconciliation activities. UMHS Revenue Cycle staff had competing implementation priorities that caused a delay in developing the reports, and reports were only recently available. As of June 2014, the DFM Finance Manager has eliminated the backlog of monthly reconciliations and is now current.

DFM staff have developed a process in MiChart charge capture that has standardized the ordering of services and should reduce the number of billing inaccuracies for services provided. DFM has also hired a project manager to assist the Clinic Business Manager in improving controls over the JEPP billing and collection process. During September 2014, DFM plans to open a second location in Livonia that will provide JEPP services. DFM is taking this opportunity to evaluate all clinic processes, including tracking and monitoring of JEPP billing and collections for both locations.

The project manager will take the lead in flowcharting and mapping the billing and collection duties to ensure proper separation of duties is created at both the existing clinic location and then duplicate the process in the new clinic location. A template spreadsheet will be created for tracking and monitoring invoices for use in both clinic locations. Procedures will be written to document roles and responsibilities.

University Audits will conduct a third follow-up in January 2015 to assess that processes and controls have been in place, and are sustainable and effective over a period of time

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ITS MCommunity Enterprise Directory and Identity Management System 2012-310

Report issued January 2013

First follow-up report issued October 2013

Second follow-up report issued January 2014

Third follow-up report issued September 2014

During January 2013, University Audits issued a report on the MCommunity Enterprise Directory and Identity Management System. A third follow-up review was recently completed to ascertain the status of the open discussion items. Management has sufficiently addressed all remaining items. **This audit is closed.**

- **MCommunity Server Security:** Vulnerability scans performed by University Audits identified some of the same critical- and high- risk vulnerabilities as detected in a previous follow-up. When notified of this finding, management from the Information and Technology Services (ITS) Identity and Access Management (IAM) team stated that previous actions were taken to address other vulnerabilities. However, the remaining threats were overlooked. IAM management has since been in contact with the vendor that supplied the vulnerable product and has begun the process to resolve the vulnerabilities. The vulnerability is confined to the University of Michigan network and, while still considered a risk, the vulnerable service is not directly exposed to the Internet. IAM management stated that the fix will be deployed to the vulnerable service once fully tested and the production change freeze has passed at the end of September 2014. **Closed**
- **Server Access:** Access to all MCommunity servers is now fully managed by ITS Access and Account Services. User and administrative access to servers that comprise the IAM service that includes MCommunity are handled by the ITS Access and Accounts team. The Access and Accounts Online Access Request System (OARS) has undergone a separate audit. **Closed**
- **Security Information and Event Management (SIEM):** Funding for the SIEM service has been approved. The service will allow the reviewing, analyzing, and correlating of security events to provide valuable information regarding security incidents. A project to develop the service and determine staffing needs is underway. **Closed**

Kelsey Museum of Archaeology

2012-207

Report issued April 2013

Follow-up report issued September 2014

University Audits issued the report on the audit of the Kelsey Museum of Archaeology, which is part of the College of Literature, Science, and the Arts, in April 2013. In the course of the audit, issues were identified related to operations of the Museum Store and safety and security. A follow-up review has been completed to determine the status of the management action plans. All action plans have been implemented. See below for details. **This audit is closed.**

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- **Kelsey Museum Store – Purpose and Objectives:** Management committed to reviewing the purpose and objectives of the Kelsey Museum Store as part of a review of the budget and business plan for the store. A Mission Statement and Budget and Business Plan have been defined for the store. Kelsey no longer has volunteers working in the Museum Store. They hired work-study students to work in the store. The Museum Store is now open the entire time the museum is open, not just in the afternoons.
Closed
- **Kelsey Museum Store – Inventory Management and Pricing:** Manual processes used in the store for processing sales and relieving inventory resulted in the lack of accurate inventory records making it difficult to track sales and manage inventory. Inventory management procedures have been documented. Kelsey Museum purchased a new inventory system and the Administrative Specialist is in the process of loading the inventory into the system. The new automated point of sales and inventory management system is fully operational. **Closed**
- **Kelsey Museum Store – Inventory Security:** The physical setup of the store and the lack of security cameras put assets at risk in the Museum Store. Cameras have been installed and the store is now staffed the same hours as the museum is open. **Closed**
- **Kelsey Museum Store – Cash Handling:** Kelsey Museum Store's cash handling procedures do not adequately control cash, checks, and credit cards in a store setting. Cash collections and deposit procedures have been created and documented. Sales and return procedures have been created and documented. All temps working in the store are being trained on cash and credit card handling procedures. **Closed**
- **Kelsey Museum Store – Use of a Cash Register:** At the time of the audit, the Kelsey Museum Store used a manual system for controlling cash, tracking sales, and managing inventory. A computer with a locking cash drawer has been installed to process sales. The cash register is now fully integrated with point of sale /inventory management system. **Closed**
- **Kelsey Museum Store – Change Fund:** The change fund used in the Kelsey Museum Store was not properly constituted or maintained as a proper imprest cash fund. The old change fund has been eliminated and a \$200 imprest fund has been instituted.
Closed
- **Security Staff:** At the time of the audit, Kelsey Museum lacked a security supervisor. A security supervisor was hired in June 2013. He reports directly to the Division of Public Safety and Security (DPSS) with a dotted line reporting relationship to Kelsey's Associate Director. This position also supports the U-M Museum of Art. **Closed**

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- **Security Training:** Kelsey lacked a formal training process for safety and security. Training documents have been developed and presented to staff, guards, and volunteers including docents. Training on specific Standard Practice Guide sections is also conducted. **Closed**
- **Physical Access Control:** Kelsey lacked an effective way of managing building keys. A Key Issue Policy has been developed with on- and off-boarding processes for key return. An inventory of keys has been generated and reviewed and Kelsey personnel are reviewing the list to identify missing or inappropriately assigned keys. **Closed**
- **International Travel Planning:** The process for international travel planning was not documented. Management agreed to create written procedures and checklists for staff and faculty to follow to ensure finance and budget oversight steps are completed for international programs. Financial and budget planning procedures have been documented, along with corresponding checklists to be used for excavation planning. Specific guidelines are documented for the various phases of excavations, including pre-departure, budgeting, and post-excavation. **Closed**

Medical Center Information Technology Data Center and Arbor Lakes North

Campus Data Center

2012-307

Report issued April 2013

First follow-up report issued March 2014

Second follow-up report issued September 2014

University Audits conducted a review of Medical Center Information Technology (MCIT) managed data centers and issued the audit report in April 2013. The report recommended that MCIT develop a continuity of operations plan (COOP) that identifies the critical functions of the data centers and key personnel. This plan should address data center recovery and continuity strategies to maintain critical functions and disaster recovery procedures used to restore IT infrastructure systems that support critical functions of the data center. **This audit remains open.**

In response to the audit recommendations, MCIT Infrastructure and Systems Operations staff coordinated meetings with key personnel and departments throughout the University in order to develop a cohesive COOP. MCIT has made significant progress towards the completion of a well-designed COOP. The following has occurred since the last update:

- Development of a framework to assist in creating and managing a COOP
- Strategic plan that outlines expectations, deliverables, and scope for disaster recovery of the MCIT managed IT environment
- Creation of the MCIT Major Service Data Collection Form
- Established a MCIT Disaster Recovery Plan outline

MCIT has moved on to the second phase of the IT Disaster Recovery Strategic Plan. The focus of this phase is to refine both the Disaster Recovery Plan and the accompanying Information

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System Contingency Plan (ISCP), put the minimum infrastructure in place to support disaster recovery planning and ISCP development, and ensure that recovery is in place for Platinum and Gold services. The successful completion of this phase is contingent on funding two FTE.

Without dedicated FTEs the IT Disaster Recovery plan will not undergo any testing and implementation of the plan will be delayed.

MCIT efforts to date are producing a well-designed COOP. For the plan to be effective it must undergo necessary and regular testing. We will continue to monitor MCIT's efforts at defining a comprehensive COOP. This is an ongoing process. We plan to conduct further follow-up procedures during the third quarter of fiscal year 2015.

Medical School - Office of Graduate and Postdoctoral Studies 2013-210

Report issued December 2013

Follow-up report issued September 2014

University Audits completed an audit of the Medical School's Office of Graduate and Postdoctoral Studies (GAP) and issued a report in December 2013. The report identified opportunities to improve oversight of the Biomedical Science Graduate Student admissions process, distribution of the Maas Fellowship Award, and the office staff structure. A follow-up review has been completed to determine that outstanding audit issues have been satisfactorily completed. Based on audit recommendations, GAP management implemented the following improvements:

- Implemented an admissions process that uses a waiting list and gradual release of offer letters to more effectively manage admissions rates
- Streamlined the process for the distribution of designated gift funds to graduate students
- Eliminated the utilization of long-term, non-student temporary employees
- Developed detailed job descriptions, duties, and expectations for administrative staff

Details can be found below. **The audit is closed.**

- **Biomedical Science Graduate Student Admissions:** The audit identified that the admission process for Biomedical PhD candidates was not optimized to effectively forecast and manage graduate student admission offers and acceptance rates. This was due in part to competing departmental priorities as well as national admission parameters. The GAP Office has now incorporated a detailed assessment for the unit programs to complete prior to the start of the recruiting season to determine the number of trainee positions needed. The plans are vetted and approved by a recruiting committee with consultation and ultimate approval from the Dean's Office. The office has also implemented a process where admission offers are released in gradual increments, paying close attention to the acceptance response rate. This proactive approach has allowed actual admissions to match planned admissions. **Closed.**

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- **Financial Award Distribution:** The disbursement of Maas Foundation awards to qualified students were overly restrictive, going beyond the original donor intent. The GAP Office has implemented a streamlined process that ensures the funds are distributed in full to the student by the end of the program. With this proactive approach, there is a greater degree of confidence that GAP will come closer to their target number each year than they have in the past. **Closed.**
- **Comprehensive Human Resources Model:** The audit identified a lack of clear office staff roles and responsibilities and outdated job responsibilities. There was also an over reliance on long-term, non-student temporary employees. A comprehensive work structure has now been implemented that includes updated roles, detailed responsibilities, and unit expectations. The program has also significantly reduced the use of employing temporary staff, except for specific short term needs. **Closed.**

MiChart System Interfaces

2012-306

Report issued January 2014

Follow-up report issued September 2014

In January 2014, University Audits issued the MiChart System Interfaces audit report. The audit noted opportunities to improve controls managing contractor access to MiChart. Management has addressed the audit issue identified and developed a solution ahead of the schedule to which they committed. Below is a summary of the audit observation and description of the corrective actions taken by management. **The audit is closed.**

- **Contract Employee Access to MiChart:** MCIT did not manage and track contract employee MiChart accounts so that only contract employees with an active assignment could access healthcare data. University Audits recommended that MCIT identify contract employees that have active assignments who have a MiChart account and remove access for any contract employees who do not have active assignments. The recommendation also suggested that MCIT reassess the process for recording and tracking contract employee MiChart accounts.

MCIT committed to completing an action plan to address this issue by December 2014. The MCIT MiChart team developed a standard operating procedure to review contract employee access to MiChart for appropriateness that will go live on October 1, 2014. In cooperation with the MiChart vendor (Epic), MCIT will review Epic contract employee access monthly. Non-Epic contractor access will be reviewed on a quarterly schedule.

Closed.

MHealthy

2013-213

Report issued December 2013

Follow-up report issued September 2014

University Audits issued a report for the audit of MHealthy in December 2013. We recently conducted a follow-up review to assess progress toward addressing audit recommendations in

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several areas, including written agreements with outside entities, employee waiver and release of liability forms, taxation of gift cards to employees, Project Healthy Schools, cross-training and documentation for data management processes, and timeliness of cash deposits. MHealthy has taken steps to address the majority of these issues. University Audits will follow-up on the remaining open issues during the third quarter of fiscal year 2015. **This audit remains open.**

- **Written Agreements with Outside Entities:** Coordinating with Procurement Services, there is now a written agreement between the University and Bodies in Balance , an external location where MHealthy conducts its fitness classes. MHealthy leadership will make sure to establish written agreements if they decide to hold future classes at another outside location. **Closed.**
- **Employee Waiver and Release of Liability Forms:** The online registration system now requires that individuals complete the waiver and release of liability form as well as the readiness questionnaire before they are able to register for a fitness class. MHealthy management stated that 99% of their registrations are handled through this system. There is one class at the Cube that still uses a paper process for the registrations and waiver forms. The instructor of this class is responsible for confirming that participants complete all required forms. **Closed.**
- **Taxation of Gift Cards to Employees:** To ensure compliance with IRS and University tax policies related to gift cards, MHealthy leadership consulted with the University Tax Department and will either pay the taxes for all gift cards they distribute under \$50 or have the employee pay the taxes. MHealthy will continue to work with Payroll to tax employees for cards given over \$50. Since taxes will be paid up-front, this updated process eliminates the need for MHealthy to calculate the aggregate of gift cards they issue to an employee and eliminates the need to coordinate with the employee's administrative unit. MHealthy plans to implement the new process effective October 1, 2014. University Audits will review support documentation for the new process during the second follow-up. **Open.**
- **Project Healthy Schools:** MHealthy and the Cardiovascular Center are in the process of drafting a memorandum of understanding to clarify roles and responsibilities including financial management and compliance with research regulations. The memorandum should be finalized and signed by December 2014. **Open.**
- **Cross-training and Documentation for Data Management Processes:** MHealthy's Research Program Manager, who is primarily responsible for collecting, validating, and preparing data, has created several documents that will help prevent the possibility of a disruption or errors in MHealthy's data collection and management processes. Updated processes have been shared with MHealthy leadership. The Research Program Manager has also been training her support staff on the documented processes.

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MHealthy leadership is now comfortable that if the Research Program Manager should leave, someone else with the right credentials and experience coming into the position would be able to follow the processes and instructions to continue operations. **Closed.**

- **Timeliness of Cash Deposits:** MHealthy coordinated with the Treasurer's Office to determine the most practical and cost-efficient method for depositing checks. To ensure that cash and check deposits are made within 24 hours of receipt, MHealthy installed remote deposit capture systems at the Wolverine Tower and Fitness Center locations. The new system allows MHealthy staff to scan checks for direct deposit at the time they are received, eliminating the need for the Fitness Center to transport deposits to Wolverine Tower. **Closed.**

Molecular and Behavioral Neuroscience Institute

2013-214

Report issued May 2013

Follow-up report issued August 2014

University Audits issued an audit report for the U-M Medical School (UMMS) Molecular and Behavior Neuroscience Institute (MBNI or Institute) in May 2013 and a follow-up memorandum in January 2014. During the first follow-up, we noted management had implemented five of eight action plans. University Audits recently performed a second follow-up review to assess progress on the three remaining open action plans.

The status of open action items is summarized below. University Audits will conduct a third follow-up review in March 2015 to reevaluate progress. **This audit remains open.**

- **Long-term Financial Viability:** Over the last several years, MBNI overspent general fund allocations and accumulated a significant deficit in its general fund balance. Fiscal year 2014 reports show an overall operating loss of \$515,000; however, after spending down some of its expendable restricted gift funds, MBNI was able to show a positive net change of \$149,000 in its general fund account. Although MBNI maintained a \$4.6 million balance in its expendable restricted gift funds at year-end, the current funding model will not sustain MBNI indefinitely.

In November 2013, the UMMS Dean assembled a committee to perform an academic review of MBNI. The committee analyzed MBNI annual reports and began interviewing U-M faculty to collect information needed for the review. UMMS administrators expect the committee to complete interviews within the next few months and estimate summary reports will be available after January 2015. The committee's charge includes summarizing MBNI achievements and progress, providing feedback regarding MBNI performance, and providing advice on the status, directions, needs, and optimal structure for the Institute.

University Audits will review the committee's recommendations related to MBNI's long-term viability during our third follow-up review. **Open.**

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- **IT Disaster Recovery:** MBNI drafted a disaster recovery plan (DRP) for IT services and systems, but has not yet established agreements with potential alternate sites for use of designated space and resources. MBNI recently contacted Medical School Information Systems (MSIS) personnel to discuss the DRP. University Audits will continue to monitor. **Open.**
- **IT Incident Response:** An incident response plan defines, in specific terms, what constitutes a security incident and outlines processes that should be followed when an incident occurs. MBNI adopted the Security Incident Response Plan used by MSIS, but has not yet adapted and implemented the plan at MBNI. University Audits will continue to monitor. **Open.**

University of Michigan-Flint Banner

2013-306

Report issued November 2013

Follow-up report issued July 2014

University Audits issued the Flint Banner audit report on November 5, 2013. The audit noted opportunities to improve process and procedures in the areas of IT security, documentation, and securing sensitive Protected Personal Information (PPI). Management has addressed the audit issues identified and completed some of their actions plans. Below is a summary of each audit observation and description of the corrective actions taken by management. A second follow-up will be conducted during January 2015. **This audit remains open.**

- **Java Update Process:** Java is a required piece of software that enables staff to interact with University enterprise applications. This software is vulnerable to exploitation if not patched effectively. The Java patching process is challenging in that certain enterprise applications are locked into a specific version of Java. Updating the Java client will cause functionality issues with enterprise applications and not patching the client puts University data at risk. Flint ITS has committed to developing a process that will enable Java to operate in a secure environment that mitigates the risk of vulnerable clients and patching Java clients that are not limited by a version requirement. Flint ITS is in the testing phase of this process and they expect to have it completed by December of 2014. **Open.**
- **Access Revocation Process:** The audit identified several active Banner user accounts for former University employees and determined that accounts were not regularly reviewed. Flint ITS committed to crosscheck Banner user accounts against University human resources systems to remove inappropriate access. ITS also committed to reviewing Banner accounts on a monthly basis. A follow-up review of Banner user accounts did not identify any inappropriate accounts. **Closed.**
- **Web Application Vulnerabilities:** Flint ITS did not perform web application security assessments of the Internet accessible portion of the Banner system (SIS). The security

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vulnerabilities identified in the audit have been evaluated by Flint ITS and fixed where appropriate. Flint ITS has acquired a tool to perform regular security assessments and will begin scanning in July 2014. **Open.**

- **Vulnerability Scanning:** Regular vulnerability scanning of UM Flint networks was not conducted, which enabled vulnerabilities to go undetected and unmitigated. Management committed to regular vulnerability scanning and vulnerability remediation. Currently, vulnerability scans are being conducted monthly and fed into a security database so that vulnerabilities can be tracked. Patching and remediation efforts have been delayed due to staff turnover. **Open.**
- **Encryption of Protected Personal Information (PPI):** Data stored in Banner defined as PPI was not encrypted at rest or masked when displayed to an end user. Flint ITS was able to encrypt PPI at rest and mask all but the last four numbers Social Security numbers when displayed to an end user. **Closed.**
- **Access of Protected Personal Information:** Flint ITS developers had access to PPI in development environments and fine grain auditing of access to sensitive data was not configured. Flint ITS accepted the risk of allowing developers to access PPI without de-identifying the data. Fine grain auditing of PPI was configured and enabled. **Closed.**
- **Audit Logging Guidance:** Guidance documentation for the configuration, management, and collection of audit logs was not available to Flint ITS staff. A policy that outlines how audit logs should be managed has been created and disseminated to Flint ITS staff. **Closed.**
- **System Documentation:** Flint ITS information systems are not adequately documented. Management committed to developing policy and documentation of information systems where vendor documentation is not available. Flint ITS developed a policy governing the documentation process, however, other documentation has not been completed. **Open.**

University of Michigan-Flint Educational Opportunity Initiatives

2010-211

Report issued February 2011

First follow-up report issued April 2012

Second follow-up report issued April 2013

Progress Review in April 2014

Third follow-up report issued September 2014

University Audits reviewed the EOI Office and issued an audit report in February of 2011.

Follow-ups were conducted in April 2012 and April 2013. During inquiries in May 2014, significant issues remained unaddressed and the Chancellor and the Provost requested additional time to work with EOI. An additional follow-up took place in July 2014 shortly before the new Chancellor began her appointment on August 1, 2014. The Provost has provided the information below as a follow-up response. University Audits will give sufficient time for new

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leadership to implement the changes described below and then re-evaluate the status of the remaining open issues in the fourth quarter of fiscal year 2015. **This audit remains open.**

STRATEGIC OVERSIGHT AND CAMPUS COLLABORATION

A change in leadership within EOI occurred recently. We are pursuing the hiring of an external consultant with expertise in programs that EOI currently offers to review the existing programs and to develop a strategic plan that would ensure better alignment of EOI programs with our mission as well as with other existing programs. The planned study also will examine possible duplication of programs and services.

EOI is composed of two sets of programs, one directed at pre-college (K-12) students and the other designed to support our UM-Flint students, particularly those students from underserved populations. A review of the current EOI structure is needed to explore better integration of its operations with those of similar support programs on campus (such as the Student Success Center and the Office of K-12 Partnerships), thereby maximizing the impact of our resources dedicated to enhancing student achievement.

One example of the duplication of certain efforts and services was reflected in each pre-college program's student recruitment efforts at different times of the school year. This made for a virtual never-ending cycle of recruitment, orientation, and intake processes. The proposed coordination of these programs allows for a single process for all pre-college student recruitment and the establishment of more consistent admissions standards and application forms, intake and orientation processes. It further enhances the placement of students in program services including classes, seminars and workshops, and enables the program to offer more consistent services across the entire student body and from one year to the next.

BUDGET AND FINANCIAL MANAGEMENT

The Human Resources staff conducted a job analysis of the EOI Director, Office Manager and all other staff positions in order to assess roles and responsibilities within EOI. Delegation of duties and responsibilities as needed has been one main area of focus. These reviews will be helpful in the reorganization of the operation.

For the first time in several years, EOI's budget for fiscal year 2012 was very nearly balanced, and the fiscal year 2013 budget was underspent by approximately \$80,000. However, a hiring freeze mandated by the Provost was necessary to ensure that the EOI budget would not add to its deficit. In addition, the Provost assigned an intermediate budget supervisor to EOI to develop budget controls, record keeping procedures, and other processes to ensure that the unit's operations were consistent with university practices. However, the limited role of this supervisor only allowed basic fiscal controls to be established. As a result, the Vice Chancellor for Business and Finance has agreed to oversee the budgetary operations of the reorganized operation to ensure long-term fiscal sustainability.

The Budget Manager assigned by the Vice Chancellor for Business and Finance will verify that sufficient funding is available for budget requests prior to routing to the Director for approval,

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and will have the authority to approve, reject, or postpone expenditures when the Director is not available. Compliance with terms of grant expenditures will also be more tightly monitored in light of a recent disallowance.

A budget plan is under development to incrementally reduce and eventually eliminate the historical deficit of the unit due to fiscal overruns.

STAFF MANAGEMENT

Program Managers will develop performance evaluations for all direct reports and forward drafts to the EOI Director for review, revision, and approval once finalized. The Human Resources department staff will assist the Director by providing consultation with regard to annual performance evaluations for all staff.

Staff will also receive more intense training as to their responsibilities for risk reduction due to the nature of their exposure to minors on campus.

EVENT MANAGEMENT

Management has advised all staff to plan events through the office receptionist. EOI worked with the U-M Flint Event and Building Services (EBS) to comply with their guidelines to the extent possible. EOI will continue to monitor this issue for additional improvement opportunities.

CONTINUITY OF OPERATIONS AND DISASTER RECOVERY

EOI has worked with UM-Flint ITS to develop and implement the proper security measures to keep data safe and accessible in the event of an emergency. EOI has worked to transfer all critical digitized files to the UM-Flint “I” drive which are backed up 2-3 times weekly off site.

EOI purchased and has begun to routinely use external hard drives to back up critical information. Greater emphasis has been placed on scanning forms, data, and critical paper work and then backing up those data onto hard drives and off site external hard drives. This work is ongoing.

The area of disaster recovery has been reviewed by the ITS office. Three years ago the older digitized student files were found to contain inappropriate data (social security numbers). Those records were carefully scrutinized by ITS using a software program, after which EOI staff manually reviewed all files and made certain that all such data have been removed.

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Open Audits Follow-up Table

As of September 30, 2014

Audit	Report Date	Open Issues	Expected Completions Date
UM-Flint Educational Opportunity Initiatives 2010–211	February 2011	Strategic oversight and guidance; campus support and collaboration; budget and financial management; staff management; event management; business continuity; documentation of policy and procedure	First follow-up April 2012 Second follow-up April 2013 Progress reviewed May 2014 Third follow-up September 2014 Fourth follow-up scheduled for June 2015
Financial Considerations for International Activity 2011–101	June 2011	Coordination of effort; documented policies and procedures	First follow-up February 2014 Second follow-up originally scheduled for August 2014; rescheduled for October 2014
UM–Flint Business Continuity 2011–303	August 2011	Business Continuity Planning standards template	First follow-up March 2012 Second follow-up December 2012 Third follow-up September 2013 Fourth follow-up originally scheduled for September 2014; rescheduled to October 2014

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Audit	Report Date	Open Issues	Expected Completions Date
e-Verify 2011-402	February 2012	Contract information; identification of employees; e-Verify notice requirements	Follow-up February 2014 Audit to be closed - long-term action plans being finalized
UM-Dearborn College of Engineering and Computer Science 2012-302	June 2012	Financial oversight; documented policies and procedures; contracts, grants, and agreements; gift handling and monitoring; Engineering professional development	First follow-up April 2014 Second follow-up scheduled for December 2014
Residential Dining Service 2012-216	November 2012	Financial metrics; CBORD inventory	Follow-up September 2013 Second follow-up March 2014 Third follow-up originally scheduled for August 2014; rescheduled for October 2014
University Unions 2012-201	April 2013	Supplemental systems; credit card merchant processes	Follow-up June 2014 Second follow-up scheduled for December 2014
Medical School Department of Family Medicine 2013-211	April 2013	Japanese Executive Physical Program	First follow-up December 2013 Second follow-up August 2014 Third follow-up scheduled for January 2015

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Audit	Report Date	Open Issues	Expected Completions Date
Medical Center Information Technology and Arbor Lakes/North Campus Data Centers 2012-307	April 2013	MCIT Managed Data Centers lack a comprehensive continuity of operations plan. Note: This issue requires long-term corrective actions and planning efforts are ongoing.	COOP Meetings June 2013 September 2013 First follow-up March 2014 Second follow-up September 2014 Third follow-up scheduled for March 2015
Molecular and Behavioral Neuroscience Institute 2013-214	May 2013	Long-term financial viability; IT disaster recovery	First follow-up January 2014 Second follow-up August 2014 Third follow-up scheduled for March 2015
Office of Student Publications 2013-203	July 2013	Strategic Plan and Vision; External Bank Account/Student payments; Documented Policies and Procedures; training; IT services; Internal Controls certification and Gap analysis; procurement contracts	Follow-up March 2014 Second follow-up June 2014 Third follow-up scheduled for December 2014
School of Natural Resources and the Environment 2012-210	September 2013	Center/institute oversight; effort certification; admissions documentation; lab safety; documented processes	Follow-up June 2014 Second follow-up scheduled for November 2014

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Audit	Report Date	Open Issues	Expected Completions Date
UM-Dearborn College of Arts, Sciences, and Letters 2013-204	September 2013	Financial oversight; conflicts of interest/conflicts of commitment; safety of minors; agreements with third parties; faculty course releases and stipends; records and advising; roles and responsibilities;	Follow-up June 2014 Second follow-up scheduled for December 2014
UM-Dearborn Office of Financial Aid 2013-201	September 2013	Concentration of duties; conflicts of interest or commitment	Follow-up June 2014 Second follow-up scheduled for November 2014
College of Engineering Research Software Licensing 2013-310	October 2013	Software licensing and usage; software for commercial research; acceptance of “click-through” licenses; tracking of software licenses in nanotechnology labs; creation of a research lab; definition of PhD student; recording software purchases to program codes; classification of software purchases	Follow-up April 2014 Second follow-up deferred to September 2014
Donor & Alumni Relationship Tool (DART) 2013-106	October 2013	Changes to the Default Master Encryption Password; Office of University Development Dev/Net Web Application Security; DART Web Application Security; Network Vulnerabilities; Terminations and Periodic Review of User Access; Organization of Key Information; Assignment and Completion of Project Tasks; Ongoing User Training; Use of Help Desk Questions; System Metrics	Follow-up June 2014 Second Follow-up scheduled for October 2014

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Audit	Report Date	Open Issues	Expected Completions Date
UM-Flint Banner System 2013-310	November 2013	Java update process; web application vulnerabilities; vulnerability scanning; system documentation	Follow-up July 2014 Second follow-up scheduled for January 2015
MHealthy 2013-213	December 2013	Taxation of Gift Cards to Employees; Project Healthy Schools	Follow-up September 2014 Second follow-up scheduled for March 2015
Financial Operations Cost Reimbursement Office Effort Certification Process 2013-501	January 2014	Maximum allowable effort on federal projects; data validation	Follow-up originally scheduled for July 2014; rescheduled for October 2014
Department of Chemistry 2013-212	March 2014	Recharge billing; facility access and security; reconciliation process; electronics shop oversight; support for lab fees; system configuration documentation; chemical inventory documentation; review and approval of student designed lab projects; international travel registry; inaccurate asset inventory records; Rackham research grants; admission and award process documentation	Follow-up scheduled for September 2014 still in progress, memo planned for October 2014
Center for the History of Medicine 2014-210	April 2014	Segregating purchasing duties; approval of expenses on behalf of the director; educating employees on reporting responsibilities; management of medical artifacts	Follow-up scheduled for October 2014

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Audit	Report Date	Open Issues	Expected Completions Date
Export Controls 2014-404	April 2014	Governance; recordkeeping; Education and training; Lack of return or destroy procedures; foreign nationals; IT security; overseas travel	Follow-up scheduled for October 2014
International Center 2014-206	May 2014	Protection of sensitive data; statement of activity reconciliation process	Follow-up scheduled for November 2014
University of Michigan Dearborn Information Technology Services 2014-216	May 2014	Vulnerability detection and remediation; malware detection and remediation; account provisioning and de-provisioning; network segmentation; software asset management ; it disaster recovery and business continuity; it change management; fixed asset management ; P-Card review process; management reports; conflict of interest/ commitment	Follow-up scheduled for November 2014

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Audit	Report Date	Open Issues	Expected Completions Date
School of Dentistry 2014-215	May 2014	salary and incentive model; patient payment plans; controlled substances procurement and inventory; business associate agreement ; credentialing; adjunct onboarding and oversight; additional compensation payments; clinic Medicaid procedures; job responsibilities and performance evaluations; compliance roles and responsibilities; disposal of controlled substances; human subject incentive payments; conflict of interest and conflict of commitment; nepotism; procurement expenses; segregation of duties; leased space agreements; service agreements; internal control gap analysis; travel registry and policy; cash handling and depository training; student discount eligibility verification; graduate program admission	Follow-up scheduled for November 2014
General Laboratory Safety 2014-401	July 2014	Safety culture; oversight and monitoring; defining the lab population and identifying hazards; training and education; monitoring reports and trend analysis; safety role definitions; communication and awareness	Follow-up scheduled for January 2015
Student Domestic Travel – Sponsored Teams and Groups 2013-110	July 2014	Process owner; policy and guidance	Follow-up scheduled for February 2015

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Audit	Report Date	Open Issues	Expected Completions Date
UM-Flint Department of Public Safety 2014-204	July 2014	Effectiveness of the Oversight Committee; information about the Oversight Committee; physical inventory of the Property Room; segregation of duties; MyLINC training; management plans of duties	Follow-up scheduled for January 2015
Administrative Services Transformation Shared Services Vendor Selection and Payment 2014-812	July 2014	Contract change orders – approval; conflict of interest/conflict of commitment - management plans; contract change orders - delegated authority; non-competitive purchasing	Follow-up scheduled for January 2015
Bentley Historical Library 2014-201	July 2014	External work performed by Conservation Lab staff; Detroit Observatory; security of facilities; contract oversight; DRP; environmental controls in archives; insurance for fine art; security of donor information; collection backlog management; time reports and travel expenses; conflicts of interest and conflicts of commitment; cash handling	Follow-up scheduled for February 2015
University of Michigan Health System MiChart Revenue Cycle 2014-112	July 2014	Protected Health Information; Reconciliations; Segregation of Duties; Write-off Approval and Review; Refund Practices; Physician Coding; Use of Coding Modifier 25	Follow-up scheduled for February 2015

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Audit	Report Date	Open Issues	Expected Completions Date
University Library 2014-217	July 2014	Storage of collections; collection inventory; cash handling; PCI compliance; verification of equipment inventory; Statement of Activity reconciliations; disaster response and recovery plan; building access; international travel safety; pay rate verification; IT change management; IT support management	Follow-up scheduled for February 2015
Office of Technology Transfer	August 2014	Documentation of key procedures; work procedure efficiencies	Follow-up scheduled for March 2015
Social Media	August 2014	Social media strategy; acceptable use guidelines; training and awareness	Follow-up scheduled for March 2015
Sponsored Programs Office of Contract Administration 2014-502	September 2014	Subrecipient monitoring roles and responsibilities; subrecipient eligibility requirements; pre-award compliance requirements; nonfederal subcontract templates; invoice numbering system	Follow-up scheduled for April 2015
School of Education 2014-209	September 2014	Affiliation agreements; fire alarm system; risk evaluation of computers on open networks (RECON) – security issues; graduate and undergraduate grade changes; equipment tracking – research incentive and discretionary funds; building keys and M-Cards; conflict of interest and conflict of commitment; joint appointments	Follow-up scheduled for April 2015

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Audit	Report Date	Open Issues	Expected Completions Date
Life Sciences Institute 2014-207	September 2014	Equipment transfer; risk evaluation of computers on open networks (RECON) and security plan; internal and external services; Internal Controls Gap Analysis and Certification Process	Follow-up scheduled for May 2015
Payment Programs for Research Subject Incentives 2012-501	September 2014	Tax reporting compliance; internal control and operational efficiency; HSIP procedures; enhancing training; updating University policy; system compliance monitoring; third party vendors	Follow-up scheduled for May 2015

Appendix 1: Audit Issue Risk Definitions

Risk	Definition
High	<ul style="list-style-type: none"> Describes a control breakdown with a combination of potential impact and likelihood of occurrence to create significant risk to the audited entity. A high-risk issue generally requires immediate corrective action or implementation of an interim control to minimize the risk until permanent corrective actions occur. A high-risk issue could be a repeat medium-risk issue (i.e., during the last audit, the same issue was reported but was not corrected on a sustainable basis).
Medium	<ul style="list-style-type: none"> Describes a control breakdown with a combination of potential impact and likelihood of occurrence to create enough risk to require corrective action within six months. A medium-risk issue could be a repeat low-risk issue (i.e., during the last audit, the same issue was reported to unit management but was not corrected on a sustainable basis).

Note: Low risk issues are reported directly to the audited unit, do not require senior management attention, and are not included in the audit report. University Audits does not formally follow up on low-risk issues

Appendix 2: Audit Issue Follow-Up Process

High- and Medium-Risk Issues: Every three months until completed, unit management will report the status of their action plans to University Audits. At six months, and every six months thereafter until the actions are completed, University Audits will follow-up to verify the actions are complete and are effectively managing the risk. University Audits will issue a follow-up memo on the results.

Low-Risk Issues: Low-risk issues are expected to be addressed by unit management and may be reviewed during our next audit. However, a status update is not required and University Audits will not conduct follow-up procedures.