

ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE

July 31, 2006
10:35 a.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Paul Seaton, Vice Chair
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

Representative Tom Anderson
Representative Carl Gatto
Representative Vic Kohring

COMMITTEE CALENDAR

STATE STAFFING FOR NURSES

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

CRISTY WILLER, Director
Division of Behavioral Health
Department of Health and Social Services
Juneau, Alaska
POSITION STATEMENT: Discussed API.

RON ADLER, CEO
Alaska Psychiatric Institute
Division of Behavioral Health
Department of Health and Social Services
Anchorage, Alaska
POSITION STATEMENT: Related the successes, challenges, and opportunities of API and answered questions.

ACTION NARRATIVE

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at [10:35:32 AM](#).

Representatives Wilson, Seaton, Cissna, and Gardner were present at the call to order.

State Staffing for Nurses

10:35:57 AM

CHAIR WILSON announced that the only order of business would be to review the e-mail received by Representative Seaton and discuss a course of action.

10:36:42 AM

REPRESENTATIVE SEATON explained that a personal friend of his resigned from her nursing position at the Alaska Psychiatric Institute (API). Upon her resignation, she shared her concerns regarding the situation at API, which she did in the e-mail dated June 1, 2006. The e-mail was provided to the committee. The e-mail relates that this nurse left because she felt that her license was at risk. He then recalled the discussions during the last regular session regarding mandatory overtime issues, which ultimately were found to be issues at only API.

10:41:24 AM

CHAIR WILSON requested that the department representative come forward for response.

10:42:35 AM

CRISTY WILLER, Director, Division of Behavioral Health, Department of Health and Social Services, said that her primary purpose is to introduce the CEO of API to the committee and to highlight that API falls within the Division of Behavioral Health. She then related that the report entitled, "Grading the States" from the National Alliance on Mental Illness identifies API as an example of "stellar accomplishment ... transformation in both facility and personnel development." She noted that there has been other national recognition of the quality of API.

MS. WILLER then turned to API's responsiveness to issues from the public, consumers, and patients. For example, more than 60 percent of the API governing body is comprised of consumers of psychiatric services. This group meets quarterly to review the status of the hospital and address issues that may require attention. She noted that as the division director, she sits on the governing board and thus she said she is well aware of the

issues that are discussed. Furthermore, the meetings always include a lengthy portion for consumer input. In fact, not long ago issues regarding API's grievance policy were brought forth and resulted in the formation of a subcommittee on the matter. Ms. Willer informed the committee that in September 2003, API implemented a consumer & family specialist staff position to initiate some fundamental changes in the way consumers and family members provide input directly to the API CEO and the senior management team. The API is transformative in ways beyond the new building. Of more lasting importance is the commitment to consumer planning and a changed attitude about mental illness and those who are mentally ill. The aforementioned is illustrated in the renaming of API from the Alaska Psychiatric Institute to the Alaska Recovery Center, which identifies recovery as a critical feature and expectation.

MS. WILLER related that the Division of Behavioral Health endorses the concept of transformation and in fact, the current administration has taken on the task of integrating substance abuse and mental health services under the roof of one division. She opined that API has consistently taken on the challenge to be at the forefront of these developments, as shown by their emphasis on recovery, consumer involvement, and other ideas that are part of modern health care nationally. Change isn't easy in any organization, particularly in the only state-funded psychiatric hospital. Furthermore, this change involves a change in attitude, which is often the most difficult change to make. Still, API has consistently shown leadership in accepting challenges, working with them, learning from them, and incorporating them into the way they do business, which follows the basic continuous quality improvement philosophy.

[10:51:06 AM](#)

RON ADLER, CEO, Alaska Psychiatric Institute, Division of Behavioral Health, Department of Health and Social Services, paraphrased from the following written testimony [original punctuation provided]:

Thank you for this opportunity to explain the successes, challenges and opportunities in operating Alaska's state psychiatric hospital. Since my start at API in March 2003, not a month has gone by without some reference (internal or external) to the issue of nursing salaries, mandatory overtime, nursing shortages and staff-patient safety. First and

foremost, these issues can only be understood within the context of the following facts:

(1) API-Alaska Recovery Center is Alaska's only state psychiatric hospital that exclusively treats patients under Alaska Title 47 and Title 12 Statutes. The hospital operates 24/7 and cannot refuse to accept the patient who is committed to the hospital under Title 47 or Title 12.

[10:52:27 AM](#)

MR. ADLER, in response to Representative Gardner, specified that 99.9 percent of the patients admitted to API are admitted under some type of legal status. Generally, API doesn't accept voluntary admissions.

[10:53:07 AM](#)

MR. ADLER continued:

(2) Title 47 patients, by the very nature of their serious mental illness, can be out of control, and present a danger to self or others, or be gravely disabled.

(3) There exists a national 'shortage' of qualified, Registered Nurses. Alaska is also experiencing a statewide shortage of RN's. This shortage is quite evident in the Alaska Department of Health & Social Services at API, Public Health, and Pioneer Homes. The Department of Health & Social Services employs approximately 3200 staff of which 700 are Registered Nurses. API employs about 10% of the Department's total workforce of RN's.

(4) Of all the nursing sub-specialties, psychiatric nursing remains one of the less sought-after fields for employment.

Yearly admissions to the hospital range from 1200-1452 patients per annum. For the employees at API, regardless of job classification, the days are long and the work is difficult.

[10:55:00 AM](#)

MR. ADLER, in response to Chair Wilson, explained that typically the Monday through Friday shifts are 7.5 hours while the nursing department runs 12-hour shifts on the weekends.

[10:55:17 AM](#)

MR. ADLER continued:

Although these challenges seem formidable, API has developed a national reputation for innovation and quality 'recovery-oriented' clinical services. This is largely the result of dedicated employees!!

Let's review the number of nursing issues which have surfaced through legislative testimony during the past year:

Nursing salaries: it has been well established the API nurses, as well as all nurses employed in state government, are under paid. They are due a comprehensive, market-based salary study and commensurate wage adjustment.

Nursing recruitment and retention: it has been recommended that the necessary state departments become more pro-active in the recruitment and retention of qualified nurses and that employment within the DHSS presents a variety of work opportunities in nursing.

Mandatory Overtime: regardless of the need, today's workforce does not appreciate the constraints and interference of mandatory overtime. The API Senior Management Team has made a commitment to reduce this burden on employees.

Bargaining Unit representation: it has been suggested that state government establish a Healthcare Bargaining Unit to represent Nurses and other licensed professionals as has been done in other states (testimony provided by ASHNHA and Alaska Nurses Association).

Overhaul state compensation plan: regardless of any monetary award that may be afforded to this job classification, it is well established [that] state employed nurses will again fall behind the competitive

salaries which exist in the private sector within two years.

[10:59:15 AM](#)

MR. ADLER moved on to the details of mandatory overtime, as follows:

Use of Mandatory Overtime

Mandatory overtime is used when no other staffing options are available at the time. Mandatory overtime is the last resort for staffing. If staff may be needed for mandatory overtime, the Nursing Shift Supervisor (NSS) will notify them as soon as the possibility is apparent. The NSS will keep the staff apprised of the status as the shift progresses. Staff members may be directed to remain on duty for mandatory overtime up until the end of their regular shift.

Staff doing mandatory overtime have the choice of remaining on their home unit or to another unit where staff is needed. An employee who has worked voluntary overtime of at least four hours in duration within the past 30 calendar days shall have the right to one pass per month on a mandatory overtime requirement. In the event that all employees on the mandatory overtime list decline, the Employer has the right to refuse to accept the declination by the employee.

[11:01:20 AM](#)

CHAIR WILSON surmised then that the nurses are very careful about when to pass since it's only allowed once a month.

MR. ADLER agreed, adding that the nurses are thinking about this all the time.

[11:01:53 AM](#)

REPRESENTATIVE SEATON related his understanding that API nurses work an eight-hour shift. He then inquired as to how the breaks are determined.

MR. ADLER specified that according to the bargaining unit agreements there is a morning, afternoon, and lunch break.

REPRESENTATIVE SEATON asked if an additional break is scheduled between shifts when one is forced to work mandatory overtime.

MR. ADLER said there are rules for that in the bargaining unit agreement for overtime and mandatory overtime, which he offered to provide to the committee later.

[11:03:44 AM](#)

CHAIR WILSON related that in a hospital situation one of the nurses from the outgoing shift informs the incoming shift of [the status of] each patient. She asked if something similar occurs at API.

MR. ADLER related that when he arrived at API, there was no change of shift report in the nursing department. However, there has been discussion about doing so. He reminded the committee of the situation with regard to the elimination of standby pay during the prior administration of API. After the aforementioned situation subsided, a change of shift nursing report was implemented such that every day 30 minutes of overtime was built-in for the reporting nurse to provide the detailed nursing report to the incoming nurses. He clarified that each treatment unit does such a report. In further response to Chair Wilson, Mr. Adler explained that the physician's assistants really need to remain on the floor because the change of shift is a critical time.

[11:06:59 AM](#)

REPRESENTATIVE CISSNA recalled hearing strong positives [from the] staff of API, save those in the nursing section. Therefore, she surmised that "it sounds like it's different for the nurses than it is for the rest of the staff." If that's the case, she inquired as to why. She inquired as to how API determines the number of nurses needed at any given time. She then questioned whether there is a need for more staff at API.

MR. ADLER said that he will address these points in his testimony.

[11:10:00 AM](#)

MR. ADLER continued with his testimony:

If a mandatory overtime person finds someone else to work for them this is acceptable. The name of the mandatory staff remains at the top of the Mandatory Overtime List. The volunteer cannot be someone who is also required to stay mandatory that day.

All prospective employees to the Nursing Department are advised of the necessity of mandatory overtime, the reasons for this policy, and efforts to reduce this burden on employees.

Let's be clear about this: mandatory and voluntary overtime correlates directly to the API census, acuity level and nursing staff shortage. For example, this past Fiscal Year, API recorded 1,452 admissions to the hospital, the highest admission rate since FY 2002. Utilization was exceptionally high in March 06 (155), April 06 (124), May 06 (136), June 06 (139). Although we made some progress in managing Mandatory Overtime during FY 05, usage will certainly exceed all previous years with the kind of admission rates experienced in FY 06.

Another example: on Saturday, July 22 and Sunday July 23, just two weeks ago, API admitted 16 acute care patients. In fact, the hospital was full and no other beds were available. It was almost certain we had several patients under close observation status. Under these circumstances, API has no other alternative than to exercise the use of Mandatory Overtime.

When an employee is required to work mandatory overtime, the Nursing Shift Supervisor provides a meal ticket - and by the way, we serve restaurant quality food at API. All employees are encouraged to make use of the employee lounge which has a 32" color TV, a number of desk top terminals with internet access and a full kitchen. Some employees make use of the meditation room located in the front lobby for quiet time during breaks.

MR. ADLER informed the committee that recently API submitted a draft letter of agreement requesting another way to manage some of the mandatory overtime through standby and premium policy. The draft letter conforms to state personnel regulations and policies relative to standby pay. Furthermore, it looks very

much like the methodology utilized in private hospitals. Therefore, a RN on standby pay would have a telephone number or pager for contact. At this point, API knows when such is necessary. Mr. Adler highlighted that the nurse on standby receives a monetary increment.

[11:15:53 AM](#)

MR. ADLER then continued by addressing recruitment efforts. He highlighted that API is utilizing informal networking in order to capture those nurses who are interested in pulling shifts in other hospitals.

MR. ADLER, in response to Representative Seaton, clarified that API nurses are burdened with mandatory overtime and thus aren't likely to be working in other nursing jobs. However, in other facilities nurses typically work another shift at another facility. The API would like to be positioned such that it could take advantage of those interested in shift work.

REPRESENTATIVE GARDNER inquired as to whether the API nursing staff require special training.

MR. ADLER answered that API orients [new staff].

[11:18:11 AM](#)

MR. ADLER then informed the committee that API has become a major internship site for the University of Alaska - Anchorage nursing program. He specified that every student nurse comes through API for an internship. The aforementioned is viewed as a marketing opportunity. Mr. Adler reminded the committee that about a year ago Assistant Deputy Commissioner Janet Clarke began a series of informal meetings with the director of the Division of Personnel, a new professional recruiter, Mr. Adler, and other DHSS division directors who employed nurses. The general topic was in regard to how DHSS could position itself to become more proactive and competitive in the marketplace. Although that series of informal meetings has temporarily stopped, API has moved ahead. Mr. Adler specified:

The API-Alaska Recovery Center Nursing Department, under the leadership of newly appointed Director of Nursing Sharon Bergstedt, held a special 'Open House' for registered nurses in the greater Anchorage area on June 29, 2006, from 4:00 - 9:00 PM.

The event, which was advertised in the Anchorage Daily News as well as via a direct mail brochure, targeted RNs, LPNs, and ANPs. The result: over 49 licensed professionals came into the hospital for a tour and inquired about employment opportunities. This event is scheduled to be repeated in October, 2006. As of this moment, the Director of Nursing continues to receive phone calls regarding job openings.

MR. ADLER informed the committee that API has a new assistant director of nursing with over 20 years experience in psychiatric nursing. He opined that the new assistant director will add additional energy to the nurse recruitment process. He then turned to the current nursing vacancy report and related that the nursing administration has had a difficult time over the past nine months as it has experienced significant retirement, including the previous director of nursing, two nursing unit managers, one nursing shift supervisor, and a nursing health educator. He highlighted that it's difficult for nurses to consider employment at a hospital when the nursing management team isn't present to support the nurses. However, as of this week, API only has one vacancy left in nursing administration and interviews for that position are occurring this week. Mr. Adler specified that on January 24, 2006, when he provided testimony before this committee, API had 20 vacancies out of 58 direct-line nursing positions. As of this date, there are only 10 vacancies. If the increment in the governor's budget is maintained by the legislature, there will be interest [in the vacant positions at API].

[11:23:33 AM](#)

MR. ADLER paraphrased from the following written comments: "In summary, API can report substantial progress in filling numerous vacancies in Nursing Administration. With a fresh approach to recruitment, and the widely anticipated wage increment, it is expected that filling RN staff vacancies will be as successful."

[11:23:55 AM](#)

REPRESENTATIVE SEATON asked if the 10 vacancies are filled with RNs.

MR. ADLER replied no, and specified that 20 of 58 are staff RN positions, which is the RN I/II flex position. Those 20 positions include the on-call, full-time, and permanent part-time positions.

11:24:42 AM

MR. ADLER, in response to Chair Wilson, related that API is very competitive with its salaries for psychiatric nursing assistants (PNAs). Furthermore, API seems to have an adequate supply of PNAs. He then informed the committee that when the census increases, the PNA position requires an extraordinary amount of additional help in API. If the API units aren't larger than 25 patients, then two RNs or the combination of an RN and LPN can adequately handle the duties.

11:25:40 AM

MR. ADLER continued to address nursing salaries and paraphrased from the following written testimony:

Nursing Salaries

API Nurses, as well as all RNs in the DHSS were awarded a 7.5 % increment effective July 1, 2006, which they have yet to see materialize.

Dept. of Administration conducted the market based study on the nurses salary and expects to have the findings finalized at the end of July (which is today!), with the recommendations for the official range.

If they recommend a 1 range increase we have funding for the year; if it is 2 ranges we'll have to request additional funding.

In any event, any monetary award will be retroactive to July 1, 2006.

MR. ADLER then suggested that committee members put themselves in the shoes of the nurse who wrote the e-mail in regard to the lack of the salary increase materializing. The aforementioned is becoming a morale issue at API.

11:27:27 AM

MR. ADLER moved on to discuss LPNs and advanced nurse practitioners (ANPs). He paraphrased from the following written testimony:

LPNs and ANPs

These abbreviations stand for Licensed Practical Nurse and Advanced Nurse Practitioner. The accreditation standard relative to the deployment of RNs in a psychiatric hospital requires API to staff each shift and Treatment Unit with a Registered Nurse. On the larger Units, API attempts to have 2 RNs on each shift, however, with staffing shortages, this is difficult to maintain.

It has become standard practice in the industry to pair an LPN with an RN to accommodate the clinical needs of psychiatric patients on larger units. API has moved in this direction as one possible solution to ease the burden of mandatory overtime.

MR. ADLER explained that LPNs can't perform all of the functions that RNs can. He related that LPNs can pass medication, provide nursing care relative to the scope of their practice. However, LPNs can't perform a comprehensive nursing assessment. Furthermore, LPNs don't have access to the medication carts. Still, LPNs are being used in both private and state facilities. Similarly, the industry has effectively utilized an advanced nurse practitioner to enhance the medical staff of an inpatient unit. He explained that ANPs have prescriptive authority and are used in two areas of API. The medical officer has two mid-level practitioners working for her because each admitted patient must have a history and physical performed within 24 hours. Therefore, API plans special weekend coverage in order to cover those times when there are 16 admissions. He informed the committee that API medical staff decided to create a psychiatric advanced nurse practitioner who reports to and is supervised by the medical director of the hospital. Mr. Adler said he was reasonably pleased with the outcome and is likely to recruit for such a position again. These, he opined, are viable alternatives. In fact, he further opined that ANPs bring something to the table that biologically trained psychologist don't, which he specified is the holistic approach to treatment.

[11:32:37 AM](#)

MR. ADLER, in response to Representative Cissna, confirmed that LPNs are the lowest level of licensed individual. In further response to Representative Cissna, Mr. Adler confirmed that PNAs, who aren't licensed, can help with lifting and such.

[11:33:31 AM](#)

MR. ADLER continued by paraphrasing from the following written testimony:

Communication between API Nurses and Nursing Administration

In September 2004, Nursing Administration implemented a plan to communicate directly with staff RNs. Since this date, the hospital has consistently held a monthly meeting for registered nurses. API nurses construct the agenda and the meetings have been regarded as successful and beneficial to both nurses and Nursing Administration. New initiatives, changes in policy and procedures are discussed in detail.

API will also present a regularly scheduled CEO update which is recorded and employees may watch the meeting on desk top computers in the hospital.

[11:35:31 AM](#)

MR. ADLER moved on to the realignment of patient treatment units and paraphrased from the following written testimony:

Realignment of Patient Treatment Units

For a number of years, API operated an admitting unit and one adult acute unit. The admitting unit was the point of entry for patients coming into the Hospital. On this unit the patients were seen by a psychiatrist and multi-disciplinary treatment team for an evaluation and treatment planning. If the patient responded quickly to treatment he or she might have been discharged in 2 or 3 days. If, however, the individual required longer and more intensive treatment, as the majority of patients do, that individual would then have been transferred to the acute adult unit. Here the patient would be required to meet a new clinician and treatment team, become acquainted with a whole new unit and staff, and repeat their history again. This process required at least a day for the individual to settle in and begin treatment on the new unit.

After API occupied its new building last July, it became apparent for a number of reasons that the admitting unit was not an effective or efficient part

of patient flow. Feedback from API professional staff indicated that having patients transfer from one unit to another to complete treatment was the cause of redundant and time-consuming evaluations. It was felt that it not only slowed down the treatment process, but it did not allow for continuity of care to be delivered by one provider during a hospitalization. Additionally, it was observed that the process of transferring a patient from one unit to another increased the opportunity for communication errors and this was seen as a potential safety hazard.

MR. ADLER mentioned that over the last three-and-a-half years the implementation of the single point of entry with the Providence psych emergency room has helped API's ability to decrease reliance on an admissions and screening unit. The belief is that those patients entering API with the screening can proceed to a treatment unit and have one doctor and treatment team for the duration of that patient's treatment. He then continued paraphrasing from the following written testimony:

Based upon these observations and concerns expressed by staff and consumer advocacy groups, the decision was made to re-organize and have two acute adult admitting units. Patients would be admitted to the care of a clinician and treatment team and remain there for their entire hospitalization. Additionally, API policies and procedures were changed to allow for patients that required re-hospitalization within a 6 month period following discharge to do so with the treatment team and clinician that treated them last. This was seen as yet another move to improve continuity of care, efficiency, and safety for API patients.

MR. ADLER, referring to Representative Cissna's earlier questions, pointed out that API's well-documented database illustrates that one-third of its discharged patients return to the hospital within six months. The aforementioned is also relevant to the continuity of care concept and notion of patients returning to the doctor and team that treated them during their last episode of care.

[11:40:00 AM](#)

MR. ADLER then recalled last legislative session when HB 343 was passed. He pointed out that many API employees are subject to verbal abuse, spitting, stalking, and assaultive behavior. The aforementioned can occur with patients who are gravely disabled and don't realize what they are doing. However, such abusive and assaultive behavior is from patients with very severe characterological disorders. The staff has never had recourse. In fact, when the Anchorage Police Department (APD) has been called, APD would come and take a report. The ultimate result was APD saying that the abusive patient is in the right place. However, in many other states licensed health care professionals are generally protected by some law. Therefore, HB 343 is viewed as protection for API employees and is welcomed by API staff. Currently, API is writing a policy and procedure to address this.

[11:41:46 AM](#)

REPRESENTATIVE SEATON surmised then that the e-mail is correct in that the patient isn't held accountable for his/her behavior when law enforcement are called. Therefore, there isn't any basic assault protection for the nurses.

MR. ADLER replied yes.

[11:42:28 AM](#)

MR. ADLER continued with his testimony, and informed the committee that API has a well-documented quality improvement program. Furthermore, API tracks various things occurring in the hospital such as medication errors, slips and falls, assaults, patient injuries, and staff injuries. All of the aforementioned is documented on the unusual occurrence report (UOR). He related that generally when a UOR is submitted, the immediate supervisor has to investigate the situation and the information is entered into a database. The UOR is used as a source of feedback and the database in which the information is entered is used to track how the hospital is managing. He noted that some staff view the UOR as an adversarial report placing management against line staff. However, the UOR provides critical information and is exactly what the joint commission wants to see during the accreditation process because it wants to be sure that data-driven management decisions are being made for the hospital and its patients.

[11:45:40 AM](#)

REPRESENTATIVE CISSNA recalled her college years in the early 1960s when there was much discussion regarding closing institutions and moving toward outpatient community care for the long-term mentally ill patients. Some of the things brought up today are reminiscent of the behaviors and feelings individuals experience when they are institutionalized. However, currently there are homeless camps filled with mentally ill individuals who don't come to API for help. She questioned how much of this [problem] is a nursing problem and how much of this is the lack of ability to address mental health care. She questioned whether there is the need to get more out of institutional care while having a network that is fully capable and without a lot of holes. "Our system has enormous holes ... and I think we're paying a price for that." she opined.

[11:48:27 AM](#)

CHAIR WILSON commented that there are certain individuals who, no matter what's available, make the rounds. She attributed the aforementioned to why the number of beds was ratcheted down in API.

[11:48:51 AM](#)

MR. ADLER related that the commissioner's office is doing much in analyzing needs. He then recalled back when outreach teams were funded.

MS. WILLER agreed with Representative Cissna. She then specified that the objective of downsizing the beds at API was to include and compliment the community mental health network to allow receipt of services closer to home in order to eliminate negative responses to institutionalization. She commented that much of the pressures on API are occurring because of [Alaska's] system of care needing more work in the outlying areas.

[11:51:03 AM](#)

REPRESENTATIVE SEATON highlighted the e-mail reference to most staff working at least one mandatory overtime per week. He asked if there is any data with regard to how much overtime a week is worked. He then inquired as to the incidence of mandatory overtime during the higher vacancy rate at API as compared to the current lower vacancy rate.

MR. ADLER offered to provide the committee with the raw data and an analysis. From anecdotal observations, Mr. Adler opined that

the mandatory overtime rates remain high, which he attributed to the unlimited vacation time. He identified one solution as capping vacation leave for each individual to two week annual leaves. However, he recognized that state employees generally accumulate more than 10-14 days of annual leave. Mr. Adler then related his belief that the nursing department works hard and if a nurse has the ability to take three weeks annual because of a special event, then that should be accommodated. Therefore, there needs to be a system such that not all of the most qualified [nurses] are on leave at the same time.

[11:53:32 AM](#)

REPRESENTATIVE SEATON related his belief that four of the five issues discussed by Mr. Adler appear to deal with wages. He noted that the other issues are mandatory overtime and retention. However, the e-mail doesn't seem to relate concerns with regard to wages and thus Representative Seaton expressed the need to focus on other aspects of a nursing job at API that caused a very qualified nurse to leave the system. He asked if Mr. Adler would believe that API will be fully staffed with RNs in the next months.

MR. ADLER replied yes, API will continue to make progress in that area. He related that RNs view themselves as professionals and they like training. However, the health educator position in charge of hospital training has been vacant for some time and is an issue. Many licensed professionals, he opined, feel that the hospital has let them down with regard to ongoing continuing education.

[11:57:36 AM](#)

MR. ADLER, in response to Representative Seaton, specified that continuing education for nurses is paid time. In further response to Representative Seaton, Mr. Adler explained that continuing education is scheduled such that the nurses come to the classroom in the hospital while another RN would be scheduled to cover that time as part of his/her normal work week. He remarked that [continuing education] is an area that needs work at API. In response to Chair Wilson, Mr. Adler confirmed that although the health educator position has been vacant, nurses have received training from nursing administrators with competency in a certain area.

[11:59:40 AM](#)

REPRESENTATIVE CISSNA asked if API performs exit reviews when employees give notice.

MR. ADLER replied yes, and noted that it's documented through the Director of Nurses Office. He related that the e-mail reads almost verbatim to that nurse's exit interview. The information from exit interviews are reviewed for possible improvements, he mentioned.

[12:00:18 PM](#)

REPRESENTATIVE CISSNA returned to the notion of utilizing community-based treatment options. She asked if there has been any cost-benefit analysis to determine the cost of treatment in a hospital versus in a community-based treatment option.

[12:02:37 PM](#)

REPRESENTATIVE SEATON referred to the portion of the e-mail regarding the nurse's inability to note on a patient's chart that a patient is on suicide watch because there isn't adequate staff to supervise such a patient. He inquired as to how such a circumstance has been addressed.

MR. ADLER noted that the aforementioned portion of the e-mail wasn't included in the exit review. He explained that the normal protocol for an RN is to notify the nursing shift supervisor, who is the de facto executive of the hospital after 5:00 p.m. and is responsible for staffing and other leadership responsibilities. Under no circumstances would the hospital compromise the close observation status policy and procedure. There are documented occasions in which the nursing shift supervisor comes onto the floor to provide close observation until an additional staff person arrives. Mr. Adler said that he wasn't aware of the situation related in the e-mail and if it had been documented in a UOR it would've been investigated. He noted that he signs every UOR every day and thus is aware of every safety concern in the hospital.

[12:05:01 PM](#)

REPRESENTATIVE SEATON presumed now that Mr. Adler is aware of the situation related in the e-mail, he will speak with the physician about it.

MR. ADLER said that he will request the safety officer to run a cross check on all the UORs submitted by this employee in order

to determine whether a UOR was documented on the matter. If a UOR did document the matter, then he will review who performed the investigation and the outcome. Mr. Adler then informed the committee that the director of nursing, the hospital CEO, and the medical director participate in morning report on each patient every morning. At the same time, all UORs within the last 24 hours are reviewed. If the situation was reported in a UOR, it would've been addressed with the physician at that time. Mr. Adler then pointed out that the doctor referred to in the e-mail is a locum tenens physician, rent a physician, which are in use due to the almost 100 percent turnover with medical staff over the past few years. He opined that such a situation wouldn't happen with any of API's permanent full-time staff psychiatrists.

CHAIR WILSON related her experience with suicidal patients and emphasized the need to review the particular situation related in the e-mail.

[12:08:29 PM](#)

CHAIR WILSON turned attention to the e-mail's reference to the feeling of the lack of appreciation, which she said could easily be addressed.

REPRESENTATIVE SEATON, recalling a portion of the e-mail, asked if it's correct that physicians at API have lockers but nurses don't.

MR. ADLER replied yes, noting that he isn't sure why. He further noted that was the design of the new facility before he arrived. Once the issue was raised, there were attempts to address the issue. However, there isn't enough square footage to make changes at this point.

CHAIR WILSON opined that the space could be found somewhere.

MR. ADLER said he was putting the locker issue on his to do list.

[12:12:03 PM](#)

CHAIR WILSON highlighted the e-mail's reference to the assignment of treatment teams based on whose turn it is rather than based on the patient's needs.

MR. ADLER explained that API follows a rotating assignment that is established in policy and procedure. If a patient and/or treating physician believe the patient should be reassigned, it has to go through the medical director. The medical staff, he related, insist upon such.

CHAIR WILSON posed a situation in which the cycle is such that a PA is to provide treatment. However, the patient's insurance doesn't cover treatment by a PA.

MR. ADLER answered that during the normal work week, the medical director would handle such a situation. Treatment assignments aren't changed during weekends or holidays. If there was a reason, whether clinically or financially, for a reassignment, it would occur. Mr. Adler then related:

I have to be very honest with you, it's much easier ... for me to operate the hospital within the Department of Health and Social Services if we're increasing our revenue every year. And there are ... certain customer bases in Anchorage that come our way because ... those facilities don't support their own free standing psychiatric units. The two bases are very good examples of that. They ... exclusively use API and I don't believe it's the right thing to offset public dollars when third party revenue is available. ... I have very strong feelings about that and very strong management style about it. So, we ... do take that under consideration.

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REPRESENTATIVE SEATON related his understanding that the military requires a standard of care such that there is a physician supervisor on the treatment team and private insurance has a certain standard of care. However, the treatment team is assigned on a random basis. Therefore, Representative Seaton expressed concern that the state would be held liable if something happens.

MR. ADLER began by relating that API is classified as an institution for mental diseases (IMD), a classification which prohibits API from billing Medicaid for patients between the age of 22 and 64. He then informed the committee that the third-party population at API is very small, only 1-2 percent. Furthermore, whether the ANP is working for the medical officer performing history and physicals or working under the direction

of the medical director, that clinical work is peer reviewed on an ongoing basis. In fact, ANPs are in regularly established clinical supervision with the physician provider. Therefore, Mr. Adler said that he doesn't believe ANPs provide a lower standard of care. Moreover, state risk management knows of the use of ANPs in this manner, which is standard operating procedure in many other hospitals.

CHAIR WILSON noted her agreement that just because an APN provides the care, it doesn't mean the standard of care is different than it would be under a physician. The situation is created by the insurance company determining what standard of care it will cover.

MR. ADLER informed the committee that [the procedure with the ANPs] is written within the bylaws of API. The medical staff of a joint commission accredited hospital oversees the clinical operations. If the joint commission determines that the hospital isn't meeting a clinical standard, then medical staff meeting minutes are reviewed to determine whether there were changes approved by the medical staff. The medical staff insists that the mid-level practitioner has ongoing supervision and peer review by a licensed physician.

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REPRESENTATIVE SEATON referred to the e-mail and the nurse's observations that physicians tended to choose more aggressive treatment and have better results than ANPs. The aforementioned, he opined, seems to indicate a difference in the standard of care. Therefore, he expressed the need for Mr. Adler to determine whether there is a difference in the standard of care when it's an ANP versus a physician.

MR. ADLER related his understanding that the nurse who penned the e-mail is referring to the aggressiveness of the licensed provider in medicating patients, which is a point of contention in the industry. Mr. Adler explained that some physicians want to place patients on the maximum dosage right away, which may come at the risk of the individual experiencing side effects some of which may be profound. However, some physicians place patients on a slow uptake with medication. Mr. Adler said that the nurse practitioner referred to in the e-mail took a holistic approach to treatment and often ordered counseling and psychotherapy in addition to medication management. Therefore, Mr. Adler opined that it's more a matter of style and a practice

pattern than a standard. He further opined that there's a place for both.

MR. ADLER informed the committee that API has taken a treatment approach that recognizes that if patients don't meet the criteria for forced medication, it's the patient's right to determine how and when and how much medication he/she will take. Furthermore, there's a seductive process in working with patients who have an illness that tell them not to trust providers. Part of that process is building the trust and orienting to classroom activities that relate to wellness and disease management in order that they understand the real concepts of recovery. The aforementioned seems to be the approach followed by the ANP referenced in the e-mail. Mr. Adler acknowledged that such a treatment approach may result in a longer stay in API. However, if patients agree to be the authors of their own treatment and recovery plans and the hospital can demonstrate that the right combination of treatments can work, then people may come into the hospital less often.

REPRESENTATIVE SEATON said he is fine if it's the standard of practice and the medication rate of the supervising physician. However, if the ANP is utilizing a standard of care that's not within the supervising physicians' standard of care, then it's problematic. He indicated his belief that the aforementioned is what the e-mail seems to relate.

MR. ADLER offered to research and provide to the committee the position description of an ANP and the medical staff bylaws. In response to Chair Wilson, Mr. Adler specified that API employs seven physicians and two ANPs, one of which is functioning as a replacement for one of API's vacant physician positions. He stated that API hasn't had positive experiences with locum tenens physicians.

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REPRESENTATIVE CISSNA opined that there is artistry in providing human services and just because physicians have a degree doesn't necessarily mean that they will always heal. She indicated that she likes the notion of different perspectives and allowing people having a say in their treatment. She then asked if API is doing any longitudinal research on the outcomes of the different therapeutic programs and styles of care.

MR. ADLER pointed out that API doesn't have the research department to review such. However, it's certain that people need choices, which is what API tries to provide. He informed the committee that API's consumer and family specialist performs an exit exam of every patient with regard to patient safety, dignity and respect, and satisfaction with services. The aforementioned is reported into the research component of a national database. Furthermore, it's mandatory that API report seclusion and restraint data.

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REPRESENTATIVE CISSNA asked if the aforementioned database tracks the quantity of psychotropic drugs.

MR. ADLER replied no, but added that API is tracking the amount of court-ordered forced medication orders per month. He explained that API doesn't care whether a patient is on medication or not but rather if his/her symptoms are reduced. It seems that the courts agree with this philosophy as evidenced by changes to its statutes on this issue. Over the past three years, he related, API has reduced forced medication issues by two-thirds. The aforementioned is a dramatic reduction. He mentioned that pharmacists are requesting pharmacological studies of medication, but API isn't funded to do so and moves beyond API's core mission.

MS. WILLER informed the committee that for non-hospitalized psychiatric, mentally ill, and substance abusing clients, there is an outcome measure instrument referred to as the client status review. At entry and exit clients are asked questions about nine different life domain variables, including interactions with emergency rooms, police, and family supports. This has been a very useful tool that provides information related to the good API is doing by diagnosis, problem, region, and type of client. She noted that there has been discussion with regard to expanding the aforementioned to include psychiatric patients.

MR. ADLER related that API tracks medication errors and slips and falls, and has infection control benchmarks.

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CHAIR WILSON requested that Mr. Adler address the charge that there is no safe place at API to place violent patients.

MR. ADLER pointed out that the Taku Unit is a medium security forensic unit that has very skilled staff for managing patients with criminal behavior and those who are assaultive. The Taku Unit is often used as a behavior modification unit. However, he noted that the Taku Unit isn't expressly reserved for competency restoration and evaluations. In further response to Chair Wilson, Mr. Alder explained that if there is a problem with [a violent patient] during the night shift, staff should contact the nursing shift supervisor who calls the physician on-call who can make decisions related to patient and employee safety. He highlighted that both patients and staff are at risk in a violent situation.

CHAIR WILSON requested that Mr. Adler address the assertion that patients [of varying and different levels of illness] are mixed together in one unit under one program.

MR. ADLER indicated that it would be great to have different categories of illness in separate units, but it isn't how it works in the industry. The challenge is to individualize treatment within a heterogeneous population, particularly with acute patients. He agreed that the situation is frustrating.

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CHAIR WILSON referred to the e-mail's reference to the lack of information being shared with [nurses] in a constructive manner. Chair Wilson indicated that perhaps there could be improvements within this area.

MR. ADLER commented that there is no question that the nurse who penned the e-mail is a quality individual. However, there seems to be a communication gap for which he has some of the responsibility, he said.

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CHAIR WILSON recalled Mr. Adler's comments regarding providing extra staff and she highlighted the benefit of it, especially for the night shift.

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REPRESENTATIVE SEATON related his understanding that Mr. Adler will provide the committee with the number of mandatory overtime hours worked.

MR. ADLER reviewed that the committee had asked for the following: the rules for breaks on mandatory overtime; a comprehensive breakdown of mandatory overtime by month, staff, and shift; ways that nurse appreciation is achieved; issues and hospital policy related to suicidal patients; lockers for nurses; position description and medical staff bylaws for ANPs; review of all issues being benchmarked; and the plan to add an on-call nurse.

REPRESENTATIVE SEATON asked if Mr. Adler could provide the committee with the number of nurses that leave per month in order to address retention and how many positions are filled with permanent or temporary employees.

REPRESENTATIVE CISSNA inquired as to whether there have been conversations regarding the least restrictive care alternatives. She explained that during the construction of API, she promised that API [and the funds it receives] would be reviewed in order to ensure that community care institutions aren't hurt. Therefore, she surmised that there must be ways in which to reduce the number of admissions through alternative community placements.

CHAIR WILSON inquired as to the ages of patients at API.

MR. ADLER answered that API has a teenage unit that treats adolescents between the ages of 13-17. At age 18, the individual has to move on to an adult unit. In state, children are treated at the Northstar Unit.

CHAIR WILSON requested that Mr. Adler let the committee know of anything that the legislature can do to help.

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ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at [12:54:07 PM](#).