FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
AUDIT AND COMPLIANCE COMMITTEE

Florida International University
Modesto A. Maidique Campus
Graham Center Ballrooms

Wednesday, February 26, 2020
8:00 a.m.

Chair: Gerald C. Grant, Jr.
Vice Chair: Natasha Lowell
Members: Leonard Boord, Joerg Reinhold, Sabrina L. Rosell

AGENDA

1. **Call to Order and Chair's Remarks** — **Gerald C. Grant, Jr.**

2. **Approval of Minutes** — **Gerald C. Grant, Jr.**

3. **Action Items**

   AC1. Performance Based Funding and Emerging Preeminence Metrics — **Trevor L. Williams**

   A. Performance Based Funding and Emerging Preeminence Status – Data Integrity Certification
   B. Audit of Performance Based Funding and Emerging Preeminence Metrics Data Integrity

   AC2. FIU Office of Internal Audit Quality Assurance Review 2019 — **Trevor L. Williams**

4. **Discussion Items** *(No Action Required)*

   4.1 Office of Internal Audit Status Report — **Trevor L. Williams**

   4.2 University Compliance and Ethics Quarterly Report — **Jennifer LaPorta**

   4.3 Review of Office of Internal Audit Policy and Charter — **Trevor L. Williams**

   4.4 Review of the Compliance and Ethics Charter for the Office of University Compliance and Integrity — **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.**

FIU Board of Trustees Audit and Compliance Committee Meeting

Time: February 26, 2020 8:00 AM - 9:00 AM EST

Location: FIU, Modesto A. Maidique Campus, Graham Center Ballrooms

Section	Agenda Item	Presenter	Page
5.1	Office of Internal Audit Discussion of Audit Processes		
6.	**Concluding Remarks and Adjournment**	Gerald C. Grant, Jr.	

THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
Audit and Compliance Committee
February 26, 2020

Subject: Approval of Minutes of Meeting held December 5, 2019

Proposed Committee Action:

Approval of Minutes of the Audit and Compliance Committee meeting held on Thursday, December 5, 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 Thursday, December 5, 2019, at the FIU, Modesto A. Maidique Campus, Graham Center Ballrooms.

Supporting Documentation: Minutes: Audit and Compliance Committee Meeting, December 5, 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
DECEMBER 5, 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 8:07 a.m. on Thursday, December 5, 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.

General Counsel Carlos B. Castillo 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.

Trustee Michael G. Joseph was excused.

Trustees Dean C. Colson, Justo L. Pozo, 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 September 18, 2019. A motion was made and unanimously passed to approve the Minutes of the Audit and Compliance Committee Meeting held on Wednesday, September 18, 2019.

3. Discussion Items

3.1 Office of Internal Audit Status Report

Chief Audit Executive Trevor L. Williams presented the Internal Audit Status Report, providing updates on recently completed audits. In terms of the audit of the revenues and expenditures for the continuing education programs at the Nicole Wertheim College of Nursing and Health Sciences, he explained that while some aspects are functioning well, improvements to operational and financial controls are needed. He pointed out that the audit resulted in 18 recommendations. Turning his attention to the audit of Treasury Management, Mr. Williams indicated that the objectives of the audit were to determine whether adequate and functioning procedures and internal controls are in place for fundamental duties, namely, the monitoring and reporting of the subject portfolio's performance, adherence to investment policies, and proper segregation of duties. He stated that the audit resulted in six recommendations and noted that one particular area for improvement pertained to the inconsistent manner in how investment manager fees are reported.

Mr. Williams explained that one of the responsibilities of the Office of Internal Audit is to investigate allegations of financial fraud, waste, abuse, wrongdoing, and any whistle-blower complaints. He pointed out that a number of such allegations and complaints have been received and are currently being evaluated. In response to the Trustees' feedback regarding the timely implementation of outstanding audit recommendations, he reported that the Office of Internal Audit has been working on the development of an application for managing the implementation of audit recommendations. He indicated that the application will provide the platform through which management will be informed about recommendations coming due for implementation and will enable them to manage their response. Mr. Williams facilitated a brief demonstration of the application, the Panther Audit Platform, highlighting the expectations for greater efficiency and effectiveness, and that the rollout will follow within the coming months after testing and training is completed.

In response to Trustee Leonard Boord's request from the prior Committee meeting, Mr. Williams reported that the Office of Internal Audit compiled a matrix of the ratings assigned to the five internal control criteria that the audit reports, from FY 2017 to current, generally contained. He explained that of the 29 audits that were issued during that period, the data gathered could not provide a singular compelling indicator of the overall state of compliance and risk management at the University. He pointed out that if there were an inference to be drawn from the data, it would be that the areas audited during that period reflect a maturing risk and control environment, in that 97% of the inflection points were rated either satisfactory or fair.

Mr. Williams stated that the Office of Internal audit is undertaking an internal self-assessment and has also started the process of arranging for the performance of an independent external validation of the internal self-assessment. He pointed out that the results of the internal self-assessment and the external validation review will be shared with the Committee, once completed. He also provided an update on recruitment efforts within the Office of Internal Audit, indicating that all vacancies, except for a Senior Auditor position, have been filled.

In response to Trustee Boord's inquiry, Mr. Williams explained that the audit platform will log participation and track activity. Committee Chair Grant and Trustee Roger Tovar commended the work of the Office of Internal Audit.

3.2 University Compliance and Ethics Update

Chief Compliance and Privacy Officer Jennifer LaPorta provided the University Compliance and Ethics Update. She reported that three new compliance platforms, namely, the compliance hotline, policy and training, and training content are on schedule for launch in January 2020. She explained that the Compliance newsletter is on schedule for a January 2020 launch and pointed out that the transitions to the new platforms will be the focus of the first issue. She explained that the newsletter subsequently will focus on ethical decision making and will provide a platform to recognize outstanding efforts in compliance.

In terms of the University's Enterprise Risk Management program, Ms. LaPorta explained that in collaboration with the Office of Internal Audit, a "risk mitigation toolbox" for risk owners, is being developed and this will include templates for documenting controls and best practices. She pointed

out that these efforts will be supported with the Compliance liaisons as they work with risk owners on developing mitigation tools.

Ms. LaPorta pointed out that the first meeting of the Foreign Influence Task Force is scheduled for December 12, 2019, noting the growing concerns over foreign influence in higher education. She added that as FIU continues its efforts in building its research portfolio and engaging in critical emerging technologies, the University is operating at a higher risk of being targeted by individuals and entities of concern to the U.S. government. She explained that the University must address these challenges by continuing to develop systems with the adequate controls in place where connections with foreign concerns can be understood and managed effectively. She described agency focus in terms of foreign influence, namely, that long-standing statutes are being expanded upon, that new guidance is being issued, and that comprehensive reporting is being required of universities. She indicated that, in collaboration with the Office of the General Counsel, the University's compliance with said statutes is being assessed in order to address any deficiencies that might have occurred in the past, and to also ensure that moving forward, the nature of relationships with foreign entities remain transparent and meet any mandated disclosure requirements. She highlighted the importance of managing FIU's relationships with foreign entities responsibly and that the Foreign Influence Task Force will be critical to that effort.

Ms. LaPorta described ongoing efforts toward supporting FIU's cleared facility status, namely, the establishment of a security program. She delineated the process for the development of the 2020 Compliance calendar and provided updates on completed policy and training campaigns, policy development workshops, and trends identified from policy program surveys. In terms of recruitment, she pointed out that the position for the Director of Compliance for Health Affairs has been filled and that two professional Compliance positions have been posted and are in process.

In response to Trustee Tovar's inquiry, Ms. LaPorta explained that there are two compliance positions in the central Compliance office, four in Athletics Compliance, and one in Health Affairs Compliance. In terms of foreign influence concerns, Trustee Tovar pointed out the importance of monitoring the University's regional locations. Relating to grants, Vice President of Research and Economic Development Andres G. Gil explained that the University's Research office has a considerable responsibility relating to foreign influences, and therefore, the pre-award unit works closely with the Compliance office. In response to Trustee Marc D. Sarnoff's inquiry regarding instances of foreign infiltration, Ms. LaPorta pointed out that while there may be no known occurrences, it is critical to have the systems in place that allow the University to be aware of interactions in order to effectively mitigate risks.

4. New Business

4.1 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 the Office of Internal Audit and senior management, separately, to discuss the audit process. 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. University President Mark B. Rosenberg indicated that there were no instances or issues

that warranted the attention of the Board with respect to the offices of Internal Audit and Compliance and noted that ongoing efforts have led to improved operations.

5. 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 Thursday, December 5, 2019, at 8:49 a.m.

There were no Trustee requests.

THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
Audit and Compliance Committee
February 26, 2020

Subject: Performance Based Funding and Emerging Preeminence Metrics

A. Performance Based Funding and Emerging Preeminence Status – Data Integrity Certification

B. Audit of Performance Based Funding and Emerging Preeminence Metrics Data Integrity

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Proposed Committee Action:

Recommend that the Florida International University Board of Trustees:

1. Approve the Performance Based Funding and Emerging Preeminence Status – Data Integrity Certification to be signed by the Chair of the FIU Board of Trustees and the University President; and

2. Approve the Audit Report - Audit of the Performance Based Funding and Emerging Preeminence Metrics Data Integrity.

Background Information:

This item is presented pursuant to a request from the State University System of Florida Board of Governors (BOG) dated June 18, 2019. The Chair of the Florida International University Board of Trustees (BOT) and the President of the University shall execute a Data Integrity Certification, furnished by the BOG. The certification document shall be signed by the President and BOT Chair after being approved by the BOT.

To make such certifications meaningful, the University's Chief Audit Executive has been directed to perform an audit of the University's processes that ensure the completeness, accuracy, and timeliness of data submissions. The results of the audit shall be provided to the BOG after being accepted by the BOT. The completed Data Integrity Certification and audit report shall be submitted to the Office of Inspector General and Director of Compliance no later than March 2, 2020.

Supporting Documentation: March 2020 Data Integrity Certification

Audit of the Performance Based Funding and Emerging Preeminence Metrics Data Integrity

Facilitator/Presenter: Trevor L. Williams

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STATE UNIVERSITY SYSTEM of FLORIDA
Board of Governors

Data Integrity Certification

March 2020

University Name: **Florida International University**

INSTRUCTIONS: Please respond "Yes" or "No" for each representation below. Explain any "No" responses to ensure clarity of the representation you are making to the Board of Governors. Modify representations to reflect any noted **significant or material** audit findings.

Data Integrity Certification Representations			
Representations	**Yes**	**No**	**Comment / Reference**
1. I am responsible for establishing and maintaining, and have established and maintained, effective internal controls and monitoring over my university's collection and reporting of data submitted to the Board of Governors Office which will be used by the Board of Governors in Performance Based Funding decision-making and Preeminence or Emerging Preeminence Status.	☒	☐	
2. These internal controls and monitoring activities include, but are not limited to, reliable processes, controls, and procedures designed to ensure that data required in reports filed with my Board of Trustees and the Board of Governors are recorded, processed, summarized, and reported in a manner which ensures its accuracy and completeness.	☒	☐	
3. In accordance with Board of Governors Regulation 1.001(3)(f), my Board of Trustees has required that I maintain an effective information system to provide accurate, timely, and cost-effective information about the university, and shall require that all data and reporting requirements of the Board of Governors are met.	☒	☐	
4. In accordance with Board of Governors Regulation 3.007, my university shall provide accurate data to the Board of Governors Office.	☒	☐	
5. In accordance with Board of Governors Regulation 3.007, I have appointed a Data Administrator to certify and manage the submission of data to the Board of Governors Office.	☒	☐	

Data Integrity Certification

Data Integrity Certification Representations			
Representations	**Yes**	**No**	**Comment / Reference**
6. In accordance with Board of Governors Regulation 3.007, I have tasked my Data Administrator to ensure the data file (prior to submission) is consistent with the criteria established by the Board of Governors Data Committee. The due diligence includes performing tests on the file using applications, processes, and data definitions provided by the Board Office.	☒	☐	
7. When critical errors have been identified, through the processes identified in item #6, a written explanation of the critical errors was included with the file submission.	☒	☐	
8. In accordance with Board of Governors Regulation 3.007, my Data Administrator has submitted data files to the Board of Governors Office in accordance with the specified schedule.	☒	☐	
9. In accordance with Board of Governors Regulation 3.007, my Data Administrator electronically certifies data submissions in the State University Data System by acknowledging the following statement, "Ready to submit: Pressing **Submit for Approval** represents electronic certification of this data per Board of Governors Regulation 3.007."	☒	☐	
10. I am responsible for taking timely and appropriate preventive/ corrective actions for deficiencies noted through reviews, audits, and investigations.	☒	☐	
11. I recognize that Board of Governors' and statutory requirements for the use of data related to the Performance Based Funding initiative and Preeminence or Emerging Preeminence status consideration will drive university policy on a wide range of university operations – from admissions through graduation. I certify that university policy changes and decisions impacting data used for these purposes have been made to bring the university's operations and practices in line with State University System Strategic Plan goals and have not been made for the purposes of artificially inflating the related metrics.	☒	☐	

Data Integrity Certification

Data Integrity Certification Representations			
Representations	**Yes**	**No**	**Comment / Reference**
12. I certify that I agreed to the scope of work for the Performance Based Funding Data Integrity Audit and the Preeminence or Emerging Preeminence Data Integrity Audit (if applicable) conducted by my chief audit executive.	☒	☐	
13. In accordance with section 1001.706, Florida Statutes, I certify that the audit conducted verified that the data submitted pursuant to sections 1001.7065 and 1001.92, Florida Statutes [regarding Preeminence and Performance-based Funding, respectively], complies with the data definitions established by the Board of Governors.	☒	☐	

Data Integrity Certification Representations, Signatures

I certify that all information provided as part of the Board of Governors Data Integrity Certification for Performance Based Funding and Preeminence or Emerging Preeminence status (if applicable) is true and correct to the best of my knowledge; and I understand that any unsubstantiated, false, misleading, or withheld information relating to these statements render this certification void. My signature below acknowledges that I have read and understand these statements. I certify that this information will be reported to the board of trustees and the Board of Governors.

Certification: _____ Date_____
President

I certify that this Board of Governors Data Integrity Certification for Performance Based Funding and Preeminence or Emerging Preeminence status (if applicable) has been approved by the university board of trustees and is true and correct to the best of my knowledge.

Certification: _____ Date_____
Board of Trustees Chair

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FIU | Office of Internal Audit

FLORIDA INTERNATIONAL UNIVERSITY

Audit of the Performance Based Funding and Emerging Preeminence Metrics Data Integrity (Revised)

Report No. 19/20-06
February 12, 2020

We have reissued the *Audit of Performance Based Funding and Emerging Preeminence Metrics Data Integrity,* Report No. 19/20-06, dated February 7, 2020, to correct two dates on page 21 relating to the original submission and resubmission dates for the Instruction & Research file.

FIU | Office of Internal Audit

FLORIDA INTERNATIONAL UNIVERSITY

Date: February 7, 2020

To: Kenneth G. Furton, Provost and Executive Vice President
Hiselgis Perez, Vice Provost of Office of Analysis and Information Management

From: Trevor L. Williams, Chief Audit Executive

Subject: **Audit of the Performance Based Funding and Emerging Preeminence Metrics Data Integrity, Report No. 19/20-06**

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 allocated by the BOG for fiscal year 2019-2020, FIU received $64.4 million. Furthermore, in 2019, the University achieved sufficient preeminent metrics to receive the designation of an emerging preeminent state research university by the authority of Florida Statute 1001.7065.

Pursuant to a request by the (BOG), we have completed an audit relating to the University's performance based funding and emerging preeminence metrics. The primary objectives of our audit were to:

1) Determine whether the processes established by the University ensure the completeness, accuracy, and timeliness of data submissions to the BOG, which support the Performance Based Funding and Emerging Preeminence Metrics; and
2) Provide an objective basis of support for the University Board of Trustees Chair and President to sign the representations made in the *Performance Based Funding - Data Integrity Certification* that will be submitted to the Board of Trustees and filed with the BOG by March 2, 2020.

Our annual audit confirmed the results of past audits that FIU continues to have good process controls for maintaining and reporting performance metrics data. In our opinion, the system, in all material respects, continues to function in a reliable manner. Nevertheless, we made five recommendations to reduce potential risks to data integrity which management agreed to implement.

I also take this opportunity to express our appreciation for the cooperation and courtesies extended to us during this audit.

Attachment

C: FIU Board of Trustees
Mark B. Rosenberg, University President
Kenneth A. Jessell, Chief Financial Officer and Senior Vice President
Javier I. Marques, Vice President and Chief of Staff – Office of the President
Carlos Castillo, General Counsel

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OBJECTIVES, SCOPE, AND METHODOLOGY

As directed by the State University System of Florida (SUS) Board of Governors (BOG), we have completed an audit of the data integrity and processes utilized in the University's Performance Based Funding (PBF or "Funding Metrics") and Emerging Preeminence Metrics. The primary objectives of our audit were to:

(a) Determine whether the processes established by the University ensure the completeness, accuracy, and timeliness of data submissions to the BOG, which support the Performance Based Funding and Emerging Preeminence Metrics; and

(b) Provide an objective basis of support for the University Board of Trustees Chair and President to sign the representations made in the *Data Integrity Certification,* which will be submitted to the Board of Trustees and filed with the BOG by March 2, 2020.

Our audit was conducted in conformance with *the International Standards for the Professional Practice of Internal Auditing* promulgated by the Institute of Internal Auditors and ISACA *IS Audit and Assurance Standards*, and included tests of the supporting records and such other auditing procedures, as we considered necessary under the circumstances.

During the audit, we:

1. Updated our understanding of the process flows of data for all of the relevant data files from the transactional level to their submission to the BOG;

2. Reviewed BOG data definitions, SUS Data workshop documentation, and meeting notes to identify changes to the BOG Funding Metrics;

3. Interviewed key personnel, including the University's Data Administrator, functional unit leads, and those responsible for developing and maintaining the information systems;

4. Observed current practices and processing techniques;

5. Tested the system access controls and user privileges within the State University Database System (SUDS) application, upload folders, and production data; and

6. Tested the latest data files for two (2) of the 10 performance based funding metrics as well as three (3) of the eight (8) emerging preeminence metrics achieved and submitted to the BOG as of August 31, 2019. Sample sizes and transactions selected for testing were determined on a judgmental basis applying a non-statistical sampling methodology.

Audit fieldwork was conducted from September 2019 to January 2020. In fiscal year 2018-2019, we issued the report Audit of Performance Based Funding Metrics Data Integrity (Report No. 18/19-06), dated January 23, 2019. During the current audit, we reviewed the prior audit report and followed-up on the one recommendations, which are addressed within this report.

BACKGROUND

The Florida Board of Governors has broad governance responsibilities affecting administrative and budgetary matters for Florida's 12 public universities. Beginning in fiscal year 2013-2014, the BOG instituted a performance based funding program, which is based on 10 performance metrics used to evaluate the universities on a range of indicators, including graduation and retention rates, job placement, and access rate, among others. Two of the 10 performance metrics are "choice metrics" – one picked by the BOG and one by each University's Boards of Trustees. These metrics were chosen after reviewing over 40 metrics identified in the Universities' Work Plans but are subject to change yearly.

The BOG model has four guiding principles:

1. use metrics that align with SUS Strategic Plan goals;
2. reward Excellence or Improvement;
3. have a few clear, simple metrics; and
4. acknowledge the unique mission of the different institutions.

The Performance Funding Program also has four key components:

1. Institutions are evaluated and receive a numeric score for either Excellence or Improvement relating to each metric;
2. Data is based on one-year data;
3. The benchmarks for Excellence were based on the Board of Governors 2025 System Strategic Plan goals and analysis of relevant data trends, whereas the benchmarks for Improvement were decided after reviewing data trends for each metric; and
4. The Florida Legislature and Governor determine the amount of new state funding and the proportional amount of institutional funding that would come from each university's recurring state-base appropriation.

In 2016, the Florida Legislature passed, and the Governor signed into law the Board of Governors' Performance-Based Funding Model, now codified into the Florida Statutes under Section 1001.66, *Florida College System Performance-Based Incentive*.

During the 2019 Legislative Session, lawmakers approved Senate Bill 190 that contains language, amending section 1001.706, Florida Statutes. The new language states:

> *Each university shall conduct an annual audit to verify that the data submitted pursuant to ss. 1001.7065[1] and 1001.92[2] complies with the data definitions established by the board and submit the audits to the Board of Governors Office of Inspector General as part of the annual certification process required by the Board of Governors.* **[(1) Florida Statutes, Preeminent State Research Universities Program; (2) Florida Statutes, State University System Performance-based Incentive]**

FIU's Performance Based Funding Metrics			
1.	Percent of Bachelor's Graduates Employed (Earning $25,000+) or Continuing their Education (One Year After Graduation)	6.	Bachelor's Degrees Awarded in Areas of Strategic Emphasis
2.	Median Wages of Bachelor's Graduates Employed Full-time (One Year After Graduation)	7.	University Access Rate (Percent of Undergraduates with a Pell-grant)
3.	Average Cost to the Student (Net Tuition per 120 Credit Hours)	8.	Graduate Degrees Awarded in Areas of Strategic Emphasis
4.	Four Year Graduation Rate (Full-time, First-Time-In-College)	9.	Board of Governors' Choice - Percent of Bachelor's Degrees without Excess Hours
5.	Academic Progress Rate (2nd Year Retention with GPA above 2.0)	10.	Board of Trustees' Choice - Bachelor's Degrees Awarded to Minorities

The following table provided by the BOG summarizes the performance funds allocated for the fiscal year 2019-2020 using the performance metrics results from fiscal year 2018-2019, wherein FIU earned 87 points.

Florida Board of Governors Performance Funding Allocation, 2019-2020[1]				
	Points*	Allocation of State Investment	Allocation of Institutional Investment	Total Performance Funding Allocation
UF	95	$ 47,282,102	$ 52,634,792	$ 99,916,894
UWF	94	10,442,148	11,624,278	22,066,426
USF	92	36,504,867	40,637,494	77,142,361
FSU	88	42,084,561	46,848,851	88,933,412
UCF	88	36,760,351	40,921,901	77,682,252
FIU	**87**	**30,459,667**	**33,907,930**	**64,367,597**
FAU	86	20,517,518	22,840,256	43,357,774
FGCU	81	10,895,127	12,128,538	23,023,665
UNF	78	12,358,238	13,757,283	26,115,521
FAMU	70	13,750,113	15,306,730	29,056,843
NCF	67	3,945,308	4,391,947	8,337,255
Totals		**$265,000,000**	**$295,000,000**	**$560,000,000**

*Institutions scoring 51 points or higher receive their full institutional funding restored.

[1] The amount of state investment is appropriated by the Legislature and Governor. A prorated amount is deducted from each university's base recurring state appropriation (Institutional Investment) and is reallocated to each institution based on the results of the performance based funding metrics (State Investment).

In addition to the data integrity audit for the Performance Based Funding Model, universities designated as preeminent or emerging preeminent will need to conduct a similar audit for the data and metrics used for preeminence status consideration. This audit may be included with or separate from the Performance Based Funding Data Integrity Audit.

In 2019, Florida International University achieved sufficient preeminent metrics to qualify for designation as an emerging preeminent state research university by the authority of Florida Statute 1001.7065. Emerging preeminence status is achieved upon meeting six (6) of the 12 metrics, while preeminence status requires meeting 11 of the 12 metrics. The University met eight (8) of the 12 metrics as noted in **bold** below:

FIU's Emerging Preeminent Metrics			
1.	**Average GPA and SAT Score for incoming freshman in Fall term**	7.	**Total Amount R&D Expenditures in Non-Health Sciences**
2.	Public University National Ranking	8.	**National Ranking in Research Expenditures**
3.	**Freshman Retention Rate (Full-Time, First-Time-In-College)**	9.	**Patents Awarded (over a 3-year period)**
4.	4-Year Graduation Rate (Full-Time, First-Time-In-College)	10.	**Doctoral Degrees Awarded Annually**
5.	**National Academy Memberships**	11.	**Number of Post-Doctoral appointees**
6.	Total Annual Research Expenditures (Science & Engineering only) ($M)	12.	Endowment Size ($M)

Organization

FIU's Office of Analysis and Information Management (AIM) consists of Institutional Research (IR) and the Office of Retention & Graduation Success. One of the goals of AIM is to provide the University community with convenient and timely access to information needed for planning and data driven decision-making and to respond to data requests from external parties. IR is currently responsible for:

- Faculty Perception of Administrators (FPOA) formerly Faculty Assessment of Administrator System;
- Assisting with the online system used to credential faculty;
- Academic Program Inventory; and
- Assignment of CIP (Classification of Instructional Program) codes to courses and certificate programs.

IR has been the official source of FIU's statistics, providing statistical information to support decision-making processes within all academic and administrative units at FIU, and preparing reports and files for submission to the BOG and other agencies. It is also responsible for data administration, enrollment planning, and strategic planning.

The Office of Retention & Graduation Success identifies barriers to student success and works to eliminate those barriers. This Office helps to carry out the Graduation Success Initiative (GSI), primarily by providing "Major Maps" and alerts for students and academic advisors, and information and analyses to departments and decision-makers.

The Vice Provost for AIM, who is also the University's Data Administrator reports directly to the Provost and is responsible for gathering data from all applicable units, preparing the data to meet BOG data definitions and requirements, and submitting the data.

At FIU, the Performance Funding Metrics reporting process flows consist of three layers: (1) Production, (2) Upload, and (3) SUDS. The Production data (extracted from the PantherSoft databases) are originated from the following functional units -- the Admissions Office, Registrar's Office, Academic Advising, and Financial Aid. AIM and a Division of Information Technology (DoIT) team work collaboratively to translate the production data, which is sent to staging tables, where dedicated developers perform data element calculations that are based on BOG guidelines and definitions. Once the calculations are completed, the data is formatted into text files and moved to an Upload folder. Users then log into SUDS and depending on their roles, they either upload, validate, or submit the data to the BOG. The DoIT assists with the entire consolidation and upload process.

OBSERVATIONS AND RECOMMENDATIONS

Based on our audit, we concluded that there are no material weaknesses or significant deficiencies in the processes established by the University to report required data to the Board of Governors in support of their Performance Based Funding Metrics and the Emerging Preeminence Metrics. While there is always room for improvement as outlined in the detailed findings and recommendations that follow, the system is functioning in a manner that can be relied upon to provide complete, accurate, and timely submission of data to the BOG.

Accordingly, in our opinion, this report provides an objective basis of support for the Board of Trustees Chair and the University President to sign the representations made in the BOG's *Data Integrity Certification*, which the BOG requested be filed with them by March 2, 2020. Our evaluation of FIU's operational and system access controls that fall within the scope of our audit is summarized in the following table:

INTERNAL CONTROLS RATING			
CRITERIA	**SATISFACTORY**	**OPPORTUNITIES TO IMPROVE**	**INADEQUATE**
Process Controls	**X**		
Policy & Procedures Compliance	**X**		
Effect	**X**		
Information Risk		**X**	
External Risk	**X**		
INTERNAL CONTROLS LEGEND			
CRITERIA	**SATISFACTORY**	**OPPORTUNITIES TO IMPROVE**	**INADEQUATE**
Process Controls	Effective	Opportunities exist to improve effectiveness	Do not exist or are not reliable
Policy & Procedures Compliance	Non-compliance issues are minor	Non-compliance Issues may be systemic	Non-compliance issues are pervasive, significant, or have severe consequences
Effect	Not likely to impact operations or program outcomes	Impact on outcomes contained	Negative impact on outcomes
Information Risk	Information systems are reliable	Data systems are mostly accurate but can be improved	Systems produce incomplete or inaccurate data which may cause inappropriate financial and operational decisions
External Risk	None or low	Potential for damage	Severe risk of damage

The results of our audit are as follows:

1. Review of Process Flows of Data

During prior years' audits, we obtained an understanding of the processes the University implemented to ensure the complete, accurate, and timely submission of data to the BOG. During this audit, we met with the Data Administrator and other key personnel to update our understanding of the processes in place to gather, test, and ensure that only valid data, as defined by the BOG, are timely submitted to the BOG. Based upon our updated understanding, we determined that no significant changes have occurred in the process flows of data.

At FIU, the PantherSoft Security Team and AIM collaborated and developed a tool that generates edit reports similar to the ones found in the State University Database System (SUDS). This tool allows users at functional units more time to work on their file(s) since the BOG edits are released closer to the submission deadline. The purpose of the review is for users at functional units to correct any problems concerning transactional errors before submitting the files.

We found the Registrar's Office, which generates data for five (5) of the 10 performance based metrics, the Office of Financial Aid, and the Graduation Office are using the tool.

The Data Administrator's team routinely reviews error and summary reports to identify and correct any data inconsistencies. As explained, the Data Administrator's team is responsible for the day-to-day reporting and understands the functional process flows, while the functional units are responsible for their data and understand the technical process flows. According to AIM, they plan to continue to extend the use of the tool to all appropriate users upon request. Furthermore, for certain files, there are additional PantherSoft queries in place that users run to identify errors or bad data combinations.

In addition to the internal FIU reports, the BOG has built into the SUDS a data validation process, which through many diagnostic edits, flags errors by critical level. The SUDS also provides summary reports and frequency counts that allow for trend analysis. The AIM team reviews the SUDS reports and spot-checks records to verify the accuracy of the data. Once satisfied as to the validity of the data, the file is approved for submission.

As a result of a prior audit recommendation, AIM developed the *AIM-BOG Business Process Manual*. The Manual addresses the BOG SUDS Portal Security, BOG SUDS File Submission Process (see table on the following page), and details of the process for each file submitted to the BOG. It is also evident that the Manual has been continually updated since its implementation.

Steps	**BOG Files Submission Cycle**
1.	The PantherSoft (PS) Team extracts data from the PantherSoft database. Data is formatted according to the BOG data elements definitions and table layouts.
2.	The PS Team uploads data to the SUDS and runs edits.
3.	SUDS edits the data for possible errors and generates dynamic reports.
4.	Functional unit users are notified that edits are ready to be reviewed.
5.	Functional unit users review the edits and make any required transactional corrections in the PantherSoft database.
6.	AIM Lead/PS Team/Functional Unit users communicate by email, phone, or in person about any questions/issues related to the file.
7.	Steps 1 through 6 above are repeated until the freeze date.
8.	On the freeze date, a final snapshot of the production data is taken.
9.	The file is finalized, making sure all Level-9 (critical) errors were corrected or can be explained.
10.	AIM Lead reviews the SUDS reports, spot-checks data, and contacts functional unit users if there are any pending questions.

Conclusion

Based upon the review performed, we concluded that the data submitted to the BOG is properly validated prior to submission and approval and no material weaknesses were found in the University's current process flows of data.

2. System Controls Overview and Follow-up

To understand the process for ensuring complete and accurate submissions, we reviewed the SUDS Data Dictionary, BOG methodology, and procedures applicable to the PBF submissions. We obtained procedures from the Office of Analysis and Information Management (AIM) and interviewed key personnel involved in the submission process. For the two metrics selected for testing: Metric 7 – Percent of Undergraduates with a Pell-grant and Metric 10 – Bachelor's Degrees Awarded to Minorities (see report Subsection No. 3, page 14, we reviewed controls around the extraction, compilation, and review of their data to ensure completeness and accuracy of the submission.

We observed that IT system controls were in place for change management for both production scheduled jobs and the ad hoc generated reports, access, data quality, audit logging, and security. We noted that there were no significant changes since the prior audit. DoIT staff could make system and program changes while functional staff could make changes to data only through the applications, providing a separation of job functions.

AIM implemented an annual review process, which is performed in collaboration with the functional areas, to limit functional unit personnel access to critical data. The annual review included examination of user privileges within the SUDS application and examination of audit log files and production data. AIM works annually with the functional units and the PantherSoft Security team to:

- Review user accounts to ensure on-boarded and off-boarded SUDS users have an associated PAWS ticket and the existing users' access match their current job description;
- Review and reduce access privileges to the production environment to appropriately mitigate least privileged and segregation of duties risks; and
- Review log reporting for all metric data files, where appropriate, to ensure the integrity of the data sent to the BOG.

The areas covered during our audit are as follows:

a) SUDS On-boarding and Off-boarding
b) PantherSoft Access Control
c) PantherSoft Audit Logs
d) SUDS Metric Tables to BOG Reconciliation
e) Data Modification
f) Transfer Server Controls

a) <u>SUDS On-boarding and Off-boarding</u>
It is the responsibility of the individual's supervisor or functional unit lead to notify the security manager when an employee no longer requires SUDS access. Contrary to established protocol, we observed that the AIM Data Analyst, initiates PAWS tickets to add, change, or remove users with access to SUDS. Furthermore, this process is done on an annual basis or

when AIM has knowledge of changing employment status. A delay in the updating of an employee's status could increase the risk of unauthorized access.

b) PantherSoft Access Control

We observed there is an effective analysis performed by AIM to determine that functional users, PantherSoft developers, and AIM users have the appropriate levels of access to PantherSoft. Additional testing performed indicated that controls are in place to enforce segregation of duties between PantherSoft and SUDS.

c) PantherSoft Audit Logs

Audit logs capabilities in the production environments, as appropriate, increases the effectiveness of detection control to help the data administrator mitigate least privileges and segregation of duties risks. The purpose of this test was to review management implementation of a prior audit recommendation. The remediation stated was to: "Continue to create a log reporting mechanism for all metric data files, where appropriate, to help ensure the integrity of the data sent to the BOG".

Our testing confirmed that PantherSoft Security has developed queries that allow functional unit leads and AIM to identify actions that have been taken on relevant fields. The auditing capability is typically limited to a small number of specified fields due to the performance and resource intensive nature of audit logging. Any field that has the audit flag enabled will be captured in a log. The audit logs are separate tables in PantherSoft that cannot be modified. Any actions taken by a user on an audited field (e.g., logging in to the system) is recorded. The actions taken by a user can be reviewed by either the functional unit or the AIM team. Thus, the functional units are responsible for the integrity of data entered in PantherSoft. Similarly, PantherSoft Security is responsible for ensuring the integrity of the audit logs.

The proprietary PeopleSoft table's audit logging configuration can be deactivated after receiving an Oracle patch. Based on the annual AIM review documentation provided, the audit flags were disabled during the review of the following fields: FIU_AUD_ACADPLN and STDNT_ENRL_STATUS. Having disabled audit logs prevents proper validation and monitoring of activities to maintain information and system integrity.

d) SUDS Metric Tables to BOG Reconciliation

The purpose of our testing was to verify the integrity of files uploaded to SUDS. The test was performed by comparing production data received from PantherSoft (data translated to tables based on BOG guidelines) with data submitted to the BOG. We obtained access to the SUDS Portal and matched the information submitted to the BOG to the Metric translated data tables. The tables tested were those used for Metrics 7 and 10 (see report

Subsection No. 3, page 14): a) SFA-Financial Aid Awards; b) SIF-Enrollment; c) SIFD-Degrees Awarded; d) SIF-Person Demographic. There were no exceptions noted.

e) Data Modification

When there is one or more errors in the submitted data, the functional units will attempt to correct those errors through PantherSoft. However, in the event that data cannot be corrected at the source, data modification is done through scripts. Before launching a script in production, it is tested in several deployment environments, including development, test, and staging, and is validated by developers and functional users at each level. For data modification samples selected during testing, we obtained evidence of an approval process through PAWS tickets. We were able to observe segregation of duties between AIM (requesting and approval) and the subsequent processing by the PantherSoft Team. However, we noted an absence of formally documented procedures describing internal controls in place to prevent and detect errors while processing scripts. Lack of standard operating procedures can increase ambiguity and decrease the clarity of the data modification process.

f) Transfer Server Controls

A UNIX share owned by the Enterprise group is used by the PantherSoft Team to store Performance Based Funding data prior to upload to SUDS. During our testing, we observed that there are several controls in place to ensure the integrity of data on the UNIX share: segregation of duties within the site, access to the share must be previously approved, and authorized users have “Read Only” access. In addition, notifications are used to communicate the success or failure of the jobs processed. SUDS edits can be used to indicate whether any errors were introduced between writing data and uploading to SUDS. However, we found a lack of formally documented procedures describing internal controls put in place to detect success or failure of data written to UNIX share that is subsequently transmitted to SUDS, as well as a lack of documentation for granting access to the UNIX share. Lack of standard operating procedures can increase ambiguity and decrease the clarity of controls ensuring the integrity of data on the UNIX share.

Recommendations

The Office of Analysis and Information Management should:	
1.1	Coordinate with PantherSoft Security and the functional units to timely update the status of employee’s roles in SUDS and PantherSoft.

The PantherSoft Division of Information Technology should:	
1.2	Perform regression testing, upon receiving Oracle patches, to ensure that updates have not adversely affected any existing features including audit logging and formally document the patch management process for PantherSoft and integrate it with the existing change management systems.
1.3	Formally document current practices used in the process of BOG submissions that support data modification outside of PantherSoft (via scripts) within the AIM BOG Process Manual.
1.4	Enhance jobs monitoring activities for the UNIX share by (a) Describing in the AIM-BOG Business Process Manual the procedures involved in detecting the success or failure of data written to UNIX share, which is subsequently transmitted to SUDS. This verification could be done via observation of job alerts and SUDs edits to conserve completeness and integrity of data transmitted; and (b) Describing in the AIM-BOG Business Process Manual the authorization process for users with access to UNIX share.

Management Response/Action Plan:

1.1 A query has been developed to include all SUDS users who have changed departments or separated from FIU. The results of the query will be analyzed monthly by AIM beginning at then of February 2020. Terminated employees will be removed from SUDS. For employees who have changed departments, AIM will contact the new department head to see if that employee still needs SUDS access. In order to address other cases where the employee is in the same department but the employee's responsibilities may have changed, AIM will send out an email every semester (starting at the end of the spring 2020 semester) to the respective functional unit directors and remind them of their responsibility to inform AIM if the access to SUDS and/or PantherSoft for their employee needs to be changed. If a change in access is needed, they will be asked to submit a change request using a PAWS ticket.

Implementation date: May 31, 2020

1.2 This item has been completed. Documentation has been updated for the Oracle patch management process that includes testing and validation of the audit logs table and fields already in production. The DoIT will complete the necessary regression testing and validation of audit table configuration review as recommended by the Office of Internal Audit upon application of scheduled and critical patches as provided by Oracle.

Implementation date: Immediately

1.3 This item has been completed. DoIT provided the update and AIM updated the BOG Process Manual to document accordingly.

Implementation date: Immediately

1.4 (a) This item has been completed. BOG Process Manual has already been updated by DoIT describing the procedures involved (including screenshots) in detecting the success or failure of data written to the UNIX share. (b) This item has been completed. The AIM-BOG Process Manual has been updated by DoIT with the process for authorizing and granting access to UNIX shares.

Implementation date: Immediately

3. Data Accuracy Testing – Performance Based Funding Metrics

This is our sixth audit of the Performance Based Funding Metrics since it became effective in 2014. During our first-year audit, we performed data accuracy testing on all 10 metrics as requested by the BOG. In subsequent years' audits, since internal controls have always been deemed satisfactory, we have limited our data accuracy testing to specific metrics and followed up on any prior year recommendations. Metrics to audit are chosen based on different factors: audit risk, changes to the metric, or how long it has been since the metric was last subject to audit. Depicted in the following table are the metrics audited by year.

AUDIT COVERAGE OF PBF METRICS			
Audit FY		**Metrics Tested**	**Comment**
1.	2014-15	1-10	First year; test of all metrics required by BOG
2.	2015-16	6, 7, 8, & 10	
3.	2016-17	1, 2, 4, & 5	
4.	2017-18	3 & 9	First year of the revised Metric 3
5.	2018-19	4 & 5	First year of the revised Metric 4
6.	2019-20	7 & 10	

At the May 2018 meeting of the *State University Audit Council* (SUAC), the BOG Chief Data Officer presented a risk rating, ranging from low to high, for each PBF metric. The four metrics identified at the SUAC with the highest risk, either "moderately high" or "moderate", were audited during the two most recent audits, without exceptions. In developing this year's audit scope, since there were no prior year audit findings stemming from our data accuracy testing and there have been no significant changes to the metrics affecting this year's audit, we determined to test Metrics 7 and 10, last audited in 2015-16. In addition, these two metrics represented the only two metrics the University received the highest possible rating of "Excellence" awarding 10 points. Points are distributed based on a rating of either "Excellence" or "Improvement."

PBF Metrics Testing

The two PBF metrics tested were as follows:

- Metric 7 – Percent of Undergraduates with a Pell-grant.
- Metric 10 – Bachelor's Degrees Awarded to Minorities.

We identified the main data files and tables related to the calculations of the two metrics under review, as follows:

- Student Instruction file (SIF), Enrollment table;
- Student Financial Aid (SFA), Financial Aid Awards table; and
- Degrees Awarded file (SIFD), Degrees Awarded and Person Demographic tables.

The BOG provided us with the in-scope data elements for each of the metrics under review (see Appendix A – In-scope BOG Data Elements), which we used in our testing.

Data accuracy for the two metrics was tested by reviewing the corresponding data files, tables, and elements, and by tracing them to the source document data in PantherSoft. Testing was limited to the PantherSoft data itself as the objective of our testing was to corroborate that the data submitted were in fact unabridged and identical to the data contained in the University's PantherSoft system.

Metrics 7 and 10

The data for Metrics 7 and 10 are generated by the BOG from the Student Instruction file (SIF), Student Financial Aid file (SFA), and the Degrees Awarded file (SIFD) submitted by the University.

> ***Metric 7, University Access Rate (Percent of Undergraduates with a Pell-grant),*** *is based on the number of undergraduates, enrolled during the fall term, who received a Pell-grant during the fall term. Unclassified students, who are not eligible for Pell-grants, are excluded from this metric.*

In order to verify that the data submitted in the SIF fall 2018 file to the BOG were accurate, we selected a sample of 25 students and verified that the data provided to the BOG were the same as the data contained in PantherSoft student records. We verified the data in the six elements relevant to the Enrollment table (containing 58,063 students) without exception. In addition, we selected a separate sample of 25 students from the Annual 2017 SFA file and likewise, verified that the data provided to the BOG were the same as the data contained in PantherSoft student records. We verified the data in the four elements relevant to the Financial Aid Awards table (containing 49,160 students) without exception.

> ***Metric 10, Bachelor's Degrees Awarded to Minorities****, is based on the number, or percentage, of baccalaureate degrees granted in an academic year to Non-Hispanic Black and Hispanic students. This metric does not include students classified as Non-Resident Alien or students with a missing race code.*

In order to verify the data submitted in the SIFD fall 2018 file to the BOG were accurate, we selected a sample of 30 students and verified that the data provided to the BOG were the same as the data contained in PantherSoft student records. We verified the data in the five elements relevant to the Degrees Awarded table without exception. In addition, we selected a separate sample of 30 students and verified that the ethnicity/race data provided to BOG were the same as the data contained in PantherSoft student records. We verified the data in the nine elements relevant to the Person Demographic table without exception.

In addition, as part of our testing of the SIFD file, we reconciled the number of students and degrees awarded reported to the BOG with the records maintained by the Office of the Registrar. The SIFD file contained 5,301 degrees awarded (4,662 **single degrees**, 536 **single degrees** with double major, 51 **double degrees**, and 1 **single degree** with a triple major) to 5,247 students (3 students had both a Bachelor's degree and a second Bachelor's degree with a double major). The BOG rule allows for the multiple degrees, not double majors, to be counted individually. Thus, double majors are counted as half and triple majors as thirds. Included in the 5,301 degrees awarded were 109 out-of-term degrees.

We examined the out-of-term degrees reported to the BOG to understand why they were posted late. We found 109 such late postings. Of the 109, we found that 30 pertained to students from the Nurse Anesthesia Program who had simultaneously earned both a Masters and a Doctorate degree prior to the fall 2018 term. These were identified by the School of Nursing management during the submittal process. It was subsequently determined that due to an algorithm error these nursing students' double degrees had been counted as single degrees when originally reported to the BOG.

As explained to us by DoIT, this was the result of the late degrees selection algorithm, which would normally pick up late degrees from three terms prior. Thus, any graduation approved and posted more than three terms after having been earned would not be reported to the BOG. As a result of the algorithm error found, in fall 2018, the University changed its late degrees selection algorithm from the standard look-back of three-terms prior, and examined all prior terms starting in 2015. This resulted in the additional out-of-term degrees that had not been previously reported to the BOG**.** As a result, the BOG was notified by the University and the students' degrees were reported during the fall 2018 term (submitted spring 2019). However, subsequently, the algorithm was changed back to the standard prior three terms.

To test the reasoning for the inclusion of the other out-of-term students included, we examined a sample 10 other non-nursing students' degrees posted out of term. We found six (6) additional cases similar to the nursing students in that they had simultaneously earned double degrees with only one being reported at the time of submittal to the BOG. As for the four (4) other cases, we found that the students' graduation approval was received late from the department and posted more than three terms after earning their degrees: one (1) degree had been earned in fall 2017 (posted early spring 2019); one (1) in spring 2016 (posted fall 2017); two (2) in summer 2015 (posted in fall 2016 and fall 2017). Since they were approved more than three terms after they were earned, the algorithm did not pick them up for reporting to the BOG.

Furthermore, we then compared the fall 2018, and spring and summer 2019 SIFD submittals, examining for duplicate students. We found eight (8) students that were reflected on two of the submittals. Upon review, we learned that three (3) had earned double degrees. The remaining five (5) students earned one degree with double majors, with one major awarded in fall 2018 and the other major awarded in spring 2019. As a result, AIM requested the original degrees submitted in fall 2018 be rescinded and were resubmitted in spring 2019 to pick up the primary and the secondary major.

As part of the reconciliation between the fall 2018 SIFD submittal to the BOG and the Office of the Registrar's records of graduates in fall 2018, we found 54 students not reported to the BOG; however, 43 students were subsequently reported to the BOG in spring 2019 as out-of-term degrees, and another eight (8) students were reported in summer 2019. Three (3) of the students remain to be reported. Since the algorithm goes back three terms, these three students should be picked up in the fall 2019 SIFD submittal as their degree dates are now posted in PantherSoft as of fall 2019.

Upon discussing the issue with management, they informed us that the reconciliation error has since been corrected. They stated that prior to submitting the Degrees Awarded file in SUDS, they always ran an internal query to obtain the headcounts. The internal headcount was then compared to the headcounts in the SUDS site. However, the internal query was pointing to the Degrees Awarded file itself. As a result, a new query was prepared which now compares the headcounts in the Degrees Awarded file to the degree headcounts in the reporting PantherSoft database.

Conclusion

Our testing of the SIF, SFA, and SIFD data files found no differences between the information submitted to BOG and the data in FIU's system relating to the relevant elements for Metrics 7 and 10. However, based upon management's own finding of student degrees awarded not being reported to the BOG on a timely basis, we found that AIM's reconciliation of the Degrees Awarded file and the related records from the Office of the Registrar did not properly capture all out-of-term degrees. They have since corrected the deficiency in the reconciliation process.

4. Data Accuracy Testing – Emerging Preeminence Metrics

In 2019, the University achieved eight (8) of the 12 Preeminence metrics, earning it the Emerging Preeminence designation. Three (3) of the eight (8) metrics are associated with data in the file submissions tested within the PBF Metrics: Average GPA and SAT Score, Freshman retention rate, and Doctoral degrees awarded annually. Therefore, we have determined to select three (3) of the five (5) other metrics not previously audited for testing during this audit, as follows:

Emerging Preeminence Metrics Testing

The three metrics tested were as follows:

- 7 – Total Amount R&D Expenditures in Non-Health Sciences
- 9 – Patents Awarded (over a 3-year period)
- 11 – Number of Post-Doctoral Appointees

In October 2019, the BOG issued the *Preeminent Metrics Methodology Document*, which we used in our testing.

Data accuracy for the three metrics was tested by obtaining the respective University files and reviewing them against the data provided to the respective organizations associated with each metric, e.g., the National Science Foundation (NSF) and the United States Patent and Trademark Office (USPTO). In addition, where applicable, we agreed the information to the data in PantherSoft.

No. 7 - Total Amount R&D Expenditures in Non-Health Sciences

> ***No. 7, Total Amount R&D Expenditures in Non-Health Sciences.*** *Total annual Science & Engineering research expenditures in diversified non-medical sciences of $150 million or more, based on data reported annually by the NSF.*

In order to test the accuracy of the data related to R&D expenditures in non-health sciences, we reconciled the research expenditures data received from the BOG's Office of Data & Analytics (ODA) to the data reported by the National Science Foundation (NSF), without exception. The NSF website reported research expenditures totaling $153,113,000. We further grouped the data by cost center and tested all expenditures, totaling $15,600,247, from 20 cost centers selected, to ensure the expenditure was: (1) related to research, (2) for non-health sciences, and (3) in agreement with the amount reported in PantherSoft Financials. The results of our testing found no exceptions.

No. 9 - Patents awarded (over a 3-year period)

> ***No. 9, Patents Awarded.*** *One hundred or more total patents awarded by the United States Patent and Trademark Office (USPTO) for the most recent 3-year period.*

In order to test the accuracy of the data related to patents awarded, we compared the list of 126 utility patents provided by the ODA to the USPTO database listing for such patents from 2016-2018 without exception. We then selected and tested 10 patents, ensuring each qualified as a utility patent and had been awarded in the 2016-2018 period. We found no exceptions.

No. 11 - Number of Post-Doctoral Appointees

> ***No. 11, Number of Post-Doctoral Appointees.*** *Two hundred or more postdoctoral appointees annually, as reported in the TARU annual report.*

The 2019 Florida Legislature allowed the 2019 evaluation of this metric to be based on ODA's review of the annual NSF/National Institute of Health annual *Survey of Graduate Students and Postdoctorates in Science and Engineering* ("GSS") reporting fall 2017 data.

In order to test the accuracy of the data related to post-doctoral appointees, we obtained the listing of post-doctoral appointees for fall 2017, totaling 222. From the listing, we selected 10 appointees to determine if the post-doctoral appointee worked in the science, engineering, or health fields, and to ensure the data agreed with the information obtained from the PantherSoft Human Resources database for fall 2017 and that the appointee qualified for such appointment. We found no exceptions.

Conclusion

Our testing of the data for the Emerging Preeminence metrics tested found that the data provided complies with the definitions and methodology for the Preeminence metrics as outlined in the BOG's *Preeminent Metrics Methodology Document.*

5. PBF Data File Submissions and Resubmissions

Data File Submissions

To ensure the timely submission of data, AIM used the due date schedule provided by the BOG as part of the SUS data workshop to keep track of the files due for submission and their due dates. AIM also maintains a schedule for each of the files to be submitted, which includes meeting dates with the functional unit leads, file freeze date, file due date, and actions (deliverables) for each date on the schedule. We used data received directly from the BOG-IRM Office in addition to data provided by AIM to review the timeliness of actual submittals.

The following table and related notes, where applicable, reflect the original due dates and original submission dates of all relevant Performance Based Funding Metrics files during the audit period:

File	File Submission	Period	Original Due Date Including Extensions	Original Submission Date
ADM	Admissions	Summer 2018	09/14/2018	09/14/2018
SIF	Student Instruction	Summer 2018	09/25/2018	09/25/2018
ADM	Admissions	Fall 2018	10/10/2018	10/10/2018
SFA	Student Financial Aid	Annual 2017	10/04/2018	10/04/2018
SIFD	Degrees Awarded	Summer 2018	10/04/2018	10/04/2018
SIFP	Student Instruction Preliminary	Fall 2018	10/17/2018	10/17/2018
IRD	Instruction & Research	Annual 2017	10/23/2018	10/23/2018
EA	Expenditure Analysis	Annual 2017	10/30/2018	10/30/2018
HTD	Hours to Degree	Annual 2017	11/07/2018	11/07/2018
SIF	Student Instruction	Fall 2018	01/23/2019	01/23/2019
RET	Retention	Annual 2017	01/30/2019	01/30/2019
SIFD	Degrees Awarded*	Fall 2018	02/01/2019	02/08/2019
ADM	Admissions	Spring 2019	03/01/2019	03/01/2019
SIF	Student Instruction	Spring 2019	06/12/2019	06/12/2019
SIFD	Degrees Awarded**	Spring 2019	06/26/2018	06/28/2019

* Management informed us that the Fall 2018 Degrees Awarded file (SIFD) was submitted seven days late due to communication and technical issues. Guidance was requested from the BOG because of errors generated upon submission, but the response was not received by the due date. Furthermore, the University experienced technical issues, as the institutional edits would not run properly.

**Management explained that the Spring 2019 Degrees Awarded file (SIFD) could not be submitted until the Student Instruction file (SIF) was officially approved by the BOG. Due to the required resubmission of the SIF file (see No. 6 in Data File Resubmissions, page 22), this caused the SIFD file to be submitted two days late.

Data File Resubmissions

We obtained the list of resubmissions since the last audit from the BOG-IRM staff. The Data Administrator described the nature and frequency of the six required resubmissions and provided correspondence between the BOG and the University related to the data resubmissions. AIM examined the correspondence to identify lessons learned and to determine whether any future actions can be taken that would reduce the need for resubmissions.

The Data Administrator has acknowledged that although their goal is to prevent any resubmissions, they are needed in cases where inconsistencies in data are detected by either University or BOG staff after the file has been submitted. According to her, a common reason for not detecting an error before submission is that some inconsistencies only arise when the data are cross-validated among multiple files.

In regards to the frequency of the resubmissions, a list was provided by the BOG-IRM staff for all files submitted pertaining to the 10 PBF metrics. For files with due dates between October 1, 2018, and August 31, 2019, the University submitted 15 files to the BOG with five (5) files requiring resubmissions (one file was resubmitted twice).

The following table describes the five files resubmitted and AIM's reason for the resubmission.

	File Submission	Period	Original Due Date	Original Submission Date	Resubmission Date
No. 1	**Admissions**	**Fall 2018**	**10/10/2018**	**10/10/2018**	**02/18/2019**
	AIM Reason for Resubmission: We received an email from BOG requesting for the file to be reviewed, particularly in reference to test scores. We ultimately discovered an error in the submission. There is a flag in the file that needed to be changed to report all test scores (from N to Y), not just those test scores used for admissions purposes.				
No. 2	**Instruction & Research**	**Annual 2017**	**10/23/2018**	**10/23/2018**	**11/19/2018**
	AIM Reason for Resubmission: The BOG added a new element called BOG JOB to all files containing HR data. All employees had to be categorized under one of these 13 BOG JOB categories. There were 5,504 records for which the DoIT extract program did not assign a BOG JOB value in the 2017-18 IRD File. Unfortunately, this did not come up as an error in any of the edit reports and was not detected by our internal data verification procedures. When alerted of this omission by the BOG, AIM worked with DoIT to correct this error. AIM and DoIT have taken actions to ensure that verifying the correct mapping of this element is part of our routine data validation processes.				

	File Submission	Period	Original Due Date	Original Submission Date	Resubmission Date
No. 3	**Hours to Degree**	**Annual 2017**	**11/07/2018**	**11/07/2018**	**11/30/2018**
	AIM Reason for Resubmission: The BOG requested the resubmission due to students that were not included in the original file and listed in the HTDNOMATCH report. Upon review, students were awarded a second major, which allows removal from HTD. However, BOG required clean-up of the record at their database as well as resubmission of HTD. Also, the BOG handled the corrections differently for this submissions cycle than in previous years.				
Nos. 4 and 5	**Retention**	**Annual 2017**	**01/30/2019**	**01/30/2019**	**02/20/2019 03/08/2019**
	AIM Reason for Resubmission: (02/20/2019) There was an error is SUDS system database accepting original file. There was a student missing a PersonDemo at their end. This resulted in us having to resubmit the file with a PersonDemo record. (03/08/2019) The BOG requested for comparable exclusions be applied to non-affected cohorts. The cohort being evaluated was CH 2014 while the non-affected cohort was CH 2013.				
No. 6	**Student Instruction**	**Spring 2019**	**06/12/2019**	**06/12/2019**	**06/27/2019**
	AIM Reason for Resubmission: The BOG requested a more detailed review of Student Credit Hours reported as continuing education but not self-supporting. We worked with FIU's Office of Financial Planning and discovered that some of the data was incorrectly categorized. As a result, the student credit hours had to be updated and reported as self-supporting and the file was resubmitted on 06/27/2019.				

As a result of the increase in resubmissions from the prior two audits issued in fiscal years 2018/2019 and 2017/2018, we inquired of the Data Administrator as to the reasons for the increase, and she provided us the following statement:

> While both AIM and DoIT continuously monitor our data validation processes and look for opportunities to improve data accuracy and avoid resubmissions, there have been several changes in personnel and business processes, both at FIU and at the BOG, that have led to an increase in resubmissions in the past year. Specific reasons for resubmissions included the BOG staff giving us the wrong instructions, inconsistency in the BOG internal review processes, and BOG staff not responding to our inquiries in a timely manner. These issues are compounded by the fact that some errors cannot be detected locally because the fields are derived by the BOG programs and the raw values are not available to us. Similarly, some file errors only surface once the BOG accepts the file and merges the FIU data with the SUS system data. In addition, the BOG changed their business processes. Items that could be explained previously [via email], now require resubmission. Further, the level of review the BOG places on a file changes from one semester to the other. This inconsistency has resulted in the BOG asking us new things they

did not ask before and for which there are no edits or reports in their system that can detect the errors. There have also been changes in personnel in FIU functional areas leading to slower turnaround time and inconsistent validation of data.

Furthermore, we inquired as to whether any steps had been taken to reduce/prevent the number of resubmissions in the future and the Data Administrator provided us the following list:

Efforts Taken by AIM to Prevent Resubmission

- Review and document email chains between BOG, AIM and DoIT to make sure documented issues from the past have been investigated to ensure they are not re-occurring.
- Review of current logic with DoIT to make any necessary adjustments to prevent future occurrences of the same issues that cause errors.
- Creation of new queries and reports to check for things we now know are an issue.
- Requesting from the BOG that they inform AIM of any additional checks or data validation done on their end that are not part of existing error reports.
- AIM hired a new employee whose duties will cover the manual processes and follow up with functional units, so other employees can focus more of their time on analytics and cross-validation.
- We are working with the BOG and DoIT to attempt to replicate internally the logic used to calculate the BOG derived elements and incorporate into the PantherSoft edit tools.
- FIU and other data administrators formed a committee to review data elements for particular files to ensure that we are providing information that is consistent with the other SUS universities and accurately reflect what the BOG wants. We are beginning with the HTD file.

Efforts Taken by DoIT to Prevent Resubmission

- Replication of queries and reports sent in prior years by the BOG to run for future submissions.
- Translate programming code technicalities into pseudo business language for better understanding by AIM and other functional users.
- Share program logic with AIM technical team for cross-validation. This was particularly helpful to develop the enhancement that lead to reporting old/missing late degrees that were delayed in being posted.
- PantherSoft Team hired a new resource to assist in the technical preparation of the BOG files.
- Replicate the logic used to calculate the BOG derived elements and insert into reserved/internal fields.
- Advise AIM on edits that do not currently exist that could be suggested to the BOG for implementation as Level 9 or Level 5 errors.
- Translate and recreate SUDS-platform-specific SQL (structured query language) sent by the BOG in our PantherSoft database in order to produce equivalent

Conclusion

Our review disclosed, that even though the process used by the Data Administrator provides reasonable assurance that complete, accurate, and for the most part timely submissions occurred, the increased number of resubmissions this year was the result of changes in processes at FIU and the BOG, along with personnel turnover and other issues not considered systemic in nature. Furthermore, all the reasons for the resubmissions continue to be addressed as noted by the Data Administrator's list of efforts taken to reduce/prevent resubmittals above. Notwithstanding the increase in the number of resubmittals, we noted no reportable material weaknesses or significant control deficiencies related to data file submissions or resubmissions.

6. Review of University Initiatives

We obtained the following list of the University initiatives that are meant to bring the University's operations and practices in line with SUS Strategic Plan goals:

- Implemented E&G revenue reallocation model;
- Implemented faculty reallocation model for academic units;
- Provided greater access to on-demand analytics relevant to the metrics;
- Implemented student level graduation benchmarking;
- Implemented student attendance and midterm progress monitoring and outreach;
- Integration of career and academic advising;
- Strategic enrollment planning and course scheduling optimization via Noel Levitz and Platinum Analytics;
- Created an Office of Scholarships and Academic Program Partners to support all colleges in their efforts to apply foundation scholarship funds to student success and enrollment goals;
- Expanded merit scholarship opportunities and initiated two new scholarships – "Jumpstart FIU" and "Panther Achievement Award";
- Implemented centralized coordination and local deployment for student recruitment efforts; and
- Established centralized retention, graduation, and student success outreach.

University senior management also states that they are in the process of establishing much greater central oversight and control of the scheduling and course offering practices and policies.

Conclusion

None of the initiatives provided appear to have been made for the purposes of artificially inflating performance goals.

APPENDIX A

In-Scope BOG Data Elements				
No.	**Metric**	**Definition**	**Submission/Table/Element Information**	**Relevant Submission**
7	**University Access Rate** *Percent of Undergraduates with a Pell-grant*	This metric is based the number of undergraduates, enrolled during the fall term, who received a Pell-grant during the fall term. Unclassified students, who are not eligible for Pell-grants, were excluded from this metric. This metric is based the number of undergraduates, enrolled during the fall term, who received a Pell-grant during the fall term. Unclassified students, who are not eligible for Pell-grants, were excluded from this metric.	**Submission:** SIF **Table:** Enrollments **Elements:** 02041 – Demo Time Frame 01045 – Reporting University 01413 – Student at Most Recent Admission Type 01060 – Student Classification Level 01053 – Degree Level Sought 01107 – Fee Classification Kind	Summer 2018 Fall 2018 Spring 2019
			Submission: SFA **Table:** Financial Aid Awards **Elements:** 01045 – Reporting University 02040 – Award Payment Term 02037 – Term Amount 01253 – Financial Aid Award Program Identifier	Annual 2017
10	**Bachelor's Degrees Awarded to Minorities (BOT Metric)**	This metric is the number, or percentage, of baccalaureate degrees granted in an academic year to Non-Hispanic Black and Hispanic students. This metric does not include students classified as Non-Resident Alien or students with a missing race code.	**Submission:** SIFD **Table:** Degrees Awarded **Elements:** 01082 – Degree Program Category 01083 – Degree Program Fraction of Degree Granted (This field is a summed field) 01045 – Reporting Institution 01412 – Term Degree Granted 01081 – Degree Level Granted	Summer 2018 Fall 2018 Spring 2019
			Submission: SIF **Table:** Person Demographic **Elements:** 01044 – Racial/Ethnic Group 01491 – Hispanic or Latino 01492 – American Indian/Alaska Native 01493 – Asian 01494 – Black or African American 01495 – Native Hawaiian or Other Pacific Islander 01496 – White 02043 – Non – resident Alien Flag 01497 – No Race Reported	Summer 2018 Fall 2018 Spring 2019

Definition Source: State University Database System (SUDS).

THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
Audit and Compliance Committee

February 26, 2020

Subject: Office of Internal Audit Quality Assurance Review 2019

Proposed Committee Action:

Recommend that the Florida International University Board of Trustees approve the independent assessor's report, Office of Internal Audit Quality Assurance Review 2019.

Background Information:

Florida Board of Governors Regulation 4.002 State University System Chief Audit Executives (6)(e) states, in relevant part, that 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.

The external assessment was performed subsequent to an internal self-assessment, which is included as an attachment in the independent validator's report.

Supporting Documentation:	Transmittal letter: Office of Internal Audit Quality Assurance Review 2019
	Office of Internal Audit Quality Assurance Review 2019
Facilitator/Presenter:	Trevor L. Williams

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FIU | Office of Internal Audit

FLORIDA INTERNATIONAL UNIVERSITY

DATE: February 13, 2020

TO: Gerald C. Grant, Jr., Audit and Compliance Committee Chair
Board of Trustees
Mark B. Rosenberg, University President

FROM: Trevor L. Williams, Chief Audit Executive

SUBJECT: Office of Internal Audit Quality Assurance Review 2019

According to the University's *Office of Internal Audit [OIA] Policy & Charter (Charter)*, audit engagements completed by the OIA shall be performed in accordance with the International Professional Practice Framework, published by the Institute of Internal Auditors (IIA). In addition, the Charter requires the Chief Audit Executive (CAE) to develop and maintain a quality assurance and improvement program (QAIP) for the OIA. This requires that the Office's activity be subject to a periodic internal assessment and an independent external assessment, to determine conformance with the IIA's standards, at least every five years.

The IIA has provided two different approaches, without prejudice or preference, which audit departments could employ to satisfy this requirement: having a full external assessment completed or allowing audit departments to perform an internal self-assessment with validation by an independent external assessor. The internal self-assessment with external validation model is suited for our office. It is much less costly and receives the same recognition, validity, and usefulness, as does a full external assessment.

At the December 5, 2019, Audit and Compliance Committee meeting, I informed the Committee that I was in the process of completing an internal quality assurance self-assessment of the Office of Internal Audit and contracting for the validation of that assessment by a qualified, independent, external assessor. Subsequently, I provided a summary report on the results of the self-assessment to the Board Chair, members of this Committee, President Rosenberg, selected members of FIU's executive management, and the independent assessor; and therein, informed them that the results will be validated through an external assessment to be completed during December 2019 and January 2020.

The independent assessor, whose qualifications were detailed in my December 30, 2019, memorandum to the BOT Audit and Compliance Committee Chair and Committee Members, has since completed his external quality assurance review, including his on-site visit and has issued his validation report on the internal self-assessment.

I am pleased to inform you that the independent assessor concluded that FIU's internal audit department "generally conforms" to the *International Standards for the Professional Practice of Internal Auditing*. This opinion is the highest of the three possible ratings that an audit organization can achieve from a Quality Assurance Review. Mr. Berry's full report, FIU's Office of Internal Audit Quality Assurance Review 2019, is attached for your consideration.

FIU | FLORIDA INTERNATIONAL UNIVERSITY

Office of Internal Audit

Quality Assurance Review

2019

To: The Florida International University (FIU) Management Team, Trustees and Internal Audit Staff:

I have completed a Quality Assurance Review (QAR) of the FIU Office of Internal Audit (OIA). The primary objective was to assess the department's operations regarding its conformance to the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF).

In acting as an independent reviewer, I am fully independent of FIU and have the necessary knowledge and skills to undertake this engagement (see Appendix Reviewer Background). The review consisted primarily of reviewing policies, procedures and practices. Additionally, I interviewed audit team members and several key administrators and/or Board members. These interviews helped me gain a better understanding of the internal control environment within which the audit department operates.

I have reviewed the QAR results audit management. It has been determined that overall, the audit department "Generally Conforms" with auditing Standards. This report provides additional information on the purpose and scope of the review, highlights successful practices and denotes process improvement recommendations.

Robert Berry

Robert Berry

Table of Contents

Executive Summary

Overall Opinion

I was contracted by the Florida International University (FIU) to conduct a Quality Assurance Review (QAR) of the Office of Internal Audit (OIA). Based on the information evaluated, it is my opinion that the FIU Office of Internal Audit "Generally Conforms" with the Institute of Internal Auditors' (IIA) International Standards for the Professional Practice of Internal Auditing (the *Standards*). This opinion is the highest of the three possible ratings.

Background

The IIA *Standards* require an external QAR to assess compliance with the *Standards*. The review may be (1) a full external assessment, (2) peer review, or (3) independent validation of a self-assessment (SAIV) and should occur at least once every five years. FIU has chosen option 3.

Objective(s), Scope and Methodology

The primary objective of the review is to evaluate FIU's Office of Internal Audit for compliance with auditing standards. Additional objectives included identifying commendable practices as well as areas where improvement may be needed to further enhance the audit function.

Tasks performed included:

- Evaluating the department's self-assessment.
- Interviewing audit staff, executive management and others.
- Reviewing and evaluating select audit projects.
- Reviewing administrative and support documentation, including policies and procedures, risk assessments, audit plans, the audit charter, and other relevant documents.
- Comparing practices to the *Standards* requirements.
- Comparing operations to suggested IIA best practices.

Executive Summary

Report Rating Descriptions

The IIA's Quality Assessment Manual suggests a three scale rating system – "generally conforms," "partially conforms," and "does not conform."

Generally Conforms (GC) is the top rating and means that an Internal Audit activity has a charter, policies, and processes that are judged to be in conformance with the Standards.

Partially Conforms (PC) means some practices deviate from the Standards, but these deficiencies do not preclude the department from performing its responsibilities in an acceptable manner.

Does Not Conform (DNC) means operational deficiencies seriously impair or preclude the department from performing adequately in all or in significant areas of its responsibilities.

The standards are divided into logical subsections describing the attributes (Attribute Standards) and expected performance (Performance Standards) for compliance. The IIA further divides the Standards into logical topical sections and subsections. Reviewers rate these subsections to determine compliance by topic and for the department as a whole. See Appendix Item Detailed Conformance Matrix

Report Structure

Executive Summary – Brief summary providing at a glance information.

Report Details – In depth review information.

- **Partial Conformance Areas** – Areas that do not fully conform to standards
- **Areas for Operational Improvement** – Items conform to standards but could improve operations.

Appendix

- **Stakeholder Interview Listing** – Summary of the stakeholders interviewed.
- **Survey Results** – Summary survey results from management and audit staff.
- **Detailed Conformance Matrix** – Detailed account of conformance status with each individual *Standard*.
- **Audit Maturity Matrix** – A measure of the maturity of the audit function.
- **Reviewer qualification(s)** – Background on the reviewer(s).

Executive Summary

Commendable Areas

1. There is strong support from executive management and the audit committee. The executive team spoke highly of the function and fully supports its operations. In a recent survey, management rated its' satisfaction with the function at 4.53/5. (Appendix Item Survey Results – Executive Management)

2. The department abandoned its flat structure for a more layered approach that will help promote a career progression path for employees.

3. The department demonstrated healthy stakeholder responsiveness by building and implementing, at the audit committee's request, a system for more efficient audit issue follow-up.

4. Employee satisfaction is good. In a recent survey, the department scored 4.42/5. See Appendix Survey Results – Internal Audit Staff

5. FIU has a moderately mature audit function. A rating of Generally Conforms indicates that a department meets minimum requirements. As departments mature, they introduce best in class process to improve operations. Using the Internal Audit Maturity Matrix, the audit department is one performing above the minimum requirements. See Appendix Internal Audit Maturity Matrix.

Partial Conformance Areas

1. The audit department charter needs updating to include the following required items: (a) reference to The IIA Code of Ethics, (b) the definition of Internal Auditing and (c) acknowledgement of the mandatory nature of the standards. *Attribute Standards 1000, 1010*

2. The audit department does not have periodic performance measurement tools such as required internal assessments. *Attribute Standard 1311 - Internal Assessments*

Areas for Operational Improvement

1. Increasing the audit charter review frequency would better align with the spirit of *Attribute Standard 1000 – Purpose, Authority, and Responsibility* and corresponding *Implementation Guidance*.

2. The individual engagement conflict of interest attestation process is inconsistent. Staff does not declare independence and objectivity prior to every engagement.

3. The department currently performs rudimentary data analysis. A more structured process should improve efficiency and assurance effectiveness.

– End Executive Summary –

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Report Details

Partial Conformance Areas

Item Number	1	**Responsible Party**	Office of Internal Audit

Item	Recommendation	Action Plan
The audit function partially conforms with the International Standards for the Professional Practice of Internal Auditing (*Standards*) Attribute Standard (AS) 1000 Purpose, Authority, and Responsibility. Specifically, the internal audit charter does not reference the Institute of Internal Auditors (IIA) code of ethics or the definition of auditing as required. Additionally, the charter does not acknowledge the mandatory nature of the standards. The internal audit charter is a formal document that defines internal audit's purpose, authority, responsibility and position within the organization. It is a mutual agreement outlining the work internal audit will perform and the support it will receive.	Audit management should review the charter to ensure it contains required elements. At minimum, the charter should be updated to recognize/reference: • The IIA Code of Ethics • The definition of Internal Auditing • The fact that compliance with the standards is mandatory The Audit Committee should review/approve the newly revised charter. The IIA's model audit charter provides a good benchmark for charter language and content.	I have commenced a review of the Office of Internal Audit Policy and Charter for compliance with applicable professional standards and Board of Governors' (BOG) regulations. The revised Charter will be presented to the FIU Board of Trustees Audit and Compliance Committee for review and approval by the BOT in June 2020. The planned revisions will include recognition of the IIA's Code of Ethics, definition of Internal Auditing, and compliance with the mandatory elements of the International Professional Practice Framework, among other changes.

Report Details

Item Number	2	Responsible Party	Office of Internal Audit

Item	Recommendation	Action Plan
The Institute of Internal Auditors' Standard 1311 - Internal Assessments requires the ongoing monitoring of Internal Audit department activity to ensure it provides quality services. This is typically achieved through (a) practices embedded within audit processes (i.e. templates, checklists and reviews) combined with (b) periodic measurable feedback (i.e. key performance indicators, feedback surveys) and (c) periodic internal assessments. The audit department has several good practices embedded within audit processes. However, it does not have periodic measurement tools such as key performance indicators nor the required periodic internal assessments.	The audit department should implement periodic internal assessments to measure the effectiveness of activities. Additionally, audit management should report internal assessment results to the audit committee at minimum annually.	Beginning at the end of the 2019-2020 Fiscal Year, the Office of Internal Audit will perform an annual assessment of its audit function. This assessment will include a determination of the Office's compliance with its policies and procedures and professional standards. The results of our assessment will be presented to the Audit and Compliance Committee upon its completion, annually.

Operational Improvement Areas

Areas For Operational Improvement

Audit Charter Review

The internal audit charter is a formal document that defines internal audit's purpose, authority, responsibility and position within the organization. It is a mutual agreement outlining the work internal audit will perform and the support it will receive. The Institute of Internal Auditors' (IIA) International Standards for the Professional Practice of Internal Auditing (*Standards*) number **1000 – Purpose, Authority, and Responsibility** requires a periodic charter review. Florida International University (FIU) has a 3 year review cycle.

While this time frame does generally comply with the Standards, the IIA's **Implementation Guide** suggest creating a "standing annual agenda item to discuss, update, and approve the internal audit charter as needed." Implementation Guides assist internal auditors in applying the Standards and Code of Ethics. They collectively address internal auditing's approach, methodologies, and consideration, but do not detail processes or procedures.

The intent is to ensure audit department, management and Board expectations are commonly understood and clearly communicated. And while a 3-year cycle complies with the *Standards*, an annual charter review (or at minimum inclusion as an agenda item) would be a better business practice.

Independence and Objectivity

The Office of Internal Audit generally conforms to the Institute of Internal Auditors (IIA) International Standards for the Professional Practice of Internal Auditing (*Standards*) on Independence and Objectivity. There are, however, some practices that further support and enhance conformance.

(1) The Standards require the Chief Audit Executive (CAE) to report independence and objectivity impairments to the Board. Currently the reporting is by exception (i.e. when/if impairments occur). A better practice would be to include it as an annual agenda item and provide and independence and objectivity status update (i.e. disclose no impairments or disclose the nature of any impairments). This provides consistent and transparent communication on the subject matter.

(2) Additionally, the CAE must consider independence and objectivity prior to assigning staff to individual engagements. He is only aware of issues when/if notified. The department communicates impairments using an individual engagement independence acknowledgement form, however, while reviewing audit workpapers, it was determined staff does not consistently use the form when performing engagements.

Operational Improvement Areas

Proficiency and Due Professional Care

(1) The Office of Internal Audit currently uses rudimentary data analysis techniques (i.e. excel pivot tables) when planning or executing audits. Auditing standard 1220.A2 (Due Professional Care) encourages auditors to consider using data analysis techniques during engagements. Embedding advanced data analytics into the internal audit process will allow the auditors to examine larger volumes of data in less time which can lead to greater efficiency, better quality audits, improved assurance and greater audit coverage.

There are several staff members interested in data analysis which makes this the perfect opportunity to enhance the department's data analysis capabilities. As such, the department should explore increasing data analysis capabilities and embedding elements of data analysis in audit processes where possible.

(2) The department does not have a full career development strategy. Recently, the department created a layered structure, updated job description and hired several new employees. University and department management support training and continuing education. These are good steps in building a sustainable audit function.

The Institute of Internal Auditors' Implementation Guide 1230 - Continuing Professional Development, suggests creating professional development plans to guide employees towards individual and organizational goals. This may include a) Self-assessments against a competency framework or benchmark, b) Professional development and training plans, and c) Subscriptions to sources of professional information.

– End Report Details –

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Appendix

Stakeholders Interview Listing – Executive Management

Name	Position
Michelle Palacio	Vice President Governmental Relations
Sandra Gonzalez-Levy	Senior Vice President for External Relations, Strategic Communications and Marketing
Javier Marques	Vice President for Operations & Safety / Chief of Staff
Pablo Ortiz	Vice President, Regional Academic Locations & Institutional Development
Carlos B. Castillo	General Counsel
El pagnier K. Hudson	Vice President Human Resources
Kenneth G. Furton	Provost and Chief Operating Officer
Kenneth Jessell	Senior Vice President and Chief Financial Officer
Andres Gil	Vice President for Research
Robert Grillo	Chief Information Officer
Howard Lipman	SVP University Advancement
Kevin Coughlin	VP Enrollment Management
Saif Ishoof	Vice President for Engagement
Elizabeth Bejar	Vice President of Academic & Student Affairs
Pete Garcia	Executive Director of Sports and Entertainment

Appendix

Stakeholders Interview Listing – Audit Staff

Name	Position
Trevor Williams	Chief Audit Executive
Henley Louis-Pierre	Senior Information Systems Auditor
Maria Lopez	Audit Information Systems Manager
Stephanie Price	Audit Project Manager
Lillian Faye Spell	Audit Manager
Manuel Sanchez	Assistant Audit Director
Vivian Ferradaz Gonzalez	Assistant Audit Director
Tranae Rey	Audit Manager

Appendix

Survey Results – Internal Audit Staff

Question for Measurement	Average Score
I understand the department's goals and objectives	5
I understand the Audit Committee's expectations.	4
I understand Management's expectations of the audit department.	4
I am aware of and understand the department's policies and procedures.	4
I have a solid knowledge of the organization's operations and processes.	4
I have a solid knowledge of the Institute of Internal Auditors (IIA) Auditing Standards	5
I have a solid knowledge of general auditing tools/techniques	5
I receive sufficient training through in house providers.	4
I receive sufficient training through outside seminars (i.e. conferences, etc)	5
I receive sufficient on the job training	5
I receive sufficient membership/participation in professional organizations	4
Rate your opinion on the department's ability to consult and partner with management	5
Rate your satisfaction with the performance review process	4
Rate your career satisfaction	4
Score	**4.42**

Appendix

Survey Results – Executive Management

Question for Measurement	Average Score
Internal audit is a valued member of the management team.	5
The organizational placement of the internal audit activity ensures its independence and promotes its ability to fulfill its responsibilities.	5
Auditors have free and unrestricted access to records, information, locations, and employees during the performance of their engagements.	5
The internal audit activity provides quality services.	4
Auditors perform work in an objective manner.	5
The auditors are professional.	5
Auditors are knowledge of your industry/organization/processes/success factors.	4
Please rate the quality of relationship and rapport between auditors and your department(s).	5
Audit projects cover important areas or topics.	5
Auditors often include your suggestions for areas or topics to review.	4
Auditors provide relevant feedback to you on emerging issues during audits.	5
The duration of audit engagements is appropriate.	4
Reports are delivered timely	4
Issues in reports are accurate.	4
Reports are clear and concise	4
Reports are useful in improving business process and controls.	4
I understand the mission and function of an internal audit department	5
Score	**4.53**

Appendix

Detailed Conformance Matrix

Authoritative Reference		Conclusion		
AS 1000	**Purpose, Authority, and Responsibility**	GC	PC	DNC
AS 1000.A1		GC	PC	DNC
AS 1000.C1		GC	PC	DNC
AS 1010	Recognizing Mandatory Guidance in the Internal Audit Charter	GC	PC	DNC

Comments: (If the conclusion is PC or DNC, an explanation is required)

PC

1. The audit function partially conforms with Attribute Standard (AS) 1000 Purpose, Authority, and Responsibility. Specifically, the internal audit charter does not reference the Institute of Internal Auditors (IIA) code of ethics or the definition of auditing as required. Additionally, the charter does not acknowledge the mandatory nature of the standards.

Other

2. Auditing standards require a periodic charter review. FIU has a 3 year review cycle. The IIA's Implementation Guide suggests creating a "standing annual agenda item to discuss, update, and approve the internal audit charter as needed" annually.

Authoritative Reference		Conclusion			
AS 1100	**Independence and Objectivity**	GC	PC	DNC	
AS 1110	Organizational Independence	GC	PC	DNC	
AS 1110.A1	Direct Interaction with the Board	GC	PC	DNC	
AS 1111		GC	PC	DNC	
AS 1112	Chief Audit Executive Roles Beyond Internal Auditing	GC	PC	DNC	NA
AS 1120	Individual Objectivity	GC	PC	DNC	
AS 1130	Impairment to Independence or Objectivity	GC	PC	DNC	
AS 1130.A1		GC	PC	DNC	NA
AS 1130.A2		GC	PC	DNC	NA
AS 1130.A3		GC	PC	DNC	NA
AS 1130.C1		GC	PC	DNC	NA
AS 1130.C2		GC	PC	DNC	NA

Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)

Other Items

The Office of Internal Auditing generally conforms with the Independence and Objectivity standards. There are, however, some practices that further support and enhance conformance.

For example, the **Standards** require the Chief Audit Executive (CAE) to report independence and objectivity impairments to the Board. Currently the reporting is by exception (i.e. when/if impairments occur). A better practice is to disclose independence annually (i.e. we maintained independence throughout the year or we experienced the following independence impairments). This provides transparent and consistent communication.

Additionally, the CAE must consider independence and objectivity prior to assigning staff to individual engagements. He is only aware of issues when/if notified. There is an individual engagement independence acknowledgement form, however, while reviewing audit workpapers, it was determined that the form is not consistently applied/used.

Appendix

Authoritative Reference		Conclusion			
AS 1200	**Proficiency and Due Professional Care**	GC	PC	DNC	
AS 1210	Proficiency	GC	PC	DNC	
AS 1210.A1		GC	PC	DNC	
AS 1210.A2		GC	PC	DNC	
AS 1210.A3		GC	PC	DNC	
AS 1210.C1		GC	PC	DNC	NA
As 1220	Due Professional Care	GC	PC	DNC	
AS 1220.A1		GC	PC	DNC	
AS 1220.A2		GC	PC	DNC	
AS 1220.A3		GC	PC	DNC	
AS 1220.C1		GC	PC	DNC	NA
AS 1230	Continuing Professional Development	GC	PC	DNC	

Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)

Other Items

(1) Auditing standard 1220.A2 (Due Professional Care) encourages auditors to consider using data analysis techniques. The OIA uses rudimentary data analysis techniques (i.e. excel pivot tables) when planning or executing audits. There are several staff members interested in data analysis. This is the perfect opportunity to enhance the department data analysis capabilities.

(2) Standard 1230 – Continuing Professional Development requires internal auditors to enhance knowledge through continuing professional development. The department generally complies with this standard, but does not have a full career development strategy. Recently, the department created a layered structure, updated job description and hired several new employees. University and department management support training and continuing education. These are good steps in building a sustainable audit function.

The Institute of Internal Auditor's Implementation Guide 1230 - Continuing Professional Development, suggests creating professional development plans to guide employees towards individual and organizational goals. This may include a) Self-assessments against a competency framework or benchmark, b) Professional development and training plans, and c) Subscriptions to sources of professional information.

Appendix

Authoritative Reference		Conclusion		
AS 1300	**Quality Assurance and Improvement Program**	GC	PC	DNC
AS 1310	Requirements of the Quality Assurance and Improvement Program	GC	PC	DNC
AS 1311	Internal Assessments	GC	PC	DNC
AS 1312	External Assessments	GC	PC	DNC
AS 1320	Reporting on the Quality Assurance and Improvement Program	GC	PC	DNC
AS 1321	Use of "Conforms with the *Internal Standards for the Professional Practice of Internal Auditing*"	GC	PC	DNC
AS 1322	Disclosure of Nonconformance	GC	PC	DNC

Comments: (If the conclusion is PC or DNC, an explanation is required)

Partial Conformance
The Institute of Internal Auditors' Standard 1311 - Internal Assessments requires the ongoing monitoring of Internal Audit department activity to ensure it provides quality services. This is typically achieved through (a) practices embedded withing audit processes (i.e. templates, checklists and reviews) combined with (b) periodic measurable feedback (i.e. key performance indicates, feedback surveys) and (c) periodic internal assessments.

The audit department has several good practices embedded within audit processes. However, it does not have periodic measurement tools such as key performance indicators nor periodic internal assessments.

Authoritative Reference		Conclusion			
PS 2000	**Managing the Internal Audit Activity**	GC	PC	DNC	
PS 2010	Planning	GC	PC	DNC	
PS 2010.A1		GC	PC	DNC	
PS 2010.A2		GC	PC	DNC	
PS 2010.C1		GC	PC	DNC	NA
PS 2020	Communication and Approval	GC	PC	DNC	
PS 2030	Resource Management	GC	PC	DNC	
PS 2040	Policies and Procedures	GC	PC	DNC	
PS 2050	Coordination and Reliance	GC	PC	DNC	
PS 2060	Reporting to Senior Management and the Board	GC	PC	DNC	
PS 2070	External Service Provider and Organizational Responsibility for Internal Auditing	GC	PC	DNC	NA

Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)

Appendix

Authoritative Reference		Conclusion			
PS 2100	**Nature of Work**	GC	PC	DNC	
PS 2110	Governance	GC	PC	DNC	
PS 2110.A1		GC	PC	DNC	
PS 2110.A2		GC	PC	DNC	
PS 2120	Risk Management	GC	PC	DNC	
PS 2120.A1		GC	PC	DNC	
PS 2120.A2		GC	PC	DNC	
PS 2120.C1		GC	PC	DNC	NA
PS 2120.C2		GC	PC	DNC	NA
PS 2120.C3		GC	PC	DNC	NA
PS 2130	Control	GC	PC	DNC	
PS 2130.A1		GC	PC	DNC	
PS 2130.C1		GC	PC	DNC	NA
Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)					

Authoritative Reference		Conclusion			
PS 2200	**Engagement Planning**	GC	PC	DNC	
PS 2201	Planning Considerations	GC	PC	DNC	
PS 2201.A1		GC	PC	DNC	
PS 2201.C1		GC	PC	DNC	NA
PS 2210	Engagement Objectives	GC	PC	DNC	
PS 2210.A1		GC	PC	DNC	
PS 2210.A2		GC	PC	DNC	
PS 2210.A3		GC	PC	DNC	
PS 2210.C1		GC	PC	DNC	NA
PS 2210.C2		GC	PC	DNC	NA
PS 2220	Engagement Scope	GC	PC	DNC	
PS 2220.A1		GC	PC	DNC	
PS 2220.A2		GC	PC	DNC	
PS 2220.C1		GC	PC	DNC	NA
PS 2220.C2		GC	PC	DNC	NA
PS 2230	Engagement Resource Allocation	GC	PC	DNC	
PS 2240	Engagement Work Program	GC	PC	DNC	
PS 2240.A1		GC	PC	DNC	
PS 2240.C1		GC	PC	DNC	NA
Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)					

Appendix

Authoritative Reference		Conclusion			
PS 2300	**Performing the Engagement**	GC	PC	DNC	
PS 2310	Identifying Information	GC	PC	DNC	
PS 2320	Analysis and Evaluation	GC	PC	DNC	
PS 2330	Documenting Information	GC	PC	DNC	
PS 2330.A1		GC	PC	DNC	
PS 2330.A2		GC	PC	DNC	
PS 2330.C1		GC	PC	DNC	NA
PS 2340	Engagement Supervision	GC	PC	DNC	
Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)					

Authoritative Reference		Conclusion			
PS 2400	**Communicating Results**	GC	PC	DNC	
PS 2410	Criteria for Communicating	GC	PC	DNC	
PS 2410.A1		GC	PC	DNC	
PS 2410.A2		GC	PC	NA	
PS 2410.A3		GC	PC	DNC	
PS 2410.C1		GC	PC	DNC	NA
PS 2420	Quality of Communications	GC	PC	DNC	
PS 2421	Errors and Omissions	GC	PC	DNC	NA
PS 2430	Use of "*Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing*"	GC	PC	DNC	
PS 2431	Engagement Disclosure of Nonconformance	GC	PC	DNC	
PS 2440	Disseminating Results	GC	PC	DNC	
PS 2440.A1		GC	PC	DNC	
PS 2440.A2		GC	PC	DNC	
PS 2440.C1		GC	PC	DNC	NA
PS 2449.C2		GC	PC	DNC	NA
PS 2450	Overall Opinions	GC	PC	DNC	NA
Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)					

Appendix

Authoritative Reference		Conclusion			
PS 2500	**Monitoring Progress**	GC	PC	DNC	
PS 2500.A1		GC	PC	DNC	
PS 2500.C1		GC	PC	DNC	NA
Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)					

Authoritative Reference		Conclusion			
PS 2600	**Communicating the Acceptance of Risks**	GC	PC	DNC	NA
Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)					

Authoritative Reference		Conclusion			
Code of Ethics	**Principles and Rules of Conduct**	GC	PC	DNC	NA
Comments: (If the conclusion is PC, DNC, or NA, an explanation is required)					

Appendix

Internal Audit Maturity Matrix

Internal Audit Maturity Rating	Standard 1000 Purpose, Authority and Responsibility	Standards 1100,1130 Independence and Objectivity	Standard 1200 Proficiency and Due Professional Care	Standard 1300 Quality Assurance and Improvement Program	Standard 2000 Managing the Internal Audit Activity	Standard 2100 Nature of Work
Optimized	Committee approved audit charter linked to corporate governance objectives with annual review and best in class reporting practices	Reporting arrangements defined in Internal Audit Charter and in line with good practice, independence and objectivity defined therein and a requirement for an annual conflict of interest disclosure	Internal Audit resources are credentialed, specialist resources are available when required, annual Risk Assessment conducted, ongoing and periodic Quality Assurance processes in place, training programs reinforce Internal Audit credentials and support execution of Internal Audit work	Documented ongoing and periodic Quality Assurance Program in place, Quality Assurance activities occur for internal audit engagements, Internal Assessment conducted annually, External Assessment conducted at least every 5 years	Internal Audit policies and procedures in place, Internal Audit plans linked to corporate objectives, effective Internal Audit reporting arrangements, audit client feedback sought, performance measures in place and used to drive continuous improvement	Internal Audit focuses on controls, risk and governance, Internal Audit plans are clearly linked to enterprise-wide view of risk and plans are periodically adjusted, Internal Audit uses recognized control frameworks in its work
Managed	Committee approved audit charter linked to corporate governance objectives with annual review	Reporting arrangements defined in Internal Audit Charter and in line with good practice, independence and objectivity defined therein and a requirement for conflict of interest disclosure	Internal Audit resources are credentialed, some specialist resources are available, annual Risk Assessment conducted, ongoing and periodic Quality Assurance processes in place	Documented ongoing and periodic Quality Assurance Program in place, Quality Assurance activities occur for internal audit engagements, Internal Assessment conducted annually	Internal Audit policies and procedures in place, Internal Audit plans linked to corporate objectives, effective Internal Audit reporting arrangements, audit client feedback sought	Internal Audit focuses on controls, risk and governance, Internal Audit plans are clearly linked to enterprise-wide view of risk and plans are periodically adjusted
Implemented	Committee approved audit charter with periodic review	Reporting arrangements defined in Internal Audit Charter and in line with good practice	Some Internal Audit resources are credentialed, some specialist resources are available, annual Risk Assessment conducted, ongoing Quality Assurance processes in place	Ongoing and periodic Quality Assurance Program elements in place, Quality Assurance activities occur for internal audit engagements	Internal Audit policies and procedures in place, Internal Audit plans linked to corporate objectives, effective Internal Audit reporting arrangements	Internal Audit focuses on controls, risk and governance
Defined	Committee approved audit charter	Reporting arrangements defined in Internal Audit Charter, but some elements not in line with good practice	Internal Audit resources are partially credentialed, specialist resources may be available, annual Risk Assessment conducted, some ongoing Quality Assurance processes in place	Some ongoing Quality Assurance Program elements in place, some Quality Assurance activities occur for internal audit engagements	Internal Audit policies and procedures in place, Internal Audit plans linked to corporate objectives	Internal Audit focuses on controls and risk
Initial	No Internal Audit Charter or in draft or not approved by Audit Committee	Reporting arrangements not defined in Charter or reporting arrangements not in line with good practice	Internal Audit resources not credentialed, no specialist resources, no annual Risk Assessment, limited ongoing Quality Assurance processes in place	No formal Quality Assurance Program in place, some Quality Assurance activities may occur for internal audit engagements	No Internal Audit policies and procedures in place, Internal Audit plans not linked to corporate objectives	Internal Audit focuses on controls

Appendix

Internal Audit Maturity Rating	Standard 2200 Engagement Planning	Standard 2300 Performing the Engagement	Standard 2400 Communicating Results	Standard 2500 Monitoring Progress	Standard 2600 Communicating the Acceptance of Risks	Code of Ethics
Optimized	Planning performed in collaboration with stakeholders, planning adjusted for differing circumstances, planning documented, consistent methodology applied to internal audit engagements, supervisory review and sign-off occurs	Internal Audit policies and procedures clearly define internal audit engagement process, Audit Work Plans are tailored for each engagement, supervisory review and sign-off occurs, automated audit working paper system in place, CAATs and other audit techniques actively used	Reporting protocol established for communicating results, reporting done consistently from content and format perspective, CAE reviews and signs-off audit reports before issue, management input to reporting is actively sought, reports contain management comments and agreed actions, Internal Audit prepares reports that show systemic issues found through its work	Follow-up protocol established, follow-up on implementation of audit recommendations performed consistently, reporting to Audit Committee on status of audit recommendations, automated system for receiving progress updates from management, high rate of audit recommendation clearance	Escalation protocol defined, process clearly understood by Internal Audit and management, collaborative approach to resolution, clear definition of level of risk that can be assumed by Management that precludes need for escalation protocol	Organization Code of Conduct established, IIA Code of Ethics is embedded in Internal Audit policies, ethics training is conducted, Internal Audit staff complete annual Code of Ethics declaration
Managed	Planning performed in collaboration with stakeholders, planning documented, consistent methodology applied to internal audit engagements, supervisory review and sign-off occurs	Internal Audit policies and procedures clearly define internal audit engagement process, Audit Work Plans are tailored for each engagement, supervisory review and sign-off occurs, may have automated audit working paper system in place	Reporting protocol established for communicating results, reporting done consistently from content and format perspective, CAE reviews and signs-off audit reports before issue, reports contain management comments and actions to implement recommendations	Follow-up protocol established, follow-up on implementation of audit recommendations performed consistently, reporting to Audit Committee on status of audit recommendations	Escalation protocol defined, process clearly understood by Internal Audit and Management, collaborative approach to resolution	Organization Code of Conduct established, IIA Code of Ethics is embedded in Internal Audit policies, ethics training is conducted
Implemented	Planning performed and documented, consistent methodology applied to internal audit engagements, supervisory review and sign-off occurs	Internal Audit policies and procedures clearly define internal audit engagement process, Audit Work Plans are tailored for each engagement, supervisory review and sign-off occurs	Reporting protocol established for communicating results, reporting done consistently from content and format perspective, CAE reviews and signs-off audit reports before issue	Follow-up protocol established, follow-up on implementation of audit recommendations performed consistently	Escalation protocol defined, process clearly understood by Internal Audit and Management	Organization Code of Conduct established, IIA Code of Ethics is embedded in Internal Audit policies
Defined	Planning performed and documented; consistent methodology applied to internal audit engagements	Some elements of Internal audit engagement process defined; standard Audit Work Plans used	Reporting protocol established for communicating results, reporting done inconsistently from content and format perspective	Follow-up protocol established, follow-up on implementation of audit recommendations occurs but not performed consistently	No escalation protocol established; Management may assume inappropriate level of risk	Organization Code of Conduct established, IIA Code of Ethics receives some attention
Initial	Planning not performed or documented, no consistent methodology applied to internal audit engagements	Internal audit engagement process not clearly defined or Audit Work Plans not prepared for internal audit engagements	Reporting protocol not established for communicating results, reporting is ad hoc	No follow-up protocol established, follow-up on implementation of audit recommendations not performed consistently or not performed	No escalation protocol established	Organization Code of Conduct not established, IIA Code of Ethics does not receive formal attention

Appendix

Reviewer Background

Mr. Robert Berry, CPA, CIA, CISA, MBA

Robert believes that an auditor's primary role is help improve an organization's people, processes and profits. For over 20 years, he has held positions in internal audit, risk management, accounting and compliance in the private and public sectors. Some of his experience includes (1) Director of Sarbanes Oxley for a multi-billion dollar financial institution, (2) Assistant Vice President of Internal Auditing for multi-million dollar bank, (3) Consultant at a Big 4 public accounting firm, (4) Accountant and Internal Auditor at a Fortune 500 retail grocer and (5) Audit Director in the higher education industry. He frequently presents at various training conferences throughout the country and has been published in various trade journals. Robert is a Certified Public Accountant, Certified Internal Auditor, and Certified Information Systems Auditor, and has a Master's in Business Administration.

FIU | Office of Internal Audit

FLORIDA INTERNATIONAL UNIVERSITY

Office of Internal Audit Status Report

BOARD OF TRUSTEES

February 26, 2020

FIU | Office of Internal Audit

Date: February 26, 2020

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 December 5, 2019, the following projects were completed:

Audit of the University Accounts Receivable Process

We have completed an audit of the University's Accounts Receivable Process during the period July 1, 2017, through June 30, 2019. The University's gross accounts receivable balances as of June 30, 2018, and 2019, were $40.6 and $56.5 million, respectively. The primary objective of our audit was to determine whether there are adequate and effective controls and procedures in place to ensure that accounts receivable are properly recorded, related allowances for doubtful accounts are reasonable, and collection and write-off processes are adequately managed. Overall, we noted that the University's accounts receivable process has adequate and effective controls and procedures in place for those receivables recorded in the University's books. However, we also noted that the University could benefit from having an integrated system to capture unrecorded accounts receivable balances not reported in the University's general ledger. The audit resulted in six recommendations, which management has agreed to implement.

Audit of the Performance Based Funding and Emerging Preeminence Metrics Data Integrity

We have completed an audit of the data integrity and processes utilized in the University's Performance Based Funding and Emerging Preeminence Metrics. The objective of our audit was to determine whether the processes established by the University ensure the completeness, accuracy, and timeliness of data submissions to the State University System of Florida Board of Governors (BOG), which support the Performance Based Funding and Emerging Preeminence Metrics; and provide an objective basis of support for the University

Board of Trustees Chair and President to sign the representations made in the Data Integrity Certification, which will be submitted to the Board of Trustees and filed with the BOG by March 2, 2020. The audit resulted in four recommendations, which management has agreed to implement.

Certified Audit of FIU Football Attendance for the 2019 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 2019 season. Based on the methodology adopted by the FIU Athletics Department, we found that the football attendance data reported to the NCAA on the 2019 Football Paid Attendance Summary sheets are supported by sufficient, relevant, and competent records. We are also pleased to report that the current year's average home attendance of 15,298 meets minimum NCAA requirements.

Internal Investigations

One of the responsibilities of the Office of Internal Audit is to investigate allegations of financial fraud, waste, abuse, wrongdoing, and any whistle-blower complaints. Accordingly, from time to time, our office receives and reviews complaints from various sources: The Governor's Office, the BOG's Inspector General, the FIU hotline, Human Resources, and sometimes directly from a complainant. Our office has received six (6) such complaints, three (3) of which we have completed an investigation, while the remaining three (3) are being evaluated. The table below summarizes the results of the three (3) completed investigations. The details of the complaints are generally confidential and protected from disclosure while being evaluated. The number and scope of these investigations have shifted the allocation of resources away from audits during the past few months. We anticipate redirecting those resources back towards audits moving forward in the fiscal year.

Investigations Completed			
Internal Investigation Report Number	Number of Allegations in Complaint	Results *	
		S	U
19/20 – I - 01	5	-	5
19/20 – I - 02	3	1	2
19/20 – I - 03	2 **	1	1
* S = Substantiated: The allegation is supported by sufficient evidence to justify a reasonable conclusion that it occurred and was improper or unlawful. * U = Unsubstantiated: The allegation is not supported by the evidence examined during the investigation.			
** Aside from the allegations, we investigated two additional questions posed by the complainant but could not reach a decisive conclusion. Nevertheless, our investigation led to at least one observation related to each question.			

Work in Progress

The following ongoing audits are in various stages of completion:

Audits	*Status*
Athletics Health Services Billing & Coding Process and Contract Performance	Fieldwork in Progress
Payroll Irregularities and Fraud Controls	Fieldwork in Progress
New Employee Document Verification Process	Planning
Procurement and Competitive Bidding Procedures	Planning
Compliance with Donor Confidentiality and Intent	Planning

Quality Assurance and Improvement Program (QAIP)

At the December 5, 2019, Audit and Compliance Committee meeting, I informed the Committee that I was in the process of completing an internal quality assurance self-assessment of the Office of Internal Audit and contracting for the validation of that assessment by a qualified, independent external assessor. Subsequently, I provided a summary report on the results of the self-assessment to the Board Chair, members of this Committee, President Rosenberg, selected members of FIU's executive management, and the independent assessor; and therein, informed them that the result will be validated through an external assessment to be completed during December 2019 and January 2020.

The independent assessor has since completed his external quality assurance review, including his onsite visit and has issued his validation report on the internal self-assessment. I am pleased to inform you that the independent assessor concluded that FIU's internal audit department conforms to the *International Standards for the Professional Practice of Internal Auditing*.

Other Matters

Recently, the Office has developed the inaugural issue of its quarterly newsletter, *FIU Office of Internal Audit, Risks ◈ Controls ◈ Compliance Alert*. The newsletter provides content to inform FIU stakeholders about existing and emerging risks borne out through recent and past audits, as well as other important resources. Each issue will display two centerpieces: "A Recent Success" and "Getting Ahead of the Curve" sections, where the former will highlight a recent success story in applying good internal controls, and the latter will highlight commonly encountered audit observations and preventive measures to avoid them. We believe this provides another tool to FIU stakeholders to enable the University to

maintain a system of strong internal controls, effective management practices, and firm accountability.

During the month of December, the office has experienced the separation of Alex Rivas, our Senior Auditor, who took a management position outside of the University. We are continuing the recruitment process to fill the two Senior Auditor vacancies.

Additionally, Anju Wilson, one of our student interns graduated from FIU last semester, and we wished her success in her professional career. I am pleased to inform you that we have since expanded the opportunity for our brilliant FIU students by hiring two student interns for our office in replacement of those who recently graduated.

Professional Development

The audit staff continue to take advantage of available professional development opportunities. Recently, three staff members attended the ACFE & IIA 2020 Fraud Conference sponsored by the Association of Certified Fraud Examiners and the Institute of Internal Auditors.

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THE FLORIDA INTERNATIONAL UNIVERSITY
BOARD OF TRUSTEES
Audit and Compliance Committee
February 26, 2020
UNIVERSITY COMPLIANCE QUARTERLY REPORT

2019-2020 Compliance Work Plan Status Update

The Office of University Compliance and Integrity is pleased to present the status update for the 2019 – 2020 Compliance Work Plan. The information reflects progress on the key action items and other compliance activities for the second quarter of fiscal year 2019-2020 (October 1 – December 31).

Completed	In Process	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**
Facilitate discussion and support initiatives related to compliance governance.	Privacy Governance Committee	• Drafted Privacy Governance Charter. • Identified key FIU constituents for membership. • Schedule first meeting and develop list of initiatives.	✓ ✓ ●
	Foreign Influence Task Force	• Disseminated Global Risk and Foreign Influence Task Force Charter to group for comment. • Identified, drafted and distributed resource documents to membership. • Agenda and training developed for first meeting. • Meeting held on January 27, 2020 included discussion of extensive Federal dialogue and investigation concerning Foreign Influence and Research Security	✓ ✓ ✓ ✓

		in Higher Education and a presentation educating the task force regarding key definitions, the nature of multiple agency actions, the various avenues of foreign influence and task force objectives. • Next task Force meeting set for March 16, 2020.	●
Supervisor and manager training in collaboration with Human Resources.	Develop and conduct compliance training.	• Facilitated meetings and ongoing discussions with Human Resources and the Office of the General Counsel (OGC) to identify key training areas. • Finalized interactive Compliance and Ethics training materials in collaboration with State University System ("SUS") consortium subcommittee. • Meetings with Human Resources and OGC to discuss addition of compliance topics in currently mandated training such as new manager training and faculty orientation.	✓ ✓ ●
Communicate all major compliance initiatives with senior leadership to coordinate messaging.	Develop and execute communication campaigns for major compliance initiatives.	• Reported status of major initiatives such as the Foreign Influence Task Force, the Policy Framework Project, the Code of Conduct launch, Export Controls program enhancements, etc. to OPS, DAC, and Executive Committee leadership.	●

Compliance Liaison Scorecard	The Compliance Liaison Scorecard will be used to track the level of program participation for each Compliance Liaison. The scorecard is made available to the Division of Human Resources and the supervisor of the Compliance Liaison.	• Conducted second quarterly Compliance Liaison meeting in addition to monthly one-on-one meetings between the Chief Compliance Officer ("CCO") and Compliance Liaisons. The Chief Audit Executive was invited to share the new Audit distribution platform. Full discussion of risk assessment and mitigation and the role of the liaison. • Liaison Scorecard further developed and used to track: - Participation in group initiatives such as quarterly meetings and special assignments. - Participation in monthly one-on-one meetings with the CCO (to ensure regular discussion regarding risk management and compliance challenges within each liaison's respective area).	✓ ●
Policy Working Group Member Scorecard	The Policy Working Group Member Scorecard will be used to track the level of program participation for each member. The Scorecard will include participation in group initiatives and will be made available to executive leadership through the Monthly Compliance Report.	• Implemented Policy Working Group Scorecard. • Included scorecard in the monthly Compliance Reports to DAC and OPS committees.	✓ ●

Enterprise Risk Management Advisory Committee	Compliance Liaisons will serve as the Enterprise Risk Management ("ERM") Advisory Committee and will continue with governance responsibilities related to the ERM.	• Discussed role of compliance liaisons at first quarterly meeting. • Chief Audit Executive presented the enterprise risk "heat map" in second quarterly meeting and the new Audit platform in third quarter meeting. • Developing Risk Mitigation toolbox and mitigation/control reporting form for enterprise wide risk owners. • Working with Internal Audit to leverage audit platform to develop an automated risk mitigation platform.	✓ ✓ ● ●

Standards of Conduct and Policies

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

Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Leverage the University Policy Workgroup to impact the FIU culture of compliance.	Review and update Policy Framework. Conduct substantive review of all official University policies.	• Met with the Policy Workgroup and updated the official FIU policy template after seeking feedback across campus. • Developed Procedure Template. • Solicited comments and feedback from Policy Workgroup to revise and update the Policy Framework. • Met with OGC to develop process for expedited approval of new, legally required policies or updates. • Reviewed and updated the current policy approval process, distribution audience and review process.	✓ ✓ ✓ ✓ ✓

		• Developed process and scheduled policy owner review of all official University policies for Spring 2020, to include multidisciplinary review by the Policy Workgroup.	●
Conduct policy campaigns to inform the University community of new and updated policies and core policies in need of regular dissemination.	25 Scheduled Policy Campaigns for 2019-2020.	The following policies were distributed according to schedule: • Gift Policy (Policy campaign completed) • Adding and Dropping of Courses Policy (includes Adding and Dropping of Courses policy and the Adding or Registering After the First Week of Classes procedure) (Policy campaign completed) • Drug-Free Campus/ Workplace Drug and Alcohol Abuse Prevention Policy (Policy campaign partially completed) • Incident Response Plan (Policy campaign completed) • Authorization and Modification of Courses (Policy campaign completed) • Missed Class related to Authorized University Events (Policy campaign completed) • Spouses and Relatives as Students (Policy campaign completed) • Verification of Credentials for Faculty (Policy campaign completed) • Service and Emotional Support Animals on Campus (Policy campaign completed)	✓ ✓ ✓ ✓ ✓ ✓ ✓

		• University Travel Expense (Policy campaign completed) • Approvals Required on Electronic Proposal Routing Approval Form Prior to Proposal Submission (Policy campaign completed) • Research Misconduct (Policy campaign completed) • Nepotism in Research (Policy campaign completed) • Conflict of Interest in Research (Policy campaign completed) • Office of Research and Economic Development Prior Approval of Sponsored Project Proposals (Policy campaign completed) Remaining 10 policies scheduled for Spring 2020 distribution.	✓ ✓ ✓ ✓ ✓ ●
	Transition the policy distribution, attestation and tracking system to Canvas/Catalog.	• Selected FIU Canvas/Catalog as FIU's official policy platform. • Met regularly with transition workgroup to fulfill necessary project management steps to effectuate the transition. • Coordinated with current platform (Convercent) representatives to secure necessary FIU historical data. • Designed communication campaign for Canvas/Catalogue rollout. • Rolled out Campus Catalogue in January as FIU's official policy and training distribution platform. Has been successfully launched for ongoing HIPPA and Payment Card Industry (PCI) trainings.	✓ ✓ ✓ ✓ ✓

		• Met with Human Resources and Information Technology on February 7, 2020 to plan the development of and implementation timeline for phase II of the Canvas Catalog project which will include integration with PantherSoft for reporting purposes.	●

Training, Education and Communication

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.	11 scheduled training campaigns for FY 2019-20.	The following trainings campaigns took place according to schedule: • FIU Athletics Travel (released) • Documenting Travel Expenses and Requesting Reimbursement (released) • Allowable Travel Expenses (released) • FIU Travel Business Process (released) • FIU's Travel Policy Origins (released) • Introduction to Travel at FIU (released) • FIU Data Breach Prevention Incident Response Plan Info-graphic (released)	✓ ✓ ✓ ✓ ✓ ✓ ✓

	Development of University Compliance and Integrity Newsletter.	• The remaining four campaigns are scheduled for Spring 2020. • First quarterly newsletter distributed in February announcing the roll out of several key compliance initiatives. • Begin drafting second quarterly newsletter and planning for content of future newsletters.	● ✓ ●
	Development of New Export Control Website.	• Collaborate with consultant to develop content for user friendly, enterprise-wide, interactive Export Control Website. • Work with web developers to design website. • Work with campus partners to evaluate and finalize prototype. • Launch Export Control Website.	✓ ● ● **N/B**
	Development of updated Office of University Compliance and Integrity Website.	• Work with web developers to design website. • Evaluate and finalize content. • Launch Export Control Website.	✓ ● ●
	Provide employees with training related to ethical decision making. Provide supervisors and managers with training related to communicating and modeling ethical decision making.	• Developed a comprehensive, interactive Compliance and Ethics Training Program as part of an SUS Consortium sub-committee. • Selected and implemented FIU Canvas/Catalog, EverFi and current vendors (Compliance Wave and Venngage) to provide training platform and content to the University community.	✓ ●

	Execution of University Mandatory Training Inventory and Support Project.	• Schedule ethics trainings in late Spring with Compliance Liaisons. • Institution-wide survey distributed to identify training efforts throughout the FIU Community. • Create mandatory training inventory and calendar.	● ✓ ●

Risk Assessment, Measurement and Monitoring

Organizations should have in place a system and schedule for routine monitoring and auditing of organizational transactions, business risks, controls and behaviors.

Compliance Program Objective	Key Action Items	Summary	Progress Indicator
Conduct strategic assessments to identify and address compliance and risk.	Ethisphere - Compliance Program Assessment (in progress).	• 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 issued March 19, 2019. As a result, FIU has moved forward with this assessment and is gathering documents and data for the assessment consultant.	●
	CynergisTek HIPAA Compliance Program assessment.	• Meet regularly with HIPAA committee to address findings and recommendations related to HIPAA privacy. • Develop enterprise wide HIPAA privacy policies. • Develop enterprise wide HIPAA training modules for covered units. • Set follow up meeting for April for Cynergistek re-assessment.	● ● ● ●

	Develop Compliance Calendar for 2020.	• Compliance Calendar finalized for 2020. • Each month a communication is sent to units with Compliance related filing deadlines and confirmation is received by University Compliance when filings occur.	✓ ●
Support the University-wide effort to develop and implement a comprehensive ERM program.	Educate Risk Owners regarding risk management principles. Assist Risk Owners in determining the most appropriate business response to each risk. Provide resources to Risk Owners for reporting updates related to identified risks. Evaluate and report mitigation measure progress related to identified risks.	• Met with Chief Audit Executive to further develop a process for mitigating identified risk across the enterprise by educating risk owners and risk managers and developing a system of accountability. • Develop "risk mitigation toolbox" for risk owners, including templates for documenting controls and best practices. • Work with Internal Audit to leverage audit platform to develop an automated risk. mitigation platform for reporting purposes.	● ● ● **N/B**

Investigations, Discipline and Incentives			
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**
Maintain policies and procedures to effectively enforce compliance and incentivize employees to perform in accordance with the compliance program, including the obligation to report. Take appropriate investigative actions in response to suspected ethics and compliance violations.	FIU Policy Working Group, Compliance Liaison and Executive Scorecards.	• Documented and shared on schedule.	●
	Policy and training escalation procedure for compliance.	• Escalation process in place and routinely implemented to achieve maximum campaign completion percentages.	●
	New and Integrated FIU Ethical Panther Hotline and Case Management System.	• Identified a platform which will be used by the Division of Human Resources, the Office of Inclusion Diversity Equity and Access and the Office of University Compliance and Integrity and implementation has begun.	✓
	Robust collaboration among Compliance, Internal Audit and Human Resources in evaluating reports of misconduct.	• Collaboration takes place upon receipt of a hotline report to assign the appropriate investigator and degree of urgency to each matter.	●
	Review and update materials and training related to rights and protections of reporters of misconduct	• Met with OGC, Human Resources and Internal Audit. • Reviewed current policies. • Incorporated discussion of retaliation into regular training and educational sessions.	✓ ✓ ●

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 President and executive leadership to encourage and promote a culture of compliance and ethics.	Utilize culture survey tools and focus groups to determine employee concerns and engagement related to compliance and ethics.	• Embedded culture-related questions in the Policy Program Survey. • Policy Working Group provided observations and identified trends. • Trend results will be used to benchmark additional culture survey tools following the Principles and Standards campaign.	✓ ✓ ●
Promote ethical decision making across the University community.	Conduct trainings and educational opportunities related to ethical decision making.	• Partnered with Human Resources to conduct a Compliance "table talk" small focus group discussion which will be repeated in the Biscayne Bay Campus and with a small group of supervisors. • Developed interactive compliance and ethics training program as part of a SUS Consortium sub-committee. • Present to various departments and groups to discuss ethical decision making and to promote "bystander engagement".	✓ ✓ ●

FLORIDA INTERNATIONAL UNIVERSITY

OFFICIAL UNIVERSITY POLICY

University Community (faculty, staff and students)

SUBJECT (R*)	EFFECTIVE DATE (R*)	POLICY NUMBER (O*)
OFFICE OF INTERNAL AUDIT POLICY & CHARTER	July 1, 2017	125.205

POLICY STATEMENT (R*)

Introduction

The purpose of the Office of Internal Audit (OIA) is to provide an independent and objective assurance and consulting activity designed to add value and improve Florida International University (FIU) operations. OIA assists FIU in accomplishing its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of the organization's risk management, control, and governance processes.

Reporting, Independence

The Chief Audit Executive (CAE) shall report functionally to the Board of Trustees and administratively to the President. The CAE shall conduct and report on audits, investigations, and other inquiries free of actual or perceived impairment to the independence.

Authority

The Office of Internal Audit (OIA) shall have unrestricted and timely access to all records, data, information and personnel of the University including information reported to the university's hotline/helpline. However, to ensure objectivity and independence, the OIA has no direct responsibility or authority over the activities it reviews.

Professional Standards

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.

Investigative assignments shall be performed in accordance with professional standards issued for the State University System.

Duties and Responsibilities

The Chief Audit Executive shall:

(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 as follows:

1) 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 Audit and Compliance Committee for approval. A copy of approved audit plans will be provided to appropriate university management and the Board of Governors.

2) By September 30th of each year, the CAE 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.

(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 OIA.

(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.

(m) Review this Charter with the Audit and Finance Committee at least every three (3) years for consistency with applicable Board of Governors and university regulations, professional standards, and best practices.

REASON FOR POLICY (O*)

The purpose of the Florida International University's OIA is to provide independent and objective appraisals regarding risk management and controls on financial matters within the University.

HISTORY (O*)

Effective Date: March 2006; Revision Date(s): February 5, 2010.

RESPONSIBLE UNIVERSITY DIVISION/DEPARTMENT (R*)

Office of the President
Florida International University

RESPONSIBLE ADMINISTRATIVE OVERSIGHT (R*)

Office of Internal Audit
Florida International University
11200 S.W. Eighth Street, CSC 447
Miami, Florida 33199

The University Policies and Procedures Library is updated regularly. In order to ensure a printed copy of this document is current, please access it online at http://policies.fiu.edu/ .

For any questions or comments, the "Document Details" view for this policy online provides complete contact information.

Telephone: 305-348-2465	

***R = Required *O = Optional**

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FIU | University Compliance and Integrity

MEMORANDUM

DATE: February 26, 2020

TO: Florida International University Board of Trustees

FROM: Jennifer LaPorta, Chief Compliance and Privacy Officer

SUBJECT: Office of University Compliance & Integrity Charter Review

The Florida Board of Governors Regulation 4.003 (State University System Compliance and Ethics Programs) requires that 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.

The Office of University Compliance & Integrity Charter was first approved on March 2, 2017. Because the Charter is drafted consistent and in close alignment with 4.003, we are not proposing substantive changes that would affect the work of the Office of University Compliance & Integrity. Following our internal review, the three proposed changes to the Charter are as follows:

- Add Board of Trustees approval and review dates at the end of the Charter document to illustrate the history of the Charter.

- Delete a single reference to a vendor we are no longer using for FIU's Hotline Services and replace it with the updated name of FIU's Hotline.

- Change the review period from two to three years in alignment with the Board of Governor's Regulation 4.003(6) and the review period of the Office of Internal Audit Charter).

FLORIDA INTERNATIONAL UNIVERSITY'S COMPLIANCE AND ETHICS CHARTER

Overall Purpose/Objectives

The purpose of this University Compliance and Ethics Charter (the "Charter") is to define the responsibilities, status, and authority of Florida International University's (the "University" or "University's") institutional compliance and ethics program (the "Program") and to outline the scope and structure of the Program.

The Office of University Compliance and Integrity (the "Compliance Office") serves as a point for coordination of and responsibility for activities that promote an organizational culture that encourages ethical conduct and a commitment to compliance with applicable laws, regulations, rules, policies, and procedures.

The objective of the Compliance Office is to collaborate and partner with senior leadership, compliance liaisons, faculty and administrative staff with compliance responsibilities (the "Partners") to embed the University's compliance strategy and framework for an effective compliance program into the foundation of the University. This objective is accomplished by supporting the dissemination and review of effective University-wide policies and procedures, education and training, monitoring, communication, risk assessment, and response to reported issues as required by Chapter 8 of the Federal Sentencing Guidelines and Board of Governors Regulation 4.003. These guidelines and regulation set forth the requirements of an effective compliance and ethics program and require promoting compliance with laws and ethical conduct.

Review and Maintenance of the Charter

This Charter will be reviewed at least every (2) two years for consistency with applicable Board of Governors and University regulations, professional standards, and best practices. Subsequent changes will be submitted to the Board of Trustees for approval. A copy of the Charter and any subsequent changes will be provided to the Board of Governors.

Reporting Structure and Independence of the Chief Compliance Officer

The Chief Compliance Officer is the highest-ranking compliance officer at the University, and reports functionally to the Board of Trustees and administratively to the President.

The Chief Compliance Officer shall have the independence and objectivity to perform the responsibilities of the Chief Compliance Officer function, conduct and report on

compliance and ethics activities and inquiries free of actual or perceived impairment to the independence of the Chief Compliance Officer.

Authority

The Program is governed by this Charter, as it may be amended.

Scope of Duties and Responsibilities

The Program includes the implementation, identification, and assessments of activities that fulfill the requirements for an effective compliance and ethics program as required by Chapter 8 of the Federal Sentencing Guidelines and Board of Governors Regulation 4.003.

The Program is designed to optimize its effectiveness in preventing or detecting noncompliance, unethical behavior, and criminal conduct by implementing the following basic elements:

- Oversight of Institutional Compliance and Ethics and Related Activities
- Development of Effective Lines of Communication
- Ensuring that Effective Training and Education is Provided
- Revising and Developing Compliance and Ethics Policies and Procedures
- Performing or Assessing Internal Compliance Monitoring, Investigations, and Reviews
- Responding Promptly to Detected Compliance and Ethics Problems and Recommending Corrective Action
- Promoting Standards through Appropriate Incentives and Disciplinary Guidelines
- Measuring Compliance Program Effectiveness
- Oversight and Coordination of External Inquiries into Compliance with Federal and State Laws and Take Appropriate Steps to Ensure Safe Harbor

The Chief Compliance Officer and staff will:

a) Develop a Program plan based on the requirements for an effective program. The Program plan and subsequent changes will be provided to

the Board of Trustees for approval. A copy of the approved plan will be provided to the Board of Governors.

b) Provide training to university employees and Board of Trustees' members regarding their responsibility and accountability for ethical conduct and compliance with applicable laws, regulations, rules, policies, and procedures. The Program plan will specify when and how often this training will occur.

c) Obtain an external review of the Program's design and effectiveness at least once every five years. The review and any recommendations for improvement will be provided to the President and Board of Trustees. The assessment will be approved by the Board of Trustees and a copy provided to the Board of Governors.

d) Identify and provide oversight and coordination of compliance partners responsible for compliance and ethics related activities across campus and provide communication, training, and guidance on the Program and compliance and ethics related matters.

e) Administer and promote the FIU Convercent, an anonymous mechanism available for individuals to report potential or actual misconduct and violations of university policy, regulations, or law, and ensure that no individual faces retaliation for reporting a potential or actual violation when such report is made in good faith.

f) Maintain and communicate the University's policy on reporting misconduct and protection from retaliation and ensure the policy articulates 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) Communicate routinely to the President and the Board of Trustees regarding Program activities. Annually report 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 will be provided to the Board of Governors.

h) 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 and ethics will be addressed through appropriate

measures, including education or disciplinary action.

i) Initiate, conduct, supervise, coordinate, or refer to other appropriate offices such inquiries, investigations, or reviews deemed appropriate in accordance with university regulations and policies, state statutes, and/or federal regulations.

j) Make necessary modification to the Program in response to detected non-compliance, unethical behavior, or criminal conduct and take steps to prevent its occurrence.

k) Assist the University in its responsibility to use reasonable efforts to exclude 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.

l) Coordinate or request compliance activity information or assistance as necessary from any University, federal, state, or local government entity. Oversee and coordinate external inquiries into compliance with federal and state laws and take appropriate steps to ensure safe harbor in instances of non-compliance.

The Compliance Office provides guidance on compliance, ethics, and related matters to the University community. The Compliance Office collaborates with compliance partners and senior leadership to review and resolve compliance and ethics issues and coordinate compliance and ethics activities, accomplish objectives, and facilitate the resolution of problems.

Professional Standards

The Compliance Office adheres to the *Florida Code of Ethics* and the *Code of Professional Ethics for Compliance and Ethics Professionals*.

Approved by the FIU Board of Trustees on March __, 2017.

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