UNIVERSITY OF MICHIGAN

REGENTS COMMUNICATION

Item for Information

Subject: Report of University Internal Audits
             February – April 2012

Background:

This is the report of the Office of University Audits activities for the period **February – April 2012**. The summaries of audits contained in this report were previously reported to members of the Regents' Finance, Audit, and Investment Committee and included in discussions at Committee meetings.

Included in this report:

- Summaries of each audit report issued during the period, including Management's Plan to enhance specific control processes discussed with the audit client and presented in the report.
- Summaries of follow-up review reports issued during the period, including the actions taken by Management. Follow-up reviews are designed to give assurance that Management's Plan for corrective action has been implemented and controls are working appropriately.
- A report on the status of follow-up reviews as of **April 30, 2012**.

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

Respectfully submitted,

Carol F. Senneff, Executive Director
University Audits

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ORIGINAL REPORTS

Campus

University Safety and Security Communication, Reporting, and Incident Investigation   #2012-809
Report issued February 10, 2012

Safety and security touches all facets of University life and involves multiple stakeholders, from students, parents, staff, patients, and families to security and law enforcement agencies. Focused efforts on safety and security are a regular part of all aspects of campus and Health System operations. These efforts require substantial coordination and collaboration across many departments within the University.

On December 3, 2011, at the request of President Coleman, University Audits began conducting:
- A review of the internal controls breakdown that contributed to a delay in a thorough investigation of a case of suspected possession of child pornography by a medical resident at the hospital
- A comprehensive review of the internal control structure and environment related to safety and security at the University of Michigan-Ann Arbor campus

Both sections of the review involve the processes and people that conduct and manage the safety and security of the University's students, employees, and patients. The results of the reviews are discussed in this report:
- Section I – the breakdown of internal controls specific to the delay in reporting of a case of potential possession of child pornography in the hospital by a medical resident
- Section II – what must happen so that future potential criminal activity is managed in a seamless, collaborative way and the outcomes are timely, thorough, and transparent
- Section III – management's response to this report
- Addendum I – May 2011 and November 2011-to-date timeline of events related to the specific issue discussed in Section I
- Addendum II – Text of attorney client privilege communication

Section I
University Audits was asked to examine the internal controls related to an issue that was first reported in May 2011 but not fully investigated until November 2011. The case was closed in May because of a lack of evidence. When it was brought forward again in November, the case was fully investigated and additional evidence showed suspected wrongdoing on the part of a University of Michigan medical resident. (Please see attached Addendum I for a timeline of related events.)

Factors that caused the case to be stalled after the first attempt at investigation:
- Primary evidence that was viewed on a USB thumb drive attached to a hospital computer disappeared between the time it was first seen and the next morning.
- There was not a clear line of responsibility for investigating the case. The Office of the General Counsel inappropriately took ownership. Hospitals and Health Centers Security and Entrance Services (HHC-Security) and MCIT (Medical Center Information Technology) assisted in the

investigation under attorney client privilege. The text of the attorney client privilege communication is attached as Addendum II.
- The lead attorney investigating the case made the determination that there was not enough evidence to file a police report and discontinued the investigation. The attorney is no longer employed with the University.
- HHC-Security did not log the case in the system shared with the Department of Public Safety (University Police-DPS). If that had been done, DPS would have seen that there was a potential issue.
- MCIT reviewed the computer internal logs where the USB thumb drive had been seen and was able to determine who had accessed the computer. MCIT was not able to retrieve other relevant information such as files accessed from a USB thumb drive.
- There was significant confusion about the roles of HHC-Security and DPS. Hospital employees who reported the incident thought they were talking to police when they were talking with HHC-Security. DPS is an accredited law enforcement agency with authority and responsibility to investigate, search, arrest, and use necessary force to protect persons and property. HHC-Security is responsible for providing security patrols and escorts, access control, visitor screening, way finding, and security camera/alarm monitoring.

DPS and HHC-Security have policies and procedures for their individual departments, but no specific guidance or communication protocols between their departments. If the following internal controls had been in place in May 2011, the delay in performing a thorough investigation may have been avoided:
- Shared documented responsibilities for all parties who have a need to respond: DPS, HHC-Security, Office of the General Counsel, Health System Compliance Office, and Office of Clinical Affairs.
- The Office of the General Counsel should be available for legal advice but should not take ownership of an investigation.
- Consistent logging of all potential criminal activity in a system that is shared by both HHC-Security and DPS.
- Clear, shared procedure that states when a case is reported by HHC-Security to DPS. The procedure should define shared and independent roles after the case is reported.
- Referring all computer forensic needs related to suspected criminal activity to DPS. DPS has trained information technology officers as well as sophisticated tools to examine technology evidence. MCIT should continue to assist in routine internal investigations related to HIPAA (protected patient health information) and other privacy breaches.
- Clear, simple information for anyone who may be reporting a security incident. This should include a process for giving feedback to the person who reports an incident to provide closure.

It is extremely important that management address the weak internal controls, as stated above, that relate to a specific set of circumstances. However, without a consistent approach, a culture of collaboration, and shared goals that deal with all types of criminal activity, the risks and control breakdowns we see in this specific case might cause a potentially more serious reporting and investigation outcome in the future. Section II of this report addresses the broader issue of all cases of potential criminal activity that require shared responsibility among departments within the Health System, HHC-Security, and DPS.

Section II
University Audits reviewed University communication and reporting processes related to security and potential criminal activity on the Ann Arbor campus to gain an understanding of the interdepartmental relationships and communication protocols related to public safety and security. The Flint and Dearborn campuses were not part of the review. The review included:
- Examining and assessing existing documentation of policies and procedures

- Interviewing senior management and other key personnel

The purpose of this report is advisory and is not intended to provide audit assurance. It is meant to provide a context and recommendations for leadership to consider for enhancing University safety and security communication and reporting processes on the Ann Arbor campus.

For the purposes of this report, the major safety and security units at the University of Michigan-Ann Arbor Campus include, but are not limited to the following:

Law Enforcement

Department of Public Safety (DPS) is a full service law enforcement agency with the authority and responsibility to investigate, search, arrest, and use necessary reasonable force to protect persons and property. DPS is responsible for enforcing the laws of the State of Michigan and the Ordinance of the Regents of the University of Michigan. DPS reports to the University Associate Vice President for Facilities and Operations.

Security Departments

University of Michigan Hospitals and Health Centers Security and Entrance Services (HHC-Security) is a separate security agency of the University and reports to the Hospital Associate Director for Operations and Support Services. HHC-Security provides security patrols and escorts, access control, visitor screening, way-finding, and security camera/alarm monitoring. Another primary role is to support patients, families, and visitors who are sometimes facing very difficult and traumatic challenges in their lives.

Housing Security is a unit of University Housing, within the Division of Student Affairs and reports to the Associate Director for University Housing. Housing Security is responsible for security, access control, and fire safety in University Housing owned and controlled properties. DPS receives and dispatches all housing security incidents.

Other Organizations that have a role in University Safety and Security

Office of General Counsel (OGC) is under the direction of the Board of Regents and the President. The Vice President and General Counsel conducts the legal affairs of and provides legal advice and representation for the University.

Office of Clinical Affairs is responsible for maintaining and improving the environment of patient care at the U-M Health System. It is also accountable for the quality of professional services by all individuals with clinical privileges within the Health System. The office reports to the Chief Executive Officer of U-M Hospitals and Health System and works closely with Risk Management, HHC-Security, and the Office of General Counsel to ensure patient care quality and safety.

Health System Risk Management is part of the Office of Clinical Affairs and is dedicated to minimizing the adverse effects of loss due to unforeseen events or situations that could result in harm to patients, staff, and visitors.

Risk Management Services assists the operating units and staff of the University to protect against or mitigate losses to the people, facilities, and other assets of the campus community. Risk Management reports to the Treasurer's Office.

The Health System Compliance Office promotes compliance with all laws/regulations governing billing, coding, Medicare and Medicaid, patient privacy, information security, vendor

relationships, conflict of interest, and governmental investigations. The department's purpose is to maximize compliance with laws and regulations to minimize risk of violations and penalties. This office collaborates with *University Audits* in investigating and responding to calls to the University's confidential hotline.

Office of Emergency Preparedness provides resources, guidance, and training for the University community in matters related to emergency preparedness, response, and recovery. The Office of Emergency Preparedness reports to the Associate Vice President for Facilities and Operations.

Occupational Safety and Environmental Health (OSEH) provides monitoring, guidance, and education to promote health, safety, protection of the environment, and ensure compliance with local, state, and federal laws dealing with hazardous materials, operations, fire and life safety, and environmental protection. OSEH reports to the University Associate Vice President for Facilities and Operations.

Each of University of Michigan's safety and security organizations plays an essential role in providing our community with a safe environment. Cooperation and better communication between these units will make this essential mission more efficient and effective.

University Audits Observations and Recommendations
Communication Among University Safety and Security Organizations
University safety and security organizations have well established policies and procedures for day-to-day operations within their respective units. However, there are no formal protocols or memoranda of understanding between safety and security organizations for the shared responsibility of reporting suspected criminal activity or other security incidents.

Current safety and security policies need simplification and alignment among organizations. There needs to be common definitions and well understood escalation procedures for suspected criminal activity.

> *Recommendation:* **Develop an extensive set of common guidelines and protocols for reporting security incidents throughout the University.** The protocols need to be actionable and should establish clear communication and procedures for hand-off of cases between University safety and security organizations. These practices can be in the form of checklists, online training, decision trees, and formal policies and procedures.

Communication protocols should include roles and responsibilities for all parties who need to react appropriately to a specific aspect of the case. Examples include:
- DPS, HHC-Security, and Housing Security when there is suspected criminal activity
- University Risk Management when there is loss of property
- Office of the General Counsel for legal analysis
- The Health System Compliance Office in cases where health related regulations may have been breached
- University Audits when internal controls may have been missing or bypassed
- Office of Clinical Affairs when a patient or health professional is potentially involved
- OSEH for occupational safety or environmental issues

Definitions of incident types are not well understood. Develop a comprehensive list of incident types. This should include definition of *potential* criminal activity as well as *proven* activity. Without a common definition of reportable activity, the course of investigation and ultimate

resolution is seen differently and is one of the causes of disagreement and tension between departments.

Privacy and Law Enforcement

Concerns about student and patient privacy sometime impede timely communication of security and safety incidents to police and security agencies. In current practice, University employees are instructed to confer with the Health System Compliance Office and the Office of General Counsel if there are privacy concerns. Generally, records that contain protected health information or protected student records are not turned over to law enforcement without a subpoena. While privacy protection is a compelling, competing interest, both HIPAA and FERPA do allow disclosure of protected information to law enforcement in certain instances.

> *Recommendation:* **Raise awareness of the different patient, employee, and student privacy rules.** Law enforcement and security officers should receive regular HIPAA and FERPA training to raise awareness and sensitivity to privacy. Commonly understood definitions are needed for when and under what circumstances protected information should be shared with security and law enforcement agencies. A streamlined process is needed when there is suspected criminal activity to ensure relevant protected information is shared with law enforcement through means that are legally appropriate.

Duty to Report

The University is subject to various legal requirements to report potential criminal activity and it is also subject to laws that restrict what information may be shared. These legal requirements can appear to be in conflict and may cause confusion about whether or not a report should be made. For example, laws that require reporting of certain crimes might conflict with laws that protect student, victim, or patient privacy.

> *Recommendation:* **Foster better understanding and sensitivity of duty to report requirements.** Develop legal guidance and training to help responders navigate the complexities and grey areas of reporting suspected criminal activity.

Emergency Response

When an individual dials 911 from a University phone, including residence halls, the call goes directly to DPS for triage and dispatch. An exception exists within the hospital, 911 calls go directly to HHC-Security for triage and dispatch. This allows HHC-Security and medical providers to respond to medical emergencies and other non-emergent situations within the hospital. However, the routing of 911 calls to HHC-Security rather than DPS can cause confusion on the part of the reporting individual, who believes they are making a report to law enforcement.

> *Recommendation:* **Review the use of 911 triage and dispatch.** DPS and HHC-Security should have formalized dispatch procedures for the operation of each facility control center. Security officer responders should clearly identify themselves as security and not law enforcement.

Shared Reporting Systems

As of January 2012, DPS has implemented a new information management system that is not part of the internally developed system previously shared with HHC-Security and Housing Security. This system, CLEMIS (Courts and Law Enforcement Management Information System), is a multi-faceted, regional law enforcement management information system that allows sharing of data between nearly 100 Michigan law enforcement agencies. Because HHC-Security and Housing Security are separate from DPS and are not law enforcement, they will not have direct access to the new system, but will continue to need access to relevant incident reporting information within CLEMIS. Other security incident reporting

and calls for service, such as lost and found, alarms, personal injury, and/or safety/hazard reports are tracked via separate reporting systems maintained by each of the Security Offices.

> *Recommendation:* DPS, HHC-Security, and Housing Security management have recently met to discuss the impact of CLEMIS on information sharing and to develop a work-around process to restore HHC-Security and Housing Security access to previously available safety and security information. **Create a shared communication system that facilitates accountability and cooperation.** Both HHC-Security and Housing Security need to be aware of crimes that have occurred in nearby areas of their responsibilities. Shared reporting mechanisms should be seamless, designed to share University-wide safety and security information, and facilitate communication protocols and decision processes.

Lessons Learned

One of the reasons that differing opinions exist about the outcomes of security incidents and criminal investigations is because there is not a consistent process to discuss the issues that arise between agencies or groups as they work toward a final resolution of each case.

> *Recommendation:* **Formally debrief on major security incidents.** Develop a process that gathers all groups involved in a case to discuss what worked well and what could have been done better. Learn from the experience so that positive actions are reinforced and the things that did not work to the satisfaction of everyone involved are discussed and resolved so that the process will be improved the next time there is a similar incident.

Training

Policies, procedures, and protocols are essential in defining a common understanding and providing a common roadmap for action in all types of cases. Additionally, to institutionalize a consistent approach to many different types of incidents and responses, it is important that everyone that may be involved in investigation and resolution of a case receive hands-on training related to these policies, procedures, and protocols. As an example, DPS will benefit by learning the reasons for protected health information safeguards as well as the reasons when it is essential to share protected information quickly and safely in a potential criminal case.

> *Recommendation:* **Develop ongoing team-building training programs.** Develop a comprehensive training program that builds knowledge and understanding of processes from all perspectives, and builds a collaborative team effort for addressing many types of issues. Training can assist all parties understand the reasons for perspectives and regulations that impact the prescribed protocols, actions, and philosophies of others involved in a particular chain of response. Training should encompass the viewpoints of all parties and be attended by a cross-section of safety and security organizations.

Organizational Structures

Safety and security organizations at U-M report through multiple channels. There is no common reporting structure or mechanism. This is particularly problematic when it comes to police and security services. Each police/security agency reports to a separate organization and has separate and sometimes conflicting policies.

> *Recommendation:*
> - **Review the reporting lines and communication structure of police and security units.** Benchmark with other universities to provide examples of effective safety and security models. Consider the optimal structure given the complexities of our University for ensuring public safety and security.

- **Consider a DPS liaison office within the Health System.** There is no consistent DPS presence within the Health System. DPS officers are only interacting with hospital faculty and staff when there is a criminal investigation or an emergent situation. This contributes to tense working relationships and miscommunication.
- **Develop cross-functional teams.** Safety and security teams should be defined by incident type, and will ensure that the right skill sets are matched to respond to the particular issue. Teams should meet regularly in non-crisis mode to further develop understanding and trust.

Culture

A common understanding and single vision is needed among the University safety and security organizations. Competing and sometimes conflicting interests and a lack of role clarity have led to mistrust and suboptimal working relationships. There is a lack of understanding and appreciation for the contributions each organization makes to ensure a safe and secure work, learning, and patient care environment.

> *Recommendation:* **The culture must change.** Define a plan to enhance team culture. Engage an outside expert to work with the leaders of the various security units and related areas to examine cultural issues that limit achievement of the common goals of the various units. This could be accomplished through a series of facilitated offsite meetings that bring the various parties together with a single vision. Without a cultural shift, there will continue to be breakdowns in the effectiveness of the organization as a whole.

> Once there is willingness to come together with common goals and understanding, the points discussed in this report should be considered by all groups and individuals involved. Not all of these recommendations may be implemented as stated, but all should be part of the consideration in finding a working relationship that supports the best safety and security of all stakeholders at the University of Michigan.

Section III
Management's Response to Report

Incident Overview

On May 24, 2011, a medical resident initiated a report of one potential child pornography image based on review of three images on a USB thumb drive attached to a computer in a lounge for medical residents in the hospital. The initiation of the report included contact with faculty physicians for assistance and a request for direction from the Health System Compliance Office. The Health System Compliance Office referred the concern to Hospitals and Health Centers' Security Services and the Health System Legal Office on May 25, 2011.

Attorneys in the Health System Legal Office investigated whether there was evidence of criminal activity that should be reported to law enforcement. The lead attorney, a recent hire, had significant experience investigating and prosecuting health care professionals. She asserted control of the investigation, sought the acquisition of evidence from the computer in question, and interviewed the resident who reported that she may have seen evidence of child pornography. The lead attorney determined that there was not enough evidence to take the report to police and reported her conclusion to the Health System Legal Office, the Health System Compliance Office, and to the reporting resident. She closed her investigation in the first week of June 2011 and left the University soon thereafter for reasons unrelated to this incident.

At the time, those who were aware of the concern and investigation deferred to the lead attorney because of her expertise and assertion of control over the review, with the (mistaken) belief that the investigation was proper. In November 2011, the matter was raised again by concerned physicians in the wake of the Penn State incident, this time with the Office of Clinical Affairs, the department charged with ensuring every physician's competence to deliver safe patient care. Upon a second review, sufficient evidence was discovered that led to the termination and arrest of a suspect in the case.

Upon learning of the gap in reporting, President Coleman immediately ordered a review of the incident by University Audits to determine reasons and root causes for delayed reporting.

As a result of that review, it has been determined that the initial investigation was insufficient and improper:

1. The resident who reported the crime described the lead attorney who interviewed her as intimidating and threatening, causing distress and a feeling that she should not have come forward with the report.

2. The lead attorney's assertion of control over the investigation caused others in the Health System to cease their investigatory efforts, awaiting direction from Health System Legal Office.

3. The review of the computer by Health System personnel was insufficient and would have been enhanced if law enforcement had been involved to lead the investigation.

Beyond the role played by the attorney who is no longer with the University, management is concerned with the missed opportunity to appropriately report by others who were aware of the allegations in May, including:

1. The failure to report the potential crime to DPS and, instead, the decision to engage in an investigation through the legal office;

2. The decision to rely on the opinion of one attorney about the sufficiency of the evidence to determine whether or not a report would be made to DPS; and

3. The failure to recognize that in light of the possible risk to patient safety a report should be filed with the Office of Clinical Affairs or the Health System Risk Management Office to explore what protections might need to be put in place, even in the absence of a criminal investigation.

University management accepts responsibility for the delay in reporting the crime, an unacceptable handling of the reporting and necessary investigation of the concern regarding child pornography. We conclude that the assertion of improper control of the investigation by the attorney and reliance on her conclusions by others were the root cause for the delay and improper handling of the initial report. The case should have been forwarded to the Department of Public Safety in May.

Individual corrective action will be taken with the involved current employees to ensure greater clarity of their respective roles and the importance of vigilance when handling complaints of possible criminal activity or risk to patient safety. This corrective action will be documented in the employees' personnel files and those employees will be held accountable for improvement through the established performance review process.

To help determine how the specific circumstances arose that led others to rely on the conclusions of the lead attorney in this case, University Audits reviewed the particulars of this matter, as well as the overall

status of safety and security operations at the University. During the course of review by University Audits, a number of observations were made involving the identification, reporting and handling of security and criminal investigations across the organization.

University management acknowledges the history of difficulties between DPS and Hospitals and Health Centers Security (HHC-Security). We accept the findings by University Audits that tensions between the two organizations contributed to the failure to report allegations of child pornography in May. We are determined to resolve these differences and create a positive safety and security culture across campus.

University Audits made a number of important recommendations to address the specifics of the incident in question as well as the systematic problems that contributed to it. Management accepts the recommendations and is committed to pursue the recommendations with strengthened policies, procedures, and training to prevent future lapses in protecting the safety and security of the patients we serve and the entire campus community.

Though not involved in this incident in any way, we believe it is important that Housing Security participate in our comprehensive efforts to ensure the development and implementation of a shared security vision campus-wide. The recommendations outlined below, therefore include Housing Security.

Specifically, Health System and Central Campus managers and staff will work together to develop an integrated response, reflecting the collaboration and interactions required to implement positive and sustainable changes in policies, practices, orientation, training, and culture. Some of the recommendations outlined in the audit report and this management plan are established or works in progress. Other recommendations will be pursued for timely implementation as summarized below.

Recommendation: **Develop an extensive set of common guidelines and protocols for reporting security incidents throughout the University.** The protocols need to be actionable and should establish clear communication and procedures for hand-off of cases between University safety and security organizations. These practices can be in the form of checklists, online training, decision trees, and formal policies and procedures.

> **Management Response:** Leadership in the following departments and offices will work collaboratively to develop recommendations for common guidelines regarding suspected criminal activity: Office of General Counsel, Health System Compliance Office, Health System Risk Management, Hospitals and Health Centers Security (HHC-Security), Housing Security, DPS, and others as appropriate.
>
> It will be made clear that, pursuant to these guidelines, suspected criminal activity is to be reported to the Department of Public Safety for investigation. An action plan consisting of draft policies, procedures, and other material with timelines needed to implement this recommendation will be written within 90 days.

Recommendation: **Raise awareness of the patient, employee, and student privacy rules.** Law enforcement and security officers should receive regular HIPAA and FERPA training to raise awareness and sensitivity to privacy. Commonly understood definitions are needed for when and under what circumstances protected information should be shared with security and law enforcement agencies. A streamlined process is needed when there is suspected criminal activity to ensure relevant protected information is shared with law enforcement through means that are legally appropriate.

> **Management Response:** It is essential that all safety and security personnel have broad understanding of the laws that govern access to student and patient records. While we have no

doubt that there are key staff members in all of our safety and security offices with deep understanding of HIPAA and FERPA, we are committed to broadening this knowledge. The Office of the General Counsel has the lead to develop the training plan, with support from HHC-Security, Housing Security, DPS, Human Resources, and the Health System Compliance Office. The plan will be developed, including a schedule for implementation within 90 days.

Recommendation: **Foster better understanding and sensitivity of duty to report requirements.** Develop legal guidance and training to help responders navigate the complexities and grey areas of reporting suspected criminal activity.

> **Management Response:** Management will issue a memo to deans, department heads, and directors as a reminder of the importance and obligation of the duty to report suspected criminal activity in accordance with relevant law. This memo will be issued by February 20, 2012.
>
> We will prepare a plan to provide all safety and security personnel a working understanding of the potential conflicts in the "duty to report" requirements and privacy requirements under various laws, such as those governing health care, education, victim and whistleblower protection, and the Clery Act and how those sometimes conflicting requirements should be balanced in the health care and campus environment.
>
> A specific training program will be developed by OGC with support from Human Resources, within 90 days, with training to be initiated no later than 120 days. Refresher training will be offered on an annual basis.

Recommendation: **Review the use of 911 triage and dispatch.** DPS and HHC-Security should have formalized dispatch procedures for the operation of the facility control center. Security officer responders should clearly identify themselves as security and not law enforcement.

> **Management Response:** Health System and Central Campus leadership are committed to review 911 public safety answering points (PSAP) requirements and standard operating procedures to ensure the response to every 911 call is held to the highest standards of effectiveness, coordination, and efficiency. This review will be initiated by March 1, 2012.

Recommendations: **Create a shared communication system that facilitates accountability and cooperation.** Both HHC-Security and Housing Security need to be aware of crimes that have occurred in nearby areas of their responsibilities. Shared reporting mechanisms should be seamless, designed to share University-wide safety and security information, and facilitate communication protocols and decision processes.

> **Management Response:** DPS, HHC-Security, and Housing Security management recently met to discuss the impact of CLEMIS on information sharing and to develop a process for HHC-Security and Housing Security to access safety and security information that meets criminal justice information requirements. Both HHC-Security and Housing Security need to be aware of crimes that have occurred in nearby areas of their responsibilities. Shared reporting mechanisms should be seamless and designed to share University-wide safety and security information, and facilitate communication protocols and decision processes.
>
> The first phase of providing access to the DPS Security Center was implemented on February 3, 2012.

Recommendation: **Formally debrief on major security incidents.** Develop a process that gathers all groups involved in a case to discuss what worked well and what could have been done better. Learn from the experience so that positive actions are reinforced and the things that did not work to the satisfaction of everyone involved are discussed and resolved so that the process will be improved the next time there is a similar incident.

> **Management Response:** Existing debrief processes are currently utilized in the University, including in the U-M Office of Emergency Planning and at the Health System through its Office of Clinical Affairs, following significant or "adverse" events.
>
> These processes will be utilized on a more routine basis after major security incidents occur, to ensure an opportunity for "lessons learned" sessions. Part of this process will be to determine what worked well and to identify opportunities for improvement in a problem-solving and non-blaming atmosphere. Immediately, these sessions will occur after major security incidents and, in the future, the sessions will be based on procedures developed as a result of this management response.

Recommendation: **Develop ongoing team-building training programs.** Develop a comprehensive training program that builds knowledge and understanding of process from all perspectives, and builds a collaborative team effort for addressing many types of issues. Training can assist all parties understand the reasons for perspectives and regulations that impact the prescribed protocols, actions, and philosophies of others involved in a particular chain of response. Training should encompass the viewpoints of all parties and be attended by a cross-section of safety and security organizations.

> **Management Response:** We are committed to develop an active training program to ensure knowledge and understanding as central to a team-building effort between and across all safety and security units. This training will be integrated with other training efforts described earlier, developed in consultation with the Office of the General Counsel, Health System Compliance Office, Human Resources, DPS, HHC-Security, Housing Security and other units as necessary. This training program will be developed within 90 days and initiated within 120 days. The leadership of the security units will be responsible to provide orientation and refresher team training on a regular basis (at least twice per year).

Recommendations:
- **Review the reporting lines and communication structure of police and security units.** Benchmark with other universities to provide examples of effective safety and security models. Consider the optimal structure given the complexities of our University for ensuring public safety and security.
- **Consider a DPS liaison office within the Health System.** There is no consistent DPS presence within the hospital. DPS officers are only interacting with hospital faculty and staff when there is a criminal investigation or an emergent situation. This contributes to tense working relationships and miscommunication.
- **Develop cross-functional teams.** Safety and security teams should be defined by incident type, and will ensure that the right skill sets are matched to respond to the particular issue. Teams should meet regularly in non-crisis mode to further develop understanding and trust.

Management Response: We are committed to exploring best practices and to determine if alternative approaches might yield benefit to the University. We will benchmark against peer institutions to review police and security reporting lines and organizational structures, with a benchmarking report completed within six months.

Regarding the liaison idea, we will expand options to enhance visibility of DPS officers in the patient care environment, including routine orientation, training, and unit visits. Our goals include improved communication, collaboration, and outreach. We will include the liaison office or officer concept among the options available to meet these goals.

The leaders of HHC-Security and DPS will provide an action plan to enhance ongoing DPS presence within 90 days.

Recommendation: **The culture must change.** Define a plan to enhance team culture. Engage an outside expert to work with the leaders of the various security units and related areas to examine cultural issues that limit achievement of the common goals of the various units. This could be accomplished through a series of facilitated offsite meetings that bring the various parties together with a single vision. Without a cultural shift there will continue to be breakdowns in the effectiveness of the organization as a whole.

> **Management Response:** We believe that creating a culture of mutual respect and understanding is essential to creating a safe and welcoming environment for all. We will develop an approach to measure the culture and identify ways to enable an improved sense of collaboration and teamwork between and across our safety and security units.
>
> Management accepts the recommendation to bring in external expertise for a full assessment of the working relationship and operational issues with HHC-Security, DPS, and the units with whom they interact regularly, in order to address significant cultural and management issues that have arisen in the course of this internal review.
>
> The University's Associate Vice President for Human Resources, the Health System's Chief Human Resources Officer, and the Associate Vice President for Student Affairs have accepted lead roles to retain one or more outside experts who will assess our safety and security culture and help us achieve needed change. The outside expert(s) will be brought on board by April 1, 2012, and an implementation plan and schedule will be developed within the following 60 days.

Report Conclusion

Everyone that we interviewed was dedicated to providing safety and security for the people, places, and things in their sphere of responsibility. Because there is limited sharing of information or collaboration in planning and execution of incident response, there is significant difference in approach and outcome. Without an in-depth, facilitated culture shift, policies, procedures, and protocols will not be universally understood and accepted or have long-term viability.

University Audits will conduct quarterly follow-up reviews until all noted risks are appropriately mitigated. These reviews will begin June 2012.

Addendum I
Chronology of Events

The chronology is based on interviews the Office of University Audits conducted. Dates and events are outlined according to the best recollections of those interviewed.

5/23/11 - Monday

- Late in the evening, a female pediatric resident (Female Resident) discovers a USB thumb drive left in a computer in a medical residents' lounge. In an attempt to identify the owner so that she can return the drive, she opens files on the USB thumb drive and sees the name of a male medicine-pediatric resident (Male Resident) on a document in one of the files. Another file contains a picture of adult pornography; a third contains a photo that she believes may be child pornography. She panics, closes the files, and leaves the residents' lounge, leaving the USB thumb drive. She goes home for the night.

5/24/11 - Tuesday
- The Female Resident returns to work in the morning and goes back to the residents' lounge to retrieve the USB thumb drive, but it is gone.
- The Female Resident reports what she saw to the Attending Physician on the same service. The Attending Physician consults with the Chair of the Medical School Department Compliance Officers (Compliance Chair).

5/25/11 - Wednesday
- The Compliance Chair contacts the Health System Chief Compliance Officer (Chief Compliance Officer). The Chief Compliance Officer arranges for the Compliance Chair to make a report to the Office of General Counsel (Health System Legal Office), and Hospitals and Health Centers Security and Entrance Services (HHC-Security).
- The Compliance Chair speaks with an attorney from the Health System Legal Office and an HHC-Security Supervisor, and relates the Female Resident's allegations.
- Within the Health System Legal Office, the attorney assigned to medical staff affairs assumes the lead role in the case (Lead Attorney). The attorney who took the original report continues to assist the Lead Attorney throughout the Health System Legal Office investigation (Assisting Attorney).
- The Attending Physician and the Compliance Chair arrange for the Female Resident to meet with HHC-Security. The Female Resident recounts the information described above (5/23) to the HHC-Security Supervisor and an HHC-Security Officer.
- After the meeting, the Female Resident and the HHC-Security officers go to the residents' lounge to look at the computer in question.
- The HHC-Security Supervisor contacts a Data Security Analyst in MCIT (Medical Center Information Technology) and requests assistance in analyzing what information can be gathered from the computer hard drive.
- The HHC-Security Supervisor leaves a voicemail for a Department of Public Safety (DPS) Police Sergeant asking whether DPS could provide some forensic assistance with images viewed on a computer from a USB thumb drive. (The phone message to DPS was never returned.).
- The Assisting Attorney sends an e-mail to the Data Security Analyst and the HHC-Security Supervisor. They are advised that their work is confidential and under attorney client privilege. The text of the e-mail can be found in Addendum II.
- The attorneys follow up with a confirming call to the HHC-Security Supervisor.
- The HHC-Security Supervisor told University Audits he did not complete a report to the police because of the e-mail (Addendum II) from the Health System Legal Office that he believed meant he should stop.
- The Data Security Analyst begins providing the attorneys with the May 23/24, 2011 computer records that confirm that the Male Resident in question logged into the computer before and after the reporting Female Resident. There were no other intervening log-ins during that time frame.

5/26/11 - Thursday

- The Health System Legal Office requests a meeting with the Female Resident. Due to scheduling conflicts, the meeting is set for 5/31, and then rescheduled to 6/2.

6/2/11 - Thursday
- The Lead Attorney interviews the Female Resident; the Assisting Attorney could not be there due to scheduling conflicts. The Female Resident leaves the interview crying.
- The Lead Attorney tells the Assisting Attorney that the Female Resident was unsure of her story and what she saw.

On or about 6/2/11
- The attorneys call the Health System Chief Compliance Officer and relay that there is not sufficient evidence to move forward, that the Health System Legal Office's assessment was that the Female Resident's story was shaky.
- The Lead Attorney reports to the Associate Vice President and Deputy General Counsel (Health System Affairs) that there was no evidence and that the case would be closed.
- The Female Resident texts the Attending Physician to tell her the meeting did not go well. She says the attorney told her the investigation is complete and the claims are unfounded. There was no evidence of child pornography on the computer. The Attending Physician tells the Female Resident she wants to follow up with the attorney, but the Female Resident asks her not to.

6/9/11 - Thursday
- The last day of employment of the Lead Attorney. The attorney's departure is unrelated to the case.

11/11/11 - Friday evening
- One of the original reporting physicians (Attending Physician) contacts (via phone call) the Risk Management Top Executive who is part of the Office of Clinical Affairs in the Health System. Two recent events caused the Attending Physician to come forward to raise questions about the case:
    - She learned that the attorney who had investigated the case in May (Lead Attorney) had left the University.
    - The Penn State incident occurred.
- The Attending Physician expressed concern about the treatment of the Female Resident and the outcome of the May case. The Risk Management Top Executive tells her this is the first time he had heard of the allegations.

11/12/11 - Saturday
- The Risk Management Top Executive meets with the Female Resident who originally found the USB thumb drive.
- The Risk Management Top Executive briefs the Chief Medical Officer for the Health System about the Attending Physician's phone call and the meeting with the Female Resident.

11/14/11 - Monday
- The Risk Management Top Executive contacts the Deputy General Counsel (Health System Affairs) and shares the Female Resident's account of the May incident and the Health System Legal Office meeting.
- The Chief Medical Officer confers with Chair of the Department of Pediatrics and Communicable Diseases (Pediatric Chair), and confirms that the Male Resident will be carefully supervised until

appropriate action including precautionary suspension under the Medical Staff Bylaws can take place.
- Efforts were made to schedule a meeting with the Female Resident. It took several days to bring everyone together.

11/17/11 - Thursday
- The Chief Medical Officer, the Director of Pediatric Education, and a Health System Legal Office attorney meet with the Female Resident. She speaks in detail about what she saw on the drive, and they find her account convincing.

11/18/11 - Friday
- The Office of Clinical Affairs and Health System Legal Office make a report to HHC-Security, with the understanding that they will immediately make a report to the Department of Public Safety (University Police-DPS).
- HHC-Security reports allegations to DPS.
- DPS advises the Office of Clinical Affairs and Health System Legal Office that they will send a detective to begin investigation but then determine that no detective was available until Monday, 11/21/2011.

11/21/11 - 12/02/11
- DPS conducts investigation: interviewing numerous witnesses, obtaining forensic evidence, and reviewing the case with the Prosecuting Attorney (11/21 – 12/16).
- Clinical Affairs and others aware of the allegations are asked by DPS not to contact the Male Resident or tell others. They are told not to remove him from service as it would alert him and evidence could be destroyed.
- The Chief Medical Officer reviews the Male Resident's files, and notes no performance issues or patient complaints. The Chief Medical Officer and department leadership continue active monitoring of the Male Resident.

12/2/11 - Friday
- A warrant to search the Male Resident's home is issued and executed.
- Chief Medical Officer and Chair of Internal Medicine issues precautionary suspension of the Male Resident's patient care responsibilities, pending the outcome of the investigation. (Male Resident is a clinical trainee in a joint internal medicine/pediatrics program.)
- President Coleman is notified.

12/3/11 - Saturday
- President Coleman asks the Executive Director of University Audits to conduct an internal review, to determine the underlying control failures that caused the delay, and recommend changes.
- Executive Director of University Audits notifies Regent White, Chair of the Finance, Audit, and Investment Committee of the Board of Regents.

12/16/2011 - Friday
- The Male Resident is arrested by DPS officers.
- The Executive Committee on Clinical Affairs unanimously voted to summarily suspend the Male Resident's appointment as a clinical program trainee effective immediately.
- The University of Michigan Graduate Medical Education Office discharged the Male Resident from his Medicine-Pediatrics residency training program effective 12/16/2011.

12/17/11 - Saturday
- The Male Resident is arraigned on charges of possession of child pornography.

Addendum II
Text of e-mail sent to Data Security Analyst and HHC-Security Officer on 5/25/2011

Per our conversation, The Office of the General Counsel (OGC) would like you to pull the windows event logs from May 23rd for the computer terminal in question located in the pediatric resident room. We are interested in determining who used the computer on May 23rd and, if possible, what programs or files were accessed by each user (the "Task").

The OGC is enlisting your assistance and delegates the necessary authority to you on behalf of the OGC to carry out various tasks that will aid the OGC in the investigation and defense of actual or anticipated litigation. All such tasks will be directed by counsel in the OGC. The objective of this engagement is to gather and review documentation related to the Task. Your principal role will be to assist legal counsel in collection and review of this information. You will inform us of any related matters that come to your attention, and all communications between you and us, shall be regarded as confidential and made solely for the purpose of assisting us in rendering legal advice, and therefore, is subject to the attorney-client privilege and the attorney work product protection. Since we are engaging you to assist us, we intend that all of the activities that you undertake pursuant to this delegation of authority also will be subject to all privileges and protections applicable to the OGC attorneys.

It may be necessary for us to disclose to you our legal theories, as well as other privileged information and attorney-work product "Confidential Information." You agree that during and after the period of your engagement you will not disclose any Confidential Information to any person or entity to whom disclosure has not been previously authorized (in writing) by us. Please do not disclose to anyone, without our prior written permission, the nature or content of any oral or written communication with us in the course of this engagement. We ask that you communicate only with attorneys in the OGC about substantive issues, the results of your activities, or any questions that you may have.

e-Verify   #2011-402
Report issued February 20, 2011

E-Verify is a free, web-based program developed and supported by the Department of Homeland Security (DHS) and the United States Citizenship and Immigration Services (USCIS) in partnership with the Social Security Administration (SSA) that assists employers in determining if employees are authorized to work in the United States. Based on information provided by the employee on the Employment Eligibility Verification Form I-9 (the Form I-9), employers use the E-Verify system to electronically check the employee's work eligibility in real time against DHS and SSA databases.

In September 2009, final rules became effective that require the use of the E-Verify system by federal contractors who are granted contracts containing the Federal Acquisition Regulation (FAR) E-Verify clause. Federal contractors were given 30 days to enroll and 90 days to begin use of the system. The University of Michigan enrolled as an E-Verify employer in October 2009, and began verifying employees that December. At the University, there are five sites where employees can be E-Verified: University Human Resources, Immigration Services, the Institute for Social Research, the Medical School, and UM-Dearborn Human Resources.

As of November 2011, the University has identified approximately 80 federal contracts that require the use of E-Verify, which account for almost $139 million dollars of federal research funding. Compliance with E-Verify program requirements is imperative as any instance of noncompliance may result in criminal and financial penalties, including the loss of federal funding.

The E-Verify Process
To use the E-Verify program, the University was required to electronically sign a Memorandum of Understanding (MOU) that outlines the terms, conditions, and penalties associated with E-Verify enrollment. Some responsibilities that are specific to the employer include:

- Initiating verification of employees within specified time periods
- Acknowledging that the information received from E-Verify is governed by the Privacy Act
- Following Tentative Non-Confirmation (TNC) result procedures, including notifying employees in private and retaining all documentation as required
- Displaying notices of E-Verify employer participation in prominent, clearly visible places

Definition of a Covered Contract – There are specific criteria that must be met before a federal contract is considered an E-Verify contract. When a contract meets these requirements, it is the responsibility of the government to specifically reference the E-Verify FAR clause in the contract. At the University, all award documents are received by the Office of Research and Sponsored Projects (ORSP). The documents are reviewed by ORSP project representatives and their support staff to determine if the award is sourced from a contract, subcontract, grant, or cooperative agreement. The E-Verify FAR clause does not generally apply to grants or cooperative agreements. Contracts are reviewed for a variety of clauses that require University compliance, including the E-Verify FAR clause. If the contract contains the E-Verify FAR clause, it is flagged as an E-Verify contract in eResearch, the University's electronic system for research administration.

Scope of Employees to be E-Verified – For certain federal contractors, enrollment in E-Verify and verification of the entire workforce is required; however, institutions of higher education qualify for an exception. Higher education federal contractors have the choice to verify either their entire workforce or only those employees working directly under an E-Verify contract (i.e., covered employees). When the University enrolled as an E-Verify employer, the choice was made to verify only those employees assigned to a covered contract. Since enrollment in the program, approximately 500 employees have been E-Verified.

E-Verify Time Periods – New hires that will work under an E-Verify contract are required to be verified within three days of hire. Existing employees are required to be verified within 30 days of assignment to a project funded by an E-Verify contract. By signing the MOU, the University agreed to verify only covered employees and not to verify employees under false pretenses or for any other purpose (e.g., pre-employment screening).

The Immigration Reform and Control Act (IRCA) of 1986 prohibits employers from knowingly hiring individuals who are unauthorized to work in the United States. IRCA mandated the use of the Form I-9, for each hired individual. Until E-Verify, there was no way to determine if the information or documents provided by employees during the I-9 process were valid. E-Verify authorization results are provided to the employer within seconds and provide assurance that the University is maintaining a legal workforce.

In most cases, the E-Verify result is "Employment Authorized," though sometimes the program cannot immediately confirm if an employee is authorized to work. In the event employee information does not match DHS or SSA records, the result is a Tentative Non-Confirmation (TNC). This result does not mean the employee is not authorized to work in the United States; just that additional action is required of both the employee and the employer. When an employee receives a TNC they can choose to contest or accept the result. If they accept the result, they are terminated. If an employee chooses to contest a TNC, they are, by law, to remain working until a final resolution has been received.

E-Verify Notice Requirements – A specific responsibility of the employer detailed in the MOU is to display E-Verify notices supplied by DHS in prominent places that are clearly visible to prospective and current employees. These notices include the English and Spanish versions of the Notice of E-Verify Participation and the Office of Special Counsel Right to Work poster.

E-Verify System User Access – The *E-Verify User Manual,* published by USCIS, provides guidance to federal contractors regarding user roles and passwords. Employers may choose how to administer and review their employee's user access. Instructions are included to help program administrators generate existing user reports and update company information, including adding and deleting user access. Customer and technical support numbers are provided for additional assistance.

The primary audit objective was to determine the adequacy and effectiveness of the University's E-Verify procedures to ensure compliance with federal government program requirements. Audit procedures included interviews with key personnel from University Human Resources, ORSP, Human Resource Records and Information Services (HRRIS), Sponsored Programs, and the Office of Contract Administration.

A review of policies and procedures at all five verification sites was performed and a review of E-Verify program user access was conducted. Sample testing of contracts and subcontracts was performed to assess the accuracy of E-Verify contract identification as well as documentation and retention procedures for compliance with the MOU. Employees paid from an E-Verify project were reviewed to confirm their verification was necessary and timely.

Risk and Control Discussion
Opportunities to improve existing practices have been shared with management and are discussed below.

- Contract Identification – ORSP receives award documents and identifies the project type (e.g., grant, contract) in eResearch before submitting projects to Sponsored Programs. Sponsored Programs assigns a shortcode, which is required to process payroll and other expenses for the projects. Prior to the assignment of a shortcode, Sponsored Programs performs a secondary review of the award documents. Staff review the fully-signed documents attached to a project in eResearch to determine, among other things, if the contract contains the E-Verify FAR clause and if the project is properly identified. If it is not, the project is sent back to the responsible project representative in eResearch to be corrected and resubmitted.

   ORSP, Sponsored Programs, and HRRIS each maintain a different listing of contracts containing the E-Verify FAR clause. These listings are not reconciled or communicated among units. University Audits noted several discrepancies among the listings. For example, a grant was recorded in eResearch as an E-Verify contract. Accurate identification of award documents helps to avoid unnecessary verification of employees. As another example, some signature date fields were blank. This information is useful for tracking and monitoring timeliness.

   Management Plan – ORSP has a process that identifies parent projects that have the E-Verify obligation. The PAN (Project Award Notice) contains a note that informs the department about proper procedures. Departments that request a subproject and were not the parent project department recipient may not always receive pertinent E-Verify information. Sponsored Programs will create a process to notify departments receiving a subproject based on an E-Verify parent project of the E-Verify requirements. ORSP has created a Business Objects query that details all flagged E-Verify parents and subprojects to aid in this process. Sponsored Programs will determine which individuals should have access to the query as well as if additional

information would be helpful (e.g., E-Verify signature date). The final process will be documented.

In regard to education, ORSP and Sponsored Programs train new staff about the applicability of E-Verify (i.e., when it is likely to apply, when to look for it in contracts, and what to do when they see it). The staff are periodically reminded about this and other compliance processes. Most recently, project representatives were reminded about accurate project type use at one of their biweekly meetings in January. Support staff will be reminded at their monthly meeting in February. Within Sponsored Programs, staff has been trained on completing the project template in its entirety (making sure the date field is appropriately filled out).

A reconciliation of E-Verify projects (parent and subs) will be done once a year, at the same time the WebNow and Visa Permit Table are reviewed. In the long term, the reconciliation may become obsolete when ORSP and Sponsored Programs create an authoritative table of parent projects with start and E-Verify signature dates.

Auditor's Note: If leadership from ORSP and Sponsored Program continue to identify anomalies, the joint creation of a job aid detailing the criteria of project types and other necessary information in eResearch may be useful for new and current staff.

- Identification of Employees – As a check to ensure units have identified all covered employees, HRRIS created an Access query using University system appointment and payroll data. The query identifies employees assigned to or paid under an E-Verify project shortcode. Procedurally, HRRIS sends the results of the query on a weekly basis to unit personnel to ensure covered employees are verified within the required time period. HRRIS has begun documentation of this process for continuity of operations. Sending the query has unintentionally created a reactive response, where some units are relying on the query results to begin initiating employee verification.

While the query is a helpful monitoring tool, by not identifying employees proactively, employees may be unnecessarily verified or not verified within the required time period. There have been a significant number of untimely verifications that have occurred since enrollment in the program. One contributing factor is that principal investigators may hire staff on a covered contract without informing Human Resources or informing them after the fact.

Management Plan
- o *Education of Principal Investigators and Administrative Staff:* This has been done in previous training sessions and presentations and continues on an ongoing basis with units. Communications from the E-Verify Compliance Officer to units continues to emphasize the importance of accurate appointment and pay data. This emphasis will continue as part of the education and awareness program that will be developed. Additionally, a set of procedures/checklist for HRULs will be developed and implemented to aid in timely identification of employees. ORSP will review the actual language of the E-Verify project notification to ensure that it appropriately makes this distinction and will adjust as necessary.
- o *Weekly Appointment and Payroll Data Queries:* In the short term, the goal is to generate and send the report on a weekly basis. HRRIS will focus on enhancing the existing report queries. Documentation and identification of a skill set/competency as backup to the HRRIS Audit Report will be established. Procedures for generating the report will be documented. The current capacity of ITS resources is limited. Long-term efforts are dependent on the result of Administrative Services Transformation (AST) efforts. If an

ITS resource is recommended by AST, HRRIS will coordinate with ITS to systematize the report to the extent possible. If an ITS resource is not recommended, the report remains more analytical and less systematic, potential for weekly turn-around diminishes.

- o *Allowable Project Charges*: This assessment will include input from University Human Resources, ORSP, the Office of Sponsored Programs, the Office of Vice President for Research, and other key stakeholders. Current processes used by Sponsored Programs to identify unallowable charges for similar noncompliance issues will be adapted for E-Verify noncompliance. Sponsored Programs should work with the E-Verify Compliance Officer and HRRIS to:
    - Establish the criteria for what constitutes an unallowable charge (e.g., charges to a shortcode for an individual that has not been E-Verified)
    - Develop a process for identifying unallowable charges
    - Inform Sponsored Programs to initiate the process for reversing the charges
    - Document the process, including the responsibilities of each stakeholder
    - Create a communication plan in collaboration with OVPR leadership to inform all HRULs, site managers, etc. of the upcoming process change.

Auditor's Note: The Director of Sponsored Programs has agreed to implement the removal process immediately upon receipt of a defined process from the E-Verify Compliance Officer and the HRRIS Business Systems Analyst.

- o *Internal Controls Analysis*: Existing language associated with the E-Verify requirement for federal contracts will be reviewed, enhanced as deemed appropriate, and included in the internal controls matrix to increase awareness and compliance by unit-level management.

The feasibility of incorporating a fiscal year trend analysis reports will be assessed using input obtained from personnel in HRRIS.

Auditors Note: If this recommendation is determined to be feasible, work with the Internal Controls Coordinator for help in the design of the report implementation and inclusion in the current control matrix.

- • Document Retention – E-Verify employers are required to retain accurate records of employees that have been E-Verified. To aid in compliance of this requirement, all E-Verified employees complete a new paper Form I-9; the I-9 is then imaged and stored in WebNow, the University's imaging system. Employers are required to give a TNC (Tentative Non-Confirmation) notice to employees that receive a TNC result. The notice explains the reason for the TNC and the employee's right to contest it. Employers are required to retain all signed notices. If the employee decides to contest the TNC, they must then sign a referral letter. The referral letter must also be retained by employers. Audit testing showed that documentation for some employees that received a TNC result was not retained.

Management Plan
- o *Documented Explanations*: Significant events of noncompliance will continue to be reviewed with the Office of General Counsel, the Faculty and Staff Immigration Services Unit in the International Center, and outside counsel as appropriate. Instances of noncompliance will be documented and retained in WebNow, in an appropriate area with limited access. Procedures that outline this process will be documented.

- o *TNC Monitoring*: The current process requires E-Verifiers to send an email notification to the E-Verify Compliance Officer when a TNC arises. The E-Verify Compliance Officer will work directly with the E-Verifiers to ensure completeness of documentation and retention in WebNow.
- o *WebNow and Visa Permit Table Review*: HRRIS will conduct an annual review of E-Verify employees flagged in WebNow and verification numbers entered into the Visa Permit Table to ensure that all employees E-Verified in the previous 12 months have the appropriate reference, documentation, and data using the E-Verify system record as the authoritative source.

- E-Verify Notice Requirements – It was observed that not all verification sites displayed the required E-Verify posters. The posters, offered online from USCIS, inform current and prospective employees of their legal rights and protections.

  Management Plan – Spanish versions of the required posters were missing from two locations. A reminder notice will be sent by management, with a link to print the federally required posters, to the E-Verify site managers. Additionally, site managers will be required to confirm, in writing, site compliance with E-Verify posting requirements.

- Subcontract Language – As a federal contractor, the University has an obligation to ensure subcontractors performing work under a covered contract are also enrolled in E-Verify as an employer. The University is not required to verify individual employees of subcontractors. When a subcontract is based on a covered FAR contract, staff in the Office of Contract Administration inserts assurance language that states that by signing the subcontract, the subcontractor certifies they are enrolled in the E-Verify program.

  Currently, the Office of Contract Administration includes the E-Verify assurance language in all subcontracts based on a federal contract, whether or not the contract is a covered E-Verify FAR contract. Because verification requirements do not apply to grants or contracts that do not specify the clause, verification of employees is not required.

  To reduce the potential for the improper verification of employees, the E-Verify assurance language is only required in those subcontracts that are based on a federal contract containing the E-Verify FAR clause.

  Management Plan – In the short term, the FAR E-Verify language will continue to be flowed down to all subcontractors for projects awarded under federal contracts. We feel as though this is an appropriate risk mitigation strategy and this has been agreed to by the Office of General Counsel. The Office of Sponsored Programs will work with the Office of General Counsel to develop the most effective means to adjust flow down language in those contracts that are subject to E-Verify and obtain proof of enrollment from subcontractors in the format suggested by the USCIS.

- E-Verify System User Access – While not specifically required by the federal government, the E-Verify Compliance Officer conducts periodic reviews of E-Verify system access to ensure that only active and appropriate users have system access. Documented procedures regarding user access reviews would support the work performed, specifically procedures for granting, removing, and reviewing the access. Some backup E-Verify users have not completed the mandatory E-Verify tutorials, preventing them from verifying employees within the program until the tutorials are successfully completed. This situation could delay timely employee verification.

Management Plan – Processes in place to monitor and control access will be documented, reviewed with the E-Verify Process Planning group, and implemented. These processes will include standards for frequency of use of the E-Verify system in order to maintain access. The E-Verify system does not proactively notify users of new tutorials released by USCIS. As a best practice, the E-Verify Compliance Officer will continue to send out email notifications to system users when new tutorials are identified. A confirmation email from users detailing their successful completion of the tutorial will be required to ensure users remain active within the system.

- Future Considerations – At the end of audit testing, the results were shared with key stakeholders from ORSP, Sponsored Programs, Human Resources, HRRIS, Office of General Counsel, and the International Center. A discussion ensued regarding current process concerns and future challenges. As the University continues to receive federal contracts that contain the E-Verify FAR clause, the number of employees requiring verification will likely increase. In addition, the likelihood of state and federal mandates requiring the verification of all new hires in the next one to two years is high. The need for structuring current procedures to support program compliance while also planning for future challenges was recognized by all. The following are options presented by the stakeholders for consideration:
  a. Use satellite Human Resources offices or develop a shared services model for existing verification sites. Centralization of compliance requirements in offices with knowledgeable staff will allow for a more structured approach to accurately completing I-9s and E-Verifying employees within the required time periods. Build a project into the annual Human Resources work plan to analyze the cost-benefit of resources involved in centralizing these compliance requirements. Developing a comprehensive process for new hires will increase awareness of E-Verify, leading to greater overall compliance of established processes, specifically the I-9 process.
  b. Work with ITS to consider adding system edits. Edits to department budget earnings transactions could prevent salary charges to an E-Verify shortcode from being processed until employees have been verified. Edits to Human Resources transactions could prevent employees from being assigned to an E-Verify shortcode until they have been verified.
  c. Capitalize on the developing trend within academic units to centralize hiring and employment functions. This will allow for the centralization of I-9 and E-Verify responsibilities, which can then be performed by Human Resources staff that have specialized training and experience for handling these compliance initiatives.
  d. Implement an ongoing, effective education program that supports outreach and awareness of E-Verify requirements for ORSP and Sponsored Programs staff, Human Resources Unit Liaisons, and site administrators. Program elements may include training tools or required annual assessments in MyLinc.
  e. Establish procedures for periodic assessment of E-Verify compliance. For increased accountability, consider reconstituting the Faculty and Staff Immigration Services Advisory Group. Quarterly group meetings may help facilitate hiring process discussions and prepare the University to better accommodate future government mandates.

Management Plan
  a. In the short term, the concept of creating "satellite offices" and/or shared services model is consistent with the University's current AST efforts. The review of these concepts is now being considered as part of AST efforts. Depending on the result, this may be

incorporated into the fiscal year 2013 HR planning process for assessment as it relates to E-Verify processes and procedures.

    b.   Exploration of the necessity and feasibility of this recommendation is largely dependent upon the success of the process developed to prevent and/or retroactively stop unallowable charges from being applied to an E-Verify project. If this recommendation is determined to be necessary, it is dependent on the result of AST efforts. Due to the limited ITS resources available, if an ITS resource is recommended by AST, HRRIS will coordinate with ITS, University HR, and Sponsored Programs to identify charges (e.g., retroactive transfers, reversals) to be targeted for assessment.

    c.   Centralization and shared services are being reviewed as part of the University's current AST efforts. Depending on the result, this may be incorporated into the fiscal year 2013 HR planning process for assessment as it relates to E-Verify processes and procedures.

    d.   Guidelines for an ongoing education and awareness program will be developed to increase the knowledge and skill set of those individuals within the E-Verify process (e.g., HRULs, site managers). At a minimum the education will include:

- Steps for proactively identifying employees that require E-Verification
- Consequences for noncompliance
- Distinction between informal communications and those that require action
- Ensure awareness of submitting accurate appointment and payroll data for employees

    e.   This recommendation will be discussed between the E-Verify Compliance Officer and the head of the Faculty and Staff Immigration Services Advisory Group. Procedures for periodic assessment will be documented and communicated as necessary to individuals with a role in the E-Verify process.

As a research institution, the University of Michigan receives grants and contracts to fund research activity from the federal government. Noncompliance with E-Verify program requirements puts this funding at risk. There are several challenges that employers face in maintaining compliance with E-Verify requirements, including accurate identification of E-Verify contracts, timely and necessary verification of employees, and retention of required documents. To mitigate these risks, the E-Verify Compliance Officer has consistently worked to educate and train numerous employees about program requirements and consequences of noncompliance. Comprehensive training manuals have been developed and are regularly utilized at verification sites. Additionally, the University's E-Verify website is easily accessible and highly informative, clearly explaining the E-Verify process. These initiatives have helped to promote a compliant environment.

The University enrolled as an employer in the E-Verify program less than three years ago. In that time, great progress has been made in developing verification procedures that ensure compliance with federal requirements. By implementing the audit recommendations and strategizing today for future program changes, the University better positions itself to more quickly adapt to legislative mandates while continuing to focus on compliance.

University Audits will follow-up during the first quarter of fiscal year 2013 to assess the progress made on corrective action plans.

Rackham Graduate School Institute for Human Adjustment   #2012-219
Report issued February 27, 2012

The Institute for Human Adjustment (IHA or Institute) was established in 1937 through a gift from Mary Rackham and special grants from the Horace H. Rackham and Mary A. Rackham Fund. The

funds were designated for use in training programs, research programs, and providing speech therapy and mental health services to the residents of Southeastern Michigan.

The Institute started with a Speech Clinic and a Psychological Clinic. The following year, a Sociological Research Unit was created to provide research into the problems of social adjustment, speech, and speech disorders as well as to provide a basis for diagnostic and treatment programs. The clinics functioned as independent units working under the auspice of the Institute.

Today, the Institute is comprised of a central office and three centers designed to provide training to graduate and postgraduate students, provide clinical services to meet the diverse needs of the local community, and facilitate collaborative research related to its mission.

- The University Center for the Development of Language and Literacy (Language and Literacy Clinic) provides language and literacy services to adults and children in Southeastern Michigan. The clinic's University of Michigan Aphasia Program is nationally recognized and serves clients from all across the United States. A major focus of the clinic's research for the past decade has been to improve understanding of the oral language and literacy skills of African American students.
- The Institute's Psychological Clinic provides individual, couples, and group therapy in addition to psychological testing and assessment for local adult residents with moderately debilitating conditions such as depression and anxiety disorders. The clinic provides training for clinical psychology and social work through internships and supervised predoctoral and postgraduate training.
- The University Center for the Child and the Family (Child and Family Clinic) provides a range of mental health services for children and families in the community. Training is provided to clinical psychology and social work graduate students, as well as to psychology postdoctoral fellows and social work postgraduate fellows, who provide care under the supervision of the clinic's professional staff.
- The centers are supported by a central office, which provides overall leadership and strategic planning, spearheads Institute-wide initiatives (Invited Lecture Series, Adjustment Matters Community Forum, faculty grant awards, GSRA awards), and provides financial, human resources/personnel, network/computer, and marketing support to the centers.

The primary purpose of the audit was to evaluate key financial and operational controls to ensure the Institute and affiliated clinics are in compliance with University policies and procedures and all applicable state and federal requirements.

The internal controls evaluated included:
- Patient access and charge capture
- Patient billing and cash handling
- Credentialing and conflict of interest/commitment
- Financial reporting and analysis
- Procurement, travel, and hosting
- Payroll and benefits
- System controls, including data security and privacy
- Grant management

IHA has experienced recent leadership and organizational transition. A new Institute Director was named in 2009, and there is new leadership in all three clinical areas. To improve clinical supervisory and managerial oversight, and to grow services and increase productivity, IHA recently implemented an

electronic clinic management system. ClinicTracker includes patient scheduling, electronic health records, and billing management.

Risk and Control Discussion

- Patient Receivables – The IHA clinics manage their own patient receivables. The Psychological Clinic and the Child and Family Clinic share a joint business office that is responsible for collecting patient co-payments, preparing and submitting insurance claims, billing patients for balances not covered by insurance, and collection activity when the account balance is overdue. Many of the treatments provided by the Language and Literacy Clinic are not routinely covered by insurance; therefore, the clinic's business office is primarily responsible for collection of fees directly from clients.

  A review of IHA's patient receivables aging reports noted a sizable past due balance.
  - The Psychological Clinic and the Child and Family Clinic balance over 120 days is approximately $100,000. Much of the balance is for previously submitted insurance claims that need additional documentation.
  - The receivable balance over 120 days at the Language and Literacy Clinic is $71,000. A significant portion of this balance is many years in arrears due to a billing process no longer in use. The process was changed several years ago to improve collections. Current procedure requires clients to pay 50% before starting the program and then settle the remaining balance at the end of their four-week treatment. University Audits noted that recent patient payment history shows the current policy is operating more effectively.

  The Institute's senior management is aware of the overdue balances and had started to address the issue before the audit began. As part of the solution, the Institute began the process of replacing its existing clinic management system in January 2011. After thorough testing, ClinicTracker went live in September 2011. ClinicTracker provides a number of upgrades including an improved billing process and eventual ability to file claims on-line. Management took the following steps to address the existing overdue balances:
  - Psychological Clinic/Child and Family Clinic business office added a temporary employee. The new employee is experienced in receivable balance reviews and is researching outstanding claims, preparing proper documentation, and resubmitting the claims to the insurance carriers for reimbursement.
  - Language and Literacy Clinic business office identified thirteen clients representing 88% of the outstanding balances over 120 days. The clinic is in the process of sending these accounts to a collection agency.

  To support the new system and processes, it is important to formalize policies and processes that include:
  - Specific criteria and timeframes for sending aged accounts to a health services collection agency. Define escalation process; how many collection attempts by IHA staff over what time frame before an account is sent to formal collections. Specify form of attempts (letter, phone), and internal documentation process.
  - Monthly management monitoring reports (i.e., aging reports, past due reports, accounts sent for collections).
  - Write-off policies for aged account. General healthcare practice is to write-off past due balances once they are sent to outside collection agencies.

  Management Plan – The development of an "Aged Receivables Policy" is underway. The new policy will establish criteria and timeframes for sending aged accounts to collections. It will also

define the escalation process and write-off criteria. Review of management reports is now integrated into the monthly budget review process.

- Patient Protection and Affordable Care Act of 2010 (PPACA) – Health care reform became law in March 2010. While many provisions in the act will not be effective until 2012 or later, the new law will affect patient care at IHA and requires some planning and operational change. One area of the new health care regulation that directly affects IHA is the application of charity care and sliding fee discounts. All three clinics offer some form of charity care and the Psychological and the Child and Family clinics offer an income-based sliding scale fee as well. There are other aspects of the law, related to fee setting and disclosure, insurance acceptance, and community needs assessment that may also affect the Institute.

  Management Plan – IHA Leadership has met with the General Counsel's Office to begin the review process to ensure compliance with the new law.

- Cash and Cash Equivalent Handling – In general, IHA cash handling controls are reasonable and functioning effectively. The cash reconciliation paperwork was complete and fully documented. The review and approval process was in evidence. The Business Office Managers have implemented controls in attempt to compensate for the lack of segregation of duties due to staff size. The one exception noted was that cash deposits were not always made on a regular basis.

  University Audits noted several instances of checks being held for up to a two weeks and then deposited as one large deposit. Per Standard Practice Guide Section 519.03, *Cash Management Policies*, funds greater than $500 need to be deposited on the date of collection. Funds under $500 may be deposited the following day. This lowers the risk that cash and checks are lost, forgotten, or stolen. Based on discussion with the Business Office Manager, the problem appears to be procedural as checks were first given to the Billing Clerk for posting and then made available for deposit. The practice has been changed so the Billing Clerk is no longer holding checks until they are posted.

IHA has strong processes in place for monitoring staff credentials and managing conflicts of interest and commitment. Patient access, charge capture, and billing procedures have been streamlined and strengthened by the addition of a clinic management system. The Institute's IT support staff is effectively managing IT and compliance risks in a responsible and methodical manner. The staff is attuned and responsive to IT control issues and the security of Institute systems. Grant management, payroll management, and account reconciliations are effectively controlled.

A formal follow-up to the outstanding issues will be conducted during the second quarter of fiscal 2013.

Institute for Research on Labor, Employment, and the Economy   #2012-220
Report issued February 29, 2012

The Institute for Research on Labor, Employment, and the Economy (IRLEE or Institute) was established in July 2008 as a merger between the Institute of Labor and Industrial Relations (ILIR) and the Business and Industrial Assistance Division (BIAD). The Institute's expenditures were approximately $7.4 million in fiscal year 2011. IRLEE is comprised of the following five centers and programs:
- *Center for Business Acceleration and Incubation Studies* (CBAIS) performs market feasibility studies to assist in the establishment and promotion of business incubators.

- *Great Lakes Trade Adjustment Assistance Center* (GLTAAC) administers a federal program designed to help companies that have been negatively affected by foreign competition in Michigan, Ohio, and Indiana, and provides management and technical assistance to firms on a cost-shared basis.
- *Labor and Global Change* (LAGC) addresses the effects of economic globalization on workers, unions, and societies.
- *Center for Labor Market Research* (CLMR) provides economic forecasting and policy analysis, particularly in the area of regional economic forecasting.
- *Technology and Commercialization Assistance* (TCA) identifies capabilities and initiatives of existing companies, matches them with University technologies, and identifies supporting resources companies will need for the successful transfer of new technologies into commercial applications.

The Office of the Vice President for Research (OVPR) has oversight responsibility for the Institute.

The purpose of this audit was to assess the effectiveness of operational controls that ensure Institute stewardship and fiscal responsibility. University Audits evaluated the adequacy and effectiveness of controls governing the following processes within IRLEE:
- Grant management
- Financial reporting and budgets
- Procurement, travel, and hosting
- Payroll, timekeeping, and human resource management
- Administration
- Data access and security

Risk and Control Discussion
- Expense Reporting – The Institute has written travel and expense reporting procedures, which are widely available to faculty and staff. Administrative staff review expense reports and managerial review is included in the approval flow. The Business Administrator is the final approver for all expense reports. The control environment can be improved by:
  o Reviewing receipts to ensure that all supporting documentation is included and verifiable
  o Ensuring that any approved deviation from policy is documented and explained in the Concur comments field
  o Documenting clear business purpose
  o Using the departmental reference field in Concur to group related expenses from multiple expense reports
  o Utilizing consistent report naming methodology

Management Plan
  o OVPR will issue unit-wide policy to encourage the use of the department reference field to identify related expenses.
  o To ensure a consistent review of verifiable supporting documentation, the Business Administrator will do a more in-depth review.
  o All staff will be reminded to address the requirements for documentation, detailed explanations of business purpose, and explanations for any deviation from normal policy for unique expenditures.

- Motor Pool Cars/Fuel Monitoring – IRLEE has two motor pool cars (both minivans) and pays $340 per month for each. A log is kept for each vehicle's use that includes date, name of driver,

time in, time out, destination, and odometer reading at pickup. University Audit noted the log was not always completely filled out and that there were gaps in the log.

Stronger oversight and control is needed over motor pool car use:
- o Limit use of P-Cards for fuel purchases to out-of-town motor pool car trips to reduce the risk of inappropriate use. When motor pool cars are used for local trips, they should be fueled at Transportation Services to leverage University fuel discounts.
- o Modify motor pool car logs to include:
  - Business purpose
  - Odometer reading at pickup and return
  - Total number of miles
  - Whether gasoline was added including total number of gallons and source
- o Regularly monitor motor pool car logs for completeness and unusual activity
- o Periodically perform a cost benefit analysis of motor pool car usage to ensure that the mileage supports the need for incurring the cost of two motor pool vehicles.

Management Plan – An interim motor pool car policy will be adopted until OVPR institutes a global policy. IRLEE's Senior Management, in conjunction with OVPR, will address the overall implementation of stronger oversight for the Motor Pool Car/Fuel Monitoring policies/procedures and log.
- o All staff will be required to fuel vehicles at Transportation Service after each trip. All other fueling will strictly adhere to U-M Transportation Service policy. Surrounding area restrictions will be defined.
- o Interim pool log will be modified to include items listed in recommendations.
- o A periodic analysis will be done to determine the cost effectiveness of the motor pool cars.

- Cash Receipts – IRLEE has written cash handling procedures, including controlled access, verification, and reconciliation. There is an adequate segregation of duties with different individuals responsible for receiving, depositing, and reconciling. Staff has taken all required cash handling and depository training. Administrative staff record check receipts in a manual log. Checks are secured in a safe with limited access until they are deposited.

According to Standard Practice Guide Section 519.03, *Cash Management Policies*, all funds collected must be deposited on the date of collection or within one business day if impractical or the deposit is less than $500. The Treasurer's Office must approve any exceptions. The Institute did not always make deposits within the required timeframe. Most checks were held for several days and some for several weeks prior to deposit.

The manual check receipt log was also not routinely monitored and reconciled to actual deposits. The log contained some irregularities including amounts not matching recorded receipts, unrecorded cash receipts, and dates not matched to actual deposits.

Management Plan
- o Check retention(s) resulted from a unique client qualifying process between three federal grants. This qualifying process determines the correct charge for the funds. These grants have ended; therefore, an exemption will not be requested from Treasury. If new grant requirements create compliance issues, we will work proactively with the Treasurer's Office and Sponsored Programs to develop procedures consistent with both grant restrictions and SPG Section 519.03, *Cash Management Policies*.

- A monthly audit will take place to reconcile the cash receipts log with all departmental Statements of Activity. This audit will be conducted by an administrator who does not participate in the cash management process.

- Financial Management – Administrative staff perform detailed reconciliation of all financial transactions and retain supporting documentation for expenditures. The Business Administrator performs a secondary review of the reconciliations and other key reports. Segregation of duties is maintained for financial transactions. Areas noted where controls could be strengthened are as follows:
  - Detailed documentation supporting payments to a foreign subcontractor are not reviewed by IRLEE management and are not maintained as part of the accounting records. Further information is provided to Institute management by University Audits in a separate management advisory.
  - Reconciliations for certain projects were not detailed and complete. A former staff member did not follow the Institute's standard procedures for documenting line-by-line reconciliation and review. Administrative support staff have been instructed to follow Institute reconciliation processes.
  - Supporting documentation for all expenditures (including Service Unit Billings) and evidence of approvals should be included as part of reconciliation documentation.

Management Plan
- Immediate efforts are underway to centralize the reconciliation process for one project that has its own system. New staff has been instructed and progress is underway.
- A process will be implemented to address supporting documentation for central unit expenditures with evidence of approval. Fixed monthly expenditures will be addressed by the Business Administrator with an additional acknowledgement. Every effort will be made to provide supporting documentation as needed.

University Audits will follow up on the status of action plans during the fourth quarter of fiscal year 2012.

College of Literature, Science, and the Arts Museum of Natural History   #2012-224
Report issued March 23, 2012

The University of Michigan Museum of Natural History (the Museum) is one of six museums in the College of Literature, Science, and the Arts (LSA). The Museum, formerly the Exhibit Museum of Natural History, promotes exploration of natural sciences and has a wide variety of exhibits featuring paleontology, anthropology, zoology, and geology. It also hosts displays featuring Michigan's wildlife and natural history. Museum employees perform no research of their own but prominently showcase the products of research conducted in other schools and colleges as a way to promote public understanding and appreciation. The Museum's Planetarium was recently upgraded with the installation of a state-of-the-art digital projection system to display the night sky's constellations for astronomy-themed presentations.

Approximately 80 percent of exhibits are on loan from other

University units or outside institutions.

The Museum hosts more than 100,000 visitors each year. Nearly 20,000 elementary, middle, and high school students tour the museum annually as part of K-12 organized field trips. The Museum also draws visitors through extensive public programs, such as summer day camps, scout programs, dinosaur or astronomy themed youth birthday parties, and many seasonal activities (e.g., Halloween parties, Discovery Days, coordination with theme semesters). The Museum encourages active participation with most displays through direct interaction or computer programs.

Entry to the Museum is free, but donations are encouraged. Some special events, including the Planetarium shows, have set ticket prices. Gifts, donations, Museum memberships, and gift shop sales are a significant part of the Museum's revenue. Additional support from LSA helps fund full-time staff who are assisted by student docents. Student docents perform a wide range of responsibilities, including museum tours and administrative support.

The Museum is one of four units housed in the Ruthven building, which was recently approved for extensive renovations beginning in 2014. These renovations may require temporary relocation of the Museum.

University Audits performed testing and analysis of the following areas:
- Exhibit Management – assessed the adequacy of controls for managing and tracking both University and external collections or objects
- Facility Maintenance – reviewed standard and emergency procedures designed for safe upkeep of the Museum's physical space
- Financial Reporting and Budget Monitoring – assessed processes for providing financial reporting and management oversight to ensure they are sufficient to support the Museum's financial operations
- Visitor Safety – determined the sufficiency of procedures designed to ensure the safety of Museum visitors
- Payroll – determined whether the Museum has established adequate controls over the payroll function
- Employment – evaluated controls designed to ensure compliance with University human resources policies and procedures
- Cash Handling – assessed controls designed to ensure the physical and data security of cash and cash equivalents
- Procurement – evaluated controls over expenses, including P-Card expenses, travel and hosting expenses, POs, and Non-POs for appropriateness and adequacy
- Gift Management – determined if current processes support effective stewardship of donor gifts
- Grants – reviewed procedures to ensure grants are adequately managed
- Museum Store – appraised controls designed to oversee operations of the store for adequacy and effectiveness

Risk and Control Discussion
- <u>Inventory Tracking System</u> – There is no formal process to track, identify, and manage objects in the Museum's possession. Some specimens have no tracking information to ascertain ownership or establish value or provenience[1]. Documentation, when available, varies widely

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[1] Provenience refers to the origin of an item. It may include, for example, the date and location where a specimen was collected, along with its scientific name. Accurate provenience is of critical importance for an object's research value.

depending on when the collection was made. Examples include leather-bound logs from the nineteenth century, index cards, and paper forms. Most items have been in the Museum for over twenty years. It is difficult to estimate the value of the Museum's collections because of the ineffective tracking process. An accurate value is necessary for the Office of Risk Management to ensure that the collection has adequate insurance coverage.
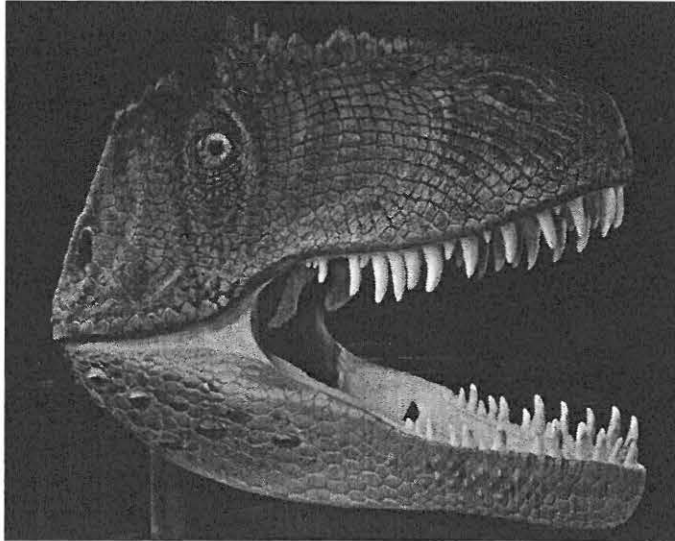
An update to the ten-year-old acquisition policy has been in draft form since July 2010. It does not include a process to report theft or damage to objects, which may include notification to Risk Management, the Department of Public Safety (DPS), or the donor of the object.

Management Plan – An LSA committee, led by the Associate Dean for Special Projects, is currently evaluating collections management software to select the most appropriate options for LSA museums. In the meantime, exhibits will be photographed and information gathered to document all exhibits and specimens. These records will be added to the new system, once determined. All new acquisitions will be recorded immediately upon receipt. We will ask Risk Management to review our work to make sure it meets their needs.

We will review our policies and processes and make any necessary updates on a regular basis. We will document our process for reporting theft or damage, including steps for gauging extent of loss or damage, and appropriate contacts (Risk Management, DPS, and the donor of the object, if any).

- Museum Store – Cash Handling and Security – The Museum Store is in a newly remodeled space and is primarily staffed by student docents. The store carries an assortment of jewelry, t-shirts, puzzles, stuffed animals, and other items that promote the overall theme of the Museum. The following observations are related to the Museum's processes for handling cash and cash equivalents (e.g., checks):
  - o All cashiers working in a single day share one cash register drawer. The amount of funds in the cash drawer is reconciled nightly to the amount of funds collected per the register tape. University Audits' review of the reconciliation log noted repeated nominal discrepancies between these amounts. Because the drawer is shared, there is no way to isolate which employees may be responsible for the variances and require coaching or other management action.
  - o The cash register drawer, stocked with $175, remains in the cash register after store closing. The register is not attached to the counter or in some other way prohibiting theft. Furthermore, former student employees know the location of the key for the cash drawer.
  - o Both the Museum Store and the main Museum office make deposits weekly. Standard Practice Guide Section 519.03, *Cash Management Policies*, requires that deposits be made the same day as receipt. If this is inconvenient and the total of the deposit is less

than $500 (including cash and checks), the deposit may be made the following business day.

- o There are two safes located in the Museum Office. One is used primarily to secure deposits from the Museum Store. The second safe is used for general office deposits, such as funds received for group tours. The combinations for these safes have not been changed in at least three years.

Management Plan – The safe combinations have been changed and will be changed annually in the future. A wall-mounted key safe has been ordered to secure the cash register key; the combination will be changed on a periodic basis or when personnel change. We will make every effort to make cash deposits in accordance with University policy. The cash register has been bolted to the countertop.

As discussed with University Audits staff, implementing a multiple cash drawer system would create significant complexity in terms of student staff scheduling, increased expense (purchasing a larger safe, paying for additional student staff time for counting cash, providing supervision while students are counting cash), and increased security risks (a significantly larger number of staff would need to know the combination of the safe, more cash would be kept on hand than presently, and depending on the location of the new safe, carrying cash drawers through unsecured areas).
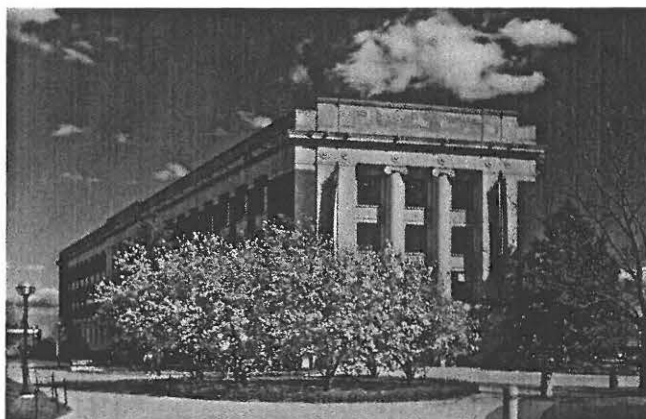
In lieu of multiple cash drawers, we propose trying a different approach and evaluating its success during the audit follow-up. We will create a new policy setting a threshold for acceptable variances in the cash drawer, a reporting requirement when variances exceed the threshold, and prescribed follow up on unacceptable variances. We will provide refresher training on cash handling and the new policies for current student employees and train new hires in these practices as part of the onboarding process.

- Museum Store – Merchandise Management – The cash register system at the Museum Store does not record details of specific items, only the total dollar amount sold by merchandise category (e.g., puzzles, plush, books). A manual inventory system is therefore necessary to ensure merchandise quantity is reasonable based on sales volume. A full count of all store items is performed annually, but the count takes place over several days while normal sales activity takes place. There is no true point-in-time inventory value established. Due to the limitations in the register system, it is also impossible to reconcile the inventory count to sales, which is typically a strong control in a retail sales environment.

Management Plan – We will move to a point-in-time annual inventory for the Museum Store. The Store Manager will schedule students to help achieve this task in a concentrated period of one day. The Store Manager will perform monthly inventory counts of random items, routinely recording the results in the Quarterly Store Reports. The industry standard for moving to a Point of Sale (POS) system with a scanner is when annual gross sales reach $125,000. With our new

larger store, we expect to reach $100,000 in fiscal year 2012, and hope to reach $125,000 in fiscal year 2013.

- <u>Facility Management – Continuity of Operations Planning</u> – Every University unit should establish plans to ensure continuity of operations in case of emergencies. LSA has developed an *All Hazards Disaster Preparedness and Emergency Action Plan* as a high-level plan to ensure orderly and coordinated response to major emergencies. The Museum has not developed and implemented specific procedures tailored to their needs. Examples of such procedures include emergency preparedness and continuity of operations plans specific for the Museum, procedures for communicating with staff, student-docents, and visitors during an emergency, and succession plans. Developing robust continuity of operations plans facilitates smooth transition in the event of major disruptions.

  Management Plan – We will develop customized, written emergency plans for a variety of situations and make these available to all staff and docents. We will reference the existing LSA plans as well as the new University Building Incident Response Team (BIRT) process, which should be implemented in the coming year. The final document will include a succession plan in case of a pandemic, steps for communicating with LSA Facilities, DPS, and other units in the Ruthven Building, and our process to communicate with and evacuate visitors and employees in an emergency. We will work with LSA Facilities to ensure our plans are in line with LSA efforts.

- <u>Hazard Training and Safety Documentation</u> – While most exhibit fabrication is done outside the Museum, small jobs are completed in the Museum's workshops. Employees who work with exhibit preparation in these shops are trained in different areas, including equipment use, chemical hygiene plans, and personal protective equipment use. University Audits observed:
  o Employee training documentation (chemical hygiene training, personal protective equipment training) was not up to date.
  o Chemicals inventory was not up to date.

  Management Plan – We will reorganize and update paperwork regarding employee training documentation (chemical hygiene training, personal protective equipment training) and chemical inventories.

- <u>Financial Reporting – Segregation of Duties</u> – The Financial Analyst is responsible for reconciling the Statement of Activity (SOA) for the Museum. The same employee is also the Museum Store Manager and has procurement access to initiate purchases for the store. This creates inappropriate segregation of duties, as one individual can control a transaction from start to finish.

  Management Plan – The Museum's Administrative Specialist will review the Financial Analyst's purchases monthly. This will include all purchasing activity, such as P-Card, PO, or non-PO purchases. On a quarterly basis, the LSA Senior Business Manager will conduct a high level review of the Financial Analyst's purchases using the SOA.

- <u>Internal Controls Certification</u> – LSA requires each sub-unit to complete an annual internal controls certification. This certification includes a gap analysis to allow management to self-identify and correct weaknesses in their unit. The Museum's gap analysis was completed by only one individual who did not have complete knowledge of processes within all areas of the

Museum. As a result, some procedures were not accurately described and existing control weaknesses were not identified.

Management Plan – We will review and update any areas of the 2011 gap analysis reports as needed. In the future, the Administrative Analyst will circulate gap analysis paperwork to the appropriate staff to review for accuracy and additional input in advance of the deadline for document submittal to LSA.

- Employment – On- and Off-Boarding Checklists – The Museum does not have a formal process to ensure appropriate steps are taken when employees join or leave the Museum's staff. Items to consider include return of equipment or supplies provided to employees, such as keys, M-Tokens, or Museum name badges, as well as removal of systems or building access. Upon termination, transfer, or retirement, access needs to be cancelled and equipment returned in a timely manner. A formal process would ensure that these items are consistently addressed.

  Management Plan – On-boarding and off-boarding checklists were customized using templates and samples provided by LSA and University Audits. We will consistently use these checklists and update them with each new hire and departure.

  Auditor's Note: The on-boarding checklist was completed by Museum staff in time for a hire in January 2012. The checklist was reviewed and noted to be sufficient. An off-boarding checklist has been created but has not yet been needed. Use of the off-boarding checklist will be evaluated during the follow-up.

- Student Docent Screening – Student docents are the primary employees who interact with the Museum's visitors. They conduct tours for K-12 student field trips to the Museum and also work as camp counselors during the Museum's summer camp program. The Summer Safety Oversight Group, a University group developed to provide best practice and policy guidance for all U-M camps, indicates that background checks should be performed for all staff that are alone with or supervise youth groups of ages 17 or under. At the Museum, background checks are currently only performed on docents working as summer camp counselors, not those interacting with minors during the academic year.

  Management Plan – We will ensure that all new employees receive background checks when they are hired. Camp counselors will receive background checks annually.

- Payroll
  - The Museum is enrolled in self-service time reporting. Regular staff report time online and supervisors approve time online. To facilitate time reporting for student-docents, the Museum has assigned a timekeeper to enter their time in M-Pathways. Student-docents record their time on hardcopy timesheets, and hours are reconciled to a weekly schedule maintained by the timekeeper. A designated approver approves time in the system. The approver does not always have direct knowledge of docent hours worked. Hardcopy timesheets are not always approved by a direct supervisor.
  - Annual merit raises are approved by both the Museum Director and the LSA Undergraduate Education Office, where the Museum reports. Discrepancies were observed for some employees between the pay rates approved during the annual merit process and the rates in the payroll system.

Management Plan
- o The Administrative Assistant and Financial Analyst work together on student docent payroll. They will ensure that any student time reported for which they have no direct knowledge will be approved by the appropriate supervising staff member. In most cases, this will mean that the staff supervisor will sign the hard copy timesheet, or if necessary, verify the time via an e-mail message. We will collaborate with LSA Human Resources to make sure our timekeeping procedures reflect best practices.
- o The Museum Director will continue to submit merit increase recommendations to LSA Undergraduate Education Office and will cross check with recommendations when approved rates are provided by LSA. She will share the approved rates with the Financial Analyst and Administrative Specialist, who will ensure that the numbers match the gross pay register and online HR systems.

- Conflict of Interest or Commitment Process – Four Museum employees have a management plan in effect to address reported conflicts of interest or conflicts of commitment. Two of these plans are for employees who hold elected positions on a school or library board, and two are for two employees married to each other. LSA received proper notice and has approved the plans in place for these employees. However, there is no form used to document the management plan. Without a document signed by both the employees and the Museum Director, there is limited accountability to attest that all parties are aware of the conflict and the restrictions in place.

   Management Plan – The Administrative Specialist will use the standard LSA template to document conflicts of interest. They will be signed by the relevant staff members and the Museum Director and will be filed in the staff members' personnel files. The LSA Human Resources Office will also receive a copy of the document.

   All LSA employees sign a Checklist as part of their Year-End Assessment each May. The Checklist includes a checkbox requiring employees to affirm that they have read and understood LSA's Conflict of Interest and Conflict of Commitment policy documents.

Our review of the Museum of Natural History identified sound management processes designed to oversee the safety of museum visitors, manage gifts, ensure appropriate procurement activity, and monitor grants. Significant planning will be required to prepare for upcoming renovations to the Museum space. Refining internal controls and operations as noted in this report will be a beneficial first step in that process. The Museum should utilize LSA resources as they work towards enhancing the controls highlighted in this report, in order to gain efficiency as well as ensure their processes represent best practices and LSA standards. A formal follow-up to the outstanding issues will be conducted during the first quarter of fiscal year 2013.

University of Michigan Facilities and Operations Parking Operations   #2012-107-1
Report issued March 27, 2012

The Parking and Transportation Services (PTS) Department manages the University employee permit parking system, and the hospitals patient/visitor parking facilities, as well as providing cashier-attended and central pay station parking areas for visitors to the Ann Arbor campus. A third party vendor provides valet parking service for a fee to patients/visitors at several of the Hospitals and Health Centers locations. A separate vendor provides special events parking attendant services for campus venues such as concerts and some athletic events.

The University of Michigan Hospitals and Health Centers (UM-HHC) has the largest volume of on-going hourly and single entry parking activity at the University. Parking space for employees is limited

at UM-HHC locations. UM-HHC staff is provided with options for off-site parking with shuttle service. Employees are generally prohibited from using the patient/visitor parking areas. The opening of the new Children's and Women's hospitals in December of 2011 created additional demand for patient/visitor parking. Approximately 300 employee parking spots were reallocated to patient/visitor parking.

The chart below summarizes the annual volume of patient and visitor parking activity for calendar year 2011.

Parking Structure	Patient/Visitor Volume (Calendar Year 2011)	Collections in $ (Calendar Year 2011)
Cancer Center (P1)	125,511	$ 243,871
Taubman Health Center (P2)	912,850	2,713,463
Cardio Vascular Center (P5)	76,747	197,861
Children's and Women's Hospital (P4)*	9,581	22,819
Fletcher	95,868	175,659
Palmer	86,410	474,888
Total	1,306,967	$3,828,561

*Note-This lot opened in early December 2011 and amounts reflect less than one month activity.

The audit focused on cash handling and patient/visitor parking operations on the Ann Arbor campus, including the hospitals and health centers. The Department of Athletics, University Housing, Dearborn campus, and Flint campus have separately managed parking operations and were not part of the audit scope. Specific objectives included assessing the adequacy and effectiveness of controls over:
- Cash handling
  - Patient/visitor parking operations
  - Parking customer service operations (employee permits, Automatic Vehicle Identification (AVI), special permits)
- Gate attendant operations
- Staff use of patient parking
- Discounted parking options
- Credit card security
- Special events parking

The results of an audit of valet parking operations at UM-HHC are explained in a separate report, *Valet Parking Operations*. The vendor contract for central pay station parking areas was not included in the scope of this audit

Risk and Control Discussion
Parking Services has generally strong controls over cash handling and parking operations:
- Cash is kept in a secure manner
- Duties are appropriately segregated
- Reconciliations are performed on a daily basis
- Cash receipts are deposited frequently and in accordance with University policy
- Special parking vouchers are appropriately inventoried and accounted for
- Errors and unusual items are promptly followed up on and corrected
- Staff is well-trained and supervised

In 2006, University Audits performed a business operations review of Ann Arbor campus parking operations. Issues identified during that audit, related to staff use of patient/visitor parking continue to

exist. Opportunities to improve procedures and strengthen internal controls are discussed below.

- Staff Use of Patient/Visitor Parking – UM-HHC currently provides discounted parking to patients and visitors as a customer service. Discounted parking ranges from free to $2 per entry as compared to a maximum of $10 per day. A patient or visitor is instructed to have their parking ticket stamped by clinic or inpatient staff to receive the discount. The use of discounted parking stamps are widely disbursed throughout the hospitals and clinics and are easily accessible to employees. Parking management is aware of the risk and known misuse by staff.

  In response to the continued need to preserve patient and visitor parking and deter employee misuse, UM-HHC and Parking Services management have instituted, or are in the process of developing, new parking options, fee structures, and policies.
  - Additional off-site staff parking options with expanded shuttle service have been added.
  - There is expanded patient/visitor parking lot gate attendance.
  - Staff and patient/visitor parking areas have been separated in the Taubman Parking Structure.
  - A new policy is under development that will prohibit faculty and staff from parking in patient and visitor spaces. Clear disciplinary measures up to and including dismissal for repeat employee offenders will be part of the new policy.
  - The discounted parking stamps for most locations have been collected and relocated to a few centralized locations with stronger control mechanisms. As of March 5, 2012, 116 stamps have been removed from the hospitals and health centers. There are a few more that will be removed by the end of March 2012.
  - Remaining stamps will be replaced with updated stamps.

  Management Plan – Prior to the audit, Parking Services began process improvements to streamline the validation process. There are now fewer validation stamps, fewer departments that have the stamps and a more consistent process for patient and visitors to receive their validation. We believe it to be an improvement from a control perspective and this change has reduced the number of parking tickets that need to be validated. As noted in the discussion above, we expect the March 5 Medical Campus changes in the visitor parking validation process (removing the validation stamps from UH inpatient units and Taubman Center outpatient clinics) and in the visitor parking rate structure (eliminating the need for validation of parks 4 hours or less) will reduce the likelihood of staff misusing the validation process. Stamps for the validation locations remaining will be replaced with updated stamps. The proposed UMHS policy to strictly prohibit staff parking in patient/visitor areas, with disciplinary consequences for parking violations, should further reduce the incidence of such parking.

- Override Controls for Gate Operations – At certain locations, parking booth attendants have the ability to override the control system and activate the exit gate by use of a toggle switch in the booth. A report that was used to monitor overrides was disabled in June 2011 as part of a system upgrade. PTS management was not aware that the override capability still existed. Unmonitored overrides can lead to employee misuse and fraud.

  Management Plan – At the initiation of the audit, four locations were identified as having override switches. Since then, the override switches at all four locations (M15, M85, N13, and N26) have been removed and the booths have been rewired so that when an attendant is logged on to the fee computer, the gate is in operation.

- Monitoring of Parking Activity – Parking booth attendants are required to record certain parking transactions on the Suspected Fraud Report and the Waived Fee Report. The reports are

collected daily and reviewed by management. Improvements are needed in the effective use of these reports.

When management observes a trend on the Suspected Fraud Report, it is referred to a higher level of management for investigation. University Audits reviewed reports submitted and identified trends that were not referred to the next level of management. University Audits also reviewed the Waived Fee Reports submitted and other evidence to determine that not all waived fee transactions are recorded on the report. By not accurately documenting all waived fee transactions or following up on suspicious parking trends, misuse of parking could occur and not be detected by management.

One type of waived fee transaction, a turnaround, is not required to be recorded on the Waived Fee Report. For this parking transaction, the customer is allowed a 15 minute grace period to park for free. The enter time and exit time of the customer is recorded. University Audits reviewed this data and determined that 78% of the transactions reviewed exceeded the 15 minute limit. Several of the transactions exceeded 40 minutes.

Management Plan – The Suspected Fraud Report is used to monitor unauthorized parking in patient and visitor areas, primarily by hospital staff with a stamped parking ticket. On March 5, 2012, the parking rates have changed and most parking validation stamps were removed from circulation. This streamlined process should significantly reduce the opportunity for parking fraud by staff. As part of the new validation process, the Suspected Fraud reports and Waive Fee Reports are being reviewed on a daily basis by the Attendant Services Manager. Monitoring of license plates is also performed and, if a license plate is reported three times as suspected fraud, it is reported to the Associated Director for Attendant and Customer Services. Any discrepancies or issues are elevated to the Associate Director for Customer Service for appropriate follow-up.

Review of turnaround transactions began on March 5, 2012. There is a built in grace period of 15 minutes for patient/visitor parkers on the Medical Campus, however, the fee computers have a code that would lengthen the grace period (turnaround time). This code has been eliminated from the fee computers, effective March 5, 2012. Due to the size of Medical Campus parking structures and the volume of parkers that fell within the 15-20 minute turnaround time range, the built in grace period has been extended to 20 minutes for patient/visitor parkers on the Medical campus effective March 7, 2012.

- Imprest Cash Funds – PTS uses an imprest cash fund that is not maintained in accordance with University policy. The fund is on record with the Accounts Payable Office; however, the fund is logistically split between two locations and is not under the control of one custodian. One portion of the fund is divided into six different cash bags at one location, used for different purposes. The entire fund is not completely balanced and accounted for on a regular basis. The fund was last balanced in its entirety on August 30, 2010. Three cash bags are counted on a daily basis. One cash bag is counted on a weekly basis. The others are counted when used, but not on a daily or regular basis. There is a risk that shortages could go undetected if the entire fund is not completely balanced on a frequent basis. (Note: University Audits performed a surprise cash count of the entire fund and determined there were no shortages)

PTS uses another imprest cash fund that also is on record with the Account Payable Office. The fund is well-controlled and balanced daily. However, employees who have been assigned to perform back up duties have not taken the annual cash handling training.

Management Plan – Since the cash actually exists at two separate locations, the Financial Manager will work with the Accounts Payable office to establish a new imprest cash fund for Customer Service. Concurrently, the Attendant Services Manager and the Parking Customer Service Office Manager will be made the custodians of their respective funds, while the Financial Manager will become the next higher administrative authority over each fund. Although there has been a short period where the imprest cash fund was not audited due to turnover in the Financial Manager position, the new Financial Manager will resume the independent and periodic cash count of each imprest cash fund beginning in the latter half of fiscal year 2012.

Annual cash handling training is currently performed by Parking Customer Services personnel on an annual basis via MAISLinc (course TME103). Since this is considered best practice, annual cash handling training will be expanded to include Parking Attendant Services and Parking Maintenance and Operations employees handling cash as a primary or backup function.

- Credit Card Controls – Parking Services accepts credit cards as a form of payment. The Treasurer's Office is responsible for setting up merchant accounts and monitoring compliance with Payment Card Industry (PCI) Data Security Standards. The PCI Data Security Standard is a set of information security guidelines designed to protect cardholder information and transactions. The standard applies "to all members, merchants, and service providers that store, process or transmit cardholder data." All major credit card issuers (e.g., American Express, Diners Club, Discover Card, MasterCard, and Visa) require that merchants, such as the University of Michigan, comply with the PCI Data Security Standard and be able to demonstrate this compliance.

Parking Services has nine locations accepting credit cards; each has their own merchant number. PCI standards are listed in the Merchant Services Policy document. University Audits reviewed documents on file with the Treasurer's Office and Parking Services practices and noted the following variances from Treasurer's Office policy:
   o Credit card locations do not have a copy of the Merchant Service Policy document on hand.
   o Six locations did not have a current Authorized Staff Roster on file with the Treasurer's Office. The list of authorized staff has not been updated since 2007.
   o Staff authorized to process credit card transactions in seven of the locations have not received annual online merchant certification training.

Management expressed concern that some staff required to take the training do not have access to do so on-line. University Audits discussed this with the Treasurer's Office who is willing to work with Parking Services and develop a group training format as part of a staff meeting to meet their training needs.

The Office of Internal Controls provides guidance and tools to help units across campus manage financial related processes. One such tool is the Annual Internal Control Certification and the Gap Analysis Self Assessment Review. University Audits reviewed the Parking Operations gap analysis for credit cards and determined that Parking Attendant Services was not included in the self assessment process. Parking Attendant Services is logistically separate from the main Parking Operations and was inadvertently not included in the annual process.

Management Plan – The Attendant Services Manager will work with the Treasurer's Office to develop credit card security policies and procedures that are specific for Attendant Services Operations. The Attendant Services Manager will coordinate with the Treasurer's Office for

training for all staff on an annual basis. The Attendant Services Manager will maintain the current Authorized Staff Roster and will have it on file in the Attendant Services office. Attendant Services Manager will provide a copy of Merchant Services Policy to all parking booths and place them in the policy and procedure binder.

Parking Customer Services does maintain the original signed Merchant Services Policy document in their vault on location. However, the information in the document has been revised, so a copy of the new document has been printed and is stored with our Merchant Account information.

Attendant Services and Parking Customer Service will:
- o Provide/oversee annual merchant certification training to staff.
- o Maintain a current Authorized Staff Roster with employee signatures as they complete the annual training.
- o Provide regular updates to the Treasurer's Office.

All points of credit card and cash handling contact/interaction will be included when completing the annual Office of Internal Control Gap Analysis Self Assessment.

- Special Events Parking Contract – Parking Services contracts with Park-Rite Inc. to provide parking attendants and supervisors for concerts, some athletic events, and other general activities on campus. The contract requires Park-Rite Inc. to conduct background checks on attendants selected to work on events. The contract manager had not verified that Park-Rite, Inc. was performing background checks as required.

  The special events parking contract requires that Parking Services and Park-Rite, Inc. perform a quarterly reconciliation of parking tickets to detect missing tickets and account for revenues. Parking Services eliminated the quarterly reconciliation because there were no discrepancies in previous reconciliations but continued to perform and annual reconciliation. During the most recent annual reconciliation of unused tickets, the contract manager discovered 100 tickets that were not accounted for in fiscal year 2011. Park-Rite, Inc. subsequently reimbursed the University for the missing tickets/revenue.

  Management Plan – When Park-Rite, Inc. hires attendants, they perform a background check. As the contract states under General Information, Park-Rite, Inc. is responsible for conducting background checks on attendants selected to work on events. The current contract expires on July 31, 2012. The next RFP for Contracted Parking Services is schedule to occur in conjunction with the current contract expiration. PTS will clearly identify in the new contract that the vendor will be responsible for performing background checks on employees assigned to U-M services. PTS will also implement an annual certification process in the new contract where the vendor will attest to performing background checks. PTS will work with University Audits and Risk Management to establish the annual certification document.

  Park-Rite, Inc. receives over 91,000 permits to sell on our department's behalf. The quarterly audit records the permits that have been accounted for as being issued and also lists the permits that are unissued. An audit was done in early January 2012 and sent to Park-Rite, Inc. We will resume a quarterly audit immediately.

A formal follow-up to the outstanding issues will be conducted during the second quarter of fiscal year 2013.

The Provost and Vice Chancellor of Academic Affairs (Provost) at the University of Michigan – Flint, serves as the chief academic officer for the campus. Reporting directly to the Chancellor, the Provost oversees the Division of Academic Affairs (the Division). The Division is comprised of four schools and colleges and many support programs and centers.

Schools and Colleges
- College of Arts and Sciences
- School of Education and Human Services
- School of Health Professions and Studies
- School of Management

Support Programs and Centers
- Frances Willson Thompson Library
- Office of Research
- International Center
- Office of Admissions
- Institutional Analysis
- Educational Opportunities Initiatives
- Genesee Early College
- Office of Extended Learning

As chief academic officer, the Provost advises on undergraduate and graduate academic policy and plans, and supports the UM-Flint Strategic Plan in three primary areas:
- Teaching, learning, and scholarship
- Student centeredness
- Civic engagement

The Provost manages a $3 million budget with two endowments that collectively earn over $130,000 per year. UM-Flint follows a common, decentralized budget model. The Provost is ultimately accountable for the fiscal, as well as academic, health of each unit in the Division.

Appointed in July 2010, the Provost took office during a period of significant growth for the Flint campus. UM-Flint has claimed the title of fastest growing university in Michigan for the last four years, and attributes increases in enrollment to new academic programs and the introduction of a residential housing option for students.

At the request of the Chancellor and Provost, University Audits completed a review of the Provost's Office internal control environment to verify efficiency and effectiveness.

The audit scope is based upon audit objectives and includes departmental processes and financial controls within the Provost's Office.

Risk and Control Discussion
The following recommendations are intended to build upon the significant organizational change already underway and support the Provost's efforts to strengthen internal controls and streamline procedures within his office, throughout Academic Affairs, and across campus.
- Strategic Plan Funding Model and Procedure – The campus Strategic Plan does not include a formal funding plan or a comprehensive timeline for the implementation of initiatives. During the course of the audit, numerous academic and administrative leaders reported difficulty obtaining the funding necessary to implement Strategic Plan initiatives. Since the Provost's goals for Academic Affairs are tied closely to the Strategic Plan, acquiring funding for implementation of initiatives in a timely manner is essential to moving the Division and the campus forward towards its academic goals and objectives.

Management Plan – The Provost will work with the Chancellor and the rest of the executive leadership team to develop a funding plan for implementation of Strategic Plan initiatives. The plan will include a timeline for implementation of initiatives and assess the amount of funding needed to support each initiative. A funding method cohesive with our current budget model will be developed to ensure timely distribution of the funds needed to support implementation.

- Organizational Structure and Resources – The Provost's scope of responsibility has expanded significantly since his initial appointment. In the past year alone, two units with heavy debt burdens in need of close oversight were transferred to Academic Affairs. No additional funding was provided to Academic Affairs to offset the debt or associated administrative costs the Division must carry while working with these units to resolve their deficits.

  To improve high-level oversight and balance workloads, the Provost, with the support of UM-Flint Human Resources (UM-Flint HR), recently redesigned and filled a vacant senior leadership position, Associate Provost and Dean for Undergraduate Studies. This move is expected to improve divisional oversight and provide opportunity for the delegation of some of the Provost's many responsibilities.

  Observation of day-to-day operations indicates that workload balance is still an issue within the Provost's administrative office. Interviews confirm that the Provost's administrative team is widely respected, effective, and productive. However, workloads appear uneven with exempt staff often working 20 or more hours of overtime per week. Delegation of responsibilities to staff with fewer duties is difficult given differences in job classification and associated skillsets. The campus Human Resources Director confirmed that the Provost's Office organizational structure and staffing needs have not been reviewed in some time.

  Management Plan – The Provost will work with UM-Flint HR to review the Provost's Office organizational structure and assess roles and responsibilities. Where possible, duties will be shifted to address workload balance issues. Job descriptions, classifications, and compensation will be assessed to ensure they properly reflect the level and type of support needed to sustain effective operations.

  In consultation with UM-Flint Financial Services and Budget and UM-Flint HR, the Provost's Office will calculate the costs absorbed by the Division when two units were transferred to Academic Affairs. The Provost will review findings with the Chancellor and investigate options for offsetting these costs at the division level. Work will continue at the unit level to resolve deficits through responsible stewardship of resources.

Provost's Office Fiscal Responsibilities

Testing and interviews indicate the Provost is effective in managing his budget and stewarding University resources. The Provost and his staff meet regularly to review budget reports and source-use data at both the department and division level. Commitments are encumbered upon approval and tracked to completion. Segregation of duties related to financial transactions and time reporting are appropriate. Important processes including statement of activity and gross pay register reconciliation are completed in a timely manner.

Financial controls in the Provost's Office are generally strong, and a number of improvements are in process:

- Policy and Procedure Manual – One of the Provost's goals for his staff this year was the development of a comprehensive policy and procedure manual. Key processes, including tenure

review and graduation, are already complete. Development and documentation of a formal discretionary fund request procedure is underway.

- Delegation of Authority – A review of purchasing and travel and hosting documentation indicate the Provost delegates his authority appropriately while away from the office. The Provost is in the process of documenting his delegation of authority for the following:
    o Preapproval of small, routine discretionary fund requests.
    o Approval of time reports for the Provost's direct reports within the University's self-service time reporting system. The Provost's review and approval of time precedes any approval in the system and segregation of duties is sufficient.

- Management Oversight Reports – The Provost has been working with UM-Flint Financial Services and Budget to develop comprehensive oversight reports for both the Provost's Office and the Division of Academic Affairs as a whole. The Provost regularly reviews budget and source-use information with his staff, but does not have ready access to other key oversight reports and metrics including spend analysis, vendor utilization, overtime use, and additional pay. The Provost's staff are also working to automate financial reporting procedures in an effort to eliminate some minor redundancies of effort.

- Gift Fund Management – In the Division, there is an endowed visiting professorship with a substantial expendable fund balance of $375,000 (equal to 4 years of endowment distributions). The current Provost succeeded in filling the position this year and is working with his staff to develop a funding plan to ensure effective use of the endowment.

A formal follow-up to the outstanding issues will be conducted during the second quarter of fiscal year 2013.

Information Technology

North Campus Auxiliary Service Building/North Campus Data Center   #2011-301
Report issued February 3, 2012

Medical Campus Information Technology (MCIT) Infrastructure and Systems Operations along with University of Michigan Hospital Facilities manages and maintains the North Campus Auxiliary Service Building (NCASB). The North Campus Data Center (NCDC), located inside NCASB, serves as the primary data center for the University of Michigan Health System (UMHS) with an alternate site located at Arbor Lakes. NCDC was built to support UMHS life safety systems such as UM-CareLink, CareWeb, Mi-Chart, Clinical Data Repository, and Voice Systems. The North Campus Auxiliary Service Building was built with redundant systems including power generation, battery backup, utility power sources, and network connections. This redundancy allows the data center to be concurrently maintainable meaning that planned maintenance can be performed without bringing systems or networks down. Maintaining a highly redundant data center requires coordination between all parties that support network operations, facilities, and data center personnel. Maintenance activities elevate the risk of unplanned outages. Efficient communication between all personnel that provide services and support to the data center is essential to minimize a leading cause for data center outages - human error.

The objective of the audit was to verify that safeguards are in place to ensure that NCDC maintains continuous operations in an efficient and secure manner. Detailed objectives were to:
- Verify maintenance affecting NCASB is communicated and coordinated
- Ensure proper notifications are sent during outages/reduced capabilities

- Verify that proper data center restoration priorities have been established
- Assess how change control is performed and managed
- Review and assess policy governing NCASB operations
- Verify Service Level Agreements exist with entities providing services to the data center
- Follow-up on Management Advisory #2010-308[2]

This audit examined day-to-day operations of NCDC including notification of maintenance, outages, and reduced capabilities. Continuity of Operations Plans for MCIT Infrastructure and Systems Operations are currently being reviewed by UMHS Compliance and will be included in an upcoming audit of MCIT data centers along with physical access controls and, security procedures and responsibilities. Alternate site configurations and operation capabilities were outside the scope of this audit

Risk and Control Discussion
- Security Cameras – Video surveillance occurs inside and outside NCASB. There are 53 cameras monitoring NCASB. Interior cameras are monitored by NCASB staff, while exterior cameras are monitored by both MCIT and Hospital Security. If a door alarms, a Hospital Security staff member will view the video feed for that door and assess the situation. Security personnel receive alarm notifications via pager, and video is accessed manually. Hospital Security and MCIT have differing expectations for what is monitored. Discussion with Hospital Security and MCIT management revealed that there is no documented protocol for monitoring and responding to suspicious activity.

  Management Plan – UMHS Security Services, UMHS Facilities Operations, and MCIT management have met to discuss monitoring of the external and building entry cameras at NCASB. Security Services has provided written documentation of their security monitoring and incident response procedures for NCASB. Based upon the documentation provided, Security Services does not actively monitor the cameras at NCASB. The cameras are used to view locations at NCASB if a security alarm is received as a means to investigate the alarm. MCIT will work with Security Services and Facilities Operations to determine if changes to the procedures are necessary to ensure security at the data center.

- Service Level Agreements – Service Level Agreements (SLA) should explicitly define services provided, priorities, and responsibilities. The SLA between UMHS Operations and Support Services and MCIT barely mentions security functions, services are poorly defined, and response times would be inappropriate for a security incident. Additionally, ITS Com is responsible for the interconnecting fiber-optic cables between NCASB, Arbor Lakes Data Center, and the medical campus. There does not appear to be an SLA between ITS Com and MCIT.

  Management Plan – MCIT and UMHS Operations and Support Services management will review, make changes, and agree to a revised SLA addressing security services and other services that may need better definition.

  MCIT and ITS Com management will work to develop an SLA to address services provided, responsibilities, and response times concerning the fiber optic cable that provides communication services between MCIT managed data centers and the UMHS medical campus.

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[2] North Campus Data Center #2010-308, A review of NCDC monitoring systems

The North Campus Auxiliary Service Building has safeguards in place to ensure that NCDC maintains continuous operations in an efficient and secure manner. Controls are in place to minimize the risk of unplanned data center outages due to human error. Maintenance affecting NCASB is properly communicated, procedures detailing how to report outages are established, and change control processes are in place, all contributing to continuous operation of NCDC.

University Audits will conduct a follow-up review in the fourth quarter of fiscal year 2012 to assess progress on management action plans.

Healthcare

U-M Hospitals and Health Centers Valet Parking   #2012-107-2
Report issued March 27, 2012

The University of Michigan Hospitals and Health Centers (UM-HHC) makes it a high priority to ensure patients and visitors have parking spaces available to them. In addition to patient and visitor self-parking options in structures, valet parking service is available at six locations. A $5 valet parking fee is charged at four hospital locations; Taubman Health Center, Cancer Center, Cardiovascular Center and more recently at the new C.S. Mott and Von Voigtlander Children's and Women's Hospitals. Valet parking services are available at no charge at the two Emergency Department Entrances and the University Center for Development of Language and Literature (Victor Vaughn Building).

UM-HHC uses a third party vendor, Parking Solutions, Inc. (Parking Solutions) to manage valet parking services. Parking Solutions provides personnel to park patient/visitor cars and collect fees. The collected fees are remitted to UM-HHC on a daily basis. UM-HHC contractually pays Parking Solutions $11.00 per hour based on actual valet hours worked. Valet parking activities are part of UM-HHC Operations and Support Services (Support Services).

In fiscal year 2011, Parking Solutions parked a total of 145,888 cars bringing in revenue of $729,440. At the time of the audit, Parking Solutions employed one site manager, two cashiers, and thirty valet employees to provide the valet parking service for UM-HHC. UM-HHC Entrance Services places staff at entrance locations to assist patients in and out of their vehicles. At the four valet locations that collect a fee, the Entrance Services staff and valet staff often coordinate services.

This audit focused on reviewing business operations and controls over valet contract management and performance. Specific objectives included assessing the following:
- Contractual obligations, including monitoring controls, over contract performance and valet supervision
- Cash handling
- Controls over valet employee use of Automatic Vehicle Identification parking devices that allow automatic gate entry to parking structures

This audit was done in conjunction with a separately reported review of parking services cash handling.

Risk and Control Discussion
- Reconciliation Practices – For each valet service shift, valet employees complete a Daily Reconciliation Sheet recording ticket usage and cash collected. The Daily Reconciliation Sheets are often incomplete and consistently contain errors that make the cash deposit reconciliation process time consuming and ineffective. Valet supervisory staff assigned to review reconciliations are not consistently following up on discrepancies. University Audits also noted

that cash deposits, which are taken to the Hospital Cashiers Office, are not routinely reconciled to the monthly Statements of Activity. Management was not aware of basic reconciliation practices.

Management Plan – A new cash reconciliation procedure has been developed by Parking Solutions with the Administrative Manager's review and approval. All new and existing Parking Solution employees will complete the cash handling training through Parking Solution's cashier training guide, which will be updated to include the new cash reconciliation procedure.

Parking Solutions will implement a new report entitled "Variance Report." The functionality of this report will detail and track all shortages and overages and hold respective employees accountable.

Administrative Manager and Entrance Attendant Manager will meet monthly to reconcile cash deposits to the Statement of Activity.

- Vendor Employee Use of Patient/Visitor Parking Space – Valets use an Automatic Vehicle Identification (AVI) device to gain access to parking structures. The device automatically opens the gate when a vehicle approaches. At the time of the audit, each valet was permanently assigned an AVI device that they were required to bring to each work shift. Parking Solutions has an AVI Policy/Accountability Statement that includes the following for contract valets:
  o Valets are never to give their specified AVI to anyone else, including other employees
  o Valets are never to use their AVI before/after their shift has been completed
  o No valet may use an AVI to park their personal vehicle in a valet controlled area of a parking garage at any time

University Audits examined AVI usage logs, access information, and valet shift schedules and noted activity where valet personnel used their AVI device to enter and exit a parking structure before and after their work shift in a location other than their assigned work shift. This limited review detected that one valet was using the AVI for personal parking use. When University Audits brought this issue to the attention of the Parking Solutions Manager and the Valet Contract Administrator, the process was immediately changed. Previously each valet was permanently assigned an AVI. The AVIs are now centrally held and checked out by the valets at the beginning and end of their shift to deter personal use.

Management Plan – Parking Solutions employees will be trained in the correct use of an AVI device during new employee orientation. AVI devices are currently being documented/assigned to individual Parking Solution employees through a sign-in and sign-out process per each employee's shift. Parking Solutions employees are accountable for their device activity throughout their entire work shift.

Weekly random audits through a system-generated report will be performed by the Administrative Manager, Entrance Attendant Manager, and Parking Solutions management to detect improper AVI usage.

- Valet Parking Vouchers – Certain UM-HHC departments issue valet parking vouchers to their patients as a customer service. In most circumstances, the patient receives the voucher directly from the department as part of the appointment process. These vouchers allow patients and accompanying visitors to valet park at no cost. The vouchers are retained with the Daily Reconciliation Sheets and are accounted for during the reconciliation process. At the end of the month, the departments are charged back the cost of each voucher used.

Controls over the use of vouchers are not strong, which could lead to inappropriate use of valet parking by UM-HHC employees. Most of the vouchers are photocopies and not dated. Only 24% of the vouchers reviewed had an original authorized signature from the issuing department.

Management Plan – The Administrative Manager will order new pre-numbered vouchers and will dispense to interested departments. A memorandum from the Administrative Manager will be forwarded to departmental authorized signers outlining the new process for obtaining valet parking vouchers along with guidelines on issuing vouchers to patients and visitors.

Vouchers accepted will be reconciled during the daily reconciliation process. The voucher recharge process will occur monthly.

- Imprest Cash Fund and Cash Handling Practices – The valet parking service operates on a cash basis and each location starts the work shift with a change fund. The change fund is not established as an imprest cash fund with the U-M Accounts Payable Office and is not maintained according to University policy.
    - There is no single source of accountability for cash collections for three of the four locations that collect cash (Taubman Health Center entrance employs a cashier).
    - Both UM-HHC Entrance Services employees and contract valet employees perform cash handling duties. Not all individuals handling cash have taken cash handling training.
    - Checks are not restrictively endorsed at time of receipt.
    - Change funds are not independently reconciled and balanced on a daily basis.

Management Plan – Management has established imprest cash funds for each of its four cash collection locations: University Hospital/Taubman Center, Cancer Center, Cardiovascular Center, and C.S. Mott Children's and Von Voigtlander Women's Hospitals. The imprest cash funds will be renewed every six months.

A stamp has been ordered for all cash locations and valet staff will be instructed to restrictively endorse checks upon receipt.

All employees of Parking Solutions and University employees affiliated with Valet Services will be required to complete class TME103, *Treasury Management-Cash Handling*, provided through the Hospital's Administrative Manager. As part of the educational process, the Administrative Manager will conduct "train the trainer" classes for Parking Solutions management, so that they may conduct training for Parking Solutions employees in the future. The Administrative Manager will periodically audit the class to verify that classes are conducted according to standards.

Parking Solutions has developed a cash handling policy that will be reviewed with existing and new employees (orientation) and will be part of the employee file.

The Administrative Manager, Entrance Attendant Manager, and management of Parking Solutions will investigate alternatives for establishing a single source of accountability of cash collections for the following locations: Cancer Center, Cardiovascular Center, and C.S. Mott Children's and Von Voigtlander Women's Hospitals

- Annual Certification of Internal Controls and Gap Analysis – The UM Office of Internal Controls provides guidance and tools to help units across campus manage financial related processes. One such tool is the Annual Internal Control Certification and Gap Analysis Self

Assessment Review. University Audits identified that the Valet Parking Service, which is part of the UM-HHC Support Services Administration, is not included in the Annual Internal Control Certification and Gap Analysis.

Management Plan – Administrative Manager will ensure that the department ID of Valet Services is included in future Internal Controls Certification processes.

- Background Checks on Vendor Employees – Valets are normally entry-level positions with high turnover. Because valets routinely interact with patients, background checks are an important risk management tool. The contract requires Parking Solutions to perform background checks and drug testing on all employees associated with the valet service at UM-HHC. As part of the employment screening/application process, Parking Solutions is required to check applicant criminal history.

  Parking Solutions Management stated that background checks and drug testing is performed on new employees when hired and on all employees on an annual basis. However, documented evidence of checks and results are not forwarded to the Valet Contract Administrator. A subsequent review by the Administrative Manager revealed that the recurring annual checks are not performed as originally stated and required by contract.

  Management Plan – Background checks include local, state, and sexual offences, and offences committed outside of Michigan. Parking Solutions also runs a Michigan State Police Internet Criminal History Report and a driver's license validation for all employees. To ensure all Parking Solution employees remain compliant with criminal and drug testing checks, and a have valid driver's license as per the University's requirements, the Administrative Manager and management of Parking Solutions will meet semi-annually to review required reports and take action when necessary.

Valet Parking Services has some unique management challenges. It is primarily a cash basis operation that is susceptible to theft and employee misuse. Valet employees are entry level positions with unsupervised access to patients and cash. Strong supervision and internal control practices will deter fraud and ensure a positive patient and visitor experience.

A formal follow-up to the outstanding issues will be conducted during the second quarter of fiscal year 2013.

Follow–up Reviews

UM-Flint Cashier's Office (First Follow-up Memorandum)   #2010-804
Original report issued March 22, 2011   Follow-up report issued February 9, 2012

The Cashier's Office has taken several steps to strengthen their internal controls. Management is still addressing the action plan for one item. A second follow-up review will be conducted during the fourth quarter of fiscal year 2012 to address this item. The current status of each action plan is summarized below.

- Vault Balance – The Accounts Receivable Manager and the Director of Financial Services and Budget performed an analysis of cash on-hand in late fall 2011. The cash on-hand balance is now being tracked each month using information from the bank reconciliation. As a result of the assessment, the current vault balance is deemed sufficient for operations. **This issue is closed.**

- Accuracy of Cash – The Director of Financial Services and Budget reviews and signs-off on the month-end reconciliation, which includes M-Pathways reports. Daily cash count sheets and night drawer sheets were updated. Cashiers sign their respective sheets and immediately report any overage or shortage to management. The Accounts Receivable Manager reviews the sheets and tracks her review each day to ensure all days and sheets are reviewed by month-end. The Cashier's Office manual includes these updated procedures.

  Surprise cash counts (audits) of teller drawers are performed quarterly by the Intermediate Accountant, who does not have any other responsibility for managing cash. The Accounts Receivable Manager reviews the audit results. Quarterly audit sheets were created and are signed by the individual performing the count and the teller. The first surprise audit took place in late spring 2011. The Accounts Receivable Manager tracks dates of the audits so that they do not become predictable. **This issue is closed.**

- Petty Cash Reimbursement – Petty cash is reimbursed on a biweekly basis rather than weekly. This new schedule is feasible given the time required and limited resources. The Intermediate Billing Clerk reimburses teller drawers twice per month unless a teller gives out $1,000 or more in advances or has ten or more petty cash transactions; these instances warrant additional reimbursement. The Accounts Receivable Manager reviews reimbursement sheets and the Intermediate Billing Clerk updates the cash on-hand activity sheet with current information.

  The Assistant Controller is working with individual departments and programs to ensure everyone is trained on acceptable receipts and approval for petty cash reimbursements. The imprest cash journal was redesigned and is now easier for the Cashier's Office staff to use as part of their process. **This issue is closed.**

- Deposit Delays – A clearing account has been established to allow for the deposit of checks as they are received. A new deposit form was created that allows for easier review and promotes a more efficient deposit process. Management has documented procedures for depositing checks. **This issue is closed.**

- Segregation of Duties – To address segregation of duties issues, an incoming mail log was created and is used to record all mail (e.g., checks). There are limited instances when checks are copied to assist with processing. In these instances, the Cashier's Office has agreed to redact sensitive information for enhanced privacy and security. A daily cash count sheet for the night drawer was created. Processes are adequately segregated and procedures have been documented in the UM-Flint Cashier's Office manual. **This issue is closed.**

- Security and Access – During a follow-up visit to the Cashier's Office, University Audits observed that the vault door was locked and remained locked throughout the day. The Accounts Receivable Manager periodically checked teller drawers when they were away to ensure they were locked. The vault combination is changed when employees with knowledge of the combination leave the department. Office door access for employees who leave the department is also removed by the UM-Flint Department of Public Safety (DPS). After discussion with DPS, two additional surveillance cameras were installed in the Cashier's Office to ensure all areas where cash is handled are monitored. **This issue is closed.**

- Policies, Procedures, and Training – Procedures for petty cash reconciliations, vault combination changes, deposit tracking, and credit card refund processing have been documented and are included in the Cashier's Office manual. **This issue is closed.**

- Collection Process Efficiency – In the short term, the Cashier's Office will image all historical collections data to securely retain the information. An Access database will be developed to track all new collection activity and procedures will be documented. The Cashier's Office will continue assessing their existing collection process and vendors for transition to an electronic receivables tracking system. University Audits will review the status of this item during the second follow-up review.

UM-Flint Cashier's Office (Second Follow-up Memorandum)   #2010-804
Original report issued March 22, 2011   First follow-up report issued February 9, 2012
                                    Second follow up report April 26, 2012

University Audits recently completed a second follow-up review to assess the effectiveness of the remaining open action plan. A summary of the review is detailed below. **This audit is closed.**

- Collection Process Efficiency – During the audit, it was determined that the collection process was inefficient because document retention efforts were manually intensive. The Cashier's Office continues to image all historical and current collection information in WebNow, the University's electronic document imaging system. The Cashier's Office is working with Administrative Information Management Services (AIMS) to modify folders and identify documentation tools in WebNow (e.g., account flagging) for easier reference and review. AIMS is actively working to assess the use of a more web-focused system for the Flint campus. The Cashier's Office will continue to use WebNow for their collection process needs until a decision is made. As the process continues to be modified, procedures will be documented on an ongoing basis. **This issue is closed.**

Department of Afroamerican and African Studies   #2010-820
Original report issued June 25, 2010   Follow-up report issued February 9, 2012

University Audits performed a review of the Center for Afroamerican and African Studies (CAAS), a unit within the College of Literature, Science, and the Arts (LSA), during fiscal year 2010. A second audit was conducted in fiscal year 2011 following significant changes in structure and many academic and financial processes. CAAS received department status from the Board of Regents, and is now the Department of Afroamerican and African Studies (DAAS). A follow-up review was completed to assess progress toward action plans detailed in the second audit report. Based on this review, management has made significant progress towards strengthening internal controls and establishing an effective tone at the top. Business and academic affairs are regularly conducted in accordance with University policies and guidelines, and effective coordination and communication with the LSA Shared Services department is enabling more efficient review of departmental activities. A summary of the second audit observations and management's actions to address them are noted below. **This audit is now closed.**

- Financial Controls
  Cash Handling Procedures – DAAS has segregated the duties of receiving and depositing cash and checks. Two employees are trained on receiving funds and deposits occur in a timely manner. The Department Manager periodically reviews the receipt book to ensure receipts are issued according to department policy.

  Travel Advance Procedures – Implementation of Concur has significantly reduced the manual processes that were previously used for travel advances. Travel advances now receive the review and approval of both the Department Manager and the Chair. Advances from a faculty member's discretionary research account are only reviewed by the Department Manager.

Repayment/settlement arrangements are discussed in advance of the trip, and the Department Manager has an effective process to monitor outstanding travel advances. A new travel advance policy was formalized and distributed.

- Purchasing Controls
  Purchasing Review – Employees with a business need to make purchases have been issued their own P-Cards. Purchases are reviewed to ensure they represent the most efficient use of University funds, balancing the cost of the item with any additional effort. Employees are more diligent to remind vendors that the University is tax-exempt. Expenses are reviewed to verify that the business needs are legitimate, approvals are appropriate, and documentation supporting purchases is complete.

  P-Card Concur Process – The Department Manager and LSA Shared Services share duties in the P-Card reconciliation and approval process. Electronic receipt images from Concur are used to validate expense activity, and the Chair's expense reports receive final approval from LSA.

- Human Resource Controls
  Conflicts of Interest – Related Faculty – A management plan for the two faculty married to each other has been submitted to Academic HR within LSA. Conflicts of interest and conflicts of commitment (COI/COC) policies and examples were reviewed with all employees during mandatory fall meetings. Additionally, an e-mail reiterating the COI/COC policies was sent to all department faculty and staff, and included links to the online policy as well as examples of potential COI/COC scenarios.

  Payroll Records – The Gross Pay Register is reconciled timely by LSA Shared Services, and the Department Manager also reviews the reports on a regular basis. Their review has enabled timely identification of instances where employees were inappropriately billed to DAAS shortcodes.

- Academic Programs
  Study Abroad Program Administration – DAAS has partnered with LSA's Center for Global and Intercultural Study (CGIS) to administer study abroad programs. A formal memorandum of understanding to document this partnership has been drafted and discussions are ongoing between DAAS and CGIS. An informal protocol has been established to immediately document which department will be responsible for various study abroad processes. A study abroad orientation checklist is used to ensure key information is shared with students. Graduate students assisting on study abroad programs sign an agreement to ensure they understand their expected responsibilities.

- Information Technology Controls
  Management of DAAS Equipment – The Department Manager has instituted a robust tracking method for DAAS-owned equipment. The departure checklist also includes a step to remind the employee to return any equipment. The departure checklist is used anytime an employee leaves the department, whether via termination, retirement, or transfer to another University unit. These procedures will be performed for graduate or temporary students, visiting researchers, as well as regular faculty and staff.

  Storage of Business Critical Data – DAAS has moved business-critical files to a shared network drive where access can be restricted based on job responsibilities. The departure checklist, as an

added safeguard, requires employees to verify that necessary work-related files are stored online for the department's future access needs.

eResearch Proposal Management   #2010-304
Original report issued June 27, 2011   Follow-up report issued March 12, 2012

The original eResearch Proposal Management report contained one open issue pertaining to contractual restrictions on access to the eResearch system by the software vendor, Huron Consulting Group (Huron). The absence of a comprehensive data security and confidentiality agreement with Huron presents a risk to not only the data stored in Proposal Management, but also data in the Regulatory Management and Animal Management systems.

ITS began negotiating terms of a Data Protection Agreement with Huron in the fall of 2011. The agreement is based on a template ITS has used with vendors of other U-M enterprise systems such as the Donor and Alumni Relations Tool (DART). Audit follow-up was postponed from December 2011 to allow ITS to conclude negotiations with Huron. However, these negotiations remain ongoing.

University Audits reviewed a draft of the proposed Data Protection Agreement. Huron has informally accepted most of the agreement's terms. Two significant items remain under discussion. The progress made to this point is substantial. Due to the sustained negotiation period and the scope of the data this agreement is designed to protect, this issue will remain open, and University Audits will follow-up again in the fourth quarter of fiscal year 2012.

Export Controls Compliance   #2010-402
Original report issued October 21, 2010   Follow-up report issued March 26, 2012

The scope of the Export Controls Compliance audit included export controls compliance processes in research activities at the University of Michigan. Federal export regulations impose restrictions over certain sensitive technology, services, and information. While no instances of non-compliance were noted during the audit, opportunities existed for improving the supporting infrastructure at the University, including training and education on export controls, identification, and communication of projects, monitoring for compliance with Technology Control Plans (TCPs)[3], and disposition of controlled technology. A follow-up review to assess the status of management action plans was conducted in June 2011. University Audits recently performed a second follow-up to re-assess the open items. The purpose of this memo is to provide an update on progress made.

Several organizational changes have occurred in recent months that have an effect on the export controls compliance program. Specifically:
- The Division of Research Development and Administration (DRDA), which coordinates export compliance efforts at the University, has reorganized and is now the Office of Research and Sponsored Programs (ORSP). ORSP's mission remains assisting faculty and staff in all aspects of externally funded research projects and other scholarly activities.
- The Senior Export Compliance Officer retired from the University. His part-time appointment has been replaced with a full-time Export Compliance Manager position, which is already filled.
- ORSP is in the process of hiring a new Executive Director. The Executive Director of ORSP is the designated institutional official for export controls matters.

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[3] A Technology Control Plan is a documented plan that defines the specific technology, equipment, software, or data and indicates how it will be controlled in accordance with the federal export control requirements.

Management has developed a working plan to improve the compliance program for export controlled research activities and to further address the risks highlighted in the audit report. The main objectives and specific steps of this plan are summarized below.

- Improve existing and develop new management tools.
  - o Update an internally developed database to track export controlled projects, facilitate compliance, and generate management reporting. Continue to flag projects in the electronic Routing and Proposal Management system (eRPM).
  - o Improve the inclusion of critical export control information in eRPM. Such information will include TCPs and their status, publication exclusions, non-disclosure agreements, and other related documentation.
  - o Ensure that information regarding export controlled technology is adequately and efficiently organized during the upcoming merger of the Special Service Projects (SSP) database[4] with eRPM.
  - o Create new tools to assist Project Investigators and Project Representatives with the identification and communication of export controlled activity, development of TCPs, monitoring for compliance with TCPs, and disposition of export controlled technology. Examples of such tools are:
    - A TCP template
    - A decision tree for identifying projects with export controls
    - A checklist or template for disposition of equipment, data, and software
    - Aids related to equipment and software transfers overseas and other foreign visitor and foreign travel restrictions

- Increase outreach to the research community.
  - o Enhance training and education on export controls. Consider mandatory training requirements for PIs and their research staff through web-based tools such as PEERRS or CITI[5] or group sessions with the Export Compliance Manager.
  - o Continue to expand communication and outreach with IT staff, research administrators, and students involved in projects with export controls. Increase accountability and transparency by including IT staff, department chairs, and Deans in the TCPs.
  - o Establish a formalized compliance monitoring program with periodic and for-cause reviews.

Several of the aforementioned steps are already under way. The Export Compliance Manager has:
- Reached out to the research community to determine the most efficient methods to increase training and education.
- Updated an internal database with current known export controlled project information.
- Drafted a TCP template that is currently under review.

Export controlled research activity is a small portion of the University's research portfolio, but poses risks that require a robust compliance program. University Audits supports the working plan outlined above, and acknowledges that the implementation of a fully developed program will take time. As there is ongoing commitment by the Office of the Vice President for Research to provide resources to develop a robust compliance program, **this audit is closed.** University Audits will conduct an audit of the fully implemented program in fiscal year 2014.

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[4] The SSP database is an internally developed database to track special agreements in which the University receives controlled technology, but not related funding.

[5] Collaborative Institutional Training Initiative (CITI) is an external service providing research education to members of the research community. It offers web-based training in multiple areas of responsible conduct and research compliance.

University of Michigan Comprehensive Cancer Center   #2011-203
Original report issued June 24, 2011   Follow-up report issued March 28, 2012

Management has adequately addressed all of the audit issues discussed in the original University of Michigan Comprehensive Cancer Center (CCC) audit report. **This audit is closed.**

The following summarizes management's response to improve the control environment:

- Travel and Hosting Expense – CCC management communicated to all managers the importance of providing sufficient documentation and supervisory review of travel and hosting expenses. Particular control concerns noted in the Health Communication Core have been addressed by providing additional staff training and management monitoring. A limited review by University Audits of recent Health Communication Core travel and hosting expenditures showed appropriate supervisory review, documentation, and business purpose.

- Recharge Activity – The Clinical Trials Office worked with the Office of Financial Analysis to correct recharge rates and develop new rates, as needed. CCC management has also reviewed the Tissue Microarray core service unit activity with the Office of Financial Analysis, and has determined that it does not need to be a recharge unit.

- Financial Review – Segregation of duties concerns related to Statements of Activity reconciliation has been eliminated by hiring an additional financial specialist and reassignment of procurement and reconciliation duties.

- Donor Access Databases – Medical School Information Services have appropriately secured a donor database maintained by the CCC Development Office.

Office of the Provost – Ann Arbor Campus   #2012-203
Original report issued December 22, 2011   Follow-up report issued March 28, 2012

Both open items in the original audit report of the Office of the Provost – Ann Arbor have been satisfactorily addressed as summarized below. **This audit is closed.**

- Information Systems Shared Services – Recharge Activity – The services provided by Information Systems Shared Services will be moved to a shared services model as part of the End User Services project within NextGen Michigan by the end of 2012 or early 2013. Further review by the Office of Financial Analysis was deemed unnecessary based on the upcoming move to the shared services model.

- Concur Approvals – The Office of Budget and Planning (OBP) now reviews a monthly workflow detail report for approved expense reports from the deans and other employees who report to the Provost. OBP staff are now able to identify instances where expense reports were not properly routed to OBP for final approval and address the situation in a timely manner. This ensures that all expenses are ultimately reviewed for compliance by OBP.

University Audits recently conducted a follow-up review to assess the status of management's corrective actions. OGC management has taken appropriate steps to address the audit issues and improve internal controls. **This audit is closed.**

- Monitoring of Legal Matters Requiring Retention of Outside Counsel – OGC developed procedures to monitor legal matters that require retention of outside counsel. Attorneys who monitor outside counsel and OGC management continue to determine budget estimates at the outset of each case. OGC is working with an external vendor to develop a robust database application that will assist with monitoring expenses related to such legal matters. The system will track expenses and notify OGC management when a case is approaching its budget limit. The new database is in the final phase of development and is planned to be in use by the end of March 2012.

- Document Management – OGC took several actions to enhance their document management system. An agreement was established with the Whole Brain Group, a web-based software provider, to ensure non-disclosure of confidential information maintained in the FileTracker database. OGC recently replaced the FileTracker system with a new, more robust system called NetDocuments (NetDoc). NetDoc offers improved document management, backup, and security. OGC leadership continues to encourage full utilization of the system through training, education, and policies and procedures. Current utilization of NetDoc is an improvement over the FileTracker system. FileTracker is still used for retaining documentation from older cases. A RECON (Risk Evaluation of Computers on Open Networks) assessment for OGC is scheduled for May and June 2012. We encourage OGC management to take timely action on any RECON recommendations.

- Expense Reimbursement – OGC uses Concur for travel and expense reporting. Concur provides better tools for documenting the business purpose for expenses and listing attendees for hosting events. Concur training for staff was an opportunity to reinforce related policies and procedures. University Audits verified compliance with University policies for a sample of travel and expense transactions.

- OGC Procedures – OGC has documented important operational procedures. Examples of documented procedures include processing legal matter invoices, determining legal matter budgets, processing legal matters for insurance claims, record retention and destruction, and purchasing procedures. OGC developed an authority matrix to assist Fleming Shared Services in confirming appropriate approvers for OGC's transactions. Leadership is committed to documenting and regularly updating their policies and procedures to ensure clear roles and responsibilities and continuity of operations.

- Annual Certification and Internal Controls Assessment – OGC completed the internal controls gap analysis for fiscal year 2011 in collaboration with Fleming Shared Services. The Office of Internal Controls provided significant support during this process. Fleming Shared Services has documented their procedures and shared them with the Fleming units to assist with the gap analysis. The close collaboration will continue in the future to ensure the internal control gap analysis tools are completed accurately.

UM-Flint Business Continuity   #2011-303
Original report issued August 12, 2011   Follow-up report issued March 30, 2012

The original audit report, UM-Flint Business Continuity, contained four action items. University Audits recommended development and implementation of a Business Impact Analysis (BIA), revision of existing continuity of operations planning templates, a process change whereby process owners work closely with UM-Flint ITS to develop disaster recovery plans, and completion of continuity of operations testing.

UM-Flint has assembled a team to specifically look at the development and implementation of a BIA on campus, and enhancement of existing University continuity planning. The team is comprised of a cross section of directors and leaders representing each of the Executive Officers and is currently in the planning phase of addressing the business impact analysis. This planning will allow UM-Flint to create and maintain a sustainable and comprehensive continuity of operations plan.

University Audits will conduct a second follow-up during the second quarter of fiscal year 2013 to assess additional progress made addressing the action items.

Conference Services   #2010-102
Original report issued February 25, 2011   Follow-up report issued April 5, 2012

Management has evaluated various solutions for the risks discussed in the original audit report. During this follow-up review, University Audits assessed all current and planned changes.

- Department Accounting and Reporting
    - *Project Grant Code Use* – Conference Services staff began requesting unique project grant codes for each new conference during the original audit. University Audits confirmed this is still happening and is working effectively to enhance reporting and monitoring.
    - *Department IDs* – The Director of Housing Business and Finance reviewed all department IDs associated with Conference Services. Only two department IDs (instead of the original five IDs) are now used to process internal and external conferences.
    - *Agency Fund* – Agency funds have been established to hold conference payments for external clients. The Director of Housing Business and Finance is proactively analyzing deposit levels for external clients to ensure University funds are not used.

These issues are now closed.

Recently, Housing Business and Finance assigned an accountant on a half-time basis to handle the financial functions of Conference Services. These functions include managing contracts, performing Statement of Activity reconciliations, reconciling bank statements, reviewing credit card refunds, reconciling credit card and check payments to participant registration in the Conference Programmer software, and meeting monthly with each conference manager to review final bills. The Director of Marketing and Conference Services is working with the accountant to document procedures for performing these functions.

Conference Services has made significant progress toward improving their internal control environment as summarized below. Given that the majority of conferences take place during the summer, it will take time to ensure the corrective action plans are fully operational and working effectively. Therefore, University Audits will conduct a second follow-up during the first quarter of fiscal year 2013.

- Contract Compliance – Revised contract language requires earlier mailing and response from clients. A draft of the modified contract was submitted to the Office of General Counsel for review. Copies of contracts are electronically retained and now reside in one location. The conference tracking spreadsheet was revised to consolidate events at each residence building for easier review. The accountant maintains the tracking spreadsheet and retains contracts. Escalation procedures are in place and documented.

- Billing Payment and Accuracy – Review of the final conference bill is included as part of the updated job responsibilities of conference managers. Managers work with the accountant to ensure final bills are accurate using source documents (e.g., Conference Programmer, original contract). Individual participant administration fees were eliminated because the new overall contracted price structure includes administrative costs. Client calls made to Housing Business and Finance staff are routed to the applicable conference manager.

- Payroll and Time Reporting – Review and approval of time entry and the Gross Pay Register (GPR) are appropriately segregated. Pre-approval overtime forms are used for staff and student overtime requests; these forms act as source support for overtime charges on the GPR. The Director of Human Resources, University Housing is in the process of determining the best way to standardize overtime procedures for all Housing units. Documented overtime procedures will include appropriate use of flex time and comp time based on employee exemption status. Job responsibilities of Conference Services staff are also being reviewed for alignment with documented job descriptions.

- Statement of Activity Reconciliation – Reconciliation of the Statement of Activity is now the responsibility of the accountant. Source documentation is stored centrally on the department's shared drive. Clarifying questions are answered at the Conference Services monthly staff meetings. The Director of Marketing and Conference Services reviews and signs the reconciliations each month.

- Background Check Verification – Student hiring and background checks are centralized with University Housing Human Resources. Screenshots of background checks are printed and retained in a secure file cabinet in that office.

- Client Management
  - Client Feedback – A short customer satisfaction survey was developed by Conference Services and distributed to clients in December 2011. Unfortunately, the free, online survey tool used to administer the survey was decommissioned before performing an analysis of the data. Conference Services will develop and document procedures for creating, distributing, analyzing, and reporting customer survey results. To provide a more reliable service, internal survey options or the use of established agreements (e.g., Survey Monkey) will be considered.
  - Client Acceptance – The Director of Housing Business and Finance and the Director of Marketing and Conference Services developed a policy for prioritizing groups for use of residence hall space. The policy aligns with the core values and mission of Housing and Division of Student Affairs.

University of Michigan Health System Level 2 Identity Management   #2011-306
Original report issued August 26, 2011   Follow-up report issued April 13, 2012

As discussed in the original audit report, Level 2 password distribution methods were not in accordance with UMHS Information Security Supplement and Requirements. University Audits recommended the MCIT Identity Management Team ensure that password distribution methods meet UMHS standards by either requiring that passwords be reset upon initial logon or seeking a documented exception from the UMHS Compliance Office.

The Identity Management Team acquired a documented exception from the UMHS Compliance Office on March 29, 2012. **This audit is closed.**

Center for Human Growth and Development   #2009-206
Original report issued November 17, 2009   First follow-up report issued August 26, 2010
                                      Second follow-up report issued April 19, 2012

Since the first follow-up was performed in August 2010, CHGD has experienced a change in leadership and significant changes in the key business administrator role. A new Director was hired in July 2011. A new administrator began in October 2011.

University Audits recently completed a second follow-up review to assess the status of internal control improvements. Management has taken appropriate steps to address and/or mitigate risks identified during the audit. Summaries of management's actions are detailed below. **This audit is closed.**

- Security/Maintenance of Sensitive Data – To improve management of sensitive information, PEERRS training (U-M's Program for Education and Evaluation in Responsible Research and Scholarship), which includes a section on privacy and confidentiality, is now required for all administrative staff at CHGD. The Human Subjects Incentive Program payment system is used for all of CHGD's research projects.

  CHGD reorganized their server. CHGD faculty and staff are now educated that this is the location for sensitive, research documentation to be maintained. CHGD's IT staff also restricted access to certain documents in individual folders. CHGD drafted a comprehensive written policy for managing the storage of sensitive data. This topic was discussed during regular meetings with faculty and staff.

- Monitoring Grant Budgets – CHGD no longer uses a supplemental system for financial reporting and budget monitoring. The administrative staff is successfully using M-Reports and other Business Objects reports to monitor their budgets. The budget monitoring process is now documented. CHGD is in the process of establishing quarterly meetings with their Principal Investigators and training faculty to properly use M-Reports for monitoring their research budgets.

- Disaster Recovery/Business Continuity Planning – CHGD completed the transition of its data storage to the Mainstream Storage Service provided by Information and Technology Services. CHGD is in the final stages of updating their network infrastructure to satisfy the storage demands of research projects.

  CHGD started drafting a Business Continuity Plan. The plan contains many important components including:
  - Key contact information and lead emergency coordinators within the unit

- o Essential department operations by area, the contact person(s), a back-up person
- o Specific action plans to continue essential operations and services
- o Detailed action items related to IT and how to keep the systems functioning

CHGD should continue their efforts to consider and plan for potential threats that could effect on the continuity of the departments essential processes.

- Statement of Activity (SOA) Reconciliation/Segregation of Duties – For CHGD's sponsored funds, the role of reconciling the SOAs is appropriately assigned to an individual who does not have access to initiate and approve a procurement transaction. For CHGD's non-sponsored funds, the person who is primarily responsible for reconciling the SOAs does have a procurement role and the ability to control a procurement transaction (less than $5000) from start to finish. The Business Administrator reviews the SOAs for non-sponsored funds as a mitigating control. CHGD has been using eReconciliation for reconciling some of their sponsored projects, as they transition from paper processes. Staff has been trained on eReconciliation and CHGD plans to fully implement its usage for all of their funds by the end of the current fiscal year. CHGD drafted a written procedure for reconciling their SOAs.

  If CHGD is not able to completely separate the purchasing role from the reconciliation role for all of its funds, it is important that compensating controls exist, such as a higher-level review of all transactions generated by any person who has a separation of duties issue. Documented procedures should be updated to incorporate all secondary, high-level reviews and any other compensating controls that are implemented to address potential separation of duties risks.

- Procurement Process – The Office of the Vice President for Research (OVPR) requires that all of the Director expenses, including those on the Department Administrator's expense reports, be approved by OVPR in advance or reviewed in Concur by adding OVPR as the final approver. This policy is now documented and shared with all units via a CTools website. University Audits confirmed that expense reports for CHGD's Director were properly approved by OVPR.

- Registration with U-M's International Travel Oversight Committee (ITOC) – Insurance Requirements – Faculty and staff were reminded of the requirement to ensure that all international travel was registered with ITOC. CHGD created an International Travel Oversight policy. The policy includes links to U-M policies regarding international travel and states the requirement to register all international travel and obtain required international health insurance. CHGD redesigned their public website, which now includes a link to the University's global portal, M Global Michigan.

- Documented Procedures – Management drafted a plan for creating a procedure manual. The plan lists all of the center's processes that should be documented, includes target dates for completing the most critical processes, and identifies who is responsible for documenting the specific process. All documented procedures are maintained on a CTools website for employees to view. The following lists a few of the procedures that have been documented to date:
  - o Concur travel and expense procedures
  - o Gift card processes
  - o P-Card procedures
  - o Human Subjects Incentive Payments procedures
  - o New employee and termination checklists

UMHS Staff Licensure/Certification/Registration Policy Review   #2011-107-2
Original report issued June 30, 2011   Follow-up report issued April 20, 2012

This follow-up review assessed progress toward strengthening compliance with *UMHHC Policy 04-06-040, Verification of All Applicable Current Staff Licensure/Certification/Registration.* Management has adequately addressed the audit recommendations. **This audit is closed.**

The following summarizes management's response to improve compliance.

- Non-State Mandated Certifications – Management reminded departmental personnel responsible for ensuring compliance with licensing that the auditing process should include verifying required credentials for both regulatory licensing and UMHS specific certifications.

- Credentialing Time Extension – Management created two new classifications for employees who are in the process of obtaining their required credentials.

- Annual Review of the Licensure Matrix – Human Resources implemented an annual review of the licensure matrix to the on-going auditing process.

Division of Student Affairs Recreational Sports-Club Sports   #2010-816
Original report issued March 2, 2011   Follow-up report issued April 26, 2012

At the request of the Division of Student Affairs (DSA), University Audits conducted an audit of the Club Sports Program (a program of the Department of Recreational Sports), which was completed in March 2011. The DSA request for an audit followed the institutional decision to transfer supervision of Recreational Sports to DSA from a joint reporting relationship to the Office of the Provost and Department of Intercollegiate Athletics. Club Sports are student-led sports organizations composed primarily of students, but may also include faculty and staff. Club Sports vary from student-led teams competing locally to coach-led nationally ranked teams. The audit found that there was solid management and oversight of certain aspects of the program, but there were significant areas of Club Sports activity that were not under University control. The University was assuming legal responsibility for the Clubs without sufficient span of control.

In response to the audit, and because of a broader interest in evaluating Club Sports governance, accountability, and risks, DSA hired a management consulting firm to perform an extensive operational improvement review of the Club Sports Program. The consulting project provided an implementation plan for addressing the specific risks noted in the audit report, but also provided a broader strategic framework for management consideration. The current status of the issues noted in the audit report is summarized below. University Audits will conduct a second follow-up in the third quarter of fiscal year 2013, upon completion of the implementation plans.

- Student Sponsored Organizations
  - o DSA Management completed an evaluation of the University sponsored student organization categories and concluded that an additional category for Club Sports organizations was appropriate. DSA Management is currently undertaking the formal steps required to create a separate category for Club Sports teams that addresses their unique requirements.
  - o Recreational Sports Management identified and moved eight of the clubs that were of an instructional and or recreational nature (non-competing clubs) to voluntary student organization status.

- o A formal memorandum of understanding between the University and Club Sports Booster Clubs has been drafted and is under review by the Office of General Counsel.
- o All Clubs have been recognized either as sponsored student organizations or as volunteer student organizations.

- Guidance
  - o DSA Management has initiated more meetings with Club Sports leadership and coaches to improve team understanding of policies, expectations, and responsibilities.
  - o Additional staff have been added to provide more oversight and support.
  - o Management software has been purchased and will assist in managing day-to-day Club Sports activities. The software will also be shared with Center for Campus Involvement for general student organization use.
  - o A participation agreement form for student athletes that outlines expectations, legal liability, and insurance requirements is in draft form.
  - o A coaching agreement is currently in development. All teams will be expected to have at least one coach and/or advisor by December 2013. All coaches and advisors will undergo background checks and have letters of commitment.

- Financial Management and Travel
  - o All teams that remained in sponsored organization status have been notified of the requirement to close their external bank accounts by August 2012.
  - o Management has set up separate agency chartfield funds to assist in financial management and monitoring of each Club.
  - o Extensive travel policies, specific to Club Sports activities, have been created and disseminated to team leadership.

- Practice, Game, and Fitness Space
  - o A memorandum of understanding between the Department of Recreational Sports and the Department of Intercollegiate Athletics regarding facilities usage between the two organizations has been drafted.
  - o The Department of Recreational Sports recently completed a comprehensive survey and analysis to address long-term campus-wide recreational facility needs.
  - o Management is working individually with teams to ensure that Recreational Sports management is involved in any processing of contracts for use of facilities that are external to the University.
  - o Safety and security training was provided to team members during recent orientations.

- Medical Support
  - o All participants will be required to provide proof of current medical insurance as a condition of team membership beginning fall term 2012. Current team membership has been informed about this upcoming requirement.
  - o Management is continuing to assess the need for Club Sports trainer support.

- Property
  - o Management is currently in the process of drafting appropriate policies for the acquisition, tracking, maintenance, and disposal of significant equipment.
  - o The teams have been asked to complete and return an equipment inventory form by the end of April 2012 in order to develop a baseline equipment inventory. Management is working with the teams to address storage concerns.

Emergency Loans in Financial Aid #2010-112
Original report issued June 7, 2011 Follow-up report issued April 26, 2012

A follow-up review of Emergency Loans in Financial Aid was conducted to assess the status of management's corrective action plans. All audit recommendations have been addressed. The implemented action plans are summarized below. **The audit is now closed.**

- Inconsistent Processing
  Inconsistencies were created by using two methods for processing and approving emergency loans, manually or using the eUloan program online through Wolverine Access. Inconsistencies in processing fees and interest rates have been eliminated. The Office of Financial Aid short term, emergency loan policy now reflects these changes. The policy was also revised to state that only one eUloan may be taken out at a time; additional manual loans can be approved at the discretion of the Financial Aid Advisor.

  Students receiving a manual loan may not have the convenience of viewing their loan activity through Wolverine Access; however, payment information is based on their promissory note, which is signed by the student as recognizing their obligation. Monthly statements are sent out and all students have the ability to discuss their loan activity with Student Financial Services at any time. Students defaulting on a manual loan have a longer period of interest-free accrual because the pre-collection process contains manual steps (e.g., checking to ensure there are no misapplied loan payments). The manual efforts will continue to exist to ensure all loan activity is accurate to avoid incorrectly sending loans to Student Loan Collections.

- Regulatory Compliance
  The Office of the General Counsel reviewed the emergency loan process for compliance with Regulation Z of the Truth in Lending Act (TILA). Revisions to the emergency loan extension due date policy were made based on this review and guidance. Extensions are only provided if the student repays half of their original loan and the loan is not past due by more than ninety days. Students receiving a loan extension are provided TILA documentation and must wait the mandatory three business day period before issuance of the newly extended loan.

- Policies and Procedures
  The Office of Financial Aid and Student Business Services worked together to update documentation for the emergency loan process to ensure that it accurately details the entire process. The documentation includes source fund accounting and donor reporting procedures. Activity for past due loans transferred to Student Loan Collections is now recorded to the actual source fund. A newly developed query tracks funds that have donor restrictions and/or reporting requirements to ensure compliance. Documentation is accessible to all individuals within the process.

Service Unit Billing #2011-104
Original report issued July 26, 2011 Follow-up report issued April 26, 2011

Management has made significant process improvements that have enhanced the efficiency and effectiveness of the SUB process. Audit observations have been satisfactorily addressed as summarized below. **This audit is closed.**

- Ownership of SUB Process – Accounting Services has taken the lead as the SUB process owner. They facilitated meetings with stakeholders to prioritize tasks and align people and effort. A

new SUB website was launched on March 30, 2012, following extensive communication and coordination between the involved groups. The website will be announced at the next Financial Unit Liaison meeting.

- Identifying Recharge Activity – A process is in place to classify internal vendors based upon the type of billing services they provide. Accounting Services has a team working to classify existing internal vendors. They are continuing their efforts to identify SUB activity inappropriately processed as journal entries and encouraging those users to transition to the SUB process. An outreach program is being planned in order to meet with units and review the SUB process, which will likely result in units self-reporting previously unknown recharge activity.

- Inactive Recharge Information – Accounting Services has a new process to track units that report discontinued recharge activity. This allows them to monitor each unit to verify billing has ceased and terminate the unit's vendor ID and recharge shortcode. A team is working to identify current internal vendors without recent recharge activity in order to terminate their recharge accounts. Accounting Services is also working with Vendor Maintenance to identify existing internal vendors with insufficient contact information.

- FTP Account Management – Four unsecure File Transfer Protocol (FTP) accounts were identified by ITS. Three of the account owners will immediately transition to a secure protocol for transmitting data. The fourth will be able to transition at the end of the calendar year when their current system will be decommissioned. An annual process has been established and implemented to identify and remove inactive SUB FTP accounts. Subsequent to the audit, ITS determined that limiting the number of unsuccessful login attempt would have a negative impact across the entire FTP server, not just the SUB accounts. ITS does not believe this change can be implemented and University Audits agrees.

- Reporting Options – Several new reports were developed after consultations between Accounting Services, Office of Financial Analysis, and several units with SUB activity. Three reports now exist to aid the SUB vendor, and four reports exist for the SUB customer. The new reporting options are included on the SUB webpage. These new reports better enable units to monitor their SUB activity.

UM-Flint Educational Opportunity Initiatives   #2010-201
Original Report issued February 18, 2011   Follow-up report issued April 26, 2012

University Audits concluded an audit of EOI's fiscal and operational controls in February of 2011. The audit identified a number of opportunities for improvement in oversight and operations. In response, there have been significant changes to reporting lines, budget oversight, and financial management practices. A portion of the corrective actions recommended, particularly those related to strategic planning, budget management, and employment controls, required the support of campus leadership and the assistance of campus service units, including Financial Services and Budget, UM-Flint Human Resources, and Information Technology Services,. Progress towards implementation of audit recommendations is detailed below. University Audits will conduct a second follow-up review on open issues during the second quarter of fiscal year 2013.

- Strategic Oversight and Guidance – Audit work indicated EOI would benefit from additional strategic guidance and oversight to ensure the department's objectives aligned with campus priorities. Effective July 1, 2011, UM-F leadership shifted EOI's reporting line to the Provost. The shift to an academic division is expected to allow for more strategic collaboration and

synergy with other programs within Academic Affairs dedicated to serving students and increasing community engagement and involvement on campus.

The Provost has met with the EOI Director to begin work on defining clear, measurable objectives for EOI that align with the new five-year strategic plan for the campus. To support this effort, Financial Services and Budget (FS&B) is working with EOI to develop a plan to correct budget deficits and quantify funding available to support EOI programs.

A documented performance evaluation for the EOI Director is forthcoming. Efforts to organize campus-wide meetings for student services administrators are also under way.

- Campus Support and Collaboration – Although EOI had been successful in obtaining community and foundation grants to help support its programs, additional fundraising guidance was needed to support annual giving efforts. The UM-Flint Advancement Office met with EOI in 2011 and recently developed a high-level fundraising plan. The Advancement Office has committed to creating a more granular, comprehensive plan that includes a feasibility study identifying potential giving opportunities for EOI programs. The fundraising plan will be tied to upcoming development campaign goals.

  University Audits reviewed two comprehensive, alternate plans developed by UM-HR to address EOI's organizational and staff needs. According to the HR Director, both plans were developed based on interviews with all EOI employees and a review of their job responsibilities and duties. Next steps include meeting with the Provost and the EOI Director to review both plans, agree on organizational changes to support the Director, and discuss training and development needs including data analytics.

- Budget and Financial Management – The Provost has been working with the Directors of both FS&B and EOI to develop a budget plan that would address programmatic funding needs while resolving the department's overall budget deficit. The organizational proposals mentioned above allow for delegation of the EOI Director's responsibilities and address the need for additional oversight of departmental expenditures.

- Staff Management – UM-F HR recently developed onboarding/offboarding checklists for departments, including EOI, to use for managing new hire and termination tasks. UM-F HR is monitoring for proper use of these internal control mechanisms.

  The EOI Director did not provide his staff with performance evaluations this year, due in part to competing demands. It is critical that all staff receive regular, written performance evaluations this year in accordance with UM-F guidelines.

  EOI is working with FS&B to determine the most efficient way to monitor payments to staff from outside departments to ensure any potential conflicts of commitment are handled appropriately.

- Time Reporting and Payroll – EOI showed initiative by taking several actions to improve their time reporting and payroll process prior to the end of the audit. These improvements included requiring approval of time reports by a supervisor with knowledge of an employee's actual time worked and timely monitoring of payroll oversight reports. During follow-up, testing showed that these improvements were still in place and working effectively. UM-Flint HR and FS&B

will monitor for continued use of these procedures and ongoing compliance with UM-Flint guidelines through the annual internal controls certification. **This issue is closed.**

- Event Management – Interviews with UM-F Events and Building Services (EBS) staff and the EOI Office Manager indicate that there has been some improvement around concerns noted in the audit report. Proposed organizational plans address the need for improved communication and tracking of information for recurring events.

- Cash Handling – FS&B set up a UM-F agency account for EOI to use to deposit revenues from fundraising activities conducted by EOI program participants and their parents. This corrective action will help to ensure compliance with University accounting guidelines.

  The UM-F Development Office was hopeful that donors could be identified to provide the funding needed to pay for the fieldtrip associated with EOI's Intensive Summer Program (ISP), eliminating the need for participants to fundraise on their own. To-date a donor has not been identified and as a result, the ISP trip was cancelled this year. This funding need will be addressed as part of the fundraising plan discussed above. **The cash handling issue is closed.**

- Business Continuity and Disaster Recovery Planning – Follow-up procedures confirmed that EOI and UM-F ITS have developed and implemented security measures to safeguard records and control access to locally-held programmatic data. EOI is working to address issues identified as a result their new security scans.

- Documentation of Policy and Procedure – Documentation of department procedures, including supplemental budget requests, event planning, and student fundraising, is needed to ensure consistency and compliance. Use of policy and procedure templates provided by the Office of Internal Controls is recommended to ensure adequate documentation of departmental processes.

Open Audits Follow-up Table
April 30, 2012

Audit Title	Report Date	Issues	Expected Completion
CAC and ITS Use of Federal Hardware in the Flux HPC Cluster 2011–810	4/12/11	Transitory oversubscription of federal hardware	First follow–up June 2011 June 2012
UM–Flint Business Continuity 2011–303	8/12/11	University impact analysis; BCP standards template; business continuity testing; disaster recovery plan	First Follow-up March 2012 November 2012
ITS CTools Software Development Processes 2011–808	8/29/11	Documentation; back–ups; use of wush.net	May 2012
College of Literature, Science, and Arts Information Technology Asset Management 2011–311	7/22/11	Use of the K2 client; firewalling license servers; changing and deleting users; key process areas; project management; disaster recovery and business continuity plans testing; management of copyrighted software; licensing processes; maintenance of access control lists	June 2012
Information and Technology Services eResearch Proposal Management 2010–304	6/27/11	Contractual restrictions on vendor access; "Site Manager" access	First follow-up March 2012 June 2012
Information and Technology Services MCommunity Sponsored Accounts 2011–304	11/22/11	Sponsorship administrator roles; improper permissions; monitoring of sponsored accounts; data verification policy; recurring training; policy enforcement	September 2012
Institute of Social Research Data Security 2011-308	12/7/11	Identification and assessment of sensitive and critical systems; risk mitigation activities; ITsecurity incident management; security plan	August 2012
UMHS Lost Laptop Exercise 2011-809	12/16/11	Risk assessment; encryption; compliance and security awareness training	November 2012
North Campus Auxiliary Service Building/North Campus Data Center 2011-301	2/3/12	Security cameras; service level agreements	June 2012

UM–Flint School of Health Professions and Studies 2010–209	1/25/11	Segregation of duties; faculty and staff certifications; privacy and data security; policies and procedures; P–Card controls; conflict of interest and conflict of commitment management; affiliate payment processing	May 2012
University of Michigan–Flint Educational Opportunity Initiatives 2010–201	2/18/11	Strategic oversight and guidance; campus support and collaboration; budget and financial management; staff management; time reporting and payroll; event management; cash handling; business continuity; documentation of policy and procedure	First Follow-up April 2012 ——————— November 2012
Conference Services 2010–102	2/25/11	Contract compliance; department accounting and reporting; billing and payment accuracy; payroll and time reporting; statement of activity reconciliation; background check verification; client management	First follow-up April 2012 ——————— September 2013
Division of Student Affairs Recreational Sports – Club Sports 2010–816	3/2/11	Sponsored student organizations; guidance; financial management; practice, game, and fitness space; medical support; property	First Follow-up April 2012 ——————— March 2013
Financial Analysis – Management of Asset Data, Space Data, and University Surplus 2010–111	5/10/11	Staff oversight; capital asset inventory management; government–titled assets; asset tagging; data security; outside trucking; sale of goods; physical security of assets; system access/data integrity; space survey submissions; building phase definitions	First follow-up January 2012 ——————— May 2012
Leased Employees 2011–112	6/7/11	Central process owner; identification of leased employees; U–M guidance; contracts	July 2012
University Unions 2011–814	6/15/11	General control environment; financial monitoring and oversight; purchasing management; human resource management; building renovation and maintenance	June 2012
Financial Considerations for International Activity 2011–101	6/30/11	Coordination of effort; documented policies and procedures; currency exchange; cash purchases; international bank accounts	June 2012
UM–Dearborn Office of the Provost 2011–210	6/30/11	Segregation of duties; timekeeping; policies and procedures; Fairlane Center procedures; collections and exhibitions	June 2012

Department of Geological Sciences Camp Davis Rocky Mountain Field Station 2011–813	7/28/11	Fire safety and inspections; documented policies and procedures; inventory management; documented emergency plans; cash handling; external entities	June 2012
Ross School of Business 2011–202	10/19/11	Budget preparation and review; Ross art collection; institutes and centers – oversight and monitoring; loans to international students; international programs – coordination; verification of Aramark reported data; sub–certification of internal controls; credit card monitoring/guidance; continuity of operations planning; unit assessments	June 2012
School of Dentistry Admissions and Financial Aid 2011–812	10/26/11	Multiple Mini Interviews (MMI); application review; documentation; application fees; spreadsheet controls; need–based aid	June 2012
Intercollegiate Athletics Stephen M. Ross Academic Center 2011–212	11/4/11	Laptop loan programs; attendance tracking	June 2012
Intercollegiate Athletics Complimentary Tickets 2011–110	11/16/11	Documented policy and procedure; monitoring and oversight; recording of complimentary tickets; complimentary parking and access passes; system access and use; compliance monitoring	June 2012
Plant Operations Information Management and Reporting 2011-102	12/22/11	Data management; reporting and analysis	Review progress June 2012 ⎯⎯⎯ Follow-up December 2012
e-Verify 2011-302	2/20/12	Contract information; identification of employees; document retention; e-Verify notice requirements; subcontract language; e-Verify System user access	September 2013
Rackham Graduate School Institute for Human Adjustment 2012-219	2/27/12	Patient receivables; Patient Protection and Affordable Care Act of 2010; segregation of duties; cash and cash equivalent handling	December 2013
Institute for Research on Labor, Employment, and the Economy 2012-220	2/29/12	Expense reporting; motor pool car/fuel monitoring; cash receipts; financial management	June 2012

University Safety and Security Communication, Reporting, and Incident Investigation 2012-809	02/10/12	Communication among University safety and security organizations; privacy and law enforcement; duty to report; emergency response; shared reporting system; lessons learned; training; organizational structures; culture	Quarterly beginning in June 2012
College of Literature, Science, and the Arts Museum of Natural History 2012-224	03/23/12	Inventory tracking system; cash handling and security; merchandise management; continuity of operations planning; hazard training and safety documentation; segregation of duties; internal controls certification; on and off-boarding checklists; student docent screening; payroll; conflict of interest or commitment process;	September 2012
University of Michigan Facilities and Operations Parking Operations 2012-107-1	3/27/12	Staff use of patient/visitor parking; override controls for gate operations; monitoring of parking activity; imprest cash funds; credit card controls; special events parking contract	December 2012
UMHS Michigan Health Corporation 2011–109	6/30/11	Assess effectiveness of JV compliance programs; standardized management analysis and operational reporting; streamline consolidation accounting; update COI policy; documentation of board deliberative process	June 2012
Michigan Nanotechnology Institute for Medicine and Biological Sciences Fiscal Responsibilities 2012–218	11/22/11	Subcontract payments to NanoBio; conflict of interest disclosures; financial management; safeguarding of assets	June 2012
Medical School Department of Emergency Medicine 2011-204	12/5/2011	Internal Control Assessment certification; non-certified effort reporting; purchasing; P-Card transactions; gross pay register reconciliation; statement of activity reconciliation; delegation of authority	September 2012
U-M Hospitals and Health Centers Valet Parking 2012-107-2	3/26/2012	Reconciliation practices; vendor employee use of patient/visitor parking space; valet parking vouchers, imprest cash fund and cash handling practices; annual certification of internal controls and gap analysis; background checks on vendor employees	December 2013