THE ALASKA PSYCHIATRIC INSTITUTE

A Presentation to the Health & Social Services Committee
of the Alaska House of Representatives

by

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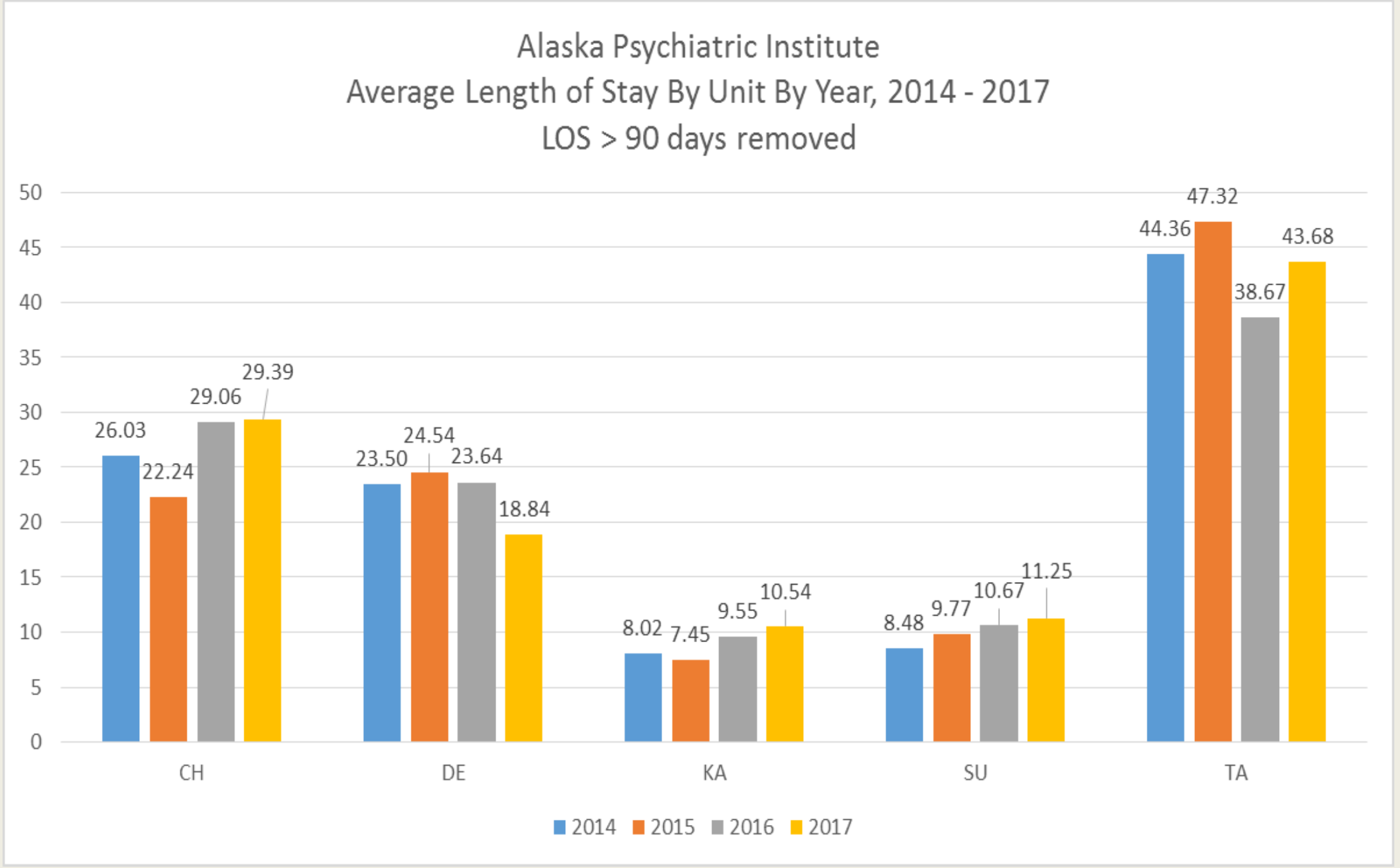
April 10, 2018

Alaska Psychiatric Institute: the Basics

- API's proposed SFY19 budget is $33,360.0
- Only 22% of API's funding is UGF: $7.2 Million
- More than half of the remainder of API's budget is funded by DSH (Disproportionate Share Hospital) Medicaid Funds: $18.7 Million
- The remainder of API's budget comes from Statutory Designated Program Receipts (SDPR - $7.4 Million), including Medicare, Medicaid, third party / private payers, grants, etc.
- API is the largest user of the State's DSH funds
- DHSS currently uses its other available DSH funds to pay for the Division's support for Alaska's 3 important designated hospitals providing psychiatric evaluation and treatment services [Fairbanks Memorial Hospital (FMH); Providence Alaska Medical Center for the Providence Psychiatric Emergency Department (PPED); and Bartlett Regional Hospital (BRH)]
- FMH has a 20 bed mental health unit, with 4 acute beds; BRH has 12 mental health beds; and the Providence Psychiatric Emergency Department, which acts as a behavioral health triage center for the Anchorage area, has 7 beds. All three have psychiatrists at the head of their units.

An 80 Bed Hospital

- API is an 80 bed hospital with 5 distinct units:
  - *Two **adult acute** units: Katmai (24 beds) and Susitna (26 beds) for a total of 50 adult acute patient beds*
  - *One 10 bed unit for **adolescent** patients (Chilkat) – ages 13 through 17*
  - *One 10 bed unit for **longer term adult** patients (Denali) with a real mix of diagnoses, from TBI, autism, dementia, IDD, and all with very difficult and complex behavioral issues*
  - *One 10 bed unit for **"forensic"** patients (Taku) – for defendants' whose criminal trials are on hold because of concerns for their mental status (competency to stand trial)*


Alaska Psychiatric Institute
Average Length of Stay By Unit By Year, 2014 - 2017
LOS > 90 days removed
50
45
40
35
30
25
20
15
10
5
0
26.03
22.24
29.06
29.39
23.50
24.54
23.64
18.84
8.02
7.45
9.55
10.54
8.48
9.77
10.67
11.25
44.36
47.32
38.67
43.68
CH
DE
KA
SU
TA
2014
2015
2016
2017

History: A Range of Bed Options: From 162 Beds to Just 45 Beds

- Beginning in 1986, and over the next 14 years, there were a variety of scenarios proposed to replace the aging API
- Most of the scenarios ended up being primarily based on the funding available and did not significantly rely on the approximately $6 Million in programming work DHSS had contracted for as it prepared its CON for the replacement hospital
- DHSS issued is preliminary study in February of 1992, summarizing the work of many of its consultants; this study targeted the new API as requiring 162 beds: 72 Adult, 18 adolescent, 36 forensic, and 36 elderly (although a year later, in 1993, a final DHSS study suggested Alaska would need between 198 and 237 beds)
- DHSS' early 1992 report was highly criticized by advocates and community behavioral health providers who supported a focus on more community-based services

History: The "Alyeska Accord": Finding Stakeholder Agreement on the Bed Capacity of the New API

- The Alaska Mental Health Board held a meeting at Alyeska of 42 community mental health advocates and mental health service providers in June, 1992 (over 25 years ago)
- The results from this weekend meeting became known as the "Alyeska Accord" and was a set of principles which were to guide the AMHB's response to DHSS' Certificate of Need (CON) application for a new API
- Agreements reached included the decision that the central purpose of API was to provide "tertiary" care and agreement that the **new API should be built at 114-beds**, as follows:
  - *Adolescents:* *18 beds*
  - *Elderly:* *18 beds*
  - *Adults:* *36 beds*
  - *Swing (complex adults):* *18 beds*
  - *Forensic:* *24 beds (not a part of the original accord, but adopted by the AMHB a month later, in July of 1992*

History: From 114 beds to 57 to 72 to 80!

- Based on the Alyeska Accord result, a CON for the 114 beds was submitted in August of 1993 by DHSS
- However, this CON and its cost ($64.9 Million) was DOA. Four years later, in 1997, the DHSS Commissioner reviewed a report with different five scenarios, based primarily on funding availability: a 72-bed option, a 63-bed option, two different 54-bed options, and even a 45-bed option.
- Based on this report, the DHSS Commissioner selected one of the 54-bed options (which included adolescent beds).
- After four more years, in 2001, with over $16 Million in legislative-approved COP bonds, the re-appropriation of $19 Million in existing committed capital funds, and a Trust Authority contribution of $3 Million, DHSS finally had the funds to procure a 72-bed facility. Another controversy: the construction proposal was issued as design-build.
- Because of concerns for the ability of the 72 beds to handle API's capacity issues in 2001, DHSS issued API a CON for 72 beds but did allow for an expansion to 80 beds with proof of a history of needing additional beds. API opened with 80 beds in 2005.
- As a part of this effort to fund a new hospital, DHSS also applied for and was awarded a SAMHSA grant for $5 Million a year for three years to help fund expanded community-based treatment to support the downsized-hospital. These funds primarily were used to support the development of additional DET capacity, and training in role recovery, dual diagnosis, cultural competence, and crisis intervention.

Calendar Year Snap Shot of API Utilization

Calendar Year	Official Bed Capacity	Maximum Patient Bed Days	Total No. of Admissions	No. of Unduplicated Admits With Just a Single Stay during the Year	No. of Unduplicated Admits With Multiple Stays during the Year	Total No. of Actual Bed Days Used as a Percentage of Maximum Days Possible (# / %)	Average Daily Census	Average No. of Admissions Per Month	No. of Days in the Year Where API Handled 8 or More Admissions in a Single Day	No. of Days in the Year Where API Handled 5 or More Admissions in a Single Day	No. of Days in the Year with Just One Admission	No. of Discharges
1990	160	58,400	831	529	126	33,147 / 57%	90	69	3	32	90	831
2000	74	27,010	1,448	872	213	23,954 / 88%	65	121	24	140	40	1,448
2010	80	29,200	1,286	782	199	24,698 / 85%	68	107	10	104	48	1,281
2011	80	29,200	1,489	863	232	25,225 / 85%	69	124	20	143	25	1,506
2015	80	26,595*	1,547	936	228	23,276 / 88%	64	129	23	166	32	1,555
2016	80	28,297*	1,519	880	239	25,873 / 91%	71	126	18	162	31	1,499
2017	80	28667*	1,486	839	249	26528 / 93%	73	124	9	151	21	1,488

*Maxumum Patient Bed Days reflects unit closures during the year.

The Current Bed “Capacity” Issue

- As members of this Committee are aware, API needs – and has been going through – an expensive but very necessary face-lift, retrofitting every bathroom and portions of every bedroom to meet revised Joint Commission safety requirements
- Since mid-November of last year, this six-month long, temporary closure of each of API’s five hospital units for repairs has had a major impact on community hospital EDs and Alaskans experiencing psychiatric emergencies: patients with court orders for hospitalization for evaluation at API have been held for days – not hours – sometimes up to a week or more – awaiting transfer to API for evaluation and treatment [or transfer to one of the two other hospitals with Designated Evaluation and Treatment (DET) mental health units]
- The API contractor has been working on the last unit for about a month now (the Susitna Unit); unfortunately, it is the hospital’s largest unit, with 26 adult acute beds, so API’s census capacity has been set at just 54 patients, not 80 (or even 70)

API's Current Estimated Bed Capacity

- The construction on the Susitna unit was completed last week; other off-patient-unit bathrooms were also being repaired last week (e.g., restrooms off the gym and dining room); the Susitna Unit is being thoroughly cleaned and should be ready to open back-up this very week
- However, because of a shortage of nursing staff – on April 11th – when API will have completed the renovation project on time and the contractor is out of the building –at this time, and for at least the next several months, **we believe API will only be able to run a census of 58 beds, down a total of 22 beds for the foreseeable future.**
- We are **not** going to be able to open up the Denali Unit (10 beds) and we will be forced to run the Katmai unit at half of its normal census, or just 12 beds instead of the normal 24 beds.
- Until we are able to hire more RNs (travelers or full-time positions), or the staff currently out on various types of leave (whether it be workers' comp or FMLA) are able to return to work, we are not going to be able to fully staff the Katmai unit, nor open the Denali Unit.

API's Current Estimated Bed Capacity

- We have hired four (4) traveling RNs, but we continue to run at an RN deficit. The salaries that API is able to pay for starting RNs is not competitive with private sector hospitals
- DHSS is presently exploring hiring bonuses and other types of incentive pay in an attempt to make the positions more attractive to prospective RNs (incentives used by other departments, like DOC)
- We have been meeting with Southcentral Alaska hospitals and are going to be implementing some admissions changes that should somewhat help mitigate the stress on hospital ED's during this perfect storm of problems affecting API
- While we have been pleased with the Certificate of Need (CON) applications from both Alaska Regional Hospital and MatSu Regional Medical Center, CONs that Commissioner Davidson has approved, we are anxious about the actual dates that these facilities will be able to open and actually begin accepting behavioral health patients
- Finally, in Governor Walker's capital budget for FY19, there is a request to remodel the Anchorage Pioneer Home to add at least six beds for psychiatric patients needing dementia care.

API's Need for Expanded Capacity

- There is another side to the capacity issue: API – essentially since it opened – has not been able to successfully meet the psychiatric treatment needs of Alaska's communities and its residents
- Since at least 2011, almost every community with a hospital – whether a critical access hospital or a general acute care hospital – has experienced the need to "board" psychiatric patients in their emergency departments (EDs) awaiting an evaluation and / or treatment bed(s) at API or one of the two designated evaluation and treatment (DET) hospitals with mental health units (i.e., Fairbanks Memorial or Bartlett Regional Hospitals)
- With only a 10 bed adolescent unit, there have been a number of very difficult occasions when an adolescent in Fairbanks or MatSu or at the Providence Psych Emergency Department has been held in their EDs for sometimes as many as 14 days – this is utterly unacceptable and is one of our most serious treatment concerns
- Fortunately, the Trust Authority, at the request of DHSS, has agreed to undertake a study of whether – as originally conceived – API could add another wing, giving it up to 20 additional beds to meet the statewide demand for more involuntary psychiatric treatment beds, possibly including some additional adolescent beds or beds for other identified special populations
- And, as mentioned before, we believe Alaska's application for an 1115 behavioral health waiver is exactly what Alaska requires in order to take the pressure off API and the other DET hospitals; it is what Alaska needed back in 2001, as the new API was under construction. By creating a range of new treatment services in 14 regional hubs, local communities will be able to better serve their residents, avoiding the need for hospitalization with home and community-based services that are clearly less expensive and provide better, quality care

API and its Forensic Population

- There is another population besides adolescents that pose a particularly problem for API.
- The Alaska Court System's demand for DHSS's forensic services has simply outstripped API's ability to manage the caseload assigned to its staff utilizing API's 10-bed, medium security unit – the Taku Unit – to serve the defendants court-ordered to API for treatment
- API did seek consultation on this issue and Dr. Patrick K. Fox, a psychiatrist with significant forensic experience, was hired by the Western Interstate Commission for Higher Education (WICHE) to provide API with a report. His report was issued in November, 2016.
- The report offered a number of recommendations, including additional education to API staff, consideration of a jail-based competency restoration program, an evidenced-based jail-diversion program, involvement of more experienced outside forensic examiners, and training for judges and the legal community on forensic issues (including the *Sell* involuntary medication standard)
- The API Forensic Evaluation Team was served with a notice last month that an Anchorage Mental Health Court Judge had set April 16th for an "Order to Show Cause Hearing" as to why API should not be held in contempt of court for not evaluating a defendant within the judge's requested time frame. This was recently resolved, but it shows the level of frustration.
- In partial response to this crisis, and with the original support of this Committee and the eventual support of the House Finance Committee, the House of Representative is seeking Legislative and Alaska Mental Health Trust Authority support for a feasibility study to explore the value of establishing a forensic hospital in Alaska, given the various demands on API and the general needs of Alaska's mentally ill correctional population.

Studying Alaska's Need for a Forensic Hospital

- The study would look at Alaska's needs for forensic beds in order to admit, evaluate, and treat criminal defendant with issues around the insanity defense and their competency to stand trial (see AS 12.47). The list of issues is long and complex and would involve defendants:
  - *needing competency evaluations;*
  - *found incompetent to stand trial who need treatment to determine if they can be restored to competency in order stand trial;*
  - *found non-restorable and who are then civilly committed to API (including dangerous persons who often have committed serious felonies);*
  - *found Guilty but Mentally Ill (GMI) and held in prisons;*
  - *found Not Guilty by Reason of Insanity (NGRI) and committed to API's forensic unit; or*
  - *found guilty of a variety of crimes where competency was not raised and who have been incarcerated but who are experiencing a mental illness and need ongoing treatment because of the severity of their symptoms – and just as often – the severity of their crimes.*

So: the Short List of API Current Challenges:

- Admissions pressures:
  - *Continuing demand for treatment beds at API from all regions of the state*
  - *Long waits for patients (boarding) in hospital EDs for an evaluation and/or a treatment bed at API because of API's general lack of an adequate number of treatment beds*
- Staffing related budget concerns, including recruitment, retention, appropriate unit staffing coverage, quality of care (i.e., need for unit programming / therapeutic activities for patients in treatment), and the reliance on overtime to keep the hospital minimally staffed (Premium Pay)
- Concerns for the safety of staff and patients and staff training to ensure their safety and the safety of patients when staff are appropriately redirecting or intervening with challenging patients; ongoing concerns for the use of seclusion and restraint
- Current inadequate local community behavioral health programming to support patients who are discharged from API or either Fairbanks Memorial or Bartlett Regional, including inadequate community-based medication management services, and an ongoing need for community mental health (MH) treatment, for substance use/misuse disorder (SUD) treatment, for a combination of both MH and SUD (Co-occurring) treatment, and / or because of a lack of housing or appropriate living arrangements
- In partial response to the clear need for more community based services, and to address the substance use / opioid crisis in this state, the Governor has introduced an FY18 supplemental request for $18 Million to assist in providing greatly needed SUD treatment programs in local communities, especially withdrawal management and residential treatment programs

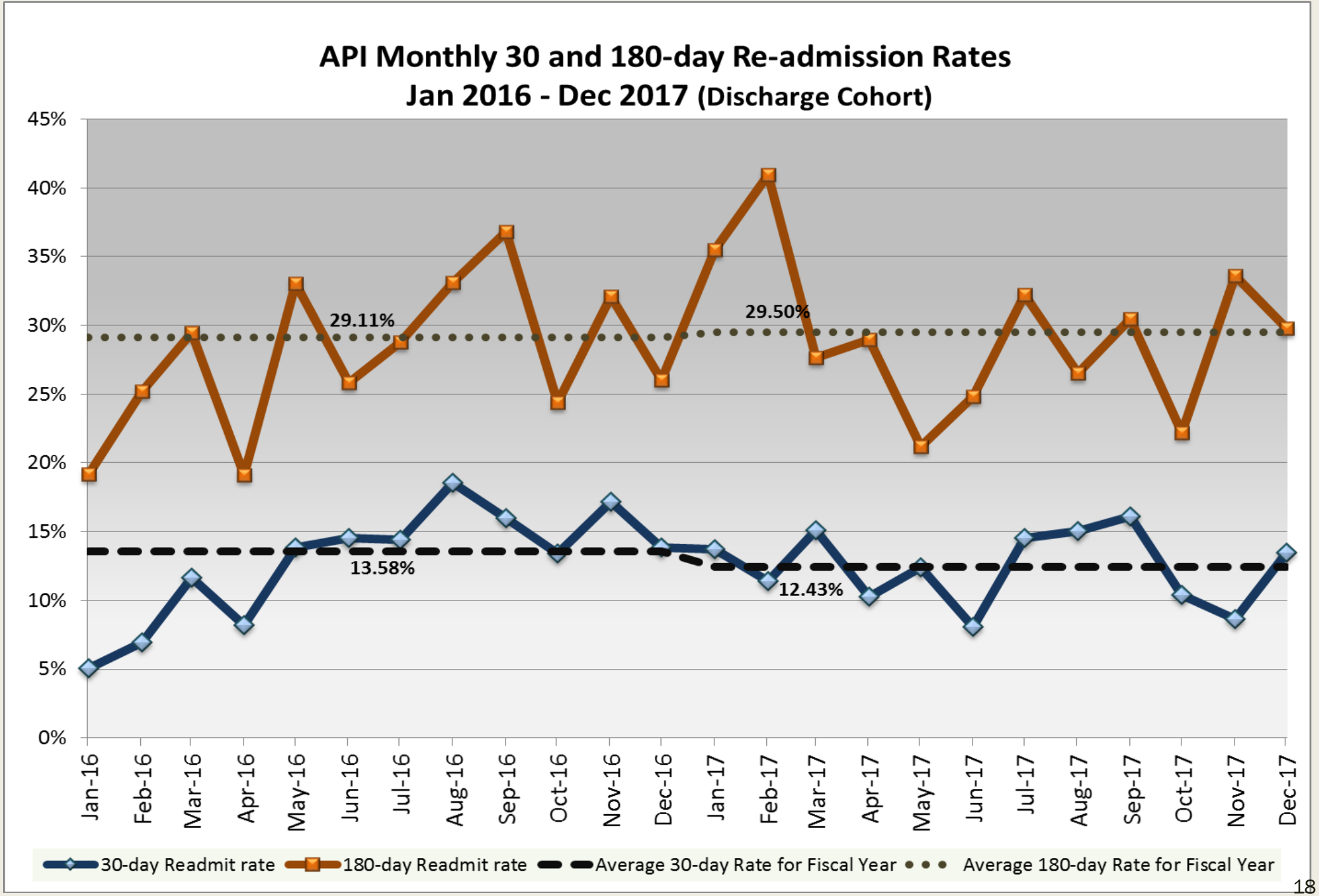
A Summary of Potential Projects that Could Significantly Improve API

There are a number of projects presently being considered by the Legislature that would have a direct – and highly beneficial – impact on API's current crisis:

- Support for an expansion of Alaska's DSH Program, allowing DHSS to explore ways to financially assist those hospitals highly impacted by the reduction in treatment bed capacity at API
- Support for the $18 Million in additional substance use/misuse disorder treatment, providing funding for inpatient and ambulatory withdrawal management services, residential and intensive outpatient residential treatment services, sobering center or 72-hour SUD crisis evaluation services, and housing assistance and support services
- Support for the $318.0 feasibility study to explore the need for a forensic hospital in Alaska
- Support for API's budget and recognition that present funding is inadequate to meet the dramatic admission, discharge, and patient and staff safety pressures facing the hospital

Some Data to Provide Perspective

The next series of slides are presented to give the Committee some perspective on the issues that we are here to discuss


API Monthly 30 and 180-day Re-admission Rates
Jan 2016 - Dec 2017 (Discharge Cohort)
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
29.11%
29.50%
13.58%
12.43%
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
30-day Readmit rate
180-day Readmit rate
Average 30-day Rate for Fiscal Year
Average 180-day Rate for Fiscal Year

Discharge Barriers and Considerations

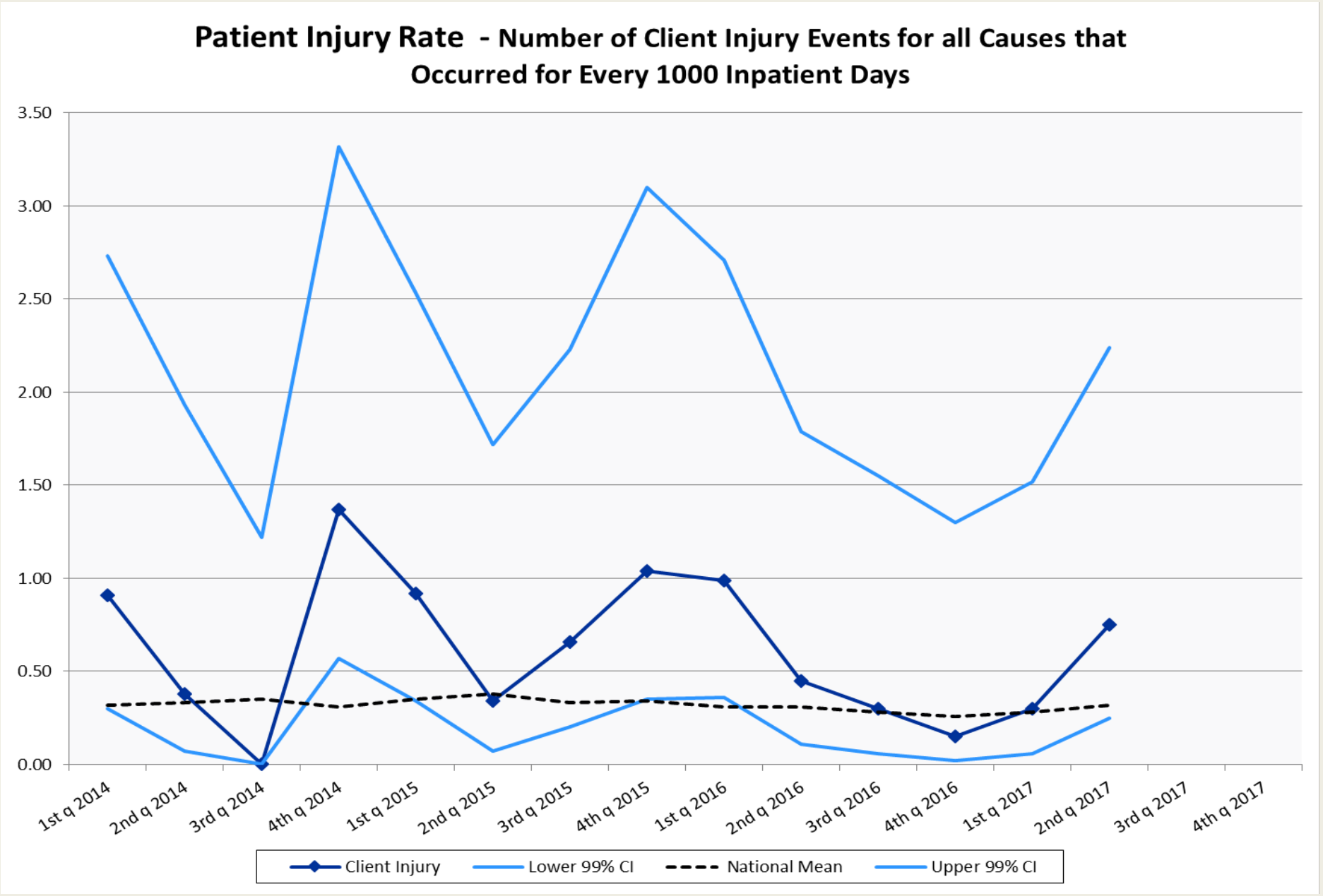
Current Primary Barrier - Week of February 5, 2018	Adolescents		Adults	
	Number of Patients >20 days	Total LOS	Number of Patients >20 days	Total LOS
Assisted Living Housing Placement	0	0	1	33
Gravely Disabled - Medical ALF	0	0	1	656
Specialized Service/Placement Doesn't Exist	3	115	3	265
General Relief Funding	0	0	0	0
Guardianship (need long-term care)	0	0	3	185
Dementia Placement	0	0	3	926
High Community Risk	0	0	3	1565
Stabilization Pending	0	0	0	0
Totals	**3**	**115**	**14**	**3630**

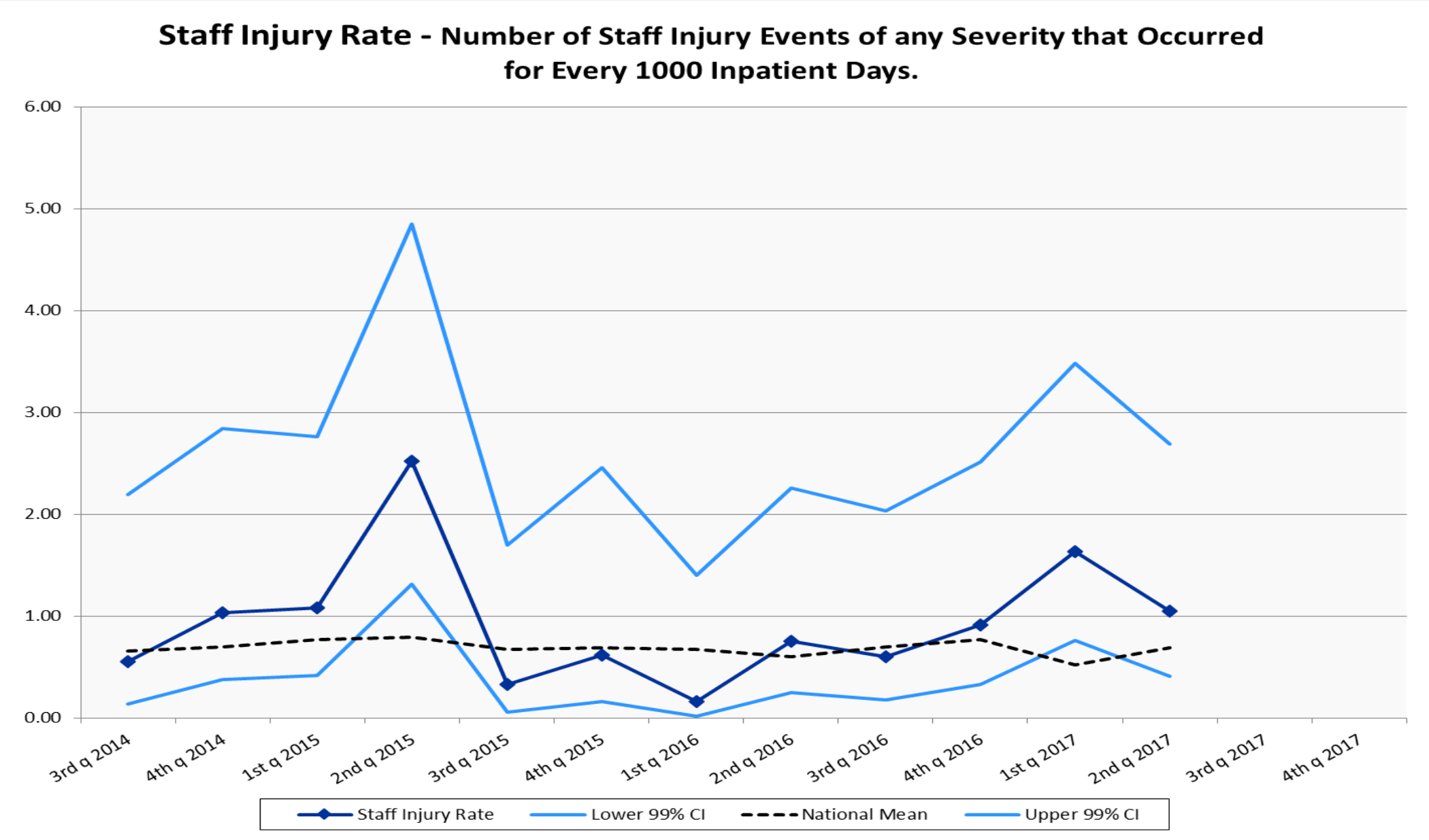
ORYX Data – A Joint Commission Accreditation Requirement

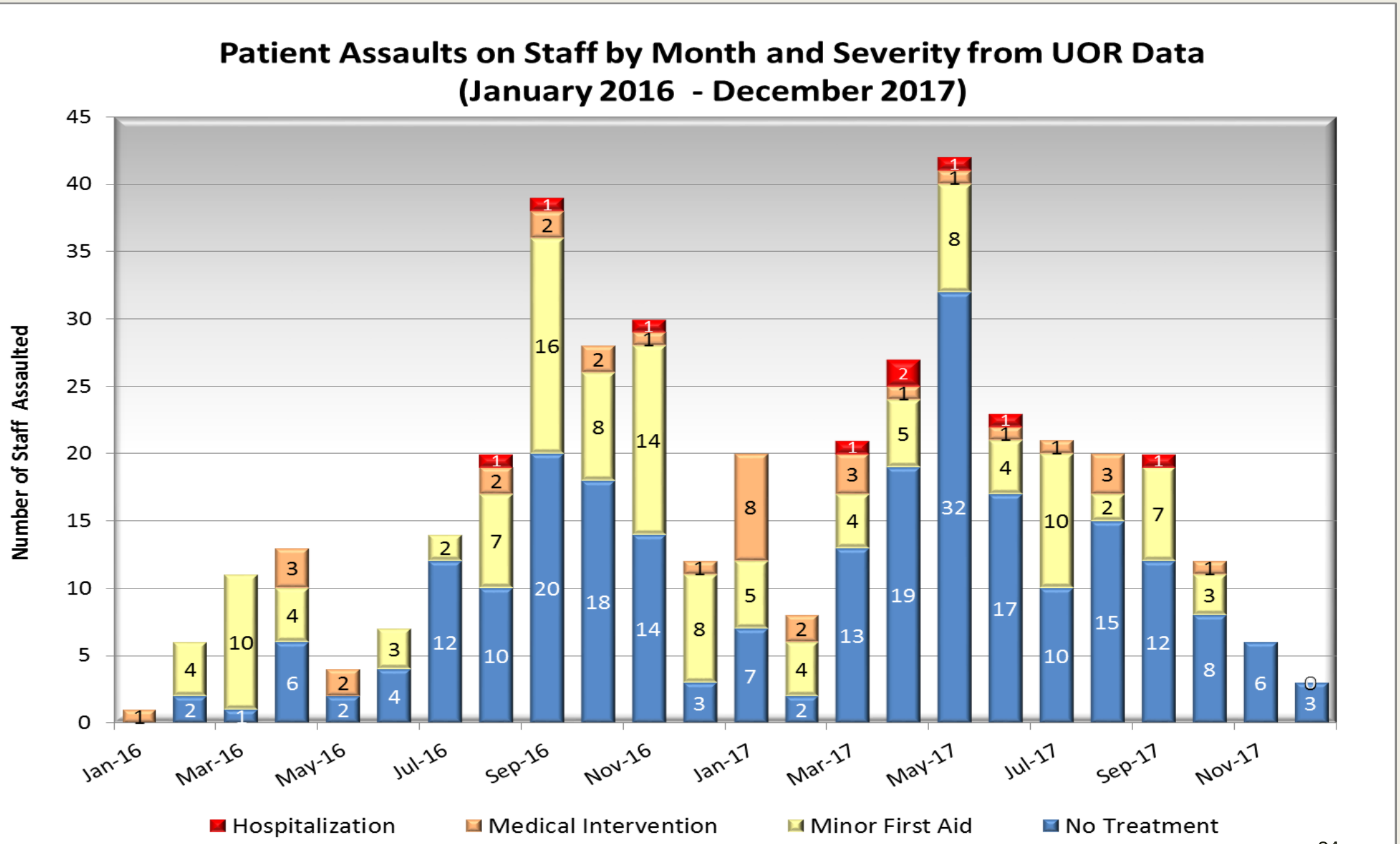
- The use of performance measures – quantitative measures used to evaluate and improve outcomes or the performance of functions and processes – are essential to the credibility of any modern evaluation activity for health care organizations.
- The Joint Commission's ORYX initiative incorporates the reporting on performance measure data into its accreditation and certification processes, and is intended to support Joint Commission-accredited and -certified organizations in their quality improvement efforts.
- ORYX chart-based data are publicly reported on The Joint Commission website at www.qualitycheck.org. The public availability of performance measure data permits user comparisons of hospital performance on individual measures at the state and national levels.
- ORYX data collected by API includes Client and Staff Injury Rates, Elopement Rate, Seclusion Hours, Restraint Hours, 30-day Readmission Rate.

The Mental Health Statistics Improvement Program (MHSIP)

- *The Mental Health Statistics Improvement Program* (MHSIP) Consumer Survey measures concerns that are important to consumers of publicly funded mental health services in the areas of Access, Quality/Appropriateness, Outcomes, and Overall Satisfaction and Participation in Treatment Planning.
- The Mental Health Statistics Improvement Program (MHSIP) Quality Report Toolkit was developed by the MHSIP Quality Report Workgroup with support from the Evaluation Center@HSRI. The *Evaluation Center@HSRI* is a technical assistance center funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services (CMHS) and operated by the Human Services Research Institute (HSRI).
- MHSIP is a program of CMHS designed to improve the quality of mental health program and services delivery decision making at all levels of government through guidance and technical assistance on the design, structure, content, and use of mental health information systems.
- MHSHIP Patient Survey data collected by API includes patient outcomes, patient dignity and rights, patient participation in treatment, the hospital's environment of care.


Patient Injury Rate - Number of Client Injury Events for all Causes that Occurred for Every 1000 Inpatient Days
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
1st q 2014
2nd q 2014
3rd q 2014
4th q 2014
1st q 2015
2nd q 2015
3rd q 2015
4th q 2015
1st q 2016
2nd q 2016
3rd q 2016
4th q 2016
1st q 2017
2nd q 2017
3rd q 2017
4th q 2017
Client Injury
Lower 99% CI
National Mean
Upper 99% CI


Staff Injury Rate - Number of Staff Injury Events of any Severity that Occurred for Every 1000 Inpatient Days.
6.00
5.00
4.00
3.00
2.00
1.00
0.00
3rd q 2014
4th q 2014
1st q 2015
2nd q 2015
3rd q 2015
4th q 2015
1st q 2016
2nd q 2016
3rd q 2016
4th q 2016
1st q 2017
2nd q 2017
3rd q 2017
4th q 2017
Staff Injury Rate
Lower 99% CI
National Mean
Upper 99% CI


Patient Assaults on Staff by Month and Severity from UOR Data
(January 2016 - December 2017)
Number of Staff Assaulted
0
5
10
15
20
25
30
35
40
45
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Hospitalization
Medical Intervention
Minor First Aid
No Treatment

API Staffing Levels

Here are the Full Time (FTE) and Non-Permanent (NP) Position totals for API since SFY14.

Fiscal year	FTEs	NPs
2014	248	6
2015	248	5
2016	246	5
2017	246	5
2018	246	6

- In FY12, API created its first PNA pool, taking one of its full-time PNA positions and funding it at a level that would allow API to hire some 25 Non perm positions within the expanded funding budgeted for that one PNA full-time position.
- In FY15, API again increased the PNA pool, adding funding that allowed an *additional* 25 NPs to be hired within the funding set aside by API for that one full-time position.

API Staffing Levels and Needs

- We have a variety of reports and studies suggesting that API is appropriately staffed, although, given how different API is from the vast majority of other public psychiatric hospitals, we believe that those studies do not fully account for the levels of patient acuity seen at API and we are working to determine if other acuity models might be useful
- We are looking at the distribution of RN staff and hoping to sign a Letter of Agreement with the Union to move to all RNs to 12 hour shifts in the near future
- As mentioned, we also struggle with recruitment and retention, and are naturally concerned for the pressures on nursing staff from the capacity issues at API
- We know that API's salary schedule is non-competitive with the private sector – RNs are paid at least $8.00 to $12.00 an hour more in Anchorage than starting API RNs; as a result, the DHSS has requested a classification study for all state nursing positions
- We believe we need more staff on the units to provide groups, work with individual patients, provide more discharge planning support, and work with the more challenging patients with a variety of therapeutic approaches, including Applied Behavioral Analysis and other modalities
- API is not presently funded for any staffing at these levels and for these purposes

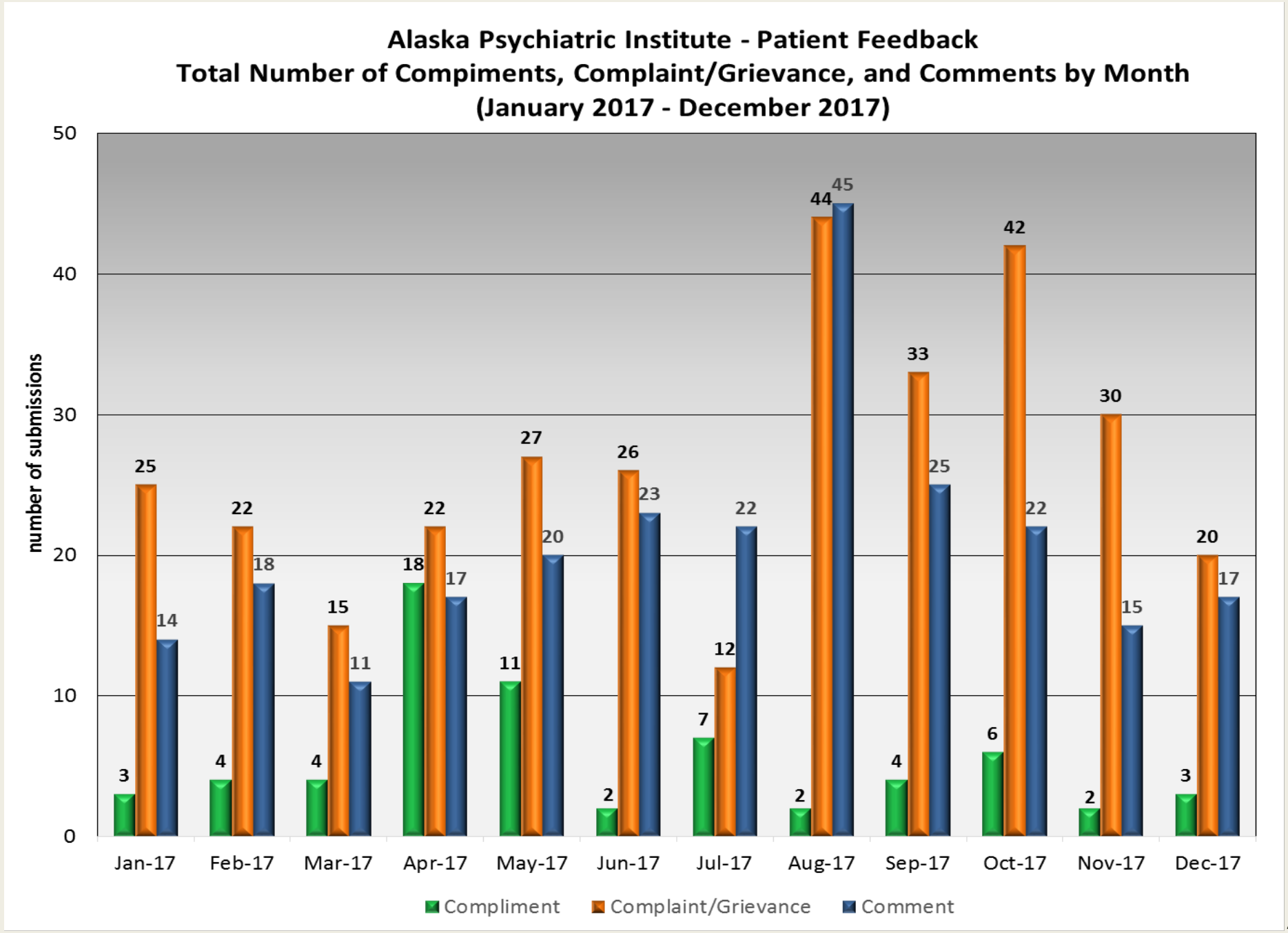
What is DBH Doing to Work these Problems? Staff Injuries

- After a 2014 OSHA complaint, API moved from the MANDT System training to the NAPPI (Non-Abusive Psychological and Physical Intervention) System (the program helps staff respond to escalating patients in ways that keep the staff and patients safe. NAPPI is primarily a verbal de-escalation intervention with some self-defense or physical intervention techniques

- Prior to the second OSHA complaint last year, API had purchased the NAPPI Advance Module, which includes more physical intervention techniques; **API is currently working to implement these new techniques into the training for all staff**

What is DBH Doing to Work these Problems? Staff Injuries (continued)

- We have asked the Western Interstate Commission for Higher Education (WICHE) to both assess the value of API's training programs and to follow up on its November, 2016 report on the needs of API's nursing administration, in order to provide API/DHSS leadership with additional, focused recommendations
- We are ensuring that the API Safety Committee is reviewing each incident report carefully, looking for systems issues that recommend practice changes
- We are ensuring that Close Observation Status Scale (COSS) policy and procedure is appropriately followed
- We have added security guards, who can be called on to assist when staff seek support with a challenging patient
- Finally, API and the Union (ASEA) have agreed to set up a Labor Management Committee as a constructive way to address issues identified by both parties as important to continuing a productive and effective work environment at API


Alaska Psychiatric Institute - Patient Feedback
Total Number of Compiments, Complaint/Grievance, and Comments by Month
(January 2017 - December 2017)
number of submissions
50
40
30
20
10
0
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
3
25
14
4
22
18
4
15
11
18
22
17
11
27
20
2
26
23
7
12
22
2
44
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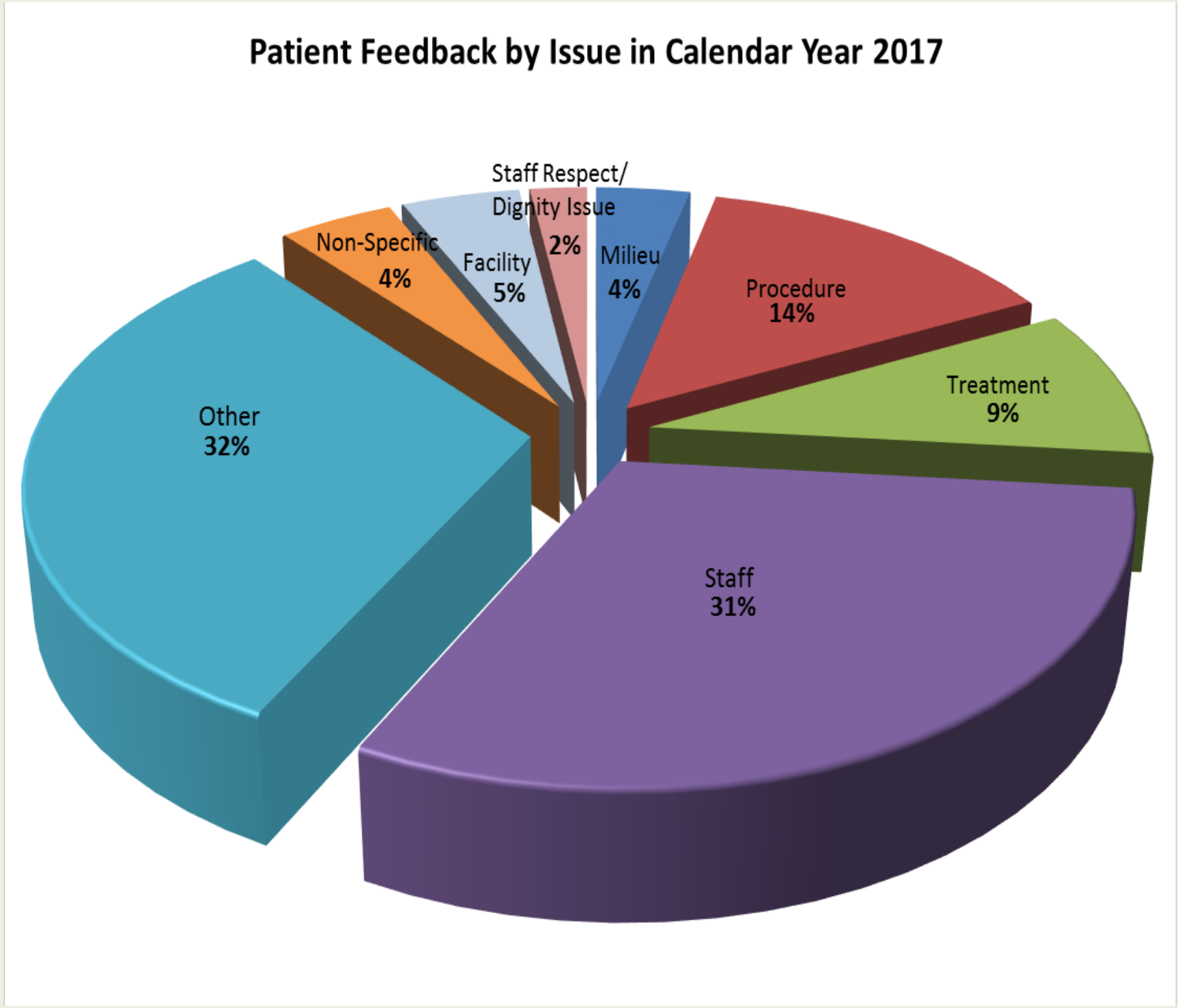
4
33
25
6
42
22
2
30
15
3
20
17
Compliment
Complaint/Grievance
Comment


Patient Feedback by Issue in Calendar Year 2017
Staff Respect/ Dignity Issue 2%
Milieu 4%
Procedure 14%
Treatment 9%
Staff 31%
Other 32%
Non-Specific 4%
Facility 5%

Thank You for Your Time!
Questions?

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