

BOARD of REGENTS



THE UNIVERSITY OF
NEW MEXICO.

AUDIT AND COMPLIANCE COMMITTEE MEETING

Tuesday, October 21, 2025

CALL TO ORDER/ QUORUM



The University of New Mexico
Board of Regents' Audit and Compliance Committee
October 21, 2025
8:30 AM – 9:45 AM
UNM Continuing Education Auditorium
1634 University Blvd. NE
Livestream: <https://live.unm.edu/board-of-regents>

Agenda

- I. Call to Order and Confirmation of a Quorum
- II. Adoption of Agenda
- III. Approval of Meeting Minutes from August 19, 2025
- IV. Roll Call Vote to close the meeting and to proceed in Executive Session as follows:
 - A. Presentation of FY25 External Financial Audit pursuant to external audit exception in RPM 1.2. (*KPMG, Moss Adams, Carr, Riggs & Ingram, University Controller's Office*).
 - B. Discussion of draft Internal Audit reports and information subject to attorney-client privilege; audit work plans; and information security and privacy report, pursuant to RPM 1.2 and NMSA 1978, § 10-15-1(H)(7);
 - C. Discussion of limited personnel matters as defined in and permitted by NMSA 1978, § 10-15-1(H)(2);
 - D. Vote to open the meeting.
- V. Certification that only those matters described in agenda item #IV were discussed in Executive Session and if necessary, vote on final actions as required by NMSA 1978, § 10-15-1(H)(2).
- VI. Information Items
 - A. Director of Internal Audit Status Report
Victor Griego, Internal Audit Director
 - B. Main Campus Chief Compliance Officer Status Report
Francie Cordova, Chief Compliance Officer & Adrienne Helms, Clery Coordinator
 - C. Status of Audit Recommendations
Chien-Chih Yeh, Internal Audit Manager
- VII. Adjournment

THE UNIVERSITY OF NEW MEXICO
Board of Regents' Audit and Compliance Committee Quarterly Meeting
August 19, 2025 – Draft Meeting Minutes

Regent Committee Members Present: Jack Fortner, Christina Campos, Paul Blanchard (Quorum)

Other Regents Present: William Payne, Victor Reyes, Patricia Williams

Other Attendees: Garnett Stokes, Terry Babbitt, Teresa Costantinidis, Francie Cordova, Daniel Jones, Ariadna Vazquez, Scot Sauder, Susan Rhymer, Beck Rivera, Ajay Gupta, Dave Strzyzewski (CLA), Rebecca Napier, Jason Galloway, Duane Arruti, Jeff Gassaway, Chris Arndt, Amy Jackson, Emily Morelli, Victor Griego, Chien-chih Yeh, Antonio Baca, Walter Peters, Connor Anderson, Jeremiah Sanchez, Amy O'Donnell. Note: This was a meeting with multiple committees at the same location going and out. It is not possible to know who else from the UNM community attended this particular meeting.

Chair Fortner called the meeting to order at 9:39. He confirmed there was a quorum.

By unanimous consent, the meeting went into Executive Session at 9:42 AM per the agenda.

By unanimous consent, the meeting returned to Open Session at 10:31 AM.

ACTION ITEMS:

- Certification that only those matters described in the agenda item #1 were discussed in Executive Session.
- The Committee approved the agenda.
- The Committee approved the minutes of the meeting of May 20, 2025.
- The Committee unanimously approved the following UNM audit reports:

University-Wide International Travel, Report 2025-04
Community Health Worker Initiatives, Report 2024-05

INFORMATION ITEMS:

- There were no Advisors' comments.
- Victor Griego, Internal Audit Director, provided his quarterly report. For operational staffing, the department is currently in the process of evaluating financial resources and reserves to determine expansion of Internal Audit (IA) staffing. The department is also in the current process of transitioning the professional intern into a full-time auditor through the professional internship program and looking at resources and reserves to determine if Internal Audit can hire an additional internal auditor or a senior auditor.

Mr. Griego communicated the audit plan status for FY 25. Of the 13 audits that are on the audit plan, nine have been completed or in process. The department just completed the audits of Community Health Work Initiatives and International Travel, presented in executive session for approval. The department is completing field work procedures or in the reporting phase of an Athletics Administration audit, and the Education Abroad programs. Those two audits will be presented in the next Audit and Compliance Committee meeting. IA is in the planning procedures to initiate an IT disaster recovery audit, and we have a contracts and grants administration audit, which is also on the FY 26 audit plan. All audits that are in process or implementation are the result of the FY 23 University-wide risk assessment, an IT risk assessment that was performed for us and EthicsPoint reports.

Mr. Griego moved on to status of complaints. For FY 25 and the beginning of FY 26 through August 8th, there were 89 concerns reported through EthicsPoint which Internal Audit has reviewed. Of the 89, 44 have been

completed or closed, 12 were substantiated or partially substantiated, and 32 were unsubstantiated or there was not sufficient information to proceed with a full review. All complaints that are reviewed by IA are typically concerns of financial management, financial issues, or compliance with laws or regulations.

Regents' Policy 7.2 requires a reporting of the department's budget and financial position on an annual basis. This is reported in the August meeting, providing a highlight on the prior fiscal year's financial results and also the current year's budget. So, for fiscal year 2025, the final budget was \$1,437,916 which primarily consisted of I&G funding from the general pooled funding account and \$111,058 from the department's reserves. Total expenses were actually \$1,174,654, resulting in I&G funding actually exceeding expenses for the year. The savings were primarily due to the retirement of a senior auditor in January of this year and a vacant internal auditor position also for half of the year, which was filled in February of this year.

The FY 26 adopted budget is \$1,542,509, of which \$1,423,834 is from the general pooled account, and \$118,675 from the department reserve. Budget expenses are primarily labor as usual, about 90%, and that actually reflects a fully staffed internal audit budget. Non labor expenses primarily consist of IT services, any kind of professional services, computer equipment, and training and professional development for the department.

The status of the external financial statement audit is that the FY 25 external financial statement audit is currently underway in the field work process. This is the third and final year of the external financial statement contract. At the October meeting there will be a status update on the plan for the RFP on the next contract.

Internal Audit will soon go through an external quality assessment review. Internal auditing standards require that the internal audit department or shop goes through an external quality assurance review. Basically, somebody outside of the University department does an audit on internal audit. And the idea is to ensure that a department follows internal auditing standards and documentation and complies with everything based on auditing standards. It is required every five years. This year, there is actually a transition to have to comply with *international* internal auditing standards. There are going to be new processes to comply with. It is a good thing to have this review to see if there are any additional procedures or anything the department needs to be doing to comply with international auditing standards. The department hopes to have that review done at the end of this year and then report on the results of that review.

Chair Fortner asked how the external quality assessor is chosen. Mr. Griego replied it is done using volunteers. If you go through the IIA, they charge fees. For volunteers, it is a service that is provided within other internal shops. There is no fee, so we do not come to the committee for approval on the vendor. It would be other university's employees that volunteer to do the service. The Department would only pay their travel costs.

Mr. Griego informed the committee about additional communication required by the internal auditing standards. He is required to report to the Committee three things. First being that there is monitoring of the performance of the department, as a part of routine activities. Secondly, ensuring that all staff members are independent and objective in completing their internal audit responsibilities. There is an attestation on every project that the audit is independent and there is no conflict of interest in conducting that audit. No audit staff has a family member or somebody that they are related to that would cause a conflict. The Department reports that responsibility to the Committee. Finally, confirmation of the fact that the department does not have any resource limitations to complete the audits and investigations.

Regent's Policy 7.2 requires that Mr. Griego report any kind of external audits or reviews conducted by other agencies or anything outside of internal audit. There are seven (7) audits or reviews to report for this reporting cycle. One of them is the Kellogg Foundation. They are completing two audits totaling \$1.6 million in grants awarded to the HSC College of Nursing, Sociology Department, and Anderson School of Management. These audits cover all expenditures for grants ranging from November 1, 2023 to July 31, 2024. The Kellogg Foundation reported minor findings for grants awarded to Sociology and Anderson School of Management. Both have initiated corrective action in response to the findings and both audits have been closed. The City of Albuquerque completed one audit totaling \$750,000 in a grant awarded to the HSC Office of Community

Health, which is similar to the same program that we just presented, and the audit period covered all expenditures during FY 25. In this particular audit, the City reported two concerns and one finding surrounding documentation. UNM has resolved both reported concerns and findings since the audit was completed.

Chair Fortner asked what the difference is between a finding and a concern. Mr. Griego replied that it might be a question for Jason Galloway, Senior Executive Officer for Finance and Administration. Mr. Galloway stated that the difference is usually between a financial review and programmatic review. Concerns are usually in programmatic activities; findings are usually financially substantiated with some type of dollar amount or internal control violation.

Mr. Griego continued the list of external audits. The Health Resources Service Administration (HRSA) completed two (2) audits totaling \$1.2 million in grants awarded to HSC Internal Medicine. The audit period covered all expenditures since the grant's inception. They did not find any reported results as a result of the audit - so a clean audit on that one. The DOJ completed one audit for a \$300,000 grant awarded to the Centro de la Raza program covering all activity from October 1, 2022 through the end of the grant period. There were no reported any findings as a result of the audit. And there are three audits that are actually currently in process with HRSA: Public Allies for \$354,000, Patient Centered Outcome and Research Institute (PCORI) for \$10.7 million totals funds awarded. As of today, there are no preliminary results of these audits that are in process.

- Francie Cordova, Chief Compliance Officer, provided her status report to the Committee. She addressed the Committee about finally finding a Title IX coordinator. They have not had a Title IX coordinator since December of 2024. They had a national search that was not proving fruitful, and she wanted to thank the Regents for assisting with that effort. They decided to look internally and try to just reuse their talent and bolster what they were doing internally. The lens turned to Beck Rivera, who is the Deputy Chief Compliance Officer, as the person who had both compliance experience and Title IX experience. They are happy that Beck accepted the dual role. He is now the Deputy Chief Compliance Officer, Title IX coordinator. Beck has a lot of experience. He's an attorney who was in private practice prior. He's been at UNM since 2020. He started as an investigator doing Title IX work, got promoted to the Title IX Program Coordinator role, assisting the Title IX coordinator, and was then promoted into the Deputy Chief Compliance Officer role. Ms. Cordova stated they are filling a position of Compliance Coordinator and have two finalists interviewing this week in person.

They also did some restructuring in their office. President Stokes was able to provide some funds for 7% retention raises to the four investigators. They are looking to add a fifth, filled the Associate Title IX Coordinator position with Rachel Foster, and things to bolster the Clery Coordinator and other functions.

Mr. Rivera addressed the Committee to provide information on upcoming Title IX initiatives. He said there are four pillars that he and Ms. Foster envisioned for the next few fiscal years in terms of building out their Title IX work. He is grateful to have worked with his predecessor to help support some of the framework and is excited to build upon that. They are particularly excited about building out relationships with the branch campuses to improve upon their footprint. They do our best as an office to reach out at least two or three times a year and have an on-campus presence to provide training, office hours, et cetera, for the staff, faculty and students on those branch campuses. But there's a great opportunity to build those connection points and give a strengthened channel for people to bring grievances and workshop ideas that might work particularly well on their campuses.

They have a vision to create Deputy Title IX Coordinator roles on each campus. They often find that the CEEEO office or the Title IX staff might sound big and scary because they only see those folks on their campuses a couple of times a year. They might have better rapport with certain roles on their branch campuses. They may feel more comfortable talking <to branch campus staff> about those concerns and learning more about the options available to them for a particular grievance. It also serves as a good channel for our Title IX staff to get a better idea as to what's going on and improve upon understanding of supportive measure opportunities. They also intend on building on the Deputy Title IX Coordinator network beyond branch

campuses. There are some areas in the student serving areas of Main Campus, as well as the Health Sciences Center. They are working very closely with the Brie Delvin, Associate Director of HSC compliance.

And as for those other two pillars, they have a YouTube channel, and resources available on the CEEO website. There is never enough information that they can provide to help educate the parties involved, the complainants, and individuals interested in what Title IX opportunities are available to them. They are expanding the types of media to share those resources with. Some people are video or visual people, some people like pamphlets, etc. They are excited about that. And then lastly, most individuals hear about CEEO grievances in the form of an investigation. But as we know, investigations don't always resolve the concern underlying that grievance or complaint. They are working to expand pathways for informal or alternative resolution.

Ms. Cordova provided information regarding the Stop Campus Hazing Summit that they hosted on July 30th here at UNM. The State Hazing Act still has not passed, although it has gotten very close in the last two sessions, and we're one of two states that do not have an anti-hazing law. However, the federal anti-hazing law did pass, and President Biden signed that into law in 2024. UNM was required to be compliant in July of 2025. They hosted a summit as part of the efforts to make sure UNM is compliant and also to bring together campus partners. There was a great turnout of people from across campus, including UNM Police, the Policy Office, Student Affairs, Greek Life, etc.

As the flagship university, they wanted to offer resources and expertise to other sister universities as well. Participants from Western New Mexico University, CNM, Highlands, Mesa Lands Community College, and even Colorado College came together on being compliant. UNM was already way ahead of the game as is typical. CEEO will be reporting hazing incidents on campus in the security report, as an amendment to the Clery Act. It will have all the crime statistics plus any hazing incidents. There has to be a transparency portal, which will be hosted on the Dean of Students' website for any violations of the Federal Hazing Act. They were happy to have EVP Costantinidis and Fern Lovo speak. The lunch speaker was New Mexico Higher Ed Deputy Secretary, Dr. Patricia Trujillo who provided really moving words. Maybe there will be a state act soon.

Ms. Cordova provided an update on UNM EthicsPoint Hotline trends. UNM started using the EthicsPoint reporting tool slowly in 2013. People certainly know about EthicsPoint now. They are just getting more and more reports. Last fiscal year, they had 1,546 reports. The vast majority are reports that come to CEEO. About 980 of those reports were discrimination, sexual harassment, sexual assault types of cases. The remainder of the cases were things that fell in financial services, etc. Average days open are going down significantly - how fast they are resolving these complaints, and that is a good thing. Some cases take longer. CEEO and Internal Audit cases take a long time because of following all the federal and audit requirements. But they are getting closed and resolved faster. Complainants are allowed to report anonymously on the system. They can communicate with the anonymous reporter, but it is not the best way to bring in complaints. It is hard to pursue them. They hope that people do not report anonymously and feel secure enough to report with their names. The number of anonymous reports has gone down over time and have at universities as a whole.

The top ten issues, of course, always involve CEEO matters including accommodations, and then human resources. Academic Affairs is the next group, then accounting, and so forth. Most CEEO complaints are always the sex-based discrimination complaints - sexual harassment, sexual assault, dating violence, etc. That is not unusual. Race, disability, and national origin are the types that follow after. The Title IX reports are going up, something they consider a good thing. They want people to report. Sexual harassment is still the biggest complaint there and always has been. That is followed by various other gender-based categories such as sexual assault, domestic violence, et cetera. That is an area that they are always addressing, which is why Title IX is so important. They will be launching their Title IX survey. They are starting kickoff right now to see where people are and where they are experiencing these things. Not all of these things happen, and most do not happen on our campuses. They are primarily in people's private residences or off campus places. But they want to see what is happening and how to support people who are experiencing these things. What is always most interesting to Ms. Cordova is who is named in the types of complaints. Students used to be the most named respondents, the

most accused. Now, faculty or staff have alternated each and every year back and forth. And this year, it was staff by far that were the most named respondents in our cases. There is some work to be done in that regard.

Chair Fortner asked Ms. Cordova, in her context, how do they define restorative justice? Ms. Cordova replied restorative justice is usually a variety of things. It can be some sort of a sit-down discussion between the parties if they're willing to do that. It can be negotiations. It can be something that's culturally restorative, looking at things that are not in the investigative realm, but what can be done to restore the climate, the culture. People like to get apologies. That is one of the things they like to see in restorative justice - somebody to acknowledge the harm, which typically does not happen if the issue is also criminal, but can happen when it is not.

Regent Reyes asked if section three of the Stop Campus Hazing Act has an implementation requirement. Ms. Cordova responded that is the transparency portal that will be on the Dean of Students' website. They only have to report things that student organizations have found to have violated on that portal. Allegations of hazing will be on the annual Clery report. Sexual assault is a form of hazing. If it is in the context of being able to stay in an organization, join an organization, or be part of an organization, then absolutely that would be included both in the Title IX statistics and in the hazing statistics. The Clery report includes all of the individuals. If a rank-and-file student has an issue, then that gets brought into the report. There could be complaints against an individual or against an organization. The individual reports would be in the Clery report, and then the organization and potentially the individuals would be in the transparency report. Those would be the two mechanisms that they get reported out. Regent Reyes asked about FERPA and at what point a respondent's name becomes public, if at all. Ms. Cordova responded if there is a finding against a student where FERPA applies, then their name can be released publicly. Until there's a finding, then their name would never be released publicly. That would have to be in response to some sort of an IPRA request or something like that. Even the transparency portal will still have limited details in terms of numbers and disclosures.

- Brie Delvin, Associate Director, Health Sciences Center Compliance Office provided the HSC Compliance Office Update. She stated the update contains the results of the compliance risk assessment interviews for 2025. Every April, the Compliance Office does a risk assessment for areas they audit and use this to identify the current controls in place for current risks and to mitigate risks, and to create the fiscal year 26 audit work plans for UNM Health System entities and the UNM Health Sciences Center. For the Health Sciences Center, they interviewed 25 individuals over all areas. There is a culture of transparency and communication at all staff levels. Leadership and OUC are highly sensitized to retaliation. Leadership understands the importance of compliance and is good at following requirements and setting a standard for compliance, which helps everyone else follow. When staff have concerns, they feel comfortable speaking to supervisory staff and have resolutions provided. Compliance hotline posters are posted throughout the campus. Risks identified for the Health Sciences Center include non-completion of Learning Central annual mandatory training, and the Minors on Campus program that is currently being renewed. There is a new program and a new platform for that.

Artificial intelligence is always a risk. Competing or conflicting policies or language within them make it hard for staff to understand what is necessary. Overall safety concerns, violence against staff, general security, employee retention, etc. are risks. Leadership change causes lack of institutional knowledge resulting in staff perception of instability and employee anxiety. Other risks are keeping up with the new federal regulations as they change, changes in federal grant money for Medicare/Medicaid, and doing business with identified areas of concern such as China, Hong Kong, Iran, North Korea, and Russia. Faculty are being hired that have never taught before. Banner is an antiquated system that is causing problems and there has been a lack of response to questions specific to compliance or other research questions from the Institutional Review Board (IRB).

Fire drills, active shooter and emergency response trainings are needed. The Minors on Campus policy, as mentioned before, was recently updated. There will be training on that for resolution of any confusion or lack of knowledge regarding the requirements or the process. There is a need to understand compliance standards regarding AI for the University. They are encouraging all HSC employees and faculty to complete the Learning Central modules and to gain understanding of all policies related to harassment. Next steps include: providing

training on minors on campus specific to departments that are actively involved in the Minors on Campus program; performing audits of documentation collected for current and past programs; collaborating with human resources to provide training on harassment; exploring participation in a privacy IT committee led by Jeff Gassaway; exploring the need for compliance audits of the FERPA process and clinical trials and research; remaining current on federal changes and their impact on federal funding; remaining current on compliance initiatives surrounding AI; and, participation, as necessary, regarding policy development.

Areas where the Health System is doing well include: improvements with ensuring professional service agreements; memorandums of agreement and memorandums of understanding are in place; patient safety; leadership and security managing situations; risks identified in 2024 being managed well; and contract management software close to being purchased; opening the critical care tower; a new payroll system, UKG is being implemented with the medical group to ensure accuracy of employee data; launch of a 340B oversight committee; identification of key stakeholders to support the processes and monitoring of compliance and reporting; LoboSTEPPS program success; good catches recognition program; and daily management huddles ensuring alignment with goals.

A top risk identified during for the Health System includes that physical safety is more of an issue this year than last. The environment towards staff and providers is becoming more hostile. Oversight of bills, invoices and change orders are issues. A lack of access for patients to ambulatory and outpatient space creates delay in care and access to care. Inconsistent use of interpreter services is a process issue that could be fairly easily remediated. Responsibilities and scope of Advanced Practice Provider and Medicare requirements need to be clear. From a practical standpoint, there is variability in the involvement of attendings in patient care. There have been HIPAA breaches due to mislabeling of documentation. Cybersecurity and AI are always an issue.

For billing accuracy, there are concerns that TigerConnect is not HIPAA secure and there's question as to whether it is compliant with records retention as the information on it is only available for ten days. Split-shared billing, grants and flows of money within those grants and who is maintaining them are concerns. Truman Center has expensive medications, and they have requested a better fridge with computer technology. Another issue is global federal changes including federal funding.

Opportunities include charge capture (are they billing everything they can and finding better ways to capture all charges?), improved communication between the Lomas and the Sandoval campuses, and validating billings from vendors, ensuring there are no related party transactions. Then from the Center of Excellence in Rio Rancho to SRMC there is a missing sidewalk that creates access issues for patients. The Agency for Healthcare Research and Quality Candor program does not exist at UNMH, but there's an opportunity there that would make an excellent program to look into. It's a good way to address adverse events and risk management. How do they organize to ensure that executive orders at the federal and state levels are kept current?

Risks that were referred to Clifton Larsen and Allen include auditing of I-9 records and other HR records for vacation accrual rates, contract repository, critical care tower equipment and money that has transpired, UKG management system accuracy, and implant tracking - operating room should be audited using the Implant Management System as some staff are still tracking that on paper. Next steps include continued billing audits, which are done every year, hence the audit plan. They will continue quarterly compliance updates in the Compliance Corner published in the various newsletters. They continue to: explore opportunities to improve provider documentation; remain current on all federal changes and their impact on funding; and remain current on compliance initiatives surrounding AI, participating as necessary in development of policies and procedures to ensure it is being used properly.

Summary of the Regents' Audit and Compliance Committee Meeting
August 19, 2025

- The meeting adjourned at 11:13 AM.

Approved:

Audit and Compliance Committee Chair

ROLL CALL VOTE AND PROCEED IN EXECUTIVE SESSION

CERTIFICATION

**Internal Audit Director's Status Report
Audit and Compliance Committee Meeting
October 21, 2025**

Internal Audit Operations and Staffing. Internal Audit has an open requisition for two Senior Auditor positions. IA is also in the process of upgrading the department's Professional Intern to an Internal Auditor.

Audit Plan Status. The FY26 audit project status with hours for the current audit plan is below. The status of the proposed audit plans is for the period of July 1, 2025 through September 30, 2025:

Completed/Report Writing	3
Planning/Fieldwork	4
Subtotal	7
Assigned	3
Unassigned	1
Total	11

Seven (7) of 11 audits from the FY25 and FY26 audit plan have been completed or are in process. Internal Audit has currently completed the audit of Education Abroad Programs, which was presented in executive session.

Internal Audit is in the process of fieldwork procedures for Athletics Administration and the annual Audit of President's Travel and Entertainment Expenses. Planning procedures have been initiated for an audit of Contracts and Grants and IT Disaster Recovery. All audits in process resulted from the Risk Assessment, Three-Year Audit Plan and IT Risk Assessment.

The following is the status of the FY25 and FY26 audit plans:

Description	Status	FY 26 Budgeted Hours	FY 26 Actual Hours	Variance
Audit Plan				
FY 2025 Audit Work Plan				
Travel (International)	Completed - Follow up	0	87	(87)
Office of Community Health	Completed - Follow up	0	109	(109)
Education Abroad Programs	Completed	0	9	(9)
Athletics Administration	Fieldwork	335	407	(72)
IT - Disaster Recovery	Planning	400	0	400
UNM Gallup	Assigned	500	0	500
College of Nursing	Assigned	500	0	500
FY 2026 Audit Work Plan				
President's Travel and Entertainment FY25	Fieldwork	250	78	172
Contracts and Grants	Planning	400	81	319
FY26 Risk Assessment	Assigned	100	0	100
Biology	Unassigned	500	0	500
Audit Plan Subtotal		2,985	771	2,214

**Internal Audit Director's Status Report
Audit and Compliance Committee Meeting
October 21, 2025**

Complaint Status. The current status of complaints assigned to Internal Audit for FY26, as of October 9, 2025, is:

	FY26
Completed/Closed	28
Planning/Fieldwork	27
Unassigned	11
Total	66

Of the 28 completed/closed cases, five (5) complaints were substantiated or partially substantiated and 23 were unsubstantiated.

Complaints assigned to Internal Audit for review are those of financial related matters (i.e., fraud, theft, misuse of funds, time abuse, etc.). A confidential formal memo of Internal Audit complaint reviews is distributed to applicable UNM management and/or leadership to report outcomes of reviews and IA recommendations, if substantiated.

External Financial Statement Audit

The FY25 external financial statement audit was completed, which was in its third and final year of the existing contract. The Controller's office intends to request permission from the Office of State Auditor (OSA) to go out for RFP as soon as November 1st and have an RFP out for a new external audit financial statement contract by mid-November.

Internal Audit External Quality Assessment (EQA)

Internal Audit is planning to schedule fieldwork for its External Quality Assessment (EQA) in December 2025 or January 2026. An EQA is required by Internal Auditing Standards to include an external review of Internal Audits' audit files and reports to ensure the department is complying with internal auditing standards. Beginning in 2025, Internal Audit must conform with Global Internal Auditing Standards.

IA has finalized a contract with the external EQA reviewers. The EQA reviewers work at other higher education institutions, have internal auditing expertise, and provide the services on a volunteer basis. UNM will only have to pay for travel costs to conduct the EQA.

The lead EQA reviewer will likely request meetings with selected UNM officials and the A&C Committee Chair to discuss Internal Audit operations. The IA Director will communicate those meeting requests as they become known.

External Audits and Reviews. Internal Audit obtains status update information from UNM Contracts and Grants regarding external audits/reviews of various grants and contracts by various grantor agencies. At Tab #6 is the summary information as of September 30, 2025 regarding the external audits/reviews (third party financial audits) of various grants, contracts, and programs by various grantor agencies. There are currently four (4) audits/reviews to report for this reporting period.

**Internal Audit Director's Status Report
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UNM is currently under audits of awards from the Health Resources and Services Administration (HRSA) for \$3 million, Public Allies for \$354K, Patient Centered Outcomes Research Institute (PCORI) for \$10.7 million, and Family Health Center (FHSCD) for \$106K. Audits are in their early stages and no preliminary results of the audits have yet been received.

Third Party Audits as of September 30 2025

	In Process	In Process	In Process	In Process
Granting Agency/Entity	HRSA	Public Allies	PCORI	FHCSD
Contract/Grant/Program Title	3RQU2	2RXB0	3RSF7	3RTZ5
Contract/Grant Period	09/30/2023 - 09/29/2026	09/01/2023--09/30/2024	04/01/2024-10/31/2029	08/01/2024-02/28/2025
Contract/Grant Total Amount	\$3,000,000	\$354,605.00	\$10,738,360	\$106,285
Contract/Grant Amount - Current FY		\$354,605.00		
Department	HSC - Office of Research	Community Engagement Center	Project ECHO	Project ECHO
Agency Audit/Review Notification Date	7/7/2025	4/11/2025	4/16/2025	9/3/2025
Audit/Review Entrance/Visit Date(s)	7/16/2025			
Campus	HSC	Main	HSC	HSC
Comments	In Progress	In Progress	In Progress	In Progress

Note: Third Party audit information provided by UNM Contracts and Grants.



OFFICE OF COMPLIANCE, ETHICS & EQUAL OPPORTUNITY

FRANCIE CÓRDOVA, JD, CHIEF COMPLIANCE OFFICER

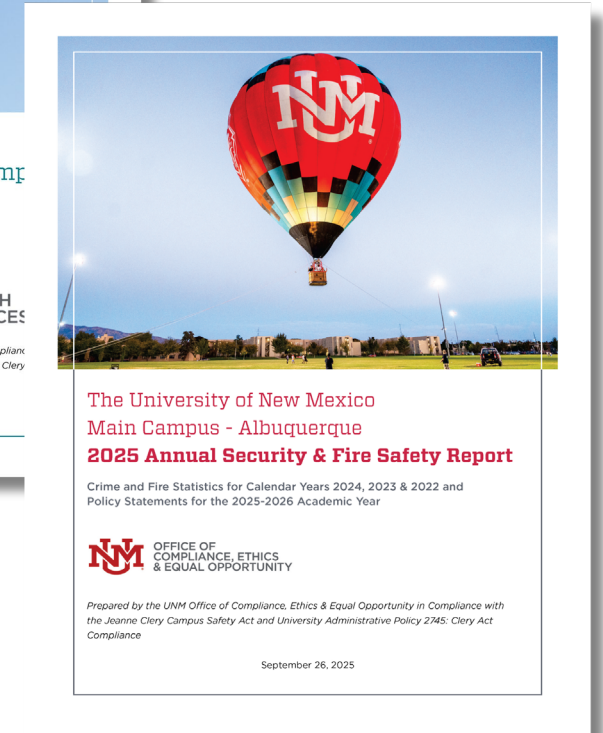
ADRIENNE HELMS, CLERY COORDINATOR

UNM BOARD OF REGENTS CLERY UPDATE

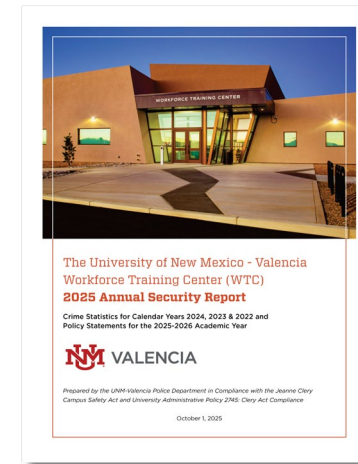
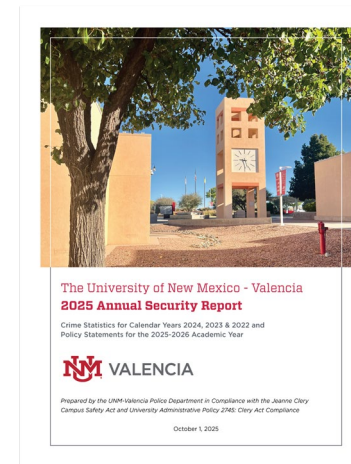
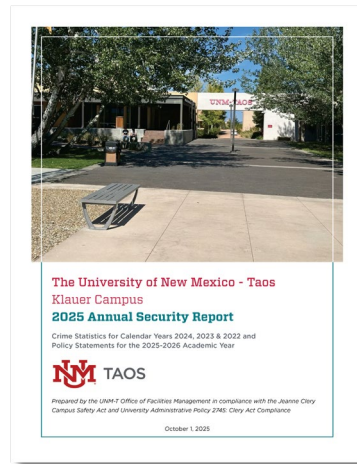
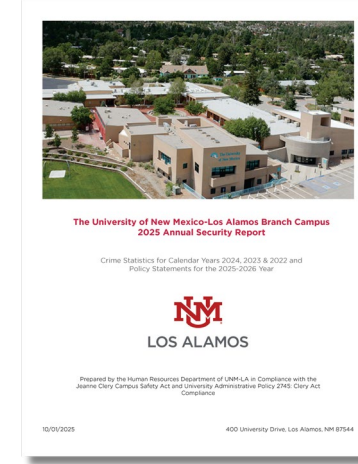
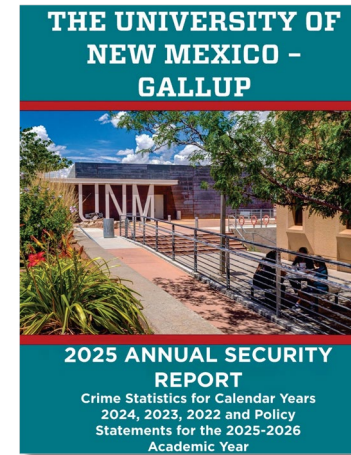
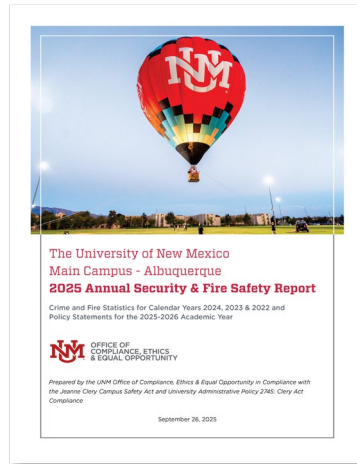
OCTOBER 21, 2025

ANNUAL SECURITY & FIRE SAFETY REPORTS

- Released October 1:
 1. Main Campus – Albuquerque (ASFSR)
 2. Health Sciences Rio Rancho (ASR)
- Annual crime and fire statistics for calendar years 2022, 2023, and 2024
- Policies and procedures for current academic year (2025-2026)



ANNUAL SECURITY REPORTS



CLERY LIAISON PROGRAM

- Established communication channels at every UNM Campus
- Comprehensive, online support HUB



CLERY ACT
COMPLIANCE
LIAISON

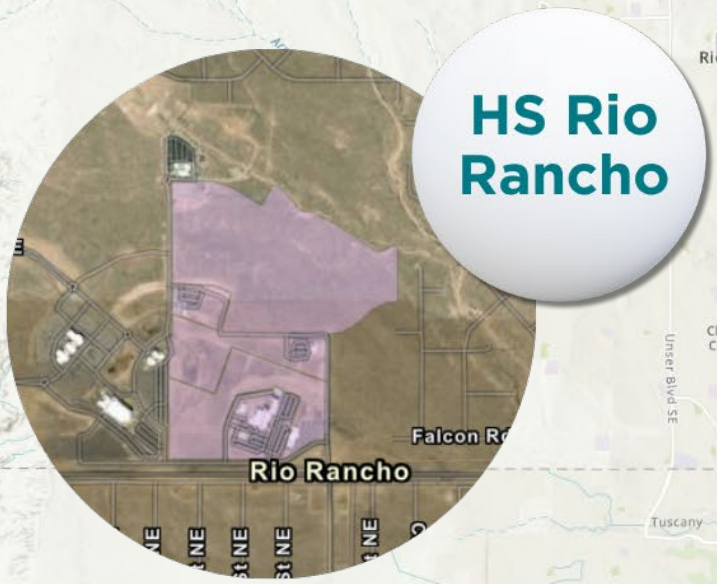
THE UNIVERSITY OF NEW MEXICO

CRIME STATISTICS

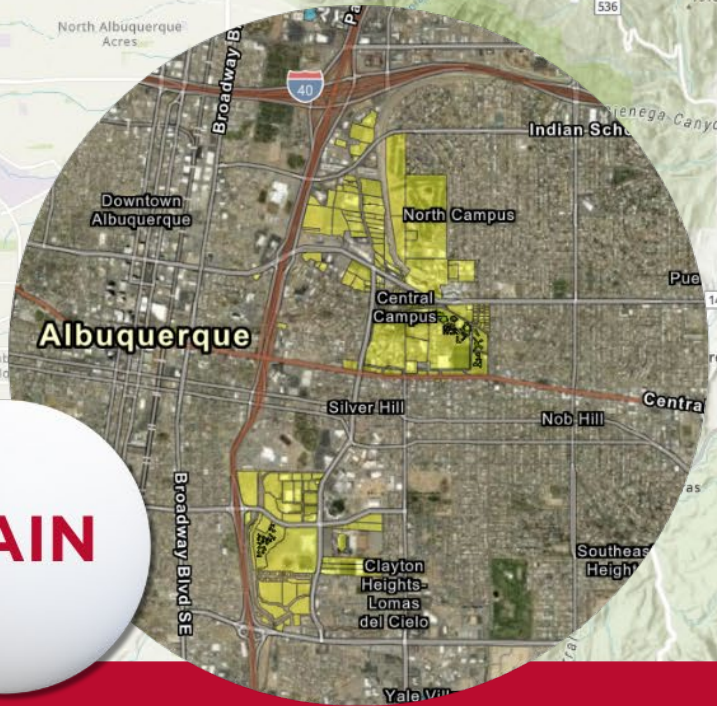
- Based on **reports**, not substantiated reports
- Are not limited to students and employees
- Counted in the year they are reported
- Some incidents account for multiple statistics.
- **Not** affected by...
 - Whether campus is open
 - What time of year it is
 - Whether an investigation takes place
 - Whether an arrest is made
- Good faith effort requirement for external law enforcement reports



“SEPARATE” CAMPUSES UNDER CLERY



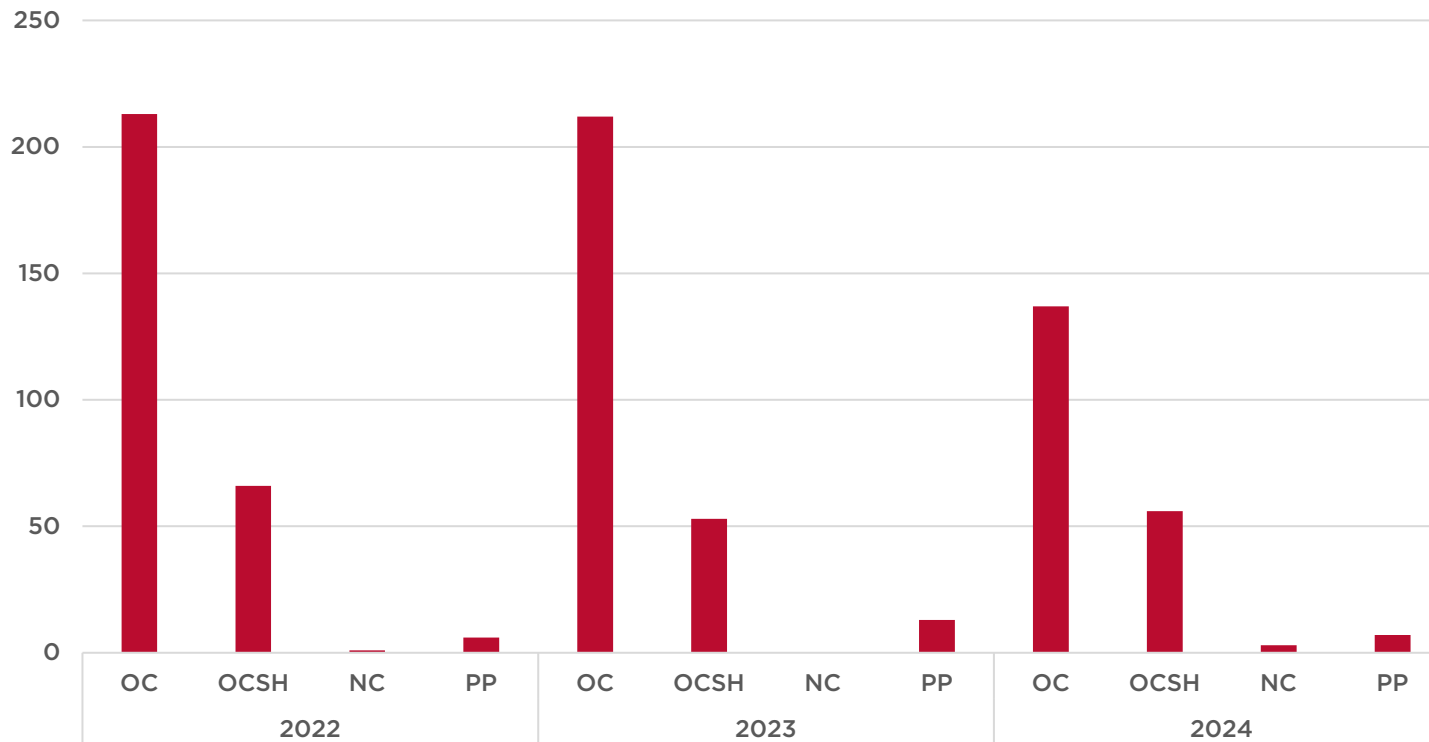
**HS Rio
Rancho**



MAIN

MAIN CAMPUS

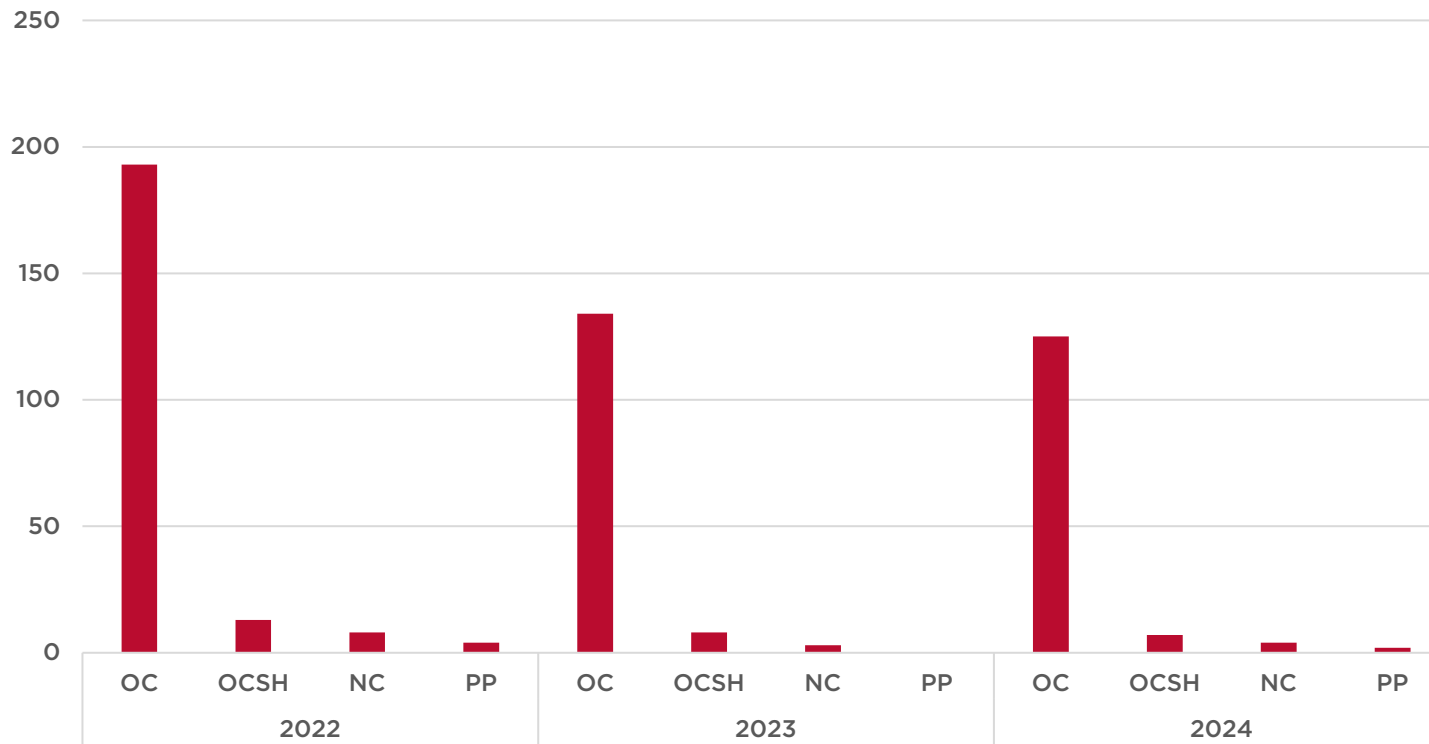
Crimes Against People, CY 2022-2024



- Murder/Non-negligent Manslaughter
- Manslaughter by Negligence
- Rape
- Fondling
- Incest
- Statutory Rape
- Robbery
- Aggravated Assault
- Domestic Violence
- Stalking
- Simple Assault (Hate Crime)
- Intimidation (Hate Crime)

MAIN CAMPUS

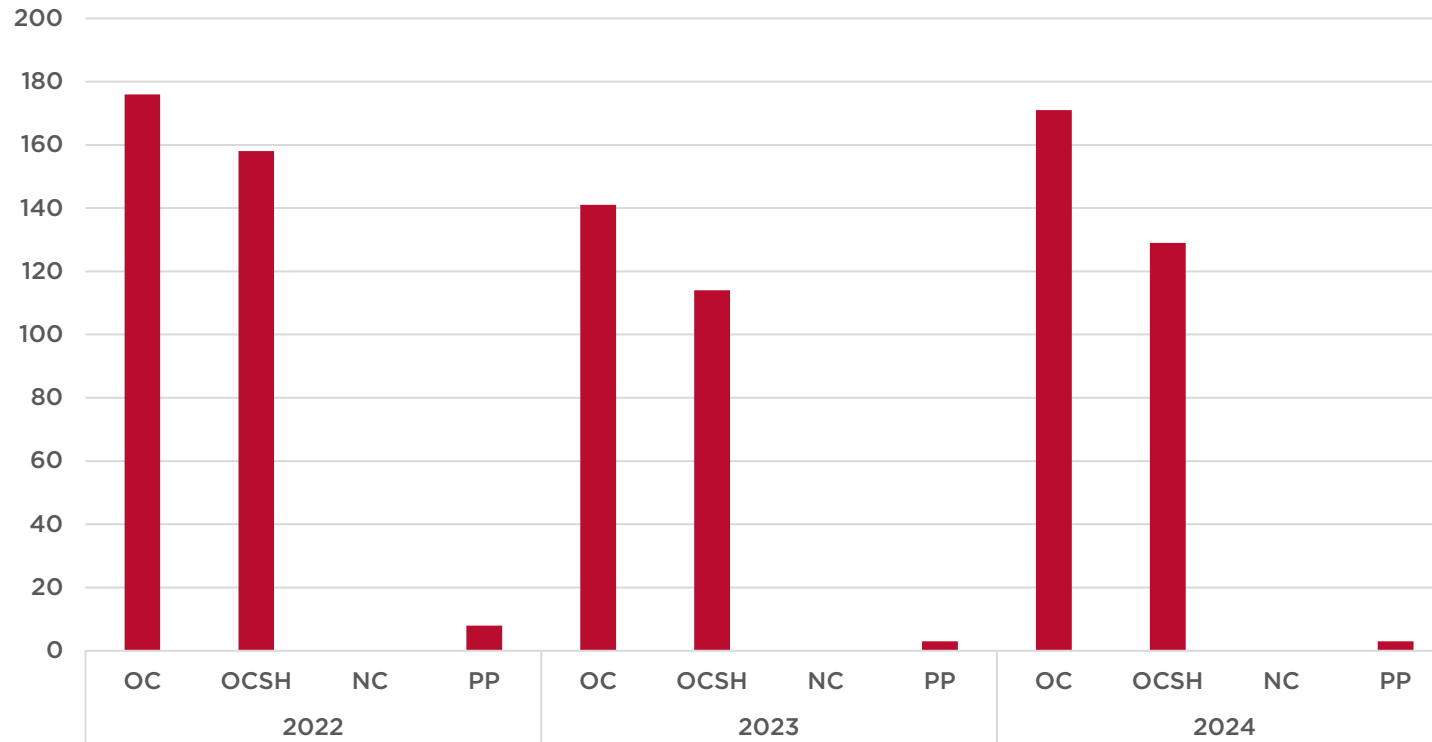
Crimes Against Property, CY 2022-2024



- Burglary
- Motor Vehicle Theft
- Arson
- Larceny-theft (Hate Crime)
- Destruction/Damage/Vandalism to Property (Hate Crime)

MAIN CAMPUS

Crimes Against Society, CY 2022-2024

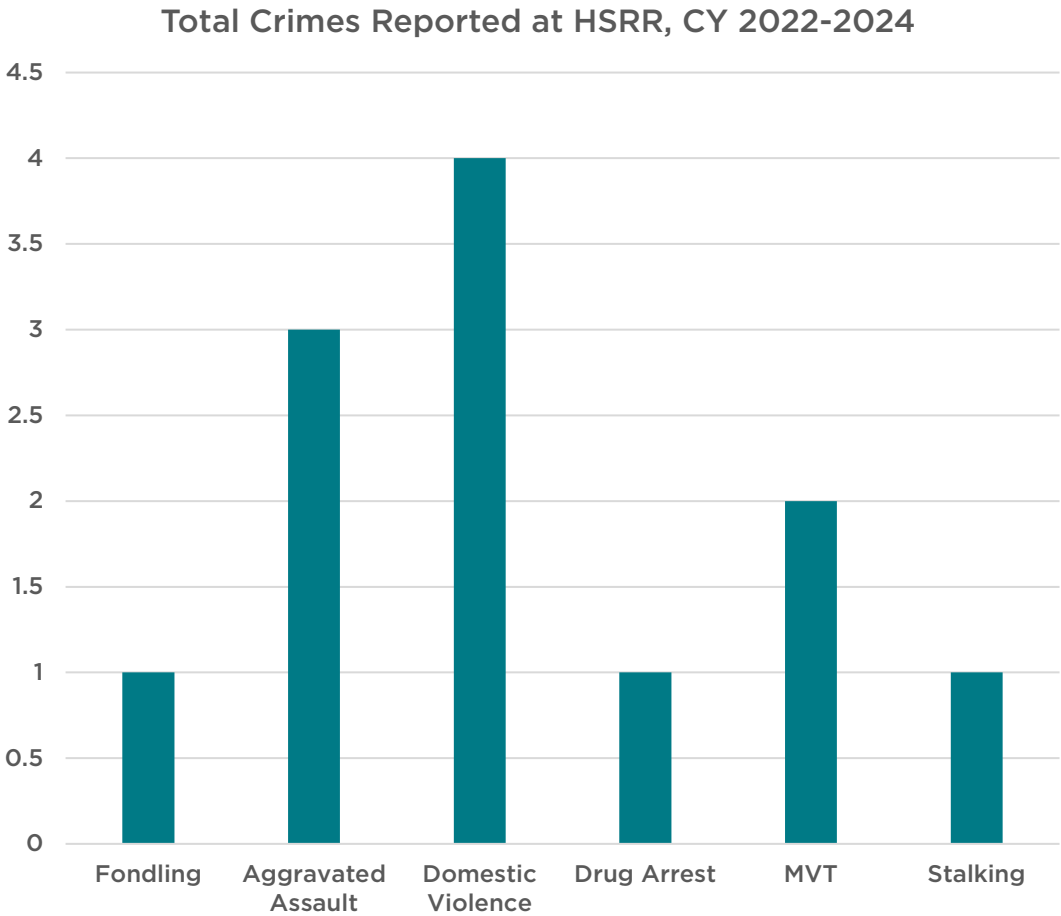


Arrests and Disciplinary Referrals

- Weapons Law Violations
- Drug Abuse Violations
- Liquor Law Violations

HEALTH SCIENCES RIO RANCHO

	On Campus	Public Property
2022	1 Domestic Violence	1 Domestic Violence
2023	1 Domestic Violence 1 Stalking 1 Motor Vehicle Theft	
2024	1 Domestic Violence 1 Fondling 3 Aggravated Assaults 1 Motor Vehicle Theft 1 Drug Arrest	





CAMPUS SAFETY WEEK SEPTEMBER 2025





CAMPUS SAFETY WEEK SEPTEMBER 2025



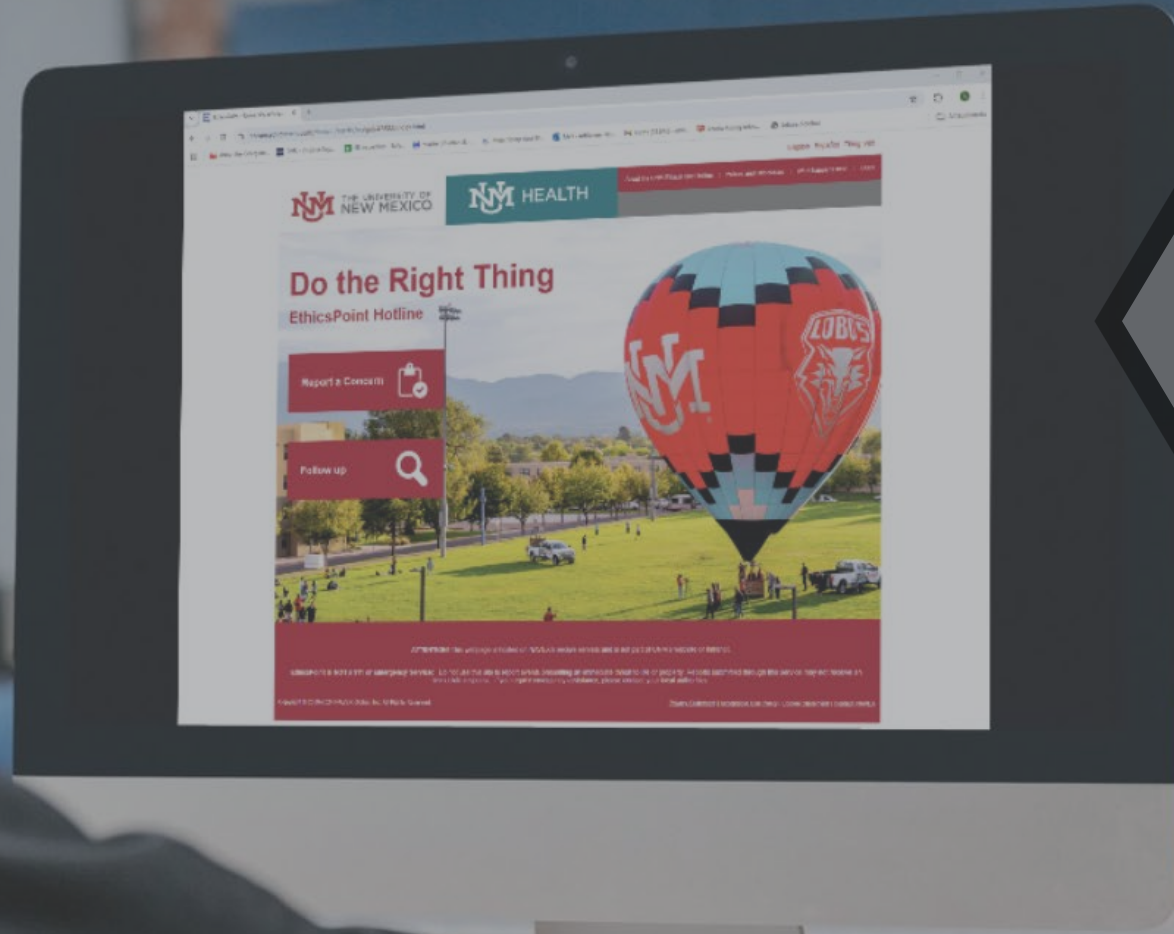
COMING SOON



QUESTIONS?



OFFICE OF
COMPLIANCE, ETHICS
& EQUAL OPPORTUNITY



Follow Up Report - Implemented
October 21, 2025 Open Session

No	Project Name	Report Approval Date, # of Recommendations, Risk (H/M/L)	Recommendation Title	Executive Recommendation	Management Response	Estimated Implementation Date	Recommendation Action	Responsible Party
1	<u>Office of the Medical Investigator (OMI)</u>	5/2/2024, 9, M	<u>Recommendation 5 - FDMI Scheduling and Dispatching</u>	The OMI Operations Director should strengthen scheduling procedures to ensure scheduling is a centralized process and work is performed by an appropriate designated OMI position. In addition, internal controls should be strengthened to ensure only FDMI personnel are responding to the scene. Written communication should be distributed to FDMI staff stating that non-affiliated UNM personnel should never be dispatched to the scene as an FDMI representative.	The Chief Medical Examiner will work with the Operations Director and the Field Investigations Supervisor to strengthen scheduling procedures, which are limited by lack of adequate quantity of field investigators to cover all counties; more specifically, the northeastern quadrant of the state lacks adequate coverage. The Chief Medical Examiner will work with the Operations Director and the FDMI Supervisor to provide written communication and a SOP to address that only FDMIs employed by the OMI will be dispatched to scenes.	5/1/2025	OMI has implemented scheduling policies and procedures for its FDMI staff in response to issues identified in the audit. OMI reports having implemented these procedures initially on a trial basis to test their effectiveness before proceeding to a full roll-out. OMI reports that scheduling procedures are working as intended. Recommendation appears to have been implemented.	Heather Jarrell, CME, OMI
2	<u>Office of the Medical Investigator (OMI)</u>	5/2/2024, 9, M	<u>Recommendation 6 - Indigent Burial Program and Personal Effects</u>	The OMI Chief Medical Examiner should work with the Board of Medical Investigators, which does have mortuary representation on the Board, to develop appropriate procedures addressing the delivery of personal effects of decedents buried under the indigent burial program.	The Chief Medical Examiner will work with UNM Legal Counsel to ensure that the plan for personal effects of unclaimed decedents released to the county operates within the confines of state law. The Chief Medical Examiner will work with the NM Association of Counties to communicate the plan for all counties, including the timeline for carrying out the plan.	6/1/2025	OMI has updated its policies on personal effects to address the identified audit condition. Recommendation appears to have been implemented.	Heather Jarrell, CME, OMI
3	<u>Non-Standard Payments (NSP)</u>	8/8/2024, 7, M	<u>Recommendation 1 - Non-Standard Payment Business Process Manual</u>	The Executive Vice President for Finance and Administration Office should develop and implement a comprehensive NSP business manual that outlines policies, specifically UAP policies 2000 and Faculty Handbook Policy 140. The manual should also provide guidance and requirements to departments, employment areas, and payroll personnel involved in processing each NSP type.	Human Resources and Health Sciences administration will partner with the employment areas (EA) to create a centralized repository for NSP processing standards utilizing the Employee Knowledge Base. The Employee Knowledge Base is an existing centralized repository for personnel action processing guides, including ePAF-based transactions. Each EA will be responsible for creating their processing guide, consistent with the applicable policies, to include documentation, approval standards, and systematic changes and process improvements identified through the process review referenced in Recommendation 2.	6/30/2025	Business manual has been developed and included in their internal website for employees to access.	Teresa Costantinidis, EVP Finance & Administration

Follow Up Report - Implemented
October 21, 2025 Open Session

No	Project Name	Report Approval Date, # of Recommendations, Risk (H/M/L)	Recommendation Title	Executive Recommendation	Management Response	Estimated Implementation Date	Recommendation Action	Responsible Party
4	<u>Non-Standard Payments (NSP)</u>	8/8/2024, 7, M	<u>Recommendation 3 - NSP Documentation</u>	Internal Controls surrounding documentation supporting NSPs should be strengthened. The Executive Vice President for Finance and Administration office should require completeness of supporting documents for all payments. In addition, documentation submitted with approved NSPs should be sufficient for the employment area reviewer and payroll to recalculate an NSP disbursement for accuracy.	Human Resources and Health Sciences administration will coordinate an effort with all applicable employment areas (EAs) to inform the EAs of the recommendations from the audit, actions needed to support the PMIO Lean process review, and to reinforce NSP documentation and approval requirements. The EAs will be responsible for reviewing and updating NSP processing documentation, including the standards for sufficient supporting documents. The EAs will be responsible for communicating these standards to their applicable departmental clients and leadership. Health Sciences administration will be responsible for identifying, documenting, and communicating documentation standards for clinical faculty payments.	Phase 1: 10/15/2024 Phase 2: 6/30/2025	Based on follow up testwork, Internal Audit believes that all audit recommendations have been implemented.	Teresa Costantinidis, EVP Finance & Administration
5	<u>Non-Standard Payments (NSP)</u>	8/8/2024, 7, M	<u>Recommendation 4 - Formally Documented Approvals</u>	Internal Controls surrounding NSP approvals should be strengthened. NSPs should not be processed unless documented approval is provided for the approved NSP amount. The Executive Vice President for Finance and Administration should submit formal communication to employment areas and Payroll indicating NSPs should not be processed without first verifying required approvals have been obtained.	Human Resources and Health Sciences administration will coordinate an effort with all applicable employment areas (EA)s to inform the EA of the recommendations from the audit, actions needed to support the PMIO lean process review, and to reinforce NSP documentation and approval requirements. The EAs will be responsible for reviewing and updating NSP processing documentation, including the requirement for documented approvals. The EAs will be responsible for communicating these standards to their applicable departmental clients and leadership. Health Sciences administration will be responsible for identifying, documenting, and communicating approval requirements for clinical faculty payments.	Phase 1: 10/15/2024 Phase 2: 6/30/2025	Departments have implemented affidavit requirements as well as ensured that all approvals are available for review by the Area of Employment (AOE) prior to AOE approval.	Teresa Costantinidis, EVP Finance & Administration

Follow Up Report - Implemented
October 21, 2025 Open Session

No	Project Name	Report Approval Date, # of Recommendations, Risk (H/M/L)	Recommendation Title	Executive Recommendation	Management Response	Estimated Implementation Date	Recommendation Action	Responsible Party
6	<u>Non-Standard Payments (NSP)</u>	8/8/2024, 7, M	<u>Recommendation 5 - Accuracy of Documentation and Account Coding</u>	Internal controls should be strengthened to ensure documentation is accurate and NSPs are recorded to the appropriate account coding. Departments should verify accurate information related to the disbursement is documented in the EPAF system prior to submitting an NSP to the area of employment for review. Area of employment reviewers should have access to all NSP supporting documentation to confirm accuracy of details of the NSP, such as: accurate end date, Job Code, and Organization Code.	Payroll will provide guidance to EAs as to the appropriate use of account and earn codes based on the type of payment and work performed. Human Resources and Health Sciences administration will coordinate an effort with all applicable EAs to inform the EA of the recommendations from the audit, actions needed to support the PMIO Lean process review, and to reinforce NSP documentation and data entry standards. The EAs will be responsible for reviewing and updating NSP processing documentation and standard operating procedures to reflect data entry standards and appropriate account code and earn code usage. The data entry standards will be identified through the PMIO Lean process review. The data entry standards will be documented in the centralized process repository identified in recommendation 1. The EAs will be responsible for documenting and communicating data entry standards to their applicable departmental clients and leadership.	Phase 1: 12/31/2024 Phase 2: 6/30/2025	Upon completion of follow up test work, IA confirms that issues related to accuracy of documentation and account coding requirements have been refined and addressed.	Teresa Costantinidis, EVP Finance & Administration
7	<u>Non-Standard Payments (NSP)</u>	8/8/2024, 7, M	<u>Recommendation 6 - Training for NSP Processing and Review Procedures</u>	The Executive Vice President for Finance and Administration should develop and implement a training curriculum for the NSP process. The training should focus on key elements for initiating, reviewing, and approving NSPs before being disbursed. Training curriculum should provide guidance to area of employment reviewers on the use of available Banner reports for reviewing details of NSP activity, including Index, Organization Code, Suffix, etc. In addition, training should also provide information on types of NSPs, completing required documentation to initiate an NSP, and review and approval requirements.	The Executive Vice President for Finance and Administration agrees with the recommendation to improve NSP training for department users and approvers. The Human Resources' Employee and Organizational Development (EOD) department will review and update current training required of end users prior to submission of the ePAF originator and approver BAR roles. The updated training will include reinforcement of the processing standards applicable across employment areas, including documentation and approval standards, and reference to the centralized repository for EA processing guidelines.	6/30/2025	IA confirms that NSP-specific training has been implemented and included in Learning Central.	Teresa Costantinidis, EVP Finance & Administration

Follow Up Report - Implemented
October 21, 2025 Open Session

No	Project Name	Report Approval Date, # of Recommendations, Risk (H/M/L)	Recommendation Title	Executive Recommendation	Management Response	Estimated Implementation Date	Recommendation Action	Responsible Party
8	<u>Audit of the Dissolution of the ASMF</u>	5/20/2025, 2, M	<u>Recommendation 1A - Maintenance of Accounting Records</u>	The ASM Dean's Office should: 1. Enforce established document management processes to ensure that all ASM business activity and records that impact ASM are always obtained and maintained. Supporting documents should be readily available and support business transactions that have occurred. 2. Develop SOPs that address the absence of key employees and turnover for key business processes.	1. Under the supervision of the Academic Operations Officer, ASM is already in the process of creating a document management system and SOPs for redundancy of key ASM personnel and record keeping that impacts ASM and enforcing document management processes. We plan to complete this work by the target date indicated above. 2. ASM Dean's Office is also ready to support the Provost's Office as needed in order to facilitate the completion of the Provost's Office response to the audit recommendations.	6/30/2025	ASM has created a shared file system with different access rights with permissions to house a number of different folders that relate to different functional areas of Anderson. In addition, ASM has created several new SOPs to address the absence of key employees and turnover for key business processes.	Alina Chircu, Dean: ASM Administration
9	<u>Audit of the Dissolution of the ASMF</u>	5/20/2025, 2, M	<u>Recommendation 1B - Verification of ASMF's Ending Balance for Transfer</u>	The Provost's Office should: 1. Review and complete an assessment of the current balances of the funds transferred during the ASMF dissolution, specifically related to the endowed scholarship and development funds. At the completion of the assessment, the Provost's Office can determine if s reallocation process is necessary for meeting ASM scholarship needs. 2. Utilize resources, including but not limited to engaging with an external CPA firm to conduct an external close-out audit for FY22, which was during the year of ASMF dissolution. The external audit should provide reasonable assurance that all financial activity during FY22 and during the dissolution of the ASM Foundation is accurate.	1. We reviewed the current balances, including endowed scholarship and development funds, to ensure alignment with ASM's scholarship needs and any donor intent that may have existed prior to the dissolution. Based on this review, we concluded that the allocation of \$640,359 to the Dean's Development Fund, representing 20% of the initial ASMF transfer, is appropriate given ASM's size and the scope of fundraising and development activities typical of a business school. 2. The Provost's Office fiscal team will conduct an internal close-out audit for FY22 and will provide documentation demonstrating reasonable assurance that financial activity during that fiscal year, including activity related to the dissolution of the ASM Foundation, is accurate.	7/31/2025	Provost Office performed their review and assessment and was able to make a reasonable determination that expenditures and transactions during FY22 were accurate and within the normal scope of activity for an organization such as ASMF as well as confirm with reasonable assurance that the financial activity for FY22, including transactions related to the dissolution of the ASM Foundation are accurate.	Barbara Rodriguez, Interim Provost/Exec VP; Nicole Dopson, AVP for Academic Resources Mgt

Follow Up Report - Pending
October 21, 2025 Open Session

No	Project Name	Report Approval Date, # of Recommendations, Risk (H/M/L)	Recommendation Title	Executive Recommendation	Management Response	Estimated Implementation Date	Last Status Update	Responsible Party
1	<u>Project ECHO</u>	8/3/2023, 8, M	<u>Recommendation 2 - Timely Perform Effort Certification</u>	Internal controls should be strengthened to ensure effort certification is completed by the due date. The Project ECHO Director should assign the pre-reviewer role to individuals more directly tied to the project, possibly the employee, and/or perform interim effort reviews, to allow for faster turnaround of the full six-month period effort certification.	Contracts and Grants are rolling out a new system and Project ECHO will be Beta Testing for them. The system will use the close of each fund to certify effort. The PI will have access to all employee efforts for the fund at the time of the closeout. The completion time for Effort Certification will be in compliance with the deadline set by HSC.	12/31/2026	Management indicated an extension is needed. The extension of the estimated implementation date to December 31, 2026 was approved.	Karla Thornton, Clinician Ed - Professor: IM Infectious Disease; Lynn Waln, Chief Adm Ofcr/Project ECHO
2	<u>Office of the Medical Investigator (OMI)</u>	5/2/2024, 9, M	<u>Recommendation 3 - Non-Exempt Time Keeping and Reporting</u>	The Health Sciences Senior Executive Officer for Finance and Administration should work with UNM Senior Vice President for Finance and Administration to identify and implement an electronic time reporting system for OMI. Electronic time keeping would allow employees and supervisors to capture non-exempt time via a virtual time clock as well as employee and supervisor approvals before being uploaded directly into Banner for processing.	UNM, including Health Sciences, is in the process of executing a contract for a cloud-based time management system that will significantly address the challenges associated with the diverse geographical locations for the various OMI team members. The system will also provide robust reporting that will support administrative oversight to ensure accurate time entry. The expected implementation timeline is 12-18 months for the system to be fully operational. In the meantime, UNM HSC HR, will work with the director to provide intermediary steps until the time that implementation occurs.	12/31/2025	HSC VP for Finance and Administration indicates OMI's employees will be included as part of the group that will be included in the rollout of the new time keeping solution, expected to be implemented in November 2025. Internal Audit received and has approved an extension on implementation date to December 31, 2025.	Rebecca Napier, HS VP for Fin and Adm
3	<u>Office of the Medical Investigator (OMI)</u>	5/2/2024, 9, M	<u>Recommendation 4 - Adequate Employee Supervision AND Field Deputy Medical Investigators (FDMI) Job Description</u>	The OMI Chief Medical Examiner should: Work with the EVP for Health Sciences office to secure adequate financial resources to add supervisor positions that address current Supervisor-to-FDMI ratios and lack of oversight. Restructure FDMI County FDMI reporting and communication to Albuquerque headquarters for adequate oversight for day to day operations. Conduct a review of its employee activity and determine if these employees should be reclassified into more appropriate job titles/position codes. Ensure that OMI employees with an FDMI job assignment physically reside within the State of New Mexico.	The Chief Medical Examiner will work with HSC leadership to secure funding for the FDMI supervisor positions. Reorganization structure has been designed for these positions and is pending funding. The Chief Medical Examiner will work with OMI Operations Director and OMI HR Administrator to review employee duties to determine if job reclassification should be recommended. Additionally, the OMI Operations Director and the HR administrator will work with the FDMI Supervisor to verify that FDMIs reside within New Mexico and work primarily in their county of residence.	7/1/2026	OMI has hired two FDMI shift supervisors whom have been assigned responsibility over half the state. OMI continues to work to secure funding to hire additional FDMI shift supervisors with the goal of each supervisor having oversight over one quadrant of the state.	Heather Jarrell, CME, OMI

Follow Up Report - Pending
October 21, 2025 Open Session

No	Project Name	Report Approval Date, # of Recommendations, Risk (H/M/L)	Recommendation Title	Executive Recommendation	Management Response	Estimated Implementation Date	Last Status Update	Responsible Party
4	<u>Office of the Medical Investigator (OMI)</u>	5/2/2024, 9, M	<u>Recommendation 7 - Monitoring Contractor Performance</u>	The Chief Medical Examiner should develop and implement a periodic Performance Audit Program for its decedent transportation vendors and contractors. Elements of a vendor monitoring and performance audit program should include, but not be limited to: Review of the contractor's employee policies and procedures as they relate to those employees that will be providing services to/for OMI. Review of vendor's performance obligations. Annual review of billed mileage.	The Chief Medical Examiner will work with OMI Accounting and the Operations Director to develop a plan to internally audit decedent transportation vendors on a periodic, scheduled basis.	7/1/2026	OMI Management has requested, and was granted, an extension from Internal Audit on the implementation deadline to July 1, 2026.	Heather Jarrell, CME, OMI
5	<u>Non-Standard Payments (NSP)</u>	8/8/2024, 7, M	<u>Recommendation 2 - System for Non-Standard Payment Process</u>	The Executive Vice President for Finance and Administration office should develop and implement a system for the processing and approval of NSP disbursements. The system should provide a centralized location with the ability to upload and house supporting documents. In addition, the system will strengthen internal controls by improving the review and approval process for NSPs disbursed throughout the University. An implemented system may also perform edit checks and other automated functions.	Human Resources and Health Sciences administration will partner with the employment areas (EA) to engage the Project Management and Improvement Office (PMIO) to conduct Lean methodology-based process reviews to document NSP processing standards across employment areas and identify areas for process improvements, including utilizing available technology solutions. While the responsible parties agree that technology solutions are needed to improve NSP processing, they are committed to implementing process improvements using currently available systems (ex. Banner, ePAF, document management systems, financial reconciliation processes). Upon completion of the PMIO facilitated process review, the responsible parties will have identified and implemented the appropriate technology solutions and data entry standards for NSPs across all applicable employment areas.	6/30/2025	System of tracking NSP has been documented and implemented at their website; however, we are currently waiting to review their NSP reconciliation process.	Teresa Costantinidis, EVP Finance & Administration

Follow Up Report - Pending
October 21, 2025 Open Session

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6	<u>Audit of the Dissolution of the ASMF</u>	5/20/2025, 2, M	<u>Recommendation 2 - Non-Compliance with Donor Intent</u>	ASM should ensure gift/endowed spending (and all disbursements) are allowed, supported by appropriate documentation, and reviewed in accordance with donor agreement and UNM's policies, where applicable, for accuracy and compliance. The ASM Dean's Office should: 1. Strengthen controls and processes related to understanding compliance related to donor intent for all endowments, 2. Establish processes to complete periodic reviews for endowed agreements, 3. Review all endowments for unallowable costs due to spending endowed funds not in compliance with donor intent, 4. Complete an internal review for remaining scholarships awarded, 5. Strengthen the scholarship distribution process.	Anderson leadership and UNMF development officers for ASM will work together to review all spending in UNMF spending indexes established for ASM (from endowed and spendable gifts) for FY24 through December 31, 2024. FY25. The review of the remaining indexes will be completed by the target date. ASM will correct known errors and reverse unallowed costs with correcting journal entries. ASM will ensure that our internal review for remaining scholarships awarded under the same scholarship requirements is complete, analyze these expenses to determine if they are charged to the correct fund, and reverse unallowed costs. ASM will complete an additional internal review of these updated processes and make necessary adjustments to ensure compliance for all scholarships yearly, analyzing expenses to confirm proper fund allocation, and strengthening the scholarship distribution process.	12/31/2025	Corrective Action not yet due.	Alina Chircu, Dean: ASM Administration
7	<u>University-Wide International Travel</u>	8/19/2025, 2, M	<u>Recommendation 1 - Strengthening Internal Controls on International Travel</u>	The University Controller could strengthen internal controls over international travel by working with the appropriate offices to review, revise, and develop additional training materials and/or communications to educate relevant faculty and staff on the need to obtain the appropriate pre-approval of all University-related travel. Additionally, ensuring warnings regarding the need to have domestic or international travel pre-approved by a person with authority over the traveler are configured in current and future University-used ERP systems or interfaces, referencing appropriate UAPs as statutory guidance as well as ensuring all required pre-approvals have been appropriately uploaded and are available for review.	Pre-approval of travel is a process that occurs at the department level in advance of a trip, and not an officially required process for core accounting office review under UNM Travel Policy. Travel Policy is clear with respect to pre-approvals of foreign travel in that written pre-approval is only required on certain Contract & Grant/restricted awards, not on foreign travel paid with unrestricted funds. Of the 67 sample items tested, Internal Audit found 2 instances of foreign travel where written pre-approval was not attached to the reimbursement report. In both cases, however, written pre-approval was not required under policy since the travel was not charged to Contract & Grant/restricted awards. In both cases, pre-approval was handled at the department level, just not attached to the reimbursement report – in full compliance with UNM Travel Policy.	10/1/2026	Corrective Action not yet due.	Bruce Cherrin, Int University Controller

Follow Up Report - Pending
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8	<u>University-Wide International Travel</u>	8/19/2025, 2, M	<u>Recommendation 2 - Development of International Travel Registry</u>	The University Controller should work with the UNM Travel Group and other relevant campus stakeholders (such as the UNM Provost and/or Executive Vice President, Health Sciences) on the development of an international travel registry which provides executive leadership with actionable data pertaining to the travelers in keeping with policy 4030 and duty of care considerations.	We propose to revise travel policy 4030 to proscribe [ed: create] a method by which travelers will be required to register their pre-approved international travel. We will form a working group to evaluate viable methods to gather and warehouse this data for rapid access to executive leadership as needed.	10/1/2026	Corrective Action not yet due.	Bruce Cherrin, Int University Controller

MEETING ADJOURNMENT