



**FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
AUDIT AND COMPLIANCE COMMITTEE**

Wednesday, September 18, 2019
8:00 am
Florida International University
Modesto A. Maidique Campus
MARC 290, Earlene and Albert Dotson Pavilion

Committee Membership:

Gerald C. Grant, Jr, *Chair*; Natasha Lowell, *Vice Chair*; Leonard Boord; Michael G. Joseph; Joerg Reinhold; Sabrina L. Rosell

AGENDA

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| 1. Call to Order and Chair's Remarks | Gerald C. Grant, Jr. |
| 2. Approval of Minutes | Gerald C. Grant, Jr. |
| 3. Discussion Items <i>(No Action Required)</i> | |
| 3.1 Audit and Compliance Committee Charter | Carlos B. Castillo |
| 3.2 Office of Internal Audit Status Report | Trevor L. Williams |
| 3.3 University Compliance and Ethics Update | Jennifer LaPorta |
| 4. Reports <i>(For Information Only)</i> | |
| 4.1 Office of Internal Audit Annual Activity Report 2018-19 | Trevor L. Williams |
| 4.2 Compliance Program Annual Report 2018-19 | Jennifer LaPorta |
| 5. New Business | Gerald C. Grant, Jr. |
| 5.1 Office of Internal Audit Discussion of Audit Processes | |
| 6. Concluding Remarks and Adjournment | Gerald C. Grant, Jr. |

The next Audit and Compliance Committee Meeting is scheduled for December 5, 2019

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FIU Board of Trustees Audit and Compliance Committee Meeting

Time: September 18, 2019 8:00 AM - 8:45 AM EDT

Location: FIU, Modesto A. Maidique Campus, MARC 290, Earlene and Albert Dotson Pavilion

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3.	Discussion Items <i>(No Action Required)</i>		
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**THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES**

Audit and Compliance Committee

September 5, 2019

Subject: Approval of Minutes of Meeting held June 19, 2019

Proposed Committee Action:

Approval of Minutes of the Audit and Compliance Committee meeting held on Wednesday, June 19, 2019 at the FIU, Modesto A. Maidique Campus, Graham Center Ballrooms.

Background Information:

Committee members will review and approve the Minutes of the Audit and Compliance Committee meeting held on Wednesday, June 19, 2019 at the FIU, Modesto A. Maidique Campus, Graham Center Ballrooms.

Supporting Documentation: Minutes: Audit and Compliance Committee Meeting,
June 19, 2019

Facilitator/Presenter: Gerald C. Grant, Jr., *Audit and Compliance Committee Chair*

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**FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
AUDIT AND COMPLIANCE COMMITTEE
MINUTES
JUNE 19, 2019**

1. Call to Order and Chair's Remarks

The Florida International University Board of Trustees' Audit and Compliance Committee meeting was called to order by Committee Chair Gerald C. Grant, Jr. at 8:09 a.m. on Wednesday, June 19, 2019, at the FIU, Modesto A. Maidique Campus, Graham Center Ballrooms.

Committee Chair Grant welcomed all Trustees and University faculty and staff to the meeting.

Deputy General Counsel Liz Marston conducted roll call of the Audit and Compliance Committee members and verified a quorum. Present were Trustees Gerald C. Grant, Jr., *Chair*; Natasha Lowell, *Vice Chair*; Leonard Boord; Joerg Reinhold; and Sabrina L. Rosell (arrived late).

Trustee Michael G. Joseph was excused.

Trustees Cesar L. Alvarez, Dean C. Colson, Marc D. Sarnoff, and Roger Tovar and University President Mark B. Rosenberg also were in attendance.

2. Approval of Minutes

Committee Chair Grant asked that the Committee approve the Minutes of the meeting held on March 4, 2019. A motion was made and unanimously passed to approve the Minutes of the Audit and Compliance Committee Meeting held on Monday, March 4, 2019.

3. Action Items

AC1. Internal Audit Plan, 2019-20

Chief Audit Executive Trevor L. Williams presented the Internal Audit Plan for fiscal year 2019-20 for Committee review and approval, noting that the plan was developed using a systematic risk-based approach that aids in the determination of the audits that need to be performed, while also considering the most appropriate allocation of available resources to maximize productivity. He provided an overview of the University risk assessment heat map, which identifies risks based on their likelihood and impact, pointing out that the heat map provided the basis for the development of planned future audits. Mr. Williams described how direct time was utilized over the past five years and presented an overview of carryover audits from the 2018-19 fiscal year, stating that these audits are in process. Mr. Williams delineated the proposed audits for the 2019-20 fiscal year and described how the 13 audits aligned with the University risk assessment heat map and past audit coverage as demonstrated in the risk-based five-year audit plan.

Trustee Roger Tovar commended the 2019-20 Internal Audit Plan and recommended that, in terms of avoiding negative audit findings, departments with upcoming audits should scrutinize their operations and address their responsibilities. Trustee Tovar encouraged a closer examination into a number of the subject matters falling within the 4/4 risk index, which could be addressed proactively, stating that this approach could allow the Office of Internal Audit to focus on areas that pose a challenge in terms of risk mitigation. In response to Trustee Tovar's comment and relating to the motor pool category, which is categorized with a risk index of 4/4, Senior Vice President of Administration and Chief Financial Officer Kenneth A. Jessell explained that a multi-year plan was developed where some vehicles nine or more years beyond their expected useful life have already been replaced.

In response to Trustee Tovar's inquiry relating to turnover in the Office of Internal Audit, Mr. Williams indicated that, through efforts already in place, the Division of Human Resources has been working to identify qualified candidates and that it is the expectation that the vacancies will be filled in the near future.

In response to Trustee Leonard Boord's inquiry, Mr. Williams indicated that the Audit Plan will address areas falling within the heat map's red categories. In response to additional inquiries from Trustee Boord relating to 3/4 and 4/4 risk-indexed subject matters, namely, brand alignment and affinity management and admissions policy compliance, Mr. Williams explained that efforts are already in process by the University's marketing consultant and concurred with Trustee Boord that the planned audit coverage relating to admissions policy compliance should be accelerated.

Committee Chair Grant concurred with Trustee Boord's comments relating to the expectation that, as a general policy, any subject matter with a risk index of 3/4 or 4/4 should have audit coverage within three years, except in the case where a subject matter is already being reviewed and/or addressed by another mechanism.

University President Mark B. Rosenberg pointed out that in terms of proactively working to address availability of talent in this domain, the Division of Human Resources is developing a track that employs eligible students in internships and apprenticeships with the possibility of leading to career tracks within the University once they graduate.

A motion was made and unanimously passed that the FIU Board of Trustees Audit and Compliance Committee approve the amended University Internal Audit Plan for Fiscal Year 2019-20 to reflect that generally any subject matter with a risk index of 3/4 or 4/4 should have audit coverage within three years.

AC2. University Compliance and Ethics Work Plan, 2019-20

Chief Compliance and Privacy Officer Jennifer LaPorta presented the 2019-20 University Compliance and Ethics Work Plan for Committee review and approval. She delineated the focus and guidance of the U.S. Department of Justice in terms of the concrete steps an organization's leadership takes to foster a corporate culture of compliance, emphasizing the difference between a "paper program" and a "real program," and eleven (11) topics and questions, which serve as best practices to measure compliance programs and further refine existing programs. She provided a

comprehensive review of the proposed 2019-20 Work Plan objectives in relation to the corresponding Federal Sentencing Guidelines provisions. Among the highlighted Work Plan objectives, Ms. LaPorta described the development of a comprehensive and interactive ethics training program, the development of an integrated risk assessment process in collaboration with the Office of Internal Audit, and the transition from the University's current external software provider, Convercent, to an in-house policy distribution and tracking platform.

In response to Trustee Natasha Lowell's inquiry, Ms. LaPorta explained that the escalation process contributed towards the increase in training percentages, which currently are between 95% – 100%. In response to Trustee Boord's inquiry, Ms. LaPorta described the rationale that led to the decision to transition away from Convercent, namely feedback from faculty, staff, and executive leadership, the provider's response rate for issuing updates, and the requirement to sign on with a username and password to an external website. Vice President for Information Technology Robert Grillo explained that the University will leverage the off-the-shelf application where content can either be procured or be developed in-house, in order to ensure adherence to University regulations and policies and responsiveness to password complexities.

Based on his experience using Convercent, Trustee Joerg Reinhold indicated that, while training percentages are being met, learning outcomes should also be considered.

A motion was made and unanimously passed that the FIU Board of Trustees Audit and Compliance Committee approve the University Compliance and Ethics Work Plan for Fiscal Year 2019-20.

4. Discussion Items

4.1 Office of Internal Audit University Risk Assessment

Mr. Williams provided an overview of the risk assessment development methodology, pointing out that risk owners were surveyed and were also part of the risk analysis process. He explained that the risk-based approach incorporated past audit coverage, previously completed risk assessments, and the University-wide risk rating survey. Mr. Williams presented the University risk assessment heat map, explaining that categories were rated based on parameters pertaining to impact and likelihood. He stated that, while the categories reflected in red will receive focused attention, mitigation strategies will be developed in terms of addressing areas reflected in yellow and green as part of an ongoing collaboration with the Office of Compliance and Ethics. He described the risk assessment development schedule, noting that an enterprise-wide assessment will occur every five (5) years with annual reviews and evaluations of risks.

4.2 Office of Internal Audit Status Report

Mr. Williams presented the Internal Audit Status Report, providing updates on recently completed audits. He explained that, while past audits have been completed related to FIU's access to the Florida Department of Highway Safety and Motor Vehicles' driver license and motor vehicle data to complete that agency's required attestation, the current audit was based on an expanded scope, which included a cybersecurity component, as required by the current MOU. He stated that the audit concluded that, in all material respects, the internal controls and data security governing the Department's use and dissemination of personal data pursuant to the MOU and applicable laws,

which if operating effectively, were those necessary to provide reasonable assurance that personal data is protected from unauthorized access, distribution, use, modification, or disclosure.

Mr. Williams reported on the audit findings pertaining to the procurement process at the Chaplin School of Hospitality and Tourism Management, pointing out that the audit identified opportunities to improve internal controls. He described the audit findings relating the College of Business and explained that overall, the audit concluded that the financial controls included within the prior audit of the College have improved. He indicated that opportunities for improvement exist in the following areas: (1) fund balance accumulation; (2) payroll overload expenditures; (3) controls over expenditures; (4) attractive property; and (5) control environment. Mr. Williams delineated the audit findings relating to the Patricia and Phillip Frost Art Museum's operations, noting the improvement in controls over the Museum's collection records from the previous audit. He explained that opportunities for improvement exist over operational and expenditure controls related to the collection's safeguarding.

Mr. Williams also reported that reviews were completed for four (4) institutions who are sub-recipients under FIU grants and that the purpose of these reviews is to ensure that sub-recipients are compliant with the financial reporting requirements. He indicated that six (6) audits are in various stages of completion and that the Coordinator of Administrative Services position has been filled.

Trustee Tovar commented on the continual improvement in terms of the implementation of the audit recommendations and recommended that as part of the onboarding process, University Deans and directors receive past audit reports. Mr. Williams indicated that all audits are shared with University Vice Presidents and Deans.

4.3 University Compliance and Ethics Quarterly Report

Ms. LaPorta provided a status update on the 2018-19 Compliance Work Plan, indicating that the report reflects progress on the key action items and other compliance activities for the third and fourth quarters of fiscal year 2018-2019. She reported that all key action items and program objectives have been fully executed, except for the Compliance program external assessment.

4.4 Review of Audit and Compliance Committee Charter

Deputy General Counsel Marston explained that, while the Florida Board of Governors requires a review of the Committee's Charter at least every three (3) years, the FIU Board of Trustees' Audit and Compliance Committee Charter requires a review at least every two (2) years. She indicated that members of the University administration will confer with Committee Chair Grant in terms of what recommendations, if any, should be presented to the Board of Trustees. She explained that if there are changes as a result of the review, the proposed amendments will be presented to the Committee and Full Board at the next regularly scheduled meeting.

5. Report

There were no questions from the Committee members in regards to the Athletics Compliance Report.

6. New Business

6.1 Senior Management Discussion of Audit Processes

Committee Chair Grant noted that, as is stipulated in the Audit and Compliance Committee Charter, the Committee must meet with senior management without the presence of the Chief Audit Executive. He further noted that because this meeting is conducted in the Sunshine, no one present was required to leave during the discussion with senior management, adding that this was strictly voluntary. The Committee met with senior management to discuss the internal audit process. Senior management commented on the positive collaboration with the Office of Internal Audit.

7. Concluding Remarks and Adjournment

With no other business, Committee Chair Gerald C. Grant, Jr. adjourned the meeting of the Florida International University Board of Trustees Audit and Compliance Committee on Wednesday, June 19, 2019, at 9:40 a.m.

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**THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES**

AUDIT AND COMPLIANCE COMMITTEE CHARTER

1. Overall Purpose/Objectives

The Audit and Compliance Committee (“Committee”) is appointed by the Florida International University Board of Trustees (“Board”) to assist it in discharging its oversight responsibilities, including but not limited to, reviewing procedures in place to assess and minimize significant risks, overseeing the quality and integrity of financial reporting practices (including the underlying system of internal controls, policies and procedures, regulatory compliance programs, and ethical code of conduct), and overseeing the overall audit process.

The Committee will oversee the financial operations and reporting process for both the University and its direct support organizations (“DSO”). The committee will review: 1) the University’s internal financial controls and processes; 2) the internal audit function; 3) the independent audit process, including the appointment and assessment of the external auditors for the University; and 4) the DSO and University processes for monitoring compliance with applicable laws and regulations, meeting regulatory requirements and promoting ethical conduct.

2. Authority

The Board authorizes the Committee to:

2.1 Perform activities within the capacity of its charter.

2.2 Evaluate the Office of Internal Audit's role and scope of activities.

2.3 Participate, through the Chair, in the process of the appointment and dismissal of the Chief Audit Executive.

2.4 Engage independent counsel and other advisers as it deems necessary to carry out its duties.

2.5 Have unrestricted access to management, faculty and employees of the University and its DSOs, as well as to all books, records, and facilities thereof.

2.6 Develop and review procedures for the receipt, retention and treatment of complaints received from employees regarding financial or operational matters.

2.7 Review and approve the Office of Internal Audit’s annual audit plan (and any subsequent changes thereto), considering the University-wide risk assessment and the degree of coordination with the Auditor General's Office for an effective, efficient, non-redundant use of audit resources.

- 2.8 Review and discuss with management and the Office of Internal Audit (1) significant findings and recommendations, including management's response and timeframe for corrective action; (2) the degree of implementation of past audit recommendations; and (3) any difficulties encountered in the course of the audit activities such as restrictions on the scope of work or access to information.
- 2.9 Assess the staffing of the Office of Internal Audit, including the annual budget.
- 2.10 Review and approve modifications to the Office of Internal Audit.
- 2.11 Review the organizational reporting lines related to the Office of Internal Audit, particularly related to confirming and assuring the continued independence of the Office of Internal Audit and its staff.
- 2.12 Review the work of the external auditors for the University and DSOs.
- 2.13 Evaluate the effectiveness of the University's compliance program by (1) reviewing the results of the program effectiveness evaluation; (2) assessing the staffing of the Office of Compliance & Integrity, including the annual budget; (3) reviewing major modifications to the University's compliance program; and (4) reviewing compliance-related training topics for the Board.
- 2.14 Participate, through the Chair, in the process of the appointment and dismissal of the Assistant Vice President, Chief Compliance and Privacy Officer.
- 2.15 Review and approve the Office of Compliance & Integrity's annual compliance plan (and any subsequent changes thereto), considering the University-wide risk assessment.
- 2.16 Review and approve modifications to the Office of Compliance & Integrity.
- 2.17 Review the organizational reporting lines related to the Office of Compliance & Integrity, particularly related to confirming and assuring the continued independence of the Office of Compliance & Integrity and its staff.

3. Organization

Membership

- 3.1 The Chair of the Board of Trustees will appoint the chair and members of the Committee.
- 3.2 The Committee consists of at least five (5) members, all of whom are voting Trustees of the University.
- 3.3 A majority of Committee members, if not all, shall possess general accounting, business and financial knowledge, including the ability to read and understand fundamental financial statements.

3.3.1 If possible the Committee will include at least one member who is a "accounting or financial expert"; a person who has an understanding of generally accepted accounting principles and financial statements; the ability to assess the application of these principles in connection with accounting for estimates, accruals and reserves; an understanding of committee functions; experience preparing, auditing, analyzing or evaluating financial statements, or experience actively supervising persons engaged in such activities; and an understanding of internal controls and procedures for financial reporting. The person must have acquired these attributes through one or more of the following: education or experience actually doing these functions or similar ones; actively supervising someone who is performing these functions or similar ones; experience overseeing or assessing the performance of companies or public accountants who are preparing, auditing or evaluating financial statements; or other relevant experience.

3.4 Members shall be independent and objective in the discharge of their responsibilities. They are to be free of any financial, family, or other material personal relationship, including relationships with members of University management, University auditors and other professional consultants

3.5 Members will serve on the Committee until their resignation or replacement by the Chair of the Board.

Meetings

3.6 A simple majority of the members of the Committee will constitute a quorum for the transaction of business.

3.7 Meetings shall be held not less than four (4) times per year and shall correspond with the University's financial reporting cycle.

3.8 The Committee shall maintain written minutes of its meetings, and for the Committee Chair to approve each meeting's agenda.

3.9 The Committee shall meet with the General Counsel, Chief Audit Executive, and Assistant Vice President, Chief Compliance and Privacy Officer on a regular basis.

3.10 The Committee may request special reports from University or DSO management on topics that may enhance their understanding of their activities and operations.

4. Roles and Responsibilities

The Committee shall:

4.1 Provide the Board with regular updates of Committee activities and make recommendations to the Board for matters within the Committee's area of responsibility.

- 4.2 Meet separately with the Office of Internal Audit and Senior Management, separately, in order to discuss any matters the Committee or these individuals believe should be discussed privately. This should be performed at least two (2) times annually, at the conclusion of a regularly scheduled Committee meeting.
- 4.3 Affirm that the Chief Audit Executive and Assistant Vice President, Chief Compliance and Privacy Officer are ultimately responsible to the Committee and the Board and they should communicate directly with the Committee Chair when deemed prudent and necessary. Said Chief Audit Executive and Assistant Vice President, Chief Compliance and Privacy Officer, in consultation with the General Counsel, will regularly meet and correspond with the Chair of the Committee, advise and keep informed, as needed, both the President and the Chair of the Board on a regular basis regarding matters brought before and actions taken by the Committee, and in further consultation with the Chair, prepare the agenda for meetings of the Committee.
- 4.4 Have the authority to conduct investigations into any matters within the Committee's scope of responsibilities as set forth herein. The Committee shall have unrestricted access to the University's independent auditors and anyone employed by the University, and to all relevant information in order to conduct such investigations. The Committee may retain, at the University's expense, independent counsel, accountants and other professional consultants to assist with such investigations. The results of any such investigations must be reported to the Board by the Committee Chair.

With regard to each topic listed below, the Committee shall:

Internal Controls

- 4.5 Consider and review the effectiveness of the University's process for identifying significant financial, operational, reputational, strategic and regulatory risks or exposures and management's plans and efforts to monitor and control such risks.
- 4.6 Evaluate the overall effectiveness of the internal control framework and consider whether recommendations made by the internal and external auditors have been implemented by management, including but not limited to the status and adequacy of information systems and security, for purposes of meeting expectations of the U.S. Sentencing Guidelines, personnel systems internal controls, and other relevant matters.
- 4.7 Understand the internal control systems implemented by management of the University and each DSO for the approval of transactions and the recording and processing of financial data.

Risk Management

- 4.8 Evaluate the overall effectiveness of the risk management process.
- 4.9 Evaluate the University's oversight and monitoring of its affiliated organizations, and the University's insurance coverage and the process used to manage any uninsured

risks.

Financial Reporting and Disclosures

- 4.10 Review the adequacy of accounting, management, and financial processes of the University and its DSOs.
- 4.11 Review the financial reporting process implemented by management of the University and its DSOs.
- 4.12 Review as applicable for the University and its DSOs: 1) interim financial statements, 2) annual financial statements, 3) the annual report, and 4) the audit report on federal awards that is required under Office of Management and Budget (OMB) Circular A-133.
- 4.13 Review University and DSO management processes for ensuring the transparency of the financial statements and the completeness and clarity of the disclosures.
- 4.14 Meet with University management and the external auditors to review the financial statements, the key accounting policies, the reasonableness of significant judgments, and the results of the audit.

Compliance with Laws, Regulations, Policies and Standards

- 4.15 Review the independence, qualifications, activities, resources, and structure of the compliance function and ensure no unjustified restrictions or limitations are made.
- 4.16 Review and discuss any significant results of compliance audits; any significant matters of litigation or contingencies that may materially affect the University's financial statements; and any legal, tax or regulatory matters that may have a material impact on University operations, financial statements, policies and programs.
- 4.17 Ensure that significant findings and recommendations made by the university compliance officer are received, discussed, and appropriately acted on.
- 4.18 Review the effectiveness of the system for monitoring compliance with laws and regulations and management's investigation and follow-up (including disciplinary action) of any wrongful acts or non-compliance.
- 4.19 Ascertain whether the University has an effective process for determining risks and exposure from asserted and unasserted litigation and other claims of noncompliance with laws and regulations.
- 4.20 Receive information and training regarding specific elements of the University's compliance program.
- 4.21 Obtain reports concerning financial fraud resulting in losses in excess of \$10,000 or involving a member of senior management.

- 4.22 Obtain regular updates from the University Compliance Officer regarding compliance matters that may have a material impact on the organization's financial statements or compliance policies.
- 4.23 Review the University's monitoring of compliance with University policies, including (but not limited to) policies regarding the conduct of research, including the results of the University's monitoring and enforcement of compliance with University standards of ethical conduct and conflict of interest policies.
- 4.24 Review the findings of any examinations or investigations by regulatory bodies.

Working with Auditors

Independent External Audit

- 4.25 Review the professional qualifications of all external auditors, and when determined by the committee, require such auditor to be hired by and report directly to the Committee.
- 4.26 Review on an annual basis the performance of all external auditors and make recommendations to the appropriate Board for their appointment, reappointment or termination.
- 4.27 Ensure that significant findings and recommendations made by the independent auditors for both the University and any DSO, and management's proposed response thereto, are received, discussed and appropriately acted upon.

Internal Audit

- 4.28 Review the independence, qualifications, activities, resources and structure of the internal audit function and ensure no unjustified restrictions or limitations are made.
- 4.29 Review the effectiveness of the internal audit function and ensure that it has appropriate standing within the University.
- 4.30 Ensure that significant findings and recommendations made by the internal auditors and management's proposed response are received, discussed and appropriately acted on.
- 4.31 Review the proposed internal audit plan for the coming year [or the multi-year plan] and ensure that it addresses key areas of risk and that there is appropriate coordination with the external auditor.

Complaints and Ethics

- 4.32 Ensure procedures for the receipt, retention and treatment of complaints concerning financial, internal accounting controls or auditing matters.

- 4.33 Review the University and DSO conflicts of interest policies to ensure that: 1) the term "conflict of interest" is clearly defined, 2) guidelines are comprehensive, 3) annual signoff is required, and 4) potential conflicts are adequately resolved and documented.

Reporting Responsibilities

- 4.34 Regularly update the Board about Committee activities and make appropriate recommendations.
- 4.35 Ensure the Board is aware of matters that may significantly impact the financial condition or affairs of the University or its DSOs.
- 4.36 Receive prior to each meeting a summary of findings from completed internal audits and the status of implementing related recommendations.

Evaluating Performance

- 4.37 Evaluate the Committee's own performance, both of individual members and collectively, on a regular basis.
- 4.38 Assess the achievement of duties specified in the charter and report findings to the board.
- 4.39 Review the Committee charter, at least every two (2) years, and discuss any required changes with the board.
- 4.40 Ensure that the charter is approved or reapproved by the Board, after each update.

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4.002 State University System Chief Audit Executives

- (1) Each university shall have an office of chief audit executive as a point for coordination of and responsibility for activities that promote accountability, integrity, and efficiency in the operations of the university.
- (2) Each board of trustees shall establish a committee responsible for addressing audit, financial- and fraud-related compliance, controls, and investigative matters. For purposes of this regulation, this committee will be referred to as the audit and compliance committee. This committee shall have a charter approved by the board of trustees and reviewed at least every three (3) years for consistency with applicable Board of Governors and university regulations, professional standards, and best practices. A copy of the approved charter and any subsequent changes shall be provided to the Board of Governors.
- (3) Each board of trustees shall adopt a charter which defines the duties and responsibilities of the office of chief audit executive. The charter shall be reviewed at least every three (3) years for consistency with applicable Board of Governors and university regulations, professional standards, and best practices. A copy of the approved charter and any subsequent changes shall be provided to the Board of Governors. At a minimum, the charter shall specify that the chief audit executive:
 - (a) Provide direction for, supervise, and coordinate audits and investigations which promote economy, efficiency, and effectiveness in the administration of university programs and operations including, but not limited to, auxiliary facilities and services, direct support organizations, and other component units.
 - (b) Conduct, supervise, or coordinate activities for the purpose of preventing and detecting fraud and abuse within university programs and operations including, but not limited to, auxiliary facilities and services, direct support organizations, and other component units.
 - (c) Address significant and credible allegations relating to waste, fraud, or financial mismanagement as provided in Board of Governors Regulation 4.001.
 - (d) Keep the president and board of trustees informed concerning significant and credible allegations and known occurrences of waste, fraud, mismanagement, abuses, and deficiencies relating to university programs and operations; recommend corrective actions; and report on the progress made in implementing corrective actions.
 - (e) Promote, in collaboration with other appropriate university officials, effective coordination between the university and the Florida Auditor General, federal auditors, accrediting bodies, and other governmental or oversight bodies.
 - (f) Review and make recommendations, as appropriate, concerning policies and regulations related to the university's programs and operations including, but not limited to, auxiliary facilities and services, direct support organizations, and other component units.

- (g) Communicate to the president and the board of trustees, at least annually, the office's plans and resource requirements, including significant changes, and the impact of resource limitations.
 - (h) Provide training and outreach, to the extent practicable, designed to promote accountability and address topics such as fraud awareness, risk management, controls, and other related subject matter.
 - (i) Coordinate or request audit, financial- and fraud-related compliance, controls, and investigative information or assistance as may be necessary from any university, federal, state, or local government entity.
 - (j) Develop and maintain a quality assurance and improvement program for the office of chief audit executive.
 - (k) Establish policies which articulate the steps for reporting and escalating matters of alleged misconduct, including criminal conduct, when there are reasonable grounds to believe such conduct has occurred.
 - (l) Inform the board of trustees when contracting for specific instances of audit or investigative assistance.
- (4) The board of trustees must obtain Board of Governors' approval before outsourcing the chief audit executive's entire audit or investigative function.
- (5) Each board of trustees shall ensure that the university chief audit executive is organizationally independent and objective to perform the responsibilities of the position. The chief audit executive shall:
- (a) Report functionally to the board of trustees and administratively to the president.
 - (b) Report routinely to the board of trustees on matters including significant risk exposures, control issues, fraud risks, governance issues, and other matters requested by the president and the board of trustees.
 - (c) Conduct and report on audits, investigations, and other inquiries free of actual or perceived impairment to the independence of the chief audit executive's office.
 - (d) Have timely access to any records, data, and other information in possession or control of the university including information reported to the university's hotline/helpline.
 - (e) Notify the chair of the board of trustees' audit committee or the president, as appropriate, of any unresolved restriction or barrier imposed by any individual on the scope of an inquiry, or the failure to provide access to necessary information or people for the purposes of such inquiry. The chief audit executive shall work with the board of trustees and university management to remedy scope or access limitations. If the university is not able to remedy such limitations, the chief audit executive shall timely notify the Board of Governors, through the OIGC, of any such restriction, barrier, or limitation.

- (6) In carrying out the auditing duties and responsibilities set forth in this regulation, each chief audit executive shall review and evaluate controls necessary to enhance and promote the accountability of the university. The chief audit executive shall perform or supervise audits and prepare reports of their findings, recommendations, and opinions. The scope and assignment of the audits shall be determined by the chief audit executive; however, the president and board of trustees may request the chief audit executive direct, perform, or supervise audit engagements.
- (a) Audit engagements shall be performed in accordance with the *International Professional Practices Framework*, published by the Institute of Internal Auditors, Inc.; the *Government Auditing Standards*, published by the United States Government Accountability Office; and/or the *Information Systems Auditing Standards* published by ISACA. All audit reports shall describe the extent to which standards were followed.
 - (b) At the conclusion of each audit engagement, the chief audit executive shall prepare a report to communicate the audit results and action plans to the board of trustees and university management. A copy of the final audit report will be provided to the Board of Governors consistent with Board of Governors Regulation 1.001(6)(g).
 - (c) The chief audit executive shall monitor the disposition of results communicated to university management and determine whether corrective actions have been effectively implemented or that senior management or the board of trustees, as appropriate, has accepted the risk of not taking corrective action. If, in the chief audit executive's judgment, senior management or the board of trustees has chosen not to take corrective actions to address substantiated instances of waste, fraud, or financial mismanagement, then the chief audit executive shall timely notify the Board of Governors, through the OIGC.
 - (d) The chief audit executive shall develop audit plans based on the results of periodic risk assessments. The plans shall be submitted to the board of trustees for approval. A copy of approved audit plans will be provided to appropriate university management and the Board of Governors.
 - (e) The chief audit executive must develop and maintain a quality assurance and improvement program in accordance with professional audit standards. This program must include an external assessment conducted at least once every five (5) years. The external assessment report and any related improvement plans shall be presented to the board of trustees, with a copy provided to the Board of Governors.
- (7) Each chief audit executive shall initiate, conduct, supervise, or coordinate investigations that fall within the purview of the chief audit executive's office and be designated by their board of trustees as the employee to review statutory whistleblower information and coordinate all activities of the university as required by the Florida Whistle-blower's Act. Investigative assignments shall be performed in

accordance with professional standards issued for the State University System. All final investigative reports shall be submitted to the appropriate action officials, board of trustees, and the Board of Governors if, in the chief audit executive's judgment, the allegations are determined to be significant and credible. Such reports shall be redacted to protect confidential information and the identity of individuals, when provided for by law.

- (8) By September 30th of each year, the chief audit executive shall prepare a report summarizing the activities of the office for the preceding fiscal year. The report shall be provided to the president, board of trustees, and the Board of Governors.

Authority: Section 7(d), Art. IX, Fla. Const.; History: New 11-3-16.

4.003 State University System Compliance and Ethics Programs

- (1) Each board of trustees shall implement a university-wide compliance and ethics program (Program) as a point for coordination of and responsibility for activities that promote ethical conduct and maximize compliance with applicable laws, regulations, rules, policies, and procedures.
- (2) The Program shall be:
 - (a) Reasonably designed to optimize its effectiveness in preventing or detecting non-compliance, unethical behavior, and criminal conduct, as appropriate to the institution's mission, size, activities, and unique risk profile;
 - (b) Developed consistent with the Code of Ethics for Public Officers and Employees contained in Part III, Chapter 112, Florida Statutes; other applicable codes of ethics; and the Federal Sentencing Guidelines Manual, Chapter 8, Part B, Section 2.1(b); and
 - (c) Implemented within two (2) years of the effective date of this regulation.
- (3) Each board of trustees shall assign responsibility for providing governance oversight of the Program to the committee of the board responsible for audit and compliance. The charter required by Board of Governors Regulation 4.002(2) shall address governance oversight for the Program.
- (4) Each university, in coordination with its board of trustees, shall designate a senior-level administrator as the chief compliance officer. The chief compliance officer is the individual responsible for managing or coordinating the Program. Universities may have multiple compliance officers; however, the highest ranking compliance officer shall be designated the chief compliance officer. Nothing in this regulation shall be construed to conflict with the General Counsel's responsibility to provide legal advice on ethics laws. The chief compliance officer shall not be the same individual as the chief audit executive with the exception of New College of Florida and Florida Polytechnic University who may, due to fiscal and workload considerations, name the same individual as both chief audit executive and chief compliance officer.
- (5) The chief compliance officer shall report functionally to the board of trustees and administratively to the president. If the university has an established compliance program in which the chief compliance officer reports either administratively or functionally to the chief audit executive, then the university shall have five (5) years from the effective date of this regulation to transition the reporting relationship of the chief compliance officer to report functionally to the board of trustees and administratively to the president.

- (6) The office of the chief compliance officer shall be governed by a charter approved by the board of trustees and reviewed at least every three (3) years for consistency with applicable Board of Governors and university regulations, professional standards, and best practices. A copy of the approved charter and any subsequent changes shall be provided to the Board of Governors.
- (7) The Program shall address the following components:
- (a) The president and board of trustees shall be knowledgeable about the Program and shall exercise oversight with respect to its implementation and effectiveness. The board of trustees shall approve a Program plan and any subsequent changes. A copy of the approved plan shall be provided to the Board of Governors.
 - (b) University employees and board of trustees' members shall receive training regarding their responsibility and accountability for ethical conduct and compliance with applicable laws, regulations, rules, policies, and procedures. The Program plan shall specify when and how often this training shall occur.
 - (c) At least once every five (5) years, the president and board of trustees shall be provided with an external review of the Program's design and effectiveness and any recommendations for improvement, as appropriate. The first external review shall be initiated within five (5) years from the effective date of this regulation. The assessment shall be approved by the board of trustees and a copy provided to the Board of Governors.
 - (d) The Program may designate compliance officers for various program areas throughout the university based on an assessment of risk in any particular program or area. If so designated, the individual shall coordinate and communicate with the chief compliance officer on matters relating to the Program.
 - (e) The Program shall require the university, in a manner which promotes visibility, to publicize a mechanism for individuals to report potential or actual misconduct and violations of university policy, regulations, or law, and to ensure that no individual faces retaliation for reporting a potential or actual violation when such report is made in good faith. If the chief compliance officer determines the reporting process is being abused by an individual, he or she may recommend actions to prevent such abuse.
 - (f) The Program shall articulate the steps for reporting and escalating matters of alleged misconduct, including criminal conduct, when there are reasonable grounds to believe such conduct has occurred.
 - (g) The chief compliance officer shall:
 - 1. Have the independence and objectivity to perform the responsibilities of the chief compliance officer function;
 - 2. Have adequate resources and appropriate authority;
 - 3. Communicate routinely to the president and board of trustees regarding Program activities;

4. Conduct and report on compliance and ethics activities and inquiries free of actual or perceived impairment to the independence of the chief compliance officer;
 5. Have timely access to any records, data, and other information in possession or control of the university, including information reported to the university's hotline/helpline;
 6. Coordinate or request compliance activity information or assistance as may be necessary from any university, federal, state, or local government entity;
 7. Notify the president, or the administrative supervisor of the chief compliance officer, of any unresolved restriction or barrier imposed by any individual on the scope of any inquiry, or the failure to provide access to necessary information or people for the purposes of such inquiry. In such circumstances, the chief compliance officer shall request the president remedy the restrictions. If unresolved by the president or if the president is imposing the inappropriate restrictions, the chief compliance officer shall notify the chair of the board of trustees committee charged with governance oversight of the Program. If the matter is not resolved by the board of trustees, the chief compliance officer shall notify the Board of Governors through the Office of Inspector General and Director of Compliance (OIGC);
 8. Report at least annually on the effectiveness of the Program. Any Program plan revisions, based on the chief compliance officer's report shall be approved by the board of trustees. A copy of the report and revised plan shall be provided to the Board of Governors;
 9. Promote and enforce the Program, in consultation with the president and board of trustees, consistently through appropriate incentives and disciplinary measures to encourage a culture of compliance and ethics. Failures in compliance or ethics shall be addressed through appropriate measures, including education or disciplinary action;
 10. Initiate, conduct, supervise, coordinate, or refer to other appropriate offices (such as human resources, audit, Title IX, or general counsel) such inquiries, investigations, or reviews as deemed appropriate and in accordance with university regulations and policies; and
 11. Submit final reports to appropriate action officials.
- (h) When non-compliance, unethical behavior, or criminal conduct has been detected, the university shall take reasonable steps to prevent further similar behavior, including making any necessary modifications to the Program.
- (8) The university shall use reasonable efforts not to include within the university and its affiliated organizations individuals whom it knew, or should have known (through the exercise of due diligence), to have engaged in conduct not consistent with an effective Program.

Authority: Section 7(d), Art. IX, Fla. Const.; History: New 11-3-16.

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Office of Internal Audit Status Report

BOARD OF TRUSTEES

September 5, 2019



Date: September 5, 2019

To: Board of Trustees Audit and Compliance Committee Members

From: Trevor L. Williams, Chief Audit Executive

Subject: OFFICE OF INTERNAL AUDIT STATUS REPORT

I am pleased to provide you with our quarterly update on the status of our office's activities. Since our last update to the Board of Trustees Audit and Compliance Committee on June 19, 2019, the following projects were completed:

Student Activity and Service Fee

We completed an audit of the student activity and service (A&S) fee for the period July 1, 2017, through June 30, 2018, and an assessment of the current fee allocation practices through February 2019. The primary objective of our audit was to ensure that A&S fees collected by the University were appropriate and that funds were disbursed properly as designated by Florida Statutes and University policies and procedures.

For fiscal year 2017-2018, the University's A&S fee gross revenue totaled approximately \$20 million. The A&S fee of \$14.85 per credit hour affords benefits for the entire student body, and provides for membership and maintenance of the recreation and student centers on both the Modesto A. Maidique Campus (MMC) and Biscayne Bay Campus (BBC). It also provides funding for student organizations and clubs, as well as various departments within the University's Student Affairs division and throughout the University.

Our audit concluded that there were adequate controls and procedures over the allocation and use of A&S fees. However, opportunities for improvement exist. We concluded that the calculation of the A&S fee increase could be refined. In addition, the manner in which expenditures are accounted for and processed, including the timeliness of approving payroll contracts needs enhanced diligence when being executed. The audit resulted in nine recommendations for the A&S Business Office and one for the Office of Financial Planning, which the management teams have agreed to implement.

Facilities Management Data Systems Controls

The mission of the Facilities Management Department (“Facilities”) is to provide for the physical development and growth of the University community. Facilities is committed to providing quality, sustainable facilities and diligent oversight of all aspects of the physical environment. To meet its mission, Facilities maintains over 2,800 devices that control systems, which include, but are not limited to, electrical, fire, metering, and surveillance.

The primary objective of our audit was to determine whether general Information Technology (IT) controls related to Facilities’ data systems were adequate and effective. Our audit identified opportunities to strengthen Facilities’ internal controls that pertain to malware prevention, risk assessments, enabling audit log capability, disabling generically-named user accounts, mitigating information systems’ vulnerabilities, reviewing firewall rules, sharing the University’s continuity of operations plan with the Department of Emergency Management, and documenting business continuity test results, corrective actions, and lessons learned. The audit resulted in 10 recommendations, which management agreed to implement with the assistance from the Division of IT.

Internal Controls and Data Security over Personal Data Pursuant to Florida Department of Highway Safety and Motor Vehicles Contract Number HSMV-0910-16

We performed an audit of Admissions Operations, Enrollment Management and Services (“Enrollment Processing Services”) internal controls and data security governing the use and dissemination of personal data pursuant to the requirements of the Florida Department of Highway Safety and Motor Vehicles (DHSMV) Contract Number HSMV-0910-16 (“MOU”). Through the agreement, Enrollment Processing Services is permitted electronic access to driver license and motor vehicle data to be used to validate residency classification of student applicants.

The objectives of the audit were to determine whether the Enrollment Processing Services has policies and procedures in place to prevent unauthorized access, distribution, use, modification, or disclosure of the personal data that is provided/received pursuant to the MOU and to provide a basis to complete DHSMV’s required Attestation Statement.

The audit concluded that, in all material respects, the internal controls over personal data are adequate to protect the personal data from unauthorized access, distribution, use, modification or disclosure pursuant to the terms of the MOU and that any and all deficiencies or issues found during the audit have been corrected and measures enacted to prevent recurrence.

The following ongoing audits are in various stages of completion:

<i>Audits</i>	<i>Status</i>
Nicole Wertheim College of Nursing and Health Sciences	Drafting Report
Treasury Management	Fieldwork in Progress
Accounts Receivable	Fieldwork in Progress
Health Services Billing and Coding Process and Contract Performance	Planning

Semi-Annual Follow-Up Status Report

Our prior audit recommendation follow-up process has recently evolved to include examination of corroborating documented evidence to validate the self-reported status of the recommendation. When we are unable to validate the reported status, we notify the auditee and adjust the status accordingly.

Through this process of surveying management on their progress towards completing past recommendations that were currently due for implementation and our validation of the reported status, we have concluded that 25 of 44 recommendations (57 percent) were completed. Management has provided expected completion dates for the remaining 14 partially implemented recommendations and five (5) recommendations that were not implemented. We thank management for their cooperation and encourage continued improvement.

Areas Audited	Total Due for Implementation	Implemented	Partially Implemented	Not Implemented
Center for Children and Families	2	2		
Mobile Health Center	2	2		
Performance Based Funding Metrics Data Integrity	2	2		
Steven J. Green School of International and Public Affairs	5	5		
South Beach Wine & Food Festival	1	1		
University Implementation of Prior Years' Recommendations	1	1		
University IT Network Security Controls	2	2		
University Technology Fee	1	1		
Review of Nepotism Policies and Procedures	2		2	
Review of Bank Account Reconciliations	1		1	
The Wolfsonian-FIU	6		6	
College of Engineering and Computing	10	2	3	5
HCN's Billing, Collections and Electronic Medical Record Systems	6	5	1	
Patricia and Phillip Frost Art Museum	3	2	1	
Totals	44	25	14	5
Percentages	100%	57%	32%	11%

MANAGEMENT RESPONSES TO OUTSTANDING AUDIT RECOMMENDATIONS WITH REVISED TARGET DATES

Review of Nepotism Policies and Procedures (July 19, 2016)

1. Audit Issue: **Nepotism** (Recommendation #1.2)

Recommendation:

Perform further analysis whenever related employees within or outside of the reporting lines have approval authority that may require additional mitigating controls.

Action Plan to Complete:

We have completed the development and are finalizing the documentation of the Nepotism form that checks the reporting structure of two related individuals in the University when the relationship is disclosed. This check will allow the Division of Human Resources to mitigate any risk associated with reporting structures and, thus, approvals of transactions. Since the 9-month faculty are not back from the Summer, thus, we will wait until we are a couple of weeks into the Fall semester to allow the faculty to settle in and require all employees to disclose all relationships.

Original Target Date: October 31, 2016

New Target Date: October 1, 2019

2. Audit Issue: **Nepotism** (Recommendation #1.3)

Recommendation:

Develop proactive procedures for identifying potential relationships at various points of an employee's career life beyond onboarding including, but not limited to, promotion, reclassification, and/or departmental restructuring, which are required to be disclosed.

Action Plan to Complete:

As part of the Nepotism form, we have developed the ability to validate if any movement that occurs in the reporting structure results in a conflict to proactively detect it. This piece is ready but is dependent on the relationship disclosures we will be capturing in number 1.2. If a change is done or suggested, it will require additional approvals equal to the original disclosure.

Original Target Date: October 31, 2016

New Target Date: October 1, 2019

Review of Bank Account Reconciliations (October 27, 2016)

1. Audit Issue: **Reconciliation** (Recommendation #1.1)

Recommendation:

Continue exploring ways to automate the reconciliation process, where possible.

Action Plan to Complete:

As of June 30, 2019, we are parallel reconciling the AP and SF disbursement Bank Accounts. The Payroll disbursement account is still being developed. As for depository type accounts we will look to implement them once we have completed the selection of our banking partner as a result of the ITN process.

Original Target Date: June 20, 2017

New Target Date: June 30, 2021

The Wolfsonian-FIU (April 23, 2018)

1. Audit Issue: **Access to Collection and Collection Records** (Recommendation #2.1)

Recommendation:

Implement adequate surveillance camera coverage of the Collection.

Action Plan to Complete:

Management is working collaboratively with University Facilities and Technology has added basic video surveillance to the Annex facility. Management will augment the existing video surveillance with increased camera coverage of all points of entry and exit within the Annex facility and collections storage areas along with a limited deployment of cameras to monitor major cross aisle and work areas on each floor within the collection storage areas. This deployment would be supported by continued enforcement of mitigating controls such as access control, bag checks, and any other related security policies and procedures.

Original Target Date: December 31, 2018

New Target Date: June 30, 2020

2. Audit Issue: **Information Systems Security** (Recommendation #7.3)

Recommendation:

Continue to work with the FIU PCI Compliance Team to implement PCI compliant payment card readers and with the Division of IT to conduct a formal risk assessment of the Museum's information systems.

Action Plan to Complete:

The Wolfsonian has implemented Point of Sale systems, policies and procedures that are compliant with University PCI-DSS requirements. The unit continues to work with Division of IT to develop a formal risk assessment tool.

Original Target Date: June 30, 2019

New Target Date: December 31, 2019

3. Audit Issue: **Network Security Control** (Recommendation #9.2)

Recommendation:

Include the business need and duration for all active rules and work with the Division of IT to review firewall rules, and disable all inactive connections.

Action Plan to Complete:

We continue to work with the Division of IT to ensure the inactive connections are disabled.

Original Target Date: December 31, 2018

New Target Date: December 31, 2019

4. Audit Issue: **Business Continuity** (Recommendation #10.1)

Recommendation:

Adopt procedures to ensure that the Business Continuity Plan's IT operations can meet the self-identified critical ratings.

Action Plan to Complete:

FIU Ready Plan update is complete. In partnership with University Emergency Management team, the Wolfsonian has completed a tabletop exercise to identify needs and ideas to incorporate into revised emergency procedures for common perils.

Original Target Date: June 30, 2018

New Target Date: December 31, 2019

5. Audit Issue: **Business Continuity** (Recommendation #10.2)

Recommendation:

Include formal test results, lessons learned, and corrective actions taken to ensure the success of the business continuity plan.

Action Plan to Complete:

The Wolfsonian Team in partnership with the University Emergency Management team has completed an initial baseline tabletop exercise with 24 unit staff members. Emergency policies and procedures will be updated based on the

findings from this tabletop experience. Upon completion of both the update and staff training, a second tabletop exercise will occur to evaluate success of the update, training and staff learning.

Original Target Date: June 30, 2018

New Target Date: December 31, 2019

6. Audit Issue: **Implementation of Prior IT Audit Recommendations**
(Recommendation #11.1)

Recommendation:

Perform formal contingency plan testing with key personnel. Test results should be formally reviewed and corrective actions taken to ensure the plan's ability to support the operations and protect its data in the event of a disaster. – Reported initially as Recommendation #11.9

Action Plan to Complete:

The Wolfsonian Team will schedule testing exercises.

Original Target Date: June 30, 2018

New Target Date: December 31, 2019

College of Engineering and Computing (November 6, 2018)
--

1. Audit Issue: **Non-Payroll Expenditures Controls** (Recommendation #3.1)

Recommendation:

Ensure that all expenses from optional student fees collected are only limited to equipment or supplies and materials used directly by the student for their course.

Action Plan to Complete:

See email communication from Dean Volakis to Department Chairs Nov. 27, 2018. Pending more action regarding "Lab Equipment Fees", specifically large balance on SCIS equipment fee activity # 2127130008. Also pending to include policy in College's Internal Operations Manual.

Original Target Date: February 28, 2019

New Target Date: June 30, 2020

2. Audit Issue: **Non-Payroll Expenditures Controls** (Recommendation #3.4)

Recommendation:

Implement controls to ensure that parking permits purchased are for official University business.

Action Plan to Complete:

Formal training pending to take place. Departments have been asked verbally to please include the necessary tracking information to ensure that parking permit are purchased only for official University business.

Original Target Date: December 14, 2018 New Target Date: November 27, 2019

3. Audit Issue: Non-Payroll Expenditures Controls (Recommendation #3.6)

Recommendation:

Ensure that all funds using University credit cards are spent in accordance with the University's policies and procedures.

Action Plan to Complete:

In anticipation of announcements regarding changes in personnel assignments, the preparation of training sessions was delayed due to the uncertainty as to the target audience.

Original Target Date: December 21, 2018 New Target Date: November 27, 2019

4. Audit Issue: **Non-Payroll Expenditures Controls** (Recommendation #3.7)

Recommendation:

Ensure that all employees obtain Travel Authorization prior to travel and use the most efficient and economical means of travel.

Action Plan to Complete:

In anticipation of announcements regarding changes in personnel assignments, the preparation of training sessions was delayed due to the uncertainty as to the target audience.

Original Target Date: December 21, 2018 New Target Date: November 27, 2019

5. Audit Issue: **Operating Manual** (Recommendation #4.2)

Recommendation:

Develop, disseminate and periodically update an operations manual.

Action Plan to Complete:

The College has never had an internal Operations Manual. Putting together one for the first time is an overwhelming task that involves many individuals whose contribution is needed for different areas. Some have already been working on policies such as, Faculty Administrator Appointment Terms (done), Summer

Teaching Assignments (done), Payment for Online Teaching when Enrollment Exceeds 50 Students (in progress), and Internal Communications Protocols (almost finalized). We will organize a team with representatives in each area of operations and assign each area to work on their portion of the Operations Manual. We will have periodic meetings to assess progress. The goal is to have the Operations Manual done by January 3, 2020.

Original Target Date: February 28, 2019

New Target Date: January 3, 2020

6. Audit Issue: **Asset Management** (Recommendation #5.1)

Recommendation:

Work with the Asset Management Department to ensure that all accountable property are tagged and recorded in the University's property records.

Action Plan to Complete:

In anticipation of announcements regarding changes in personnel assignments, the preparation of training sessions was delayed due to the uncertainty as to the target audience.

Original Target Date: December 21, 2018

New Target Date: November 27, 2019

7. Audit Issue: **Asset Management** (Recommendation #5.2)

Recommendation:

Implement the guidelines delineated in the University's Property Manual for identifying, cataloging, and tracking its attractive property.

Action Plan to Complete:

In anticipation of announcements regarding changes in personnel assignments, the preparation of training sessions was delayed due to the uncertainty as to the target audience.

Original Target Date: December 21, 2018

New Target Date: November 27, 2019

8. Audit Issue: **Implementation of Prior Audit Recommendations**
(Recommendation #6.1)

Recommendation:

Continue to work closely with its Principal Investigators and ORED to ensure that all the Electronic Proposal Routing Approval Forms are submitted within required timeframe – Reported initially as Recommendation #1.1.

Action Plan to Complete:

On a regular basis, faculty are reminded of the ORED deadlines verbally and via email on an individual basis for their particular proposal submission. Pending to prepare section for the College's Operations Manual.

Original Target Date: December 21, 2018

New Target Date: January 3, 2020

Health Care Network's Billing, Collections and Electronic Medical Record Systems (January 14, 2019)
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1. Audit Issue: **Access Controls** (Recommendation #1 (g))

Recommendation:

(g) Establish mitigating access controls, including the regular review of audit logs to ensure the appropriate use of data by multi-cross functional and those identified with specific skills sets – Reported initially as Recommendation #8.3.

Action Plan to Complete:

The Director of Health Care Compliance completed this review for the fourth quarter of FY2019. This involved a review of the access of (5) different users at HCN. These users were two Medical Students, a Medical Assistant, a Receptionist/MA and a Biller. The review performed was for access that took place in April 2019. All access by the different users seemed appropriate and no issues identified related to such access. Additionally, the HIPAA Compliance Committee, in conjunction with Cynergistek, is in the process of identifying a vendor to determine a technological solution for regular review of audit logs.

Original Target Date: March 31, 2019

New Target Date: February 29, 2020

Patricia and Phillip Frost Art Museum (May 24, 2019)

1. Audit Issue: **Payroll and Personnel Administration** (Recommendation #2.3)

Recommendation:

Work with Human Resources to ensure that all relevant employees obtain the required Level II screenings.

Action Plan to Complete:

The Assistant Director Administrative Services notified individuals that require Level II screening, for whom there was no record, that they must go through the process.

Original Target Date: June 30, 2019

New Target Date: August 31, 2019

Other Matters

Towards the end of the 2019 fiscal year, Mr. Vincent Iovino, an esteemed member of the Internal Audit staff, separated from the University to work closer to home. The filling of all current vacant positions in the Office is of the utmost urgency and efforts towards that end are progressing well.

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Office of Internal Audit

Annual Report

2018-2019

Date: September 5, 2019

To: Members of the Board of Trustees of Florida International University
Dr. Mark B. Rosenberg, University President

From: Trevor L. Williams, Chief Audit Executive

Subject: **Annual Report for FY 2018-2019**

In compliance with Florida Board of Governors Regulation 4.002, the FIU Office of Internal Audit has prepared this annual report to summarize the Office's activities for the 2018-2019 fiscal year. Board of Governors' Regulation 4.002(8) states that "By September 30th of each year, the chief audit executive shall prepare a report summarizing the activities of the office for the preceding fiscal year." In addition, Board of Governors' Regulation 4.002(6)(d) states that: "The chief audit executive shall develop audit plans based on the results of periodic risk assessments. The plans shall be submitted to the board of trustees for approval." On June 19, 2019, the Board of Trustees' Audit and Compliance Committee reviewed and approved the 2019-20 Internal Audit Plan included herein with amendments.

The FIU Office of Internal Audit will continue to promote effective controls, evaluate operational effectiveness and identify opportunities to more efficiently and cost effectively deliver education and other beneficial services to the students of our University. We are committed to providing you with quality information to assist you in decision-making and fulfilling your duties and responsibilities.

We appreciate the support and encouragement you have provided and the cooperation extended to us by University staff.

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INTRODUCTION

The FIU Office of Internal Audit (OIA) serves as an independent appraisal function for the University. Our audits of the University's colleges and departments evaluate financial processes, internal controls, and compliance with applicable laws, rules and regulations, and University policies with a view towards ensuring that services are appropriately delivered in the most efficient, effective, and economic manner possible. Our Office is also responsible for conducting investigations for allegations of fraud, waste, or abuse, and whistleblower complaints.

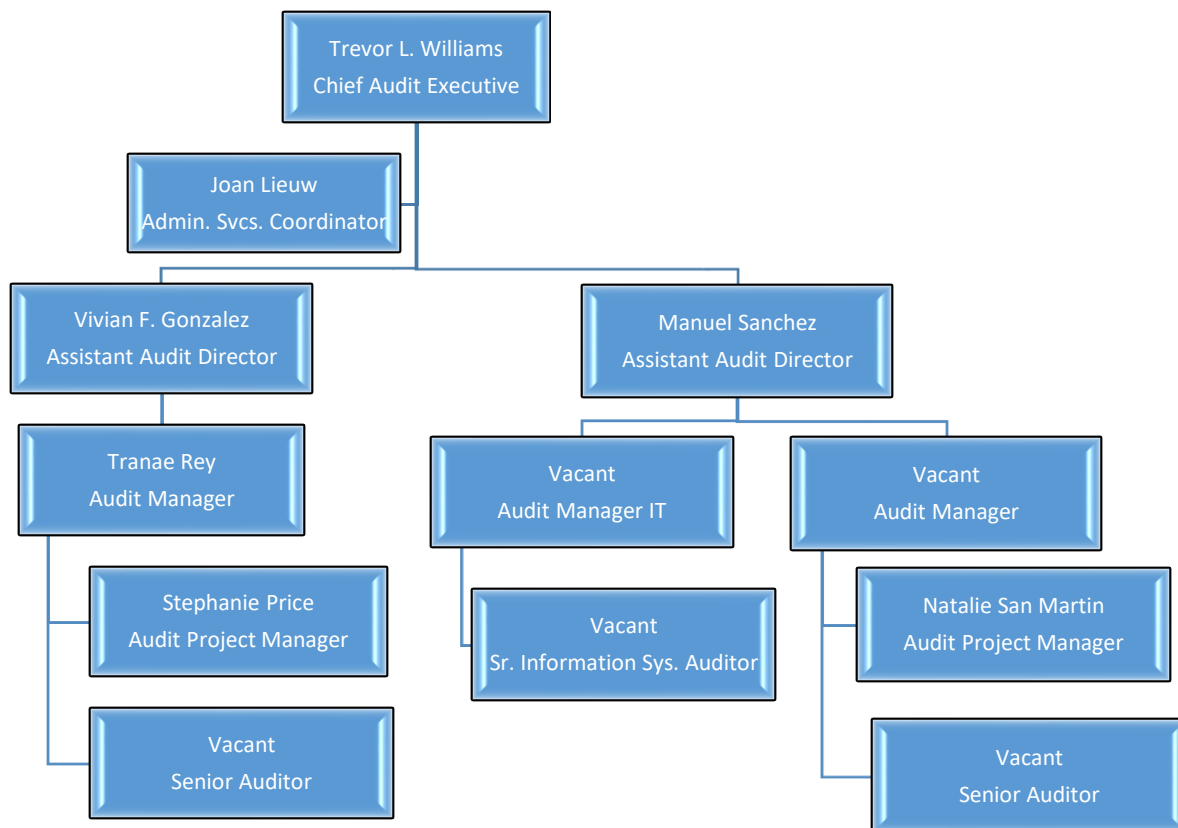
Recognizing the need for independence, the Chief Audit Executive (CAE) has direct reporting responsibility to the University's Board of Trustees' Audit and Compliance Committee. In addition, the audit staff has unrestricted access to all persons, records, systems, and facilities of the University.

In order to accomplish our work, we prepare a risk-based annual audit plan that is reviewed and approved by the Audit and Compliance Committee. We perform our audit work in accordance with the *International Standards for the Professional Practice of Internal Auditing* adopted by the Institute of Internal Auditors.



ORGANIZATION

The Chief Audit Executive is appointed by and operates under the general oversight of the University President. The Chief Audit Executive reports functionally to the Board of Trustees through the Audit and Compliance Committee and administratively to the President through the Chief of Staff. This reporting relationship promotes independence and assures adequate consideration of audit findings and planned corrective actions. The OIA staff reports to the Chief Audit Executive as depicted in the Organizational Chart below.



Mrs. Vivian Gonzalez, who has been a professional staff member with the OIA for approximately nine years, was selected to fill the Assistant Audit Director position vacated by the retirement of Mr. Pyong Cho. In addition, Ms. Joan Lieuw filled the Coordinator of Administrative Services position in the OIA when Ms. Dayanis Borges accepted a position in the University Compliance Office. Other vacancies in the office were created by the departure of three additional staff members who accepted managerial and supervisory positions with non-FIU employers.

The filling of all currently vacant positions in the Office is of the utmost urgency.

STAFF TRAINING

Our internal auditors must possess the knowledge, technical skills, and other competencies needed to perform their individual responsibilities. Accordingly, we have a mandatory continuing professional development program. The entire audit staff individually receives a minimal number of approved training hours. During the year, we also maintained group and personal affiliations with the following professional organizations:

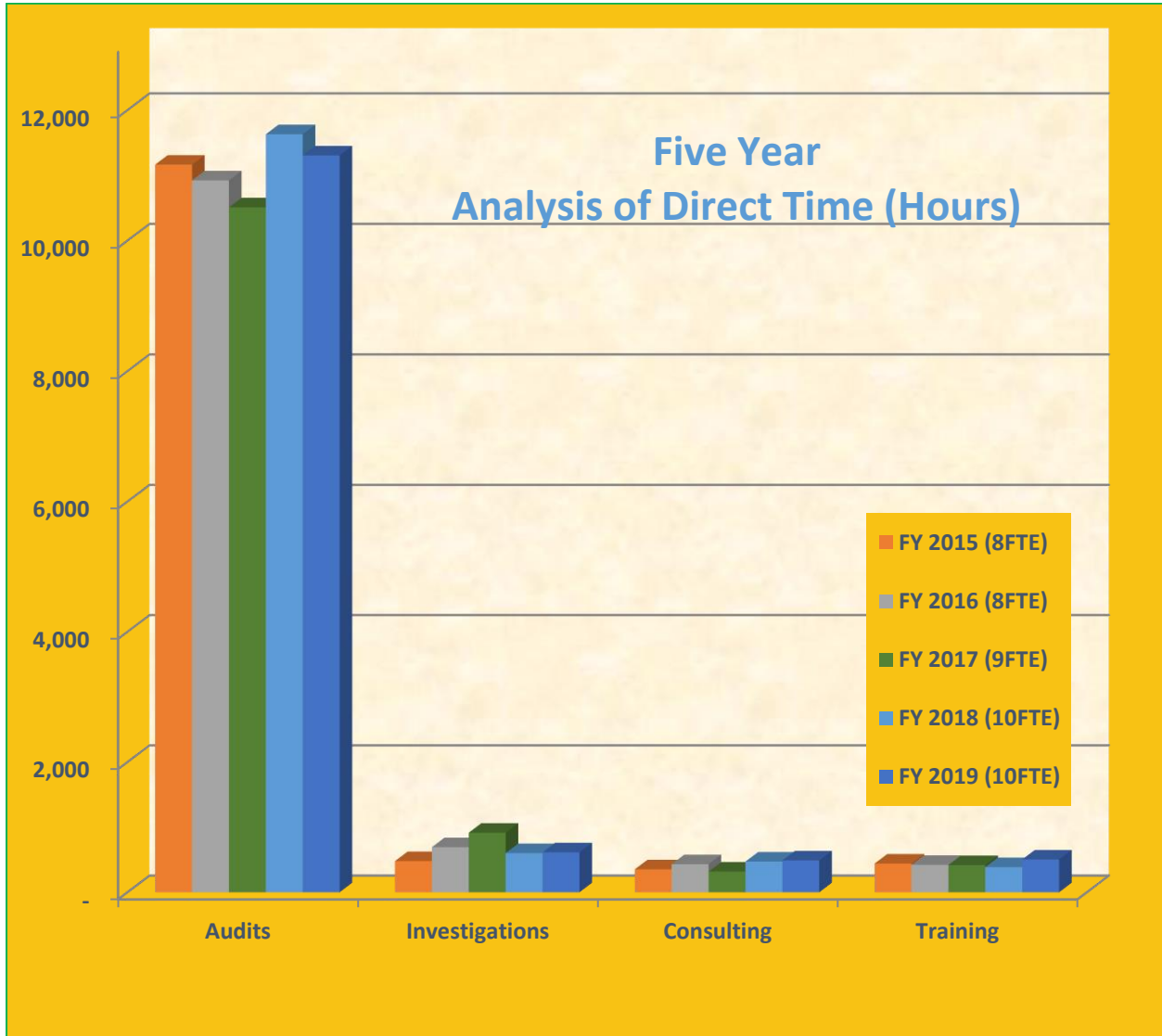
- The Institute of Internal Auditors
- Association of College & University Auditors
- Association of Certified Fraud Examiners
- Association of Healthcare Internal Auditors
- Information Systems Audit and Control Association
- American Institute of Certified Public Accountants
- Association of Local Government Auditors
- Association of Inspectors General

Professional Development

The Office is committed to maintaining a competent, professional staff. To that end, the audit staff continues to take advantage of available professional development opportunities. During the year, three staff members attended an Association of Inspectors General training conference and two received the designation of Certified Inspector General Auditor, while another received the designation of Certified Inspector General upon completion of the requisite course. Collectively, the OIA staff members completed 248 hours of professional development that are directly related to maintaining their professional competence. In addition, his attendance at the State University Audit Council (SUAC) meetings of fellow CAE, and by other means, the Chief Audit Executive stayed abreast of emerging issues that are of State University System of Florida Board of Governors (BOG) concern.

TIME ANALYSIS

The following graph reflects how the OIA's direct staff time was spent during the past five fiscal years:



As depicted, our workload is often difficult to predict as investigations and other unplanned work affect our progress towards completion of the planned audit projects. Nevertheless, we have continued to ensure that an appropriate balance was maintained between audit, investigative, and other accountability activities such as following up on the implementation status of past recommendations.

AUDIT ACTIVITIES

Audit of the Food Network South Beach Wine and Food Festival

The 2017 Festival, held on February 22 – 26, highlighted a collection of world-renowned culinary talents and attracted over 250 sponsors and approximately 65,000 guests from around the world. The Festival's management reported that since its inception, it has raised over \$26 million directly benefiting the Chaplin School of Hospitality and Tourism Management. Particularly, the 2017 Festival generated over \$9 million in auxiliary fund revenues, with almost \$2 million directly benefiting the University.



The objectives of the audit were to determine whether the Festival's auxiliary operations were properly accounted for and were managed in accordance with established University policies and procedures, and applicable laws, rules, and regulations.

Our audit concluded that the Festival's operations were properly accounted for and managed in accordance with established policies and procedures, and revenues generated were used as intended and in accordance with University policy. Nevertheless, opportunities for improvement existed in the following areas: administration over recording of ticket sales, personnel administration, disbursements, supplier contract management, and adherence to PCI compliance. The audit resulted in seven recommendations, which management agreed to implement.

Audit of the Steven J. Green School of International and Public Affairs (SIPA)

SIPA brings together many of the University's international disciplines and supports a variety of community outreach programs and study abroad opportunities. It offers 38 interdisciplinary programs at the Bachelor, Master, and Doctoral levels, as well as 35 undergraduate and graduate certificate programs. Enrollment for the 2016-2017 academic year, the year audited, consisted of 6,961 students (5,980 undergraduate and 981 graduate/post graduate). The School had more than 450 faculty members and approximately 150 staff members. Its operating revenues totaled \$44.2 million and operating expenditures totaled \$43.8 million for the fiscal year ended June 30, 2017.



Our audit focused on the adequacy and effectiveness of financial and operational controls, and concluded that the School's financial management needed improvement, particularly in the areas of revenue controls, approving payroll and extra compensation, expenditure controls, and asset management. Better oversight over the use of lab and equipment fees collected is needed. Specifically, the School needed to assess the rates charged for these fees, annually, to establish the correct rate and ensure that the use of the fees comports with the purpose for their establishment. The audit resulted in 16 recommendations, which management agreed to implement.

Audit of the College of Engineering and Computing

The College is home to one of the University's signature achievements, the Wall of Wind, one of the most powerful full-size hurricane simulators. Enrollment at the College for the 2017-18 academic year totaled 5,592, which included 4,754 undergraduate and 838 graduate students. For the fiscal year 2016-17, the last complete fiscal year at the time of

the audit, the College's operating revenues totaled approximately \$55 million while operating expenditures totaled approximately \$54 million.

Our audit concluded that the College's financial controls were generally adequate and in accordance with University policies and procedures. Nevertheless, we found opportunities for improvement in internal controls, particularly pertaining to: (1) the payroll and extra compensation process; (2) the expenditure process related to student fees, auxiliary programs, parking permits, and credit cards; (3) financial management; and (4) asset management. The audit resulted in 15 recommendations which management agreed to implement. We also followed up on the prior audit recommendations related to the scope of this audit and found that for the 19 recommendations tested; all but two were fully implemented, representing an implementation rate of 89 percent.

Follow-up Audit of the Health Care Network's (HCN's) Billing, Collections, and Electronic Medical Record Systems

The audit included a review of transactions for the period of July 1, 2016, through December 31, 2017, and an assessment of current practices through December 31, 2018. During the fiscal year 2016-17, the HCN's operating revenues totaled approximately \$8.2 million and operating expenses totaled approximately \$4.9 million. Operating revenues consisted of approximately \$4.3 million in management fee revenue, \$3.4 million in Office of International Affairs revenue, and \$0.5 million in rental income and other revenue. The cost for managing and operating the Herbert Wertheim College of Medicine (HWCOM) Clinics was \$2.1 million, representing approximately 50 percent of HCN's management fee revenue.

Our assessment revealed that 18 of the 30 prior recommendations were fully implemented, 11 were partially implemented, and one was not implemented. In addition, while testing management's implementation of the prior audit recommendations, we found that opportunities for improvement existed in other areas; specifically related to billing and coding for services provided, HIPAA and Security Awareness trainings, asset management, breach notification policies alignment, facility access logs, and the business continuity plan. This resulted in six additional recommendations, which management agreed to implement.

Certified Audit of FIU Football Attendance for the 2018 Season in Accordance with the National Collegiate Athletic Association Operating Bylaws

The objective of our audit was to certify the accuracy of the season's attendance at FIU home football games reported by the University to the National Collegiate Athletic Association (NCAA) for the 2018 season. Based on the methodology adopted by the FIU Athletics Department, we found that sufficient, relevant, and competent records supported the football attendance data reported to the NCAA on the 2018 Football Paid

Attendance Summary sheets. We were also pleased to report that the current year's average home attendance of 15,398 met the minimum NCAA requirements.

Audit of the Performance Based Funding Metrics Data Integrity

Beginning in fiscal year 2013-14, the State University System of Florida Board of Governors (BOG) instituted a performance-funding program based on 10 performance metrics used to evaluate Florida's public universities. Of the \$560 million dollars in performance-based awards made by the BOG for fiscal year 2017-2018, FIU received \$73.7 million.

Our annual audit confirmed the results of past audits that FIU continued to have good process controls for maintaining and reporting performance metrics data. In our opinion, the system, in all material respects, continued to function in a reliable manner and provided an objective basis of support for the FIU Board of Trustees (BOT) Chair and the University President to sign the representations made in the BOG Performance Based Funding Data Integrity Certification. Nevertheless, we made two recommendations, which management agreed to implement, to reduce the likelihood of incomplete and untimely submission of data.

Audit of the University Technology Fee

As authorized by Florida Statutes, section 1009.24(13), BOT Regulation FIU-1101, *Tuition and Fees Schedule*, established a technology fee at 5 percent of the tuition per credit hour, the statutory limit. Per the Regulation, the revenue from this fee shall be used to enhance instructional technology resources for students and faculty. All 12 State University System (SUS) institutions have adopted the technology fee at 5 percent.

The Division of Information Technology's Business Project Management Office administers FIU's Technology Fee program. For the two fiscal years ended June 30, 2017, the University generated \$20.1 million in revenues from the Technology Fee assessment and incurred \$22.3 million in expenditures.

The Division of Information Technology's established controls and procedures for administering the University's Technology Fee were generally adequate. Nevertheless, the function could benefit from identifying expenditures incurred by each project in PantherSoft and better allocating Technology Fee funding of expenditures to align with the intended purpose of the fee. A final reconciliation of project costs is also needed. In addition, better documentation of the Technology Fee Advisory Council's methodology for reviewing and recommending project proposals, as well as obtaining the Provost and Chief Information Officer's final approvals for all proposals will strengthen the process. We made 10 recommendations, which management agreed to implement.

Audit of Internal Controls and Data Security over Personal Data Pursuant to Florida Department of Highway Safety and Motor Vehicles Contract Number HSMV-0512-18

We performed an audit of the Department of Parking, Sustainability and Transportation's ("Parking") internal controls and data security governing the use and dissemination of personal data pursuant to the requirements of the Florida Department of Highway Safety and Motor Vehicles (DHSMV) Contract Number HSMV-0512-18 ("the Memorandum of Understanding" or "MOU"). Through the MOU, Parking is permitted electronic access to driver license and motor vehicle data to be used to verify vehicle registration and ownership information for the purpose of issuing University parking permits and collecting fines related to citations.

Although we have completed past audits related to FIU's access to the DHSMV's driver license and motor vehicle data to complete that agency's required Attestation Statement, the scope of this audit expanded to include a cybersecurity component, as required by the MOU. The objectives of the audit were to determine whether the Department had policies and procedures in place to prevent unauthorized access, distribution, use, modification, or disclosure of the personal data that is provided/received pursuant to the MOU and whether a Risk Management IT Security Professional had approved those data security policies and procedures.

The audit concluded that, in all material respects, the internal controls and data security governing the Department's use and dissemination of personal data pursuant to the MOU and applicable laws, which if operating effectively, were necessary to provide reasonable assurance that personal data is protected from unauthorized access, distribution, use, modification, or disclosure. Our audit also confirmed that a Risk Management IT Security Professional had approved the Department's data security policies and procedures, and verified that management had corrected the deficiencies found during the audit and had implemented measures to prevent recurrence.

Audit of the Chapman Graduate School

The College of Business is fully accredited by the Association to Advance Collegiate Schools of Business (AACSB). The Chapman Graduate School ("the School"), with a total enrollment of 2,556 for the 2017-2018 academic year, brings together all of the graduate and executive education programs the College offers. It consists of multiple MBA specialized master's degree and PhD programs, which are continuing education programs classified as either market rate, self-support, or tuition-plus graduate programs. The operations of these programs are accounted for in the Auxiliary Fund.



The primary objectives of the audit were to determine if the established controls and procedures were: (a) adequate and effective; (b) being adhered to; and (c) in accordance with established University policies and procedures, and applicable laws, rules, and regulations. The audit focused on transactions during the period July 1, 2017, through September 30, 2018, and the School's current practices through January 2019. Overall, our audit concluded that the School's financial controls included within the prior audit of the College have improved and those unique to the School were adequate. Revenues were properly accounted for and managed in accordance with established policies and procedures. Nevertheless, opportunities for improvement existed in the following areas: (1) fund balance accumulation; (2) payroll overload expenditures; (3) controls over expenditures; (4) attractive property; and (5) control environment. The audit also identified the need for targeted training in ethics to the School's employees. The audit resulted in 14 recommendations, including one (1) for the University's Payroll Division, which both the School and Payroll management teams have agreed to implement.

Audit of the Procurement Process at the Chaplin School of Hospitality and Tourism Management

On September 27, 2018, the Office of Internal Audit completed an investigation of suspicious financial transactions occurring at the Chaplin School of Hospitality and Tourism Management ("the School") involving the use of a blanket purchase order issued for laundry services. Our investigation concluded that segregation of duties related to the specific blanket purchase order was lacking and that the University paid \$4,136 in unallowable expenses. In light of the findings, and at the request of the School's Interim Dean, we conducted an audit of the School's procurement processes and practices for the period July 2016 to January 2019. The audit principally focused on determining if the School had controls in place to prevent or detect errors or irregularities and their operating effectiveness.

Our audit found some aspects of the procurement process at the School, specifically its use of unencumbered and smart billing payments and supplier selection, to be operating

effectively and compliant with established University policies and procedures. However, the audit also identified opportunities to improve internal controls particularly pertaining to: (1) the segregation of incompatible duties performed when executing purchase orders for the procurement of goods or services; (2) the lack of independent verification of purchases; and (3) the inappropriate use of funds. Additionally, the audit concluded that greater operational and budgetary efficiencies could be achieved through fuller utilization of donated products. The audit resulted in seven recommendations, which management agreed to implement.

Audit of the Patricia and Phillip Frost Art Museum

Located on the Modesto A. Maidique Campus, the Patricia and Phillip Frost Art Museum ("Museum") is a 46,000-square-foot facility. The Museum is an independent unit under the direct authority of the Provost. Its mission is to provide transformative experiences through art; collect, exhibit, and interpret art across cultures; and advance FIU's stature as a top tier research University.



The audit covered the Museum's operations during the period July 1, 2017, through February 28, 2019, and focused on whether procedures and practices for the recordkeeping, safeguarding, and maintaining of the Museum's collection/inventory were adequate; payroll and other expenditures were appropriate and adhered to University policies and procedures, and applicable laws, rules, and regulations; and applicable information technology risks are mitigated. Based on our audit, we noted improvement in controls over the Museum's Collection records from our previous audit. However, opportunities for improvement existed over operational and expenditure controls related to the Collection's safeguarding, payroll and personnel administration, expenditures, and deaccessioning of assets. We also identified areas related to information technology that needed attention, particularly identifying and mitigating risk, disabling local generically named administrator accounts, and removing inactive firewall rules that are no longer needed. The audit resulted in 23 recommendations, which management agreed to implement.

Audit of the Student Activity and Service Fee

We examined the student activity and service (A&S) fee for the period July 1, 2017, through June 30, 2018, and an assessment of the current fee allocation practices through February 2019. The primary objective of our audit was to ensure that A&S fees collected by the University were appropriate and that funds were disbursed properly as designated by Florida Statutes and University policies and procedures.

For fiscal year 2017-2018, the University's A&S fee gross revenue totaled approximately \$20 million. The A&S fee of \$14.85 per credit hour affords benefits for the entire student body, and provides for membership and maintenance of the recreation and student centers on both the Modesto A. Maidique Campus (MMC) and Biscayne Bay Campus (BBC). It also provides funding for student organizations and clubs, as well as various departments within the University's Student Affairs division and throughout the University.

Our audit concluded that there were adequate controls and procedures over the allocation and use of A&S fees. However, opportunities for improvement existed. We concluded that the calculation of the A&S fee increase could be refined. In addition, the manner in which expenditures were accounted for and processed, including the timeliness of approving payroll contracts needed enhanced diligence when being executed. The audit resulted in nine recommendations for the A&S Business Office and one for the Office of Financial Planning, which both management teams agreed to implement.

Sub-recipient Monitoring (Division of Research)

We reviewed sub-recipients' annual financial report submissions pursuant to the Federal and the State of Florida's respective single audit acts. The purpose of these reviews is to ensure that sub-recipients are compliant with the financial reporting requirements under the respective acts, that their reports reflect that they are fiscally responsible and are free of, or have adequately addressed significant or material findings reported by their independent auditors.

During FY 2018-2019, we completed reviews of six institutions who were sub-recipients under FIU grants:

Amazon Center for Environmental Education and Research Foundation
American University of Beirut and Subsidiary
Banyan Research and Innovation Center, Inc.
McGuire Research Institute, Inc.
Nevada System of Higher Education
Public Health Research Institute of India

The results of our review were submitted to the management of the University's Research and Economic Development department for their review and follow-up.

Audit Follow-Up Activities

We surveyed management on their progress towards completing past recommendations that were due for implementation throughout the fiscal year. Recently, we revised our audit follow-up process to include validation of the self-reported implementation status of prior audit recommendations through the examination of corroborating evidence. A total of 126 recommendations were slated for implementation during the fiscal year. According to management, and as validated through our revised process, 98 of 126 recommendations (78 percent) were fully implemented. Management has either partially implemented or is working towards implementing the remaining recommendations. In addition, management has provided revised completion dates for full implementation of outstanding items. We are pleased to highlight that the reported rate of fully implemented recommendations was substantially higher than in previous years. This positive trend suggests that management is committed to following through on resolving identified audit issues in a timely manner.

Prior Audit Recommendations (As of June 2019)
78% of recommendations fully implemented (increase of 20% as compared to FY 2017-2018)
18% of recommendations partially implemented (decrease of 20% as compared to FY 2017-2018)
126 recommendations were due for implementation during FY 2018-2019 74 recommendations were due for implementation during FY 2017-2018

Investigations

Our office is responsible for conducting investigations for allegations of fraud, waste, or abuse and whistle-blower complaints. We completed seven such investigations and provided our investigation findings, and recommendations, where appropriate to University management for their action.

In addition, throughout the year, our office worked with the Office of Compliance and Integrity and the Department of Human Resources in evaluating and assigning complaints received through the University's complaint hotline (Convercent) to the appropriate personnel to investigate.

AUDIT PLAN

Every year the BOT approves a risk-based plan prepared by the Chief Audit Executive (CAE). In preparing the plan, the CAE consults with senior management and the BOT and obtains an understanding of the organization's strategies, key business objectives, associated risks, and risk management processes. The CAE reviews and adjusts the plan, as necessary, in response to changes in the organization's business, risks, operations, programs, systems, and controls and updates the BOT on any required changes.

In developing this year's audit plan, we initiated a University-wide risk assessment. We began the process by first identifying each operational unit within the University and the respective unit head, in collaboration with a small, core group of Senior Management. Each unit head was surveyed about common risks that impact his/her operations and asked to rate their likely occurrence and potential impact.

The survey recipients were asked to consider all relevant risk factors, including operational, safety, financial, regulatory, and reputational risks. Thereafter, we spent an extensive amount of time meeting with each unit head and discussing the unit and University's risk profile, as well as the areas of greater risk sensitivity.

Our risk assessment methodology also incorporated the results of the University's last Enterprise Risk Management (ERM) evaluation, previous risk assessments completed by the OIA, and other factors, such as materiality and past audit coverage. Using all of the information gathered through this process, each risk received a final rating. A compilation of the risks and their relative rating, based on the established rating criteria, is presented in the Risk Assessment Heat Map on page 15.

The risk-based approach used in analyzing the University activities/programs and assessing the respective risks with senior management input enabled our collective knowledge to identify potential areas for audit and to develop the proposed audits for the 2020 fiscal year that will optimize our resources and capitalize on our audit staff's individual strengths. In addition, to a large extent, it serves as the framework for identifying the planned audits for the next five years as depicted on page 17.

To achieve the best added value to the University, the deployment of audit resources is determined by the relative rating of the identified risk, with the top 79 risks (those falling within the red section on the heat map) receiving targeted audits and frequent monitoring. The other categories of risks will receive periodic audit coverage and/or monitoring. The approved audit plan for the 2020 fiscal year is presented on page 16.

The risk assessment tool provides an additional valuable information source for enterprise-wide compliance and risk management. We will continue our collaboration with the Office of University Compliance and Integrity in this respect, ensuring that significant risks are evaluated and mitigated.

FLORIDA INTERNATIONAL UNIVERSITY

THE OFFICE OF INTERNAL AUDIT UNIVERSITY RISK ASSESSMENT HEAT MAP

IMPACT	Lasting damage to reputation, operations & funding.	Severe (4)	40	25	8	9
	Disrupts operations over months; up to \$1M at risk.	Significant (3)	109	128	30	6
	Short-term negative effects/press; up to \$250K at risk.	Moderate (2)	112	154	30	1
	Minor regulatory or reputational effects; < \$25K at risk.	Negligible (1)	168	43	4	1
			Remote (1)	Less than likely (2)	Likely (3)	Very likely (4)
			Chance of occurrence < 10%	Chance of occurrence = 10% - 30%	Chance of occurrence = 30% to 75%	Chance of occurrence > 75%
			LIKELIHOOD			

The following table outlines our approved audit plan for FY 2020:

Carryover Audits:	
College of Nursing and Health Sciences	
Treasury Management	
Construction - Recreation Center Expansion	
Accounts Receivable	
Proposed New Audits:	
Unit/Department	Area of Focus
Analysis and Information Management	Performance Based Funding Metrics Data Integrity
Athletics	Health Services Billing and Coding Process and Contract Performance
Athletics	NCAA Football Attendance Certification
College of Medicine	Affiliated Agreements for Student Placement and Rotation •
Environmental Health and Safety	Lab Safety •
Financial Management	Procurement and Competitive Bidding Procedures •
FIU Foundation	Compliance with Donor Confidentiality and Intent •
Human Resources	New Employee Document Verification Process •
Plant Operations and Maintenance	Motor Pool •
Research and Economic Development	Grants (Sub-recipient Monitoring)
University-wide	Conflict of Interest and Related Party Transactions •
University-wide	FERPA Compliance •
University-wide	Grant Accounting - Auxiliary and Foundation Funded •
University-wide	Payroll Irregularities and Fraud Controls •

Florida International University Office of Internal Audit Risk-Based Five-Year Audit Plan												
Operational Unit/Area	General Subject Matter	Risk Index	Past Audit Coverage				Planned Audit Coverage					
			Prior	2017	2018	2019	2020	2021	2022	2023	2024	
Academic Affairs	Student Health Center	(2/4)	x		x			✓				
Academic Affairs	Applied Research Center	(3/3)										✓
Academic Affairs	Food Network South Beach Wine & Food Festival	(2/4)	x			x			✓			
Analysis & Information Management	Performance Based Funding Metrics	(2/2)	x	x	x	x	✓	✓	✓	✓	✓	
Athletics	Major NCAA Violations	2/3						✓				✓
Athletics	Title IX Violations	3/2								✓		
Athletics	Health Services Billing & Coding Process	(2/4)					✓					
Athletics	NCAA Football Attendance Certification	(2/3)	x	x	x	x	✓	✓	✓	✓	✓	
Capital Construction	Project Administration & Funding	(2/4)	x						✓			
College of Arts & Science	Information Technology Controls	(3/3)	x					✓				
College of Medicine	Affiliated Agreements For Student Placement & Rotation	3/4	x				✓					
College of Medicine	Human Research Controls	4/4	x					✓				
Enrollment Services	Motor Vehicle Internal Controls & Data Integrity	(4/1)		x		x			✓			
Environmental Health & Safety	Lab Safety	3/4	x				✓					
Environmental Health & Safety	Hazardous Wastes & Materials Management	2/4	x							✓		
Environmental Health & Safety	Regulatory & Code Compliance	2/3	x							✓		
External Relations, Communications, & Marketing	Comprehensive/Coordinated Content Driven Solutions	4/3							✓			
External Relations, Communications, & Marketing	Brand Alignment and Affinity Management	4/4						✓				
External Relations, Communications, & Marketing	Digital/Web Communication Standards Compliance	4/4						✓				
Financial Management	Purchasing & Competitive Bidding Process	2/3	x	x	x	x	✓					
FIU Foundation	Donor Intent/Confidentiality	2/3	x				✓					
Housing & Residential Life	Student Housing	4/2		x						✓		
Human Resources	New Employee Document Verification Process	4/3					✓					
Human Resources	Payroll	(4/3)	x			x			✓			
Human Resources	Overpayment of Terminated Employees	(3/2)	x			x			✓			
Information Technology	Data Breach of Protected Information	3/4	x	x	x	x		✓				
Information Technology	IT Physical Controls	3/3	x	x	x				✓			
Information Technology	Panther Tech	(3/3)							✓			
Information Technology	Data Loss Prevention Controls	(3/2)	x	x	x	x				✓		
Information Technology	Vendor Management	(3/3)	x	x	x					✓		
Information Technology	Physician Assistant Program – IT Controls	(3/2)						✓				
Information Technology	Media Sanitation Guidelines & Controls	(3/3)						✓				
Instruction & Academic Support	Grading Integrity Management	4/3							✓			
Parking & Transportation	Motor Vehicle Internal Controls & Data Integrity	(4/1)		x		x			✓			
Plant Operations & Maintenance	Motor Pool	4/4	x				✓					
Plant Operations & Maintenance	Access Controls – Secure Locations	3/3	x							✓		
Plant Operations & Maintenance	Facilities Inspections & Deferred Maintenance	3/3	x								✓	
Plant Operations & Maintenance	Construction Accident Reporting	2/4									✓	
Plant Operations & Maintenance	Student Safety – Safety Athletic & Recreational Facilities	2/3	x							✓		
Police Department	Jeanne Clery Act Compliance	(2/4)	x								✓	
Research & Development	Research Training & Policy Compliance	3/3	x					✓				
Research & Development	Biohazards Response Management	2/3	x								✓	
Research & Development	Information Technology Controls	(3/4)							✓			
Research & Development	Grant Sub-recipient Monitoring	(2/1)	x	x	x	x	✓	✓	✓	✓	✓	
Research & Development And College of Medicine	Plagiarism & Research Misconduct Management & Controls	3/3							✓			
Student Affairs	Children's Creative Learning Center	(3/3)	x								✓	
University-wide	Conflict of Interest & Related Party Transactions	3/3	x				✓					
University-wide	Export/Import Controls	4/4						✓				
University-wide	FERPA Compliance	3/3	x		x		✓					
University-wide	Grant Accounting – Auxiliary & Foundation Funded	4/4					✓					
University-wide	Payroll Irregularities and Fraud Controls	3/3					✓					
University-wide	Natural Disaster Preparedness & Response	3/4							✓			
University-wide	Use of Student Fees	2/3	x			x						✓
University-wide	Grant Expenditure Controls	2/3	x								✓	
University-wide	General Data Protection Regulation Controls	(3/4)						✓				
University-wide	Background Check – Volunteers & Third Parties	(4/3)	x	x	x	x			✓			
University-wide	Student Safety – Hazing & Alcohol Abuse Prevention	(3/4)						✓				
University-wide	Admissions Policy Compliance	(3/4)						✓				

Note: The Risk Index represents the coordinates of the X and Y axes as plotted on the Risk Assessment Heat Map. Parenthetic Risk Index is assigned by OIA to specific audit projects identified through analyses other than the risk assessment survey tool.



THE FLORIDA INTERNATIONAL UNIVERSITY

BOARD OF TRUSTEES

Audit and Compliance Committee

September 5, 2019

UNIVERSITY COMPLIANCE PROGRAM ANNUAL REPORT (2018-2019)

ACKNOWLEDEMENTS

The Office of University Compliance and Integrity ("Compliance Office") would like to acknowledge the Executive Team and Senior Management for their support and top-down leadership in maintaining and continuing to build the Florida International University ("FIU") institutional compliance and ethics program ("Program"), and everyone who has supported our commitment to maintaining a culture of ethics and compliance. We especially acknowledge the FIU Community Members who make a robust and comprehensive compliance program possible through an individual commitment to ethical conduct, compliance with the law and *doing the right thing*.

PURPOSE AND SCOPE

The purpose of the FIU Program is to promote and support a working environment which reflects FIU's commitment to operating with the highest level of integrity while maintaining compliance with applicable laws, regulations, and policies. The Program applies to all FIU campuses, facilities, and operations, and to the senior leaders, management, faculty, and staff ("Employees"), and where appropriate, the FIU Board of Trustees ("BOT") members, vendors, volunteers, donors and contractors (collectively, "Community Members"). The Program includes structural components, systems, and practices designed to nurture and preserve a culture of truth, freedom, respect, responsibility and excellence while building ethics and compliance into the daily activities of Community Members. This is done, in part, by providing education and training on compliance-related topics, assisting in developing FIU policies, helping Community Members to understand the policy development process, explaining and supporting the responsibilities and obligations of our Community Members who are public employees and clarifying and interpreting FIU policies, procedures and regulations.

PROGRAM DESIGN

The Program is designed and administered, recognizing that building and maintaining a culture of ethics and compliance are shared responsibilities and requires a commitment from all Community Members. The Program is also designed to prevent, detect, and correct misconduct within FIU in reasonable satisfaction of the requirements of Chapter 8 of the U.S. Federal Sentencing Guidelines and Florida Board of Governors Regulation 4.003. The guidelines and regulation set forth the requirements of an "effective ethics and compliance program."

FEDERAL SENTENCING GUIDELINES FOR ORGANIZATIONS

The FSG, promulgated by the United States Sentencing Commission in 1991 outlines organizational sentencing guidelines used by Federal Judges to determine whether a defendant organization had an "effective compliance program" in place to prevent the violations for which it is being charged. In 2004, the Commission amended the Guidelines to clarify and strengthen the requirements of an "effective compliance and ethics program."

Organizations are expected to exercise due diligence to prevent and detect criminal conduct and to promote a culture that encourages ethical conduct and compliance with the law. The following elements set forth the minimum criteria for a program to be deemed effective:

Elements of an effective compliance program

(based on Chapter 8 of the U.S. Federal Sentencing Guidelines)

- **Effective program structure and oversight to ensure compliance with the governing body**
- **Documented compliance and ethics standards of conduct and policies**
- **Effective training, education, and communication to the governing body and employees**
- **Exercise of due diligence in hiring and assignment of delegation of authority and responsibility**
- **Measurement and monitoring to ensure that the compliance and ethics program is followed**
- **Promotion of the program and consistent investigation, discipline and incentives**
- **Corrective action is taken in response to identified weakness or compliance failures**
- **Development of an effective compliance risk assessment and management review and response process**

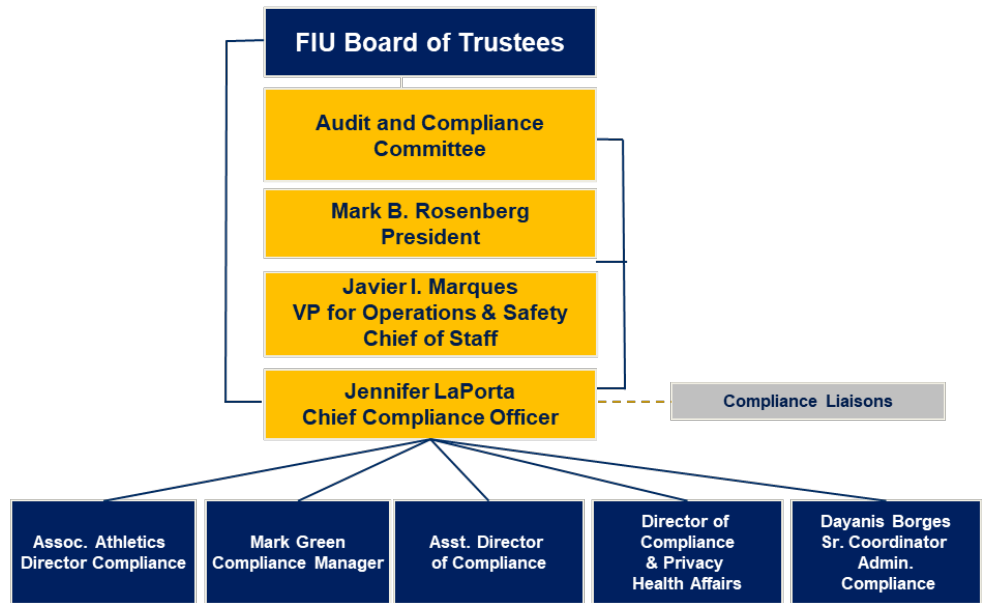
OFFICE OF UNIVERSITY COMPLIANCE AND INTEGRITY

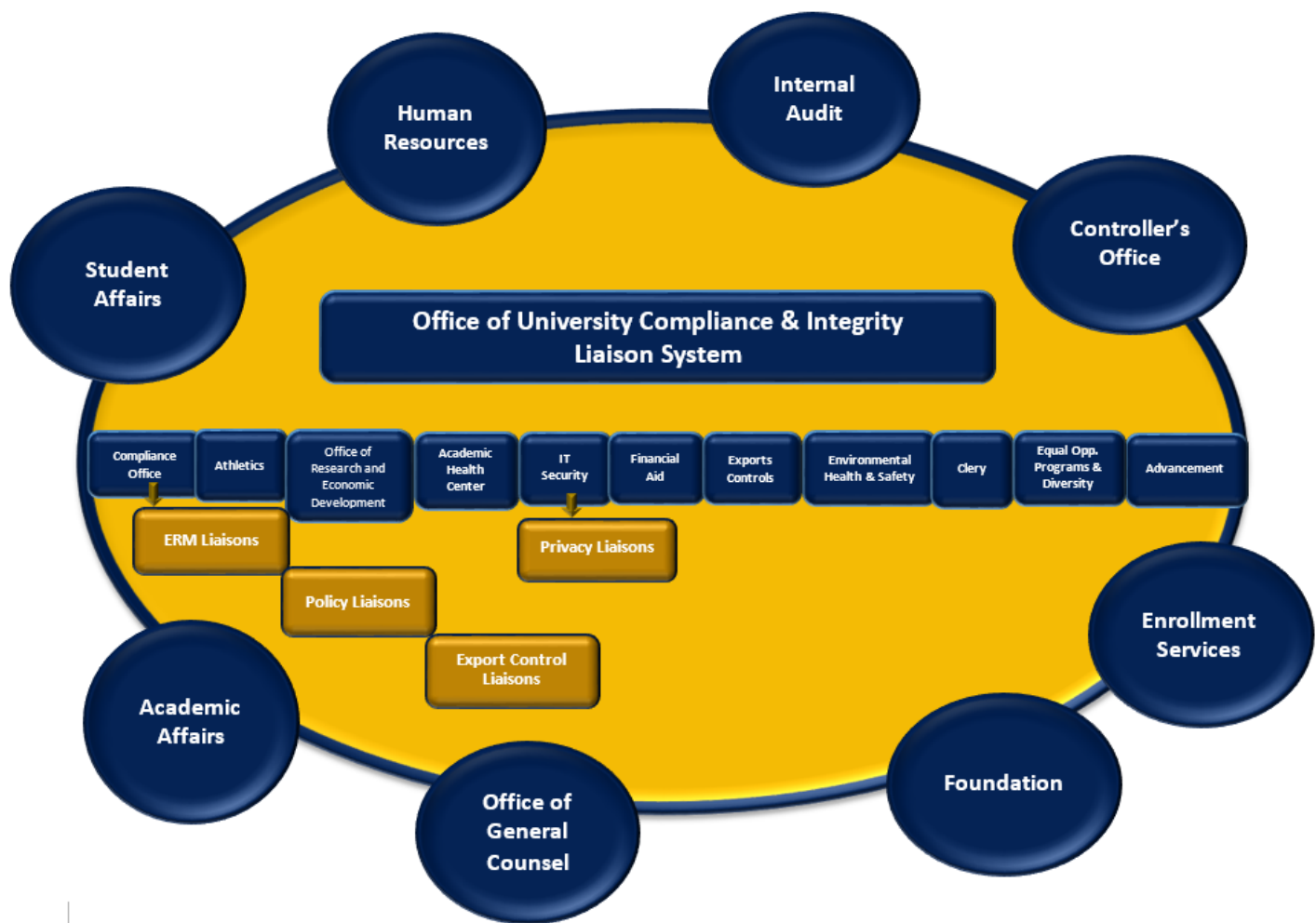
The Compliance Office is responsible for coordinating, supporting, and promoting the Program, as well as providing assurance to the BOT and to FIU leadership, that controls and mechanisms are in place to prevent, detect and mitigate compliance risk. In fulfilling these responsibilities, one of the primary objectives of the Compliance Office is to provide direction, guidance, and resources to faculty, staff and students on maintaining an ethical and compliant culture through an effective Program.

FIU Compliance Areas		
Accounting Irregularities	Discrimination	Identity Theft
Access/ Accommodations/Disability	Drug law policy violation	Immigration Concerns
Admissions Irregularities	Export Control Violations	Information Security
Animal Subject Research	Firearms and Dangerous Weapons policy violation	Interruption to campus operations or services
Anti-bribery	FIU Trademarks	Laboratory Safety
Billing for Health Care Services	Fraud and Financial Abuse	NCAA Rules Violations
Child Abuse or Neglect	Grant Expenditure Violations	Political Activity Violation
Conflict of Interest	Grant Performance	Privacy
Criminal or civil charges against FIU Executives	Harassment	Research Misconduct
Copyright infringement	Institutional Animal Care and Use Committee	Retaliation
Damage to campus property	Institutional Bio-safety Committee/Institutional Review Entity Violations	Sexual Misconduct
Death or serious bodily injury on campus	Institutional Review Board Violations	Workplace Safety
Student and faculty systems – Limited management over compliance systems, but potentially significant implications for culture or systems failure		

Compliance Governance

Program Structure and Oversight





The information below reflects the status on key action items and other compliance activities for the 2018-19 reporting year.

Completed	In Process			Not Begun
Fully Implemented	Good Progress	Slow Progress	Poor Progress	Not Begun
✓	●	●	●	N/B
Program Structure and Oversight				
Organizations are expected to have high-level oversight and adequate resources and authority given to those responsible for the program.				
Compliance Program Objective	Key Action Items	Summary	Progress Indicator	
Serves as a point for coordination of and responsibility for activities that promote an	Develop the Compliance Liaison scorecard to track Compliance Liaison participation and engagement.	This compliance program objective ("Program Objective") has	✓	

organizational culture that encourages ethical conduct and a commitment to compliance with applicable federal, state, and local laws, as well as regulations, rules, policies, and procedures.		been fully executed.	
	Leverage existing infrastructure by integrating Enterprise Risk Management (“ERM”) Advisory Committee responsibilities into the responsibilities of the Compliance Liaisons.	This Program Objective has been fully executed.	✓

Policies and Procedures

Organizations are expected to have standards reasonably capable of preventing and detecting misconduct.

Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Provide support for the development and enforcement of University policies and procedures.	Distribute the Principles and Standards (University Code of Conduct).	Principles and Standards finalized and rolled out to key campus constituents. Continued Campaign initiatives, University-wide distribution and training planned throughout the 2019-2020 Work Plan year.	✓
	Conduct the following policy campaigns:	This Program Objective has been fully executed for the 2018-2019 Work Plan year.	✓
	<ul style="list-style-type: none"> Adding and dropping of courses (policy campaign completed) 268 employees reached Clery Act training and Campus Fire and Safety report (campaign completed) 168 employees reached Ethics in purchasing policy (policy campaign completed) Gift policy (policy and training campaign completed) 1,365 employees reached 	Four policies identified by the 2018-2019 Work Plan were withdrawn by the policy owner for additional discussion and	

	<ul style="list-style-type: none"> • Family Education Rights and Privacy Act (FERPA) (policy and training campaign completed) 1,910 employees reached • Fraud Prevention and Mitigation Policy (policy and training campaign completed) • Health Insurance Portability and Accountability Act (HIPAA) (policy and training campaign completed) 1,819 employees reached • Mandatory Reporting of Child Abuse (policy and training campaign completed) 3,421 employees reached • Military Leave (policy and training campaign completed) 93 employees reached • Observance of Religious Holy Days (policy and training campaign completed) 82 employees reached • Payment Card Industry Data Security Standards (PCI-DSS compliance) (policy and training campaign completed) 1,128 employees reached • Preventing identity theft on covered accounts offered or maintained by FIU (Red Flags) (policy and training campaign completed) 820 employees reached • Five FIU research-related policies (2370.070, 2370.005, 2320.060, 2320.001 and 2320.070l) Campaign (policy campaign completed) 731 employees reached • FIU-113 Smoke and Tobacco-Free Campus Regulation 	<p>consideration or moved by the policy owner to a later campaign date. They were the following:</p> <ul style="list-style-type: none"> -Animals in the Workplace -Career and Talent Development -Conflict of Interest -Employment of foreign national in visa categories 	
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	<p>Campaign (regulation campaign completed) 4,849 employees reached</p> <ul style="list-style-type: none"> • Information Technology and Data Stewardship Policies Campaign (policy campaign completed) 86 employees reached • FIU Athletics Compliance Major Advisors PTD Rules Education (policy campaign completed) 56 employees reached • Political Activity Policy Campaign (policy and training campaign completed) 116 employees reached • Political Participation Policy Campaign (policy and training campaign completed) 116 employees reached • Anti-retaliation and University Responsibility Campaign (policy and training campaign completed) 117 employees reached • Four FIU admissions-related policies (1310.005, 1310.010, 1310.015, and 340.030) Campaign (policy campaign completed) 61 employees reached • NCAA Compliance FIU September 2018 Athletics All Staff Meeting Campaign (policy and training campaign completed) 13 employees reached 		
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Training and Education

Organizations are expected to take reasonable steps to communicate periodically and in a practical manner, its standards and procedures, and other aspects of the compliance and ethics program to members of the governing authority, high-level personnel, substantial authority personnel, the organization's employees, and, as appropriate, the organization's agents. The organization should deliver effective training programs and otherwise disseminate information appropriate to such individuals' respective roles and responsibilities.


Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Support compliance education and training efforts and leverage technology to enhance awareness of important laws, regulation, and policies, and to document training completions.	Provide training and communication support for the following compliance topics: <ul style="list-style-type: none"> • Policy Library info-graphic (released) • Policy Development Timeline (released) • Political Activity and Participation short training video (released) • Anti-retaliation training video (released) • Military Leave training video (released) • Nepotism in research (released) • Conflict of Interest in research (released) • Office of Research and Economic Development prior approval of sponsored project proposals (released) • NCAA Compliance FIU September 2018 Athletics All Staff Meeting Campaign (released) • FIU Athletics Compliance Major Advisors PTD Rules Education (released) 	This Program Objective has been fully executed.	✓
	Partner with the Division of Human Resources to identify, schedule, coordinate, support and resource enterprise-wide legally required mandatory training across the University.	This Program Objective has been met for the 2018-2019 Work Plan year. Mandatory training	✓

		workgroup has been convened and mandatory training inventory developed and disseminated. Further program objectives are continuing and scheduled for the 2019-2020 Work Plan year.	
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Measurement and Monitoring


Organizations are expected to ensure that the organization's compliance and ethics program is followed, including monitoring and auditing to detect criminal conduct.

Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Report matters of alleged misconduct, including criminal conduct, when there are reasonable grounds to believe such conduct has occurred.	Conduct compliance reviews for the following areas: <ul style="list-style-type: none"> • CynergisTek, Inc. <ul style="list-style-type: none"> ○ Information Security Program Assessment ○ Department Review ○ Risk Analysis ○ Research Assessment ○ Privacy Assessment ○ HIPAA Hybrid Entity Assessment 	This Program Objective has been met for the 2018-2019 Work Plan year. Second round of Assessments scheduled for the 2019-2020 Work Plan year.	✓

	<ul style="list-style-type: none"> Ethisphere - Compliance Program Assessment (in progress) 	<p>This Program Objective is in process.</p> <p>Assessment was moved to the 2019-2020 Work Plan year pending guidance regarding the Board of Governors' expectations for the external review of university centralized compliance programs as required in Board of Governors Regulation 4.003(7)(c). Guidance finally issued March 19, 2019.</p>	
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Allegation Reporting and Investigations

Organizations are expected to have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization's employees and agents may report or seek guidance regarding potential or actual criminal conduct without fear of retaliation.

Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Initiate, conduct, supervise, coordinate, or refer to other appropriate offices, such inquiries, investigations, or reviews as deemed appropriate and in accordance with University regulations and policies.	<ul style="list-style-type: none"> Development of guidelines for handling and reporting significant compliance matters ("Escalation Guidelines") 	Guidelines have been developed for discussion and consideration by the OGC, HR and Internal Audit.	

	<ul style="list-style-type: none"> Investigation Guidelines 	<p>This Program Objective has been met for the 2018-2019 Work Plan year as guidelines have been developed. Some additional revision to guidelines pending due to transition to new hotline and case management system. Further objectives related to training are scheduled for the 2019-2020 Work Plan year.</p>	✓
	<ul style="list-style-type: none"> Work with the Division of Human Resources and the Office of Internal Audit to review and update materials related to rights and protections of reporters of misconduct 	<p>This Program Objective has been met for the 2018-2019 Work Plan year as strategic meetings and discussion among Compliance, HR, OGC and Internal Audit have occurred. Further related objectives will be scheduled for the 2019-2020 Work Plan year.</p>	✓

Discipline and Incentives

Organizations are expected to promote and enforce consistency throughout the organization, appropriate incentives to perform in accordance with the compliance and ethics program, and appropriate disciplinary measures for engaging in criminal conduct and for failing to take reasonable steps to prevent or detect criminal conduct.

Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Support the process to address compliance failure in compliance or ethics through appropriate measures, including education or disciplinary action.	Develop an executive scorecard that highlights policy review and training requirements completed by the University President's Leadership Team.	This Program Objective has been met for the 2018-2019 Work Plan year.	✓

Enterprise Risk Management

Organizations are expected to periodically assess the risk of criminal conduct and shall take appropriate steps to design, implement, or modify each requirement.

Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Support the University-wide effort to develop an ERM program	Execute the ERM framework by working with the assigned Risk Owners to identify controls and monitoring efforts.	This Program Objective has been met for the 2018-2019 Work Plan year. The policy statement, process, framework and risk owners have been identified and mitigation planning meetings have occurred. Further objectives related to ERM are planned for the 2019-2020 Work Plan year.	✓

Organization Culture			
Organizations are expected to promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.			
Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Consult with the Board of Trustees and the President to encourage a culture of compliance and ethics.	Communicate the results of the 2016 culture survey and further develop metrics on how to assess progress.	This Program Objective has been met for the 2018-2019 Work Plan year as the results of the culture survey were communicated to the University's Operations Committee and the Deans Advisory Council. Survey results will be further used to benchmark additional culture survey tools following the Principles and Standards campaign.	✓

Benchmarking Summary

Various compliance-enforcing agencies expect organizations to have “adequate” compliance programs. A common method used to determine whether a compliance program is adequate is to compare the organization’s program with the compliance efforts of other organizations of similar type, size, and structure. Notwithstanding, it is understood that effective compliance programs address the organization’s particular risk structure. The information below provides an insight into trends as well as industry standards and best practices from reporting mid-size organizations (including for-profit and non-profit). The FIU Compliance program anticipates comparing itself to industry benchmarking data released in 2018.

Oversight and Accountability Standards

Reporting Structures and Relationships

- **Approximately half of compliance officers report to the Board.** This is true when looking at the data by industry, ownership (for profit and non-profit) and even by the gender

of the compliance officer. **Meeting with the Board four or more times a year is the norm.** Overall, 35% of respondents reported four regularly scheduled meetings per year, and another 29% reported five or more, bringing the total to 64% with four meetings or more annually.

- **FIU:** FIU's Chief Compliance Officer reports functionally to the Board through the Audit and Compliance Committee and has a reporting relationship to the President of the University. FIU provides quarterly reporting to the Audit and Compliance Committee and annually to the full Board.

Conclusions/Implications

The role of compliance in organizations seems to be solidified and strong. The consistency of the data year to year and the overwhelming consistency across the various measures suggests that the position has become an integral one in most organizations with reporting lines to the governing body or very close to it.

The idea that compliance reporting to the general counsel is the norm is not born out by the data in the survey or previous ones. Reporting to the general counsel is the exception, albeit a common one, rather than the rule.

Overall the relationship between the board and compliance seems to meet the needs of compliance professionals. Their general high satisfaction levels with the quality and frequency of the meetings is encouraging.

With the permission of the sources cited, the benchmarking data used to generate this report is from the Relationship between the Board of Directors and the Compliance and Ethics Officer, April 2018, A survey by the Society of Corporate Compliance and Ethics and the Health Care Compliance Association. Compliance Training and the Board, September 2017, A survey by the Society of Corporate Compliance and Ethics and the Health Care Compliance Association. State of the Compliance and Ethics Function 2018: Investigations and Discipline Findings © 2019 Gartner, Inc. and/or its affiliates. All Rights Reserved. Compliance and Ethics State of the Function Full Report 2019 Gartner, Inc. and/or its affiliates. All Rights Reserved.

Education, Communication and Awareness Standards

Compliance Board Training

- **While Board training is the norm,** a significant minority of companies do not offer compliance training to Board members. Overall 28% report that the Board does not receive compliance and ethics-related training, and for publicly traded companies, 34% of respondents indicated no training is provided.
- **FIU:** Ongoing Board training occurs as a function of the quarterly reporting to the Audit and Compliance Committee; during on-boarding of all new Board members and periodically in conjunction with the Office of the General Counsel. The Chief Compliance Officer is working with a sub-committee of the State University System Consortium to develop consistent, comprehensive ethics training to be used in ongoing Board education.

Conclusions/Implications

Organizations not providing training to their Board on compliance and ethics issues are clearly in the minority, and that may carry some risk. The lack of training may be difficult to

explain to a prosecutor after an incident, especially now that the Fraud Section in the Criminal Division of the US Department of Justice has indicated that, should an incident occur, prosecutors may be asking what compliance expertise is available on the Board.

Likewise, organizations providing training less than annually are clearly deficient as compared to their peers. Given the responses to this survey, it is clearly the norm to provide training at least once a year if not more. That would be expected with the changing enforcement environment and the ever-increasing number of legal and regulatory risk areas facing organizations. Providing less than annual training may be perceived as deficient.

Overall there appears to be significant room for improvement, even for organizations training their Board annually. Compliance professionals surveyed were generally not fully satisfied with the level of training provided to the Board. This suggests that likely more could and should be done. However, given the limited time of the Board, it is also likely that there will always be tension between the amount of training desired and the time available for that training.

Compliance Risk Management

Top Compliance and Ethics Risks

- **Managing compliance and reducing compliance and ethics risk to the organization is at the very core of compliance and ethics programs' mandate.** Risk management is often the key outcome of a wide range of the program's activities, driving much of the program's training, analytics and culture-building activities. **Over half of the surveyed compliance and ethics leaders report risk assessment is done annually, with another quarter of programs conducting risk assessments less frequently.** For programs that conduct an enterprise-wide compliance and ethics risk assessment, over two-thirds use a hybrid top-down and bottom-up approach to complete this assessment.
- **FIU:** FIU has regularly conducted risk assessment; however, in 2017 FIU engaged in an Enterprise Risk Management program ranking system to inform University leadership in prioritizing risk assessments and mitigation plans as we move forward. In 2018-2019 the FIU Office of Internal Audit engaged in a formalized Risk Management Process to better inform the internal audit work plan and ongoing efforts of the Office of Compliance and Integrity.

Conclusions/Implications

For compliance executives working to manage risks in a rapidly changing environment while minimizing drag on business operations, aligning the program's activities with other assurance functions can provide significant benefits to risk management outcomes.

Compliance and ethics leaders currently operate in an environment of unprecedented change. To better manage the risks their organizations' face, these executives must work to manage their program's structure, resources and activities as efficiently as possible. **Leaders of compliance and ethics programs should partner with other assurance leaders to align efforts throughout the organization.**