Report
to
The LEGISLATIVE FINANCE COMMITTEE

Department of Health
Review of Facility Management Division
May 25, 2007

Report #07-01

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DAVID ABBEY
DIRECTOR

May 25, 2007

Michelle Lujan-Grisham, Secretary
Department of Health
1190 S. St. Francis Drive
Runnels Building – North 4100
Santa Fe, New Mexico 87502

Dear Ms. Lujan-Grisham,

On behalf of the Legislative Finance Committee (committee), I am pleased to transmit the Review of Facility Management Division of the Department of Health (department).

The review team interviewed key personnel, examined documents, and analyzed data provided by the Division and the facilities to assess the effectiveness and efficiency of the Divisions' oversight, staffing patterns, capital needs, information systems, and performance measures being tracked and reported.

The report will be presented to the committee on May 25, 2007. We very much appreciate the cooperation and assistance we received from you and your staff. An exit conference was held with your staff on May 16, 2007 to discuss the contents of the report and to address any concerns.

The committee expects a corrective action plan from the department within 30-days from the date of the hearing. Staff will continuously monitor your progress.

I believe that this report addresses issues the committee asked us to review and hope the New Mexico Department of Health will benefit from our efforts. Thank you for your cooperation and assistance.

Sincerely,

David Abbey
Director

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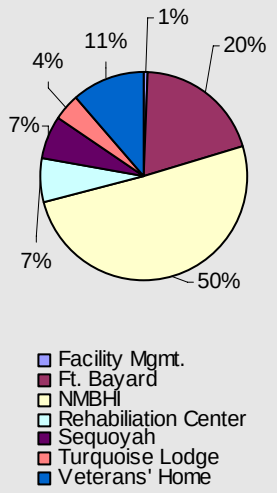
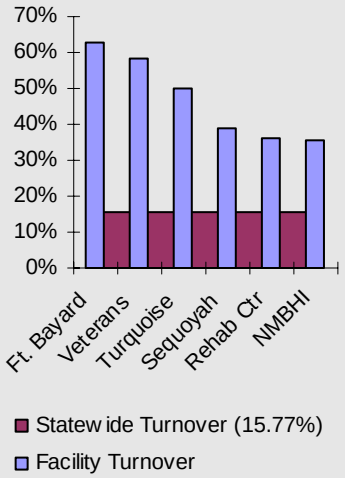
EXECUTIVE SUMMARY

FY07 Division Operating Budget $109.1 Million



Source: FY08 Division Budget

Facility Turnover Compared to the Statewide Average



Source: LFC Analysis

The review of the Department of Health (Department) Facilities Management Division (Division) was conducted to determine if the Division is meeting its statutory purpose; the six facilities it oversees have performance measures that align with the facilities' missions; if the facilities are adequately staffed to provide services; the facilities have systems that meet their needs; and infrastructure needs are addressed.

The purpose of the facilities management program is to provide oversight for Department facilities that provide health and behavioral health care services including mental health, substance abuse, nursing home and rehabilitation programs in facility and community-based settings and serve as the safety net for the citizens of New Mexico.

The facilities have a total of 1,938 employees and a budget of $109.1 million.

Personnel: turnover, vacancies and policies. The Division's three key positions turned over up to three times since FY05. The facilities turnover went from 40 percent in FY04 to almost 55 percent in FY06. The facility turnover rate ranged from 35 to 62 percent for FY06, which is 19 to 46 percent above the statewide turnover rate and 16 to 43 percent above the Department's turnover rate. Ft. Bayard had the highest percent increase from FY05 to FY06 at 42 percent followed by the Veterans' Home at 37 percent. On average the positions with the highest turnover from FY04 to FY06 were nursing and clinical positions. Nursing turnover was highest at Turquoise Lodge, 83 percent and lowest at New Mexico Behavioral Health Institute, 31 percent. Clinical turnover was again highest at Turquoise Lodge, 61 percent and lowest at NMBHI, 22 percent. All facilities except Turquoise Lodge had increased vacancy rates during FY05 and FY06.

Interviews and documentation provided by the Division and the facilities showed that the chain-of-command is not consistently followed, there is no consistency or logic regarding how pay increases for additional responsibilities are granted, the Division did not uniformly enforce the overtime policy at all the facilities, and that the NMBHI hospital administrator has been in an interim position since October 2005.

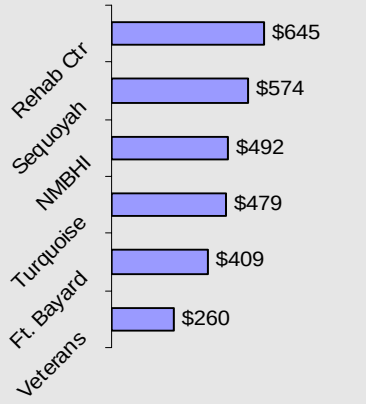
Strategic planning. The Division does not have an all-encompassing strategic plan that focuses on effectively and efficiently administering and monitoring its facilities, nor does it have a comprehensive policy and procedure manual. Without a Division strategic plan it is unclear how the Division decides its course of action and identifies facility priorities.

Sequoyah Waiting List

Fiscal Year	Number of clients referred each quarter	Number of clients admitted each quarter
FY04	39	16
FY05	39	18
FY06	32	15

Source: LFC Analysis

FY06 Per Bed Per Day Costs



Source: LFC Analysis

The FY 07 revenue shortfall for NMBHI is $1.1 million and for the Division it is $2.5 million.

The Department did not address missing functionality or infrastructure upgrades even though it had $1.2 million available.

Sequoyah is the only state facility that provides services to mentally ill, violent adolescent males. Although the number of adolescent males on the waiting list for services has decreased from FY04 to FY06, Sequoyah can only serve about half of the referrals.

Budget and operational issues. Staff shortages, infrastructure or financial issues prevents facilities from operating at 100 percent capacity. From FY04 to FY07, occupancy rates at every facility declined with the most significant drops at Turquoise Lodge and the Rehabilitation Center. In FY06, four of the six facilities had occupancy rates at or below 78 percent.

Facilities are having problems with the hospital and pharmacy information systems implemented between 2002 and 2005. Five of the six facilities expressed a need for more or improved functionality and new reports. The Department did not properly plan for ongoing technical support, systems maintenance or technical training requiring the Information Technology (IT) Division to use contractors and continue maintenance on legacy systems.

Performance measures. Performance measure results reported by the Division contain data and calculation deficiencies and do not accurately reflect the quality of resident services. Analysis of the average length of stay performance measure revealed a calculation error. The calculation uses the number of days in the month the patient was discharged and not the number of days the person was a resident at the facility. Moreover, the performance measures are not tracked for forensic or adolescent treatment services. The Rehabilitation Center's performance measures do not adequately reflect how well the treatment offered is working. Ft. Bayard does not use the New Mexico Medical Review Association's Nursing Home Quality Initiative indicators for resident care or staff satisfaction.

Capital needs. Capital deficiencies at Ft. Bayard are a hazard to residents and staff that could cause serious falls, burns or further injury.

Other. The Veterans' Home does not take full advantage of price agreements negotiated by the Federal Veteran's Administration Department for food, drugs and other clinical supplies.

Recommendations.

- Work to counter the prevailing trends causing job churning. Thoroughly document and analyze all vacant positions to determine the reasons for the high vacancy and turnover rates.

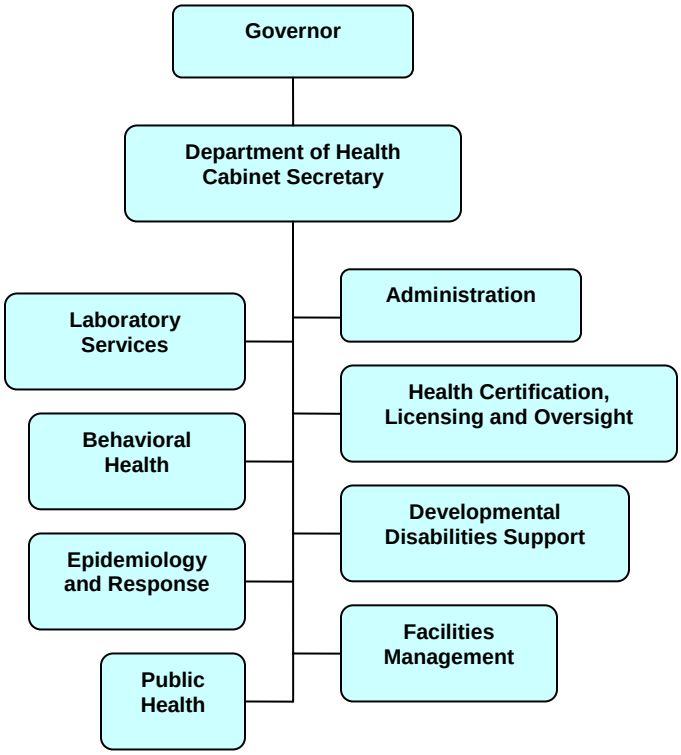
- Immediately advertise and fill the NMBHI hospital administrator position with a person with requisite education and skills.
- Review each facilities organizational chart, clarify roles and responsibilities for the Division, and facility administrators, establish goals and objectives for the facilities, and communicate these decisions to facility employees.
- Clarify the Department's overtime compensation policy.
- Develop a comprehensive, Division-wide strategic plan and individual facility strategic plans that complement one another.
- Consider the possibility of expanding Sequoyah's services to meet the growing needs of mentally ill or violent adolescents throughout the state.
- Conduct a through analysis of facilities occupancy rates and the specific internal and external factors that impact each facility's ability to fill available beds.
- Hold facilities accountable for accurate budget projections. Require NMBHI, the Division and the IT Division to work to resolve Medicare Part D electronic billing issue.
- Develop timelines and implement action plans to address software and technical issues at the facilities.
- Consider more appropriate and meaningful performance measures for the different types of services offered including chemical dependency. Develop quality assurance mechanisms capable of validating facility data for performance measures.
- Work with General Services Department and Geo-Care to immediately address the repairs and short-term capital needs at Ft. Bayard. Work on final details of the construction at Ft. Bayard so that construction can begin soon. Review the impact of the constitutional amendment allowing state lease purchase option in construction of the facility to protect taxpayers' financial interest.
- The state legislature may consider legislation to place the Veterans' Home under the jurisdiction of the Department of Veterans Services.

BACKGROUND INFORMATION

Background. The Department of Health (Department) was created by Sections 9-7-1 through 9-7-15 NMSA 1978 to serve the citizens of New Mexico through programs designed to prevent disease and disability, promote health, and prevent or treat problems of mental health, substance abuse, developmental disabilities, and chronic disease. The agency licenses health and long-term care facilities and operates public health offices in all but one county throughout the state, seven treatment centers and the state scientific laboratory.

During the 2005 Legislative Session, the Department requested a reorganization to create a Facilities Management Division (Division). The 2005 General Appropriation Act states "Upon reorganization and creation of the deputy secretary for facilities the Department of Health is authorized to create a facilities program in the fiscal year 2006 operating budget and may transfer existing resources from other programs. The authorization is contingent upon a certified reorganization plan approved by the department of finance and administration and reviewed by the legislative finance committee."

Chart 1. Department Organizational Chart



Source: LFC FY06-07, Volume II

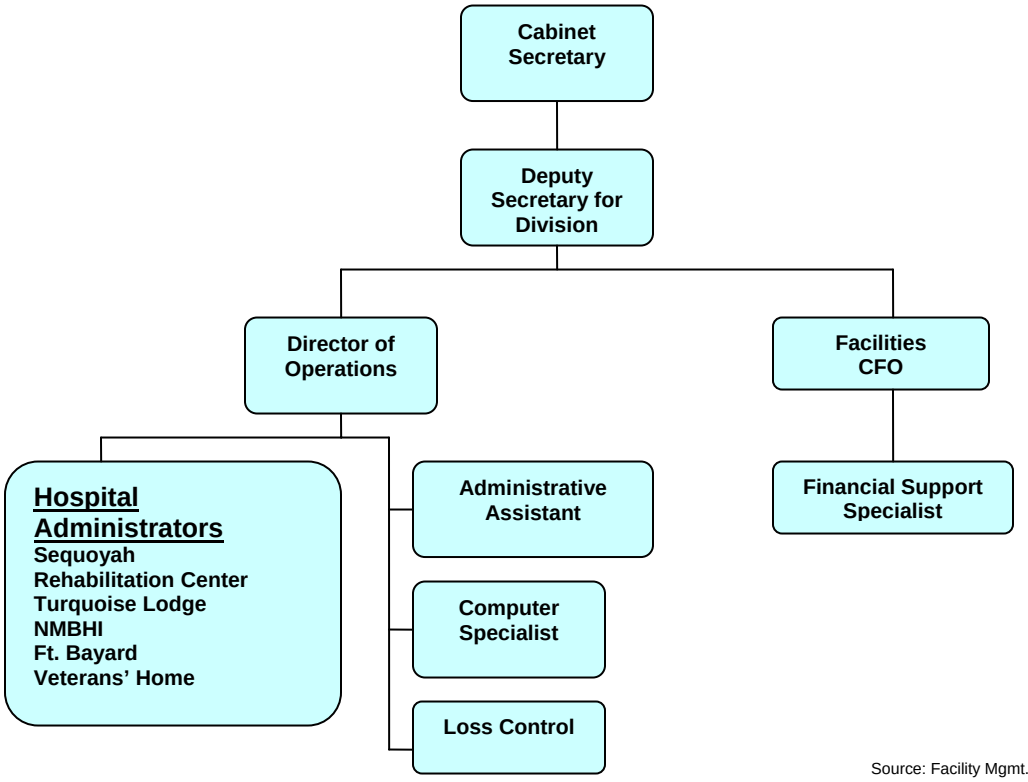
In FY07, the Department restructured and consolidated nine programs into eight programs: Public Health; Epidemiology and Response; Laboratory Services; Behavioral Health Services; Developmental Disabilities Support; Health Certification, Licensing and Oversight; Administration and created the Facilities Management program. Whereas, in FY06 the Department programs were Prevention and Health Promotion; Health Infrastructure; Surveillance, Response, and Reporting; Testing and Pharmaceutical; Behavioral Health Services;

Long-Term Care Services; Developmentally Disabled Community Services; Licensing, Certification, and Oversight; and Administration and Policy.

The purpose of the facilities management program is to provide oversight for Department facilities that provide health and behavioral health care services including mental health, substance abuse, nursing home and rehabilitation programs in facility and community-based settings and serve as the safety net for the citizens of New Mexico.

The Division manages the program and operates the Fort Bayard Medical Center (Ft. Bayard) outside of Silver City, New Mexico Behavioral Health Institute in Las Vegas (NMBHI), New Mexico Rehabilitation Center in Roswell (Rehabilitation Center), New Mexico Veterans' Home in Truth or Consequences (Veterans' Home), Sequoyah Adolescent Residential Treatment Facility (Sequoyah) and Turquoise Lodge Treatment Facility (Turquoise Lodge) both located in Albuquerque.

Chart 2. Facilities Management Division – Organizational Chart



Source: Facility Mgmt. Division

Fort Bayard Medical Center. The mission of Ft. Bayard is to provide quality healthcare services to individuals who need long-term care, short-term rehabilitation, chemical dependency treatment, outpatient therapy, or case management services. Ft. Bayard provides long-term care, rehabilitation, physical therapy, chemical dependency treatment, home care case management services, and operates a veterans' nursing home. The facility also contracts with the Human Services Department to provide a coordinated community in-home program in Grant, Catron and Hidalgo Counties.

New Mexico Behavioral Health Institute. The commitment of NMBHI is to meet the diverse and evolving mental and health care needs of all New Mexicans. NMBHI provides adult psychiatric, forensic, and adolescent, long-term care and community-based services. It also supports the Northern NM Rehabilitation Center, which provides a continuum of physical rehabilitation services and daily skills assistance that allow individuals to attain and maintain the highest level of independence possible.

New Mexico Rehabilitation Center. The mission of the Rehabilitation Center is to provide quality comprehensive habilitation and rehabilitation services to the citizens of the State of New Mexico. The Rehabilitation Center provides inpatient and outpatient medical rehabilitation to enable children and adults to achieve maximum independence within the framework of their physical disability and also provides chemical dependency treatment services.

New Mexico Veterans' Home. The mission of the Veterans' Home is to lead the provision of integrated care that assures the well-being of our veterans and community. The Veterans' Home is a nursing care facility for veterans, spouses of veterans and Gold Star parents. It provides long-term intermediate, skilled nursing and domiciliary care; and inpatient and outpatient physical therapy, occupational therapy, speech language pathology and aquatic therapy services. The home also provides outpatient services to local residents with doctors' orders.

Sequoyah Adolescent Treatment Center. The mission of Sequoyah is to provide care, treatment, and reintegration into society services for adolescents who are violent or who have a history of violence, have a mental disorder, and who are amenable to treatment. Services are provided based upon clients' need and integrated within the continuum of services offered throughout the state and consistent with the least restrictive means principle. Sequoyah is a 36-bed licensed facility located in Albuquerque, and has been providing treatment services to adolescents since 1992.

Turquoise Lodge. The mission of Turquoise Lodge is to provide intervention, treatment and rehabilitation of the diseases of alcoholism, chemical dependency and co-occurring disorders to adult New Mexico residents. Services are provided to meet the patient's individual treatment and cultural needs in the least restrictive environment appropriate to patient needs, either on site or through referral services to statewide providers. The facility is located in Albuquerque and is a 34-licensed bed facility.

The table below shows the total number of full-time authorized positions at each facility.

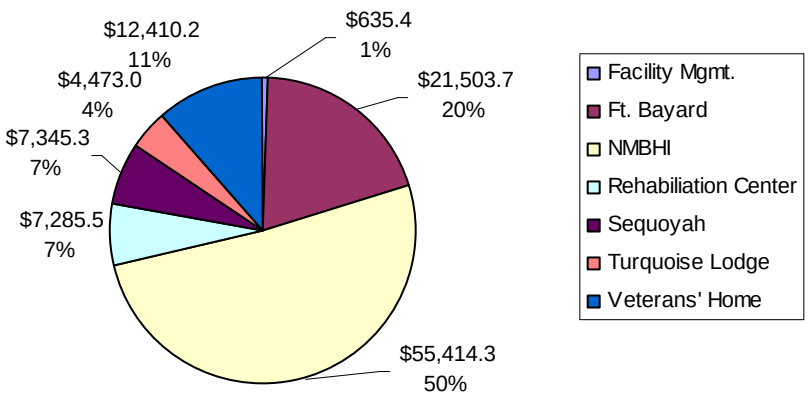
Table 1. Number of Facility Employees

Facility	Permanent Employees	Term/Temp Employees	Total
Ft. Bayard	307.5	77.5	385
NMBHI	936.5	83	1,019.5
Rehabilitation Center	100	18	118
Sequoyah	128	1	129
Turquoise Lodge	44	18	62
Veterans' Home	175	50	225
Total Employees	**1,691**	**247.5**	**1,938.5**

Source: FY 08 Budget

The Division's FY07 operating budget is $109.1 million. NMBHI is allocated 50 percent of the entire budget.

Graph 1. FY 07 Division Operating Budget – Total $109.1 Million



Source: FY08 Division Budget

Facilities System Enhancement Project. The facilities system enhancement project was an information technology project at all the Department's facilities to implement commercial off-the-shelf hospital information and pharmacy systems to support clinical, medical, financial and administrative functions, and to improve hardware and network infrastructure. The facilities found it difficult to meet their organizational responsibilities with outdated or non-existent information technology capabilities. The greatest need at the facilities was for new software and equipment to support severely limited clinical and medical functions, and financial and administrative functions. The life expectance of the systems is reported to be 8 years from the date the first facility was implemented.

The initial project estimate was $5.9 million based on a detailed requirements analysis performed in 2000. From 1999 through 2006 the legislature appropriated $7 million. The table below

outlines the appropriation by year and includes over $1 million that the Department allocated out of its base budget.

Table 2. FSEP Funding
(in thousands)

Funding Source	Total
Laws of 1999, Chapter 3, Section 7, Subsection 12	$500.0
Laws of 2001, Chapter 64, Section 7, Subsection 20	$3,100.0
Laws of 2002, Chapter 4, Section 7, Subsection 20	$1,550.0
Laws of 2003, Chapter 76, Section 7, Subsection 17	$1,500.0
Laws 2004, Chapter 33, Section 7, Subsection 22 (HIPAA compliance)	$750.0
Laws of 2006, Chapter 109, Section 7, Subsection 16 (HIPAA special appropriation)	$300.0
Department Base Budget	$1,083.5
Total	**$8,783.5**

Source: LFC and Department Files

Implementation at the Rehabilitation Center was originally targeted for February 2002 with all the facilities becoming operational on the new system by October 2002. The October 2002 final implementation date would have allowed the Department to meet the federal deadline for the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set requirement. The federal government later amended the deadline to October 2003. The table below shows the date the hospital information system (Avatar) and the pharmacy system (Mediware) went live at each facility.

Table 3. Avatar and Mediware Implementation by Facility

Facility	Date
Rehabilitation Center	12/2002
Ft. Bayard	6/2003
Veterans' Home	9/2003
Sequoyah	9/2003
Turquoise Lodge	11/2003
NMBHI	2/2005

Source: Department Project Documents

In 2006, the Department applied for and received $300 thousand from the Human Services Department HIPAA appropriation to make necessary changes to Avatar and Mediware for the national provider identifier. The upgrades would allow the facilities to produce compliant bills.

Performance Measures. The Accountability in Government Act, Section 6-3A-1 NMSA 1978, was enacted to provide for more cost-effective and responsive government services by using the budget process and defined outputs, outcomes and performance measures to annually evaluate the performance of state government programs. The Act defines "performance measure" as a quantitative or qualitative indicator used to assess the output or outcome of an approved program. Program performance is illustrated through a comparison of to-date achievement for individual measures and pre-established targets.

The six facilities submit performance data on two performance measures:

- Number of substantiated cases of abuse, neglect and exploitation per 100 residents in agency-operated long-term care programs confirmed by the Division of Health Improvement (DHI); and
- Average length of stay of residents (at each individual facility).

According to the Department's quarterly performance report, the first measure is tracked and measured because it is an indicator of resident safety. The second measure is a quality of care indicator for residents and patients.

Performance Measures Best Practices. The Joint Commission on Accreditation of Healthcare Organization (JCAHO) is an independent, not-for-profit organization that evaluates and accredits nearly 18,000 health care organizations and programs including hospitals, behavioral health and ambulatory care centers, health plans, home care organizations, laboratories, long-term care facilities and long-term care pharmacies. It is considered the foremost expert of quality-of-care clinical indicators.

Another international, independent, nonprofit organization that accredits rehabilitation services providers is the Commission on Accreditation of Rehabilitation Facilities (CARF). A rehabilitation service or program that is CARF accredited means the provider has passed an in-depth, rigorous review of its services; conforms to nationally and internationally recognized service standards; and is focused on delivering the most favorable results for the patient. It assures third-party payers and governmental regulators that the organization has met internationally recognized standards. CARF guidelines are a tool for quality improvement within the organization.

Joint Commission Definition: Performance Measurement System

- A set of process and or outcome measures of performance, processes for collecting, analyzing and disseminating these measures from multiple organizations.
- An automated database which can be used to facilitate performance improvement in healthcare organizations.

Objectives.

- Assess the effectiveness and efficiency of the Divisions' oversight of state operated facilities including planning, maintenance, and capital outlay funding.
- Determine adequacy of each facilities' funding and capacity to bill third party payers.
- Review staffing patterns in all facilities.
- Review and assess quality of performance measures for facilities related to quality of care and cost effectiveness.
- Determine how the Department's quality of care measures compare to best practices followed by private hospitals and recommended by accreditation organizations.
- Review the hospital information and pharmacy systems to ensure functionality and deliverables were achieved, users were satisfied, and that the facilities have adequate infrastructure.

Scope and Methodology.

- Review laws, rules and regulations;
- Review Facilities, Division and Department policies, procedures and strategic plans;
- Review Legislative Finance Committee files;

- Analysis of staff vacancy and turnover data from FY04 through FY07;
- Review Department financial audits for FY04 through FY06;
- Analysis of Division and Facilities financial and budget reports;
- Analysis of occupancy and census reports;
- Review performance measures for the six facilities;
- Review of performance audits from other states relative to this review;
- Conduct research on performance measures best practices;
- Review Division contracts;
- Interview Department and facilities staff;
- Research best practices followed by private hospitals and recommended by professional organizations; and
- Review and analysis of information systems project documentation.

Authority for Review. The Legislative Finance Committee (Committee) has the statutory authority under 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. The committee is also authorized to make recommendations for change to the legislature. In furtherance of its statutory responsibility, the committee may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state law.

Review Team.
Consuelo Mondragon, Performance Auditor
Scott Roybal, Performance Auditor
Andy Gutierrez, IT Auditor

Exit Conference. The contents of this report were discussed with the Deputy Secretary of the Division Katrina Hotrum and the Deputy Secretary of Finance and Administration Duffy Rodriguez on May 16, 2007.

Report Distribution. This report is intended for the Office of the Governor, Department of Finance and Administration, State Auditor's Office, Department of Health, Facility Management Division, Fort Bayard Medical Center, New Mexico Behavioral Health Institute, New Mexico Rehabilitation Center, New Mexico Veterans' Home, Sequoyah Adolescent Center, Turquoise Lodge, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report which is a matter of public record.

Manu Patel
Deputy Director for Performance Audits

PERSONNEL: TURNOVER, VACANCIES AND POLICIES

Turnover And Vacancies Are High At Both The Division And The Facilities. The Division and Facilities are experiencing high turnover and vacancy rates that can affect revenues and quality of patient care. A study conducted by the Voluntary Hospitals of America found that organizations that had a turnover of 21 percent or higher also had a 36 percent higher cost per discharge rate than hospitals with turnover rates of 12 percent or less. High turnover also leads to lower profitability. Organizations with low turnover averaged a 23 percent return on assets compared to a 17 percent return for high turnover organizations.

High Turnover in Key Division Personnel. In FY05, the Division was created with three key positions: the deputy secretary, director of operations and a general manager. The duties of these individuals are to manage, provide oversight and formulate policy that governs and directs all of the facilities in a consistent, effective, and productive manner.

The deputy secretary position was filled January 2005, six months after the division was created. That individual occupied the position for only seven months. The second deputy secretary was hired November 2005, four months after the first deputy secretary left, and served for 16 months. The position was again vacated in February 2007 and subsequently was filled in April 2007.

The director of operations position was filled in July 2004; the individual served for seventeen months, and then vacated the position in January 2006. It was filled again in March 2006 and remains filled by the same individual.

The general manager position was filled when the Division was created in July 2004, and became vacant in February 2007. A new individual was hired in March 2007.

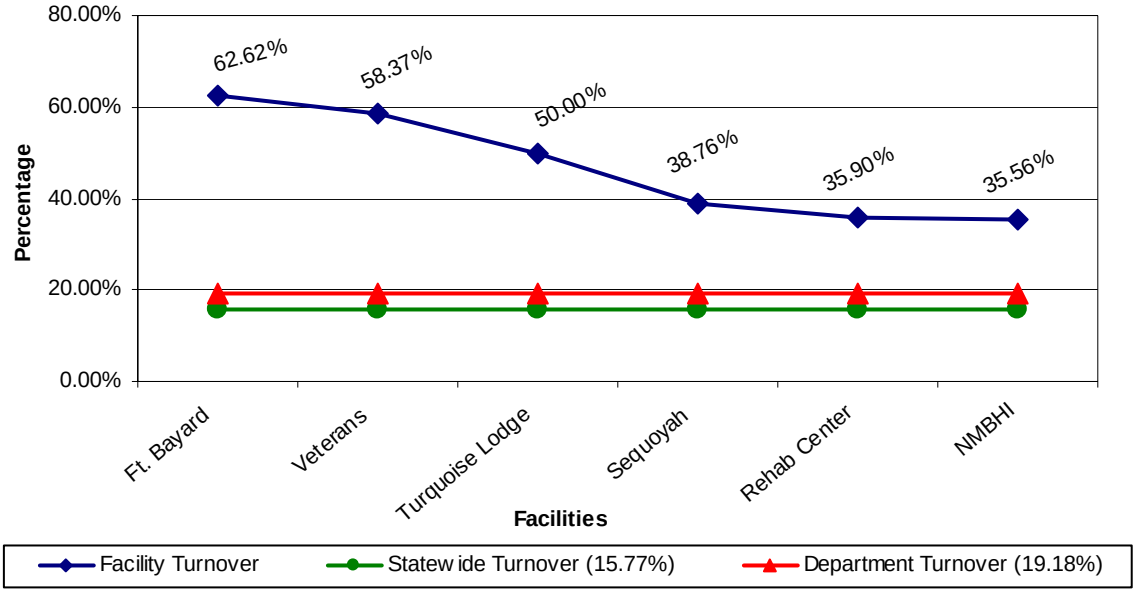
Although the cause for turnover in these key positions could not be determined, turnover can be very costly to an organization. Based on studies conducted by Price Waterhouse Institute and the University of Wisconsin, it is estimated that direct turnover costs per employee are 25-30 percent of an individual employee's salary and benefits package. Not only could the Department experience a loss in monetary value, but there is also a loss in institutional knowledge. A program is expected to be operating effectively and efficiently after three years of operation. However, high turnover in key Division positions has contributed to the overall difficulty of bringing the new division to its expected performance levels.

According to management experts, retaining talented staff is essential to organizational success, and the Division is no different. People need to feel wanted, valued, appreciated. They want to do meaningful work and have some say in how their jobs are designed, managed, and measured.

All Facilities Are Experiencing Difficulty With Their Turnover And Vacancy Rates. An analysis of FY04 through FY06 vacancy reports from the General Services Department human resource management system for each facility shows that turnover went from almost 40 percent in FY04 to almost 55 percent in FY06. Appendix A contains detailed turnover information by facility by fiscal year. The graph below shows the turnover by facility for FY06. Based on the

State Personnel Office (SPO) FY06 Annual Report, the turnover for all statewide operations was 15.77 percent and the turnover for the Department was 19.18 percent. The FY06 facility turnover rate ranged from 35 to 62 percent for FY06, which is 19 to 46 percent above the statewide turnover rate and 16 to 43 percent above the Department's turnover rate.

Graph 2. Percent of Turnover by Facility for FY06



Source: GSD HRMS Data Analysis and FY06 SPO Annual Report

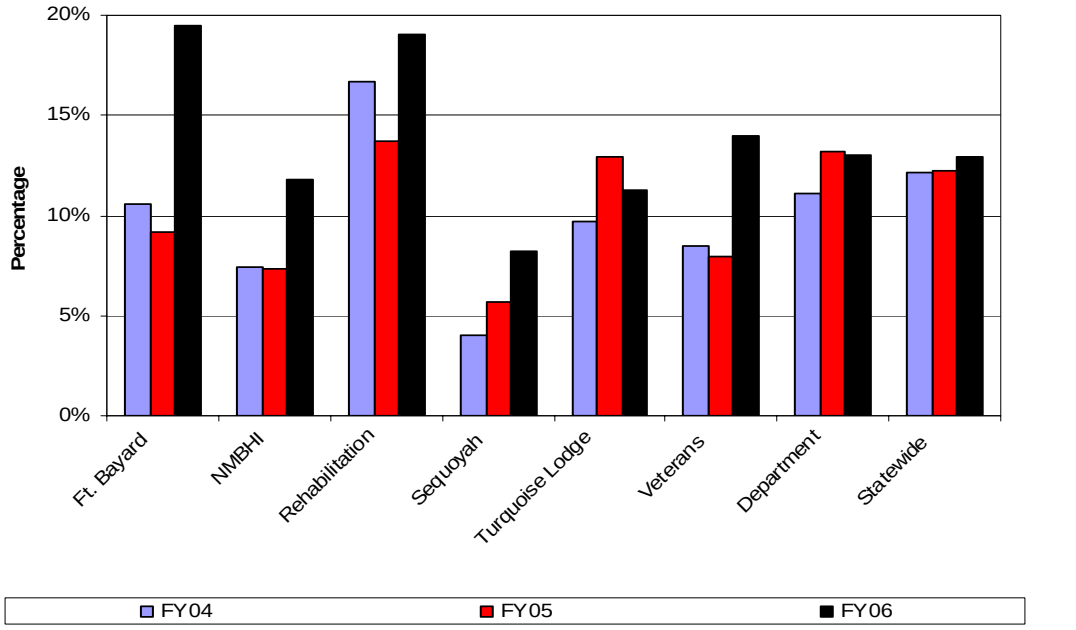
Additional analysis of each facility showed that on average the positions with the highest turnover from FY04 to FY06 were nursing and clinical positions. Nursing turnover was highest at Turquoise Lodge (83 percent) and lowest at NMBHI (31 percent). Clinical turnover was again highest at Turquoise Lodge (61 percent) and lowest at NMBHI (22 percent). More detailed information by facility is available at Appendix B. All facilities are struggling to fill and retain their nursing positions. According to a 2001 American Health Care Association Nursing Positions Vacancy and Turnover Survey, the national turnover rate for the nursing industry was 55.5 percent. New Mexico, by comparison, had a 69.3 percent turnover rate, which was 13.8 percent higher than the national turnover rate.

The facilities identified the following as main reasons for turnover and vacancies:

- Lower level jobs do not pay enough;
- Higher pay and fewer hours elsewhere;
- Difficulty attracting candidates to rural areas;
- General labor shortages;
- Nursing shortages in New Mexico;
- Uncompetitive pay despite good benefits;
- Entry level pay is higher than pay for individuals on the job more than 10 years;
- Upper management instability.

The graph below presents vacancy rate by facility, for the Department and for the state by fiscal year. All facilities except Turquoise Lodge experienced increased vacancy rates during FY05 to FY06. Vacancy rates range from 8 percent at Sequoyah to 19.5 percent at Ft. Bayard. Vacancy rates at the Rehabilitation Center, Ft. Bayard and Veterans' Home currently remain above the statewide and Department rates.

Graph 3. FY04 – FY06 Facilities Vacancy Rates Compared to Department and Statewide Rates



Source: LFC Analysis of HRMS and SPO Data

Retaining employees and developing a stable work force involves a two-step process - understanding why employees leave, and developing and implementing strategies to get them to stay.

Employees leave jobs for five main reasons:

- Poor working conditions,
- Lack of appreciation,
- Lack of support,
- Lack of opportunity for advancement, and
- Inadequate compensation.

Recommendation. Work to counter the prevailing trends causing job churning. Proactive employers make it a strategic initiative to understand what their people want and need -- then find a way to give it to them.

Put the following best practices into place:

- Hire right to begin with.
- Engage in longer orientations with new employees.
- Live the values.
- Use creative rewards and recognition.
- Create annual personal growth plans for each employee.
- Make it easy for people to get their jobs done.
- Conduct exit interviews with employees who resign. Consider an independent third party interviewer for those cases where claims of harassment or retaliation are the cause. Thoroughly document and analyze all reasons why employees leave the agency. Address all root causes for turnover, not just the salary issue.

Overcome retention issues by engaging strategies that:

- Create and maintain a workplace that attracts, retains and nourishes good people.
- Focus on how you treat your people and how they treat each other.
- Give people the tools, equipment and information to get the job done.
- Deal with personal and professional growth.
- Cover the broad spectrum of total compensation, not just base pay and salary.

Thoroughly document and analyze all vacant positions to determine the reasons for the high vacancy rates.

The NMBHI Hospital Administrator Position Has Been Effectively Vacant Since October 2005. The hospital administrator plays a key Department and management role in a facility's day-to-day function. A key position's instability or uncertainty can affect morale, effectiveness and quality of patient care. Not only is it important that the person be qualified, it is important that the position not turnover constantly. NMBHI's hospital administrator position has been filled on an interim basis since October 2005. His personnel file shows that he has a Bachelor's degree in Business Administration and 20 years of finance and management experience, the Department recently gave this individual an increase for assuming the hospital administrator role and responsibilities.

The hospital administrator job description requires a Master's degree in business, public administration or public health field. This position also must have administrative or managerial experience of which five years must be in health care administration to include health finance and knowledge of the Joint Commission on Accreditation of Healthcare Organization (JCAHO). The job duties include being responsible for overseeing the formulation, development, coordination, facilitation and implementation of programs that develop and sustain NMBHI as a statewide facility of access to acute behavioral health care and specialized long-term care. The position has responsibility for governmental and legislative relations, overall organizational and fiduciary oversight in terms of budget and programmatic policy development and implementation. The position also has responsibility for development of a coordinated system of behavioral health care for the citizens of New Mexico. Intrinsic to this is the development of community behavioral health outreach and education programs as well as communications and relations with the New Mexico health and human services community." Additional duties are to

ensure budget integrity; to maintain a safe, secure environment for clients, staff and public; and to maintain and ensure JCAHO accreditation.

Section 6.08 of the Governing Board Bylaws states, "the Governing Board shall approve the selection of the Facility Administrator, based on the appropriate qualifications and experience required for the position;" however, it does not appear that the Governing Board has fulfilled its responsibilities in this area.

Recommendation. Immediately advertise and fill the hospital administrator position with a person with the requisite education and skill set so that NMBHI can begin working toward a stable management.

Policies and Procedures Regarding The Chain Of Command Should Be Enhanced and Effectively Communicated to All Division Employees. Based on interviews and documentation provided by the Division and the facilities, the chain-of-command is not consistently followed from one case to the next. Several key employees have been advised to report directly to the Division director of operations, rather than the facility hospital administrator. Several individuals stated that the director of operations has an open-door policy and that any individual can bring a complaint to her first, rather than following the chain of command established by the organizational chart and policies in place at the facilities.

Oversight Being Provided By The Division Needs To Be Clarified and Revisited. According to facility administrators, the Division does not treat the facilities equally. Several facility administrators stated that contact with the Division is rare; for the most part the Division is only heard from during hospital administrator meetings and quarterly governing board meetings. However, the Division appears to be involved in certain facilities' day-to-day operations.

No consistency or logic was apparent regarding how pay increases for additional responsibilities are granted. In April 2006, the Division's director of operations granted one individual a temporary salary increase retroactive to February 11, 2006. In November 2006, the Division granted a 15-percent promotional increase even though facility HR staff analysis showed that appropriate placement should only include a 10-percent increase, based on education and years of experience. As a result, the facility is incurring $2,538 more per year in personnel expenditures. In February 2007, the Division approved a temporary salary increase for an employee who assumed additional responsibility, even though no increase was requested or recommended by the facility.

Per the Department's Grievance Policy dated June 9, 2006, the purpose of the policy is "to offer employees a systematic method for prompt consideration and early resolution of grievance, and to facilitate the fair and equitable treatment of all employees." The policy also states that "All employee grievances shall be resolved at the lowest possible organizational level and Division directors or facility administrators have the authority and the responsibility to issue a final determination in the internal grievance process."

In February 2007, a grievance was filed against the NMBHI director of nursing by another employee. Documentation reviewed shows that the director of operations received this grievance and informed HR and the interim hospital administrator that the grievance policy is

unclear – that this particular grievance was clearly a complaint and not a grievance and that the reply to the grievance is being denied. Per the policy a grievance is "an expression of dissatisfaction, by an employee, concerning the application or interpretation of the terms or conditions of employment, including personnel management or any condition of employment beyond the employee's control and within the scope of the Department's authority except as otherwise provided for in this policy." Merriam-Webster dictionary describes a complaint as "an expression of grief, pain, or dissatisfaction or a formal allegation against a party." In accordance with the policy, the grievance should have been handled by the interim hospital administrator, who in this case is the lowest management level of the organization.

Unclear roles, responsibilities and objectives may negatively affect communication, morale, and coordination of efforts in addition to impacting organizational effectiveness and cost efficiency. When some employees report directly to the Division rather than the hospital administrator, organizational instability may be created.

Overtime Policy Is Inconsistently Applied To FLSA-Exempt Employees. Per the Department's Human Resources Policy Statement ADM 08:55 Overtime Compensation, revised 4/1/1998, "Employees determined to be non-covered from coverage under the provisions of the Federal Labor Standards Act (FLSA) shall receive compensation at a rate of one hour for each hour of overtime worked (including shift differential). Overtime shall be compensated through either direct cash payment or compensatory time off at the option of the authorizing supervisor. Only overtime that has been specifically authorized in advance will be compensated." Documentation reviewed shows that hospital administrators at some facilities received unauthorized overtime compensation.

At NMBHI a prior hospital administrator's payroll and overtime compensation from September 2004, through October 2005, was not preauthorized but was approved by the immediate supervisor or Division director after the overtime was worked. This resulted in overtime for the year totaling 243 hours or $10,617. The administrator had an unauthorized overtime balance of 7 hours. When key personnel were questioned, they stated that they would pay the overtime even though it was not preauthorized. The approved documentation was subsequently received from an immediate supervisor or Division director. In response to the unauthorized overtime balance of hours, staff stated that it could have been possible that this individual did not submit an overtime form.

The interim hospital administrator's overtime at NMBHI from January 2006 to January 2007 totaled 90 hours or $2,868. As of January 2007, his unauthorized overtime balance was 32 hours. There was no prior authorization for these hours worked, which were not approved by an immediate supervisor or the Division management. Upon questioning, key personnel stated that, after requesting approval of the overtime, they were advised by the Division that the administrator is not entitled to overtime pay without prior authorization. Staff explained to the Division that in previous year's overtime was worked and documentation was approved after the overtime occurred. When questioned about the unauthorized overtime balance, the payroll director at NMBHI chose to stop paying overtime compensation for this hospital administrator because a signature was needed in order to process the request. The payroll director has continued to track and submit overtime forms for the hospital administrator.

Documentation for the Sequoyah hospital administrator from January 2006 through January 2007 showed the administrator receiving a total of 41 hours or $1,479 for overtime compensation. The administrator did not have an unauthorized overtime balance. Staff stated they did not receive prior authorization or signatures to process this request because it was not required in the past. They chose to process the request without signed documentation.

Yet, at the Rehabilitation Center the director of operations approves and signs all over time sheets for the hospital administrator.

It appears that the Division made an attempt to enforce the overtime policy at one facility but may not have enforced it at other facilities. Based on interviews conducted, it also appears the procedure for obtaining prior authorization is unclear.

Recommendations. Review each facilities organizational chart regarding lines of communication and revise as needed to ensure consistency among facilities and eliminate possible contributory financial problems. Clarify:

- Roles and responsibilities for all Division positions in writing;
- Responsibility for awarding salary increases and the procedure to be followed for these increases;
- The role of the facility administrators; and
- Each facility's goals and objectives, as well as accountability.

Communicate these decisions to facility employees to establish and stabilize chain of command, communications, and employee morale.

In addition, clarify the Department overtime compensation policy and revise where necessary. Identify the individuals who are and are not entitled to overtime compensation. Establish procedures for the authorization of overtime. Communicate these policies and procedures to the facilities.

STRATEGIC PLANNING

Strategic planning is management's game plan to strengthen an organization, serve its clients, and achieve its performance measures. It represents a shared vision of the future, goals and objectives to achieve and a roadmap to get there. Effective strategic plans address change proactively rather than reactively.

A Written Strategic Plan Needs To Be Developed For The Division And Strategic Plans For The Facilities Need To Be Updated. The Division does not have an all-encompassing strategic plan focused on effective and efficient administration and oversight. In a September 1, 2005, letter explaining the facilities reorganization plan, the Department secretary stated "the functions of the newly created deputy secretary for facilities will be primarily to manage, provide oversight

and formulate policy that will govern and direct all of the facilities in a consistent, effective and productive manner. In addition to the duties and responsibilities the Department will charge this individual with the responsibility of developing a comprehensive policy and procedure manual for the facilities."

According to an email from the previous deputy secretary dated January 26, 2007, "there are currently no written strategic plans or master plans related to the facilities, although strategic planning is regularly discussed at governing board meetings, and is a specific agenda item for each facility's annual meeting. We also have strategic planning sessions for the facilities as a group related to specific focus areas, e.g., fiscal/financial, Avatar/IT, and nursing, but I do not believe any written plans have been developed as part of those work sessions." Without a Division strategic plan it is unclear how the Division decides its course of action and identifies facility priorities.

Individual strategic plans from five of the six facilities were inconsistent. The NMBHI strategic plan was up-to-date and had six pages that focused primarily on performance measures. In contrast, the Veterans' Home strategic plan was dated 2002-2003 and was over 100 pages and contained useful facility guidance information. Of the five strategic plans submitted, two were current for FY07 with only one to two years of planning forecasted. None of the strategic plans contained timelines as to when results would be achieved.

In addition, a comprehensive policy and procedure manual has not been created for the Division. According to an email from the deputy secretary, "The Department of Health does not have individual policies and procedures for its Divisions, but rather has Department-wide policies and procedures related to employee hiring, discipline, code of conduct, etc. Each facility also has facility-specific policies in a wide range of areas, including patient rights, admissions/discharge, medical policies, nursing policies, etc."

Recommendation. Develop a comprehensive, Division-wide strategic plan and individual facility strategic plans that complement one another. Strategic plans should be updated as needed and reviewed at least annually to guide the Division and facilities. Communicate the mission, values, and goals/objectives to all stakeholders. Implement, monitor, and review concrete action plans with timelines to assist in realizing the Department's vision for the future.

Create additional procedures to communicate oversight roles and responsibilities to the facilities. Since the Division is in its infancy, it is important to inform facility employees about the Division's responsibilities and role in day-to-day operations. Written policies and procedures should articulate facility accountability (e.g., what should be reported to the Division, who is responsible for completing and submitting incident reports, budget reports, vacancy reports, occupancy reports). Without written guidance, it may be difficult to hold facilities accountable.

Develop a Division-wide policy and procedures manual as soon as practical. Provide the manual to all facility staff as guidance to inform them of proper communication channels (i.e. chain of command, organizational chart), the Division's purpose and oversight responsibilities, and facility responsibilities. Policies and procedures should be revised as needed and reviewed at least bi-annually. The document should include review/revision dates.

Consider Expanding Mental Health Services Offered To Adolescents. Sequoyah is the only state facility that provides services to mentally ill, violent adolescent males. For the last four years, Sequoyah has maintained a 93 percent or higher occupancy rate and a balanced budget. Sequoyah is funded by a combination of state and federal appropriations.

A U.S. Department of Justice bulletin reported that more than 104,000 juvenile offenders were in custody in juvenile residential placement facilities in 2001. Of these offenders, 45.9 percent of males and 56.5 percent of females met the diagnostic criteria for one or more psychiatric disorders. Between 1980 and 2004, arrests for simple assault increased by 106 percent for male adolescents. Research has demonstrated that providing mental health services to youth in detention and redirecting them to the mental healthcare system after release may be critical to breaking the recidivism cycle. Although the number of adolescent males on the waiting list has decreased from FY04 to FY06, the following table shows that Sequoyah can only serve about half of the referrals.

Table 4. Sequoyah Waiting List of Adolescents

Fiscal Year	Number of Clients Referred Each Quarter	Number of Clients Admitted Each Quarter	Number of Days Until Admitted Each Quarter	Number of Clients Remaining on Waiting List to be Admitted Each Quarter
FY04	39	16	39	24
FY05	39	18	43	21
FY06	32	15	31	17

Source: Sequoyah Adolescent Treatment Center

Recommendation. Consider the possibility of expanding Sequoyah's services to meet the growing needs of mentally ill or violent adolescents throughout the state.

BUDGET AND OPERATIONAL ISSUES

Low Occupancy Rate Requires The Division's Attention. The Division has a total of 912 licensed beds with 843 of those beds considered operating. The table below shows the number of licensed beds, the number of beds actually operating and the FY06 occupancy rate at each facility.

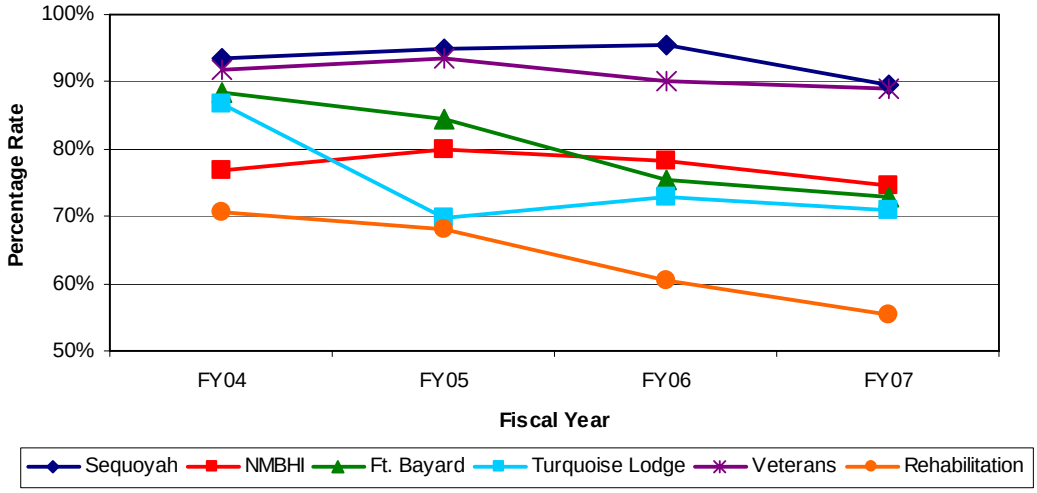
Table 5. Licensed vs. Operational Facility Beds

	Licensed Beds	Operating Beds	Operating Percentage	FY06 Occupancy Percentage
Ft. Bayard	200	183	91.50%	75.50%
NMBHI	456	404	88.60%	78.20%
Rehabilitation Center	41	41	100.00%	60.58%
Sequoyah	36	36	100.00%	95.47%
Turquoise Lodge	34	34	100.00%	72.76%
Veterans' Home	145	145	100.00%	90.02%
Total	**912**	**843**		

Source: Facilities & DHI

Staff shortages, infrastructure or financial issues are primary causes for licensed beds to be categorized as non-operating and prevent the facility from operating at full capacity.

Graph 4. FY04 – FY07 Occupancy Rate for Facilities



Source: LFC Analysis

From FY04 to FY07, occupancy rates at every facility declined, with the most significant drops at Turquoise Lodge and the Rehabilitation Center. In FY06, four of the six facilities had occupancy rates at or below 78 percent.

The table below shows that all facilities' per bed, per day costs were higher because none are operating at 100 percent capacity. The Rehabilitation Center and Turquoise Lodge had the highest increase in per bed, per day costs because they operated at 61 and 73 percent of capacity, respectively. The per bed, per day costs at the Rehabilitation Center and Turquoise Lodge were $254 and $130 more, respectively. Most hospitals operate on fixed costs, meaning that an expense exists no matter how many patients are served.

Table 6. FY06 Operating Costs vs. Occupancy Rate

	Sequoyah	Turquoise Lodge	NMBHI	Veterans' Home	Rehabilitation Center	Ft. Bayard
Operating Cost per Bed at 100% Occupancy	$547.81	$348.24	$384.38	$234.00	$390.60	$308.87
Operating Cost per Bed at Current Occupancy Rate	$573.81	$478.63	$491.55	$259.95	$644.78	$409.09
Difference	$26.00	$130.39	$107.17	$25.95	$254.18	$100.22
FY 06 Occupancy Rate	**95.47%**	**72.76%**	**78.20%**	**90.02%**	**60.58%**	**75.50%**

Source: LFC Analysis

The facilities are required to follow strict staff to patient ratios to provide quality care to clients. This requirement directly affects a facilities ability to fill available beds. As discussed in an earlier finding the majority of the facilities have significant vacancies in nursing positions.

Because of the mounting evidence of the impact of staffing on health care outcomes, although not mandating specific staffing levels or ratios, JCAHO introduced standards that will require health care organizations to assess their staffing effectiveness by continually screening for potential issues that can arise from inadequate or ineffective staffing. The standards require organizations to use data from the use of nursing-sensitive clinical and human resources

indicators such as adverse drug events, patient falls, use of overtime, staff turnover rate, patient and family complaints, and staff injuries on the job.

It would be tempting to recommend that facilities simply increase their occupancy rate, but if the facility is faced with rising vacancies then patient care may be jeopardized. Additionally, external factors such as new private hospitals attracting critical, qualified staff or low unemployment also impacts occupancy rates.

Recommendations. Conduct a thorough analysis of facilities' occupancy rates and the specific internal and external factors that impact each facility's ability to fill available beds. Work with all facilities to adopt best practices to reverse declines in occupancy.

The Facilities and Division Budget Needs Closer Scrutiny For FY07. Adequate budget appears to be an issue for five of six facilities. Only Sequoyah projects that it will breakeven in FY07. Budget projections were received for all facilities except Ft. Bayard. According to Ft. Bayard's hospital administrator, the facility recently lost its Chief Financial Officer (CFO), and the projected budget could not be found. In addition, the Department's moratorium on admissions negatively impacted revenues. The moratorium was lifted in December 2006.

NMBHI budget projection as of the end of February 2007 showed a potential revenue shortfall of $195.2 thousand. The following table shows that the entire Division is projecting an FY07 revenue shortfall of almost $1.6 million.

Table 7. FY07 Facilities Budget Projections

	NMBHI	Rehabilitation	Turquoise Lodge	Veterans' Home	Sequoyah	Ft. Bayard	Total
Revenues	$55,198,095	$6,575,590	$4,476,855	$11,209,745	$7,010,400	$ -	$84,470,685
Expenditures	$55,393,255	$6,834,736	$5,181,868	$11,620,423	$7,010,400	$ -	$86,040,682
Difference	**($195,160)**	**($259,146)**	**($705,013)**	**($410,678)**	**$ -**	**$ -**	**($1,569,997)**

Source: Facility Budget Projections

Because NMBHI monthly budget projections have contained significant variances, a more detailed review was necessary. Payroll expenditures make up about 80 percent of NMBHI's budget. A detailed examination of payroll expenditures provided by the Department showed that:

- NMBHI cannot produce accurate budget projections. Payroll information from the Department for pay periods one through six (July 1, 2006 - September 22, 2006) was received in January 2007. Payroll information for pay periods seven through ten (September 23, 2006, through November 17, 2006) was received in March 2007. No information has been received for pay periods after November 17, 2006, because of problems related to the statewide human resource and accounting management (SHARE) system.
- Department SHARE reports had errors. In many instances, individuals were reported as working and receiving overtime pay. However, neither the Kronos nor the SHARE system had a record of overtime. For example, the SHARE report showed that one individual received $1,435.01 for overtime, even though both systems showed that the individual worked 80 regular hours and two minutes of overtime. The Department states

this problem has been resolved and all other pay periods will be submitted by the end of May. NMBHI confirmed that SHARE reports now match the payroll register produced for each payroll and the Kronos time keeping records.

It is unclear why NMBHI cannot use the payroll register or Kronos timekeeping data for its projections when timely, accurate, and reliable SHARE reports from the Department are not available.

In addition to lacking accurate payroll reports, NMBHI's budget projection had the following errors.

- NMBHI included in FY07, a $171 thousand receivable for a Medicare settlement from July 2005, which was already booked as revenue in FY06. Because the claim dates back to 2005, it may be uncollectible.
- On June 18, 2006, NMBHI transferred $300 thousand it received from the Human Services Department for Behavioral Health Services provided by NMBHI, to two other facilities and included it as a "due from" on its books when in fact the funds reverted at the end of FY06.
- NMBHI included $458.6 thousand from Medicare Pharmacy D claims that may not be collectable because NMBHI cannot bill four of its 17 providers electronically. Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and went into effect on January 1, 2006. NMBHI generates an average of $115.2 thousand per month from Medicare and Medicaid claims and may face a $1.4 million loss because it cannot bill its providers electronically. The Department states that they have billed all claims through March by filing paper claims; however it is unknown how many claims will be rejected. The Department has been working on the technical issues and has contacted the providers who have verbally agreed to accept paper claims to get written documentation. Inclusion of a potentially uncollectible sum in NMBHI's projections remains a concern.

The NMBHI revenue shortfall is closer to $1.1 million when questionable amounts are removed. The Division's recalculated revenue shortfall is $2.5 million.

Table 8. LFC-Calculated FY07 Budget Projection

	NMBHI	Rehabilitation	Turquoise Lodge	Veterans' Home	Sequoyah	Ft. Bayard	Total
Revenues	$54,269,489	$6,575,590	$4,476,855	$11,209,745	$7,010,400	$ -	$83,542,079
Expenditures	$55,393,255	$6,834,736	$5,181,868	$11,620,423	$7,010,400	$ -	$86,040,682
Difference	($1,123,766)	($259,146)	($705,013)	($410,678)	$ -	$ -	**($2,498,603)**

Source: LFC Analysis

Because all other facilities use SHARE reports to prepare budget projections, additional data errors may increase any potential revenue shortfall.

Recommendations. The SHARE system produces a payroll register with actual dollar amounts by employee for regular pay and overtime pay earned. This information is available at each

facility and should be used for budget projections while the Department works on cleaning up payroll information. In this way, facilities can formulate and submit more accurate budget information and use the budget as a management tool. The Department should catch up on payroll reconciliations, so facility budget projections are accurate and up to date. The Division's general manager should hold facilities accountable for accurate budget projections.

NMBHI, the Division, and the IT Division should work together to resolve Medicare Part D electronic billing issues. Once the issues are resolved, NMBHI should recover as much lost billing revenue as possible. Similar business issues should be reported to the Division as soon as possible so solutions can be developed to avert revenue loss.

Some Facilities Expressed Concern That The Department And ValueOptions Have Not Finalized A Management Letter. Facility staff is unclear about the purpose of transferring general funds to ValueOptions. The LFC is concerned as well. The Department did not respond to repeated LFC requests to review the management letter. Facility staff agreed that ValueOptions appears to be a middleman and that transfers between ValueOptions and facilities do not make sense. Facility staff is concerned that funds transferred to ValueOptions will negatively affect patient care.

The management letter is between the Department and Value Options New Mexico regarding the services provided by the Department at the facilities. The management letter is prepared under the terms of the contract between the Behavioral Health Collaborative and Value Options. The expected outcome of this agreement is an increase in third party liability recoveries and cost savings from other liable/primary payers of mental health services rendered to New Mexicans through a comprehensive and streamlined system, as well as the development of recommendations from Value Options to the Department regarding the nature and scope of services provided by the facilities programs, to assure that the state-operated facilities are best used to maximize service delivery, quality and revenue.

Recommendation. Inform facility staff and the LFC as new information becomes available.

Department Hospital Computer Systems Lack Required User Functionality. The Division completed the implementation of the hospital information system (Avatar) and the pharmacy system (Mediware) at its six facilities between 2002 and 2005, with an upgrade completed December 2006. The Office of the Chief Information Officer (OCIO) accepted the Department's project closeout report in September 2006, based on self-reported project information. The Department reported that project objectives were met, but all planned functionality was not implemented; actual project costs could not be provided; support staff and users had been trained; and stakeholders were satisfied. However, facilities continue to experience various problems with both systems.

NMBHI and Ft. Bayard reported that both Avatar and Mediware have slow response time, which is directly related to inadequate facility network bandwidth. NMBHI, Ft. Bayard and the Veterans' Home reported that medical records contained in Avatar are not complete, and staff is required to use both paper and electronic patient medical records. NMBHI's inability to process Medicare Part D bills electronically using Avatar may result in lost revenue of approximately $1.4 million. Five of six facilities expressed a need for more or improved Avatar functionality

and new reports. At Ft. Bayard, the reports currently available in Avatar are not meeting facility needs. The table below outlines facility needs.

Table 9. Additional Avatar Functionality Required

Facility	Functionality	Reports
Turquoise Lodge	Addiction severity index assessments.	Performance and patient data breakdown by program. Detoxification and rehabilitation codes.
Sequoyah	Addiction severity index assessments.	Billing, finance and performance improvement.
Veterans' Home	Center for Medicare and Medicaid Services minimum data sets for patient and nursing home residents.	
Ft. Bayard	Center for Medicare and Medicaid Services minimum data sets for patient and nursing home residents.	
NMBHI	Additional forensic psychology assessments Additional adult psychiatric assessments. Banking.	Billing, finance and performance improvement. Medicare Part D electronic billing. Census

Source: Facilities Interviews

The Department imposed a moratorium on additional assessments and reports prior the upgrade completed in December 2006. The Avatar and Mediware project manager is currently inventorying reports and functionality that facility staff created independently and evaluating its potential usefulness to other facilities.

In addition to the need for improved functionality, NMBHI and Turquoise Lodge have older desktop computers that cannot adequately run the upgraded Avatar.

Project documents show that direct appropriations and internal funds for this project totaled $8 million, of which $6.8 million was expended. It is not clear why the remaining $1.2 million was not used to address missing functionality or infrastructure upgrades.

Recommendations. Develop timelines and implement action plans to address software and technical issues being experienced by the facilities. The action plans must ensure consistent implementation of functionality and clinical, medical, financial, and administrative processes across all facilities to support continued use of Avatar.

Conduct a functionality needs assessment and gap analysis at all facilities that includes:

- Identifying any duplicate systems and how that functionality can be incorporated into Avatar;
- Facility access to a comprehensive electronic medical record both at desktop computers and through the use of tablet personal computers for physician and clinical staff; and
- Trust and banking capabilities.

Conduct report generation training for selected facility users who demonstrate knowledge of the data and have received reporting tool training.

Develop a written cyclical plan to replace aging and outdated personal computer hardware that shows age of each computer, location of computer and estimated replacement date. Build the replacement cost into the Department's base budget. Identify hardware that must be replaced immediately.

Work with GSD to establish a timeline to implement sufficient bandwidth to fully address all facilities' needs. Request GSD to escalate the network upgrade to a critical need since the potential exists to negatively impact patient care.

Work with the OCIO to report project outcomes, user satisfaction, and revenues and expenditures accurately.

Ongoing Technical Support And Maintenance. The Department did not plan ongoing technical support and system maintenance properly. Department technical staff does not have the knowledge or skills required to upgrade and support Avatar or Mediware. As a result, the IT Division used outside contractors to complete the 2006 Avatar upgrade and assist with resumption of system operations when the systems went down. The Department is currently exploring the feasibility of having a contractor host the systems.

A maintenance and support contract has not been signed even though the systems were implemented almost two years ago. The vendors have continued to provide support without a properly executed contract. The Department's project manager cited the length of time required for all parties to review and sign the contract as the cause for the delay; however, an approval process that takes two years to complete is flawed.

The production and test environments for both Avatar and Mediware reside on the same physical servers. Best practices dictate that these environments reside on separate servers to minimize the possibility of unplanned downtime. The Department purchased servers to provide separate environments, but has not completed implementation.

NMBHI continues to use and pay maintenance on the legacy system from Advanced Institutional Management Systems and for the server on which it runs because Avatar cannot produce census reports or provide banking or trust accounting services.

Only the Rehabilitation Center could provide a written business continuity plan for Avatar and Mediware to ensure continued system access if a server in Santa Fe fails. Moreover, the existing network connections pose a single point of failure because no redundancy is built into the network.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) mandates security standards for certain transactions to safeguard protected electronic health information. Medical or other health care service providers who transmit any health information electronically are required to implement security standards if the Department of Health and Human Services has adopted a related standard. The Department's deadline to comply was April 20, 2005. Avatar and Mediware process, store, and transmit electronically protected health data. Although the Department has implemented several security requirements, technical safeguards, and all compliance policies, we could not determine if all mandated requirements have been addressed.

Recommendations. Establish separate test and production server and database environments for Avatar and Mediware as soon as possible before the next major upgrade.

Develop or acquire the technical expertise necessary to adequately support and upgrade Department systems.

Complete IT continuity plans and provisions to re-establish Avatar and Mediware services in the event of a disaster or prolonged outage.

Finalize maintenance and support contracts or outsource system hosting, including maintenance and support. Include any issues with ongoing support and maintenance in the project closeout report.

Complete and implement Department-developed procedures and processes related to security rule policies. Address all implementation specifications related to security standard safeguards. Include internal facility-developed HIPAA policies and procedures.

PERFORMANCE MEASURES

Facilities Have Adequately Functioning Quality Assurance Processes To Ensure That Health Care Performance Data Is Collected, Analyzed, And Used for Quality of Care Improvement. Facilities that provide nursing home services such as Ft. Bayard, NMBHI, and the Veterans' Home, should be encouraged to take advantage of outside resources for quality of care. For example, the New Mexico Medical Review Association (NMMRA), under contract with the federal Centers for Medicare & Medicaid Services (CMS), works closely with nursing homes as part of the national Nursing Home Quality Initiative (NHQI). NMBHI and Veterans' Home are working with NMMRA on this initiative; Ft. Bayard is not, but should consider participating in this program when the next three year cycle begins in 2009.

Current areas of focus in the NHQI program include reduction of pressure ulcers, reduction in the use of physical restraints, and better management of chronic pain. NHQI is also focusing on use of resident satisfaction surveys to target improvement activities as well as improving staff retention and job satisfaction. In addition, participating facilities must set performance targets using the NHQI Star web-based system. Those targets are based on national data reported to CMS by all nursing homes.

There are also a number of organizations and initiatives focused on nursing home culture change that seek to improve resident quality of life by promoting a resident-centered model of care vs. a traditional, institutional model. In this model, nursing home residents are given more decision making authority in some aspects of their lives, such as meal and bath times. The facilities should be encouraged to implement these resident-friendly practices to the extent possible using culture change resources such as the Innovation Network of New Mexico, the Pioneer Network, and the Eden Alternative.

Recommendation. Facilities should expand their efforts to improve quality of patient care and patient lives. Ft. Bayard should participate in the National Nursing Home Quality Initiative when the new cycle begins in 2009.

Facilities Management Reporting. Each of the six facilities submits performance data on two performance measures which is compiled and reported in the Department's quarterly performance report. These are:

- Number of substantiated cases of abuse, neglect and exploitation per 100 residents in agency-operated long-term care programs confirmed by the Division of Health Improvement (DHI); and
- Average length of stay of residents (at each individual facility).

The first measure is tracked because it is a resident safety indicator. It is a ratio calculated by dividing the number of cases of abuse, neglect and exploitation of residents receiving services in long-term care facilities by the resident capacity of that facility.

The second measure tracks the average length of stay of residents admitted into the state facilities. This measure is a quality of care indicator for residents and patients. The measure is calculated by figuring the number of residents discharged during a quarter and the number of days that these residents received services. The number of residents discharged is divided by the sum of patient days to arrive at the result. The average length of stay for residents ranged from 10 days at NMBHI for the second quarter of FY07 to 707 days at the Veterans' Home for the third quarter of FY07.

Efforts to Validate Performance Measure Results Can Be Improved. Performance measure results reported by the Division contain data and calculation deficiencies. In addition, these measures do not sufficiently nor accurately illustrate facility performance or measurable outputs and outcomes that align with program mission and objectives.

The first Performance Measure, "Number of substantiated cases of abuse, neglect and exploitation per 100 residents" is flawed for several reasons. First, the measure limits reporting to incidents occurring in facilities providing long-term care. Reporting is limited to NMBHI (Ponderosa and Meadows Units), Ft. Bayard, and the Veterans' Home. Combined these three facilities have roughly 511 licensed beds and provide services to 455 residents. Excluded are incidents occurring at the Adult Psychiatric, Forensic, Center for Adolescent Relationship Exploration and Community-Based Services at NMBHI, Sequoyah, Turquoise Lodge and the New Mexico Rehabilitation Center (roughly 348 licensed beds and residents or 43.3 percent of residents served).

Facility Capacities Used in Department Calculation

- Ft. Bayard - 200
- NMBHI - Nursing Facility – 176
- NMBHI – Psychiatric Facility – 121
- Veterans' Home – 135
- Rehabilitation Center – 44
- Turquoise Lodge – 34

Residents in long-term care are arguably more fragile and exposed to greater risk. This does not negate the fact that incidents of abuse, neglect and exploitation can and do occur at other facilities.

Second, the calculation methodology is inappropriate. The performance measure reported quarterly is calculated by taking the number of incidents investigated and substantiated by the Division of Health Improvement during the quarter, dividing that number by the facility capacity and then multiplying that result by 100. It may be more appropriate to use average daily census for the quarter in the calculation instead of the facility capacity simply because the long-term care facilities operated by the Division are operating at less than 100 percent capacity.

The number of abuse, neglect and exploitation incidents substantiated per 100 residents decreased from 10 in FY05 to 0.7 in FY07. The tables on the next page present actual cases reported by each facility in FY06 and FY07.

Table 10. Number of Abuse, Neglect and Exploitation Incidents Substantiated By Facility - FY06

Facility	Complaints				Investigations				Substantiated			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Ft. Bayard	70	30	28	23	4	1	5	1	6	0	8	10
NMBHI	17	19	8	13	6	6	2	3	1	1	3	2
Veterans' Home	10	2	4	13	2	1	1	3	2	1	3	2
Rehabilitation Center	0	0	0	0	0	0	0	0	0	0	0	0
Turquoise Lodge	0	1	1	0	0	1	1	0	0	0	0	0
Sequoyah (CYFD)												
Totals	**97**	**52**	**41**	**49**	**12**	**9**	**9**	**7**	**9**	**2**	**14**	**14**

Legend: C=Complaint; I=Investigated; S=Substantiated by DHI Source: Department Incident Management Bureau

Table 11. Number of Abuse, Neglect and Exploitation Incidents Substantiated By Facility - FY07

Facility	Complaints				Investigations				Substantiated			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Ft. Bayard	8	3	2		2	1	1		4	0	0	
NMBHI	35	16	4		8	5	1		3	0	0	
Veterans' Home	4	2	0		1	1	0		1	0	0	
Rehabilitation Center	1	1	0		1	1	0		0	0	0	
Turquoise Lodge	0	0	0		0	0	0		0	0	0	
Sequoyah (CYFD)												
Totals	**48**	**22**	**6**		**12**	**8**	**2**		**8**	**0**	**0**	

Legend: C=Complaint; I=Investigated; S=Substantiated by DHI Source: Department Incident Management Bureau

Note: The number of substantiated cases may be higher than the number of investigations because a single investigation may involve multiple incidents.

The number of complaints received and incidents investigated dropped from the first to the fourth quarter of FY06 and from the first quarter to the third quarter of FY07. Substantiated cases increased from the first to the fourth quarter of FY06, but decreased from the first quarter to the third quarter of FY07. Fewer complaints would indicate improvement; however, the

Department now strictly adheres to the Centers for Medicaid and Medicare Services (CMS) incident triage process. When an incident is received it is triaged into four categories:

1. Non-reportable;
2. Non-jurisdiction;
3. Closed at intake – desk review performed at facility; and
4. Full investigation.

The screening process uses standardized criteria to evaluate complaints, the level of jeopardy and the threat of imminent danger, which reduces numbers of complaint/incidents the Department receives, investigates and ultimately substantiates.

The results could also be misleading because the Department does not validate data and calculations are not checked for accuracy. The Office of Policy, Planning and Evaluation is responsible for reporting performance measure information. Simple tests for accuracy performed by Committee staff revealed the results posted in the quarterly performance reports cannot be derived from the data provided in Tables 10 and 11. A prime example is the third quarter of FY07. The Department reports 0.5 cases of abuse and neglect per 100 residents as illustrated in the table below.

Table 12. Number of Substantiated Cases of Abuse, Neglect and Exploitation per 100 Residents in Department-Operated long-term Care Programs Confirmed by DHI.

Fiscal Year	2006				2007		
Reporting Qtr.	1st	2nd	3rd	4th	1st	2nd	3rd
	1	0	2.63	1.36	0.2	0	0.5

Source: Department of Health

From information provided in Table 11 and using the Department calculation described earlier, this result does not appear possible since zero substantiated cases divided by 376, (the combined capacities of Ft. Bayard and NMBHI) is zero, not the 0.5 reported by the Department.

Department calculation results are also inconsistent. This is evident because the number of cases substantiated (numerator) is 14 for both the third and fourth quarter of FY06 (see Table 11). The denominator remained constant at 511, which is the combined capacities of Ft. Bayard, NMBHI, and Veterans' Home. The Department, however, reports 2.63 cases substantiated for the third quarter and 1.36 for the fourth quarter. The correct result should be 2.73 for both quarters.

Average Length of Stay Performance Measure Results May Be Unreliable. LFC staff obtained source data used by the Department to calculate the average length of stay at NMBHI for the 3rd quarter of FY06. Specifically, admission and discharge information was obtained for patients discharged during the quarter. One hundred sixty-eight patients were discharged between January 1, 2006, and March 31, 2006, according to Department data. The cumulative length of stay for these patients was 1,462 days. Thus, 168 patients discharged divided by 1,462 patient days equals an average length of stay of 8.7 days or rounded to the nine days the Department reported.

Closer examination of equation variables revealed a serious flaw in the calculation of patient days. The formula or mechanism used by the Department counts only the days in the month the patient was discharged. In other words, if a patient was discharged on March 8, 2006, the formula counted eight days as his length of stay even if he was admitted on January 13, 2006, which would have given him a length of stay of 54 days. Committee staff calculations resulted in 1,837 patient days for the same group of 168 residents and an average length of stay of 11 days. Due to time constraints, tests of average length of stay for the other facilities were not performed. Division management indicates this issue was identified and addressed. Data and calculations for this performance measure should be reliable for the last two reporting quarters.

In addition to the calculation flaws, this performance measure should be qualified and clarified to be meaningful to non-clinical persons using the results to make management and budget decisions. For example, the NMBHI provides services in four residential in-patient settings; however, the Department reports the average length of stay for the Adult Psychiatric Division alone (121 residents). The average length of stay is not reported for Forensics, the Center for Adolescent Relationship Exploration, or the Long-Term Care Division. Therefore, the measure applies to only 26.5 percent (121/456) of residents at NMBHI.

Furthermore, facilities such as the Veterans' Home and Ft. Bayard have large resident populations that are elderly and feeble. Most of these residents are categorized as *"no discharge potential."* These facilities do not actively attempt to discharge these residents. In addition to the physical and mental fragility of these residents, community-based services are scarce. Finally, it is difficult to see how this measure indicates and illustrates the quality of care and services the facility is providing or how this measure aligns with program missions and goals.

To most facility administrators, the average length of stay is associated with expressing the *cost of care* rather than the *quality of care*. The measure may be more appropriate for short-term care such as a drug or physical rehabilitation facility.

Recommendations.

- Develop quality assurance mechanisms capable of validating facility data, performance measure calculations, and appropriateness of numerators and denominators used in calculations to enhance the accuracy and reliability of reported results.
- Perform further testing of average length of stay for the remaining facilities to determine if discrepancies exist in those calculations to enhance reporting reliability.
- Perform further analysis of FY07 cases of abuse, neglect and exploitation to determine the exact reasons the numbers dropped dramatically to ensure all incidents are being reported as required.
- Consider more appropriate and meaningful performance measures for the different types of services offered.

Performance Measures Exist That Are Better Quality Of Care Indicators Than Those Currently Tracked By The Division. Discussions with clinical experts, review of quality improvement campaigns and research of best practices indicate there is a common set of core performance improvement measures that are excellent quality of care indicators for skilled nursing homes and long-term care facilities. More importantly, the long-term care facilities operated by the Division already capture and report this data, clinically known as the minimum data set, to comply with federal requirements.

Division Measures for Long-Term Care Facilities Can Easily Be Replaced With Center for Medicare and Medicaid Services (CMS) Minimum Data Set Performance Indicators. The Minimum Data Set (MDS) is a federally mandated process for clinical assessment of residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps facility staff identify health problems. MDS assessments are required for all residents, regardless of payment method, on admission to the nursing facility and periodically thereafter. MDS information is transmitted electronically by the facility to the MDS database at the Department and then captured by the national MDS database at CMS.

MDS quality indicators, developed by the University of Wisconsin, represent common conditions and important aspects of care. They reflect a measure of the prevalence or incidence of certain conditions based on a core set of screening, clinical, and functional status elements determined by CMS. There are 34 MDS indicators tracked by skilled nursing facilities.

Benefits of replacing current measures with MDS performance indicators are:

- MDS measures are automatically compiled by CMS for all residents, thus eliminating compilation, dissemination, calculation and duplication issues now experienced by the facilities and Department;
- MDS measures have easily generated Facility Quality Measure/Indicator (QM/QI) reports that illustrate a facility's performance for each of 34 performance measures in 14 domains;
- MDS QM/QI reports illustrate a facility's percentile for each performance indicator. This facility ranking, is expressed as a percentage on a given measure;
- MDS reports provide comparison group information such as state and national averages for a particular performance indicator; and
- MDS QM/QI can be generated for any reporting period desired.

The Division can also use the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as a resource to develop more meaningful performance measures that better align with its mission and goals.

Furthermore, the public can access MDS performance information in bar graph format for quick-comparison of both private and public long-term care nursing homes using the U.S. Department of Health and Human Services *Nursing Home Compare* web-site. The web address is http://www.medicare.gov/NHCompare.

The *Advancing Excellence in America's Nursing Homes* campaign promotes goals that mirror several quality indicators listed by *Nursing Home Compare* and mandated by CMS such as:

1. Reducing pressure ulcers. This measures how nursing homes prevent or reduce pressure ulcers and bed sores of residents. Nursing home residents who cannot reposition themselves are susceptible to this condition and need special care;
2. Reducing the daily use of restraints. Once regarded as necessary for patient safety, research has proven that restraints increase the likelihood of injury; and
3. Improvement of pain management in long- and short-term residents. Accurate assessment and treatment of pain allows residents to lead more comfortable lives.

The Functional Independence Measure *(FIM) is the most widely accepted functional assessments measure in use in the rehabilitation community.* The Functional Independence Measure is an 18-item ordinal scale used with all diagnoses within a rehabilitation population. These measures indicate how effective rehabilitation is and answer questions such as:

- Did the patient improve function?
- Did the burden of care decline?
- Did the patient return to the community?

Efficiency measures how inexpensively rehabilitation services were delivered. Medical rehabilitation is time intensive; therefore, time is an important measure in considering cost effectiveness. These measures are also reported to JCAHO through the Uniformed Data System (UDS).

Recommendations. The Department should:

- Consider performance measures that are more meaningful, appropriate, and specific to the services provided by each individual facility like those tracked and compiled in the MDS and UDS. Several MDS indicators considered excellent quality-of-care measures by the clinical experts contacted by Committee staff include:
    - Percent of high- and low-risk residents with pressure ulcers (decubitis);
    - Percent of residents who were physically restrained;
    - Percent of residents who have severe to moderate pain;
    - Prevalence of falls;
    - Prevalence of fecal impaction;
    - Percent of residents who loose too much weight; and
    - Prevalence of dehydration.
- Consider those performance measures developed by JCAHO such as:
    - Improve the accuracy of patient identification;
    - Improve the safety of using medications;
    - Reduce the risk of health care associated infections;
    - Accurately and completely reconcile medications across the continuum of care;
    - Reduce the risk of patient harm resulting from falls; and
    - Prevent health-care-associated pressure ulcers.
- Ensure the Governing Boards provide each facility with performance measure feedback.

Development of Meaningful Performance Indicators is Needed for the Chemical Dependency Program at the New Mexico Rehabilitation Center. The Rehabilitation Center's performance measures do not adequately reflect the effectiveness of treatment for chemical dependency. The Rehabilitation Center tracks 54 measures internally. Only two of the 54 apply to the Chemical Dependency program; treatment plan and psychosocial assessment. Treatment and psychosocial assessment require nursing and substance abuse staff to conduct an assessment for each patient within 24 hours of admission to the facility.

The National Institute on Drug Abuse indicates the basis of any effective treatment program should at a minimum recognize the following attributes:

- Treatment plans should be patient specific. No single treatment is appropriate for all individuals;
- Treatment should be readily available;
- An individual's treatment and service plan must be assessed often and modified to meet changing needs;
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness;
- Counseling and other behavioral therapies are critical components of effective addiction treatments;
- Treatment does not need to be voluntary to be effective; and
- Recovery can be a long-term process and frequently requires multiple episodes of treatment.

Recommendation. The Department should research the National Institute of Drug Abuse and the Substance Abuse and Mental Health Services Administration as guides to develop more meaningful performance measures for the chemical dependency program.

CAPITAL IMPROVEMENT NEEDS

Committee staff performed cursory inspections of campus grounds and capital infrastructure at each of the six facilities operated by the Facilities Management program for the purpose of:

1. Assessing capital needs of these facilities and determine whether those needs are being addressed by the Department; and
2. Ensuring the unacceptable conditions of facilities and residents discovered at the Walter Reed Army Medical Center are not repeated here in New Mexico.

The inspections focused on common areas frequented daily by residents/patients and those having a direct impact on day-to-day patient/resident care, safety and welfare. Also inspected were areas with significant indirect impact on patients/residents such as boiler rooms, warehouses and pump houses.

The Most Recent Department Infrastructure Capital Improvement Plan (ICIP) Does Not Address Ft. Bayard's Short-Term Needs. The Ft. Bayard main facility was built in 1920 and some structures are well over 100 years old and in dire need of repair or replacement. Laws 2005, Chapter 317 (Senate Bill 1055) authorized the Department to contract with a private

company to manage Ft. Bayard and to construct a replacement facility in Grant County. The Department entered into a contract with Geo-Care, Inc. on November 7, 2005, to operate the current Ft. Bayard and to design, oversee, and construct a replacement facility.

A major goal of the Departments strategic plan is "to provide for a safe and comfortable environment for quality patient care." However, many deficient facility conditions directly and indirectly impact the 133 long-term care residents receiving services. The Division of Health Improvement and the Department of Justice Civil Rights Division have cited Ft. Bayard for substandard facilities, equipment and living conditions.

Facility deficiencies that plague Ft. Bayard include:

- Severe roof and wall damage in the main facility warehouse and similar but lesser damage in the pump house due to heavy winter rains and flooding;
- Cracked, uneven and jagged flooring in several resident hallways and common areas that could cause residents and staff falls and further injuries;
- Heating and plumbing fixtures that secrete greasy rusty substances in resident shower rooms;
- Un-insulated rusted heating pipes in restrooms that could cause burns and other physical injuries to residents;
- Exterior doors in resident areas with deficient door jambs and thresholds that could quickly lead to a pest infestation problem; and
- Facility roadways that cross over water distribution channels collapsed by heavy trucks, hampering the delivery of goods and supplies for residents.
  (Snapshots of the items listed above can be found at Appendix C).

Laws 2005, Chapter 320 (Senate Bill 289) authorized $4 million of cigarette tax distribution for improvements at Ft. Bayard, but to date none of the funds have been expended. During the 2007 legislative session, the unused appropriation was reauthorized for purposes other than facility repairs. Department documentation indicates recognition of the items listed, repair costs determined, funding sources identified and authorized via legislation as evident in the following table. Although some repairs have been made, others have not and continue to be problematic.

Table 13. Legislative Appropriations Made for Ft. Bayard Capital Improvements

Legislation	Amount	Fund	Status
Upgrade fire system (Laws 2003, Chap. 429	$400.0	Severance Tax Bonds	On Hold.
Facility improvements (Laws 2005, Chap. 320	$4,000.0	Cigarette Tax Proceeds	Funds re-authorized.
Floor replacement (Laws 2004, Chap. 126	$150.0	Capital Project Fund	On Hold.
Renovate and equip the Facility Theater (Laws 2005, Chap. 320)	$50.0	Capital Project Fund	Contract with Property Control Division to work with local Historical Society.
Fire Safety system upgrade-public bldg. repair fund. (Laws 2002, Chap. 110)	$178.0	Capital Project Fund	Expended
Repair damaged warehouse roof – capital improvements (Laws 2003, Chap. 341)	$399.3	Cigarette Tax Proceeds	Bids received by PCD – selection of vendor pending.

Source: Department of Health

Recommendation. The Division should work with GSD and Geo-Care, Inc. to continue addressing repairs and the short-term capital needs of Ft. Bayard to ensure residents' nursing home needs are met. At a minimum, the items identified in the list above and seen in the photos at Appendix C should be addressed post haste.

Construction Completion Of The Ft. Bayard Replacement Facility Is A Minimum Two Years In The Future. According to Geo-Care, Inc. administrators in charge of designing, overseeing and constructing the replacement facility in Grant County indicate they are ready to proceed with construction of the new facility. The administrators indicate construction of the new facility will take 20 to 22 months once they get the green light from the Department. The Department expects to break ground in the fall of 2007. This timeline indicates a completed facility in mid-2009.

Therefore, the Department needs to place serious consideration in addressing short-term capital needs of the current Ft. Bayard facility in FY08 and FY09. The Department purportedly put the above-listed capital improvement projects on hold because a newly constructed facility would eliminate the need for repairs. Heavy winter rains and rapidly deteriorating facilities, however, demands immediate attention before resident health and safety is seriously impacted on a large scale.

According to Department staff, the stumbling block to new facility construction occurred when community input of Grant county citizens was solicited. The community prefers a secondary construction site on a rocky slope set further back on Ft. Bayard property as opposed the primary site chosen by Geo-Care, Inc. It was recently suggested that this secondary site is now the primary facility site. Department staff indicated additional costs will be incurred developing the land at the new site.

Construction bids for the new facility reportedly range from $41 to $47 million. An independent firm hired by the Department to provide a facility construction cost estimate confirmed the bids received by Geo-Care, Inc. are indeed reasonable and responsive. The cost of constructing the new facility will be structured through county financing.

By not using traditional state capital outlay financing for facility construction, taxpayers will pay higher long-term costs. The 1989 *Montano* Supreme Court decision barred the state from entering into certain lease-purchase agreements because they violated constitutional restrictions on state debt. Essentially the decision said lease-purchase arrangements, which allowed government entities to possess assets after making specified lease payments, constituted debt which requires voter approval. In effect, the Department would end up paying for a private or locally financed facility but never have equity interest or clear ownership after the debt was paid off.

Recommendations.

- The Department and the Division should resolve final details regarding the location, and logistics of developing the selected location for the new Ft. Bayard so construction can begin as soon as reasonably possible and new facility completion will not be delayed further.

- Review impact of the constitutional amendment allowing use of the lease purchase option in construction of the Ft. Bayard facility to protect taxpayers' financial interest.

OTHER

The State Could Be Recognizing Cost-Savings And Other Significant Advantages If The Veterans' Home Is Placed In The Jurisdiction Of The Department Of Veterans' Services. The State is foregoing cost savings for food, drugs and other clinical supplies purchased by the Veterans' Home because the facility is not utilizing federal Veterans' Administration (VA) price agreements. Only authorized Veterans' Homes have the ability to enter into VA price agreements (i.e. facilities that receive VA per diem). The food sharing agreement, for example, state VA homes can order from the federal VA contract whereas Department facilities cannot. In addition, we are not utilizing the Government Surplus Act to acquire furnishings for the Veterans' Home. Other advantages of placing the Veterans' Home under the jurisdiction of the Veterans Services include:

1. Veterans Services would have the ability to lobby the Legislature directly on behalf of the Veterans' Home for expansion services to meet VA requirements. Currently, the Veterans' Home is part of the basket of all services presented to legislators by the Department. Veterans Services could provide direct lobbying support to the legislature to ensure future funding is secured for capital projects.
2. Having the Veterans' Home under Veterans Services would allow all veterans a "one stop" shop for all services. Currently, people do not realize all the services and resources Veterans Services provide to veterans and their families.
3. Current administrative and clinical staff at the Veterans' Home has the expertise to efficiently and effectively run the facility.
4. Veterans' Services has many more resources for Veterans' services that could be directly accessed, enjoy excellent support from local Disabled American Veterans and American Legion groups and have the ability to expand that network whereas the Department does not.
5. Revenue generated by the Veterans' Home would stay at the Veterans' Home for reinvestment in the facility or needed services instead of the money going into to the "pot" for all Department facilities.

It is estimated there are roughly 200,000 veterans currently living in New Mexico. Many are veterans from WWII, and the Korean and Vietnam Conflicts meaning these veterans are 60 plus years in age and may soon need nursing home and skilled nursing facilities. Currently, a total of 5,000 nursing home beds exist in New Mexico. The Veterans' Home is the long-term care home specifically for veterans, spouses of veterans and Gold Star parents.

The home is recognized by the U.S. Department of Veterans Affairs and is subject to VA surveys and inspections to maintain certification. The nursing home and skilled nursing facility is licensed for 161 beds but currently provides services to about 133 residents. Ft. Bayard has 40 beds designated for veterans but only 36 are occupied. In the past Veterans' Services and other veterans groups lobbied the Department for at least 40 more beds (total 240 beds) for veterans but were quickly dismissed. Veterans' affairs advocates argue that the VA will provide 65

percent of funding for designing, building and constructing any state veterans home or additional wings to standing veterans homes.

Veterans' Home is Medicare and Medicaid certified and accredited by JCAHO. The state survey agency is the Division of Health Improvement's Bureau of Health Facility Licensing and Certification within the Department. The quality improvement organization is the New Mexico Medical Review Association which provides benchmarking and other best practice resources to the facility. The Veterans' Home is self-sustaining and roughly only five percent of its operating budget comes from the general fund as indicated in the table below for FY06.

Table 14. Operating Budget FY06– Veterans' Home

Budget for FY06	$11,784.9
State General Fund	$631.6
Medicaid	$6,023.7
Federal	$2,417.9
Other	$2,711.7
	Source: State Veterans' Home

For purposes of comparison, budgets and general fund portion of the six facilities operated by the Division are provided in the next table.

Table 15. General Fund Portion of the Six Facilities Operating Budget

Facility	Budget	General Fund (GF)	GF Percentage of Budget
NMBHI	$52,467.3	$27,575.7	52%
Turquoise Lodge	$4,351.4	$3,486.8	80%
Sequoyah	$6,860.4	$3,640.1	53%
Ft. Bayard	$20,036.6	$4,497.2	22%
Rehabilitation Center	$6,488.2	$3,866.4	60%
Veterans' Home	**$11,784.9**	**$631.6**	**5%**
			Source: State Veterans' Home

The Department of Veterans' Service Secretary Is Not Linked With The Administration Of The Veterans' Home. Although he is the primary advocate for New Mexico veterans and the federal Veterans' Administration (VA) contact for New Mexico, the Secretary of Department of Veterans' Services (DVS) has little influence in the management and administration of the Veterans' Home. New Mexico is the only one of 47 states in the U.S. with a Veterans' Home that is not managed and/or administered by the DVS of their state. It is the only State Veterans' Home operated by a state Health department. This situation can potentially lead to economical inefficiencies and missed opportunities when it comes to addressing the needs of veterans.

Other issues to consider include:

- DVS is more in tune with the needs of veterans and has access to many more resources than can be accessed through the Department.
- The current process of going through the Department to address veterans' issues is bureaucratically cumbersome;
- Veterans' call DVS for assistance and are unaware and confused that the current channel they're required to take is through the Department;
- The Department does not have a veterans' health or long-term care advisor or liaison.
- DVS has a five member Veterans' Advisory Board with "no teeth" to accomplish much.

Recommendations.

- The state legislature may want to consider the benefits and advantages of placing the State Veterans' Home under the jurisdiction of the Department of Veterans Services to ensure the long-term care needs of state veterans are adequately considered and cost-savings on food, drugs and VA home construction can be realized.
- The Department should recognize the advantages of VA pricing agreements and should enhance efforts to consider the needs of veterans that may be different from other long-term care residents.

Department of Justice Investigation of Ft. Bayard. In July and October 2005, the U.S. Department of Justice (DOJ) Civil Rights Division investigated conditions and practices at Ft. Bayard pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. 1997. In the two visits to the facility the DOJ focused on general care and treatment of residents and the facility's discharge planning and community integration services. The investigation concluded that numerous conditions and practices at Ft. Bayard violated the federal and constitutional rights of its residents.

Specifically, DOJ found that residents suffer significant harm and risk of harm from the facility's inadequate medical and nursing care services; improper and dangerous psychotropic medication practices; failure to provide adequate resident safety, inadequate nutritional and hydration services; and inadequate restorative care and specialized rehabilitation services. The DOJ documented numerous deficiencies which were evidenced by injury, illness and death according to the report dated May 1, 2006. The DOJ report mandated 11 remedial measures that the Department must implement *at a minimum* to avoid a CRIPA lawsuit.

According to the Albuquerque Journal article dated May 15, 2007, the DOJ has reached a settlement with the State of New Mexico on civil rights violations at Ft. Bayard. The agreement establishes systems to ensure that nursing home residents under the care of the state will receive adequate services to meet their needs according to DOJ sources.

Recommendations.

- Continue to correct deficiencies identified in the Department of Justice CRIPA review.
- Continue efforts to attain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

RESPONSES

The Department's responses except for Exhibits 1 through 18 are on the following pages. The Exhibits are available upon request either from the Department of Health or Legislative Finance Committee.

When requesting Exhibits ask for:
Department of Health Review of Facilities Management Division Response Exhibits.

New Mexico Department of Health
Response to Final Draft of
LFC Report of NMDOH Facilities

EXECUTIVE SUMMARY

The Department of Health appreciates the opportunity to comment on the final draft findings of the LFC report of our Facilities Program and Office of Facilities Management.

A letter dated November 30, 2006 to the New Mexico Department of Health stated (See Exhibit 1):

> The Legislative Finance Committee (Committee) has approved a review of the Department of Health Facilities Management Division on the 2007 work plan. The objectives of this review are to: assess the effectiveness and efficiency of the Facility Management Division's oversight of state operated facilities including planning, maintenance and capital outlay funding; determine adequacy of each facilities funding and services provided; and review staffing patterns in all facilities. The review objectives will not include a determination of the quality of care.

It should be noted that the LFC findings discovered prior to 2006 do not reflect activities of this newly created division and should not reflect the overall Facilities Program operations (see Exhibit 2). As the Department has stated previously, the issues identified in this report are a reflection of change in oversight and required improvements in patient care and safety.

It is important to remember that these facilities were stand alone facilities prior to inclusion with the Department. The Legislature folded them into the Department but, again, as stand alone entities managed by two divisions. It wasn't until FY06 that the approval was given to create a Facilities Program consisting of all our 24/7 institutions and an Office of Facilities Management to provide proper oversight and assistance to the program (See Exhibit 2).

Further, the findings from this review do not address or reflect improvements in care and services primarily because the LFC audit staff does not have the requisite experience in health facility operations. Given this limitation we understand the administrative focus but disagree in large part with the overall impression that the Department is not clear about expectations and is

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not engaged in appropriate oversight. The report reflects a genuine disagreement between the OFM and the leadership at one facility related to requirements to focus on patient care and systems' improvements. The review focused on administrative issues related to change in Department oversight of clinical operations in all facilities. The Department has and will continue to monitor and improve the patient/resident care and support in each facility and hospital operation.

Overall, the Department believes that this review should be viewed in a more appropriate context, i.e., it is clearly more a review of the relationship between the Office of Facilities Management and New Mexico Behavioral Health Institute (NMBHI) than a review of the entire program. While the report does review performance measures as they pertain to all facilities, and some photographs were taken at Ft. Bayard Medical Center, the report was almost entirely based upon interviews with NMBHI administration and staff and very few of the findings or issues addressed pertain to the other facilities.

One final note: It is important to remember that these six facilities are 24/7 health care facilities, serving many of New Mexico's most fragile citizens. These are not field offices or regional offices; they are clinical operations whose entire structure differs tremendously from other areas of state government. Recommendations that might seem appropriate for a Department's main office regarding strategic plans may not add value to the day-to-day operations of these state facilities.

SPECIFIC RESPONSES TO FINDINGS

1. PERSONNEL

Finding: Turnover and Vacancies Are High At both the Division and the Facilities
Response: The Department strongly disagrees with this finding.

Finding: High Turnover in Key Division Personnel

The Department disagrees with the review related to turnover within the Office of Facilities Management (referred to as the Division in the report), as mentioned in the Department's initial response to some draft findings.

The current structure of the Office of Facilities Management and Facilities Management Program was not officially in place until the second quarter of FY06, after substantial discussion with both DFA and LFC. Prior to that, DOH created a Deputy Secretary to assist in the development of the program. An operations manager and a general manager were put in place to assist in improving funding for facilities and, even more importantly, improving patient care with special emphasis on patient health and safety. The first Deputy Secretary and Operations Manager focused on these issues, particularly capital outlay funding for facilities. Once this work was completed,

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these individuals chose to move on to a different agency. The Secretary then hired an expert from within the agency for the Deputy Secretary position and an expert from out-of-state with direct care and private hospital background for the operations manager.

The Department's first consideration was ensuring appropriate patient care and patient health and safety. Until the actual Facilities Program was in place, the primary focus was on the financing of new and necessary capital projects and stabilizing operational finances.

There were no separation costs, turnover costs or replacement costs associated with these appointments because the first set of personnel transferred to another state agency. The only cost associated with changes made to personnel was the $8,437.97 in terminal leave for the Deputy Secretary, who served from November 2005 through February 2007, and left for personal reasons.

Finding: All Facilities Are Experiencing Difficulty with Their Turnover and Vacancy Rates
Response: The Department strongly disagrees with this finding.

The Department's turnover rate is below the national, regional, and state average for this industry. According to a study by the Institute of Medicine (2003), nursing home turnover rates range from 50% to 75% of staff leaving employment each year. Fort Bayard's three-year average was 52.24%; NMBHI's was 33.65% and the New Mexico Veterans Home was 42.93%. All of these averages are within the low end of, or actually below, national LTC turnover rates. The department recognizes, however, that recruitment in rural areas and staffing ratios based on acuity and gender are an ongoing concern; these issues are being addressed.

Data from the American Health Care Association's 2002 Survey of Nursing Staff Vacancy and Turnover in Nursing Homes indicates that the average turnover rates cited in the LFC report are generally not above the national, regional, and state averages for the long-term care industry (See Exhibit 3).

While the Department has a better than national retention rate for staff, we understand that staff recruitment and retention must be a priority in the Department. As a result, we have developed a relationship with SPO to evaluate pay for health care workers within the state and to create direct hire practices. In addition we are working with colleges and universities to train more nurses and certified nurse aides.

We recognize that a strong Department role in training and supporting employees in the facilities will improve outcomes for patients and residents as well as impact positively job satisfaction for staff. As the report states, the Department practices and supports the following HR activities:

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- DOH Orientation (3 to 5 days depending on classification)
- Ongoing training
- Employee Development Appraisal (individual improvement plans)
- DOH Grievance Policy
- Union Contracts
- SPO Rules

The Department has implemented best practices to hire and retain employees. Each facility has an orientation program in addition to the extensive DOH orientation, that is required upon employment for three to five days depending on staff categorization. The EDA process is utilized to promote personal and professional growth and to set clear job expectations to facilitate successful employment. The Department also has a grievance policy and abides by SPO rules and Union Contract requirements. The Department conducts ongoing staff training on residence rights, identifying abuse, neglect, and exploitation, and resident care plans that adequately prepare employees for their positions. The Department also operates CNA training programs to certify nurse aides while many facilities in New Mexico have lost the privilege to do this due to substandard quality of care. Currently 20 of the 72 non-DOH facilities have lost their ability to conduct a CNA training program throughout the state due to substandard quality of care identified in federal surveys.

Finding: The NMBHI Hospital Administrator Position Has Been Effectively Vacant since October 2005

Response: The Department strongly disagrees with the finding in this area.

The issue raised relative to the NMBHI administrator position, as discussed as recently as May 16th, has been resolved. The acting administrator is receiving an increase for assuming this role and DOH is unclear as to why this is still a finding. The Department recently obtained SPO approval to convert this position from classified to exempt and, although not required by SPO, it will post the position and fill it as soon as possible. The Department is searching for the right candidate who has expertise in the oversight of day-to-day operations of a complex, multiple program campus, that offers services including community-based programs, psychiatric assessment and treatment, forensics, sex offenders, and nursing homes.

Finding: Policies and Procedures Regarding the Chain Of Command Should Be Enhanced and Effectively Communicated to All Division Employees

Response: The Department strongly disagrees with this finding and the Department respectfully requests Executive Session prior to the publication of this report.

This finding is a direct result of discussions with only NMBHI staff and is related to specific personnel issues. The reviewers did not attempt to interview Office of Facility Management

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staff to verify allegations. The Department cannot comment on the allegations because of the confidentiality involved in personnel issues, and respectfully requests an Executive Session to further discuss this issue.

Finding: Oversight Being Provided By the Division Needs To Be Clarified and Revisited

Response: The Department strongly disagrees with this finding and the Department respectfully requests Executive Session prior to the publication of this report.

The Department uses the following rules and procedures: Administrator Meetings, SPO policies, Governing Board Meetings, The Joint Commission, and CARF that are followed and are common practice. This finding is a direct result of discussions with only NMBHI staff and is related to specific personnel issues. The reviewers did not attempt to interview Office of Facility Management staff to verify allegations. The Department cannot comment on the allegations because of the confidentiality involved in personnel issues, and respectfully requests an Executive Session to further discuss this issue.

Finding: Overtime Policy Is Inconsistently Applied To FLSA-Exempt Employees
Response: The Department strongly disagrees with this finding.

The OFM complies with all SPO and DOH rules and policies relating to overtime. DOH clearly has a policy -0860- Revised –7-97 (See Exhibit 4), that provides guidance to administer on-call policies and procedures and is monitored at the OFM level. The "inconsistency" or policy violation occurred at the facility level and the OFM held the individual accountable. Specific issues related to this matter can be discussed in executive session. The Department is addressing this through additional training and appropriate personnel accountability.

2. STRATEGIC PLANNING

Finding: Written Strategic Plan Needs To Be Developed For the Division and Strategic Plans for the Facilities Needs to Be Updated
Response: The Department agrees in part.

OFM operations are included in the DOH Strategic Plan (See Exhibit 5). In the past, strategic planning for the facilities had been inconsistently applied at the facility level. In January 2007, the Department discovered strategic planning was inconsistent among facilities and committed to remedying this situation. This issue was addressed in the April 2007 Governing Board Meeting, and boards are under direction to create strategic plans that meet consistent guidelines by September 2007 (See Exhibits 6,7, and 8).

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The current strategic task is to improve resident care and services in the Department's health facilities:

- Ensure that all DOH facilities meet and surpass national quality and safety standards and employ health care best practices
- Provide long-term care services using best practices and a resident-centered model
- Establish peer review systems for clinicians practicing in DOH facilities that are discipline specific, cultivate best practices through education, and serve to improve the quality of care delivery across multidisciplinary systems.
- Ensure that all individuals who receive care in DOH facilities are provided opportunities to actively participate in the development of their treatment and discharge plans
- Create home-like and active environments with DOH facilities that promote resiliency, recovery, and community integration
- Develop and implement standard guidelines and procedures for all DOH facilities that are derived from best practices

Finding: Consider Expanding Mental Health Services Offered To Adolescents

This will require an in-depth review outside of this program area and must start with the Behavior Health Collaborative and include discussions with the other HHS secretaries and staff, and ValueOptions. Once such a review is completed, a decision to implement will require an assessment and decision by the Legislature and Governor.

3. BUDGET AND OPERATIONAL ISSUES

Finding: Low Occupancy Rate Requires The Division's Attention
Response: The Department partially agrees with this recommendation.

Both the *Olmstead* decision and DOJ CRIPA report on FBMC mandate that the Department must assess and discharge residents to alternative and less restrictive settings. This requirement creates challenges for the Department because of the limited community options in New Mexico (See Exhibits 9 and 10). The Department is continually searching for adequate alternative settings for residents; therefore, occupancy rates regularly fluctuate.

Low occupancy rates require the OFM's attention. This issue was discussed at length with the LFC reviewers, and the Secretary, Deputy Secretary and Operations Manager spent a great deal of time on this issue. The Department routinely monitors occupancy rates. The factors affecting low occupancy rates are:

- Acuity
- Gender
- Financial issues

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- Moratoriums
- Staff shortages

These factors are not exclusive to DOH and are experienced in day-to-day operations of the health care industry. The Department is committed to patient safety and high standards of care. It is the responsibility of the Department to provide direct oversight of patient care, health and safety, and standards achievement through various measures including self-imposed moratoriums, internal corrective action plans, and root cause analysis.

NMBHI, FBMC, and the Rehabilitation Center have waiting lists because OFM will not admit residents when the facility is at capacity or if there are not sufficient staffing levels to provide appropriate care. Again, these aren't just field offices but clinical operations that must ensure proper quality of care. The Department does perform the analyses presented in the recommendation because they are required by law and regulation.

Finding: The Facilities and Division Budget Needs Closer Scrutiny for FY07
Response: The Department disagrees, the Issues are being Addressed.

Several of the facilities are struggling not with budget authority issues but with revenue collection issues. NMBHI is the biggest challenge. The facilities themselves come up with their own budget requests and revenue projections. The Department did not instruct NMBHI to include Pharmacy D in their projections. If they did so, they included it after a discussion with the former Office of Facilities Management CFO and the facility would have had to agree to its inclusion.

Adequate budget authority is not an issue for the program or any of the individual facilities within the program. Budget is appropriated at the program level, not by facility. In addition, the chart provided on budget projections does not include the approved budget, revenues and expenditures.

The Department's ASD does not have direct control or supervisory authority over facility finance and human resources personnel. The Department's fiscal responsibilities are handled in a decentralized manner; however, the Department is working on a centralized system with SHARE but will still require day-to-day financial management on the part of the facilities. Facility practices still vary and are yet to be standardized because these functions operate at the direction of the facility administrators rather than the DOH CFO. For this reason, the reliability of any information provided to the reviewers by NMBHI should be questioned unless it has been thoroughly reviewed and approved by ASD.

Along with all other agencies in state government, DOH implemented SHARE on July 1, 2007. This process resulted in numerous delays in posting financial transactions, including payroll, and in inconsistencies and errors as facility and ASD financial staff worked to learn the processes

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and procedures necessary to work in the SHARE environment. It is unclear whether the financial information provided to the reviewers came from SHARE, from spreadsheets maintained manually by the facilities, from a combination of the two, or from some other source.

With respect to payroll, all agencies have had posting errors. This Department is the largest agency in state government so it will have the largest number of errors. ASD is currently finalizing the journal entries necessary to correct Department codes, accounts, funds, and project ID activities as they relate to payroll. ASD has consistently advised the Program area and all pertinent facility personnel to use the SHARE data provided on the Excel Spreadsheets instead of the data in the SHARE system to do payroll projects.

NMBHI has had to correct its payroll errors since they are on site and have access to Kronos and supervisors who approve time reporting. The alleged error of $1,435.01 reported in the audit could have simply been someone being paid out of the wrong account code. If not, the Department would have asked that the facility rectify this potential overpayment.

The Department is resolving these issues over the next month. The Department's budget projections show that as a whole the Program area should end the year breaking even.

Finding: Some Facilities Expressed Concern That The Department And ValueOptions Have Not Finalized A Management Letter.

As discussed with the reviewers, no management letters for the Facilities Program were put in place for FY07. The delay occurred so that the Department could assure that the transfer of funds to ValueOptions does not prevent timely payment for day-to-day operations at these facilities given the critical nature of the care they provide. The purpose of the ValueOptions design is to identify least restrictive community services and options as well as billing enhancements.

Department management is currently working with the Behavioral Health Collaborative and ValueOptions, along with DFA, to develop the appropriate management letters. The facility's staffs are aware of this and the Department will keep them apprised as new information becomes available.

Finding: Department Hospital Computer Systems Lack Required User Functionality and Ongoing Technical Support and Maintenance
Response: Being Addressed

The Office of Facilities Management has established an Information Management Team (IMT) made up of facilities' members and chaired by the OFM Director of Operations. The IMT is charged to assess all requests for changes and enhancements to the facilities primary computer system (See Exhibit 11). This group will prioritize requests, evaluate available budget and lay out specific work plans to manage enhancement initiatives.

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The Department as a whole has a cyclical computer replacement process. One quarter of all computers are replaced each year, removing the oldest machines first. For the Facilities Program approximately 250 computers will be replaced in FY08. Network and infrastructure components are replaced on a five-year cycle.

GSD is currently testing the network bandwidth upgrade to NMBHI. Once testing is complete, the Department will conduct its own test with the application suite serving the facility. A separate network upgrade was one for the Pharmacy at NMBHI in April 2007.

Furthermore, the Department plans to physically separate instances of the applications used by facilities in FY08. Department staff currently supports both the Worx product and Avatar system at all facilities, with vendors assisting during major upgrades or changes. This is standard industry practice. Maintenance contracts for Worx and Avatar have been finalized.

In addition, the Program has business continuity procedures in place at all facilities and in Santa Fe to recover from an outage or loss of connectivity to the Avatar system. This procedure has been activated during actual outages and operates satisfactorily. The Department has adopted a full suite of HIPAA privacy and security policies that are available across the Department via the internal intranet.

3. PERFORMANCE MEASURES

Finding: Facilities Have Adequately Functioning Quality Assurance Processes to Ensure That Health Care Performance Data Is Collected, Analyzed, and Used for Quality of Care Improvement.
Response: The department agrees.

Quality assurance and quality care improvement was not a focus of this audit, as stated in the first paragraph of the letter dated November 30, 2006 from David Abbey to the Department (See Exhibit 1)

According to national statistics, the average nursing home patient is approximately 70 years of age, female, and receiving seven different medications. The state facilities' patient population has a much different demographic. They have historically been the last resort for patients with the highest acuity throughout the state. The populations serviced by the Facilities Program generally have:

- High Psychotropic Drug Needs
- Drug Addictions
- Severe Depression
- A High Risk for Falls
- Severe Behavioral Issues
- Dual Diagnosis
- Complex Psychiatric Needs

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The current MDS quality indicators measure the use of psychotropic drugs and use of restraints in facilities. Because the Department provides safety net services, the populations served typically have more complex psycho-social and medical needs. While utilizing MDS data can assist the facility with quality improvement activities, it cannot be used accurately to compare performance between facilities because the populations are different. Reduction of certain indicators such as use of psychotropic drugs and use of restraints may not be beneficial to patients. The better measure is the appropriate use of such treatment modality. Please note, the MDS data may be higher than regional, state, and national averages.

Measuring the performance of clinical operations is very complex. The Department has suffered from inappropriate performance indicators and identification of performance measures as required by different administrations and the New Mexico Legislature. The Department is in the process of the selecting appropriate models to measure quality improvement and quality measures. This administration has focused on a patient-centered model as supported by the current standards of practice. The Department is focused on clinical outcomes and not general census data.

The Department is committed to developing and selecting performance measures that support individuals to live independently in the community in the least restrictive environment. Culture change and measuring the effectiveness of the implementation of the patient-centered model are difficult to measure but the department is resolute in its obligation to accurately reflect this information and is eager to demonstrate its successes.

Facilities Management Reporting
Finding: Efforts to Validate Performance Measure Results Could be Improved
Response: the Department agrees

While the Department knows that the current measures are insufficient for providing a well-rounded picture of how each facility is operating and how it is performing relative to patient health and safety and quality of care.

The Department acknowledges the errors in calculations and has fixed those errors. The calculations for the number of substantiated cases of abuse, neglect and exploitation in department operated long-term care programs are:

	QTR 1-06	QTR 2-06	Total Q2-06	QTR 3-06	Total Q3-06	QTR 4-06	**Total '06**	QTR 1-07	QTR 2-07	Total Q2-07	QTR 3-07	Total Q3-07	QTR 4-07	**Total '07**
FBMC	6	0	6	8	14	10	24	4	0	4	0	4		
NMBHI NH	1	1	2	3	5	2	7	3	0	3	0	3		
Veteran's Home	2	1	3	3	6	2	8	1	0	1	0	1		
TOTAL	**9**	**2**	**11**	**14**	25	**14**	**39**	**8**	**0**	**8**	**0**	**8**	**0**	**0**
per 100	1.76%	0.39%	2.15%	2.74%	4.89%	2.74%	7.63%	1.57%	0.00%	1.57%	0.00%	1.57%		
Based on 511 Bed Capacity														

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In addition, as previously mentioned, the Department is revising and updating our Strategic Plan and all performance measures.

Finding: Average Length of Stay Performance Measure Maybe Unreliable
Response: The Department agrees with this finding, however, the Department identified the computation error six months ago and notified the LFC on May 16, 2007 during the exit conference.

Finding: Performance Measures Exist That Are Better Quality of Care Indicators than Those Currently Tracked By the Division
Response: The Department agrees with this finding.

Although quality of care was not to be a part of the audit, according to the letter to the Department sent on November 30, 2006 (See Exhibit 1). The Division measures for long-term care facilities can easily be replaced with CMS/MDS performance indicators. The Department agrees that there are better performance indicators and is in the process of selecting appropriate indicators for each facility.

Finding: Development of Meaningful Performance Indicators is needed for the Chemical Dependency Program at the New Mexico Rehabilitation Center.
Response: The department partially agrees with this finding.

The Department agrees that new performance standards need to be established and stated previously that it is in the process of selecting appropriate quality measures, but the listing outline by the LFC on page 33 are operational concepts and not designed to be used as operational measures.

4. CAPITAL IMPROVEMENT NEEDS

Finding: The Most Recent Department Infrastructure Capital Improvement Plan (ICIP) Does Not Address Ft. Bayard's Short-Term Needs.
Response: The Department strongly disagrees with this finding

As evidenced by FBMC's most recent surveys conducted by Health Facility Licensing & Certification, the Department is meeting the goal in its strategic plan to provide a safe and comfortable environment for quality patient care. According to the most recent survey from the Centers for Medicare Certification and the Department of Justice report, clearly indicates no areas of substandard of care identified (See Exhibit 12). The Department finds the reference to Walter Reed Army Medical Center gratuitous and insulting.

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The inference that the Department has ignored short-term needs at Ft. Bayard to the detriment of residents is also untrue. Due to the expectation that GEO Care and the county would be breaking ground for the new facility, Ft. Bayard did not submit any new, short-term items for consideration. In addition, GSD is the owner of this facility and the Department has always worked closely with GSD to fix any interim problems at the facility. GSD has stated that they did have project management problems in this area of the state and that some of these interim problems may not have been addressed as quickly as they should have been under routine circumstances.

The information in this LFC report is outdated; in fact, the Division of Health Improvement has not identified or cited FBMC for substandard quality of care since 2004.

The descriptions of "capital deficiencies" are misleading. The Department has provided detailed responses, with additional pictures, in Exhibit 17.

Finding: Construction of the Ft. Bayard Replacement Facility Will Require a Minimum of Two Years to Complete
Response: The Department strongly disagrees with this finding.

The contractors projected an 18-month timeframe on the delivery of the facility once groundbreaking occurred. The Department is very serious about the capital needs and prioritizes the issues according to severity based on:

a. Patient safety and quality of care
b. Staff and visitor safety
c. Environmental and structural requirements outlined by state and federal regulatory agencies
d. Cosmetic enhancements

Once again, the Department would like to point out FBMC is in compliance with Life Safety Code as identified by State and Federal Regulations. The department recognizes its fiduciary responsibility as well as the responsibilities to all parties including the county, tax payers, and most importantly the residents served by FBMC.

Finding: Turquoise Lodge Capital Needs
Response: The Department agrees.

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The department agrees with this finding, however, as discussed in the May 16, 2007 meeting, DOH is in discussion with the county to construct the warehouse per the lease agreement (See Exhibit 13).

5. OTHER

Finding: The State Could Be Recognizing Cost-Savings and Other Significant Advantages If the Veterans' Home Is Placed In the Jurisdiction of the Department Of Veterans' Services
Response: The Department strongly disagrees.

The Department already utilizes price agreements with the Department of Veterans' Services on pharmaceuticals. The department also has an Interagency Cross-Servicing Support Agreement for food, which is the highest form of price agreement and savings that the department can have with the Department of Veteran's Affair (See Exhibits 14 and 15). Although a cost savings could potentially be made, it is important to recognize that under the *Olmstead* decision, the Department has a mandate to place veterans in the least restrictive environment possible. As stated in this report, 200,000 veterans currently live in New Mexico. While many of these veterans need daily assistance, they all do not need nursing home care. A single expanded facility is not the answer to serve a population with such diverse needs. DOH and DVS should be looking at community-based options to support these individuals.

In addition, the Department currently lobbies the New Mexico Legislature on behalf of the Veteran's Home. Over the last three years the Department has spent over $900,000 for kitchen flooring, boilers, windows, chillers and upgrade fire alarm system. In addition, the Department succeeded in getting $1 million to plan, design, and build an expansion for the Alzheimer's unit for the facility.

The Department requests empirical evidence of the LFC's allegation that "people do not realize all the services that the VA has to offer."

Finding: The Department of Veterans' Service Secretary Is Not Linked With the Administration of the Veterans' Home
Response: The Department strongly disagrees.

The Department strongly disagrees with the statement that placing the Veteran's Home under the jurisdiction of DVS would ensure the long-term needs of state veterans are sufficiently met. The Department is already meeting the needs of the residents at the State Veteran's Home as evidenced by no patient safety issues cited in the last licensure or certification survey (See Exhibit 16). Once again, quality was not to be apart of the LFC audit as described in the letter dated November 30, 2006 from David Abbey to the Department (See Exhibit 1).

It should be noted that previously the Veteran's Home was operated by DVS, but due to poor

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fiscal management, which led to near bankruptcy, the recommendation was made to transfer management of the facility to the New Mexico Depart of Health.

Finding: Department of Justice Investigation of Ft. Bayard

Efforts are being made to ensure that no repeat findings are identified by the Department of Justice. The LFC reviewers did not uncover issues and findings cited in the DOJ report, so it is unclear why this is a finding and recommendation rather than a status report on the Department's successful efforts to obtain a resolution . Exhibit 18 provides additional information from the facility profiles.

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New Mexico Department of Health
Response to Final Draft of
LFC Report of NMDOH Facilities

EXHIBIT LISTING

1. LFC Letter to NM DOH date November 30, 2006
2. Appropriation Reference to FMP in House Bill 2
3. American Health Care Association 2002 Report
4. Policy for overtime and on-call staffing
5. 2007 Strategic Plan
6. Hospital Administrators Meeting Minutes (March 2007)
7. Governing Board Meeting Agenda (April 2007)
8. Governing Board Meeting Minutes (April 2007)
9. Olmstead Decision
10. Department of Justice Civil Rights of Institutionalized Persons Act CRIPA Settlement Agreement on FMBC
11. Information Management Team Minutes
12. Ft. Bayard Medical Center Survey Results
13. Turquoise Lodge Lease
14. DoVA Pricing Explanation
15. Interagency Cross-Servicing Support Agreement (7/1/06)
16. Veteran's Home Survey
17. Ft Bayard Pictures: Responses to LFC Pictures
18. Facility Profiles

Appendix A. FY04-FY06 Percent of Turnover by Facility

	Ft. Bayard	NMBHI	Rehabilitation Center	Sequoyah	Turquoise Lodge	Veterans' Home	Fiscal Year Average Turnover
FY04	55.15%	31.66%	32.50%	27.91%	58.06%	33.78%	**39.84%**
FY05	38.94%	33.73%	27.35%	35.94%	66.13%	36.65%	**39.79%**
FY06	62.62%	35.56%	35.90%	38.76%	96.77%	58.37%	**54.66%**
3 Year Average Turnover by Facility	**52.24%**	**33.65%**	**31.92%**	**34.20%**	**73.66%**	**42.93%**	

Source: GSD HRMS Download of Data

Appendix B. FY06 Highest Turnover by Facility by Position

Turquoise Lodge

Department	FY06 TO Rate	3-Year Turnover Rate for Positions	Average Pay
Clinical	61%	44%	$ 19.38
Nursing	83%	70%	$ 16.58

Veteran's

Department	FY06 TO Rate	3-Year Turnover Rate for Positions	Average Pay
Housekeeping	44%	48%	$ 8.40
Nursing	82%	56%	$ 14.79

Rehabilitation Center

Department	FY06 TO Rate	3-Year Turnover Rate for Positions	Average Pay
Clinical	41%	33%	$ 23.24
Nursing	50%	38%	$ 15.98

Ft. Bayard

Department	FY06 TO Rate	3-Year Turnover Rate for Positions	Average Pay
Dietary	53%	44%	$ 6.99
Facility Support	31%	28%	$ 10.70
Nursing	70%	60%	$ 13.21

NMBHI

Department	FY06 TO Rate	3-Year Turnover Rate for Positions	Average Pay
Clinical	22%	22%	$ 38.21
Nursing	31%	31%	$ 24.03
PsyTech	45%	38%	$ 10.78
Housekeeping	53%	42%	$ 8.17
Dietary	63%	58%	$ 8.85

Sequoyah

Department	FY06 TO Rate	3-Year Turnover Rate for Positions	Average Pay
Clinical	33%	31%	$ 28.62
Nursing	38%	29%	$ 24.50
Milieu	65%	50%	$ 11.36

Source: GSD Download

Capital Needs – Ft. Bayard Medical Center. March 30, 2007.

Figure 1. Basement water damage.

Figure 2. Bathroom flooring needing repair.

Figure 3. Uneven and un-level shower room flooring.

Figure 4. Water damage to boiler room ceiling and walls.

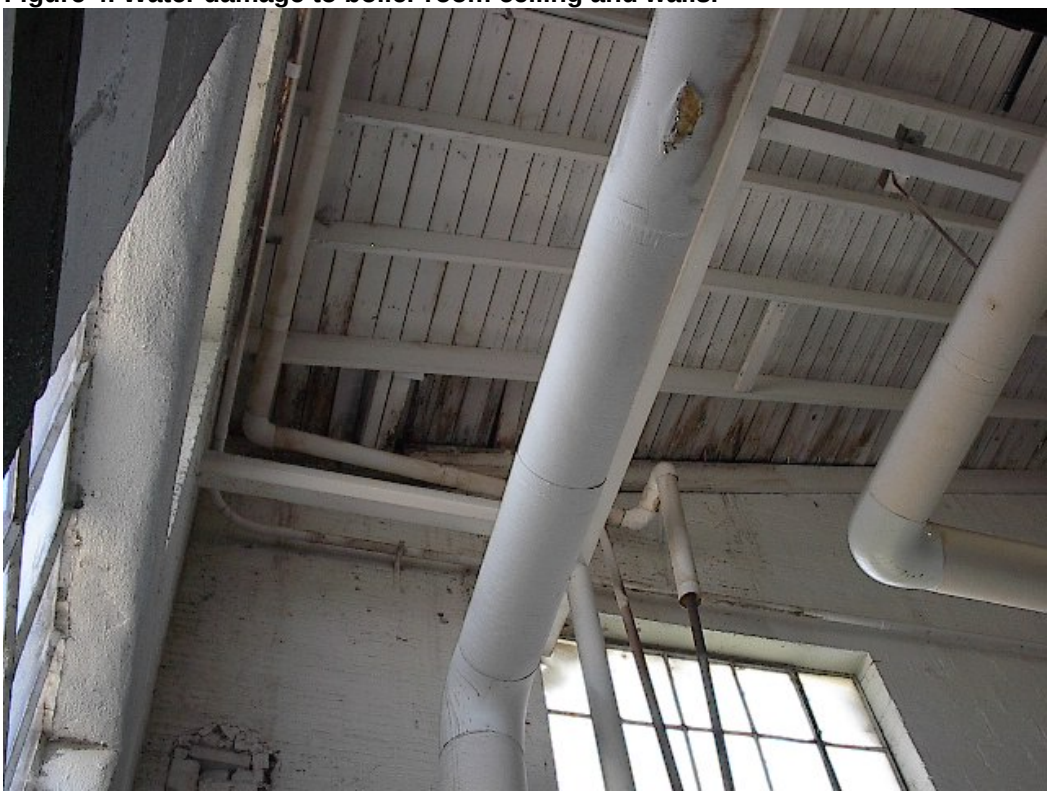

Figure 5. Electrical fuse box with severe rust corrosion.

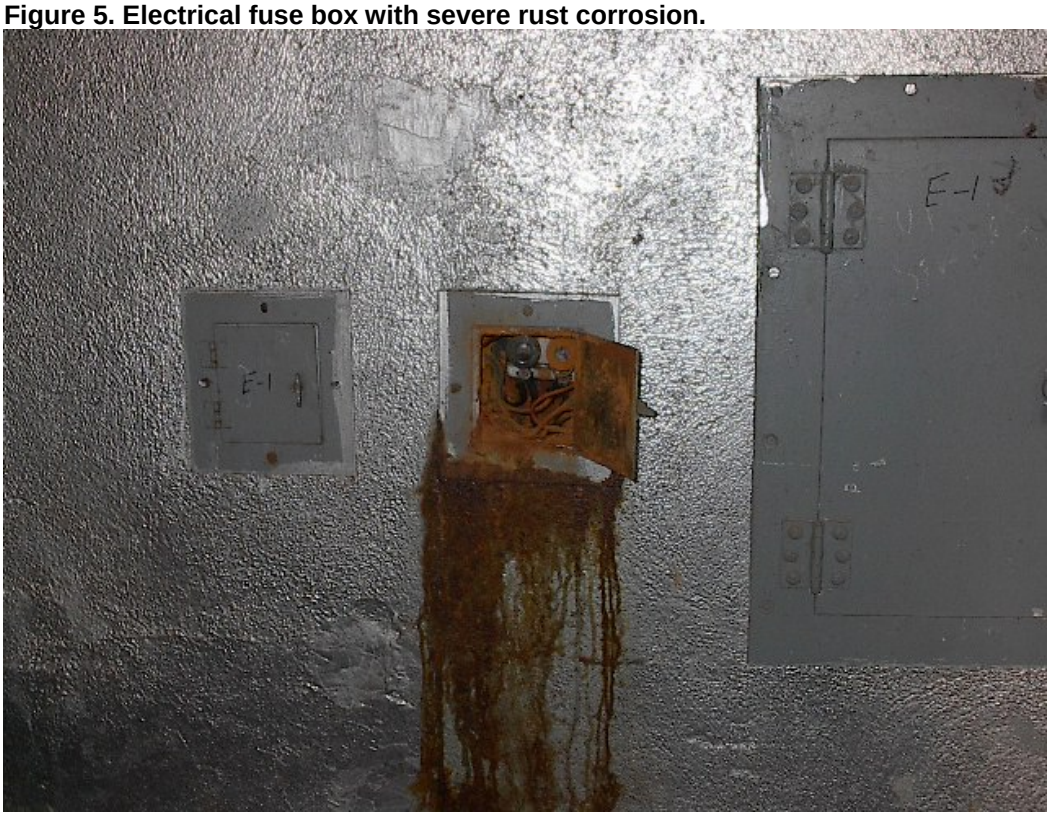

Figure 6. Jagged floor edges exposed to residents

Figure 7. Flooring with exposed jagged edges in resident common area.

Figure 8. Jagged threshold edge exposed to residents.

Figure 9. Deficient exterior door threshold exposing facility to threat of pest infestation.

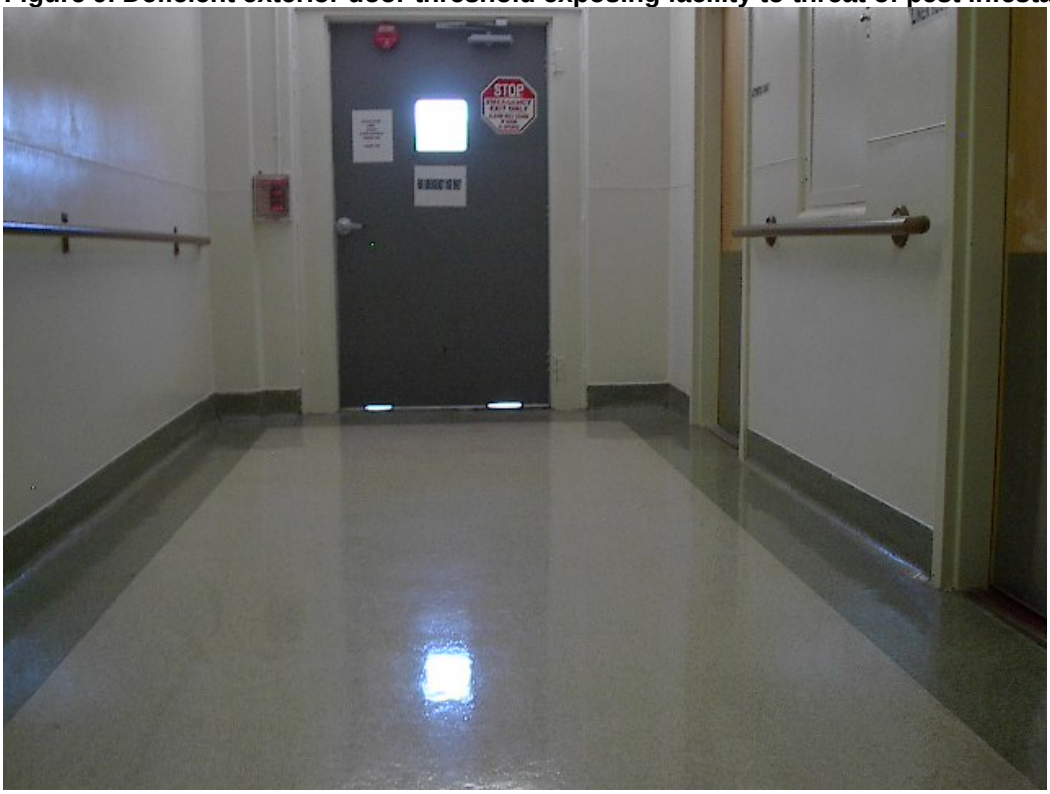

Figure 10. Partially exposed hot water valve.

Figure 11. Collapsed facility warehouse roadway exposing water distribution channel.

Figure 12. Rust corrosion to water softener system.

Figure 13. Rust damage in water softener facility.

Figure 14. Partially insulated, rusty hot water valve in resident common area.

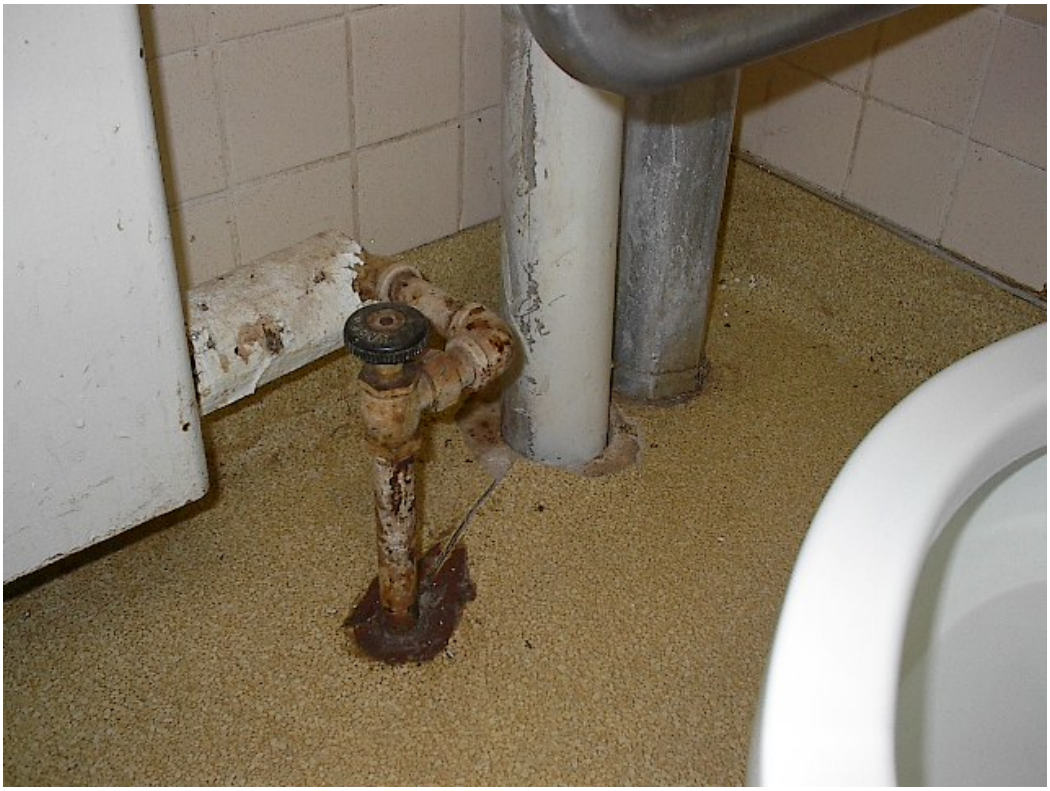

Figure 15. Rusty-greasy substance secreting from hot water valve.

Figure 16. Bathroom floor needing repair.

Figure 17. Damaged threshold in resident common area.

Figure 18. Ceiling damage in facility warehouse.

Figure 19. Water damage to warehouse ceiling that could compromise fire-alarm system.

Figure 20. Excessive water damage to ceiling near ventilation system.

Figure 21. Warehouse ceiling damage.

Figure 22. Warehouse wall and floor damaged by heavy rains.