Report
to
The LEGISLATIVE FINANCE COMMITTEE

Department of Health
Oversight of State Operated Facilities
September 28, 2009

Report #10-01

State of New Mexico
LEGISLATIVE FINANCE COMMITTEE

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David Abbey
Director

September 28, 2009

Alfredo Vigil MD, Cabinet Secretary
Department of Health
Suite N 4100, Runnels Building
1190 St. Francis Drive
Santa Fe, NM 87502

Dear Secretary Vigil;

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the *Program Evaluation: Department of Health Oversight of State Operated Facilities and Follow-up Review of the 2007 Evaluation.*

The program evaluator reviewed actions for improvement taken by the Office of Facilities Management since the 2007 evaluation and assessed the Office of Facilities Management's oversight of seven facilities and programs to ensure the delivery of cost-effective, quality services to clients. The report will be presented to the Committee on September 28, 2009. An exit conference was conducted on September 21, 2009 to discuss the contents of the report with Office of Facilities Management and Administrative Services Division staff.

I believe the report addresses issues the Committee asked us to evaluate and hope our department benefits from our efforts. We very much appreciate the cooperation and assistance we received from your staff.

Sincerely,

David Abbey, Director

DA/mt

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EXECUTIVE SUMMARY

FY 09 Facility Expenses

NM Behavioral Health Institute (NMBHI)
$57.7m
Fort Bayard Medical Center (FBMC)
$26.4m
Sequoyah Adolescent Treatment Center (SATC)
$7.6m
NM Rehabilitation Center (NMRC)
$6.0m
Los Lunas Community Programs (LLCP)
$21.1m
Turquoise Lodge (TL)
$5.4m
NM State Veterans Home (NMSVH)
$13.2m

Percent of Occupancy of Total Capacity by Year

Facility	2007	2008	2009
TL	58%	46%	64%
NMBHI			
Forensics	75%	88%	82%
Adolescent	72%	71%	66%
Adult	72%	69%	74%
Long-term care	94%	94%	91%
NMRC			
Med Rehab	35%	31%	43%
CDU	78%	77%	65%
SATC	92%	95%	97%
NMVH	89%	87%	86%
FBMC			
Long-term care	69%	67%	62%
Yucca	59%	51%	56%
Average	72%	71%	71%

Source: LFC staff analysis from OFM data

Metric Definitions

FTE per occupied bed – Number of full-time employees required or assigned per occupied bed.
Hours of care – hours of care available to each patient per shift or day.
Cost per day – The daily cost for all services for each patient.

National legislation, in the 1960s, mandated the use of community-based services, forcing the closure of many health/substance abuse treatment facilities across the country. Changes in federal healthcare reimbursement exacerbated the situation for state-operated facilities by eliminating opportunities for federal patient care revenues for those providers. In FY09, New Mexico general fund appropriations funded fifty-one percent of the operations of the state-operated health facilities.

The New Mexico Department of Health (DOH), through the Facilities Management Program administered by the Office of Facilities Management (OFM), operates seven programs to serve clients in need of long-term care, medical rehabilitation, psychiatric and substance abuse treatment services. OFM has the largest budget and most employees of all DOH divisions and programs. This budget exceeds that of many state departments.

Established in 2006, OFM has had significant turnover in key central office positions. There is no evidence that prior leadership took actions to address the original concerns justifying the establishment of OFM as the oversight authority for the facilities. Staffing for OFM did not stabilize until 2008. Since then significant progress has been made, but much is left to do.

Significant Findings

Oversight of the financial operations of the facilities continues as the major concern. In FY08, OFM received $750,000 in supplemental appropriations for operations of the facilities. In FY09, OFM received $11.8 million in supplemental appropriations. The budgets for these two years overstated revenue and understated expenses. The total amount of the supplemental appropriations was allocated to salaries and benefits. During FY09, of the stated capacity of 845, an average of 198 beds was unoccupied each day and, during the year, nearly $9 million dollars was spent on overtime and contract staffing. However, OFM considers 742 the operational capacity which would leave 103 beds unoccupied each day.

With occupancies below capacity for all the facilities except SATC, the state has approved capital appropriations for another substance abuse program for the Behavioral Health Services Division (BHSD) within the Human Services Division (HSD). BHSD identifies itself as the state's Substance Abuse Authority, with a responsibility for "monitoring progress in system capacity and comprehensive system planning." Increased collaboration between state agencies is necessary to prevent duplication of services, increased costs to the state, and clarification of authority for drug treatment program.

All Positions: Employee Turnover Rates

Facility	FY07	FY08	FY09
TL	27%	34%	20%
NMBHI	17%	13%	12%
NMRC	23%	13%	17%
SATC	14%	10%	15%
NMVH	21%	24%	13%
FBMC	31%	28%	33%
LLCP	24%	18%	19%

Supplemental Personnel Costs
(in millions)

Fiscal Year	Overtime	Contract Staff
2007	$7.0	$1.0
2008	$7.6	$1.2
2009	$7.2	$1.7
Total	**$21.8**	**$3.9**

Source: OFM

Source: OFM

Cost of Turnover

- Interviewing,
- Replacement employees during recruitment,
- Advertising, screening, interviewing, and selecting,
- Physical exams, immunizations, criminal background checks,
- Training and orientation.

Percent of Operations Funded by State General Funds

Facility	FY07	FY08	FY09
TL	92%	96%	84%
NMBHI	53%	54%	61%
SATC	53%	54%	58%
NMSVH	5%	8%	10%
FBMC	24%	22%	46%
LLCP	28%	29%	42%
NMRC	61%	65%	66%

Source: LFC Analysis

Unless there is a curb in spending or an unanticipated increase in revenues, supplemental appropriations may be needed in FY10. Budgeted revenue increases for FBMC and NMBHI will not materialize.

The inability of OFM to accurately project revenue and control expenses significantly stresses the overall state budget. The need for large supplemental appropriations suggests unrealistic budget development.

The budget should not be considered static with the budgeting process over once the budget has been developed. OFM must gather the expertise and tools to accurately and effectively develop and manage the program budgets. This evaluation did not find a monitoring process in place to quickly identify and react to changes in projected revenue or expenses. Collection and analyses of standard industry metrics would serve as a gauge for facilities to make timely budget changes.

Staffing is the expense leader for all facilities. Although a decrease from FY08, the use of overtime and contract staff totaled nearly $9 million for FY09. These costs strain the OFM budget. For example, with an occupancy of 64 percent, TL used over $1 million, 29 percent of regular salaries, for supplemental staff.

Each of the facilities has established staffing formulas. These formulas identify the number and classification of staff needed for actual patient census. No methodology was provided to validate that formulas are appropriate and in line with industry standards. Based upon the available information, one cannot discern whether the established staffing formulas are used or if staffing remains at the same levels, in spite of changes in census or acuity

There is little evidence to show staff decreases occur when occupancy or patient acuity is lower than budgeted. OFM facilities are hindered by the lack of personnel policies or union contract language which allows for staff to be unscheduled from their work assignment.

Four-hundred employees terminated from OFM facilities in FY09. A conservative, estimated cost of this turnover is $6.4 million. OFM lacks information regarding termination reasons inhibiting their ability to take actions promoting retention.

OFM, like all New Mexico health facilities, competes for professional staff. New Mexico ranks 50th for the number of registered nurses per 100,000 population. OFM registered nursing salaries are $5 thousand per year less than the state average. The national average for psychiatrists per 100,000 population is 14, while the state average is five. OFM, with severe difficulty recruiting physical and occupational therapists to NMRC, estimates the NMRC salary is $15 per hour less than other facilities in the state.

Cost per Patient Day

Facility	Cost per Day
TL	$732
NMBHI	$495
NMRC	$811
SATC	$571
NMSVH	$275
FBMC	$475

Source: LFC analysis

Revenue Management Transactions

- Referrals
- Eligibility screening
- Benefit Determinations
- Medical Necessity
- Sliding Fee Scales
- Payment plans
- Diagnosis Coding
- Regulatory Compliance
- Utilization Management
- Contract Management
- Claims Submissions
- Denial Management
- Cost and charge policies
- Appropriate Discounting.

DSH funding in NM is allocated to health facilities in New Mexico including for-profit entities, but is not available, per Medicaid regulations, to state-operated facilities.

Psychiatric and substance abuse programs are limited in revenue generation by state and federal laws and regulations. Regulations limit federal program participation through Medicare and Medicaid to state-operated facilities. Every state makes major general fund contributions to their state facilities. In 2009, NM state general funds accounted for 52 percent of all revenue for the OFM facilities.

Forensic clients are totally funded through state general funds. This is a growing population which will soon require additional funding for care and capital expansions.

Unexplored patient revenue sources may be available to state facilities. Although the federal government has limited access to public funding for state-operated psychiatric and substance abuse facilities, other states have garnered additional revenues within the federal limitations.

Funding is available for most nursing home clients through Medicare or Medicaid and long-term care facilities should be able to balance budgets.

OFM has not implemented written policies, procedures and processes to insure all possible revenue is captured. Revenue management within a healthcare provider organization is far more complicated than other industries. Policies and practices for revenue management must have tight accountability, reduced variability, and supportive information systems.

To insure that revenues from third-party payers are adequate, facilities must know the cost for services rendered, for use in third-party payer contracting. The state does not, within the SHARE system, segregate costs at the unit sub-program level. This hinders access by the legislature in monitoring budget performance. Presently the LFC only has access to program level information.

The wide variation in the cost per day for like services within OFM facilities suggests, at a minimum, opportunities to improve efficiencies are available at TL and NMRC.

Opportunities to control other operational expenses do exist. OFM has taken advantage of General Services Department (GSD) pricing and OFM proposal solicitation for certain goods and services common to all facilities. The combined amount of goods and services for all facilities may be of a volume that would generate savings with single contracts. For services or goods common to more than one facility, OFM should validate that GSD pricing is competitive to pricing acquired through the request for proposal process. Although savings generated in the operational expenses pales to that which could result from staffing controls, any expense reduction is a benefit.

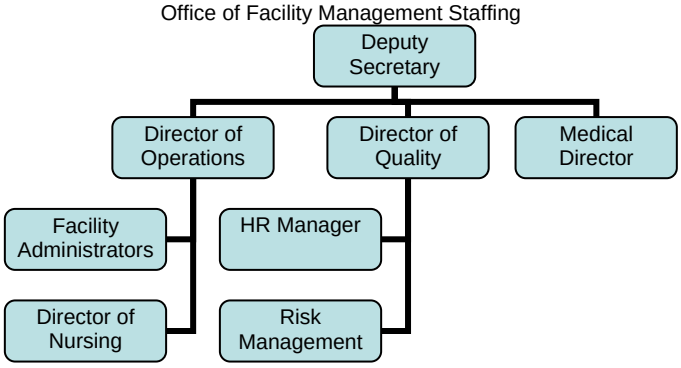
Quality of Care. The FY07 LFC evaluation cited inadequate performance monitoring. All the facilities except, FBMC and LLCP, have achieved accreditation from national accrediting and certifying agencies. These agencies require the monitoring of quality of care performance measures. OFM collects data which demonstrates the quality status of care. However, additional attention must be made to process improvement that promotes desired results.

Significant Recommendations

- OFM should develop and implement a plan to rely on not more than 45 percent state general fund for expenses.
- DOH and the Department of Finance and Administration (DFA) should immediately reduce facility expenditures as revenue may not be available for supplemental or deficiency appropriations.
- OFM should collaborate with BHSD. BHSD, as the "State Substance Abuse Authority" should be involved in decisions regarding substance abuse treatment facilities and to ensure policies are consistent between the agencies and that facility plans reflect the needs of the state.
- OFM should decrease facility capacities and staffing to match more realistic censuses, consolidate facilities, or move services to community providers.
- DOH should convene a work group of OFM, HSD with Medicaid and BHSD, Aging and Long-Term Services, and any other appropriate state agencies to investigate opportunities for: changes in regulation, statute, state mental health plan, Medicaid waivers applications, and establishment of internal agreement that third party payers, including those within the Behavioral Health Purchasing Collaborative to explore other than state general fund revenue options for OFM facilities.
- OFM should validate the appropriateness of staffing patterns and formulas using industry standards and comparisons between facilities and with other like community organizations.
- DOH should develop healthcare finance and procurement expertise at the OFM program level through reallocation and relocation of vacant positions within the program.
- OFM should work with State Personnel Office on a compensation and classification study of critical positions and identify "frozen" positions which impact revenue and appeal for hiring authority.

The Office of Facility Management is responsible for the oversight of seven facilities: New Mexico Behavioral Health Institute (NMBHI), Los Lunas Community Programs (LLCP) Fort Bayard Medical Center (FBMC) Sequoyah Adolescent and Treatment Center (SATC), New Mexico Rehabilitation Center (NMRC), Turquoise Lodge (TL), and the New Mexico State Veteran's home (NMSVH).

In FY06, the Office of Facilities Management (OFM) was created in the Department of Health (DOH) through a reorganization of existing programs. Prior to the reorganization, DOH described the state-operated facilities as "stand alone" operations. The General Appropriations Act of 2005 states, "Upon reorganization and creation of the deputy secretary of facilities for the department of health, the department 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." The purpose of the facilities management program was to provide oversight for DOH facilities providing health and behavioral health care services including mental health, substance abuse, nursing home care and rehabilitation programs in facility and community-based settings that serve as the safety net for the citizens of New Mexico.



Although the focus of this evaluation was to be the central office of OFM, it was difficult to isolate the central office from the facilities.

PROJECT INFORMATION

Program Evaluation Objectives.

- Assess the oversight by OFM of fiscal and staffing management and budgetary controls of the state facilities.
- Assess practices to maximize revenues and control costs by OFM at selected state facilities.
- Follow-up on the implementation status of findings and recommendations from the May 2007 review of OFM.

Program Evaluation Activities (Scope and Methodology). The program evaluation included:

- Review of oversight of facilities by OFM and the actions or regulations of other state agencies which impact OFM operations.
- Evaluation of materials generated by OFM including policies and procedures, budget and personnel data, corrective action plans, performance monitoring data, and contracts.
- Telephone interviews relating to specific issues with operations in other states.
- Review of federal legislation and regulation, as well as Government Accounting Office reports and Centers for Medicare and Medicaid alerts.

Authority for Review. The committee is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies and institutions of New Mexico and all of its political subdivisions, the effect of laws on the proper functioning of these governmental units and the policies and costs of governmental units as related to the laws. Pursuant to its statutory authority, the committee may conduct performance reviews and inquiries into specific transactions affecting operating policies and costs of governmental units and their compliance with state laws.

Review Team.
Manu Patel, Director of Program Evaluation
Charles Sallee, Program Evaluation Manager
Pamela Galbraith, Lead Program Evaluator

Exit Conference. An Exit Conference was held on September 17, 2009 in the LFC office. Findings and recommendations were shared with OFM and DOH Administrative Services Division staff.

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

Manu Patel
Deputy Director for Program Evaluation

Duties and Responsibilities of the Office of Facilities Management (OFM) Deputy Secretary. The Deputy Secretary for OFM oversees seven health facilities, including oversight of the settlement agreement with the U.S. Department of Justice (DOJ) for Fort Bayard, but is also responsible for the Developmental Disabilities Service Division (DDSD) and Jackson Lawsuit Compliance. This creates an organization which is the largest in budget, staffing, and span of control within the DOH and is larger than many state departments. The organizational structure does include directors for the OFM and DDSD operations. Presently, Jackson and DOJ Compliance consume a significant portion of the Deputy Secretary's time. However, OFM did voice concern that if any redistribution of workload occurred, progress gained for Jackson and DOJ compliance could be lost.

Historically, the appropriation process has moved in the direction of reducing legislative oversight of agency management and financial administration. In 2000 (Laws 2000, Chapter 5) DOH had 23 appropriation entities and each had 11 categories. With the passage of the Accountability in Government Act (Laws 1999, Chapter 5), the state strived to provide additional flexibility to agencies in managing organizations by reducing the categories to four and broadening the definitions of programs to reduce their number. The appropriation programs for DOH are now seven.

As part of this evolution, in the 2005 General Appropriation Act, the Legislature authorized DOH to create the Facilities Management Program. Flexibility has been given to the program to explore other management initiatives, such as contract management at the Fort Bayard Medical Center. However, the Legislature's intent is to allow OFM the flexibility to oversee and direct the DOH facilities and to be accountable for the results.

Organization and staffing for OFM did not stabilize until 2008. Since the establishment of OFM, three individuals have served as the deputy secretary. Other OFM positions experienced the same high turnover. There is no evidence that actions to solidify the authority of OFM over the facilities took place prior to the present OFM leadership.

Actions taken by the present OFM administration have aided in establishing OFM as the recognized authority overseeing the facilities and to providing assistance with issues they cannot resolve on their own. (Appendix A).

OFM describes their organizational structure as "blended". It has the beginning characteristics of a matrix organization, one used by corporations with field operations. This type of structure constructs direct and indirect reporting lines. For example, a facility financial officer, located in the facility, would have direct reporting responsibility to the corporate financial officer and indirect reporting responsibility to the facility administrator. This allows for expert oversight of functions, still maintaining onsite supervision. The "blended structure" of OFM physically places OFM staff in the functional department. Two finance positions have been placed in the Administrative Services Division (ASD) of DOH. They provide finance support for facility operations, under the supervision of the ASD Deputy Secretary. Presently, most functions relating to procurement, revenue management, and contracting remain at the individual facility level.

An employee's understanding of structure begins with well-defined job descriptions. A review of job descriptions of administrative level facility staff demonstrates inconsistencies in the documents, specifically, relationship to the board, reporting responsibilities, exempt versus non-exempt status.

Recommendations

- OFM should finalize an organizational structure which provides functional level expertise at the central office level, specifically procurement and hospital, healthcare finance.
- OFM should standardize facility administrative job descriptions to reflect common responsibilities and performance expectations.

Budget Projections. The legislature is in need of realistic budget projections upon which to make decisions for funding. OFM has been over projecting revenues and exceeding budgeted expenses in the operation of facilities**.** For the past two fiscal years, the OFM has required supplemental and deficiency appropriations to meet operational needs. In both years, projections for revenues and expenses were inaccurate.

A deficiency appropriation of $750,000 was made in 2009 for FY08 and $11.84 million in supplemental appropriations were approved in 2009 for FY09. The FY10 budget includes revenue that will not materialize. OFM anticipated FBMC would be in a new facility with a higher rate of occupancy and increased revenues of $2.7 million and NMBHI would receive additional revenue of $2.2 million from the Land Grant Permanent Fund. The failure of both scenarios to materialize will result in $5.4 million less revenue than projected. The FY 10 budget also expects the Los Lunas Community Program to generate an additional one million dollars in revenue. Chapter 124, General Appropriations Act of 2009, Section 3, Sub-Section F states, " The state budget office shall monitor revenue received by agencies from other than the general fund and shall reduce the operating budget of any agency whose revenue from such sources is not meeting projections. The state budget division shall notify the legislative finance committee of any operating budget reductions pursuant to this subsection."

Most hospitals and healthcare facilities use industry specific metrics and formulas to develop budgets and gauge performance. At a minimum, reviewing cost per patient day, direct hours of care, and full-time equivalents (FTE) per occupied bed, would provide timely and valuable information by which to develop and monitor facility budgets. Routine collection and analyses of this data allows a fast response to outliers. If metrics are not readily available for such functions as housekeeping, an outcome-based review of the environment of care will assist in determining if there is appropriate staffing. For example, areas would be monitored for cleanliness and maintenance, citations from accrediting bodies regarding area cleanliness would be considered, consumer satisfaction surveys addressing facility cleanliness would be reviewed. Based upon the information, increases or decreases can be made in staffing levels. OFM does not compile or use such metrics.

Historical performance is an important ingredient in budget development. It is unclear if facilities correctly value anticipated revenues in the budget process using past reimbursement history. Appropriate discounts and allowances must be calculated to produce net rather than gross revenue projections. The calculations should include contracted discounts to commercial and public payers, bad debt service and other uncompensated care, such as the difference between facility costs and sliding scale collection experience and true indigent accounts.

Facility Occupancy. OFM's operation of facilities at less than budgeted census, without appropriate changes in staffing, appears to be a major contributor to budget deficits. The FY09 supplemental appropriations were allocated totally to salaries and benefits.

The percent of occupancy varies significantly among the state-operated facilities. On an average, 198 beds are unoccupied in state facilities. This number is greater than the total number of beds in many of the New Mexico's hospitals. OFM has recently established operational capacities which are lower than their stated bed capacity. Using operational capacity, on a daily average, 103 beds are vacant each day.

Census can be impacted by several issues: delays in the admission process, gender of clients and mix of male versus female accommodations, the need for isolation for infection or behavior control, increase in acuity of clients, accreditation and certification issues limiting admissions, staff vacancies, poor referral base, or competition. FBMC was prevented from admitting Medicaid and Medicare patients but had only a minimal decrease in census compared to previous two years. Low census in other facilities has not been explained. SATC remains at a high census with waiting list, and other than the forensics unit at NMBHI, should be the only facility considered for expansion. Table 1 displays the occupancy rates, average daily census, and vacant beds for each of the facilities and units within the facilities.

Table 1. Facility Occupancy from April 08 to April 09

Facility	Capacity	ADC*	Vacant
TL	34	22	12
NMBHI			
Forensics	96	79	17
Adolescent	18	12	6
Adult	86	64	22
Long-term care	171	156	15
NMRC			
Med Rehab	21	9	12
CDU	20	13	7
SATC	36	35	1
NMVH	145	124	21
FBMC			
Long-term care	200	123	77
Yucca	18	10	8
Total	**845**	**647**	**198**

ADC=Average Daily Census Source: OFM

Even with census variations, state-operated nursing home facilities, with appropriate cost controls, should be at least budget neutral, with an expectation of revenues exceeding expenses. However, chemical dependency services are eligible for only limited funding. Increasing census in these units creates costs without the benefit of adequate reimbursement.

Each of the OFM substance abuse treatment facilities indicates referrals for admission are from all areas of the state. Based upon that information, facility locale does not appear to be an issue for clients.

The Behavioral Health Services Division (BHSD) of the Human Services Department has received state capital funding for another substance abuse program in Valencia County. On 9/15/09, the Board of Finance approved the GSD could enter into a contract for design and construction of the facility. The initial funding will be used to construct an intensive outpatient substance abuse treatment facility. Future plans include additional buildings for housing-treatment units for women and their children, adolescents, and men, in that priority order. This construction is moving forward, while on an average, the state-operated substance abuse treatment facilities have a total of twenty-seven beds vacant (TL, NMRC, FBMC) each day

Service Coordination. DOH and HSD are not integrated in substance abuse management. Coordination of these services is minimal between state agencies.

BHSD's stated functions include administration of the federal grant for substance abuse treatment and prevention, facilitation of comprehensive service planning for the provision of integrated systems of care, monitoring progress in systems capacity, and integration of comprehensive substance abuse and mental health services. While BHSD does fund substance abuse services, they do not serve as direct care providers, but contract with community providers for those services. LLCP functions as a provider and directly as the compliance monitor for community providers serving LLCP clients. This places LLCP in a dual role as provider and overseer.

Each OFM facility, within their mission, is described as a "safety net provider". The definition of "safety net provider" from the Institute of Medicine (IOM) states, "Providers have two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission they maintain an open door, offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients." Core safety net providers identified by the IOM include a variety of health venues: community health centers, migrant health centers, the health care for the homeless programs, school-based health centers, and the public health housing programs), community-based clinics, public hospitals, and many teaching hospitals. By federal law, a substantial amount of safety net care is provided in hospital emergency departments. No verifiable information is available that the same type of clients, with the same diagnoses and acuities are not served in non-state facilities, other than certain patients with unique needs served at NMBHI and LLCP. Many of the BHSD agreements with community providers direct the acceptance of clients meeting "safety net" patient definitions.

Recommendations

- DOH and DFA should immediately reduce facility expenditures as revenue may not be available for supplemental or deficiency appropriations, and provide notification of budget changes to LFC.
- OFM, in collaboration with BHSD, should work to determine appropriate placement of substance abuse treatments facilities within state government and whether services are better operated by the state or community providers.
- OFM and BHSD should consider decreasing facility capacities and staffing to realistic censuses or consolidating facilities by closing units with a low census. Per OFM, referrals for the substance abuse treatment facilities and nursing homes are from all areas of the state so location should not be an issue with consolidation.
- OFM should develop, collect and monitor industry metrics to aid in quick responses to changing budget situations.

Personnel and Operational Costs. OFM faces significant challenges in managing expenses, especially those associated with personnel, the number one cost-driver for the state-owned and -operated health facilities. Personnel costs account for over 70 percent of state facility operational expenses. In FY09, although a decrease from the previous year, overtime and contract staff expenses exceeded $8.9 million dollars. For the same time period, the staff vacancy rates ranged from 8 to 19 percent for the facilities, 6.3 percent of which was a budgeted vacancy factor. Table 2 shows employee vacancy rates by facility for the past three years. Patient occupancy rates for the facilities ranged from 54 to 97 percent. It appears as if facilities did not react to lower than projected census with an appropriate decrease in regular, overtime, or contract staffing. Table 3 displays the overtime and contract staff expenses by facility for the past three years.

Table 2. Employee Vacancy Rates

Facility	FY07	FY08	FY09
TL	8%	15%	18%
NMBHI	11%	10%	8%
NMRC	14%	16%	19%
SATC	11%	10%	11%
NMVH	17%	19%	18%
FB	25%	24%	19%
LLCP	19%	12%	8%

Source: OFM

The Los Lunas Community Programs are unique. It is not one specific facility, but a group of homes, one four-bed intermediate care facility, a day services facility, and a supported employment program providing services to the developmentally disabled. The program employs caregiver staff and also contracts with community families and providers for services to the population. The mission of the program services delivered by LLCP is to provide crisis services and operate an ICF/MR for individuals with extreme behavioral issues and court commitments. According to OFM, the program has extended services beyond this mission to clients who could be served by community providers. These services cause a significant cost in overtime for LLCP. LLCP has placed a moratorium on the admissions of other than crisis clients. Those clients not needing crisis services or not having extreme behavioral issues should be transitioned as soon as possible to community providers to reduce costs.

Table 3. Overtime Expense by Facility

	FY07	FY08	FY09
TL	$175,530	$181,889	$192,983
NMBHI	$2,009,851	$2,146,869	$1,876,624
NMRC	$161,052	$168,939	$174,404
SATC	$176,986	$204,503	$244,258
NMVH	$719,581	$772,885	$777,977
FBMC	$870,016	$1,347,658	$1,498,008
LLCP	$2,912,573	$277,4846	$2,484,776
Totals	**$7,025,589**	**$7,597,589**	**$7,249,030**

Source: OFM

Table 4. Contract Staff Expense by Facility

	FY07	FY08	FY09
TL	$252,427	$670,098	$724,894
NMBHI	0	$119,651	$16,105
NMRC	$23,557	$41,867	$71,048
SATC	0	0	0
NMVH	$382,690	$696,163	$390,642
Ft. Bayard	357,$000	$536,000	$492,488
LLCP	$4,036	$14,518	0
Totals	**$1,019,710**	**$2,078,297**	**$1,695,177**

Source: OFM

Although staffing formulas are in place, there is no information as to what methods were used to validate staffing is appropriate. Staffing formulas identify the number of employees, by classification, which are needed for the number of clients being served. Staffing cannot be determined solely by the number of clients to be served, but is also impacted by patient acuity, professional service needs and facility configuration.

In addition to inadequate attention to daily staffing levels and no available mechanisms to manage staff decreases, other situations can contribute to staff costs. Increases in staff may be required because of facility configuration. This is the situation which occurred with the move of Turquoise Lodge to a different facility. One nursing unit was replaced with two units, driving up

costs for the same level of service. If vacancies occur in positions for which personnel are difficult to recruit and are required by accrediting bodies and licensing agencies, the use of contract staff may be the only option available to provide appropriate care. A request for proposals for contract nursing staff was issued in March, 2009 and contracts have been issued.

Not having the ability to decrease staffing when census decreases exacerbates the financial position of facilities. Census and patient acuity within healthcare organizations is dynamic, allowing minimal time for staffing adjustments. It appears staffing is increased with an increase in census or acuity, but is not adjusted for decreases. Based upon the low occupancy rates of many of the facilities, this practice creates unnecessary expenses. Despite low occupancy rates, over seven million dollars were spent on overtime. State personnel policies and union contracts do not have provisions for staff decreases when actual census is below the budgeted census or acuity is less than expected. Many healthcare organizations have work rule policies or union articles which enable management to decrease the number of staff when census decreases. This can be accomplished by allowing more latitude in manager assignment of compensatory days off or allowing staff to use accrued annual leave for days unscheduled. Even though annual leave and compensatory time are also costs to a facility, it decreases the overall liability when leave is used.

New Mexico ranks far below other states in the availability of professional staff. According to the Kaiser Foundation and the New Mexico Center for Nursing Excellence, New Mexico ranks 50th in the number of registered nurses per 100,000 population. The US average of registered nurses is 860 per 100,000 population, while New Mexico is 600 per 100,000 population. In addition, according to the US Department of Labor Bureau of Labor Statistics, the OFM registered nurse salaries are $5000 below the average registered nurse salary in New Mexico. While the average number of psychiatrists in the United States is 14 per 100,000 population, New Mexico has 5 per 100,000 population. No New Mexico agency could be found which tracks the availability of other mental health professionals and paraprofessionals.

Research of the literature estimates the cost of turnover per terminating employee from 25 percent to 100 percent of total annual salary and benefits. In spite of the high cost of turnover, this is not an expense that is usually tracked within an organization. OFM does not calculate or monitor this expense. The 2007 LFC evaluation of OFM identified high employee turnover for FY06 as a contributor that affects revenues and quality of patient care. The FY06 rates may be artificially high if temporary employees, whose tenure is limited, were included in the calculations. The turnover rates by facility for the FY07, FY08, and FY09 are shown in Table 5.

Turnover Costs

-HR Processing of Separation
-Interviewing
-Replacement employees during recruitment
-Advertising, screening, interviewing, and selecting
-Physical exams, immunizations, criminal background checks
-Training and orientation

OFM does collect minimal turnover information, but it is unclear if it is analyzed or used in efforts to decrease turnover.

In FY09, four hundred employees terminated from the OFM facilities. Using a conservative cost estimate of 35 percent of total salary and benefits (average salary of $35,000 plus 30 percent for benefits), the cost to OFM in employee turnover for the year would be about $6.4 million.

It is difficult to reduce turnover if the reasons for separation are not known. At least two of the facilities attempt to obtain exit interviews with terminating employees.

Unless an employee can be assured they will not be identified in the exit interview process, the interview may not reflect the employee's true perception of their work or they may choose to not participate at all in an exit interview. Many organizations have developed an online exit interview process where contributing identities are not revealed, yet the organization has access to information which will aid them in reducing turnover.

Table 5. All Positions: Employee Turnover Rates

Facility	FY07	FY08	FY09
TL	27%	34%	20%
NMBHI	17%	13%	12%
NMRC	23%	13%	17%
SATC	14%	10%	15%
NMVH	21%	24%	13%
FBMC	31%	28%	33%
LLCP	24%	18%	19%

Source: OFM

In the administration's efforts to decrease expenses by "freezing" hires, positions with OFM facilities, which impact the ability to generate revenue, have been lost.

Usually supplies account for 25 percent of facility expenses. At this time, OFM uses GSD for the purchase of goods and services. A review of OFM provided reports show individual facilities do issue and award contracts for certain goods or services. Many purchased items are common to all facilities: paper goods, cleaning supplies, cost reports, contract staffing, food service and food goods, consultant pharmacists, pharmacy billing, pharmacy consultants, nutrition consultants, medical transcription, coding, laboratory services, biohazard waste removal, recycling, patient/payer billing, IT installations, oxygen and associated services, equipment monitoring (boilers, fire suppression systems, fire alarm systems, generator testing). For those which are common to all facilities are not included in GSD pricing, requests for proposals should be issued at the OFM level for all impacted facilities. For those which are purchased through GSD pricing, OFM should insure the prices are competitive in the market and if not, should request authority to purchase through a proposal process.

Monitoring of global contracts, based upon the performance criteria, should be conducted at the OFM level.

Recommendations

- OFM should validate the appropriateness of budgeted staffing levels.
- OFM should, excluding court-ordered clients, admit only those individuals referred and funded by the Statewide Entity.
- OFM should return to original LLCP mission with the appropriate number of staff and contract other services to community providers.
- OFM should collaborate with State Personnel Office (SPO) to serve as a test site for an online anonymous exit interviewing process. If this is not an option, ensure that each departing employee has an exit interview form and a stamped envelope for return to a neutral party, i.e., SPO.

- OFM should analyze turnover information to determine causes for separations and develop actions plan to promote retention.
- OFM should continue work with SPO to develop a per diem pool housed out of OFM for use by all facilities. Offering a higher hourly rate, with no benefits, would still be less expensive than contract and overtime expenses.
- OFM should work with SPO on a compensation and classification study of critical positions and to identify "frozen" positions which impact revenue and appeal for hiring authority.
- SPO, should include census management clauses in union contract and personnel policies.
- SPO should, once appropriate staffing levels are validated, allow a capped number of overhires into permanent positions for difficult to recruit personnel.
- OFM should do all contracting for goods and services at the OFM level and insure that all goods and services purchased through GSD pricing agreements are competitive.

Patient Care Revenues. Patient care revenue sources for state-operated substance abuse and psychiatric facilities are limited. In 1963, President Kennedy proposed the Community Mental Health Act and expressed the belief that eventually "all but a small portion of those residing in state mental health facilities would be served by the community." First, the Act created community mental health centers. Second, changes in public financing for mental health and substance abuse promoted this concept by denying state-operated mental health and substance abuse facilities the same access to public funding as community providers. These actions have redefined the populations being served by many state-operated facilities. Many admissions to these facilities have a criminal justice past, are court-ordered forensic clients, are physically or sexually dangerous persons, or are difficult to admit to or discharge from other facilities causing the admission to state facilities of unfunded clients.

Based upon OFM budget data from FY08, state general fund (SGF) appropriations contributed 41 percent of the total revenue for the state-operated facilities. In FY09, SGF appropriation was 52 percent of all revenues to the facilities. As shown in Table 6, there is wide variation of SGF contribution to operations among facilities. These calculations do not include SGF which may be included in "Other Transfers".

Table 6. Percent of Operations Funded by State General Funds

Facility	FY07	FY08	FY09
TL	92%	96%	84%
NMBHI	53%	54%	61%
SATC	53%	54%	58%
NMSVH	5%	8%	10%
FBMC	24%	22%	46%
LLCP	28%	29%	42%
NMRC	61%	65%	66%

Source: OFM

FBMC lost Medicare and Medicaid certifications and was not eligible for reimbursement from those federal agencies. FBMC also provides chemical dependency services. TL's administration, concerned about a loss in SGF appropriations, has been hesitant to increase third party payer billings. Over 90 percent of SATC's population has a third party payer. With what appears to be appropriate staffing levels, the amount of state general fund appropriation need indicates less than adequate reimbursement rates for the required intensity of services at SATC. The New Mexico State Veteran's Home receives Medicare and Veteran Administration funding. New Mexico Rehabilitation accepts indigent medical rehab clients and provides poorly-funded chemical dependency services.

Many private insurance plans do not include substance abuse and psychiatric services as plan benefits. Federal Medicaid regulations prevent Medicaid reimbursement for patients of Institutions for Mental Disease, excepting those under 21 or over 65 years of age. In addition, except for medical detoxification, most services in alcohol and substance abuse programs are not reimbursable by Medicaid or private payers.

Institutions that house prisoners, as a general rule, are excluded from Medicare payment. The New Mexico Behavioral Health Institute (NMBHI) serves as the forensic facility for New Mexico. Patients committed through the courts (forensic clients) have been found incompetent and have not regained competency, or were adjudicated as not guilty by reason of insanity. They are statutorily considered wards of the state and therefore the state is responsible for the expense of their care and no revenue is generated for their stays. The average length of stay for the forensic clients at NMBHI is about 30 years. The time of commitment equals the time they would have been sentenced to a penal facility. OFM data states the cost per patient day for the forensics unit in FY08 was $339. Using a conservative reimbursement rate of $380, the existing forensic clients would have generated a minimum of $13.5 million. (Appendix B). Per NMBHI as of May, 2009, there are three completed and four pending commitments. The increase in this financially unsponsored population will also create a near future need for additional space and staff at NMBHI. The University of Mississippi, an 1100 bed psychiatric hospital, works with the courts on each mandated commitment to determine if a civil, rather than criminal commitment can be imposed. This type of commitment allows the clinical staff more latitude in moving clients to progressively more semi- or independent services, within the facility and the community. Before a move to a community setting, a committee of hospital staff and community members evaluates the appropriateness of the move. Anyone released is done so through a conditional release from the courts which outlines and mandates monitoring of all aspects of compliance, such as where they will live and what drug regiment they will be mandated to follow.

NMBHI also serves as the facility for those individuals who have been found competent to stand trial and are stabilized on medications. They are referred to NMBHI by the Corrections Department because their behaviors are unmanageable. Although admitted to NMBHI, in lieu of a correctional facility, they are not eligible for Medicaid or Medicare. However, DOH has been unsuccessful in the pursuit of fund transfers from the Corrections Department to cover the cost of serving these adjudicated individuals. Another unfunded service is the initial evaluations referred by the courts. Although the Collaborative funds community evaluators through the Statewide Entity (SE) contract, more of those presenting for initial mental health evaluations are bypassing the community evaluators and are being sent directly to NMBHI for the evaluation. Since

January, 2009, twenty evaluation cases have been referred to NMBHI. NMBHI is not reimbursed for these evaluations through the SE.

Reimbursement options may be available to OFM for mental health and substance abuse services. Medicare reimbursement may be paid for eligible individuals under the custody of penal authorities if state law requires such individuals to repay the facility for services received and enforces the requirement that the state bill all individuals who are prisoners whether or not they are insured by any insurance plan or Medicare. The pursuit of payment must be of the same rigor as any debts owed to the state. Hospitals or units of hospitals must be Medicare certified for consideration of this option. It is unclear whether New Mexico courts consider these clients admitted to NMBHI to be "prisoners".

For federal FY09, New Mexico received $8.68 million dollars through the Substance Abuse and Prevention Grant and $6.62 million for treatment from the Center for Substance Abuse and Prevention. These dollars are allocated by the Behavioral Health Services Division (BHSD) of the Human Services Department (HSD) to community providers. Per OFM, TL is the only state facility receiving funds from the grant. In addition, BHSD through the Statewide Entity, funds facilities through general fund dollars. Historically, these funds have been given in a block grant fashion and were not tied to facility workload. The same community providers received the same "grant" year after year. BHSD is changing the reimbursement to a fee-for-service system, which should result in additional funds being available to state-operated substance abuse treatment centers.

The DOH strategic plan and the OFM operational plans ask facility administrators to "assess the potential for new services." Services should be considered only if financially sustainable without general fund appropriations and if consistent with mission.

In an internal effort to increase revenues, OFM and the Secretary of DOH have been aggressive in their negotiations with Coordinated Long-Term Services (CoLTS) vendors. They have provided reasonable reimbursement demands, in spite of the fact that vendors state they were directed to not treat DOH facilities different than community providers.

The Federal Medicaid Program distributes federal disproportionate share (DSH) dollars to states. States determine, through state regulations, which hospitals are eligible for DSH funding. Federal regulations do require that hospitals meet criteria related to numbers of Medicaid and indigent patients served. Public psychiatric hospitals participate in DSH funding in at least three states. New Mexico presently distributes those dollars to several hospitals within the state, including for-profit facilities and a children's mental health facility, but NM Medicaid regulations prohibit the state-operated psychiatric facility from participation in DSH funding. (Appendix C).

Two states, Maryland and Iowa, use federal waivers, allowing the state to take savings generated through the use of managed care to provide services and reimbursement not otherwise covered under the state mental health plan.

A seldom used, but available federal regulation, allows states to be reimbursed for administrative services in direct program management.

In 2008, the U.S. Congress passed the Mental Health Parity and Addiction Equity Act. Implementation will begin in October of this year. The Act mandates that group health plans that offer mental health and substance abuse benefits must do so in parity with medical-surgical benefits.

Many of these options could be derailed with the financial dilemmas facing federal and state governments, but still bear exploration. Investigation of applicability to New Mexico's state facilities will require collaboration among the Human Services with Medicaid and BHSD, Aging and Long-Term Care and Health Departments. Funding for state-operated facilities should be considered a priority by other state agencies in light of the existing budget situation.

Revenue Management. Revenue management requires tight accountability, reduced variability, and supportive information systems. Managing revenue for a healthcare institution involves complex systems. Many financial transactions in non-health facilities can be instantaneous, while those in a healthcare organization are governed by a multitude of rules and regulations from outside the facility and take longer periods of time to complete. Revenue management begins when the client contacts the facility. This is the beginning of numerous, complex individual transactions. OFM has not standardized policies and practices governing most of the revenue management process.

Revenue Transactions

- Referrals
- Eligibility
- Benefits
- Medical Necessity
- Sliding Fee Scales
- Payment plans
- Diagnosis Coding
- Regulatory Compliance
- Utilization Management
- Contract Management
- Claims Submissions
- Denial Management
- Cost and charge policies
- Appropriate Discounting

For individuals not meeting full financial assistance standards, sliding fees and payment plans are appropriate. However, those should be based upon pre-established income levels, using legitimate income information, with persistence in pursuit of payment. The existing practice for revenue collection is to bill the client three times and then write off the balance to bad debt.

In the SHARE system, OFM does not segregate financial information for different unit or cost centers within each facility. Being able to negotiate third-party payer contracts which are fair to the healthcare provider requires knowing the facility expense for each primary service. Of specific concern is the need to separate expenses of the NMBHI nursing home from other psychiatric services, substance abuse treatment from the nursing home at FBMC, the chemical detoxification unit from the medical rehabilitation unit at NMRC, and inpatient from outpatient services in all facilities. Knowing specific service cost is necessary to establish defensible, competitive prices. As shown in Table 7, there is wide variation in cost per day for substance abuse treatment with minimal differences in services. The calculations for gross average cost per patient day were completed using available information. These calculations do not separate services within a facility or subtract costs associated with outpatient services.

Table 7. Average Cost per Day
(based on 7/1/08 – 6/19/09 data)

Facility	ADC	Cost per Day
TL	22	$732
NMBHI	311	$495
NMRC	22	$811
SATC	35	$571
NMSVH	124	$275
FBMC	133	$475

Source: LFC Analysis

Los Lunas is not included in the calculations. The mix of services between inpatient and outpatient services and clients would create a huge misrepresentation of cost per patient day.

Recommendations

- OFM should immediately document and monitor standard revenue management policies.
- DOH should collaborate with other state departments to investigate, and if possible and appropriate, implement changes in state statute, departments policies, state mental health plan, submission of waiver applications, or any other actions which would provide new or enhanced revenues for DOH facilities.
- OFM should establish sub-program level data within SHARE to provide essential data in the development of service costs and identification of cost outliers and provide the Legislature access to sub-program level data for budget performance monitoring.
- OFM should identify the reason for the variations in cost for like units within their system.
- OFM should contract with the SE and BHSD for inclusion of all state-operated substance abuse treatment facilities to increase access to general and federal funding. These facilities should be considered priority inclusions as funding becomes available.
- OFM should seek reimbursement from the Corrections Department for adjudicated individuals placed at NMBHI for behavioral issues.
- NMBHI, through OFM, should interact with the court system to evaluate whether any forensic clients could be eligible for different type of commitments and less restrictive levels of care.
- OFM should pursue insurers who provide mental health and substance abuse benefits for inclusion of services to be provided as a result of the Mental Health Parity and Addiction Equity Act.
- Statewide Entity should contract with NMBHI to reimburse for court-ordered evaluative services.

2007 LFC Evaluation of OFM. OFM has improved management oversight of the facilities, but additional financial oversight is needed. In May of 2007, the Legislative Finance Committee staff conducted an evaluation of the DOH Facilities Management Division. The 2007 evaluation objectives were to determine if OFM was meeting its responsibility to provide administrative oversight to the state-owned and -operated health facilities. Table 8 highlights the present status of recommendations from the 2007 evaluation.

Table 8. Status of Major Findings from 2007 Evaluation

Findings	Status
High rate of employee turnover and vacancies for all facilities.	The FY08 first quarter vacancy rates for all state agencies ranged from 12 to 16 percent. The vacancy rate for facilities in this evaluation ranged from 8 to 19 percent in FY09, which is unchanged from the FY07 evaluation. The FY07 evaluation turnover rate range for all facilities was 35 to 62 percent. The turnover range for FY09 was 15 to 33 percent.
Lack of adherence to pay policies	There is no evidence to demonstrate a lack of adherence to pay policies. OFM has not standardized pay plans, but has developed plans based upon an individual facility's ability to recruit staff. There is adherence to the individual facility policies.
OFM does not have a strategic plan	The FY10 DOH strategic plan includes goals and objectives specific to OFM and addresses issues raised in the FY07 LFC evaluation. (See Appendix D)
Staff shortages, IT and facility infrastructure needs, and financial issues prevent operating at 100 percent of capacity.	As discussed in this review, financial management remains the most critical issue for OFM. Staffing is the primary cost driver. Enhancements in the information system are moving the facilities closer to the implementation of an electronic medical record. Order entry and medication administration records, essential elements, are in the planning phase. All but Sequoyah and Los Lunas Community Programs are undergoing new or renovation construction.
Performance measures are not tracked in all units of facilities and do not reflect how well treatment offered is working	Facilities have adopted performance measures from national accrediting organizations. Effort is still needed to develop and implement effective corrective action plans. Review of the quality data submitted for this review does not demonstrate the process leads to desired results. (See Appendix F)
Capital deficiencies at Fort Bayard Medical Center are hazardous.	New facility construction is underway.

Source: LFC Analysis

Fiscal oversight continues to be a major concern. The level of oversight of fiscal matters does not demonstrate accurate budget development, revenue management, cost controls, or timely reactions to changes in the operating budget. In the fall of 2008, OFM developed a cost saving-revenue enhancement actions plan. (Appendix E). Although actions to decrease costs and enhance revenue were identified, quantifiable goals have not been established in this document, nor is there direction for reporting formats making possible comparisons between facilities or outside benchmarks. Efforts to contain costs and maximize revenues have not reached the level of urgency needed to insure the continuation of client care in a climate of dwindling state resources.

Another concern in the 2007 evaluation was the level of oversight of facilities by the division. Concerns were specific to unequal treatment of facilities, failure to follow state personnel policies, and minimal contact with the facilities. There is no evidence of unequal treatment of facilities or lack of adherence to state personnel policies. Presently there are routine scheduled contacts with all facilities. These contacts are guided by a standardized agenda including a general facility overview, financial and personnel updates, clinical and census issues, incidents, deaths. OFM conducts on site reviews of facility operations, directs corrective action plan development and monitors progress of actions.

Table 9. FACILITY ACCREDITATIONS

TL	CARF
NMBHI	JCAHO
NMRC	JCAHO
SATC	JCAHO
NMSVH	JCAHO
FBMC	NONE
LLCP	N/A

OFM has adopted performance measures from national accrediting and certifying bodies which help identify problems in the care delivery system. Nursing homes participating in the Medicare program are obligated to collect federally mandated data. This data is posted on a national website to allow consumers to review and compare the quality of services of nursing homes. Consistent low ratings can lead to federal onsite audits, which could jeopardize Medicare funding. The standards from Joint Commission on Accreditation of Healthcare Organizations (JCAHO) impose specific adherence to quality of care performance measures and outcome monitoring. The Commission on Accreditation of Rehabilitation Facilities (CARF) institutional reviews focuses on outcomes of care delivery. Except FBMC, all inpatient facilities have achieved accreditation from either JCAHO or CARF. Fulfilling the requirements from these accrediting agencies insures performance measures are in place and data collection does occur. (Appendix F).

The JCAHO definition for a performance improvement system states the collected data can be used to facilitate performance improvement. Data collection alone will not lead to improved outcomes. Review of information submitted for this review validates the collection of required performance measures; however, the process does not consistently extend across facilities, to actions leading to desired results. OFM does recognize the need to refine their performance improvement process and has implemented training on how to develop meaningful performance measures and how to identify and analyze root causes for performance deficiencies.

Individual Facilities. The financial performance of two facilities requires special attention, TL and the NMRC. (Appendix G) This issue is being addressed in the construction of the new facility. TL admits to being staffed at full capacity, in spite of a 64 percent occupancy rate in FY09.

NMRC is not salary competitive for physical and occupational therapist positions. OFM estimates a $15 per hour difference in salary from the private sector. The inability to recruit for these positions impacts accreditation and revenue.

The original plan for the new NMRC facility did not include expansion, but the DOH Secretary has stated there will be an increase in capacity which will require an increase in staffing.

NEW MEXICO DEPARTMENT OF HEALTH

Alfredo Vigil, MD
Secretary

Building a Healthy New Mexico!

Bill Richardson, Governor

Katrina Hotrum
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September 23, 2009

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Dear Mr. Abbey:

Thank you for allowing us this opportunity to respond to the LFC report on the Office of Facilities Management (OFM) Evaluation. We would like to express our appreciation to Ms. Pam Galbraith and the Legislative Finance Committee (LFC) for their professionalism and the broad knowledge base they demonstrated in conducting the evaluation. They offered valuable recommendations that will be used by the Department.

The draft report recognizes as does OFM that there are many challenges involved in operating seven, diverse healthcare facilities. The Department agrees with many of the findings and had also identified and focused on many of these same issues.

Since the original LFC audit conducted in the spring of 2007, under the current leadership of the Department, OFM has worked diligently to stabilize the facility operations and has concentrated on quality of care and patient safety. In order to provide the expertise needed to effectively manage and collaborate with the facilities, the OFM staff has expanded to include a Medical Director, a Director of Quality, a Clinical Director of Nursing, and a Human Resources Specialist. Additionally a new Director of Operations was hired in January, 2008.

Goals of the newly formed group were several: assure the health and safety of patients and clients through continued compliance with national standards of quality; enhance agency-wide systematic, ongoing communication among facilities and OFM; focus on development of facility leadership and governance through revised bylaws, rules and regulations and expanded governing body oversight and authority; and implement financial monitoring and compliance through relationships with Administrative Services Division, OFM and facility financial managers.

It is important to note the accomplishments of OFM since those changes:

- OFM has assured that facilities have maintained their accreditations:
  - New Mexico Behavioral Health Institute: Joint Commission accredited for all services:
    - Comprehensive Accreditation Manual for Behavioral Health Care;
    - Comprehensive Accreditation Manual for Hospitals;
    - Comprehensive Accreditation Manual for Long Term Care.
  - New Mexico Rehab Center: Joint Commission accredited under Comprehensive Accreditation Manual for Hospitals.
  - Sequoyah Adolescent Treatment Center: Joint Commission accredited under Comprehensive Accreditation Manual for Behavioral Health Care
  - New Mexico State Veterans Home: Joint Commission accredited under Comprehensive Accreditation Manual for Long Term Care.
  - Turquoise Lodge Hospital: Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Turquoise Lodge Hospital is preparing for Joint Commission accreditation. The interim administrator is a former Joint Commission surveyor and is working closely with staff in this area.

- OFM believes that the safety-net facilities should serve as many residents, patients and clients as they have the ability to safely care for. OFM has worked diligently with facilities to increase census while providing quality care in a safe environment.
  - In FY09 facilities operated at an average of 88% of operational capacity.
  - The overall percentage of operational capacity for the first two months of FY10 was 90.29% and 90.95%, indicating a steady increase.
  - Turquoise Lodge Hospital's average occupancy for January 2008 was 11.9, January 2009; its average capacity had risen to 27.3.
  - New Mexico Rehab Center's MRU's average census for January 2008 was 5; the current census is 10.

- OFM asserts that leadership and governance are also key to sustained success of facilities. Governing bodies were restructured to assure administrators and medical directors were members of the governing body. Meetings were held quarterly as required and agendas formalized to assure necessary reports, including specific performance improvement projects and data, flowed to the leaders. Among the systems monitored at governing body are medical staff issues, credentialing, strategic planning, compliance with national patient safety goals, and performance improvement. The governing bodies for New Mexico State Veterans Home and for Fort Bayard Medical Center were revised to include representation from the Veterans Administration.

- Fort Bayard Medical Center has reached several milestones. It regained its Medicaid certification in June 2008. The Department of Justice has accepted Fort Bayard Medical Center's plan of correction. Fort Bayard Medical Center will begin preparing for Joint Commission accreditation, with application after the move to the new physical plant. OFM was finally able to establish stable medical leadership at Fort Bayard Medical Center and enter into a contract with respected local physicians (Silver Healthcare).

- OFM has worked with facilities to reduce their use of contract nursing services. Based on preliminary data, contract nursing costs have been reduced by $380K from FY09. Leadership change has occurred at two facilities and OFM is now directing operations:

    - Turquoise Lodge Hospital was in significant financial and operational non-compliance. The interim administrator, a former Joint Commission surveyor, will work with Turquoise Lodge Hospital to obtain accreditation, along with Medicare and Medicaid certification, to enhance revenues.
    - Los Lunas Community Program's administrator resigned, and OFM staff is managing operations.

- OFM has partnered with IT to improve use of the electronic medical record and streamline costs and time for documentation in the record.
    - New hardware was implemented at two facilities to allow clinical staff to chart at the patient's bedside. Dragon Naturally Speaking, an in-house medical transcription program, was implemented at New Mexico Behavioral Health Institute, to replace an expensive contract dictation service.
    - Avatar Steering Committee and Business Workgroups were re-instituted to assess new products, registry entries and modifications in a timely manner and forward recommendations to individuals with the ability to make change to the system.
    - Purchased Computers on Wheels (COWS) to allow direct patient care data entry at the bedside for New Mexico Rehab Center and Turquoise Lodge Hospital.

- As part of its support to facilities, OFM staff conducted two mock surveys, at New Mexico Rehab Center and New Mexico Behavioral Health Institute, to assess compliance with The Joint Commission. Both facilities received three-year accreditation.

- OFM developed a Memorandum of Understanding with CYFD to memorialize the relationship between Sequoyah Adolescent Treatment Center and CYFD.

- Development of strong relationships with other governmental agencies continued to be a part of OFM's strategic direction.

    - OFM met with University of New Mexico Hospital case managers to enhance communications and support a referral process designed to reduce time in the transfer process for New Mexico Rehab Center, New Mexico Behavioral Health Institute, and Fort Bayard Medical Center. OFM continues to work directly with UNMH to provide assessments and referrals.

- During the past year, OFM has been working closely with Turquoise Lodge Hospital to open an outpatient services unit. The effort is part of a combined project with Bernalillo County to implement an ambulance diversion program to relieve congestion in the hospitals' Emergency Rooms.

- OFM and New Mexico Rehab Center have participated in meetings with ENMU-Roswell as part of planning for the new building and with Jane Batson, Vice-President, to strengthen linkages with the school of nursing

- OFM has collaborated on several building projects to replace aging building and enhance services to individuals.

  - Fort Bayard Medical Center: The new Fort Bayard building project is well under way and expected completion is September 2010.
  - New Mexico Rehab Center: Construction is underway and occupancy is scheduled for December, 2010.
  - New Mexico State Veterans Home: This project is entering the planning stage for the Alzheimer's wing.
  - Sequoyah Adolescent Treatment Center: Drawings for the medical unit are complete, and the architect will send them to Santa Fe for approval signatures.
  - New Mexico Behavioral Health Institute: In the replacement of the long-term care buildings, we are moving forward toward the 95% construction drawings.

OFM would also like the opportunity to provide additional information related to the significant findings and recommendations noted in the LFC report. Those comments are noted below.

Significant Findings

Oversight of the financial operations of the facilities continues as the major concern.
We understand the concern; however, we have been working diligently on the financial operations of the facilities since their combination into a Facilities Program Area. Prior to that time, facilities operated on a cash basis and their budgets were never in line with reality. For FY08 and FY09, the requirement to keep budgets flat in the face of ever-increasing fixed costs for 24/7 operations (e.g., drugs, utilities, transportation, food) did create problems, as did the underfunding of pay raises in those years. Underfunding for pay raises alone accounted for a shortfall of $2.2 million in FY09. The breakdown for the $11.9 million is as follows:

- $4 million for loss of Medicare/Medicaid at Ft. Bayard;
- $1.9 million shortfall for pharmaceuticals and other fixed costs;
- $1.726 million Los Lunas Community Program for payroll/unfunded comp/overtime;
- $4 million New Mexico Behavioral Health Institute for unfunded comp/forensics safety and other fixed costs and;
- $180 thousand for Fort Bayard Medical Center to reinstate state-funded positions.

In addition, the primary concern for the past 18 months has been quality of care and patient health and safety.

The inability of OFM to accurately project revenue and control expenses significantly stresses the overall state budget.

It is not the intent of the Department to stress the overall state budget. As previously mentioned, there were very clear reasons for the past shortfalls. The Department is currently moving toward more toward centralized control over revenue/finance/budgeting so it is not conducive to that approach to have OFM managing budgets. Under the office of the Deputy Secretary for Finance & Administration, the agency is "rolling out" a reporting structure where all finance and Human Resource staff within facilities will have direct reports to supervisors who will directly report to the CFO/Deputy Secretary for Finance and Administration. OFM needs to stay focused on the provision of services, staffing and other programmatic concerns.

OFM does need to know and is apprised of any financial issues. There is a consistent process in place: weekly OFM meetings with all facilities; monthly finance meetings with the Cabinet Secretary and CFO; quarterly Governing Board meetings that also address finance and other issues. Additionally, OFM has relocated its offices into the Runnels Building to maintain daily, ongoing communications with the Administrative Services Division.

OFM is committed to exploring all possible revenue sources and will continue to research trends and patterns in other state facilities in the US, continue its efforts to contract with private insurance companies, and build linkages among all governmental agencies.

OFM had identified the need to implement consistent business office and collections processes throughout facilities. While not formalized at this point, we have informal revenue management policies, procedures and processes that follow all governmental accounting and auditing practices. The glitch is in the reconciliation of payments to our Avatar system, an IT issue.

OFM has worked with IT to develop reports to better track revenues. A new report provided in February, 2009, allowed all physician charges to be reviewed by both finance and administration to assess for physician productivity and accuracy of billing. Both New Mexico Behavioral Health Institute and New Mexico Rehab Center have benefited from this enhanced data tracking.

An Administrative Services Division financial manager was placed at Turquoise Lodge in summer, 2009, with established goals to capture all possible revenue, increase third-party billings and maximize collections. Other facility specific projects are underway, including revenue enhancements at New Mexico Behavioral Health Institute and New Mexico Rehab Center.

That being said, most of our facilities are statutory entities that cannot be closed down without legislative authority to do so. Patient health and safety and quality of care must always come first. The Department makes every effort to spend in the most efficient and effective manner possible.

Staffing is the expense leader for all facilities.
We agree that staffing is the largest expense in OFM. This is typical for not only state government agencies, but for most health care facilities. The Department believes that this is OFM's greatest challenge because it has a significant impact on budget. OFM has identified three major contributors to this problem: (1) Staffing and Census; (2) Turnover and; (3) Overtime.

Staffing and Census
OFM in conjunction with facilities, is constantly monitoring patient needs to provide appropriate staffing. We are unable to send staff home when census declines because that action is in violation of the current union agreements with CWA and AFSCME. Another challenge is that many of our patients have significant behaviors which necessitate a need for additional staffing and this is always fluctuating. This is often difficult for us to anticipate and financially project.

Facility licensure type also requires additional staff. In long term care facilities such as New Mexico Behavioral Health Institute's Meadows and Ponderosa, Fort Bayard Medical Center, and New Mexico State Veterans Home, with the federal residents' rights issues and the limitations on psychotropic drug usage, behavior plans often require one to one or two to one staffing. The Los Lunas Community Program is the primary tier 3 (inpatient) crisis provider for community programs statewide. It is not unusual to have two to one staffing in Los Lunas Community Program's tier three crisis situations. Additionally routine staffing is determined not by the provider, but by the interdisciplinary team comprised of therapists, case managers, guardians and the provider. Seldom is the staffing ratio during awake hours less than two clients to one staff.

Turnover
A continued staffing issue for the Department's facilities is the inability to reclassify positions and/or recruit competitively with the private sector. That inability often results in critical staff shortages and use of agency staff for nursing, physicians, and therapists. It is important to note that OFM has worked closely with the Department's Human Resources Bureau and the State Personnel Office to devise and implement strategies to hire and retain qualified healthcare personnel.

The report also discusses employee turnover. Staff turnover in the health care industry is a national problem and has reached crisis levels in some states. Of the individuals leaving state facilities employment, 33% were facility initiated based on performance, absenteeism, and in response to substantiations of abuse, neglect and exploitation. The retention of these staff would have placed the health and safety of residents and patients in jeopardy.

Overtime
Census, staffing and turnover impact and drive overtime in facilities. In 2008, OFM and IT staff in conjunction with the Department of Finance and Administration began planning for implementation of Kronos in all facilities. This electronic timekeeping system will not only reduce the time required to process payroll, it will reduce payroll errors and provide real time monitoring of hours worked for supervisors to reduce overtime and non-productive employee time. The Department has been assessing overtime usage and believes that Kronos will be a helpful tool in tracking overtime as it compares with patient needs and acuity.

New Mexico Behavioral Health Institute has developed and implemented a program called "Grow Our Own" in which staff are encouraged and supported to further their education. In this program Nurse Aides go to school to become LPNs and LPNs become RNs. This program has been very successful. Since these individuals have an investment in state employment, most of them stay with New Mexico Behavioral Health Institute. OFM would like to duplicate this program in other facilities.

OFM will also begin implementing a standardized exit interview process as recommended in the report. We believe this will aid our ability to enhance retention.

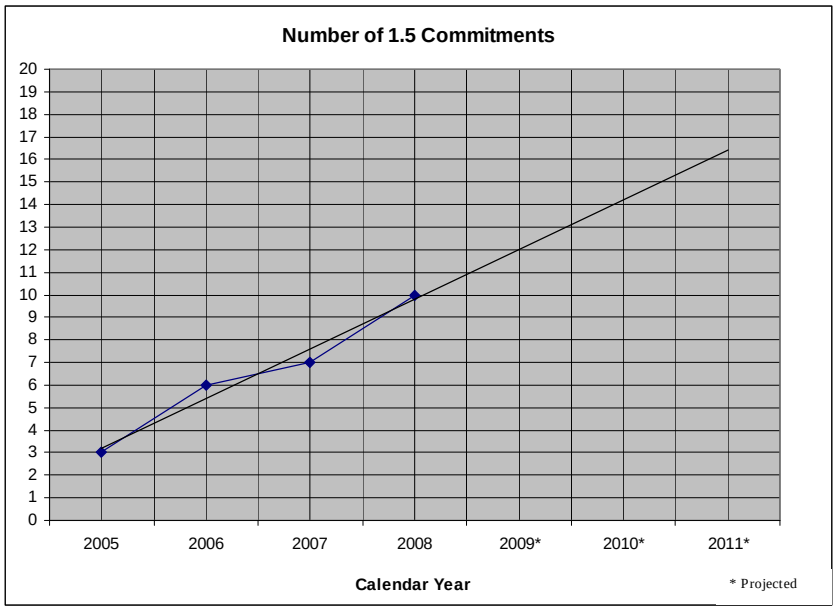
Psychiatric and substance abuse programs are limited in revenue generation by state and federal laws and regulations.

We agree with this statement. In order to better understand this issue, a definition of a 1.5 commitment and a Continuing Care Order is included:

1.5 Commitments – Individual is not competent, not restorable and remains dangerous and is legally committed to New Mexico Behavioral Health Institute Forensic Divisions' care for what would have been the maximum sentence had the case gone to trial and the individual was found guilty. Since individuals are sent to the Forensic Division for felonies (murder, aggravated assault, etc.) this is generally for a significant length of time, ranging from eighteen (18) months to life.

Continuing Care Order – Individuals who have been found competent to stand trial and are stabilized on medications. However due to their behaviors they are not manageable at the detention centers and are ordered to the Forensics Division to provide care and housing until their court date is scheduled. These individuals can occupy a forensics bed from months to years.

The individuals committed at New Mexico Behavioral Health Institute under the 1.5 statute greatly impacts costs and staffing. Following is graph of 1.5 commitments from 2005 which shows a steady increase to present.



Continuing Care Orders and 1.5 commitments occupy bed space intended for individuals court ordered for assessment for competency and treatment to competency. Forensics has 96 beds, with twenty-four of these beds being in a separate building and identified for Adult Sex Offender Treatment (STOP program). This leaves seventy-two beds for forensics to provide district court ordered evaluations for competency and treatment to competency.

New Mexico Behavioral Health Institute's Forensics Division continues to receive consistent and increasing numbers of admissions for assessment and treatment to competency while having significantly increased numbers of 1.5 commitments and Continuing Care Orders from the District Courts. This has led to a significant bed shortage, with only 49% of beds being available to provide the core service to the courts.

Los Lunas Community Program also is mandated through the courts to provide services to individuals under regulation NMSA 31-9-1.6. Those individuals are found to have mental retardation and there is not a substantial probability that the individual will become competent to proceed to trial in a criminal case. As well they are a danger to themselves and others and charged with a violent crime. Los Lunas Community Program is required to provide a secure environment while meeting the regulations for an Intermediate Care Facilities for the Mentally Retarded (ICF/MR). These individuals are staffed 1:1, but generally 2:1 in the community. Los Lunas Community Program may have as many as four individuals at any time mandated under the 1.6 criteria.

Recommendations

The Department agrees with many of the recommendations in the report and is addressing those it respectfully disagrees or partially disagrees with.

OFM should develop and implement a plan to rely on not more than 45 percent SGF for expenses.
The expectation that OFM rely on no more than 45 percent SGF may be unrealistic. This is likely to place operations like Forensics and Los Lunas Community Program in a budget crisis and jeopardize the health and safety of patients. We should be expected to provide realistic revenue and expenditure projections.

We cannot immediately reduce facility expenditures. We "park" budget authority within the SHARE system if revenues do not seem to be coming in at the level anticipated to ensure facilities do not count on them; however, if something is needed for quality of care or patient health and safety we allow for those types of expenditures. This type of situation is always discussed with both DFA and LFC.

OFM does not need to acquire finance and procurement expertise. We do global procurements and are strategically placing expert finance staff in all of our facilities to report to the CFO/Deputy Secretary.

OFM should finalize an organizational structure which provides functional level expertise at the central office level, specifically procurement and hospital finance.
While we agree that the structure that has been implemented should be finalized, we disagree that an additional level of expertise in procurement and hospital finance be acquired in OFM. Administrative Services Division has partnered with OFM in providing this expertise directly to each facility. A system is currently being implemented in Administrative Services Division to ensure appropriate expertise is developed.

OFM should standardize facility administrative job descriptions to reflect common responsibilities and performance expectations.
As previously stated, the Department is currently centralizing administrative functions by implementing a blended management concept across the agency and within each facility. This concept requires the development of a reporting structure that requires certain financial and HUMAN RESOURCES functions throughout the agency to report directly to Administration. Administration will ensure that the appropriate expertise is developed and will provide procurement and other support to each facility.

With this effort, we will have standardized job functions by October 1 for the top financial and HUMAN RESOURCES functions within each facility and, by the end of October, standardized job functions for the other personnel involved in these essential functions. Expectations will be clear.

Budget Projections
With the implementation of SHARE, the facilities are in a far better position now to produce accurate budget projections. The over-projected revenue referenced for FY 10 has been "parked" in SHARE so that those facilities cannot utilize this budget authority unless their revenue projections change over the next few months. Again, the shortfalls experienced the past two years related to substantial increases in fixed costs, the loss of Medicare/Medicaid at Ft. Bayard, increased patient load in Forensics and an underfunding of pay raises within the facilities.

DOH and DFA should immediately reduce facility expenditures as revenue may not be available for supplemental of deficiency appropriations.
This recommendation is not feasible. Neither DOH nor DFA can immediately reduce facility expenditures without a careful review of quality of care and patient health and safety issues. We "park" budget authority and will monitor the facilities' needs each month to ensure that, whenever possible and practical, we do not create a need for a supplemental appropriation.

Revenue Management
The Department through Administration has identified this and is presently addressing it. Processes are not yet formalized, but we do have processes in place in Avatar and SHARE and are working to formalize them.

In the SHARE system, OFM does not segregate financial information for different unit or cost centers within each facility.
The Department respectfully disagrees with this finding. We do segregate financial information and we have sent a list of department IDs we use for all seven facilities. Variations in costs per day are more related to age and type of facility, type of patient and those sorts of variables. Recommendations like getting reimbursements from Corrections may not be applicable in most cases and is just taking General Fund from one agency and moving it to another.

The level of oversight of fiscal matters does not demonstrate accurate budget development, revenue management, cost controls, or timely reactions to changes in the operating budget to prevent financial calamities.
The Department respectfully disagrees with this statement. We are demonstrating more accurate budget development, revenue management, cost controls and reactions to changes based on the state's financial accounting system and the modified accrual basis within which we have to work. By the end of this fiscal year, we will have fully documented all those processes, policies and procedures within every facility and normalized them across facilities as much as possible.

Again, we appreciate the opportunity you have given us to respond to the report as well as the professional and considerate manner in which this evaluation was conducted.

Sincerely,

Alfredo Vigil, M.D.
Secretary

APPENDIX A: OFM ACCOMPLISHMENTS

COMPLETED or ONGOING

- Completed on-site review of all facilities and developed action plans to correct any deficiencies.
- Conducting independent reviews of incidents.
- Developed nursing competencies and is standardizing all nursing job descriptions.
- Developed skill fairs for nursing staff.
- Standardized the structure and reporting of governing boards.
- Rotating governing board meetings to all facilities to better acquaint facilities with one another.
- Joined forces with the private sector facilities to reduce the incidence of MRSA and other drug resistant organisms.
- Medical Director meets monthly with facility medical directors to focus on AVATAR and physician billings.
- Has maintained facility accreditations for: NMBHI, SATC, NMVH, and TLH.
- Regained Medicaid certification for Ft. Bayard.
- Decreased contract staff expense by $300,000 from FY 08 to FY 09.
- Contracted with local physicians to provide medical coverage of FBMC.

IN PROCESS

- Developing evidence-based curriculum for substance abuse treatment applicable to Turquoise Lodge, New Mexico Rehab, and Yucca Lodge at Fort Bayard.
- Implementing the KRONOS timekeeping system to provide a timely monitoring and analysis personnel costs.
- Developing a performance improvement plan for DOH facilities' substance abuse programs to monitor high-risk, high volume, and problem prone processes.
- Working to transplant the "Grow Our Own" program developed by NMBHI where facilities partner with nursing schools in nurse education and recruitment. As a result of this program, NMBHI has a full complement of nurses.
- Developing a staff pool to replace expensive contract staff.
- Working to standardize contracts and service agreement.

APPENDIX B: NMBHI FORENSIC CLIENTS

Admit Date	DAYS @ FTU	Potential Reimbursement	District	County
08/09/07	727	$254,450	1	Santa Fe
05/19/09	78	$27,300	1	Rio Arriba
Total District 1	**805**	**$281,750**		
07/19/06	1,113	$389,550	2	Bernalillo
03/04/08	519	$181,650	2	Bernalillo
06/29/06	1,133	$396,550	2	Bernalillo
01/24/06	1,289	$451,150	2	Bernalillo
10/18/05	1,387	$485,450	2	Bernalillo
09/06/05	1,429	$500,150	2	Bernalillo
09/05/06	1,065	$372,750	2	Bernalillo
08/02/06	1,099	$384,650	2	Bernalillo
11/16/06	993	$347,550	2	Bernalillo
10/28/08	281	$98,350	2	Bernalillo
09/18/08	321	$112,350	2	Bernalillo
01/13/09	204	$71,400	2	Bernalillo
04/14/09	113	$39,550	2	Bernalillo
11/04/08	274	$95,900	2	Bernalillo
Total District 2	**11,220**	**$3,927,000**		
05/31/09	66	$23,100	3	Dona Ana
02/05/08	547	$191,450	3	Dona Ana
Total District 3	**613**	**$214,550**		
09/18/08	321	$112,350	4	Guadalupe
12/21/05	1,323	$463,050	4	San Miguel
Total District 4	**1,644**	**$575,400**		
05/22/07	806	$282,100	5	Eddy
10/10/86	8,335	$2,917,250	5	Chavez
05/01/08	461	$161,350	5	Eddy
06/24/08	407	$142,450	5	Chavez
01/18/05	1,660	$581,000	5	Eddy
03/25/08	498	$174,300	5	Eddy
10/02/08	307	$107,450	5	Chavez
Total District 5	**12,474**	**$4,365,900**		
01/28/04	2,016	$705,600	6	Luna
Total District 6	**2,016**	**$705,600**		
05/02/02	2,652	$928,200	7	Catron
Total District 7	**2,652**	**$928,200**		
09/04/07	701	$245,350	9	Curry
Total District 9	**701**	**$245,350**		
11/16/04	1,723	$603,050	11	San Juan
Total District 11	**1,723**	**$603,050**		
12/26/02	2,414	$844,900	13	Sandoval
11/18/03	2,087	$730,450	13	Valencia
02/25/09	161	$56,350		Chaves
Total District 13	**4,662**	**$1,631,700**		
Total all Districts	**38,510**	**$13,478,500**		

APPENDIX C: NEW MEXICO DISPROPORTIONATE SHARE HOSPITALS

Pool I- PPS Teaching Hospital
University Hospital
Pool I- PPS Teaching Hospital
University Hospital
Pool II- PPS Non-teaching Hospital
Alta Vista Regional Hospital
Carlsbad Medical Center
Cibola General Hospital
Eastern New Mexico Medical Center
Espanola Hospital
Holy Cross Hospital
Lea Regional Hospital
Lincoln County Hospital
Lovelace Women's Hospital
Memorial Medical Center
Mimbres Memorial Hospital
Plains Regional Medical Center - Clovis
Presbyterian Hospital
Rehoboth McKinley Christian Hospital
San Juan Regional Medical Center
Sierra Vista
Socorro General Hospital
St. Vincent Hospital

STRATEGIES FOR OFFICE OF FACILITIES MANAGEMENT

- Raise salaries of direct care staff as possible to current market place levels.
- Ensure that all DOH facilities meet or surpass national quality and safety standards.
- Develop and implement standard guidelines and procedures for all DOH facilities that are derived from best practices and patient/resident-centered models.
- Implement financial accountability standards facility-wide to maximize third party reimbursement.
- Provide training and advancement opportunities and provide quality supervision, to include creation of career ladders and opportunities for advancement.
- Expand recruitment efforts to include a strong web presence with a recruitment web page.
- Identify national benchmarks of quality by facility type. Assess current operations against benchmarks and establish thresholds of acceptability which are integrated into a continuous quality improvement process.
- 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.
- Develop workgroups to identify and implement best practices across facilities to include: Substance Abuse Treatment, Long-Term Care, Nursing, and Quality Improvement. Develop and implement the use of standardized indicators with which to measure, analyze and improve quality care and services.
- Address gaps in safety net services. Develop and implement plans for enhanced services for complex individuals with developmental disabilities (DD) and/or traumatic brain injuries and/or behavioral health needs (TBI) and improve long-term care capabilities, to include assessment of viability of an ICF/MR for medically complex DD clients and increased capacity for court-ordered placements.
- Explore provision of incentives to retain medical staff at DOH that could include competitive pay, signing bonuses, merit pay, bonuses, meaningful recognition, and opportunities to be trained and train.
- Assess the computer and services needs of all DOH programs.
- Offer training, technical assistance and financial support for the development of electronic health records.
- Offer technical assistance to providers interested in installing electronic medical records systems.

APPENDIX E: COST SAVINGS AND REVENUE ENHANCEMENTS

PAYROLL

1. Review of overtime with managers weekly to analyze overtime; initiate plans to reduce overtime.
    a. Overtime includes compensatory time.
    b. No overtime unless prior approval.
    c. No overtime for non-direct care staff without justification from administrator.
2. No payment for compensatory time.
3. Hiring freeze for non-direct care staff.

CONTRACTS

1. Assess to determine the following:
    a. Are contracts being used efficiently? Compare and contrast the dollar amount of the contractor to a payroll option.
    b. Is the use of agency staff minimized? Is it justified?
2. Do you really need the contract? Is it a required service or is it nice to have?

SYSTEMS

1. Managers initiate operations improvement process designed to assure all tasks are completed at the lowest level. Example: CNAs and psych techs complete all tasks for which they are trained. CMAs are used where authorized by State Board of Nursing.

2. Assure that coding and assessments accurately reflect the patient's condition, ensuring highest level of reimbursement.

3. Assure that pharmacy billing is accurate and timely.

Assure formulary is adequately restricted and followed. Move to 100% generic where applicable.

4. Assure physician billings are per protocols, per licensing requirements and timely. Assure that AVATAR reports capture needed information and information is reviewed by the administrator. Validate audits by reviewing billings per physician and billings per patient/client.

5 .Reduce committees and meetings to increase productivity of the staff: consider a committee of the whole versus a variety of subcommittees and workgroups. Reassess committee agenda items to assure that issues are discussed only once.

6. The number of management meetings has been scaled down to once a week and information funneled through them.

Outcome: 13% reduction (approximately $279.0) from FY08 in overtime costs.
6.3% reduction (approximately $117.1) from FY08 in medication costs; although, the nation is experiencing an increase of 14% to pharmaceutical costs.

PURCHASING

Inventories are no greater than 30 days.

Most cost efficient products are ordered and stocked. Adequate controls are in place to prevent loss.

1. Spend-down plans are in place for over-stocked areas.
2. Monitor gas cards for vehicles.
3. Shop using unit cost pricing.

BILLING

1. Administrators are to review days in accounts receivable to assure billings are accurate and claims are sent timely.
2. Operations improvement project to identify all potential billable codes, and a plan to bill any codes identified. Real time coding will be more representative of actual time spent on service provided.
3. Review of admission policies regarding no-pay, sliding scale, co-pays and deductibles for collections. Compare with other like facilities and discuss new policies and procedures with OFM.

SERVICES

1. **Assess potential for new services consistent with mission and vision.**
2. Consider outpatient services.
3. Develop productivity standards for professional staff. Are therapists adequately using techs for therapy extenders?

MARKETING

1. Increase census for paying patients.
2. Develop marketing collateral and assign contacts for various referral sources.
3. Develop contracts with insurance/managed care companies for private pay.

MISCELLANEOUS

1. Limit travel and training.
2. Consider telecommunications for meetings.
3. Assess all vendors to be sure that your contracts have maximum discounts.
4. Assess memberships (NMHCA, etc) to assure benefits are worth the expense.
5. Assess printing jobs; move to electronic files.
6. Monitor and reduce long distance calling.
7. Reduce repairs from "nice to have" to required only.
8. Administrators will assess all cell phone assignments and usage for appropriateness and pertinence to state business.

APPENDIX F: QUALITY INDICATORS

Long-Term Care Quality Measure/Indicators	NMSVH	NMBHI	FBMC	State Average	National Average
Green: > 1% Below State Average or 0% Yellow: = < 1% Below State Average Red: > State Average	1/1/09-3/31/09	1/1/09-3/31/09	1/1/09-3/31/09	1/1/09-3/31/09	1/1/09-3/31/09
	2/1/09-4/30/09	2/1/09-4/30/09	2/1/09-4/30/09	2/1/09-4/30/09	2/1/09-4/30/09
	3/1/09-5/31/09	3/1/09-5/31/09	3/1/09-5/31/09	3/1/09-5/31/09	3/1/09-5/31/09
	4/1/09-6/30/09	4/1/09-6/30/09	4/1/09-6/30/09	4/1/09-6/30/09	4/1/09-6/30/09
Accidents: Prevalence of falls	14.6%	14.6%	17.5%	15.9%	13.3%
	18.5%	17.2%	19.6%	14.4%	13.2%
	17.2%	16.8%	15.3%	14.4%	13.2%
	17.2%	17.3%	14.4%	14.8%	13.2%
Infection Control: Residents with UTIs	4.9%	4.6%	6.7%	8.1%	9.9%
	7.6%	4.5%	10.7%	8.3%	9.9%
	7.1%	2.1%	11.9%	8.7%	9.8%
	7.1%	2.0%	12.7%	9.3%	9.7%
Nutrition: Prevalence of dehydration	1.0%*	0%	0%	0.2%	0.2%
	1.1%*	.6%*	0%	0.2%	0.2%
	0%	.7%*	0%	0.2%	0.2%
	0%	.7%*	0%	0.2%	0.2%
Skin Care: Pressure sores – Low risk	3.1%	2.7%	1.6%	3.8%	2.5%
	5.7%	2.6%	1.7%	3.0%	2.5%
	5.1%	1.9%	3.0%	4.2%	2.5%
	3.2%	.9%	6.0%	4.2%	2.5%

Comments:

- **Note that DOH operated facilities provide safety-net services; residents have more complex medical and behavioral problems than in private sector facilities; in many cases other providers are unable or unwilling to provide care for these individuals.**
- **Note that MDS reports are done on a quarterly basis and program improvements are not immediately reflected.**
- **Facilities address all risk issues in daily meetings and immediately implement interventions through the interdisciplinary team process.**

***Only one resident is included in numerator.**

Labor is the major cost driver in all facilities and is particularly evident in small facilities (TLH and NMRC). Both of these facilities are multilevel; they are costly and inefficient to staff and operate. The current goal is to maintain census levels high enough to assure that minimum staff are always busy, and that an increase in census is sufficient to warrant the additional FTEs required. Both facilities are focusing on cross-training and rotation of staff among units, and they are implementing requirements that managers provide direct patient care.

Although some of the suggestions below are directed at revenue enhancement and not cost reduction, we believe that assuring all employees are productive and engaged in census building and revenue generating activities reduces our daily costs.

Turquoise Lodge Hospital

1. The high use of contract nurses in FY09 increased the cost of operations. OFM has mandated that contract nursing be eliminated and hiring practices be monitored to assure adequate nursing coverage.
2. Another major cost driver for this facility is medications and lack of insurance payers for most the patients served. Standard medications used to treat addictions such as suboxone and psychotropic medications do not have generic equivalents and are very costly. The cost for drugs at TLH was $176K in FY09.
3. Acute level detox services are costly to provide because the admission requires lengthy physician and nursing assessment for a very short inpatient length of stay.
4. TLH operates on two floors. This is costly and inefficient because minimum coverage must be maintained in two areas.
5. There is high patient turnover in substance abuse rehabilitation programs. In order to maintain a high census, admissions must be ongoing. Admissions and discharges are staff resource intensive. Paperwork required is extensive. OFM is working to streamline these processes.
6. With the opening of the Metropolitan Observation and Treatment Unit, TLH will have the ability to do 24/7 admissions. This will maintain a consistently higher census at TLH.
7. TLH and OFM are assessing the program criteria and considering dropping the program from 28 to 21 days.
    a. Intensive outpatient programs are appropriate for individuals who have homes and a support system.
    b. TLH could provide intensive outpatient programs if homeless individuals could be transferred to the Bernalillo transitional living, a less costly alternative to a longer inpatient stay.
8. OFM is analyzing regulatory requirements with a goal to streamline operations and drive down care given to the lowest appropriate level.
    a. OFM has directed that all tasks be undertaken by the lowest level of staff. (i.e. RNs work under their licensure and techs/clerks support all other non-nursing tasks as appropriate).

b. OFM and the facility are exploring the use of paramedics in the facility to reduce costs. Current barriers to re-classing positions inhibit the ability of the facility to proceed in this direction.
c. OFM would like to explore with the Board of Nursing additional options for specialty hospitals to use Certified Medication Aides. The ability to use CMAs (currently used in LTC) would ease the nursing burden and reduce costs.

9. Increasing the census would lower the cost per patient day. Increased census would require some level of staffing increase.
10. Expand the criteria for admission to TLH. For example, UNMH has proposed a per diem contract for management of IV therapy inpatients.
11. Eliminate 50% of administrative on-call secondary to changing administrator position to a governor-exempt position.
12. OFM is working with the facility to prepare for The Joint Commission accreditation. This accreditation will enable the facility to obtain Medicaid/Medicare certification and bill them. This will also enhance the facility's ability to contract and bill private insurers. This will enhance revenues.
13. OFM is working with TLH medical staff to develop higher levels of staff competency to enable the facility to admit patients with higher levels of medical acuity. This will enhance revenues.
14. OFM and the facility are exploring the use of additional CLIA waived laboratory tests to reduce costs.

New Mexico Rehabilitation Center:

1. NMRC is unable to fill Therapy "B" positions (1 OT and 2 PT). Because these positions are so low in salary, the facility is unable to be competitive with the market. Lack of therapists inhibits ability to increase MRU admissions as the facility must provide a minimum of 15 hours a week (2 therapies, with most therapies being individual vs. group). Most insurance carriers require therapies 6 days a week. The facility's therapy constraints make entering into these contracts difficult.
2. NMRC offers two distinct product lines: medical rehab and chemical rehab. This diversity adds to personnel costs as in many cases the skill sets are different and not interchangeable across units.
3. New Medicare regulations (effective 1/1/10) are more stringent in requiring individual therapy as opposed to the use of groups. This will limit the facility's ability to provide therapy.
4. NMRC operates on three floors. This is costly and inefficient. The new building is on one floor and will be more efficient to staff and operate.
5. The current building requires 24-hour maintenance coverage to support the steam plant. The new building will not require this and will be less costly to operate.
6. OFM is analyzing regulatory requirements with a goal to streamline operations and drive down care given to the lowest level.
    a. OFM and the facility are assessing the use of a ward clerk pool which would take clerical personnel in administrative areas and use them on the two units to assist nursing personnel and free them up to spend more time in direct patient care.
    b. OFM and the facility are exploring the use of psych techs in the CDU to drive tasks down to the lowest level and possibly reduce the number of counselors and

nursing staff needed. Barriers to re-classing positions inhibit the ability of the facility to proceed in this direction. With the freeze, the facility is unable to re-class these positions. The inability to fill the therapy positions inhibits the ability to increase census and enhance revenues.

7. OFM and the facility are exploring the use of additional CLIA waived laboratory tests to reduce costs.
8. The hiring freeze has created barriers to facilities that impact costs and morale. Through attrition, administrative support personnel and positions are lost. This puts an additional burden on direct care staff as they must pick up much of the slack. In many instances higher paid and skilled individuals are performing clerical tasks.
9. The hiring freeze has impacted facilities' ability to bill and collect revenue as these positions have been lost through attrition.
10. Lost ward clerk and medical records positions may impact the facilities' ability to maintain accreditation and licensure.
11. The facility plans to implement selected outpatient therapy services (lymphadema program) to offset the cost of additional therapists necessary to maintain a full census.
12. The facility plans to implement IV therapy and cardiac therapy programs to enhance revenue.