

**UNIVERSITY OF MINNESOTA**

**BOARD OF REGENTS**

**Audit Committee**

**Thursday, November 11, 2010**

**8:15 - 9:30 a.m.**

**600 McNamara Alumni Center, East Committee Room**

**Committee Members**

Steven Hunter, Chair  
Linda Cohen, Vice Chair  
Richard Beeson  
John Frobenius  
Maureen Ramirez  
Patricia Simmons

**Student Representatives**

Matt McGeachy  
Matt Privratsky

**A G E N D A**

1. Issues Related to: University Risk Tolerance - T. Mulcahy (pp. 2-4)
2. External Auditor Report – M. Volna/K. Vosen/K. Knudtson (p. 5)
3. Compliance Officer Report - L. Zentner (pp. 6-13)
4. Consent Report - G. Klatt (p. 14)
5. Information Items - G. Klatt (pp. 15-19)



**UNIVERSITY OF MINNESOTA  
BOARD OF REGENTS**

**Audit Committee**

**November 11, 2010**

**Agenda Item:** Issues Related to: University Risk Tolerance

review       review/action       action       discussion

**Presenters:** Vice President Timothy Mulcahy

**Purpose:**

policy       background/context       oversight       strategic positioning

The purpose of this presentation is to familiarize the board with the administration's work related to assessing the University of Minnesota's institutional appetite for risk and the formulation of risk principles. The need to reconsider the University's risk tolerance has been identified as a significant issue by the President's Advancing Excellence Committee and is consistent with the theme of this year's Audit Committee work plan. A "risk tolerance" working group was established to assess current risk philosophies, strategies, and practices and ultimately provide recommendations to the President as to whether recalibration is necessary to support the University's aspirations of excellence.

**Outline of Key Points/Policy Issues:**

This presentation to the Board will summarize the University's "risk tolerance" working group's assessment of the current risk-averse culture at the University; will review the factors that have contributed to its current conservative posture; will introduce fundamental considerations that should be incorporated in the development of principles to recalibrate the University's approach to specific risks; and to obtain the Committee's feedback on proposed principles and action items.

**Background Information:**

The Audit Committee has established *"Recalibrating the University's risk tolerance in the "new normal" financial environment"* as its work plan theme.

A presentation was made to the Audit Committee on the preliminary results of the Risk Tolerance working group in June 2010.

**UNIVERSITY OF MINNESOTA  
BOARD OF REGENTS AUDIT COMMITTEE  
ISSUES RELATED TO: UNIVERSITY RISK TOLERANCE  
NOVEMBER 2010**

Over the past fifteen to twenty years the University of Minnesota has actively cultivated a “culture of compliance” through development of effective policies and procedures, establishment of compliance and oversight structures, and creation of programs to raise the awareness of the campus community as to the ethical standards, responsibility, and accountability that must govern all of our daily activities. As an outgrowth of the University’s “exceptional status” in the early 1990s these initial efforts were intentionally conservative; designed to minimize risks across the expanse of the University’s activities. At the time, and under the circumstances, a fairly conservative approach to risk was most appropriate. In the ensuing years the University’s “culture of compliance” has matured and now represents one of its greatest strengths as a research university. However, as greater and increasingly complex challenges have confronted all aspects of the University’s mission, many additional risk-averse policies, procedures and practices have been layered on the background of those already in place, often creating highly regulated environments. All too often the need for, the appropriateness of, or the intent of existing policies have not been revisited nor have procedures and practices been re-examined for utility, efficiency or effectiveness. Consequently, the deliberately risk-averse approach at the heart of the effort to clear the “exceptional status” designation persists in many current policies and continues to strongly influence the University’s approach to the realities of the “New Normal” in which it now operates. While the University’s current posture with respect to many of the risks it confronts remains appropriately risk averse, there is a growing consensus across the University community that continued manifestation of our generally risk-averse legacy is limiting innovation, productivity and responsiveness to opportunity. This tendency toward risk-aversion is increasingly viewed as impeding fulfillment of our academic mission while taxing the limits of available resources.

Under the auspices of President Bruinink’s *Advancing Excellence* initiative a Risk Tolerance Work Group was convened to develop a set of recommendations for enabling the University to develop a strategic management approach to risk across all aspects of its operations. The intent of moving to a more strategic approach to risk management is to transform the U’s prevailing risk-averse culture to one in which leaders responsible for individual functional domains will be expected to re-define acceptable risk within areas of their responsibilities in ways that will enhance innovation, creativity, productivity, morale and overall performance. Such efforts could at the same time also reduce the financial, personnel and systems costs associated with the current risk adverse culture. The University of Minnesota should be very confident that it can leverage the many positive aspects of its current “culture of compliance” to help direct the transformation to a more productive “culture of performance with responsibility”.

Strategic risk management refers to tolerance for “risk-taking that is systematically expanding the organization’s risk portfolio with the goal of maximizing the effectiveness of resources in the deliberate pursuit of mission.<sup>1</sup>” A strategic approach to risk management acknowledges the positive as well as the negative aspects of individual risk situations and involves a deliberate risk vs. benefit analysis approach to inform decision-making throughout all facets of the University’s operations. The essential principle of strategic risk management designed to enhance overall institutional performance is the definition of the appropriate balance between decisions and activities that contribute to the optimal pursuit of mission on the one hand and ethics, responsible conduct and accountability on the other. **Advocates for strategic management of risk acknowledge that governing boards and executive leadership must collaborate**

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<sup>1</sup> Adam Oswald, *Weathering the Storm, Strategic Risk Management and Non-profit Accountability*, 2010. Hubert H. Humphrey Institute of Public Affairs; Professional Paper in Fulfillment of Degree.

**to define this critical balance point for the organization as a whole.** Essential to fulfillment of this important leadership responsibility is the adoption of a set of Tolerance Principles that will serve as framing principles for operational implementation and the corresponding cultural change that will be required to insure that a new, less conservative approach to risk is responsibly pursued in the University.

This presentation to the Audit Committee will briefly review background information considered by the Working Group and summarize key characteristics of effective strategic risk management systems. In addition, we wish to solicit the Committee's feedback on the following set of Tolerance Principles, Operational Principles and proposed implementation steps:

**1. Risk Tolerance Principles:** The University of Minnesota will have:

- a. High tolerance for risks in the pursuit of innovative, breakthrough research, scholarship and public engagement.
- b. High tolerance for strategic risk-taking that enhances instructional quality.
- c. High tolerance for strategic risk-taking that promotes productivity, creativity and reputation.
- d. Moderate risk tolerance for rewarded financial risk.
- e. Low tolerance for risks arising from inappropriate discharge of fiduciary responsibilities.
- f. Low tolerance for risks that undermine actual safety, or the perception of safety, on our campuses.
- g. Zero tolerance for intentional non-compliance with laws or regulations.

**2. Operational Principles:**

- a. The Board and the President will collaboratively define risk tolerance and champion achieving a more strategic approach to risk.
- b. Tolerance for risk will vary between and within functional domains; it must be defined by administrative leaders in each area of responsibility.
- c. Responsible risk-taking consistent with tolerance principles should be encouraged and rewarded.
- d. The level of oversight, and controls associated with managing risks, should be proportional to the magnitude of the risk involved.
- e. Employees who act in good faith, or exercise judgment consistent with the risk tolerance parameters defined for their area of responsibility, shall be held harmless.
- f. Thorough reviews will be conducted when adverse outcomes result from intentionally-taken risks, so as to continuously refine risk identification, assessment and management processes.
- g. Policies and procedures should reflect the Risk Tolerance and Operational Principles noted above, and should serve to insure their implementation.

**3. Action items:** University leadership should take the following steps to initiate the transformation to a strategic management approach to institutional risk:

- a. Initiate a review of the Code of Conduct policy and program.
- b. Inventory our assurance functions, review assurance reports to identify areas of continuing risk, and implement appropriate remedies.
- c. Instruct administrative leaders to define the appropriate risk tolerance standards for activities in all functional areas in their respective portfolio of responsibilities.
- d. Instruct all business process owners to initiate a review of their policies and procedures, and revise as necessary to reflect the new risk tolerance principles. All reviews to be completed and reported to the Presidents Policy Committee (PPC) within 1 year.
- e. Instruct the PPC to devise a process by which all new policy must be justified on the basis of the type and magnitude of risk being addressed.
- f. Continue to socialize revised risk tolerance principles by working with groups to identify strategies to implement throughout the U.



**UNIVERSITY OF MINNESOTA  
BOARD OF REGENTS**

**Audit Committee**

**November 11, 2010**

**Agenda Item:** External Auditor Report

review       review/action       action       discussion

**Presenters:** Associate Vice President Michael Volna  
Kirsten Vosen, Partner, Deloitte  
Katie Knudtson, Senior Manager, Deloitte

**Purpose:**

policy       background/context       oversight       strategic positioning

To present the External Auditor's opinion on the University of Minnesota's fiscal year 2010 financial statements and other required audit communications.

**Outline of Key Points/Policy Issues:**

Discussion of the audit results for the 2010 financial statements, including:

- Auditor's opinion
- Significant accounting policies
- Accounting estimates
- Audit adjustments
- Other required communications

**Background Information:**

The Audit Committee oversees external audit engagements on behalf of the Board of Regents. A copy of the 2010 financial statements is available in the Board office.



**UNIVERSITY OF MINNESOTA  
BOARD OF REGENTS**

**Audit Committee**

**November 11, 2010**

**Agenda Item:** Compliance Officer Report

review       review/action       action       discussion

**Presenters:** Lynn Zentner, Director  
Office of Institutional Compliance

**Purpose:**

policy       background/context       oversight       strategic positioning

This presentation provides the Audit Committee with information on the activities of the Office of Institutional Compliance to help the Committee carry out its oversight responsibilities for the University's compliance program.

**Outline of Key Points/Policy Issues:**

The Institutional Compliance Officer will provide the Committee with a summary of the most significant compliance-related risks identified since her March 2010 report to the Audit Committee, and current compliance-related initiatives, focusing on the following issues: HIPAA-related matters, export controls, International Programs, conflict of interest policy issues, assurance mapping, and UReport.

**Background Information:**

The Audit Committee is charged with the oversight of the institutional compliance program. The Institutional Compliance officer regularly reports on the institutional compliance program at least twice each year.

**REPORT OF THE DIRECTOR, OFFICE OF INSTITUTIONAL COMPLIANCE  
FOR THE AUDIT COMMITTEE OF THE BOARD OF REGENTS  
ON THE UNIVERSITY COMPLIANCE PROGRAM  
NOVEMBER 11, 2010**

**Introduction**

This report provides an update on significant compliance-related matters for the period March through October 2010. This submission also includes an update on the status of the University-wide administrative policy: *Individual Conflicts of Interest*. Information for this report was gleaned from reports submitted by and communications with each of the thirty Compliance Partners for the six-month legal compliance reporting period ending March 30, 2010 and from the Director's participation on numerous compliance-related committees and other information exchanges that have occurred since the end of that reporting period.

Further information regarding the University's Compliance Program is available at <http://www.compliance.umn.edu/complianceHome.htm>.

**The Most Significant Current Risk Areas and Brief Summary of the Actions Taken to Address Them**

**1. HIPAA-Related Matters.**

*HIPAA Breaches.* Two University employees failed to secure protected health information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and University administrative policy: *Protection of Individual Health Information by U Health Care Components (HIPAA)* and *Securing Private Data, Computers, and Other Electronic Devices*. In one circumstance, a faculty member's personal lap top, external hard drive and other mobile devices were stolen while he was attending a conference. Neither the personal laptop, hard drive nor the devices were supported by AHC IT or encrypted. They contained a substantial volume of images containing protected health information. The University investigated the circumstances under which the breach occurred and notified more than 200 individuals that their private data had been compromised. In the second incident, a University employee stored protected health information on his personal laptop. The laptop was not supported by AHC IT. When the employee connected his laptop to the internet off campus, he inadvertently downloaded a virus which the University's "intrusion detection system" discovered once he logged on to the University network again. In this circumstance, the security of information associated with 16 individuals was breached. The University made the required notifications.

With respect to both incidents, members of the University community failed to adhere to University policy. As a result, the protected data of a substantial number of individuals was compromised. The University's HIPAA Program has approached these compliance failures from two perspectives. First, the costs of investigation and notification have been calculated and those costs have been charged to the departments of the employees who

were responsible for the breaches. Second, further training has been initiated. One of the individuals who failed to follow University policy has trained faculty members in his department and others. Part of that training has included the individual's acknowledgement of responsibility for the breach to his colleagues and to those in his reporting hierarchy.

*HIPAA and the University's Move to Google.* In 2009, the Office of Information Technology (OIT) entered into an agreement with Google to provide email, calendaring and other collaboration tools/applications for use by University faculty, students and staff. We understand that the University will be the first top ranked research institution to implement the Google suite of applications and use it as its sole solution for email. Following the execution of the agreement, the University determined that Google, in its arrangement with the University, has an obligation to protect individually identifiable health information that it either holds or transmits and to enter into a written agreement reflecting this obligation. Google's obligation arises under HIPAA and the recently enacted HITECH Act (The Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009). The University's view regarding Google's obligations is consistent with that of its peer institutions.

To date, Google has refused to enter into a written agreement acknowledging its HIPAA and HI TECH Act-related obligations. As a result, the University would be unable to meet its own HIPAA and HITECH Act related obligations if it were to adopt Google email for use in the Academic Health Center and in other University health care components.

Given these circumstances, neither the Academic Health Center nor the University's other health care components will be permitted to transition to Google applications until appropriate technical and administrative safeguards are in place to ensure that the University can meet its compliance obligations. Once the safeguards are implemented, the health care components will be permitted to make the transition. The Privacy and Security Office is working closely with OIT to identify and implement appropriate safeguards. A proposed plan will be shared in December with all of the University's health care components, with the expectation that the safeguards will be implemented in the spring of 2011.

- 2. Export Controls.** The term "export controls" refers to compliance obligations imposed by three sets of federal regulations that govern the export of strategically important information, equipment, products, and services: the International Traffic in Arms Regulations (ITAR), the Export Administration Regulations (EAR), and the Foreign Assets Control Regulations (FACR). Where research is "fundamental" in nature, meaning that it involves basic and applied research in science and engineering where the information is ordinarily published and shared broadly with the scientific community, the information resulting from that research is not subject to export control rules. A significant percentage of the research conducted at the University is considered "fundamental research". However, export control issues do arise as a result of some of the research that is



conducted here, for example, when the sponsor of the research has provided propriety information to the University that must be protected. In those circumstances, export control regulations are likely to apply, requiring that consideration be given to the participation of non-resident researchers and to the security that may be required to limit access to the information. Export control issues may also arise in the context of purchasing, external sales, and technology commercialization.

To date, the Office of the General Counsel (OGC), nationally recognized for its expertise on this topic, has taken responsibility for educating the University community about export control issues and providing legal advice on particular matters as they have arisen. Recently, the Office of Institutional Compliance (OIC) recognized the need to facilitate the coordination of export control compliance-related activities and has convened an informal working group that includes representatives from Sponsored Projects Administration, Purchasing, External Sales, the Office of Technology Commercialization, Disbursement Services and OGC. The initial steps for the working group include (1) evaluating the University's export control risks; (2) determining what the compliance structure should be.

- 3. International Programs.** The University has capacity to collect only partial information about faculty and staff traveling anywhere abroad. This creates potential risk for the University and for travelers as the University cannot offer the same support to these individuals as it offers to students participating in programs through the University's education abroad offices. In addition, when significant events occur abroad, whether political in nature or the result of natural disasters, the University has no ability currently to determine the identity of faculty and staff that may be impacted by such events. Associate Vice President and Dean Meredith McQuaid, Office of International Programs, has raised this concern. She very recently engaged in discussions regarding this issue with members of the Executive Oversight Compliance Committee (EOCC) on two occasions. At the close of her first meeting with the EOCC, Dean McQuaid was asked to return to the Committee with a proposal for a "real time" system to track faculty and staff who travel abroad.

At the EOCC's October meeting, Dean McQuaid and members of her staff returned with a decision memo illustrating extensive investigation of the issue, benchmarking against peer and non-peer institutions, and recommending possible solutions. To illustrate her concerns, Dean McQuaid described the hours of effort undertaken by her staff following the Ugandan bombings to determine which colleges, departments and units might have faculty and staff in Uganda. Dean McQuaid recommended that the University:

- create an enforceable policy requiring faculty and staff to report their international travel in advance; and
- choose between an internal and external technical solution to support the policy:
  - internal option: modification to People Soft to create a "real time" tracking system, or
  - a specific commercial system (RiskInfoSys), which OIP has determined would serve our needs.

The EOCC asked Dean McQuaid to present the two technical options to the Office of Information Technology in order to determine costs, including staffing, and benefits related to both options. Any recommendations from that discussion will come forward to the President's Policy Committee.

#### **4. Conflict of Interest Program.**

Federal legislative on conflict of interest: On May 21, 2010, the Public Health Service (PHS) issued a Notice of Public Rule Making, soliciting public comment on its proposed revision of its current rule regarding financial conflicts of interest. The proposed revised rule would, if adopted, impose several substantial changes as noted below. It would:

- require investigators who receive funding from NIH to disclose all significant financial interests (SFIs) related to their University responsibilities, not just those that are related to PHS-funded research as determined by the investigator;
- lower the monetary threshold at which interests require disclosure from \$10,000 to \$5,000 and require the disclosure of all equity interests in non-publicly traded entities;
- significantly narrow the financial interests that are currently excluded from financial reporting requirements, notably, remuneration received from nonprofit organizations from seminars, lectures, teaching, and service on advisory or review panels; and
- require every institution receiving NIH funds to post, on a publicly accessible Web site, information regarding significant financial interests that the institution has determined are related to NIH-funded research and constitute a financial conflict of interest.

The Director, in consultation with Associate General Counsel Barbara Shiels, Vice Presidents Tim Mulcahy, and Kathryn Brown, and Associate Vice President Gail Klatt considered the proposed revisions to the PHS rule, drafted comments, and submitted them to the American Association of Medical Colleges, the Association of American Universities and the Council on Government Relations so that the University's views might be reflected in the comments these organizations submitted to PHS. In addition, the University submitted its own comments directly to the National Institutes of Health in July. No final rule has been issued to date.

Administrative Policy: Individual Conflicts of Interest: The development of this policy has been referenced in the Director's prior reports to this Committee (the November 2009 Report on the University Conflict of Interest Program, and the March 2010 Report on the University Compliance Program). The update in this report is brief, given that in March 2011 the Director and Provost and Senior Vice President Tom Sullivan will provide the Committee with a joint report on the revised conflict of interest policy and on the Board of Regents policy: *Outside Consulting and Other Commitments* and the related administrative policy and procedures. The revised Individual Conflicts of Interest policy became effective in early October, following nearly a year of substantial consultation with faculty leadership committees, deans, senior executives, a leadership group representing professional and administrative staff, and the University Senate.

The policy reflects a risk-based approach to the management of conflicts of interest. Five higher risk areas are identified. Faculty and staff who are involved in higher risk University activities include those:

- involved in human subjects research subject to review by the Institutional Review Board (IRB) where the IRB has determined that research conducted by the covered individual involves “more than minimal” risk to subjects;
- involved in clinical health care;
- involved in technology commercialization;
- in a position to exert control over the content of University curriculum that could benefit the commercial interests of a business entity and, at the same time, create opportunity for or further an existing financial relationship between the covered individual and that business entity; or
- in a position to take any other action on behalf of the University that could benefit the commercial interests of a business entity and, at the same time, create opportunity for or further an existing financial relationship between the covered individual and that business entity.

The policy’s most restrictive provisions apply to these individuals. All other individuals covered by the policy are subject to less restrictive standards and chancellors, deans, and administrative unit heads have greater discretion to determine how particular provisions of the policy will apply. An Appendix to the policy was also developed, which governs those involved in clinical care in the Academic Health Center. The Appendix has the most restrictive provisions, given that clinical care has been determined to be the highest risk area. Efforts are currently underway to consult with Deans and Chancellors to identify where faculty and staff are involved in clinical care in colleges and departments outside of the Academic Health Center in order to ultimately develop a single University-wide policy document to govern conflicts of interest clinical care. Senior Vice President Frank Cerra, Provost Sullivan, and the Director will be involved in these discussions.

- 5. Assurance Mapping.** Vice President Tim Mulcahy recently provided this Committee with a presentation on recalibrating the University’s tolerance for risk. Complementary to that initiative, OIC is working with Associate Vice President Klatt to complete an assurance mapping effort, focusing on compliance risks. Assurance activities are carried out by a myriad of units within the University. Assurance mapping facilitates the identification of any gaps by mapping the assurance coverage carried out within the University for individual risks. It is intended to identify if multiple departments or individual are repeating assurance activities, or if a need exists for additional assurance activities for risks with inadequate coverage. This effort will also address where the results of the assurance activities are reported. In addition, the information obtained through the mapping process will be helpful in furthering the discussion on quantifying the “cost of compliance.” OIC is beginning this initiative with three pilot groups: the Research Integrity and Oversight Office, the Department of Environmental Health and Safety, and the Office of Occupational Health and Safety.

**6. UReport.** UReport is the University’s confidential web-based reporting service. This reporting service is provided by EthicsPoint, an independent company that provides similar services for hundreds of companies and universities. UReport is intended to be used to report violations of local, state and federal law as well as violations of University policy. This reporting system is not intended to be used for employment concerns that do not involve legal or policy violations or that involve purely student concerns, or issues for which the University is not responsible. Reporters may submit reports either via a hotline or the web. Reports may also be submitted anonymously. Those who submit reports are expected to report good faith concerns and are expected to be truthful and cooperative in the University's investigation of allegations.

UReport has been in existence at the University since 2005. Since its inception, a total of 671 reports have been submitted, averaging approximately 100 per year. To date, in 2010, 113 reports have been submitted. Eighty percent of the reports submitted during this calendar year have been anonymous. Approximately 50 percent involve claims regarding:

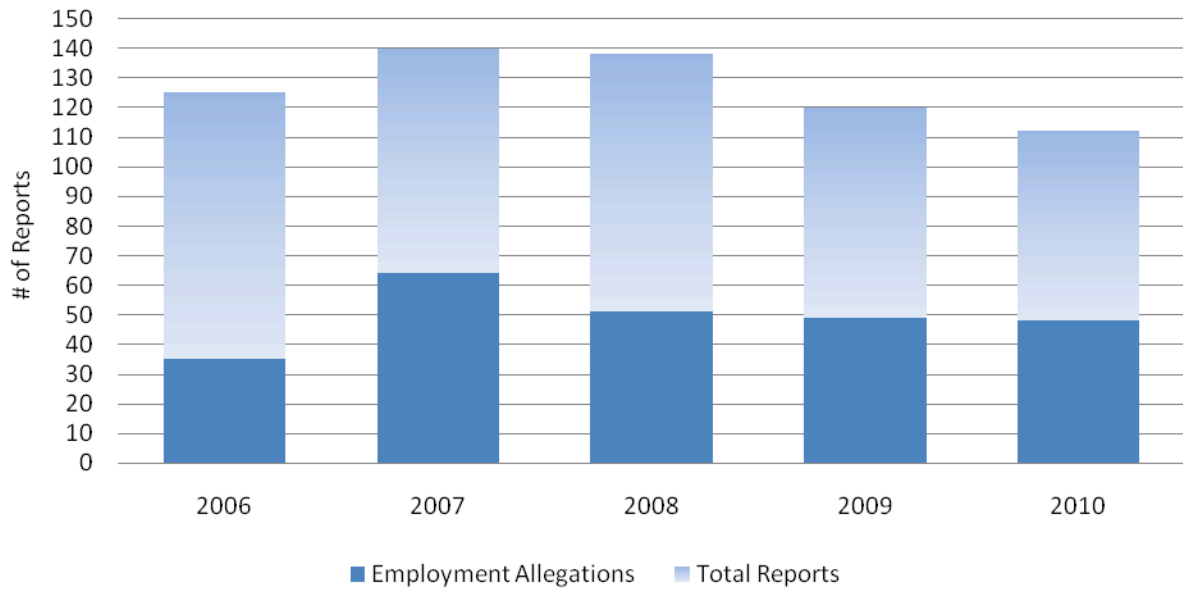
- Discrimination, harassment and/or equal opportunity
- Abuses in wage, benefits, vacation, overtime, and leaves
- Other employment concerns

Notably, for this reporting, several complaints raised nepotism, job posting and promotion issues.

Eighty percent of the reports are received via the internet. Only sixty percent of anonymous reporters check back to determine the status of the follow up conducted regarding the concerns they have described. The graphs below illustrate these figures.

Issue	Running Total	Year to date (10/26/2010)
Total Reports	671	113
Report Sources:		
Internet	85%	81%
Call Center	14%	19%
Other	1%	0%
% Anonymous	73%	80%
Reporter “check back rate” for anonymous reports	51%	60%

## Hotline Reports 1/1/2006 - 10/26/2010





**UNIVERSITY OF MINNESOTA  
BOARD OF REGENTS**

**Audit Committee**

**November 11, 2010**

**Agenda Item:** Consent Report

review       review/action       action       discussion

**Presenters:** Associate Vice President Gail Klatt

**Purpose:**

policy       background/context       oversight       strategic positioning

To approve engagements with external auditing firms.

**Outline of Key Points/Policy Issues:**

- To approve the engagement of PriceWaterhouseCoopers, LLP, by the University's Office for Technology Commercialization, to perform audit services on royalty calculations for sales by GlaxoSmithKline occurring in the calendar year 2009. The contract is for an estimated value of \$70,000.

This contract has been reviewed by the Controller's Office and does not impair the independence of PriceWaterhouseCoopers, LLP, as related to providing future external auditing services to the University.

**Background Information:**

The Audit Committee has been delegated the responsibility to review audit contracts over \$25,000.

**President's Recommendation for Action:**

The President recommends approval of the Consent Report.



**UNIVERSITY OF MINNESOTA  
BOARD OF REGENTS**

**Audit Committee**

**November 11, 2010**

**Agenda Item:** Information Items

review       review/action       action       discussion

**Presenters:** Associate Vice President Gail Klatt

**Purpose:**

policy       background/context       oversight       strategic positioning

To inform the Audit Committee on the recent accreditation of the University's Human Research Protection Program by the Association for the Accreditation of Human Research Protection Programs, Inc. (AAHRPP). This is the third consecutive time the University's program has been awarded full accreditation.

To provide the Audit Committee with the Semi-Annual Controller's Report.

**Outline of Key Points/Policy Issues:**

Semi-Annual Controller's Report

This report presents a summary of activities completed by the Controller's Office in the last six months that enhance financial accounting and reporting, strengthen internal controls, reduce financial or compliance risks to the University, and improve efficiencies and service.

**Background Information:**

The Audit Committee is responsible for oversight of the University's compliance program. The Controller's Report is prepared semi-annually and presented to the Regents Audit Committee in conformance with Board of Regents Policy: *Board Operations and Agenda Guidelines*.

**UNIVERSITY OF MINNESOTA  
BOARD OF REGENTS AUDIT COMMITTEE  
INFORMATION ITEMS  
HUMAN RESEARCH PROTECTION PROGRAM ACCREDITATION  
NOVEMBER 2010**

For the third consecutive time, the University of Minnesota Human Research Protection Program has been awarded full accreditation by the Association for the Accreditation of Human Research Protection Programs, Inc. (AAHRPP), an independent, nonprofit accrediting body which ensures that programs meet rigorous standards for quality and protection.

The AAHRPP accreditation process involves several steps, including: a rigorous self-assessment where an institution evaluates its human research protection program and makes improvements; an on-site evaluation conducted by a team of experts who review materials and conduct interviews to evaluate the program's performance with respect to AAHRPP accreditation standards; a review by AAHRPP's Council on Accreditation of the application, draft site visit report and the institution's response. The Council then determines the institution's accreditation status.

In order to be accredited, organizations must provide tangible evidence — through policies, procedures, and practices — of their commitment to scientifically and ethically sound research, and to continuous improvement. AAHRPP accreditation serves as a “gold seal” that assures research participants, researchers, sponsors, government regulators, and the general public that an organization's human research program is focused first and foremost on excellence.

In certifying the university's reaccreditation, which lasts for five years, AAHRPP noted some of the human research program's strengths, including: a commitment to community engagement and outreach; an extensive and formally defined network of relationships among the various components of HRPP leadership with interactions described as supportive, consultative and informed; optimization of available resources and a commitment to streamlining the review process through continuous quality improvement principles and practices; ensuring ethical conduct of student-initiated research and providing effective teaching for new researchers.



**UNIVERSITY OF MINNESOTA  
BOARD OF REGENTS AUDIT COMMITTEE  
SEMI-ANNUAL CONTROLLER'S REPORT  
NOVEMBER, 2010**

This report presents a summary of significant activities from the last six months that have improved financial reporting, enhanced internal controls, helped manage financial risks, improved services to the University community, or created efficiencies in financial operations.

**I. Accounting and Financial Reporting Matters**

Adoption of New Accounting Standards

Effective with the June 30, 2010 audited financial statements the University adopted two new accounting and reporting standards issued by the Governmental Accounting Standards Board (GASB). A complete discussion of their impact is included in the University's fiscal 2010 audited financial statements.

Statement No. 51, *Accounting and Financial Reporting for Intangible Assets* –

This statement addresses the recognition of intangible assets, including easements, water rights, timber rights, patents, trademarks, and computer software. This statement has been adopted effective for the University's fiscal year ending June 30, 2010 financial statements, with retroactive application to fiscal years ending after June 30, 1980.

Statement No. 53, *Accounting and Financial Reporting for Derivative Instruments* – This statement addresses the recognition, measurement, and disclosure of information regarding derivative instruments. It requires the University to measure derivative instruments at fair value, with the exception of synthetic guaranteed investment contracts that are fully benefit-responsive. In addition, the University is required to disclose a summary of derivative instrument activity and the information necessary to assess the University's objectives for utilizing derivative instruments, their significant terms, and the risks associated with the derivative instruments.

Future New Accounting Standards

Controller's Office staff is monitoring several topics that GASB is deliberating, which may give rise to future standards. However, at this time there are no new GASB standards that the University must adopt for future financial reporting periods.

**II. Initiatives to Enhance Service, Productivity, Efficiency and Internal Controls**

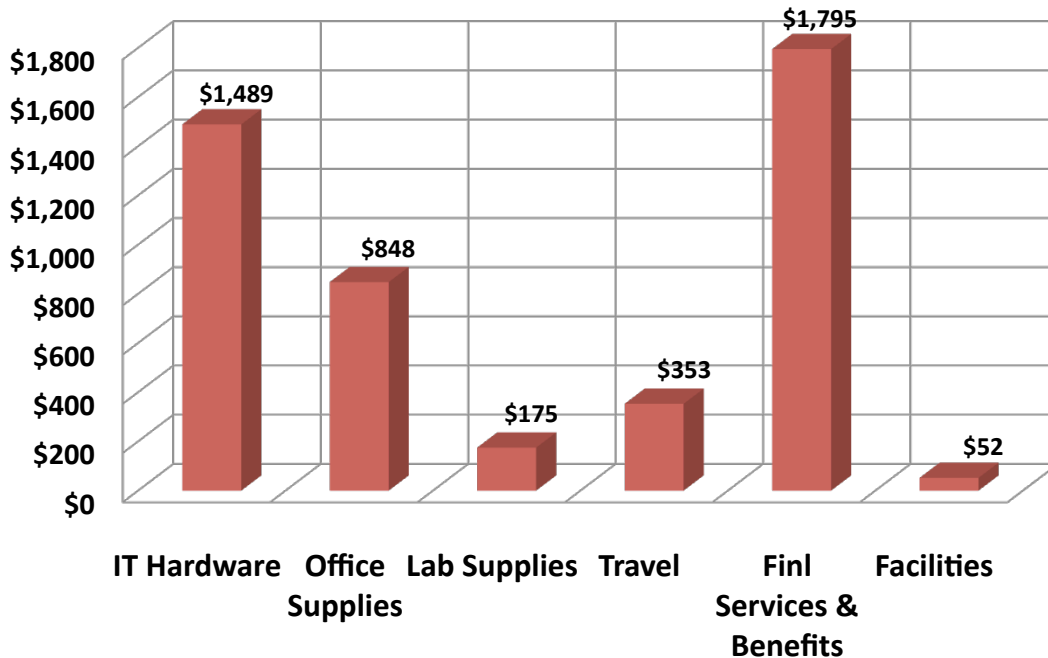
Strategic Purchasing

The Strategic Sourcing project kicked off in 2009, with the overall goal of identifying procurement strategies that will generate \$25 million in annual savings by FY 2012-2013. After an analysis of our FY 09 spend, the first five focused categories were identified as office supplies, lab supplies, air travel, desktops and laptops, and courier services. Work on these

categories is 95% complete, and, along with some additional projects, strategies and changes have been implemented that will provide \$4.7 million in annual savings. The following graph depicts the savings by commodity category, since the inception of the project.

**STRATEGIC PURCHASING PROJECT RESULTS  
1/1/10 THROUGH 9/30/10  
(Dollars in thousands)**

**Total Projected Annual Savings = \$4.7 million**



In addition, project team members have met with 41 colleges and campuses over the last 6 months to detail their specific spending, and to review how they can save money on the completed strategic sourcing projects.

FY 10 spend data is now being analyzed, and this analysis will help identify the next commodity project targets. Each commodity project is staffed with a cross section of stakeholders, who develop, communicate, and implement the savings plan. Projects currently underway include server standardization and IT contingent (contractor) staffing. The FY 10 spend data will also be provided to individual colleges and business units in the next quarter. Finally, purchasing category managers and project team members are also receiving 23 hours of strategic sourcing training so that the strategic sourcing process is consistently used for all new opportunities.

### **III. External Auditor Transition**

The Controller's Office coordinated the transition from LarsonAllen LLP, the prior external auditors, to Deloitte LLP for the fiscal year 2010 external audits of the University's financial statements and compliance audits. The overall result was successful, and the audit of the University's annual financial report was completed on time. Deloitte representatives will present their audit opinion on the audited financial statements to the Audit Committee at the November 2010 Audit Committee meeting, and the management letter and compliance audit results will be presented at the February, 2011 Audit Committee meeting.