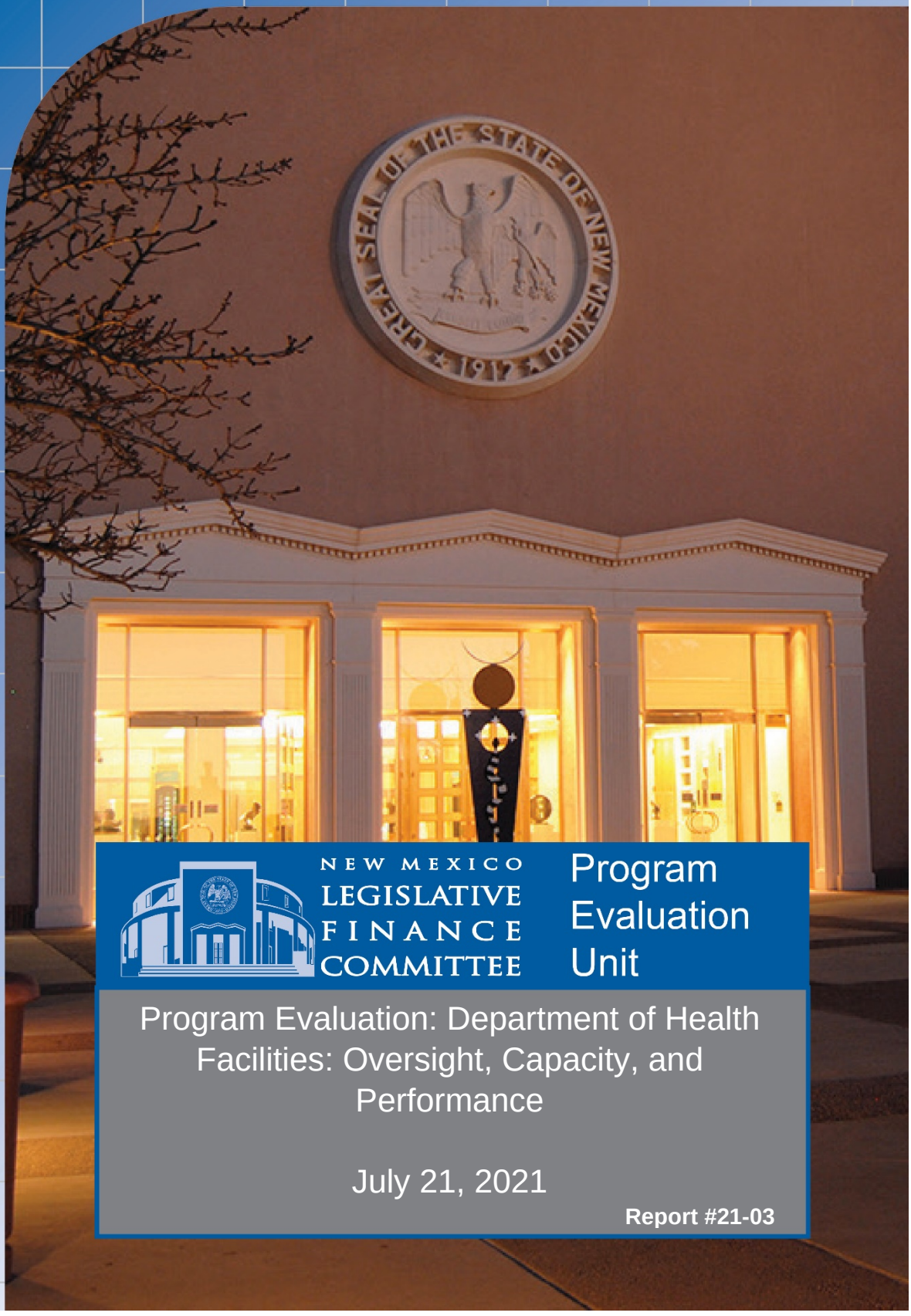

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Program
Evaluation
Unit

Program Evaluation: Department of Health Facilities: Oversight, Capacity, and Performance

July 21, 2021

Report #21-03

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David Abbey
Director

July 21, 2021

Dr. Tracie Collins, Secretary
Dr. David Scrase, Secretary-Designate
New Mexico Department of Health
1190 St. Francis Dr.
Santa Fe, NM 87505

Dear Secretary Collins and Secretary-Designate Scrase:

The Legislative Finance Committee (LFC) is pleased to transmit the evaluation, *Department of Health Facilities: Oversight, Capacity, and Performance.* The program evaluation examined operational, capital, and clinical issues and outcomes of DOH's seven health facilities. An exit conference was held with your staff on July 14, 2021 to discuss the contents of the report.

The report will be presented to the LFC on July 21, 2021. LFC would like plans to address the recommendations within this report from the Department of Health within 30 days of the hearing.

I believe this report addresses issues the LFC asked us to review and hope your department will benefit from our efforts. We very much appreciate the cooperation and assistance we received from you and your staff.

Sincerely,

David Abbey, Director

Cc: Representative Patricia A. Lundstrom, Chair, Legislative Finance Committee
Senator George K. Muñoz, Vice-Chair, Legislative Finance Committee
Mr. Matthew Garcia, Chief of Staff, Office of the Governor
Ms. Deborah Romero, Cabinet Secretary, Department of Finance and Administration
Mr. Brian S. Colón, State Auditor, Office of the State Auditor

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Department of Health Facilities: Oversight, Capacity, and Performance

July 2021 Program Evaluation

Quality and Operational Issues at DOH Facilities Require Stronger Oversight

The Department of Health's (DOH) seven facilities face chronic issues with underutilization, staffing shortages, fiscal management, and facility conditions, resulting in substantial costs to the state and risks to the health and safety of individuals in their care. These facilities provide an important array of behavioral health, substance abuse treatment, and long-term and supportive care services to some of New Mexico's most vulnerable populations.

Improved governance and oversight is needed to ensure facilities are used to their full potential and reach the populations they are intended to serve in a safe and efficient manner. A unified system of care, with strong and effective planning, oversight, and use of data to drive performance can strengthen the use of these facilities and the services they offer, but DOH faces challenging capital and operations decisions for its high-cost but underused facilities.

Evaluation Objectives:

1. Review financial management of DOH facilities, including revenue management and spending on staff and contractual services.
2. Assess DOH facility capacity, utilization, conditions, and staffing, and their impact on quality of care.
3. Review patient outcomes.

Key Findings

DOH lacks strong, dedicated leadership over facilities, affecting its ability to respond to deficiencies and address critical patient needs. DOH is currently without a dedicated deputy secretary for facilities and went over three years without a director of facilities management, and the DOH facilities governing board lacks independence and performs limited oversight of quality of care.

Inadequate oversight likely contributed to the higher rate of deficiencies causing actual harm to residents in DOH long-term care facilities since 2015 – 9 percent compared with 8 percent statewide. It was also likely a factor in the high Covid-19 infection and death rates among residents of the New Mexico State Veterans' Home, as well as significant construction issues there. Multiple independent reviews found failure to follow proper infection control and personal protective equipment (PPE) procedures despite early guidance from DOH to do so. Additionally, a pattern of deficiencies has cost NMVH over $180 thousand in federal penalties since 2015. Significant construction and maintenance issues at both the old and new buildings on the NMVH campus have left two therapy pools and multiple residential wings nonoperational.

Along these lines, failure to plan for the long term has led to underutilization, growing costs, and inefficiencies across many DOH facilities. Underutilization of facilities worsened under the Covid-19 pandemic, costing facilities as much as $41 million to keep unoccupied beds open in FY20, along with causing a 10 percent rise in total cost per occupied bed. DOH also lacks a comprehensive facilities master plan to address inefficiencies, and lacks a comprehensive strategy to address workforce needs.

Without a comprehensive approach to managing facilities as a unified system, individual facilities drive their own budgets with limited oversight from the department, and projections tend to overestimate revenues. Facilities largely conduct billing on their own, and are also individually responsible for seeking ways to improve revenues. Additionally, DOH facilities lack a standardized system to track and report operational performance in real time, instead relying on a variety of siloed tools at the facility level making oversight and planning at the agency level difficult.

Key Recommendations

The Legislature should consider

- Establishing a chief executive officer of facilities at the deputy secretary level accountable to the secretary of Health and the DOH facilities governing board;
- Formally establishing the DOH facilities governing board in statute, with voting membership independent of facility administration and with clear authority to review quality metrics, clinical outcomes, finances, and management performance; and
- Funding the state share of construction of a replacement for the original building at the New Mexico State Veterans' Home.

The Department of Health facilities governing board should

- Update its bylaws to establish standing committees on quality and safety, finance, and strategic planning.

The Department of Health should

- Take immediate action following reccomendations of infection control specialists to ensure staff follow best practices regarding use of PPE, including staff education, refresher training, rounding, real-time coaching, and random auditing;
- Develop a systemwide facilities master plan that includes a needs assessment for all facility services currently offered, including options for replacing the Veterans' Home with federal support from the VA and consolidating substance abuse treatment centers;
- At the departmental rather than facility level, develop a comprehensive strategy to recruit for and retain the highest-need positions, including
    - Establishing partnerships with New Mexico nursing schools for nurse internships and with community colleges, technical and vocational training programs, and high schools for nursing aides, psychiatric technicians, and other needed clinical support personnel; and
    - Developing a central pool of cross-trained traveling clinical staff, including nurses, technicians, and other needed providers, to be deployed strategically and as needed to fill staffing vacancies;
- Similar to current practice used by the Human Services Department for Medicaid projections, report at least quarterly to LFC and DFA on projected revenues and expenditures for each facility, including rationales for projected census, staffing and allowances for uncollected revenue and unanticipated expenses;

- Reorganize responsibilities and workflow of the department's Administrative Services Division and facilities program to centralize certain financial and billing operations, oversight, and planning;
- Assess critical data needs for management of facilities as a unified enterprise and develop a plan for integrating key operational metrics (including daily census, staffing, revenues and expenditures) with clinical data (electronic health records and clinical outcomes), including integration with the HHS 2020/Medicaid management information system replacement project. Subsequently DOH should request funding for such a system from the New Mexico Legislature; and
- Facilitate work groups across all DOH facilities to share institutional knowledge and implement best practices.

DOH Facilities Provide Safety Net Services for Vulnerable Populations

The Department of Health (DOH) operates seven facilities around the state providing an array of behavioral health, rehabilitation, and long-term care services to some of New Mexico's most vulnerable populations. Equipped with 937 licensed beds, these facilities served an average of 561 patients per day through the first three quarters of FY21 and collectively employed over 1,400 state employees as of June 2021.

Table 1. Overview of DOH Facilities

Facility	Location	Services Provided	Licensed or Total Beds*	Operational Beds (June 2021)*	Avg. Daily Census (FY21 Q1-Q3)	State Employees (June 2021)*	FY21 Adjusted Budget ($000s)	FY20 Avg. Cost per Occ. Bed ($000s)
Fort Bayard Medical Center (FBMC)	Santa Clara	Long-term intermediate and skilled nursing care	200	180	117	271	$29,634.5	$210.6
Los Lunas Community Program (LLCP)	Los Lunas	Supportive living employment and intermediate care for individuals with developmental disabilities	72*	72	61	224	$17,753.1	$294.1
New Mexico Behavioral Health Institute (NMBHI)	Las Vegas	Inpatient psychiatric care for adults, adolescents, and court-ordered individuals; long-term nursing care	401	304	230	563	$59,189.1	$230.0
New Mexico Rehabilitation Center (NMRC)	Roswell	Inpatient medical rehabilitation and substance abuse rehabilitation services; intensive outpatient treatment program	43	28	22	75	$8,060.1	$359.8
New Mexico State Veterans' Home (NMVH)	Truth or Consequences	Long-term nursing care for honorably discharged military veterans, their spouses, and gold star families	145	142	104	136	$17,937.0	$159.2
Sequoyah Adolescent Treatment Center (SATC)	Albuquerque	Residential treatment for adolescent males age 13-17 who have a history of violence a mental health disorder, and are amenable to treatment	36	18	13	73	$7,156.1	$332.2
Turquoise Lodge Hospital (TLH)	Albuquerque	Inpatient detox and substance abuse treatment services; intensive outpatient program	40	20	14	61	$7,817.9	$321.2

*Notes: Licensed beds refers to the maximum number of beds each facility is approved to operate under its operating licenses and certifications. LLCP has 4 licensed beds in its intermediate care facility; home-based services for individuals with developmental disabilities are not licensed health facilities. Operational beds refers to the number of beds each facility is capable of operating under current staffing and facility conditions. State employees do not include contract staff.

Source: DOH, LFC analysis of SHARE and SPO data

Appropriations for the operation of DOH facilities have grown 10 percent since FY16, despite a 10-percent decline in patient numbers. The Legislature appropriated $151.8 million to DOH's Facilities Management Program in FY21, 11 percent above FY15 and 5 percent above FY20 levels. The most recent increase is due to higher expected expenditures for personnel in light of raises implemented starting in FY19. Personnel costs account for the largest portion of DOH facility operating costs, and spending for this purpose totaled $111.8 million in FY20, but is expected to decrease to $106.2 million for FY21 due to pandemic-related staffing and capacity issues.

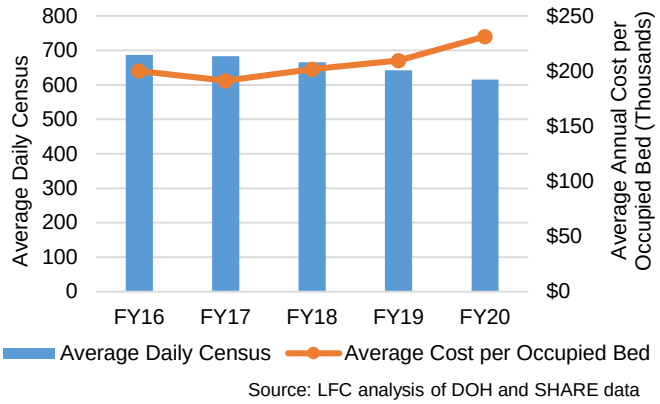
Table 2. Appropriations for DOH Facilities Management Program, FY16-FY20
(In thousands. Includes NM Veterans' Home in FY18-FY19 Under Veterans' Services Department)

Budget	FY16	FY17	FY18	FY19	FY20	FY21	FY16-FY21 Change
General Fund	$60,429.1	$60,050.7	$58,144.8	$58,494.8	$61,914.9	$62,327.7	3.1%
Other State Funds	$76,560.5	$79,771.1	$72,159.6	$71,178.1	$70,186.6	$75,441.7	-1.5%
Interagency Transfers	$716.0	$714.0	$1,118.2	$1,182.0	$4,431.8	$4,005.8	459.5%
Federal Funds	-	-	$7,345.5	$9,271.0	$8,106.7	$10,022.6	-
Total Sources	**$137,705.6**	**$140,535.8**	**$138,768.1**	**$140,125.9**	**$144,640.0**	**$151,797.8**	**10.2%**
Expenditures							
Personal Services and Employee Benefits	$104,063.3	$104,753.8	$101,970.9	$103,480.7	$102,402.0	$111,825.5	7.5%
Contractual Services	$10,679.0	$12,628.3	$12,958.6	$13,384.4	$14,712.0	$12,809.8	20.0%
Other	$22,963.3	$23,153.7	$23,838.6	$23,260.8	$27,526.0	$27,162.5	18.3%
Total Uses	**$137,705.6**	**$140,535.8**	**$138,768.1**	**$140,125.9**	**$144,640.0**	**$151,797.8**	**10.2%**

Source: LFC files, SHARE

The average daily census of patients residing or receiving treatment in DOH facilities decreased by 10 percent between FY16 and FY20, from 687 to 615. This resulted in the average annual cost per occupied bed increasing by 16 percent during this period, from $200 thousand to $231 thousand.

Chart 1. Average Daily Census and Cost per Occupied Bed, All Facilities FY16-FY20



Source: LFC analysis of DOH and SHARE data

Despite budget growth, DOH facilities have an ongoing pattern of requesting special and supplemental appropriations. The Legislature has approved $11.8 million in special, supplemental, and deficiency appropriations since the LFC's last evaluation of DOH facilities in 2015, including the period in FY18 and FY19 when NMVH was under the control of the Veterans' Services Department. Largely, these appropriations have been intended to cover shortfalls in personnel costs, but also included a $500 thousand feasibility study in FY19.

Table 3. Special, Supplemental, and Deficiency Appropriations for DOH Facilities Since FY16

Fiscal Year(s)	Appropriation Type	Source	Amount (thousands)	Purpose
FY17	Supplemental/Deficiency	General Fund	$375.0	For a shortfall in the Facilities Management Program.
FY18	Supplemental/Deficiency	General Fund	$375.0	For a projected shortfall in the Facilities Management Program.
FY18	Supplemental/Deficiency	General Fund	$300.0	For start-up costs in the memory care unit of the Veterans' Home hospital opening in 2018.
FY19	Supplemental/Deficiency	General Fund	$2,753.0	For a shortfall at the New Mexico Veterans' Home.
FY19-FY20	Special	General Fund	$500.0	To provide economic feasibility and master planning assessments for five Department of Health hospitals and the Veterans' Home in Truth or Consequences.
FY20	Supplemental/Deficiency	General Fund	$2,000.0	For personal services and employee benefits costs in the Facilities Management Program.
FY20-FY21	Special	General Fund	$5,451.2	For past and projected shortfalls in the personal services and employee benefit costs category in the facilities management program for the New Mexico Veterans' Home.
	Total		**$11,754.2**	

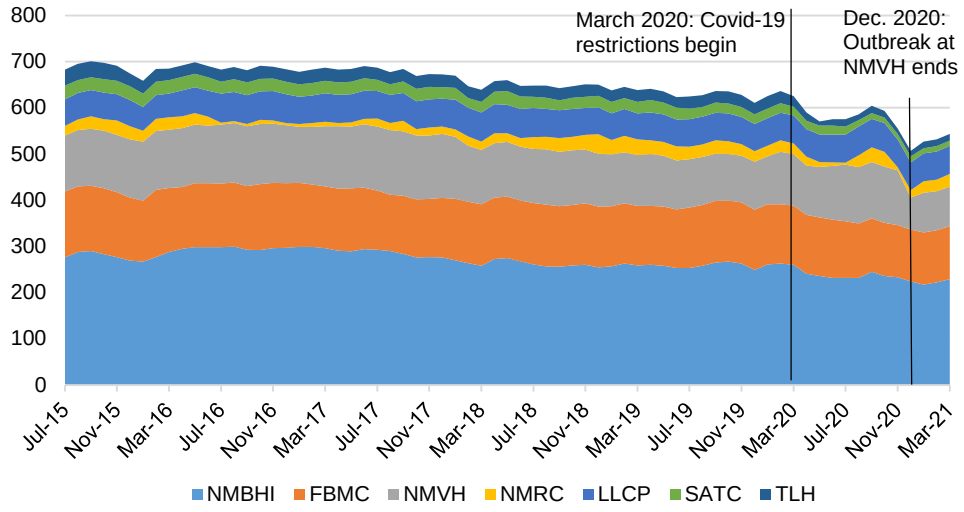
Source: LFC Files, General Appropriation Acts

DOH's average patient census was declining consistently even before the disruptions of the Covid-19 pandemic. The five-year high for average daily census in all DOH facilities occurred in September 2015, with 701 occupied beds. Since then, total census gradually declined across the system even before the Covid-19 pandemic, to 636 in February 2020. Pandemic restrictions contributed to reduced staffing and capacity in several facilities and 28 deaths at the New Mexico State Veterans' Home. Total census in all facilities reached a low of 507 in December 2020, before increasing again to 543 by March 2021. This equates to 71 percent of operational beds and 58 percent of licensed beds occupied.

Licensed beds: The maximum number of beds each facility is approved to operate under its operating licenses and certifications.

Operational beds: The number of beds each facility is capable of operating under current staffing and facility conditions.

Chart 2. Average Daily Census by Facility, FY16-Present



Source: DOH

Prior to FY06, facilities operated largely without central DOH oversight. Before FY02, facilities received appropriations individually in the General Appropriation Act (GAA). Beginning with the 2001 GAA, for FY02, appropriations were consolidated in DOH programs for behavioral health services and long-term care, and starting in FY06, all facilities were placed under a single Facilities Management Program upon the creation of the Office of Facilities Management and deputy secretary for facilities.

Past LFC evaluations found difficulties controlling expenses, staffing shortages, and quality deficiencies.

LFC staff conducted evaluations of DOH facilities in 2007, 2009, and 2015, and produced a 2013 progress report and a 2016 memo on issues at Fort Bayard Medical Center. These evaluations have reported similar findings, indicating persistent problems and substantial impediments to resolving them.

The 2007 evaluation found high turnover and vacancy rates across facilities, a finding repeated in 2009 and 2015. The 2007 evaluation also noted a lack of strategic planning, which was also repeated in 2015. Other repeat findings include deficiencies in financial management and oversight, including inadequate revenue projections and inconsistent billing practices, and insufficient collaboration with the Behavioral Health Services Division (BHSD) of the Human Services Department and other agencies. Finally, the 2009 and 2015 evaluations noted the need to implement evidence-based practices in the state's nursing homes and substance abuse treatment facilities.

Purpose of this evaluation.

DOH has historically faced challenges with staffing, third-party revenue collection, managing spending, and undesirable outcomes at the seven facilities it operates throughout the state. Past LFC evaluations have found difficulties recruiting and retaining direct care staff, leading to a reliance on contract providers, overestimating revenues and challenges with billing and collecting non-general fund sources, and a variety of health and safety concerns in official inspections, including recent Covid-19 outbreaks. While the Legislature has taken certain actions to address these concerns, including providing a significant pay raise for nurses and reviewing ongoing performance and fiscal issues, opportunities to take advantage of recent changes, such as Medicaid expansion in certain cases, merit an updated review of DOH facilities

Lack of Dedicated Leadership Over Facilities Hinders Responsiveness to Deficiencies

In authorizing funding for DOH's facilities management program, the Legislature consistently specifies its purpose is to provide oversight of the array of facilities it operates. The General Appropriation Act further includes performance measures establishing targets for certain indicators of clinical quality, including falls, medication errors, and pressure injuries for individuals in long-term care.

Since FY06, DOH has operated all its facilities under a single program budget, but its governance structure does not incorporate regular, formalized quality review. Meanwhile, leadership vacancies have not enabled the department to develop a consistent strategy to improve performance.

Roughly 9 percent of deficiencies in DOH long-term care facilities since 2015 found actual harm or immediate jeopardy, compared with 8 percent statewide.

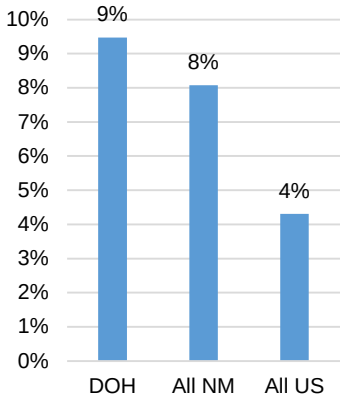
The Department of Health, on behalf of the federal Centers for Medicare and Medicaid Services (CMS), evaluates DOH facilities for licensing purposes and notes when a facility is not up to standards for resident care, medications, maintenance, infection control, or fire safety. Each deficiency observed is given a code based on its scope (from isolated to widespread) and severity (from minimal harm to immediate jeopardy). While all facilities must be licensed, only inspection surveys of long-term care facilities – in this case, Fort Bayard Medical Center (FBMC), the New Mexico State Veterans' Home (NMVH), and the Meadows long-term care facility at the New Mexico Behavioral Health Institute (NMBHI) – categorize deficiency findings based on scope and severity (see Appendix C).

The distribution in Chart 4 reveals the majority of these deficiencies (88 percent) found between 2015 and 2021 had the potential to cause moderate harm to patients receiving care at these facilities. Nine percent of identified deficiencies caused at least some actual harm, including 8 percent that caused immediate jeopardy to resident health or safety. This compares with 8 percent of deficiencies involving actual harm at all nursing facilities statewide, and 4 percent at nursing facilities nationwide.

> "The purpose of the facilities management program is to provide oversight for department of health facilities that provide health and behavioral healthcare services, including mental health, substance abuse, nursing home and rehabilitation programs in both facility- and community-based settings, and serve as the safety net for the citizens of New Mexico."
>
> - *2021 General Appropriation Act (Laws 2021, ch. 137, section 4)*

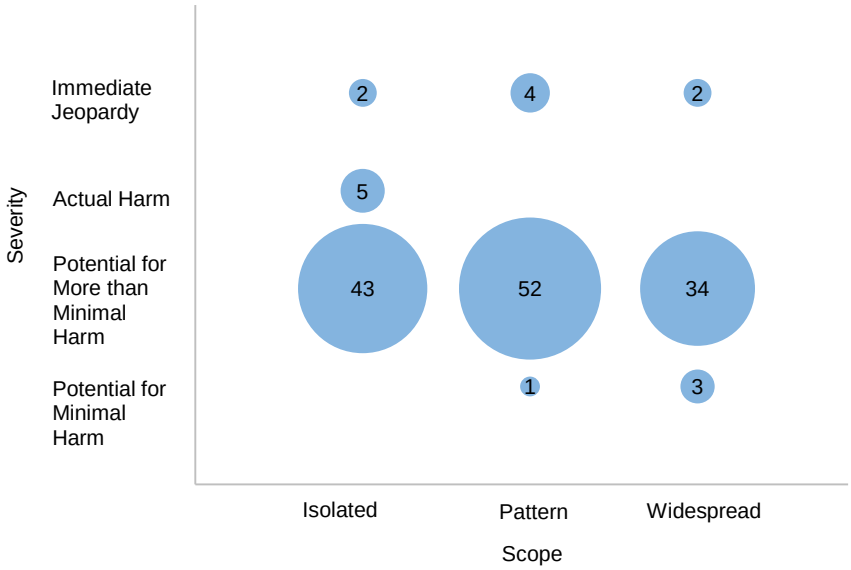
> "Immediate Jeopardy represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death."
>
> - *Centers for Medicare and Medicaid Services State Operations Manual*

Chart 3. Percentage of Deficiencies in Long-Term Care Facilities Resulting in Actual Harm or Immediate Jeopardy, 2015-2020



Source: LFC analysis of CMS data

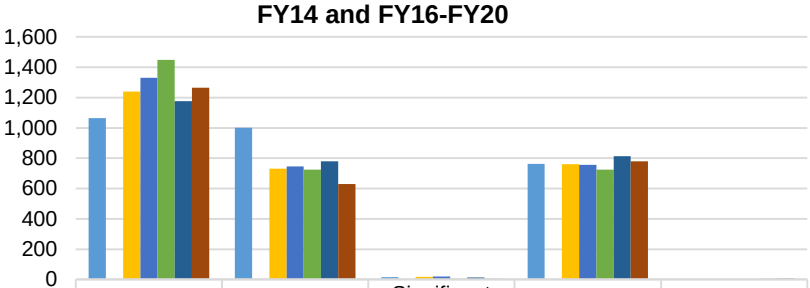
Chart 4. Number of Long-Term Care Deficiencies by Scope and Severity, 2015-2021 YTD



Source: LFC analysis of DOH data

Although DOH facilities have reduced medication errors, other negative clinical indicators have increased or remained steady. DOH uses a variety of clinical metrics to assess the health and safety of patients and residents in its facilities. These include falls, medication errors and significant medication errors (those that cause a patient discomfort or jeopardize health and safety), nosocomial (healthcare-acquired) infections, and unanticipated deaths. Preventing these incidents can reduce harm to patients and mitigate the risk of additional costs associated with treating the effects of these incidents when they occur.

Chart 5. Key Clinical Metrics for All DOH Facilities, FY14 and FY16-FY20



	Falls	Medication errors	Significant medication errors	Nosocomial infections	Unanticipated deaths*
FY14	1,065	1,001	15	764	2
FY15*					
FY16	1,241	732	17	760	2
FY17	1,330	746	20	756	2
FY18	1,450	726	5	724	2
FY19*	1,177	780	13	813	6
FY20	1,266	631	5	779	7

*Notes: FY15 data excluded because not all facilities provided information due to changes in reporting systems prior to FY16. FY16-FY20 unanticipated deaths do not include FBMC or LLCP, which reported all deaths. FBMC did not report medication errors, falls, and deaths for Q4 FY19.

Source: LFC analysis of DOH data

Medication errors fell from about 1,000 in FY14 to 732 in FY16 and 631 in FY20, an overall decrease of 37 percent, driven largely by 75-percent reductions at both NMBHI and FBMC. Medication errors at NMVH increased through FY18 before falling 15 percent in FY20.

Infections at NMBHI and NMVH also improved in FY20, with NMVH having 26 percent fewer infections than the previous year for a patient census that averaged 7 percent lower.

Health and safety deficiencies in DOH facilities increase the risk of liability to the state. When surveys find deficiencies resulting in actual harm or immediate jeopardy, up to and including the death of patients and residents, any failure to address them has the potential to expose the state to legal

liability. Reviews of facility surveys since 2015 found three cases where a deficiency resulted in the death of a resident. LFC requested information from DOH on current and recent claims or litigation against the department's facilities, but did not receive this information and thus, could not determine if these or any other deficiencies resulted in litigation. Yet the risk of liability exists, as evidenced by publicly available settlement documents.

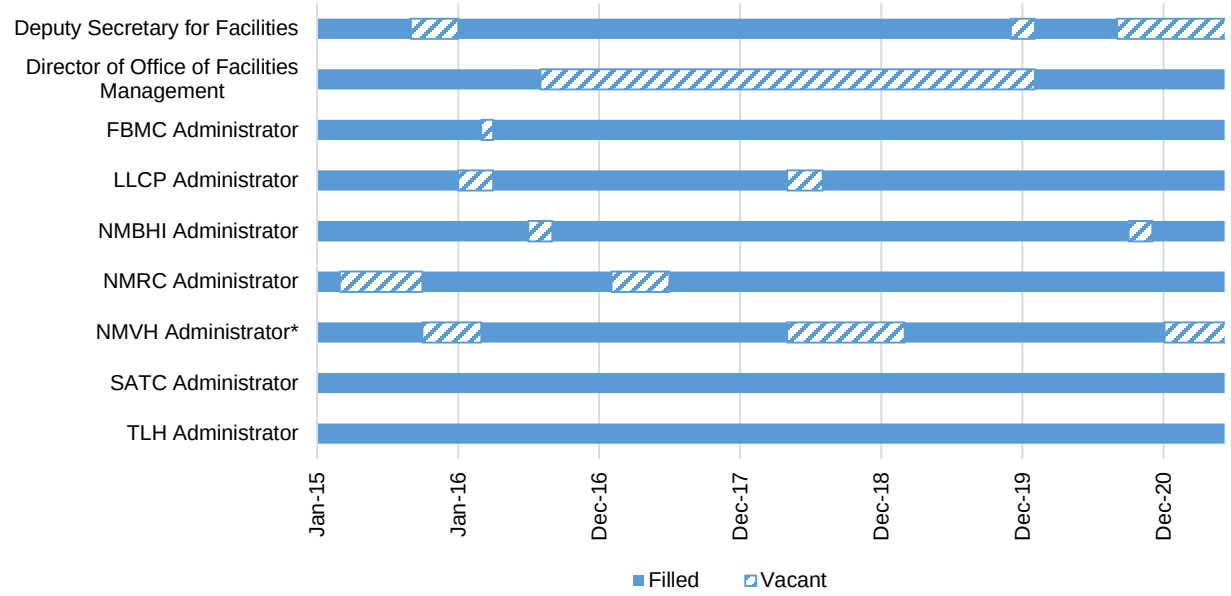
Private health systems obtain malpractice and other insurance from outside providers, whereas DOH, as a state agency, is insured through the General Services Department's Risk Management Division. Thus, New Mexico taxpayers ultimately bear the risk of the costs of litigation and settlement payments. In May 2021, the state settled a wrongful death lawsuit stemming from the death of a resident at NMBHI in June 2019 for $450 thousand. Another wrongful death settlement of $210 thousand was settled against New Mexico Rehabilitation Center in July 2018.

Inconsistent and overstretched leadership hinders accountability.

As noted in LFC's 2009 evaluation of DOH facilities, the Legislature authorized DOH to create the position of deputy secretary for facilities in the General Appropriation Act (GAA) of 2005, along with a Facilities Management Program in the state budget. However, two key leadership positions central to this oversight have seen significant periods of vacancy in recent years, and are either currently vacant or overextended. As of June 2021, DOH was without a permanent deputy secretary of facilities for nine months, and both of the department's deputy secretary positions were occupied on an acting basis by individuals serving in other executive leadership roles.

Additionally, the Office of Facilities Management (OFM) went over three years – from August 2016 to January 2020 – without a full-time director. The current occupant of that position is also performing additional duties as acting administrator of the New Mexico State Veterans' Home (NMVH) following

Chart 6. DOH Facilities Leadership Timeline, 2015 to June 2021



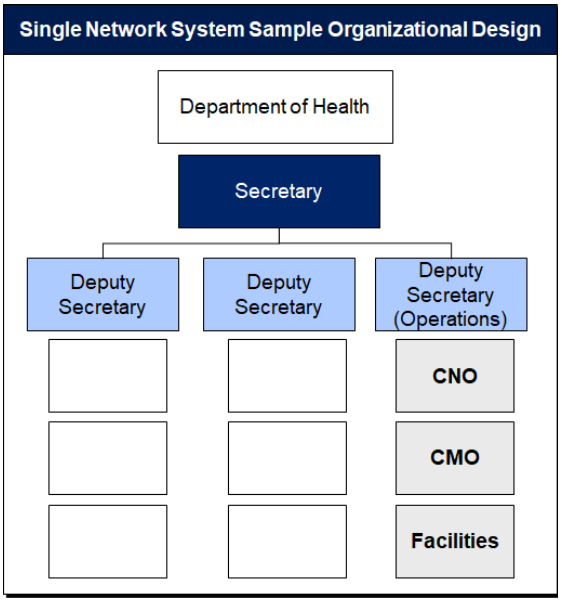
*Notes: NMVH administrator placed on administrative leave in December 2020; position assumed on an acting basis by the OFM director and is considered vacant for purpose of this analysis. All start and end dates and durations are approximate to within one month based on available data.
Source: LFC analysis of SPO data

the severe Covid-19 outbreak at that facility in late 2020. In April 2021, DOH appointed an "executive director of care operations," placed administratively within the Office of the Secretary, to provide high-level management and coordination of its facilities; however, this individual departed in June 2021. The Office of the Governor has since appointed a special director to oversee DOH facilities from outside the DOH management structure.

The administrator of NMVH was placed on administrative leave in December 2020 and remained on the facility's roster of employees as of July 1, 2021.

NMRC and NMVH have seen the most turnover among facility administrators since 2015. These two facilities have both experienced an array of challenges, NMRC with controlling costs and maintaining consistent patient levels, and NMVH with maintaining facility conditions and ensuring quality of care. NMVH's administrator was placed on administrative leave in December 2020 following a major Covid-19 outbreak at the facility, but technically remains on the state payroll as of July 2021, according to State Personnel Office (SPO) organizational listings of state employees. The facility is currently overseen on an acting basis by the department's facilities operations manager. Two facilities, Sequoyah Adolescent Treatment Center (SATC) and Turquoise Lodge Hospital (TLH), have operated under the same administrator the entire time.

Figure 1. Organizational Structure Recommended by 2019 Feasibility Study



Source: Alvarez & Marsal (2019): "Creating the DOH of the Future"

A 2019 feasibility study recommendation for a deputy secretary dedicated solely to facility operations has yet to be adopted. DOH maintains one of its two deputy secretary positions organizationally in its Facilities Management Program. This position is to oversee OFM and the six facilities for which it is responsible, but in practice, also oversees other parts of the department, limiting the attention leadership can devote to facility operations. A 2019 study of DOH facilities funded by a $500 thousand special appropriation noted other states operate health facilities under dedicated operational leadership, and recommended a deputy secretary of operations with exclusive oversight over facilities and no more than four to six direct reports.

The DOH facilities governing board lacks independence and performs limited oversight of quality of care.

The DOH facilities governing board is not established in statute or administrative rule, instead operating only under a set of bylaws. The board also lacks independence from departmental administration; facility administrators comprise the majority of the board, along with the cabinet secretary, deputy secretary, and other agency leadership, essentially providing oversight of themselves. By contrast, for example, the board of trustees of the University of New Mexico Hospital only includes key executive leadership, such as the hospital and health system chief executive officers (CEOs), as nonvoting ex officio members. Miners' Colfax Medical Center, a state health institution independent of DOH, also has its own board of trustees established in statute with members appointed by the governor (23-3-2 NMSA 1978).

The DOH facilities governing board also lacks standing committees devoted to quality and safety, finance, or strategic planning, instead only having the authority in its bylaws to convene ad hoc advisory committees and a standing medical executive committee for purposes of credentialing and privileging practitioners. The American Hospital Association's *Guide to Good Governance* includes several key practices for governing boards, including strategic planning; oversight of quality, performance, and measurement; financial oversight; CEO selection, performance evaluation, and succession planning; risk identification and oversight; and communication and accountability. LFC staff review of quarterly DOH facilities governing board minutes and agendas since 2019 shows quality and performance review only through individual facility administrators' reports to the board and no dedicated agenda items or board actions to address systemwide or facility-specific concerns around clinical performance.

Figure 2. Sample Industry Best Practice for Board Oversight of Quality and Performance

Oversight of Quality, Performance and Measurement

The board is responsible for the quality of patient care and safety. In addition, the board oversees and is responsible for organizational effectiveness in areas such as management performance, financial performance, external relations and the board's own effectiveness. The board performs its role with respect to ensuring quality through identifying appropriate performance standards and indicators, reviewing hospital and board performance against such standards and indicators, and ensuring that management has put plans in place to address variances from performance standards and indicators.

Source: American Hospital Association *Guide to Good Governance*

Other DOH divisions have boards or advisory committees that conduct regular reviews of programs and quality with broader, more independent stakeholder membership. For example, the Developmental Disabilities Supports Division has a dedicated Advisory Council on Quality (ACQ), whose mission includes reviewing quality assurance system outcomes for people with intellectual and developmental disabilities and their support networks. ACQ has a standing Policy and Quality Committee, and its overall voting membership includes individuals with intellectual and developmental disabilities and their families, service providers and direct care staff, representatives from advocacy groups, and others.

Recommendations

The Legislature should consider

- Establishing a chief executive officer for facilities at the deputy secretary level accountable to the secretary of Health and the DOH facilities governing board;
- Formally establishing the DOH facilities governing board in statute, with voting membership independent of facility administration and with clear authority to review quality metrics, clinical outcomes, finances, and management performance.

The Department of Health facilities governing board should

- Update its bylaws to establish standing committees on quality and safety, finance, and strategic planning.

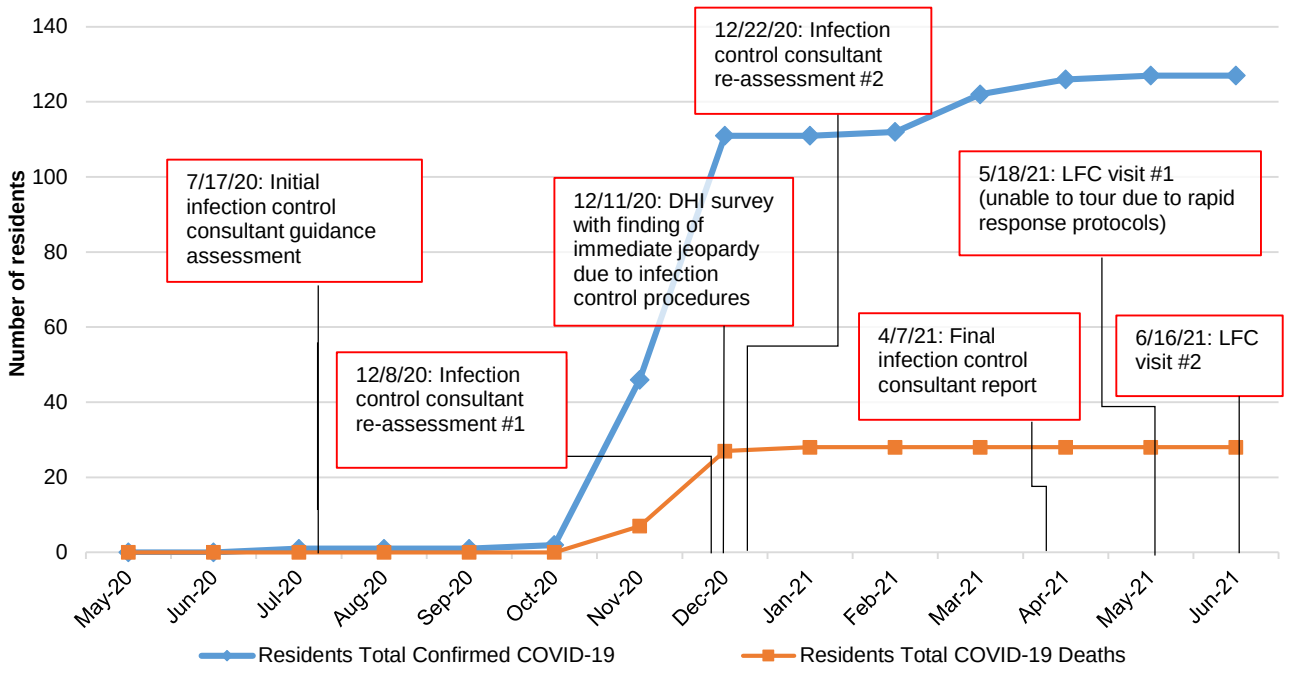
Preventable Covid-19 Deaths and Facility Construction Issues at the Veterans' Home Were Exacerbated by Inadequate Oversight

The New Mexico State Veterans' Home (NMVH) in Truth or Consequences has experienced an array of problems in recent years that have resulted in substantial risks to the health and safety of residents and staff. NMVH experienced the worst Covid-19 outbreak of any DOH facility, saw deficiency findings resulting in federal monetary penalties, and experienced construction and maintenance issues in both of its resident buildings. The inability of NMVH and DOH management to address these issues in a timely manner has likely contributed to preventable resident deaths and vacant and unusable portions of the facility.

DOH did not ensure NMVH followed proper infection control procedures, potentially contributing to preventable Covid-19 deaths.

Between October and December 2020, NMVH experienced a major outbreak of Covid-19. Since the start of the pandemic, according to data from the Centers for Medicare and Medicaid Services (CMS), 28 residents have died from the disease, equivalent to 22 percent of 127 positive resident tests and 19 percent of the facility's licensed 145-bed capacity. At one point in December 2020, NMVH transferred 14 Covid-positive residents to isolate in a different long-term care facility in Las Cruces to stem the outbreak. NMVH continued to experience further isolated positive cases through May 2021 when a planned LFC tour was postponed due to another outbreak. The facility was required to implement Environment Department rapid response protocols restricting visitors and implementing cleaning and quarantining procedures.

Chart 7. NMVH Covid-19 Pandemic Timeline



Note: Resident cases and deaths are cumulative to the end of each month.
Source: CMS, LFC files

In July 2020, NMVH staff received guidance on the use of personal protective equipment (PPE) following rounds with an infection specialist, including instructions for all staff to wear N95 masks and engage in other best practices (see Appendix D). However, subsequent inspections by DOH's Division of Health Improvement (DHI), which conducts health and safety surveys of long-term care facilities for licensing and regulatory purposes, found numerous serious deficiencies with regard to infection control procedures and PPE use, including staff moving between areas with infected patients and non-infected patients without changing PPE. Further on-site evaluations by an independent infection control consultant observed poor compliance with PPE protocols, "fair to poor" cleanliness in the old NMVH building, and no process for ensuring areas under construction, renovation, or maintenance were adequately identified and protected from exposure.

In its second interim December 2020 report, the infection control consultant noted NMVH resolved certain issues by grouping residents by recovery dates and redefining space for donning and doffing of PPE. However, the consultant noted transmission continued, with 113 residents and 79 staff testing positive for Covid-19. Further findings included male staff wearing N95 masks with beards, lack or inappropriate wearing of gowns, lack of disinfection for face shields, and other issues. The consultant's final report in April 2021 noted noncompliance with PPE use was evident on every visit and was not corrected "even after multiple explanations and prompts for correction." The consultant declined to return to the facility because of environmental safety issues.

NMVH has a recent pattern of deficiencies in health licensing surveys, costing over $180 thousand in federal penalties. According to data from the Centers for Medicare and Medicaid Services (CMS), NMVH was cited for 60 deficiencies in health and safety surveys between 2015 and 2020. For failure to come into substantial compliance with regulations around these deficiencies, CMS assessed monetary fines against NMVH of $85,400 in 2018, $94,186 in 2019, and $650 in February 2021, for a total of $180,236. Additionally, CMS denied payment to the facility for a two-day period in December 2020.

A review of reports from DHI, the state's designated survey agency for CMS, found a sampling of various health and safety deficiencies, including:

- An "immediate jeopardy" determination from findings of inadequate infection control procedures during the Covid-19 outbreak;
- An "immediate jeopardy" determination in which a resident died after dentures became lodged in their throat;
- Noncompliance with fire safety regulations such as inadequate sprinklers and deficiencies in the facilities' emergency preparedness plan; and
- Various expired food items.

Figure 3. Posted Signage Requiring N95 Masks at NMVH

Source: LFC staff, June 16, 2021

"Poor staff compliance with PPE was observed on all visits. Other issues identified included inappropriate PPE being worn based on State guidelines (Letter of Direction) and incorrect use of PPE in quarantine isolation areas."

- *Infection Control Consultants of New Mexico Final Report, April 2021*

Table 4. Federal Fines Against NMVH Since 2018

Penalty Date	Fine Amount
3/15/2018	$85,400
12/18/2019	$94,186
2/8/2021	$650
Total	**$180,236**

Source: CMS

Significant building issues leave NMVH unable to operate three residential units and two therapy pools.

Completed in 2017 at a cost of approximately $26 million, the annex at NMVH contains private rooms capable of housing 59 veterans in need of care for Alzheimer's disease, dementia, and other memory care. This building is in addition to the original structure housing the main veterans' home, built in 1935 as the Carrie Tingley Children's Hospital and occupied by NMVH since 1985. Both buildings currently face major interior and exterior capital issues, resulting in three unused residential units and one with just one resident.

Issues with soil compaction caused substantial settling to portions of the annex shortly after construction, resulting in damage to an exterior retaining wall and other building elements. Additionally, portions of exterior trim over windows did not adhere properly and began falling off, necessitating a $535 thousand emergency project to replace and reattach them. Complicating these matters, NMVH changed hands from DOH to the Department of Veterans' Services in FY18, and back to DOH in FY20. These changes contributed to delays in addressing these issues, which are expected to be completed in FY22.

Figure 4. Exterior Construction Issues at NMVH Annex

Left: Exterior trim above windows failed to properly adhere. Right: Work to repair damaged retaining wall.
Source: LFC staff, June 16, 2021

The new NMVH annex is also experiencing issues with its HVAC systems and therapy pool. The annex contains a currently vacant 13-bed residential wing undergoing work on the heating, ventilation, and air conditioning (HVAC) system to address internal temperature fluctuations and the ventilation of an unpleasant odor possibly emitted by the unused therapy pool, as well as issues with HVAC electrical control equipment requiring a $178 thousand emergency procurement. Originally intended to pump mineral spring water from approximately one mile away, the pool's pumping system did not function as intended and the pool currently sits empty. LFC staff noted the presence of the odor and standing water in the pool's drainage system during its visit to the facility. DOH intends to convert the pool to a traditional chlorinated pool.

Figure 5. Unused Therapy Pool at NMVH Annex

Left: Unused therapy pool in NMVH annex. Right: Standing water in pool drainage system.
Source: LFC staff, June 16, 2021

The original 1935 building also contains numerous issues with aging materials and systems. Among those observed by LFC staff, the old therapy pool is cracked and damaged and being used as storage for wheelchairs, some shower and restroom facilities in currently occupied residential wings are out of order, and HVAC systems are failing to maintain a consistent, comfortable temperature, with one thermometer reading an interior temperature of 82 degrees. Most recently, DOH entered into another emergency procurement in July 2021 for roughly $42 thousand to repair a failing chiller unit and rent a substitute unit during the repair. The old NMVH facility also contains a 10-bed upstairs wing for domiciliary (assisted) living, which was only housing one individual when LFC staff visited.

Just one out of 10 rooms in NMVH's domiciliary unit was occupied as of June 2021.

Figure 6. Observed Issues in NMVH's Original 1935 Building

Left: Thermometer in resident shower room reading indoor temperature of 82 degrees. Right: Out-of-order stall in bathroom shared by multiple residents.

Source: LFC staff, July 16, 2021

Figure 7. Unused Therapy Pool in NMVH Original Building

Cracks in unused therapy pool used as wheelchair storage.

Source: DOH

Despite over $3 million in recent capital investment, a facility condition assessment finds the old Veterans' Home building is outdated and unsuited for the needs of a modern nursing facility. Of $5.1 million in capital funding allocated to 33 projects at NMVH in FY20 and FY21, $3.6 million is for repairs and modernization of the old building and its support structures. This includes roof and drainage repairs, a $640 thousand HVAC upgrade to the kitchen and dining hall, an emergency boiler replacement, and an investigation of plumbing to determine the need for its replacement (see Appendix E for a full list of projects).

Following the findings of DHI and the contracted infection control consultant, DOH requested and received an emergency procurement declaration in April 2021 for a new facility condition assessment for the old building. The $52 thousand assessment found no immediate danger to patients or staff from continued occupancy but found the building's layout is "obsolete" and functional and operational deficiencies adversely impact the quality of care. The final assessment estimates a cost of $24.7 million for all necessary repairs to the old building, and a total project cost of between $21.1 million and $31.6 million to replace the facility. NMVH will likely need to be replaced if a facilities master plan finds an ongoing need to serve the population. The U.S. Department of Veterans' Affairs (VA) offers grants to states of up to 65 percent of the cost of new construction, acquisition, renovation, or repairs to state veterans' homes.

Recommendations

The Legislature should consider

- Funding the state share of construction of a replacement for the original building at the New Mexico State Veterans' Home.

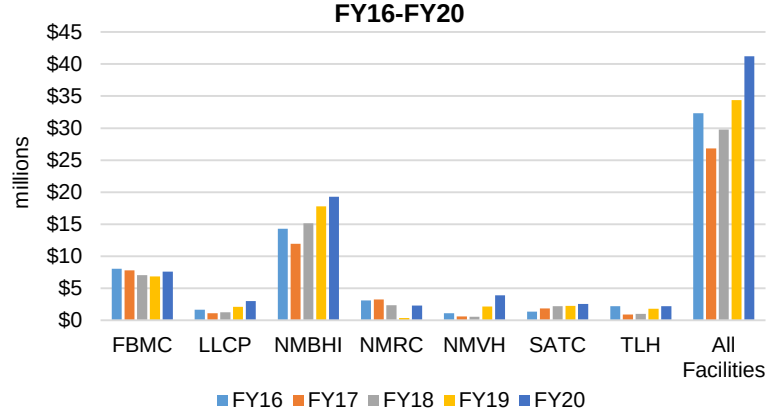
The Department of Health should

- Take immediate action following recommendations of infection conrol specialists to ensure staff are following best practices regarding use of PPE including staff education, refresher training, rounding, real-time coaching, and random auditing to help ensure appropriate use of PPE.
- Develop a systemwide facilities master plan that includes options for replacing the Veterans' Home with federal support from the VA.

Failure to Plan for the Long Term Has Led to Underutilization, Growing Costs, and Inefficiencies

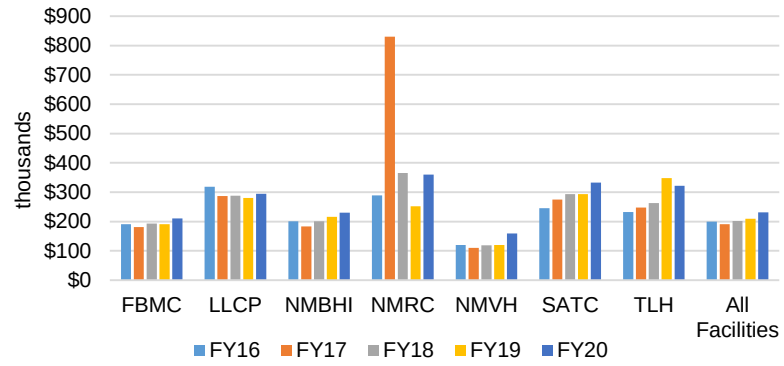
Unoccupied beds cost as much as $41 million to keep open in FY20, based on average occupancy rates.

Chart 8. Estimated Total Cost of Unoccupied Beds, FY16-FY20



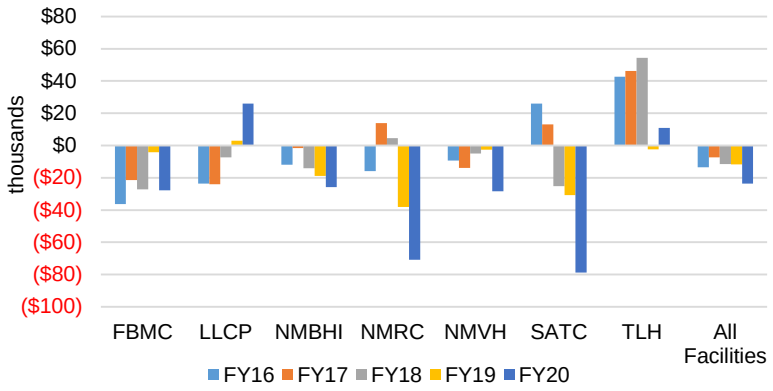
Note: Estimated cost based on annual average unused operational capacity.
Source: LFC analysis of DOH and SHARE data

Chart 9. Annual Average Cost per Occupied Bed by Facility, FY16-FY20



Note: Estimated cost based on average daily census. NMRC temporarily closed its chemical dependency unit in FY17, resulting in a significant rise in costs per bed.

Chart 10. Annual Surplus/Deficit per Occupied Bed by Facility, FY16-FY20



Note: Estimated cost based on average daily census.
Source: LFC analysis of DOH and SHARE data

With an average occupancy rate of 71 percent of operational beds across all facilities, 29 percent remained unoccupied. Allocating costs proportionally by occupied and unoccupied beds, keeping unoccupied beds operational and available in FY20 cost DOH as much as $41 million. This is an increase of 20 percent over the roughly $34.4 million cost of unoccupied beds in FY19, and 53 percent higher than the $26.8 million cost in FY17.

Average total cost per occupied bed rose by 16 percent since FY16 to $231 thousand across all facilities. Before the Covid-19 pandemic, DOH experienced consistent but gradual overall increases in costs, with the cost per occupied bed at all facilities increasing 5 percent between FY16 and FY19. Between FY19 and FY20, however, this increased by 10 percent, in part due to Covid-19 restrictions.

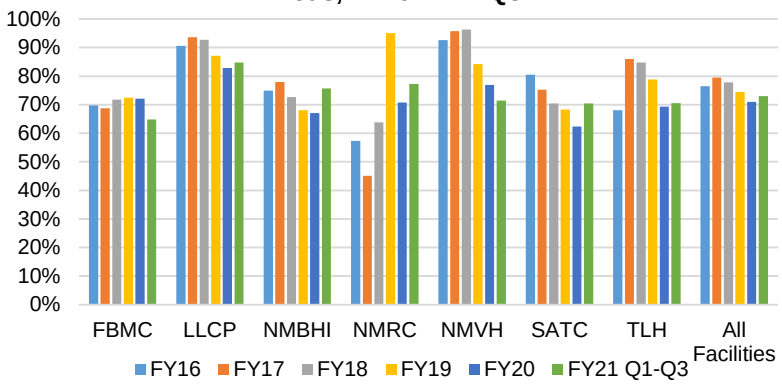
Facilities operating inpatient substance abuse treatment services have the highest costs per occupied bed across the DOH facilities system. The New Mexico Rehabilitation Center (NMRC) in Roswell had the highest average cost per occupied bed in FY20 at nearly $360 thousand, or $983 per patient per day, in part due to a temporary closure to serve as a regional Covid-19 isolation facility from April to June 2020. This was followed by $332 thousand at Sequoyah Adolescent Treatment Center (SATC) and $321 thousand at Turquoise Lodge Hospital (TLH). NMRC experienced an extremely high spike in this metric in FY17 – to roughly $830 thousand per occupied bed, or over $2,200 per patient per day – due to the temporary closure of its chemical dependency unit without a commensurate reduction in staffing expenditures.

Revenues per occupied bed averaged $208 thousand across all facilities in FY20, for a loss of nearly $24 thousand per occupied bed, or $65 per patient per day. The greatest deficits in FY20 occurred at SATC (-$79 thousand per occupied bed) and NMRC (-$71 thousand per occupied bed); these facilities, along with TLH, closed a larger percentage of beds than other facilities during the pandemic.

Underutilization of Facilities Worsened Under the Covid-19 Pandemic, Contributing to Continued Increases in Costs

DOH facilities have consistently operated under capacity. Since FY16, the occupancy rate of operational beds has generally declined, reaching a low of 71 percent across the entire system in FY20 after a high of approximately 80 percent in FY17. Both before and during the pandemic, pronounced declines occurred at the New Mexico Veterans' Home (NMVH), as well as Turquoise Lodge Hospital, which experienced a change in programming and moved to a new facility in 2019. Alternative treatment options, such as lower-cost home-based care for the elderly and effective outpatient treatment options for substance abuse are likely contributing to this trend.

Chart 11. Average Occupancy Rate of Operational Beds, FY16-FY21 Q3



Note: Excludes outpatient services at LLCP, NMRC, and TLH.

Source: LFC analysis of DOH data

Ongoing staffing issues, physical facility constraints, and restrictions put in place to combat the spread of Covid-19 exacerbate already low occupancy rates. Through the first three quarters of FY21, DOH facilities operated 764 out of 937 total licensed inpatient beds on average, or 82 percent of licensed physical capacity. These operational beds were occupied 73 percent of the time, equating to just 60 percent of licensed capacity.

Table 5. DOH Facility Capacity and Occupancy, FY21 Q1-Q3

Facility	Licensed or Total Beds*	Operational Beds	Average Daily Census	Occupancy of Licensed Beds	Occupancy of Operational Beds
FBMC	200	180	117	58%	65%
LLCP	72*	72	61	85%	85%
NMBHI	401	304	230	57%	76%
NMRC	43	28	22	50%	77%
NMVH	145	142	104	72%	73%
SATC	36	18	13	35%	70%
TLH	40	20	14	35%	71%
All Facilities	**937**	**764**	**561**	**60%**	**73%**

Notes: Inpatient beds only. Excludes intensive outpatient and other programs. LLCP has 4 licensed beds in its intermediate care facility; home-based services for individuals with developmental disabilities are not licensed health facilities.

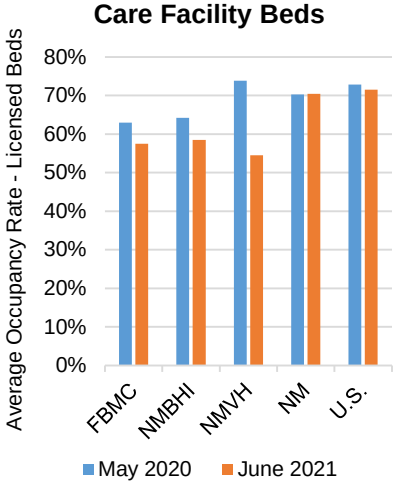
Source: LFC analysis of DOH data

Licensed beds: The maximum number of beds each facility is approved to operate under its operating licenses and certifications.

Operational beds: The number of beds each facility is capable of operating under current staffing and facility conditions.

Certain facilities continue to maintain isolation areas and social distancing protocols for potential Covid-19 exposure. NMRC operated 65 percent of licensed beds and SATC and TLH operated 50 percent of licensed beds through the first three quarters of FY21. Meanwhile, New Mexico Behavioral Health Institute (NMBHI) set aside 37 beds for Covid-19 quarantine.

Chart 12. Average Occupancy Rate of Licensed Long-Term Care Facility Beds



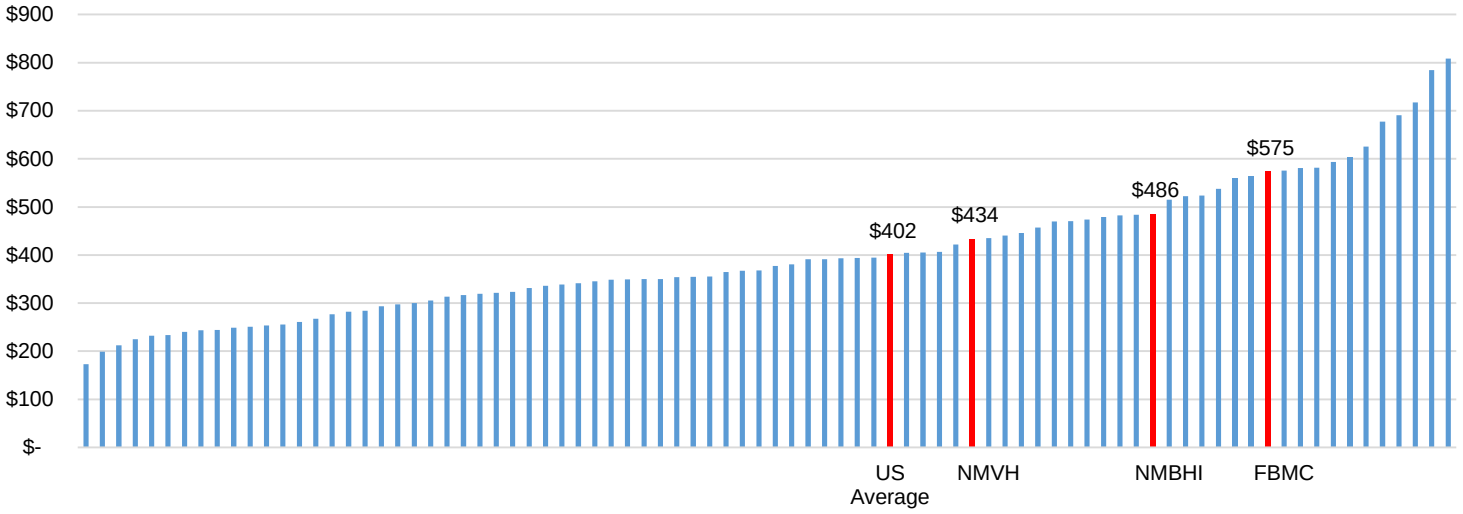
Note: CMS data based on occupancy of licensed beds in all public and private nursing homes. NMBHI data is only for its long-term care facility.

Source: LFC analysis of CMS Covid-19 Nursing Home dataset

New Mexico's state-run nursing facilities have lower occupancy and higher costs than similar facilities in the state and nationally. Occupancy rates at New Mexico's state-run nursing facilities at NMVH, FBMC, and NMBHI fell relative to all public and private nursing homes around the state and nation between May 2020 and June 2021. In May 2020, the first reported month of the CMS Covid-19 Nursing Home dataset, NMVH's occupancy rate (74 percent) exceeded the New Mexico (70 percent) and national (73 percent) averages, while FBMC and NMBHI's long-term care home were below the averages. At the end of June 2021, all three long-term care DOH facilities had lower occupancy rates compared with their own rates from May 2020, as well as the New Mexico and national averages. NMVH decreased by the greatest amount, nearly 20 percentage points, falling to a 55 percent occupancy rate. These data show DOH facilities' average occupancy rates are lagging behind other New Mexico long-term care facilities, and the national trend.

New Mexico's state-run nursing facilities tend to cost less per bed than other DOH facilities to run. However, they rank in the upper half of costs among all state-run long-term care facilities nationwide. According to CMS cost report data, nursing facilities run by state governments had an average operating expense of $402 per patient day in FY20. All three DOH nursing facilities had higher costs, from $435 at NMVH to $576 at FBMC.

Chart 13. Operating Expense per Patient Day of State Government-Operated Nursing Facilities Nationwide



Note: NMBHI long-term care not included in CMS data. Cost estimated based on SHARE codes for long-term care expenditures and proportion of other costs attributable to long-term care based on average daily census data.

Source: CMS, LFC analysis of DOH data

DOH lacks a comprehensive facilities master plan to address inefficient use of resources, yet has identified a need for the construction of several replacement facilities.

DOH received a $500 thousand special appropriation in FY19 for a feasibility study and master plan, and contracted with a consulting firm for this purpose. The resulting report noted the challenge of chronic underutilization of DOH facilities and estimated current capacity falls short of potential demand for their services by approximately $1 billion. While the study recommended DOH reconceptualize its facility operations as a comprehensive system of care, it did not offer specific steps to address ongoing issues of excess capacity and inefficiency, nor did it result in a comprehensive facilities master plan. Additionally, the General Services Department (GSD) only has updated facility condition assessments for two DOH facilities: the Los Lunas campus used by the Los Lunas Community Program and the recent emergency assessment carried out in 2021 on the New Mexico State Veterans' Home.

The alignment of DOH's residential substance abuse treatment facilities makes inefficient use of space. Previous LFC evaluations noted the inefficient distribution of DOH facilities to treat substance abuse disorders. New Mexico Rehabilitation Center (NMRC) in Roswell, in particular, had struggled to maintain occupancy levels in its chemical dependency unit, averaging eight patients per day in its 15 beds during the first three-quarters of FY20, before Covid-19 restrictions caused further disruptions. NMRC's chemical dependency unit closed for a time in 2017 and 2018, until the chemical dependency unit at Fort Bayard Medical Center (FBMC) closed and DOH consolidated residential substance abuse treatment services at NMRC and Turquoise Lodge Hospital (TLH).

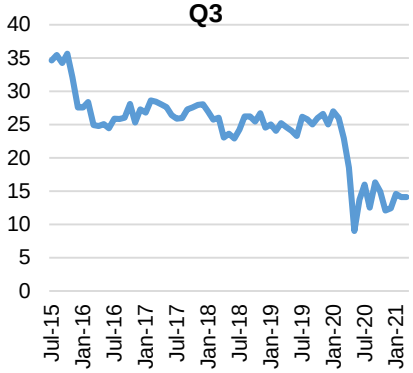
Figure 8. Vacant Former Chemical Dependency Unit at Fort Bayard Medical Center

Source: DOH

The relocation of the chemical dependency unit was the result of Fort Bayard not being able to bill for all services provided in the chemical dependency unit due to inadequate licensure. Following the relocation, the 20-bed wing at Fort Bayard formerly used by the chemical dependency unit has remained vacant, with the exception of being used as a quarantine unit during the Covid-19 pandemic.

Turquoise Lodge Hopsital relocated to a smaller, more expensive facility in 2019, yet serves half the patients it did prior to the Covid-19 pandemic. TLH relocated in 2019 from its past facility, which was collocated with Bernalillo County's substance abuse treatment services and had excess capacity. TLH now occupies space leased from the city of Albuquerque in the Gibson Medical Center. This move nearly doubled its leasing costs (from $265 thousand in FY19 to $513 thousand in FY20) while limiting its ability to grow.

Chart 14. TLH Average Daily Census, FY16-FY21 Q3



Source: DOH

TLH has not had more than 30 of its 40 licensed beds filled since November 2015. During the pandemic, TLH has been operating 20 beds, or 50 percent of its licensed capacity, and has not exceeded an average of 16 patients in any month since April 2020. Its occupancy rate of 35 percent of licensed beds was the lowest of all DOH facilities through the first three quarters of FY21, along with Sequoyah Adolescent Treatment Center. Despite underutilization even before the pandemic, DOH staff have indicated they are in need of building a new facility.

Figure 9. LLCP Secure Intermediate Care Facility

Current leased secure residence to house clients deemed dangerous and incompetent to stand trial placed in LLCP custody.

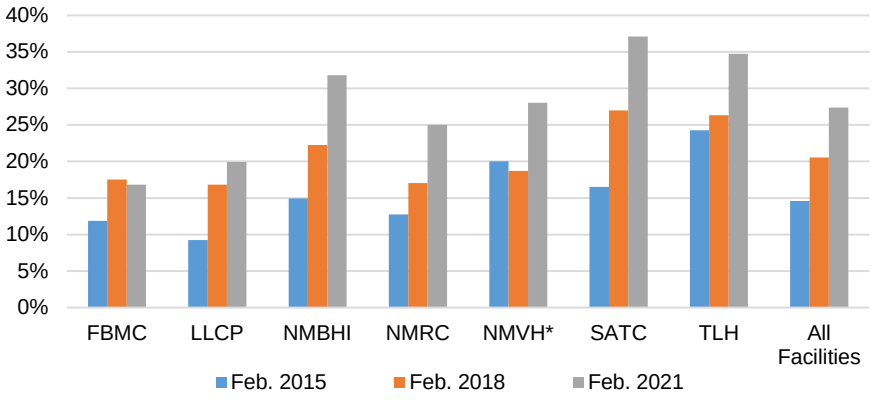
Source: LFC staff

The Los Lunas Community Program estimates a cost of $1.5 million to replace its facility to house individuals with intellectual and developmental disabilities who have committed a violent offense and are incompetent to stand trial. Located in Belen, the intermediate care facility (ICF) is a leased residential home with some security improvements, including a perimeter fence and sensors and secure doors and windows. LLCP estimates it has spent $1.6 million to lease this facility, the use of which is entirely dependent on court-ordered referrals, since 2000. The current lease, which costs $6,200 per month, expires at the end of March 2022. A 2020 feasibility study estimates a cost of roughly $1.5 million for a new, purpose-built ICF for up to six beds on the Los Lunas campus, which is owned by the state with LLCP as the primary tenant.

DOH Lacks a Comprehensive Strategy to Address Workforce Needs

Snapshots of DOH facility staffing data over time indicate increasing vacancy rates. In February 2015, shortly after the most recent LFC evaluation of DOH facilities was published, the vacancy rate among all positions at DOH facilities was 15 percent. TLH had the highest vacancy rate at 24 percent, while the Los Lunas Community Program (LLCP) had the lowest at 9 percent. By three years later, in February 2018, vacancy rates had increased at all facilities except one, the New Mexico State Veterans' Home (NMVH). As of February 2021, vacancy rates had grown dramatically at all facilities, and just one facility, Fort Bayard Medical Center (FBMC), had a lower vacancy rate than it did in February 2018. Three facilities had vacancy rates above 30 percent: SATC at 37 percent, TLH at 35 percent, and NMBHI at 32 percent. The overall vacancy rate across the system was 27 percent.

Chart 15. Vacancy Rate (All Positions) of DOH Facilities, February 2015, 2018, and 2021



* Note: New Mexico State Veterans' Home (NMVH) was administered by the Department of Veterans' Services in FY18 and FY19.

Source: LFC analysis of SPO data

Wage increases have improved nurse staffing, but hiring clinical aides and technicians remains a challenge. DOH staff nurses received an average wage increase of 20 percent in the FY19 budget, with the goal of reducing vacancies and reliance on more expensive contract nurses. Between June 2018 and June 2021, the vacancy rate among registered nurses (RNs) at DOH facilities fell from 34 percent to 26 percent, while the average hourly wage grew from $35.38 per hour to $39.62 per hour. None of the six certified nurse practitioner (CNP) positions at DOH facilities were vacant in June 2021.

Among licensed practical nurses (LPNs), who do not require as much education and training as RNs, vacancy rates have not changed significantly despite a wage increase. At LLCP, difficulty in recruiting LPNs has led to a proposal to reclassify vacant LPN positions as basic-level RNs. LLCP staff noted recruiting new RN graduates is more likely to result in hires than recruiting practicing LPNs. This is consistent with findings in LFC's 2020 evaluation of the state's nursing workforce, which found licensing of LPNs is decreasing overall, and make up a shrinking percentage of the state's nursing workforce relative to RNs.

DOH continues to struggle to recruit lower-level direct care positions, including certified nursing aides (CNAs) and psychiatric technicians. These positions comprise much of the backbone of the clinical workforce at DOH facilities, with 198 CNAs and 242 psychiatric tech positions budgeted as of 2021. Individuals working in these roles support the nursing staff and assist patients with basic needs, including personal hygiene and monitoring their overall health. However, these positions do not require a college degree, and may range in pay from the state's minimum wage of $9 per hour up to roughly $19 per hour, similar to many service sector jobs against which the state competes for employees.

The vacancy rate among CNAs grew from 21 percent to 24 percent between June 2018 and June 2021. Meanwhile, the vacancy rate among all psychiatric technicians at NMBHI is 55 percent, and is as high as 82 percent in some units. In an interview with LFC staff, NMBHI management expressed the difficulty in recruiting for these positions, which do not require a college education and pay similarly to service sector jobs with potentially less challenging work environments.

Table 6. Nursing Position Vacancy Rates and Hourly Wages, June 2018 and June 2021

	Vacancy Rate		Average Hourly Wage	
	Jun-18	Jun-21	Jun-18	Jun-21
CNAs	21%	24%	$12.34	$15.86
LPNs	34%	35%	$21.85	$25.30
RNs	34%	26%	$35.38	$39.62
CNPs	29%	0%	$46.63	$54.36
All	**28%**	**25%**	**$22.27**	**$27.16**

Note: Excludes management and administrative positions. Includes NMVH under DVS during FY18-FY19.

Source: LFC analysis of SPO data

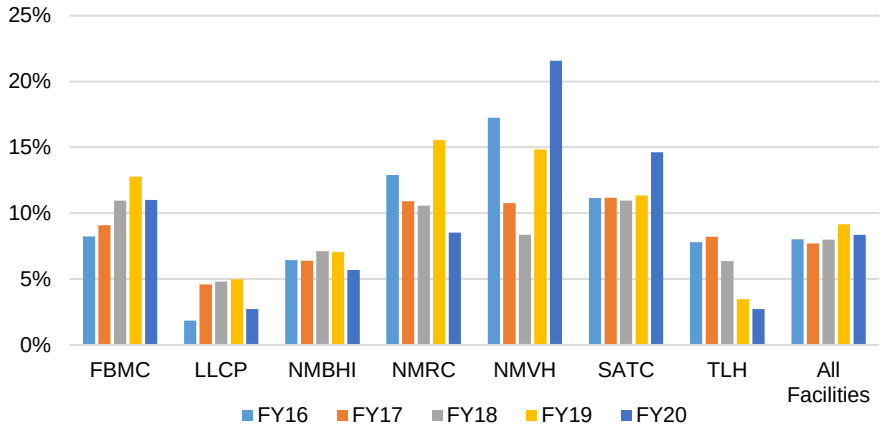
Table 7. Highest Psychiatric Technician Vacancy Rates at NMBHI, April 2021

Section/Unit	Job Title	Filled	Vacant	Total	Vacancy Rate
BHS-Extended Direct Care	PSYCHIATRIC TECH-B	2	9	11	82%
	PSYCHIATRIC TECH-O	12	12	24	50%
Direct Care	PSYCHIATRIC TECH-O	1	3	4	75%
Long Term Care-LNF	PSYCHIATRIC TECH-B	9	19	28	68%
	PSYCHIATRIC TECH-O	16	31	47	66%
Forensic Services	PSYCHIATRIC TECH-B	8	14	22	64%
Nursing/Clinical-Physical Therapy	PSYCHIATRIC TECH-B	6	8	14	57%

Source: LFC analysis of SPO data

Expenditures on contractual services decreased at five of seven DOH facilities in FY20, but remain a major driver of costs. Previous LFC evaluations identified the use of contract medical staff in place of state employees as a driver of costs and inefficiencies at DOH facilities. FBMC, LLCP, NMBHI, NMRC, and TLH all saw a smaller percentage of their total expenditures go toward contractual services in FY20 compared with FY19. Notably, TLH is alone among all DOH facilities in experiencing a significant downward trend in contractual services share of spending since FY15, decreasing from 13 percent of facility-level spending to 3 percent in FY20, the lowest among all facilities along with LLCP. The highest share of facility spending on contractual services in FY20 was at NMVH, at 22 percent.

Chart 16. Percent of DOH Facility Expenditures on Contractual Services, FY16-FY20



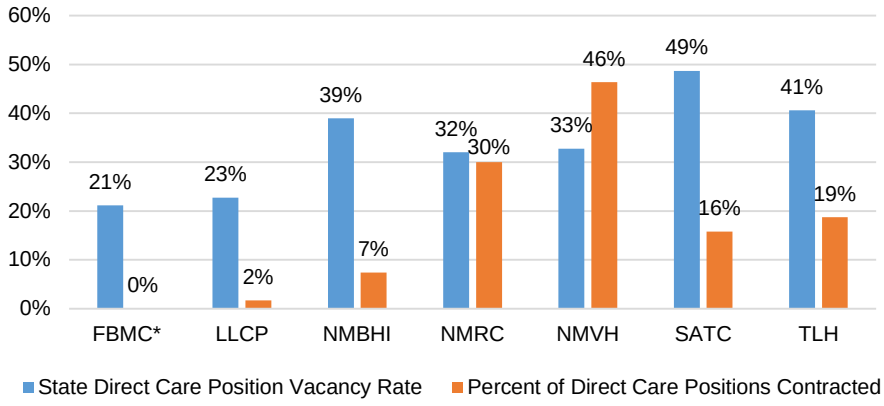
Source: LFC analysis of SHARE data

The Covid-19 pandemic increased certain contract staffing costs due to the incorporation of hazard pay for personnel treating individuals testing positive for the virus. For example, contract registered nurses at NMVH are regularly paid $59 per hour, but $135 per hour if assigned to a unit with Covid-positive patients, or 2.3 times the regular rate.

Contract employees account for between 2 percent and 46 percent of direct care staff at DOH facilities. Los Lunas Community Program (LLCP) relies the least on contract employees of any DOH facility, with four contracted direct care staff out of 233 total direct care positions as of April 2021.[1] Meanwhile, the New Mexico Veterans' Home (NMVH) had 51 contracted direct care staff, comprising 46 percent of all direct care positions and greater than the 33 percent vacancy rate for state positions at the facility. NMVH has one contracted physical therapist who, according to NMVH staff, is willing to become a state employee; however, NMVH does not have an allocated physical therapist position since one was eliminated because it was vacant for more than two years.

[1] For purposes of this analysis, direct care staff refers to medical, nursing, and other clinical positions responsible for providing care to patients or residents, but does not include janitorial, maintenance, food service, administrative, or other facility staff.

Chart 17. Percent of Direct Care Staff Contracted vs. Direct Care Vacancy Rates by Facility, April 2021

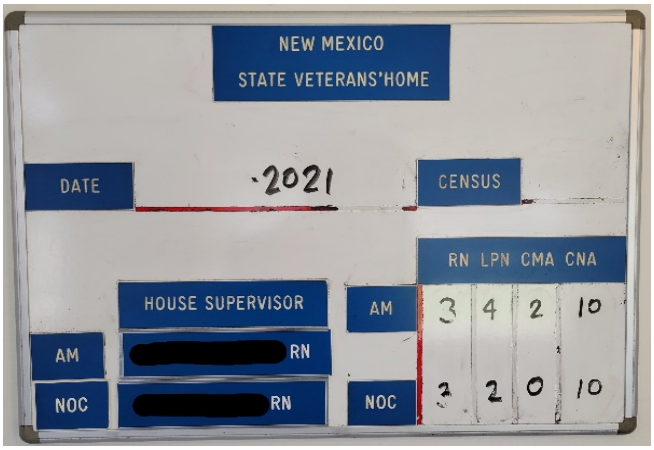


Note: FBMC did not provie information on contract employee headcount.
Source: LFC analysis of DOH and SPO data

Staffing policies across facilities remain inconsistent, limiting optimization of staffing levels. The 2015 LFC evaluation found individual facilities developed unique staffing models, with varying standards and methodologies, such as inclusion of severity of each patient's needs. In a review of current DOH facilities' staff policies, this practice persists with some facilities detailing staffing ratios by shift and patient need, and others basing staffing policies solely on facility census.

Additionally, DOH facilities do not always strictly adhere to their staffing policies. For example, NMVH's staffing policy for nursing defines three shifts – day, evening, and night – with different staffing ratios for each, as well as an adjustment for patient need severity. However, as observed by LFC staff, current practice at NMVH calls for two nursing shifts per day, not reflected in the staffing policy. Furthermore, using the staffing policy ratios at NMVH suggests 44 nursing personnel were required in March 2021 to care for 85 residents,[2] yet NMVH had 66 nursing personnel, plus contract staff. It is important to note the staffing policies are not always consistent with overall staffing levels because they do not account for leave, overtime, and other factors that impact overall staffing level needs.

Figure 10. NMVH Staffing Board Reflecting Two Shifts



Source: LFC staff

DOH is currently in the process of centralizing, reviewing, and updating all policies across facilities through the use of PolicyTech, a software platform to store and manage policy and compliance documents. PolicyTech is intended to enhance visibility and oversight of DOH facilities through additional reporting and ensuring policies are in alignment with applicable requirements.

Central staffing pools are standard practice in the healthcare industry. As noted in the 2015 LFC evaluation, healthcare systems regularly employ pools of staff, including nurses, aides, and technicians, who can be called on to fill vacancies on an as-needed, per-diem basis. Maintaining such a "float

[2] The staffing analysis calculation assumes no nursing personnel works more than 40 hours per week.

pool" of traveling staff, with sufficient cross-training to ensure they could serve the needs across the varied types of services DOH facilities provide, would be one way to address staffing challenges.

A 2018 case study of a float pool in a large hospital system found with adequate planning, shared governance, and strong systems in place for staff engagement and professional development, these pools can be effective tools for addressing staffing issues and delivering safe, quality care.[3]

DOH is pursuing partnerships with educational institutions and training programs. Several DOH facilities are located close to institutions of higher education that offer nursing or allied health profession education and training programs. However, the facilities themselves generally decide whether to engage these institutions to attract students into training positions, such as internships, or full-time jobs. Participation in the State Personnel Office (SPO)'s paid internship program depends on availability of funds, whereas facilities do not need to have additional funding to participate in DOH's program.

DOH's current internship program offers practicums and internships for credit in nursing, medicine, social work, dietetics and nutrition, epidemiology, quality coordinators, and other positions. DOH intends to extend the program into all divisions of the department, including facilities. The department's Office of Policy and Accountability (OPA) is overseeing the program, including implementing standards for all participating entities. DOH has academic agreements with 22 institutions but has not placed any interns with DOH facilities since at least 2018.

Recommendations

DOH should

- Develop a systemwide facilities master plan that includes an assessment of needs for services and options for consolidating substance abuse treatment centers;
- Continue to identify instances where staffing exists to replace contracted staff with state staff;
- At the departmental rather than facility level, develop a comprehensive strategy to recruit for and retain the highest-need positions, including
    - Establishing formal partnerships with New Mexico nursing schools for nurse internships and with community colleges, technical and vocational training programs, and high schools for nursing aides, psychiatric technicians, and other needed clinical support personnel; and
    - Developing a central pool of cross-trained traveling clinical staff, including nurses, technicians, and other needed providers, to be deployed strategically and as needed to fill staffing vacancies.
- Use PolicyTech platform to create staffing policy consistency for all facilities and ensure policies adhere to best practicies within the healthcare industry.

[3] Straw, C.N. (2018) Engagement and Retention in Float Pools. *Nursing Management*, October 2018, p. 30-36.

Decentralized Facility Operations Complicate Budgeting and Management

In previous evaluations in 2009 and 2015, LFC staff found DOH struggled to project revenues and expenditures consistently, resulting in supplemental appropriations requests. These evaluations also found DOH did not make effective use of tracking operational metrics on a daily basis to enable quick responses to operational issues as they arise. DOH's most recent projections indicate facilities continue to overestimate likely patient revenues, and the department lacks a robust system for high-level monitoring of daily operations throughout the system.

Each DOH facility operates largely autonomously with respect to finances, billing, staffing, and performance monitoring. The 2019 DOH facilities economic feasibility study noted the importance of DOH facilities operating as a single network with streamlined operations. To achieve this, the study recommended centralizing oversight and leadership of facilities, standardizing software and electronic health records, and increasing collaboration across facilities through trainings and sharing of knowledge, among other changes.

DOH's *FY21-FY23 Strategic Plan* includes an objective to "improve DOH facilities by implementing economic feasibility report suggestions." Specifically, the objective calls for sharing of tools and processes to standardize practices, creating a unified operational strategic plan, identifying and forming partnerships to create a continuum of care models, and developing a unified vision and mission statement for an integrated DOH facilities system. To date, this objective has not been implemented.

Figure 11. Excerpt From FY21-FY23 DOH Strategic Plan

Improve NMDOH Facilities by implementing Economic Feasibility report suggestions	1. Share tools and processes to improve efficiency and standardize practices (eHR, TJC reviews, P&Ps, training & education, billing, teleconferencing capabilities, etc.). 2. Create a unified operational strategic plan. 3. Identify public and private partners with similar services and establish relationships with partners to form continuum of care models. 4. Develop a unified vision & mission statement for the integrated NMDOH facilities system.	ASD OTS FMD	FY21-23

Source: DOH

Individual facilities drive budgeting and billing with limited oversight from the department.

Prior to FY02, the General Appropriation Act (GAA) funded each facility individually. Beginning with the 2001 GAA, for FY02, appropriations were consolidated in DOH programs for behavioral health services and long-term care. Starting in FY06, all facilities were placed under a single Facilities Management Program.

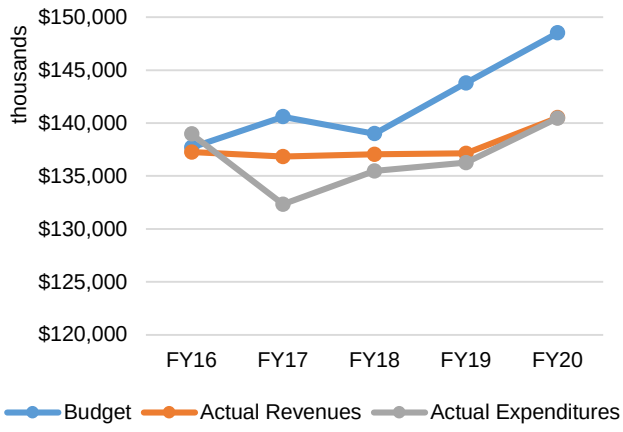
While the practice of budgeting at a programmatic level allows for greater flexibility to move funds between facilities based on need, doing so effectively requires a clear understanding and oversight of the drivers of facility costs and transparency of spending. As pointed out in previous LFC evaluations in 2009 and 2015, facilities had difficulty managing spending and continue to struggle,

with chronic underutilization and staffing issues contributing to costs in excess of patient-generated revenues.

Currently, decision-making authority over most facility operations, including staffing, the largest driver of expenses, lies with facility administrators. DOH's Administrative Services Division (ASD) conducts monthly budget projection meetings and regular procurement meetings, but does not directly oversee fiscal staff in the facilities. Facilities conduct their own billing.

DOH facilities consistently budget for more revenue than they bring in, suggesting ongoing issues with forecasting. Budgets for DOH's Facilities Management Program increased by 8 percent between FY16 and FY20, while programmatic revenues from all sources increased by 2 percent, from $137.3 million to $140.5 million, according to reports from the SHARE staffing and financial data system. This excludes special and supplemental appropriations and incorporates the New Mexico State Veterans' Home during its operation by the Veterans' Services Department in FY18 and FY19. Expenditures in FY20 were $140.5 million, 1 percent higher than in FY16, after declining to $132.3 million in FY17.

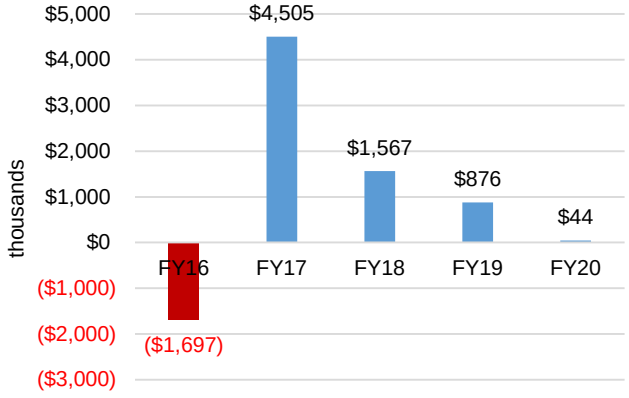
Chart 18. DOH Facilities Revenues and Expenditures, FY16-FY20



Note: Excludes special and supplemental appropriations; includes NM Veterans' Home opoerated by the Department of Veterans' Services in FY18 and FY19.

Source: SHARE

Chart 19. DOH Facilities Revenues Minus Expenditures, FY16-FY20



Note: Excludes special and supplemental appropriations; includes NM Veterans' Home opoerated by the Department of Veterans' Services in FY18 and FY19.

Source: LFC analysis of SHARE data

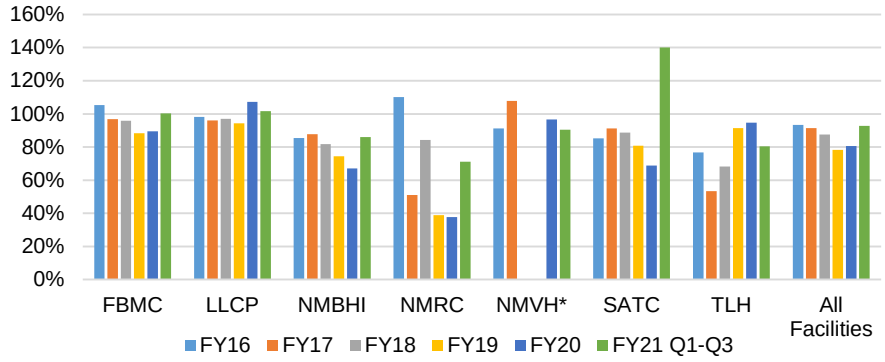
After a shortfall of nearly $1.7 million in FY16, DOH facilities have recorded more revenues than expenses in each year since FY17, although the amounts have declined annually since then. After a high surplus of $4.5 million in FY17, expenditures in FY20 nearly equaled revenues, with a difference of only $44 thousand. Yet, the Legislature has appropriated $11.8 million in special and supplemental appropriations since FY17, largely to cover shortfalls in personnel and contractual services costs, including over $5 million for FY20 and FY21. The shrinking surpluses and growing gap between budgeted and actual revenues and expenditures since FY17 indicated by SHARE suggest ongoing issues with DOH's ability to forecast its revenues and costs, a problem identified in previous LFC evaluations of this topic.

DOH projects facilities will end FY21 with a $1.8 million surplus, but the projection relies heavily on federal revenues that may not recur in the future. DOH's May 2021 projection estimates the facilities management program will end FY21 with a positive balance of $1.8 million. However, the department revised assumptions of other revenues, which include Medicaid and third-party insurance payments, downward by $11.2 million, and appears to be relying on a substantial infusion of federal funds to cover shortfalls.

DOH's May projection reflects a $6.7 million adjustment for additional federal revenues. Some DOH facilities already received additional federal funds largely derived from the federal Coronavirus Aid, Relief, and Economic Security Act (CARES Act). These funds include $841 thousand to NMBHI and $5.1 million to FBMC through the Provider Relief Fund and $225 thousand to FBMC and $13 thousand to NMVH through the Nursing Home Quality Incentive Program. The Provider Relief Fund provides supplemental payments to healthcare providers that bill Medicare fee-for-service with at least 2 percent of their 2018 gross patient revenue regardless of patient mix, with additional high-impact payments for providers experiencing high numbers of Covid-19 positive inpatient admissions. Nursing Home Quality Incentive Program payments target nursing facilities that create and maintain safe environments for their residents.

Facilities are on track to improve third-party revenue collection rates in FY21. Collections of third-party billings averaged 93 percent across all facilities through the first three-quarters of FY21, up from 81 percent in FY20 and roughly the same as in FY16. However, certain facilities continue to struggle to collect all the charges they are owed. NMRC, in particular, has experienced wide variations in collections, bringing in only 38 percent of billings in FY20. However, it hired a new finance director in 2020 and is actively pursuing payment of aging accounts, with a target to collect 75 percent of charges.

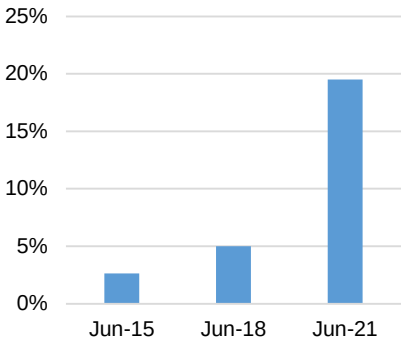
Chart 20. Percent of Third-Party Billings Collected, FY16-FY21 Q1-Q3



*Note: DOH did not provide collections data for NMVH during its administration by the Veterans' Services Department in FY18 and FY19.

Source: DOH

Chart 21. Vacancy Rate of Facility Finance Positions, June 2015, 2018, and 2021



Source: LFC analysis of SPO data

Increasing vacancies in financial management positions at facilities likely contribute to forgone revenues. Staffing challenges are not confined solely to clinical positions. Vacancies and turnover among fiscal and billing staff at the facility level can affect the ability to bill for and collect revenue. Currently, each facility is responsible for its own billing for any third-party revenues from Medicare, Medicaid, and private insurance.

DOH uses staff classified as financial specialists or office clerks to perform billing tasks. The state does not have a dedicated job classification for medical coding and billing. The total number of financial specialist and office clerk positions assigned to finance and administration sections at DOH facilities increased from 38 to 41 between FY15 and FY21. Yet eight of these 41 positions (20 percent) were vacant in June 2021, up from just one of 38 positions (3 percent) in June 2015 and two of 40 positions (5 percent) in June 2018. Turquoise Lodge Hospital had two of three financial positions (67 percent) vacant in June 2021, NMVH two of seven positions (29 percent), and NMBHI two of 16 positions (13 percent).

DOH facilities are increasing their revenue opportunities by seeking additional accreditation and certification and improved billing. "Deemed status" accreditation certifies that facilities meet or exceed all Medicare and Medicaid standards and survey requirements and can increase the ability of those facilities to bill for certain services. Among improvements that can contribute to this status are "anti-ligature" measures designed to eliminate points where patients could loop or tie a cord, rope, bedsheet, or other such material for the purpose of hanging or strangulation.

Figure 12. Ligature-Resistant Fixtures at SATC

Ligature-resistant grab bars (top) and faucet (bottom) in SATC resident bathroom.
Source: LFC staff

Such risk mitigation measures reduce the need for constant 1:1 staff supervision of residents in certain areas. Any suicide prevention and mitigation measures are important; New Mexico's suicide rate is the highest of any state and has likely been exacerbated by the Covid-19 pandemic. Residents at state behavioral health facilities are among those with the most complex needs and at highest risk, and physical measures to prevent suicide among those receiving treatment are one way to reduce this risk.

Turquoise Lodge Hospital (TLH) moved into its current space in Albuquerque's Gibson Medical Center in 2019, and has since obtained Joint Commission accreditation under both hospital and behavioral health standards, a status it did not have at the time of LFC's last evaluation of DOH facilities in 2015. This approval allows for provisional state approval as an accredited residential treatment facility, allowing it to bill for Medicaid. However, TLH leadership informed LFC staff this status is contingent on conducting an anti-ligature assessment that would identify where such measures need to be implemented. TLH leadership billing Medicaid under this structure would result in approximately $2.5 million in general fund savings. DOH has paid $136 thousand to date in FY21 to a vendor to perform an anti-ligature risk assessment at three facilities: NMRC, SATC, and TLH.

A proposed amendment to Centennial Care 2.0 could open additional services at NMBHI to Medicaid reimbursement. In January 2021, the Human Services Department (HSD) unveiled a proposed amendment to its Section 1115 Medicaid demonstration waiver, known as Centennial Care 2.0 allowing for Medicaid reimbursement for inpatient stays longer than 15 days

in institutions for mental disease (IMDs) for Medicaid members between the ages of 21 and 64 who have serious mental illness or serious emotional disorder. Since 2016, the Centers for Medicare and Medicaid Services (CMS) has permitted stays at IMDs for psychiatric and substance abuse treatment of 14 days or fewer. According to DOH, an average of 235 patients at NMBHI met this criterion in each of the last five years.

While outpatient services such as intensive outpatient treatment and medication assisted treatment can be much more cost-effective for substance abuse patients than inpatient treatment, and other treatments may also be more cost-effective for those dealing with other psychiatric and behavioral health issues, a 2018 LFC report notes inpatient treatment continues to be necessary for a certain portion of individuals with behavioral health needs. [4] As DOH facilities continue to provide these services, additional ability to leverage federal Medicaid resources for those services could reduce pressure on the general fund to cover these costs. A February 2021 article in *Health Affairs* notes that implemented IMD waivers for substance use disorder experienced increased acceptance of private insurance and non-Medicaid public insurance payments at residential facilities, as well as increased acceptance of Medicaid at outpatient facilities.[5] The researchers caution, however, that policymakers considering an IMD waiver may want to consider ways to prevent overutilization or inappropriate utilization of residential services.

DOH facilities lack a standardized system to track and report daily operational performance.

Over the last decade, best practices surrounding healthcare IT systems have included streamlining data collection, standardizing processes, and regularly reviewing analysis and outcomes. In sophisticated healthcare systems, the IT system is implemented to allow for real time analysis and viewing of data, enabling management decision-making.

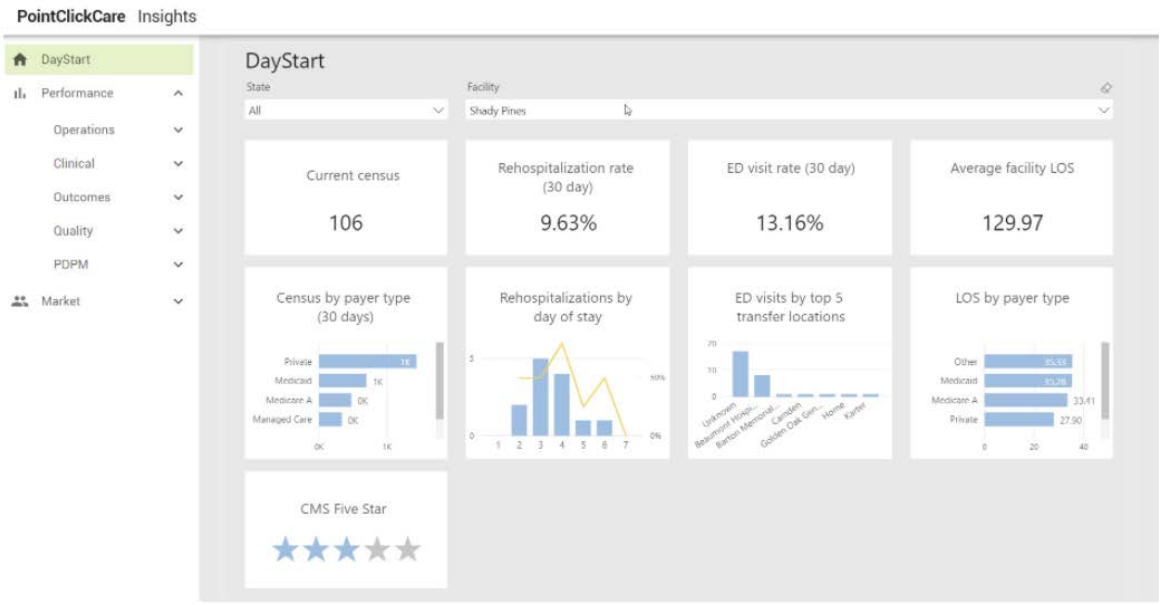
DOH contracts for two primary healthcare IT systems in its facilities: Avatar (in behavioral health and substance abuse treatment facilities) and PointClickCare (in long-term care facilities). DOH entered into a four-year contract with the vendor of Avatar in May 2019 for $2.7 million, and recently completed a four-year, $301 thousand contract with PointClickCare. Altogether, DOH paid $896 thousand for ongoing maintenance and support of these two systems in FY21.

Each of these systems has the capability to produce informative analysis in real time. The Avatar website states the software can "leverage real-time analytics and clinical decision support to drive decision-making." Similarly, PointClickCare has a series of reporting features intended to help facilities understand their operations and performance. However, these systems do not interface directly with each other or with SHARE, the state's accounting and human resources system, creating challenges for facility staff in entering and

[4] LFC (2018). "Health Notes: Cost, Use, and Effectiveness of Inpatient Behavioral Health Services for Adults."
[5] Maclean, J.C., Wen, H., Simon, K., and Saloner, B. (2021). "Institutions for Mental Diseases Medicaid Waivers: Impact on Payments for Substance Use Treatment Facilities." *Health Affairs* 40:2, p. 326-333.

monitoring data across several platforms and for DOH central leadership in monitoring day-to-day facility status.

Figure 13. Advertised Day Start Report from PointClickCare



Source: PointClickCare

While all DOH facilities have electronic health records and a healthcare software platform, the extent to which they are used to inform operational decisions varies greatly. For example, NMBHI and TLH document their daily occupancy via paper forms, while Fort Bayard Medical Center uses one of its healthcare software platforms, PointClickCare, to report and monitor its daily occupancy. Also observed is how individual facilities use their healthcare data to inform operations. Fort Bayard Medical Center actively monitors its data for negative trends, and if identified, creates a performance improvement plan to rectify the outcomes.

From a systemwide viewpoint, DOH leadership does not regularly access the healthcare IT systems, but rather relies on monthly reports from each facility using Smartsheets. Currently, facilities provide Smartsheets to the Administrative Services Division (ASD), which is not equipped to address or validate the clinical components of the data. Additionally, reviewing data on a monthly basis may not be appropriate for identifying certain issues that require quick responses. By treating DOH facilities as a unified healthcare system, as suggested in the economic feasibility study, with a unified view of data, leadership could monitor, review, and analyze costs, revenues, and health outcomes by facility in near-real time. Doing so will enable improved financial outcomes and minimize risks to the state by flagging concerning health outcomes early on.

The Medicaid management information system replacement (MMISR) project, as part of the Human Services Department's HHS 2020 initiative, is an additional opportunity for DOH to leverage a statewide data system to drive the operation of its facilities. This project intends to create a flexible data system to connect and track services across all stakeholders in the Medicaid system, including DOH. While this system would not be exclusive to DOH, the department could leverage its participation to monitor performance of

delivering services to Medicaid patients in its facilities, including costs and clinical outcomes and connections to services received through other agencies.

Recommendations

DOH should

- Develop a standard methodology to account for contingencies in staffing, census variations, and emergency capital and maintenance needs in monthly revenue and expenditure projections;
- Similar to current practice used by HSD for Medicaid projections, report at least quarterly to LFC and DFA on projected revenues and expenditures for each facility, including rationales for projected census, staffing, and allowances for uncollected revenue and unanticipated expenses;
- Reorganize responsibilities and workflow of the Administrative Services Division and facilities to allow for greater centralization of financial and billing operations, oversight, and planning;
- Assess critical data needs for management of facilities as a unified enterprise and develop a plan for integration of key operational metrics (including daily census, staffing, revenues and expenditures) with clinical data (electronic health records and clinical outcomes), including integration with the HHS 2020/Medicaid management information system replacement project. Subsequently DOH should request funding for such a system from the New Mexico Legislature through the C2 process; and
- Facilitate workgroups across all DOH facilities to share institutional knowledge and implement best practices.

NEW MEXICO Department of Health
Office of the Secretary

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

The Department of Health Response to the LFC evaluation of Department of Health Facilities: Oversight, Capacity and Performance

The LFC report reviewed financial management of DOH facilities, including revenue management and spending on staff and contractual services, assessed DOH facility capacity, utilization, conditions, staffing and their impact on quality of care as well as reviewing patient outcomes. The DOH response will focus on the key findings and recommendations of the LFC report.

The Department of Health should update the bylaws of the Health Facilities Governing Board to establish standing committees on quality and safety, finance and strategic planning.

The Department of Health concurs that inconsistent and overstretched leadership hinders accountability, and that an operational design with a dedicated Deputy Secretary and an experienced Office of Facilities Manager is optimal. Since 2015, this model has been attempted however vacancies at the leadership level have been difficult to fill and maintain. Despite this, the administrators have continued to care for complex patient mixes and have managed, as noted by the LFC, to reduce medication errors significantly. The DOH concurs that continuing to improve quality and safety, finance and strategic planning should be effectuated through the Governing Board.

Take immediate action following recommendations of infection control specialists to ensure staff are following best practices regarding use of PPE including staff education, refresher training, rounding, real-time coaching and random auditing to help ensure appropriate use of PPE.

All DOH facilities are committed to following best practices regarding the use of PPE. The COVID pandemic had a great negative impact on nursing homes, with massive outbreaks being reported in care facilities all over the world, affecting not only residents but also the care workers and visitors. There were many factors that independently contributed to higher mortality among the long-term care population. This was true of the outbreak at the New Mexico State Veterans' Home (NMSVH), where some residents were housed four to a room, with curtain dividers. DOH contracted with Infection Control Consultants of New Mexico (ICCNM) early in the pandemic to assist the Department in assessing infection control practices in both state and private long term care facilities. As noted in the LFC report, the initial infection control consultant assessment was first initiated at NMSVH in July 2020, and with continued visits and assessments in December 2020 and March 2021. A final report generated in April 2021 included dates of completion of the recommendations of the ICCNM consultant, which included concerns regarding infection control related to ongoing construction projects and standing water in the therapy pool of the Annex.

Develop a systemwide facilities master plan that includes options for replacing the New Mexico State Veterans' Home with federal support from the VA.

DOH concurs with the recommendation to replace the NMSVH with federal support from the VA. Following the outbreak and reports from both DOH Division of Health Improvement and ICCNM, DOH did request an emergency declaration from GSD and was able to contract with Architectural Research Consultant's Inc. for a facility condition assessment. As noted by the LFC, the assessment concluded that the main building did not pose a safety hazard to residents but noted issues regarding delayed maintenance, ADA compliance, and an inadequate architectural layout for a modern nursing home.

Develop a systemwide facilities master plan that includes an assessment of needs for services and options for consolidating substance abuse treatment centers.

As noted above, DOH concurs that a systemwide master plan is necessary for the efficient operation of the state's facilities. However, each facility is unique in mission, patient mix, geographical location and building design. The LFC report states that facilities operating impatient substance abuse services have the highest costs per occupied bed across the DOH facilities system, and the alignment of DOH's residential substance abuse treatment facilities make inefficient use of space. While it is accurate to report that Turquoise Lodge Hospital (TLH) relocated to a smaller facility in 2019, this move did not limit its ability to grow.

TLH moved from the space shared with Bernalillo County's substance abuse treatment services center (Zuni location) to the Gibson Medical Center (GMC) to become Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited. TLH sought JCAHO accreditation to pursue excellence in the provision of services, increase financial sustainability, and to attract patients. The move to GMC permitted TLH to increase their bed capacity from 30-40 and increased outpatient services to include an additional track of Intensive Outpatient Services (IOP), opened an Addiction Medicine Clinic, and added individual therapy services. In two years, despite the pandemic that forced TLH to operate at 50% capacity to comply with infection control and social distancing requirements, TLH was accredited by the Joint Commission under both hospital and behavioral health standards. The JCAHO accreditation enabled the hospital to become Adult Residential Treatment Center (ARTC) certified.

The LFC report suggests that expanded use of Medically Assisted Treatment (MAT) and outpatient substance use disorder treatments should obliviate the need for residential treatment services. Increasing community based behavioral health services is one of the four goals of the Behavioral Health Collaborative. New Mexico, like the rest of the country, has seen a rise in fentanyl-related deaths, surpassing both heroin and prescription opioid related deaths in the state. After almost doubling from 2018 to 2019, provisional 2020 data shows overdose rates for fentanyl increased by 129%. Fentanyl is 50-100 times more potent that morphine, is often mixed with heroin but also mixed into counterfeit opioids. Fentanyl has been found mixed in cocaine. Withdrawal management from these substances requires inpatient detoxification for buprenorphine induction to be successful. In addition to the rise of fentanyl, TLH is seeing increasing numbers of patients entering with multiple substances requiring complex withdrawal management with added psychosocial support that is best initiated in a residential treatment program.

The recent pandemic has seen a rise in the number and severity of co-occurring mental illness and substance use disorders, many requiring an ASAM level of care of 3.5 or greater. (American Society of Addiction Medicine Level 3.5 programs assist patients whose addiction is currently so out of control that they need a 24-hour supportive treatment environment to initiate or continue a recovery process.)

<u>Continue to identify instances where staffing exists to replace contacted staff with state staff.</u>

DOH concurs with the recommendation to continue to identify opportunities to replace contracted staff with state staff, and thanks the LFC for noting that expenditures for contractual services decreased at five of seven DOH facilities in 2020. Staffing safety net institutions continues to be challenging due to limited human resource pools in some locations, and the high acuity patients and low pay scales for many positions. The legislative raise for facility staff was limited to nurses, and while this did immediately improve RN staffing levels, other disciplines such as psych techs, social workers, psychologists, therapists, dietary and others did not receive a pay raise. Over 250 employees at the New Mexico Behavioral Health Institute make less than $15 an hour and must deal with psychiatric patients who can be physically and verbally aggressive.

<u>Develop a central pool of cross-trained travelling clinical staff, including nurses, technicians and other needed providers to be deployed strategically and as needed to fill staffing vacancies.</u>

DOH has utilized this strategy in other Departmental programs such as a travelling therapy team in the Developmental Disabilities Supports Division (DDSD). In the DDSD program, speech therapists can travel once a month to a remote location to train DD providers on therapeutic interventions. The facilities, however, are geographically distant and provide medical and behavioral services that are unique to the location. Staff must know the needs of their population, whether it is geriatric psychiatric care, violent adolescents, court ordered forensic patients, inpatient detox, long term care or adults with developmental disabilities. Individual specific training is essential both to safety and health outcomes for residents. While a central pool approach may provide limited staffing help, we do not believe it would be primary strategy.

At the departmental rather than facility level, develop a comprehensive strategy to recruit for and retain the highest-need positions, including establishing partnerships with New Mexico nursing schools for nurse internships and with community colleges, technical and vocational training programs, and high schools for nursing aides, psychiatric technicians and other needed clinical personnel.

DOH concurs with the recommendation to develop a strategy to recruit for and retain the highest need positions, including partnerships with New Mexico educational institutions. As the LFC noted, the Department's Office of Policy and Accountability (OPA) is overseeing an internship program offering practicums and internships for credit in nursing, medicine, social work, dietetics, epidemiology, quality coordinators as well as other disciplines.

Similar to current practice used by HSD for Medicaid projections, report at least quarterly to LFC and DFA on projected revenues and expenditures for each facility, including rationales for projected census, staffing allowances for uncollected revenue and unanticipated expenses.

DOH concurs with the recommendation, pending DFA approval, to report quarterly to the LFC on projected facility revenues and expenditures.

Reorganize responsibilities and workflow of the Department's Administrative Services Division and facilities program to centralize certain financial and billing operations, oversight and planning.

Decentralized facility operations complicate budgeting and management but facility administrators' budgets are also complicated by aging infrastructure, lack of a universal electronic medical record, outdated pharmacies, no Pyxis machines, and the complicated staffing issues discussed previously. Budget projections are based on target census and historical expenses, and fluctuations result from unexpected census changes and staff vacancies. DOH will assess needed organizational changes to support more effective operations. DOH also intends to support the RFP led by GSD to identify a medical services billing vendor for state agencies in order to better leverage Federal dollars through Medicaid.

Assess critical data needs for management of facilities as a unified enterprise and develop a plan for integration of key operational metrics (including daily census, staffing, revenues and expenditures) with clinical data (electronic health records and clinical outcomes), including integration with the HHS 2020 / Medicaid Management Information System Replacement project. Subsequently DOH should request funding for such a system from the New Mexico Legislature.

DOH concurs with this recommendation.

Facilitate work groups across all DOH facilities to share institutional knowledge and implement best practice.

DOH concurs with this recommendation.

Sincerely,

David R. Scrase, M.D.
Acting Cabinet Secretary
New Mexico Department of Health

APPENDICES

Appendix A: Evaluation Scope and Methodology

Evaluation Objectives.

- Review financial management of DOH facilities, including revenue management and spending on staff and contractual services.
- Assess DOH facility capacity, utilization, conditions, and staffing, and their impact on quality of care.
- Review patient outcomes.

Scope and Methodology.

- Visited DOH facilities and interviewed administrators and staff;
- Reviewed and analyzed financial, staffing, and clinical data from SHARE, budget documents, DOH reports, state audits, and federal agencies including the Centers for Medicare and Medicaid Services;
- Reviewed state laws, regulations, and policies related to state health facilities;
- Assessed findings and recommendations from previous LFC program evaluations of DOH facilities; and
- Reviewed best practices from the healthcare industry.

Evaluation Team.

Brian Hoffmeister, Lead Program Evaluator
Jacob Rowberry, Program Evaluator
Mary Costello, Intern

Authority for Evaluation. LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences. The contents of this report were discussed with DOH Cabinet Secretary Dr. Tracie Collins, Secretary-Designate Dr. David Scrase, and staff on July 14, 2021.

Report Distribution. This report is intended for the information of the Office of the Governor, Department of Finance and Administration, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Jon Courtney
Deputy Director for Program Evaluation

Appendix B: DOH Performance Report Card for FY21 Q3

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

PERFORMANCE REPORT CARD
Department of Health
Third Quarter, Fiscal Year 2021

ACTION PLAN

Submitted by agency?	Yes
Timeline assigned?	No
Responsibility assigned?	No

"Access to and availability of effective contraceptive methods contribute to the steady decrease in New Mexico's teen birth rate. The broad range of contraceptive methods including IUDs and implants (most-effective) and pills, injectable, and rings (moderately-effective) is available at 41 of the 43 public health offices that offer family planning services. In December 2020, 34 Public Health Offices provided family planning services, due to COVID response. Since 2014, the teen birth rate among 15-to-19-year-olds in New Mexico has declined by 34.8% to 24.4 per 1,000 in 2019 (NM IBIS) and is tied in 2018 for the seventh highest in the nation (at 25.2 per 1,000, with Tennessee and Texas) (National Center for Health Statistics)."

Source: Department of Health

Department of Health

The Department of Health's (DOH) mission is to promote health and wellness, improve health outcomes, and assure safety net services for all people in New Mexico. DOH reported some increases in performance targets across the agency during the third quarter of FY21.

Covid-19

A significant portion of the state's response to Covid-19 is either managed, delivered, or coordinated by the Department of Health. Given the tremendous department resources being dedicated to the pandemic, DOH began reporting temporary performance measures regarding this work. New Mexico has continued to rank highly nationally for vaccine distributions. As of April 2021, DOH reported that 47 percent of New Mexicans have been fully vaccinated.

Covid-19	FY21 Target	FY21 Q1	FY21 Q2	FY21 Q3
Covid-19 swab tests performed	N/A	104,540	180,511	60,246
Hours between the time a case is identified and when the case is contacted by Epidemiology and Response Division to isolate	24	24	25	21
Hours between the time a case contact is identified and when the case contact is contacted by Epidemiology and Response Division to quarantine	36	30	29	25
Facility admissions (and hospital readmissions) having two verified Covid-19 negative tests	100%	63%	53%	71%
Staff tested for Covid-19	20%	100%	100%	100%
Patients/residents tested for Covid-19	25%	100%	100%	100%
Number and percent of individuals receiving Home and Community Based Services (HCBS) who have received a Covid-19 test	N/A	2,864/ 5,134 16.8%	1,416/ 5,239 27.0%	967/ 5,364 18%
Number and percent of individuals receiving Home and Community Based Services (HCBS) who have received a Covid-19 test	N/A	24/5,134 0.7%	373/ 5,239 7.1%	115/ 5,364 2.1%
Number and percent of individuals receiving Home and Community Based Services (HCBS) who are confirmed positive for Covid-19	N/A	518/596 86.9%	1,201/ 1,558 77.1%	3,363/ 4,657 72.2%
Covid-19 tests resulted within 48 hours of receipt in the laboratory	95%	82%	99%	99%
Percent and number of individuals who have been fully vaccinated	N/A	N/A	N/A	1,525/3,258 47%

Public Health Program

The Public Health Program continues to be a cornerstone of the state's response to Covid-19. Given the significant size the of program's response to the pandemic and statewide closures the program has reported declines in performance on tobacco cessation services and behavioral health in school based health centers. During the third

quarter, the program reported meeting performance targets for females receiving the most or moderately effective contraception, increased healthy eating opportunities for children, and participation in diabetes prevention programming. During the first quarter, DOH was unable to refer participants to diabetes prevention services but increased performance during the second and third quarters. In 2018, an estimated 567 thousand New Mexican adults had prediabetes and only three out of 10 were aware of their condition. The CDC states without weight loss and physical activity, 15 to 30 percent of pre-diabetics will develop diabetes within 5 years, but with access to a services change program the risk can be reduced by nearly half.

Budget: $170,302.6 FTE: 775	**FY19 Actual**	**FY20 Actual**	**FY21 Target**	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**Rating**
Adolescents who smoke	8.9%	Not Reported	N/A	Reported Annually			
Adult who smoke	16%	Not Reported	N/A	Reported Annually			
Adult cigarette smokers who access cessation services	2.7%	2.6%	2.9%	0.4%	0.5%	0.5%	R
Successful overdose reversals per client enrolled in the NMDOH Harm Reduction Program	3,446	3,444	3,000	754	657	Not Reported	R
Births to teens per 1,000 females aged 15-19	21.7	Not Reported	N/A	Reported Annually			
Female clients ages 15-19 seen in NMDOH public health offices who are provided most or moderately effective contraceptives	68.5%	85.8%	62.5%	90.3%	89.8%	84.9%	G
Teens that successfully complete teen pregnancy prevention programming	512	502	232	Reported Annually			
School-based health centers that demonstrate improvement in their primary care or behavioral health care focus area	86%	50%	95%	0%	0%	0%	R
Third grade children who are considered obese	20.8%	22.9%	N/A	Reported Annually			
Children in Healthy Kids, Healthy Communities with increased opportunities for healthy eating in public elementary schools	99%	97%	89%	98%	98%	98%	G
Participants in the National Diabetes Prevention Program that were referred by a health care provider through the agency-sponsored referral system	29%	27%	25%	0%	100%	52%	G
Preschoolers (19-35 months) who are indicated as being fully immunized	69.9%	62.9%	65%	64.6%	64.3%	63.7%	R
Older adults who have ever been vaccinated against pneumococcal disease	71.6%	Not Reported	75%	Reported Annually			
Program Rating	Y	Y					Y

Epidemiology and Response

The Epidemiology and Response Program (ERD) also plays a key role in the state's response to the pandemic, including case investigations of individuals who test positive for Covid-19 and contact tracing of individuals with direct exposure to Covid-19. The program did not meet a majority of performance targets.

As of July 1, 2020, a newly created home and community-based waiver was federally approved. The Supports Waiver is an option for individuals who are on the Developmental Disabilities (DD) waiver wait list. Supports Waiver services are intended to complement unpaid supports that are provided to individuals by family and others.

In FY21 Q1, the Developmental Disabilities Supports Division (DDSD) began providing offer letters to individuals on the DD waiver waitlist. Over 200 people have begun receiving services.

Budget: $108,305.7 FTE: 204	**FY19 Actual**	**FY20 Actual**	**FY21 Target**	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**Rating**
Youth who were sexually assaulted in the last 12 months	11.4%	11.4%	N/A	Reported Annually			
Youth who have completed an evidence-based or evidence-supported sexual assault primary prevention program	5,905	13,051	7,000	0	287	1,958	R
Suicide per 100,000 population	24.1	Not Reported	N/A	Reported Annually			
Community members trained in evidence-based suicide prevention program	522	1,030	225	0	143	213	G
Hospitals with emergency department based self-harm secondary prevention program	New	2.5%	7%	2.5%	2.5%	2.5%	R
Alcohol-related deaths per 100,000 population	Not Reported	Reported Fall 2021	N/A	Reported Annually			
Persons receiving alcohol screening and brief intervention (a-SBI) services	20.8	62.7	5%	Reported Annually			
Retail pharmacies that dispense naloxone	83%	95%	85%	90%	88%	88%	G
Opioid patients also prescribed benzodiazepines	12%	11%	5%	11%	11%	11%	R
Heat related illness hospitalizations per 100,000 population	2.1	Reported Fall 2021	N/A	Reported Annually			
Cardiovascular disease (heart disease & stroke) deaths per 100,000 population	203.7	Not Reported	N/A	Reported Annually			
NM hospitals certified for stroke care	16%	14%	24%	14%	14%	16%	R
Rate of fall-related deaths per 100,000 adults, aged 65 years or older	91.6	Reported Fall 2021	N/A	Reported Annually			
Emergency department based secondary prevention of older adult fractures due to falls programs	Data not collected	5%	7%	5%	0%	0%	R
Rate of pneumonia and influenza death per 100,000 population	13.1	Not Reported	N/A	Reported Annually			
Cities and counties with Access and Functional Needs (AFN) plans that help prepare vulnerable populations for a public health emergency	New	5%	65%	15%	20%	15%	R
Rate of avoidable hospitalizations per 100,000 population	751	Reported Fall 2021	N/A	Reported Annually			
Program Rating	Y	Y					R

Scientific Laboratory

The Scientific Laboratory Program provides a wide variety of laboratory services to programs operated by numerous partner agencies across the State of New Mexico. The program provides a significant level of Covid-19 testing in the state. The program met all performance targets for the second quarter.

As of 2016, New Mexico has the twelfth highest drug overdose death rate in the nation. The consequences of substance use are not limited to death, but include many medical and social consequences, including poverty and lack of adequate insurance. Turquoise Lodge Hospital (TLH) is a specialty hospital that provides safety net services for New Mexican adults with substance use disorders.

Budget: $16,963.1 FTE: 136	**FY19 Actual**	**FY20 Actual**	**FY21 Target**	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**Rating**
Blood alcohol tests from driving-while-intoxicated cases that are completed and reported to law enforcement within 30-calendar days	44%	91%	95%	96%	97%	99%	G
Environmental samples for chemical contamination that are completed and reported to the submitting agency within 60-business days	91%	91%	90%	99%	93%	99%	G
Public health threat samples for communicable diseases and other threatening illnesses that are completed and reported to the submitting agency within published turnaround times	97%	97%	90%	99%	97%	99%	G
Program Rating	Y	Y					G

Facilities Management

The Facilities Management Division (FMD) provides services for mental health, substance abuse, long-term care, and physical rehabilitation in both facility and community-based settings. Intake and capacity of state facilities has also been impacted by the global pandemic. Many of the state facilities have experienced declining occupancy. If facilities are unable to increase their occupancy there will be significant operational funding strains. The Department of Health has projected an estimated operating deficit in current fiscal year due to declining occupancy. Occupied beds fell to 55 percent in the third quarter, falling 25 percent below the previous fiscal year. In particular, the New Mexico Veterans' Home (NMVH) and the Behavioral Health Institute have seen significant declines is occupancy. NMVH spent $16.9 million on operations in FY20, with total revenue of $14.1 million. Between July 2019 and December 2020, the average monthly census at NMVH was 109 individuals, with a high of 123 in July 2020 and a low of 69 in December 2020. The average monthly cost per patient over this period was $12,400, and noticeably increased to $19 thousand when the census dropped in December 2020. New Mexico Medicaid data indicated the average cost per member Nursing Facility Private – Low Level of Care in 2020 was $4,738.

According to the U.S. Centers of Disease Control and Prevention, for the year 2013, the average specialty hospital occupancy rate in the United States was 63 percent and in New Mexico the average rate was 56 percent.

Budget: $151,277.2 FTE: 2,003	**FY19 Actual**	**FY20 Actual**	**FY21 Target**	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**Rating**
Eligible third-party revenue collected at all agency facilities	83%	81%	93%	95%	87%	96%	G
Beds occupied	New	New	75%	61%	58%	55%	R
Overtime hours worked	New	New	387,000	182,686	178,853	175,350	R
Direct care contracted hours	New	New	N/A	36,015	49,598	47,236	

New Mexico has one of the highest suicide rates in the country. The state's Medical Advisory Team estimated that the Covid-19 pandemic will likely exacerbate behavioral health issues and could lead to an increase in suicides. State agencies and the suicide prevention coalition should expand and use proven initiatives, including ensuring care is provided to those in crisis and that care continues after a crisis, increasing access to behavioral healthcare through telehealth, and expanding gatekeeper training. Finally, the Legislature could enact laws to restrict access to lethal means and to strengthen best practices for the coalition and strategic plan.

Significant medication errors per 100 patients	2.4	.2	2.0	0.7	.6	1	G
Long-term care residents experiencing one or more falls with major injury	3.9%	5.3%	4%	4.5%	3%	4.5%	R
Long-term Veterans Home residents experiencing facility acquired pressure injuries	.8%	4.4%	2%	4.9%	2.8%	4.8%	R
Adolescent residents (SATC & NMBHI Care Unit) who successfully complete program	78%	77%	90%	86%	100%	100%	G
Priority Request for Treatment clients who are provided an admission appointment to Turquoise Lodge's program within 2 days	68%	66%	50%	55%	70%	69%	G
Medical detox occupancy at Turquoise Lodge Hospital	83%	68%	75%	69%	67%	72%	R
Naltrexone initiations on alcohol use disorders	New	New	360	38	46	47	R
Naltrexone initiations on opioid use disorders	New	New	12	1	0	1	R
Buprenorphine inductions conducted or conducted after referrals on opioid use disorders	New	New	240	34	29	41	R
Narcan kits distributed or prescribed	New	New	180	49	48	70	R
Program Rating	Y	Y					Y

Developmental Disabilities

DOH reported a decline in the number of individuals receiving Developmental Disabilities (DD) and Mi Via Medicaid waivers. The program reported as of April 2021, there were 4,646 individuals on the waiting list for waivers. Of those individuals, 485 have placed their allocation on hold, meaning these individuals were offered waiver services and chose to remain on the waiting list, for now. During the third quarter, the number of individuals on the waitlist decreased. As of January 2021, over 200 individuals on the wait list had enrolled in the community supports waiver, far less than the 1,000 expected. The slow enrollment of people on wait list for the community supports waiver and increased federal matching dollars have led to a significant projected surplus for the program.

Budget: $167,880.4 FTE: 182	**FY19 Actual**	**FY20 Actual**	**FY21 Target**	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**Rating**
Individuals on the developmental disabilities' waiver waiting list	5,064	4,743	N/A	4,713	4,660	4,646	
Individuals receiving developmental disability waiver services	4,641	4,934	N/A	4,859	5,034	5,053	
Individuals receiving developmental disability supports waiver services	New	New	N/A	0	4	44	

People on the waiting list that are formally assessed once allocated to the DD Waivers	New	New	100%	100%	100%	100%	G
Developmental disabilities waiver applicants who have a service and budget in place within 90-days of income and clinical eligibility	87%	96%	95%	93%	97%	100%	G
Adults of working age (22 to 64 years), served on the DD Waiver (traditional or Mi Via) who receive employment supports	29%	29%	34%	27%	27%	25%	Y
DD Waiver providers in compliance with General Events timely reporting requirements (2-day rule)	66%	84%	86%	70%	55%	27%	Y
Program Rating	Y	Y					Y

Health Certification, Licensing, and Oversight

The Health Certification, Licensing, and Oversight Program met a majority performance measures targets during the third quarter of FY21. The program also has many Covid-19 related activities such as routine outreach to all nursing homes and assisted living facilities in the state in order to obtain information on how many staff and residents have been tested for Covid-19, test results, deaths, number of test kits available, and identifying any issues with PPE and staffing.

Budget: $14,371.1 FTE: 183	**FY19 Actual**	**FY20 Actual**	**FY21 Target**	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**Rating**
Rate of abuse for developmental disability waiver and mi via waiver clients	10.6%	12.8%	NA	7.4%	9%	5.5%	G
Rate of re-abuse for developmental disability waiver and mi via waiver clients	7%	8.5%	N/A	Reported Annually			
Percent of abuse, neglect and exploitation investigations completed within required timeframes	48.6%	81.7%	86%	99.5%	99%	92%	G
Percent of (IMB) assigned investigations initiated within required timelines	New	90.3%	86%	96.2%	92.7%	93.3%	G
Percent of Assisted Living Facilities in compliance with caregiver criminal history screenings requirements	New	77%	85%	97%	96%	93%	G
Percent of Nursing Home survey citation(s) upheld as valid when reviewed by the Centers of Medicare and Medicaid Services (CMS) and through Informal Dispute Resolution	85%	83%	90%	100%	100%	60%	Y
Program Rating	Y	Y					G

Appendix C: Nursing Facility Deficiency Scope and Severity Grid

7400.3.1 - *Matrix for Scope & Severity*

(Rev. 185, Issued: 11-16-18, Effective: 11-16-18, Implementation: 11-16-18)

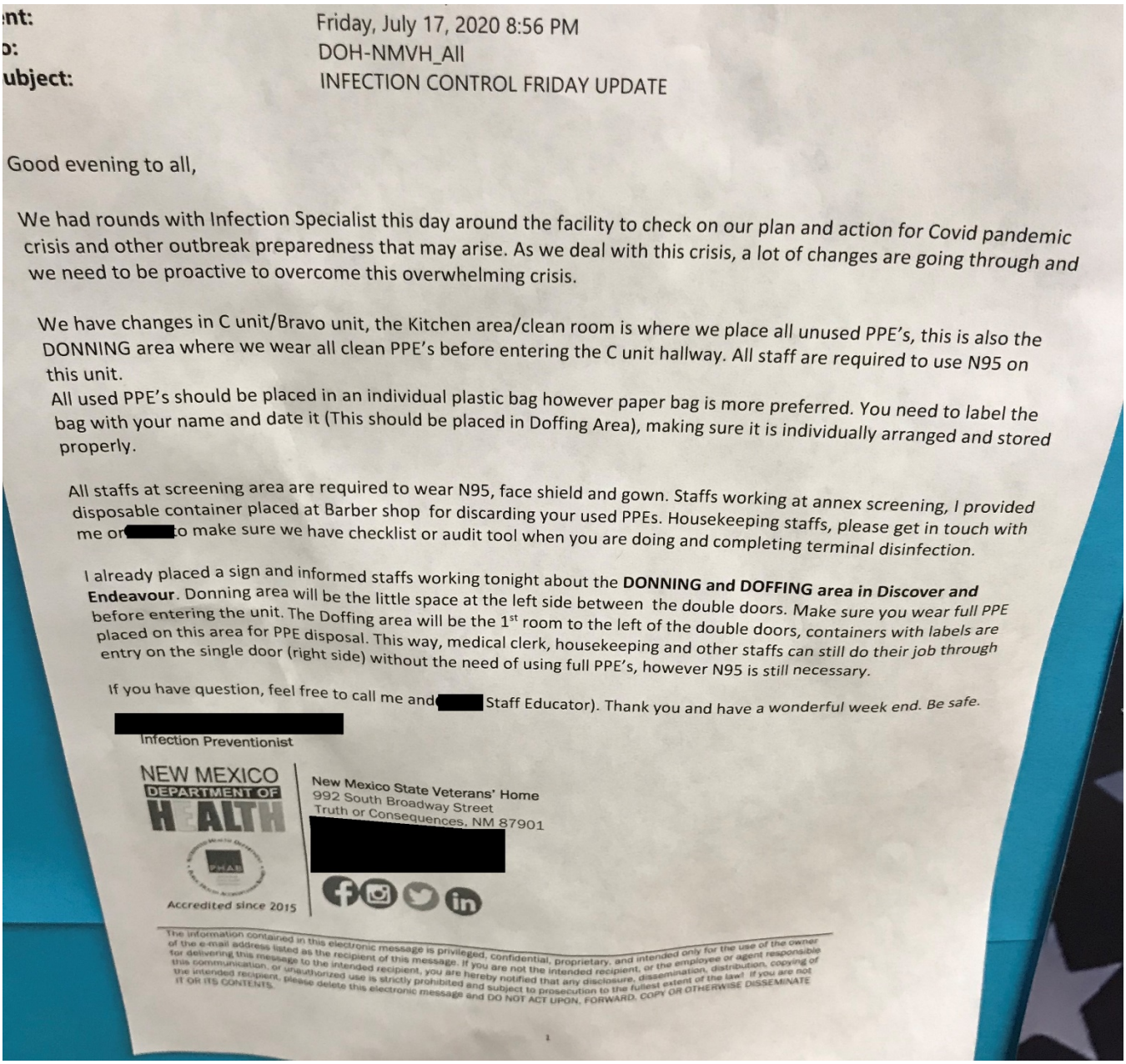
Immediate jeopardy to resident health or safety	*J* ▒	*K* ▒	*L* ▒
Actual harm that is not immediate	*G*	*H* ▒	*I* ▒
No actual harm with potential for more than minimal harm that is not immediate jeopardy	*D*	*E*	*F* ▒
No actual harm with potential for minimal harm	*A* ▒ *No PoC* ▒	*B* ▒	*C* ▒
	Isolated	***Pattern***	***Widespread***

▒ *Substandard Quality of Care (SQC) is defined in* 42 C.F.R. §48*8.301 as one or more deficiencies which* constitute *either* immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, *but less than* immediate jeopardy, with no actual harm, *related to certain participation requirements.*

▒ Substantial` compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements (42 C.F.R. §488.301).

Source: Centers for Medicare and Medicaid Services State Operations Manual

Appendix D: NMVH Covid-19 PPE Direction E-mail



nt: Friday, July 17, 2020 8:56 PM
o: DOH-NMVH_All
ubject: INFECTION CONTROL FRIDAY UPDATE

Good evening to all,

We had rounds with Infection Specialist this day around the facility to check on our plan and action for Covid pandemic crisis and other outbreak preparedness that may arise. As we deal with this crisis, a lot of changes are going through and we need to be proactive to overcome this overwhelming crisis.

We have changes in C unit/Bravo unit, the Kitchen area/clean room is where we place all unused PPE's, this is also the DONNING area where we wear all clean PPE's before entering the C unit hallway. All staff are required to use N95 on this unit.
All used PPE's should be placed in an individual plastic bag however paper bag is more preferred. You need to label the bag with your name and date it (This should be placed in Doffing Area), making sure it is individually arranged and stored properly.

All staffs at screening area are required to wear N95, face shield and gown. Staffs working at annex screening, I provided disposable container placed at Barber shop for discarding your used PPEs. Housekeeping staffs, please get in touch with me or[redacted]o make sure we have checklist or audit tool when you are doing and completing terminal disinfection.

I already placed a sign and informed staffs working tonight about the **DONNING and DOFFING area in Discover and Endeavour**. Donning area will be the little space at the left side between the double doors. Make sure you wear full PPE before entering the unit. The Doffing area will be the 1st room to the left of the double doors, containers with labels are placed on this area for PPE disposal. This way, medical clerk, housekeeping and other staffs can still do their job through entry on the single door (right side) without the need of using full PPE's, however N95 is still necessary.

If you have question, feel free to call me and[redacted] Staff Educator). Thank you and have a wonderful week end. Be safe.

[redacted]
Infection Preventionist

NEW MEXICO DEPARTMENT OF HEALTH
Accredited since 2015

New Mexico State Veterans' Home
992 South Broadway Street
Truth or Consequences, NM 87901
[redacted]

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Source: LFC staff photo, June 16, 2021

Appendix E: Summary of NMVH Capital Projects

Summary of FY20-FY21 Capital Projects at NMVH			
Project	**Phase**	**Amount (Thousands)**	**Notes**
Boiler repair	Planning	$73.3	Emergency
Tunnel repair	Close out	$896.5	
Annex HVAC retrofit and repair	Construction	$220.1	
Annex re-work	Planning	$535.3	Emergency
Main building roof repairs	Construction	$114.2	
Surveillance system upgrades	Construction	$394.7	
Backup generator replacement	Construction	$96.4	
Annex HVAC controls	Planning	$95.3	Emergency
Education building roof replacement	Construction	$169.5	
Main building drainage improvements	Construction	$125.7	
Annex pool systems repair	Construction	$176.1	
Annex pool water line repair	Construction	$58.5	
Annex dishwasher booster heaters	Construction	$36.1	
Annex HVAC electrical issues	Construction	$141.6	
Annex settlement monitoring	Construction	$9.7	
Main building B&C units plumbing investigation	Construction	$81.4	
Main building comprehensive facility assessment	Close out	$51.9	Emergency
Dietary boiler blower fan replacement	Construction	$3.8	
Drainage repairs	Construction	$238.7	
Education building RTU replacement	Construction	$31.6	
Fiber communication interconnections	Planning	$59.8	
Annex geotechnical testing	Design	$4.5	
Annex HVAC electric meter and accusine and harmonic filter installation	Planning	$178.0	Emergency
Main building kitchen/dining hall HVAC replacement	Close out	$640.4	
Plumbing repairs	Construction	$12.1	
Main building resident units A-4 and A-5 drain remodel/repair	Construction	$91.4	
Sewer line pressure test	Close out	$3.1	
Sliding door replacement	Close out	$520.3	
Tunnel section support	Construction	$14.8	
Underground valve replacement	Close out	$1.7	
Unit C access controls	Construction	$43.4	
Water totalizer replacement	Planning	$5.4	
Unit C window replacement	Construction	$18.6	
Total		**$5,143.9**	

Source: GSD

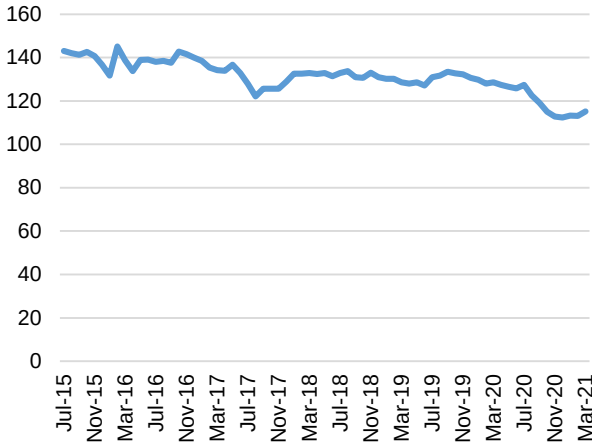
Appendix F: Facility Summary Information

Fort Bayard Medical Center

Location:	Santa Clara, Grant County
Licensed Beds:	200
FY20 Average Daily Census:	130
FY20 Spending:	$27.3 million
FY21 Budget:	$29.6 million

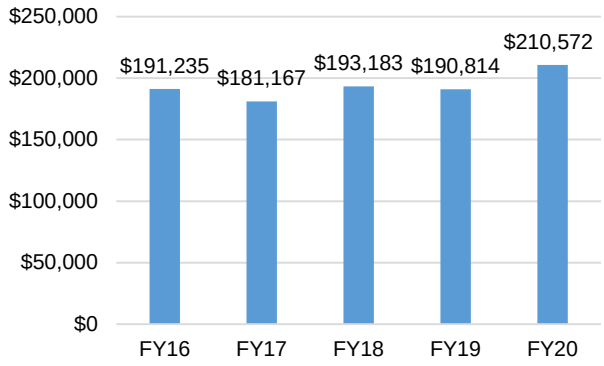
Fort Bayard Medical Center (FBMC) is a 200-bed long-term care facility in Santa Clara, near Silver City. FBMC provides long-term intermediate and skilled nursing care to individuals who have a medical need and can no longer care for themselves. The current building opened in 2010 and includes a 40-bed veterans' unit, serving honorably discharged military veterans, their spouses, and gold star parents. The facility formerly housed Yucca Lodge, a residential treatment center for individuals with substance abuse disorders. Since that unit ceased operation in 2017, the 20-bed wing it formerly occupied is vacant.

FBMC Average Daily Census, FY16-FY21 Q3



Source: DOH

FBMC Average Expenditure per Occupied Bed, FY16-FY20



Source: LFC analysis of DOH and SHARE data

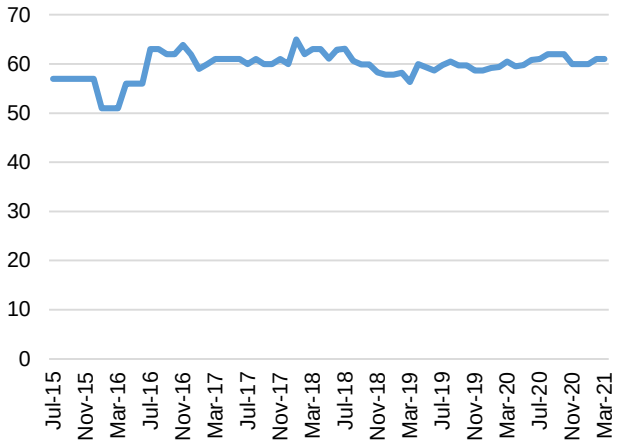
Los Lunas Community Program

Location:	Los Lunas/Belen, Valencia County
Licensed/Total Beds*:	60 Supported Living 6 Intensive Medical Living Services 4 Intermediate Care Facility (licensed) 2 Crisis Services **72 Total**
FY20 Average Daily Census:	60
FY20 Spending:	$17.6 million
FY21 Budget:	$17.8 million

*Note: LLCP has 4 licensed beds in its intermediate care facility; home-based services for individuals with developmental disabilities are not licensed health facilities.

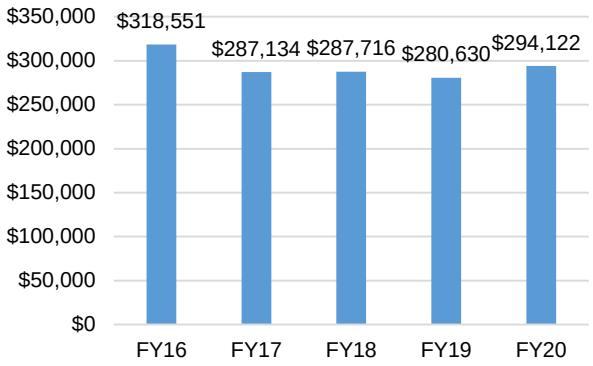
Los Lunas Community Program (LLCP) primarily offers supportive living services to individuals with intellectual and developmental disabilities (IDD) and significant medical or behavioral challenges. Services are provided in a network of homes throughout Los Lunas, Belen, and other communities in Valencia County, and funded primarily through the Developmental Disabilities Medicaid Waiver. LLCP also has six beds providing home-based intensive medical living services to individuals with IDD who have significant medical needs, as well as a leased home with secure modifications serving as a four-bed intermediate care facility housing individuals deemed by the courts as not competent to stand trial.

LLCP Average Daily Census, FY16-FY21 Q3



Source: DOH

LLCP Average Expenditure per Occupied Bed, FY16-FY20



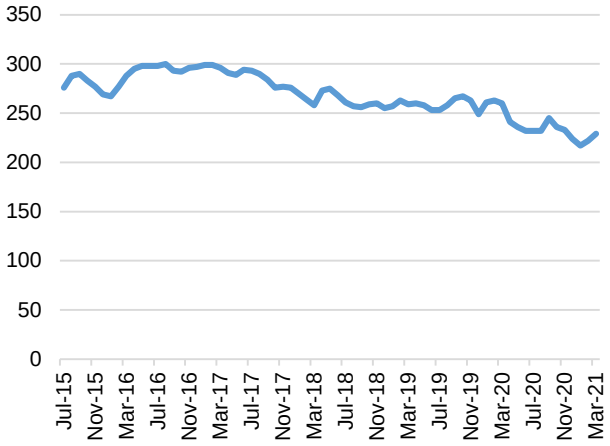
Source: LFC analysis of DOH and SHARE data

New Mexico Behavioral Health Institute

Location:	Las Vegas, San Miguel County
Licensed Beds:	121 Adult Psychiatric 176 Long-Term Care 92 Forensic 12 Adolescent **401 Total**
FY20 Average Daily Census:	254
FY20 Spending:	$58.4 million
FY21 Budget:	$59.2 million

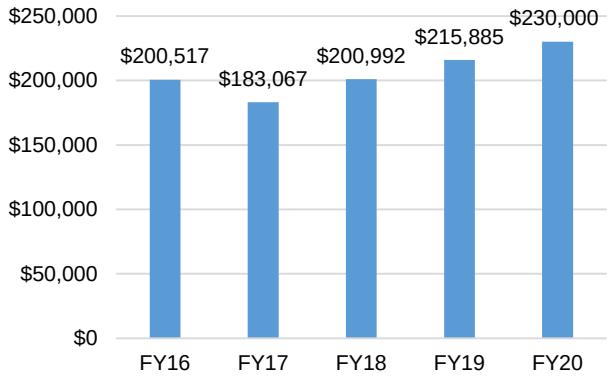
New Mexico Behavioral Health Institute (NMBHI) is the largest facility operated by the Department of Health, with 401 licensed beds across four main areas of treatment. The **Adult Psychiatric Division** provides inpatient care to individuals with severe mental illness and behavioral needs, while the **Forensic Division** provides these services in a secure environment to persons who have been court-ordered for treatment to achieve competency to stand trial. NMBHI also operates the 176-bed **Meadows Home,** a long-term care skilled nursing facility, and the 12-bed **Center for Adolescent Relationship Exploration (CARE)**, which offers inpatient treatment to males aged 13 to 17 with a history of sexually harmful behavior and a diagnosis of a co-occurring mental illness. Several of the buildings on the NMBHI campus are aging, including the secure Forensic Unit, which was built in the 1970s and does not meet anti-ligature standards, increasing the risk of strangulation.

NMBHI Average Daily Census, FY16-FY21 Q3



Source: DOH

NMBHI Average Expenditure per Occupied Bed, FY16-FY20



Source: LFC analysis of DOH and SHARE

New Mexico Rehabilitation Center

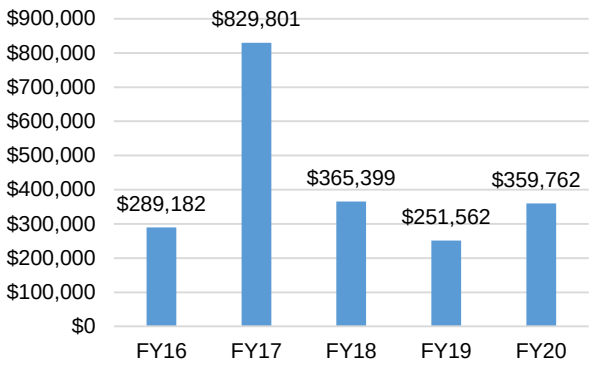
Location:	Roswell, Chaves County
Licensed Beds:	15 Inpatient Medical Rehabilitation 16 Inpatient Residential Substance Abuse Treatment 12 Inpatient Medical Detoxification **43 Total**
FY20 Average Daily Census:	22
FY20 Spending:	$8 million
FY21 Budget:	$8.1 million

New Mexico Rehabilitation Center (NMRC) offers medical rehabilitation and substance abuse treatment services at a licensed specialty hospital facility in Roswell. Medical rehabilitation includes physical, occupational, and speech therapy for individuals recovering from major surgery, injury, or illness. Inpatient substance abuse treatment services include residential treatment and medical detoxification. NMRC also offers an intensive outpatient program (IOP) for individuals with substance abuse disorders, with two program tracks of up to 15 participants each receiving group therapy services. NMRC has struggled to maintain consistent census levels in recent years and has the highest cost per bed of all DOH facilities.

NMRC Average Daily Census, FY16-FY21 Q3

Source: DOH

NMRC Average Expenditure per Occupied Bed, FY16-FY20



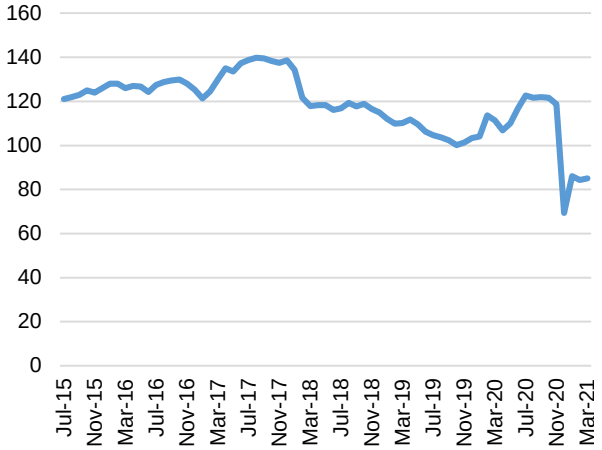
Source: LFC analysis of DOH and SHARE data

New Mexico State Veterans' Home

Location:	Truth or Consequences, Sierra County
Licensed Beds:	135 Long-Term Care Nursing 10 Domiciliary (Assisted Living) **145 Total**
FY20 Average Daily Census:	106
FY20 Spending:	$16.9 million
FY21 Budget:	$17.9 million

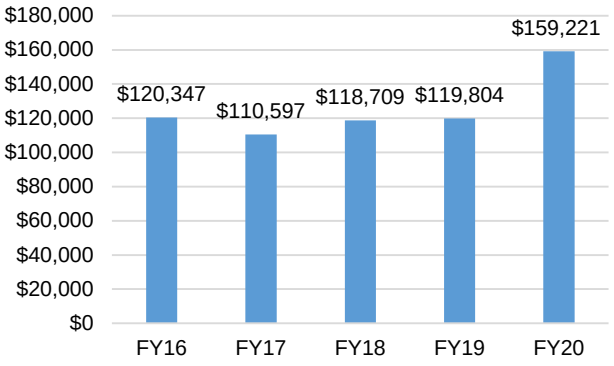
The New Mexico State Veterans' Home (NMVH) provides long-term care to honorably discharged military veterans, their spouses, and gold star parents. NMVH occupies two buildings on its campus in Truth or Consequences, one originally built in 1935 as the former Carrie Tingley Children's Hospital, and a new annex constructed in 2017 to provide residential memory care. Both buildings have experienced problems with their construction in recent years, and NMVH has been fined over $180 thousand since 2015 by the Centers for Medicare and Medicaid Services due to resident health and safety concerns.

NMVH Average Daily Census, FY16-FY21 Q3



Source: DOH

NMVH Average Expenditure per Occupied Bed, FY16-FY20



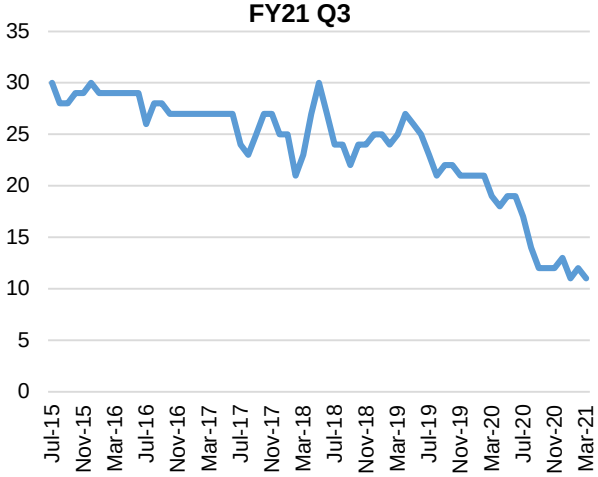
Source: LFC analysis of DOH and SHARE data

Sequoyah Adolescent Treatment Center

Location:	Albuquerque, Bernalillo County
Licensed Beds:	36
FY20 Average Daily Census:	21
FY20 Spending:	$6.8 million
FY21 Budget:	$7.2 million

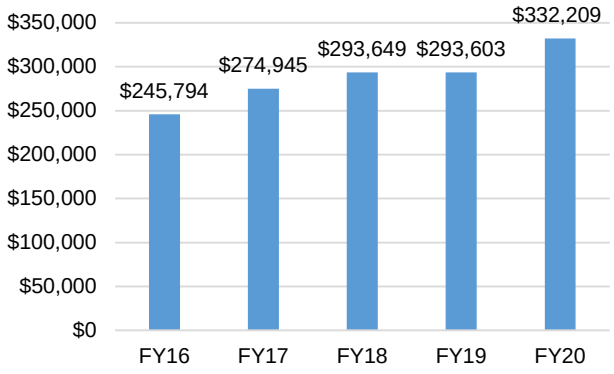
Sequoyah Adolescent Treatment Center (SATC) is a 36-bed residential treatment facility for males aged 13 to 17 who have a history of violent behavior, a diagnosed mental health disorder, and are amenable to treatment. SATC clients may be referred to services through their families, healthcare providers, or the Children, Youth and Families Department. SATC is not a forensic facility and does not detain youth or conduct court-ordered competency evaluations. Services are provided through multidisciplinary teams offering a variety of therapeutic and educational interventions tailored to the client's needs. SATC has operated only 50 percent of its licensed capacity through much of the Covid-19 pandemic, resulting in low census and high costs per bed.

SATC Average Daily Census, FY16-FY21 Q3



Source: DOH

SATC Average Expenditure per Occupied Bed, FY16-FY20

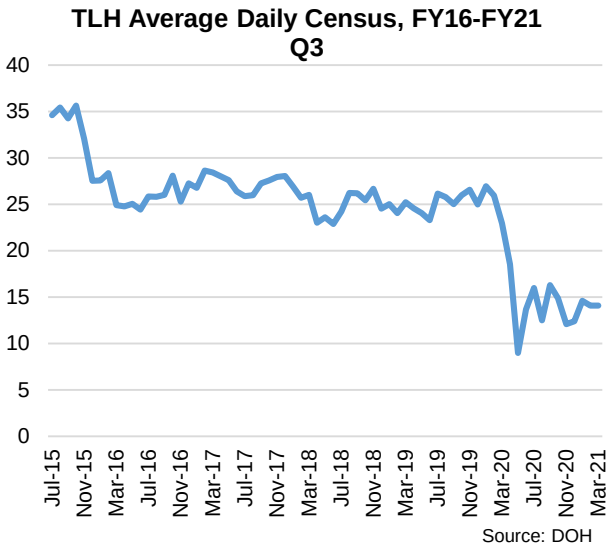


Source: LFC analysis of DOH and SHARE data

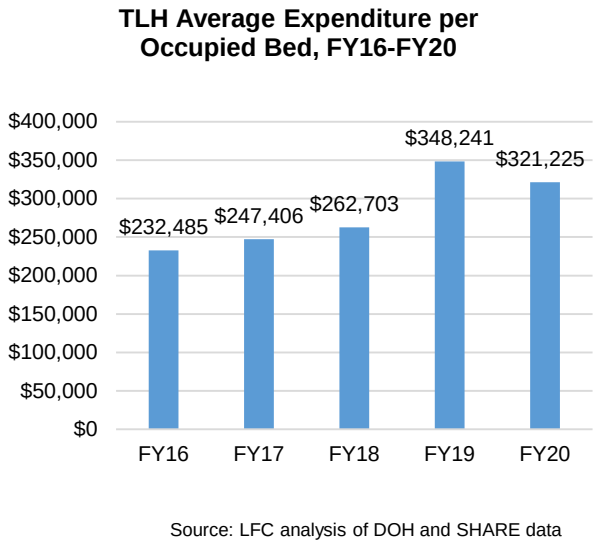
Turquoise Lodge Hospital

Location:	Albuquerque, Bernalillo County
Licensed Beds:	20 Inpatient Residential Substance Abuse Treatment 20 Inpatient Medical Detoxification **40 Total**
FY20 Average Daily Census:	23
FY20 Spending:	$7.3 million
FY21 Budget:	$7.8 million

Turquoise Lodge Hospital (TLH) provides inpatient residential treatment and medical detox services for individuals with substance abuse disorders. Since 2019, TLH has leased space in the Gibson Medical Center building in Albuquerque, having formerly shared a campus with Bernalillo County's behavioral health services center. In addition to its 40-bed inpatient services, TLH provides an intensive outpatient program (IOP) with 15 slots for group therapy and treatment sessions. TLH has operated just 50 percent of its licensed beds throughout much of the Covid-19 pandemic, resulting in low census and high costs per bed.



Source: DOH



Source: LFC analysis of DOH and SHARE data