State of New Mexico
LEGISLATIVE FINANCE COMMITTEE
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David Abbey
Director

February 16, 2016

MEMORANDUM

TO: Senator Howie Morales

FROM: Pamela Galbraith, Program Evaluator LFC

THRU: David Abbey, Director LFC; Charles Sallee, Deputy Director LFC

SUBJECT: Fort Bayard Medical Center

Legislative Finance Committee staff was asked to follow up previous evaluations that included financial and operational issues at Fort Bayard Medical Center (FBMC). In particular staff assessed the status of the institution's staffing levels and performance including the quality of care of FBMC's residents. Part of this follow up included a site visit to FBMC during which LFC staff was allowed free access within the institution and FBMC staff was made available to answer questions.

This memo covers:

- Financial operations
- Facility staffing
- Performance outcomes
- Findings from independent review agencies

In summary, FBMC has taken steps to improve its financial practices but may experience another deficit in FY16. FBMC is unable to financially compete for staff in the provider community leading to the expensive use of contract staff unfamiliar with the residents and the facility and may cause risk to residents from inexperienced employees. Additionally, surveys and reviews by accrediting and certification agencies demonstrate issues with patient safety, facility deficiencies and a lack of operational oversight. It is the view of LFC staff that the information in this memo illustrates the need for a more in-depth, independent review of the facility.

FINANCIAL OPERATIONS

FBMC has experienced a measured recovery from an inferior fiscal management system which did not accurately reflect the financial status of the facility. Past program evaluations have found the operations of FBMC facilities did not produce or provide needed financial information close to real-time transactions. Information was stale by the time data was produced, limiting the success of corrective actions. A new CFO, a recent change in the electronic billing system and internal processes have brought new approaches to financial management which will provide more current and accurate data. Revenue projections are completed each month representing actual financial performance. Future months' projections are modified to reflect changes. Because the revenue projections are more timely, the first year in the process may result in lower revenue projections during the year, but yearend write offs should be less than previous years.

Review of financial information shows an over projection of revenues in past years. The revenue projections now consider allowances for uncollectable accounts. Scrutiny of revenue for collectability shows that despite cash recovery efforts, collections in November, 2015 will result in a $1 million shortfall from projections and decreased collections. Revenues are now being posted on an accrual basis from the beginning of the year, rather than on a cash basis during the year, with an accrual posting at the end of the year. Aging accounts are routinely monitored. Of the $2.1 million in the aging accounts, the facility has already collected $600 thousand this year. The facility's goal is to collect another $1 million prior to the end of the fiscal year. Revenues are posted on an accrual basis and not a cash basis. This would prevent revenue from being "booked" when billed and again when the revenue was actually received.

With more current, accurate data, the facility is in a better position to make budget adjustments and to understand what is driving financial performance. However, many expenditures are costs which cannot be adjusted by the facility: risk management, workers compensation and unemployment premium increases, and with lesser impact, the increase costs for IT, drugs, and food. Revenue projections for the current year included an enhanced reimbursement for high-level care residents. With federal changes in high-risk definitions, the average daily census of those individuals has decreased from 65 to 13, or a $3 million decrease in revenue. Revenue has also been impacted by a fluctuating census. The facility is striving for an average daily census of 150. Changes in how census is projected have been made and are now realistic based on actual performance. In November, the average census was 137 and has dropped to 130 in December.

Increased census can also have a negative impact on financial performance. The FY15 average daily census was 143, but at a contract employee cost of $1.8 million. As of November, 2016, $360 thousand has been spent on contract staffing. FBMC claims it is not able to compete with the private and other public facilities in this area and frequently serves as training ground for new graduates and individuals seeking skills certification, but lose them to other providers once they are trained at FBMC.

The monthly monitoring of uncollectible accounts aids in more accurate revenue projections. To ensure that accounts do not age beyond the ability to collect, FBMC has received approval to employ a contract employee to work delinquent accounts.

It appears claims submissions to MCOs are filed in a timelier manner than in the past. The practice of posting revenues on denied claims has also been stopped until revenue is realized. Revenues were posted for denied claims and for which revenue would not be collected: late submissions beyond filing mandates and lack of service documentation. The FBMC CFO is designing the accounting system to allow more discreet collection of data, displaying contractual allowances, bad debt, and uncompensated care. Nursing homes, including FBMC, take a risk with every admission depending on whether or not the client will qualify for Medicaid. The length of time for HSD and MCOs to qualify an individual can be more than 30 days, meaning the facility gives a minimum of one month of care unfunded by Medicaid.

The current CFO's worst case deficit projection for FY16 is $4.5 to $5 million. The CFO projects additional savings can occur with the increased effort on timely filing of claims, the temp staff person working aging accounts, and challenges to MCOs on reimbursement issues. However, by law, a department cannot overspend and must take action to prevent deficit spending.

Comparison of FY15 and FY16 Budgets

FY16 Approved Operating Revenue Budget is $1.8 million less than FY15 actual revenues.
FY16 state appropriation and other state funds were decreased by $1.8 million
FY16 Other Sources Revenue has been $3 million less than the original based upon prior years revenue expectations that will not materialize and the decrease in patient census.
FY16 salary and benefit expenses are projected to be $1.5 million over budget primarily due to deceased state funding.
FY16 through November contract nursing costs are $690 thousand under FY15 for same time period, with a full year projected decrease of $1.3 million.

Source: FBMC Financial Reports

FBMC is in the process of implementing other cost saving measures: improve collection rate to 95 percent, continue to pursue aging accounts, hold recruitment of a plumber, and eliminate contract pharmacist and replace with an employee staff pharmacist.

FACILITY STAFFING

In each of the past two years, the facility has experienced turnover of nearly 30 percent of staff. This disrupts an institution's pace and quality of service delivery. Time has to be continually dedicated to new staff orientation and exhausts the ability of older staff to monitor new personnel care delivery. The vacancy rate shows that nearly 30 percent of staff left the institution each year for the past two years. The CEO's resigned effective January 20, 2016.

FBMC Turnover and Vacancy Rates FY15-FY16

Measure	Nursing Home	VA Nursing Home
Staff Turnover	26% FY15 17% FY16 YTD	30% FY15 11% FY16 YTD
Staff Vacancy	13% FY15 7% FY16 YTD	8% FY15 3% FY16 YTD

The primary national accreditation body for health care facilities is the Joint Commission. The Commission requires self-evaluations prior to an accreditation review. In December 2015, the assistant administrator for FBMC completed a review of staffing adequacy, identifying issues and causes relating to staffing problems including:

- Salaries are not competitive with other healthcare providers in the area: another nursing home facility, the local acute care hospital, and home and hospice care agencies.
- The facility is geographically isolated and hiring options are limited.
- Turnover rates are high across the nursing home industry and FBMC is not an exception.
- The budget situation has limited the ability to hire contract staff.

The assistant administrator preparing the report cites the following reasons for facility's inability to recruit staff. Source data justifying findings was not available.

- State Personnel does not recognize temporary licenses issued to graduate nurses and does not allow hiring of those individuals into vacant RN positions.
- Applicants are lost in the time delay between application and employment.

Over the past five years, several FTE budgeted positions have been eliminated by DOH. The following table shows the number of positions eliminated and the facility reasons for the reductions. In addition to these positions, the facility has chosen to eliminate the house supervisor positions. Filled and vacant position information for the time periods of the below actions were not provided for this review.

Numbers of Positions Eliminated by Year	
July 2010	5 positions transferred to DOH
July 2010	5 positions reduced per legislative directive
January 2012	1 IT position eliminated
FY12	11 positions eliminated per legislative directive
September 2012	4 positions transferred to Turquoise Lodge
September 2012	1 position transferred to Office of Facilities Management
July 2013	1 nursing position reclassified for IT
FY14	20 positions eliminated per legislative direction (including 7 CNAs and 1 LPN)
FY15	5 positions eliminated per legislative directive (including 3 CNAs)
August 2018	4 positions transferred to Human Resource Bureau of DOH (including 1 CMA and 1 CNA)

Source: FBMC Self Assessment of Staffing Adequacy

Of note, the legislative process does not direct the classification of personnel positions to be eliminated and does not address transfer of positions to other sections of the department. However, the legislature does consider elimination of positions which have remained vacant for long periods of time.

System to Determine Staffing Needs

The primary process for staffing nursing services is based upon industry standard hours of care for nursing home residents. However, this process does not adequately address individual patient needs. In addition, staffing is not routinely addressed in incident reports to determine if staffing was a contributing factor to incidents.

FBMC has developed an acuity-based staffing methodology, but has not yet deployed the process to determine staffing needs. Per FBMC, the industry standard for hours of care per resident per day in nursing homes is between 2.5 and 3.5 hours per day. According to FBMC, frequently residents at this facility receive more than 4 hours per day of care. This is explained by the facility labeling itself as a "safety net" provider which is required to admit patients with needs more complex that community nursing homes. However, many "specialty" nursing homes are available in the state for patients with special needs. The Centers for Medicare and Medicaid Nursing Home Compare reports FBMC as a 5 star facility in general and RN staffing. It is not

known if the facility reported staffing based on filled or vacant positions. A review of staffing schedules by resident unit does not reveal uneven staffing between weekdays and weekends.

Actions demonstrate the facility is actively recruiting staff, which will continue to decrease the use of contract employees. However, delays in the process from the State Personnel Office and the DOH Office of Facilities Management may still delay process and result in applicant losses.

Physician Coverage

The facility, finishing year 2 of a 4 year contract with the present physician coverage group, decided to issue an RFP in an effort to reduce costs. One physician group did respond to the RFP, significantly reducing costs, but also reduced physician coverage by 55 percent. Although the facility was going to award the contract to this group, that decision was delayed for unknown reasons. The responding group are not local physicians. Past awards to "outside" physicians resulted in significant decreases in local physician referrals to FBMC, but it is not clear if this entered into the decision to delay an award.

PERFORMANCE OUTCOMES

The monitoring of performance relating to patient outcomes is primarily driven by external review agency mandates. Department reported performance monitoring does demonstrate risks to patients cared for in the facility. Any reviews relating to the causes impacting performance outcomes were not provided. However, many of the outcomes can be related to staffing levels and staff training. Despite a worsening trend, the facility did not acknowledge poor performance outcomes and did not present a plan for improvement.

INSTITUTIONAL REVIEWS

In 2015, FBMC was subjected to 6 external reviews. Each of the reviews did cite findings which did not comply with standards established by the federal or state governments. Many reviews are identified as DHHS/CMS surveys which indicate the US Department of Health and Humans Services, through the Centers for Medicare and Medicaid have contracted with the New Mexico Department of Health Division of Health Improvement to conduct the review using federal survey standards.

DHHS/CMS, March 31, 2015
Laboratory Review
Findings:

Year	Medications Errors	Falls	Nosocomial Infections Acquired in Facility	Decubiti Ulcers Occurring in Facility
2012	227	146	211	
2013	108	89	95	
2014	263	222	217	
2015	344	340	350	255
2016 YTD*	58	155	109	89

Source: FBMC
*through Dec

- Laboratory does not document date or time a specimen is received in the lab.
- No evidence of required humidity monitoring for storage of lab reagents and specimens.
- No evidence of a required testing system to be followed prior to reporting test results for patients.
- Failure of the lab to have control procedures to monitor accuracy and precision of complete analytic process.
- Lack of corrective action policies and procedures being available and followed to ensure testing ensures accurate and reliable patient results.
- Failure to establish and follow written policies and procedures to monitor, assess and correct problem in the analytic systems.
- Lack of a director who meets the CMS qualifications for a director and absence of a technical consultant in the absence of a qualified director.
- Discrepancies between reported activities of a laboratory supervisor and actual happenings.

It should be noted that the major finding for each accreditation section is reported here, but each includes several findings within the major finding. A corrective action plan was submitted and no follow up report was provided.

DHHS/CMS, 10/29/15
Complaint Survey
Findings:
A complaint was filed by someone not identified by the report or the institution. Findings by the review included:

- Failure to follow care plans for 5 patients resulting in injuries to 2 residents. Seat belt alarms for wheelchairs were faulty resulting in falls, or not activated, or staff lacked the knowledge on how to operate the alarms. The incidents occurred despite care plan directing alarms be monitored with each use to ensure lights indicate operational seat belt and alarms sound if unbuckled. Float staff, not receiving orientation to seat belt operations, were assigned to the units.
- Bed alarms not operational resulting in patient falling from bed without alarm sounding. Staff indicated alarm was not working.
- Failure to ensure assistance to residents not capable of self-grooming. Results of the failure included: maggots found between toes for a patient who stated she could not bend to clean feet.
- During the review, the investigation team found a resident with a history of incontinence of bladder and bowels in the wheelchair with "an overflowing adult diaper". With the team observing while patient was cleaned, dried feces and urine were present on the patient's skin. This was despite a care plan requiring checks for incontinence every two hours at a minimum, with no documentation that checks were completed.

DHHS/CMS 4/17/15
Complaint Survey
Findings
The survey was in response to a complaint relating to two standards, Dignity and Respect of Individuality and Reasonable Accommodations of Needs and Preferences.

- Staff did not attend to dietary needs of residents as evidenced by one CNA attempting to feed 8 individuals who couldn't eat unassisted, another CNA attempting to feed 5 residents.
- CNA staffing on units is decreased to 2 on weekends compared to 4 on weekdays, although feeding assistance need does not change on weekends. Each of the care plans of those requiring assistance reflects the need for that assistance.
- Absence of automatic door openers to allow wheelchair-bound residents access to the outdoors and the hall.
- Failure to serve food in a sanitary condition.

DHHS/CMS 4/21/15
Life Safety Code Recertification Survey
Findings:

- Facility failed to ensure all exit doors with delayed egress locks are unlocking upon activation of fire alarms and all doors are provided with prober instructional language. These doors would not open to allow patients an exit in the case of an emergency.
- Fire drills were not conducted at the required quarterly mandate. This would be especially important because of the level of staff turnover.
- Electrical wiring and equipment does not meet the National Electrical Code.

This is the one review that had a finding categorized severe and wide spread. The deficiency is pervasive in the facility and represents systemic failure that has or could affect a large portion or all of the facility's residents.

- Standard: Exit is arranged so that exits are readily accessible at all in times.
  Finding evidenced by: delayed egress locks are not unlocking upon activation.
- Fire drills are held at unexpected time under varying conditions, at least quarterly.
  Based upon record review, the facility failed to conduct drills at least quarterly on each shift.

Failure to ensure safe passage from danger and not preparing staff for emergency situations places residents in a dangerous situations.

Department of Veterans Affairs 8/24/15
Annual VA Survey
Findings:

- Neither federal nor state veteran offices were notified of the change in the facility administrator.
- Emergency preparedness policies and plan have not been updated per required schedule.
- Documentation recording unannounced emergency procedure drills does not exist.
- The facility failed to properly install and maintain the automatic fire alarm system.
- Doors remain open during active fire drills preventing smoke compartmentalization.

- Emergency exit doors in one of the resident units are locked at all times and only release 60 seconds after an alarm has been initiated. Operational language is not affixed to fire doors so employees know how to operate.

The facility did submit a corrective action plan, but documents noting acceptance by the Veteran's Administration long-term care unit were not provided. On April 21, 2015, FBMC requested a waiver for certain citations, which was denied.

FBMC presented corrective action plans for all reviews and findings, except a finding in the Life Safety Review, for which FBMC was seeking an exception to the standard. This request has been denied by the DOH Division of Health Improvement. Excluding the request for exception, all violations from reviews have been cleared by the Division based upon the corrective action plan and return site visits.

Prior to the visit, concern was expressed by a community member that deficiencies were cleared as a result of intervention by a former FBMC employee who was now working in Santa Fe. After review with the Division of Health Improvement, this accusation does not appear valid. The reviews in question were conducted and cleared by Las Cruces staff, through FBMC document reviews and return site visits.

CC: Legislative Finance Committee Members
Retta Ward, Secretary, NM Department of Health
Jeremy Averella, Chief Facilities Officer