

**ALASKA STATE LEGISLATURE**  
**HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**

March 7, 2019

3:02 p.m.

**MEMBERS PRESENT**

Representative Ivy Spohnholz, Co-Chair  
Representative Tiffany Zulkosky, Co-Chair  
Representative Matt Claman  
Representative Harriet Drummond  
Representative Geran Tarr  
Representative Sharon Jackson  
Representative Lance Pruitt

**MEMBERS ABSENT**

All members present

**OTHER LEGISLATORS PRESENT**

Representative Andy Josephson  
Representative Dan Ortiz

**COMMITTEE CALENDAR**

PRESENTATION: ALASKA PSYCHIATRIC INSTITUTE

- HEARD

PRESENTATION: WELLPATH RECOVERY SOLUTIONS

- HEARD

**PREVIOUS COMMITTEE ACTION**

No previous action to record

**WITNESS REGISTER**

ALBERT WALL, Deputy Commissioner  
Office of the Commissioner  
Department of Health and Social Services  
Juneau, Alaska

**POSITION STATEMENT:** Presented a PowerPoint titled "Alaska Psychiatric Institute."

JEREMY BARR, President  
WellPath Recovery Solutions  
Nashville, Tennessee

**POSITION STATEMENT:** Presented a PowerPoint titled "Wellpath Recovery Solutions."

DR. KEVIN ANN HUCKSHORN, Senior Consultant  
Wellpath Recovery Solutions  
Nashville, Tennessee

**POSITION STATEMENT:** Presented a PowerPoint titled "Wellpath Recovery Solutions."

#### **ACTION NARRATIVE**

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**CO-CHAIR TIFFANY ZULKOSKY** called the House Health and Social Services Standing Committee meeting to order at 3:02 p.m. Representatives Zulkosky, Spohnholz, Pruitt, Tarr, Claman, Drummond, and Jackson were present at the call to order. Also, in attendance were Representatives Josephson and Ortiz.

#### **PRESENTATION: ALASKA PSYCHIATRIC INSTITUTE**

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**CO-CHAIR ZULKOSKY** announced that the first order of business would be a presentation on the Alaska Psychiatric Institute.

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The committee took a brief at-ease.

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**ALBERT WALL**, Deputy Commissioner, Office of the Commissioner, Department of Health and Social Services, presented a Power Point titled "Alaska Psychiatric Institute." He reported that upon appointment to Department of Health and Social Services both he and Commissioner Crum were aware that there were extenuating circumstances at the Alaska Psychiatric Institute (API), which he described as "difficult." He added that "there was a lack of open beds, lack of staffing, and there were safety and security issues including the issue of restraint and seclusion." He opined that, at the outset, neither he nor Commissioner Crum were aware for the severity of the problems. He pointed specifically to the "timeline of certification and

survey process for plans of correction." He reported finding several critical issues at API, and he shared slide 2, titled "Critical Issues at the Alaska Psychiatric Institute." These issues included staff and patient safety, inability to fulfill its mission, pending legal issues with extreme risk of high cost to the state, and the ethical treatment of Alaskans.

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MR. WALL introduced slide 3, titled "Regulatory Relationships," which depicted an overview of the regulatory authorities at API. He pointed to Professional Licensing, noting that the requirements changed for each type of profession and each had its own licensing requirements which delineated what could and could not be done for health care. He noted that each of the remaining regulatory bodies were outside the organization, looking in at conditions in the hospital.

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MR. WALL introduced slide 4, "Occupational Safety and Health Administration," reporting that this was a Federal agency that sets and enforces protective workplace safety and health standards, and that it may levy fines on agencies not in compliance. He referenced a report that the department had received from OSHA (Occupational Safety and Health Administration) which declared that API was an unsafe workplace.

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MR. WALL moved on to slide 5, "Alaska Ombudsman," and explained that among the many services provided, this agency investigates complaints that involve state agencies and determines appropriate remedies. The Alaska Ombudsman had initiated an investigation in July of 2018 and the final report of findings was given to the Department of Health and Social Services yesterday [March 6, 2019] evening.

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MR. WALL addressed slide 6, "The Joint Commission," and explained that this was a national, not-for-profit accrediting organization for nearly 21,000 health care organizations. It provides peer-to-peer standards for members, offers joint evaluations, and holds and certifies each member to professional standards. He added that the commission could also be an agent for the Centers for Medicaid and Medicare Services and may act

in their stead to inform on deficiencies in organizations. He added that API was currently under a plan of correction with the Centers for Medicaid and Medicare Services.

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MR. WALL presented slide 7, "Health Facilities Licensing and Certification," which read: "To operate in Alaska, a hospital must be licensed by the state under AS 47.32. The Department sets standards and requirements for licensure (through state regulations). If API does not maintain state licensure, it cannot operate."

CO-CHAIR SPOHNHOLZ asked if any hospital in Alaska had lost its license.

MR. WALL replied that he would find out and "I can get it to you."

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MR. WALL directed attention to slide 8, "Centers for Medicare and Medicaid Services." He added that, as Medicaid evolved out of the Medicare law, Medicare itself was the "key to all federal funding, it's all tied up in the same statute federally." He stated that CMS (Centers for Medicare and Medicaid Services) provided oversight for health care services and controlled all federal funding to all facilities and providers throughout the nation. He reported that API received approximately \$23 million annually in federal funding, dependent on how much Medicaid was billed each year. API must meet federal requirements to receive funding and meet Conditions of Participation (CoPs) (certification of compliance with the health and safety requirements). If these conditions are not met, the certification would be withdrawn and there would not be the use of any federal funds. He pointed out that there were several surveys at every facility through CMS, and that some of these were triggered by complaints filed for issues at the facility, or by a report of harm or a report of an incident which was required to be reported to a CMS authority. He noted that some of these surveys were on a routine basis to ensure compliance with the rules and regulations.

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MR. WALL moved on to slide 9, "Conditions of Participation for federal funding." He stated that API must be in "substantial"

compliance with each Condition of Participation, which was a little bit different for each type of facility. If a hospital is not in substantial compliance and does not correct by the deadline, CMS will de-certify the hospital and terminate its participation in Medicare and Medicaid.

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MR. WALL presented slide 10, "Types of Citations," and explained the three types of citations that could be issued in a survey, although each of these three consisted of hundreds of individual types of deficiencies: standard level deficiency, which was out of compliance with a specific regulation that could usually be easily fixed; condition level deficiency, which was very serious, as the facility would be found to be not in compliance with its CoP, although this was fixable through a plan of correction in an ongoing fashion; and finally, immediate jeopardy, which was deviation from regulatory standards and was an immediate threat to patient health and safety, including life or limb, or a humanitarian issue. He labeled immediate jeopardy as a "showstopper" which could lead to an immediate shutdown of a facility if it was not immediately dealt with in a manner satisfactory to the survey team.

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MR. WALL directed attention to slide 11, "Immediate Jeopardy," which was defined by the CMS State Operations Manual as "[a] situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident."

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MR. WALL shared slide 12, "Plans of Correction," and stated that these plans start as a negotiation with CMS after their survey and findings are presented to the hospital. Although the Hospital has 10 calendar days to provide an acceptable Plan of Correction for each cited deficiency, the plan may not be accepted initially by CMS. If the hospital doesn't come into compliance by the deadline, the state agency certifies "noncompliance." He explained that the first plan of correction had 90 days, with a subsequent re-survey to determine substantial compliance. If still not in compliance, this was extended an additional 90 days. The hospital would be out of time after 180 days, and there were not any more extensions.

CO-CHAIR SPOHNHOLZ asked about the date for the event which initiated the Plan of Correction for API.

MR. WALL, in response, explained that every time there was a survey team which found a deficiency, a plan of correction was written. He stated that, currently, API was under many plans of correction, with the latest being on January 29. He pointed out that API was still working on plans of correction from previous visits. He added that plans of correction could have multiple dates, as they were working from multiple survey dates.

CO-CHAIR SPOHNHOLZ asked if it was "fairly common that there is an issue that's been identified that a plan of correction is requested and then you provide the plan of correction and then there's routine follow-up just to make sure that you're actually implementing."

MR. WALL replied that was correct.

CO-CHAIR SPOHNHOLZ asked if this was typical and happened with fair frequency.

MR. WALL replied that it depended on the level of deficiency. He reported that API had a survey team from a regulatory body engaged in a high level of scrutiny and involvement in the building almost every other week for the previous 8 - 9 months.

MR. WALL moved on to slide 13, "API Plans of Correction." He reported that the 180-day timeline mark for API compliance on a Plan of Correction had been passed on November 26. He pointed out that there was not a plan of correction that had been accepted by the federal government for the July survey, noting that the July survey had been on the day of the earthquake, resulting in a state of emergency. Consequently, API had been granted another extension which expired on February 1.

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CO-CHAIR SPOHNHOLZ asked if Mr. Wall was discussing the CMS citations dated July 19, and the Plan of Correction in response to this citation.

MR. WALL suggested that this was correct. He added that a Plan of Correction was a dialogue between the agency and the government, and he offered his understanding that, as of that date, there was not a plan to which both sides agreed. He clarified that this did not mean that work was not being done to

come into compliance with the issues or to mitigate the deficiencies. It only meant that the documentation had not been accepted.

CO-CHAIR SPOHNHOLZ reported that she had reviewed a series of survey citation reports in which the former director, Duane Mays, had responded to CMS. She noted that these documents had been dated and signed on September 17, 2018, most of which were due to be completed in November. She asked if Mr. Wall was indicating that there had not been any progress on any of these.

MR. WALL replied that, although work was being done, the finalized version of the plan of correction had not been agreed upon by both sides.

REPRESENTATIVE SPOHNHOLZ asked to ensure that work was in progress, and it was not as if the issues had been identified but no work had been done.

MR. WALL expressed his agreement that work had been done. He relayed that it was necessary to have an accepted plan of correction and then show substantial compliance with that plan by the time the survey team returned. He offered an example from the previous administration in which the plan of correction had taken a long while to put together and, as the date for return of the survey team "was looming," there was less of a chance for showing substantial compliance. He offered an example for the difficulty of scheduling new staff training while still maintaining full staffing during work shifts.

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MR. WALL moved on to slide 14, "Seclusion & Restraint," adding that this was a specific problem resulting in numerous citations for API and had been the bulk of the findings in the survey prior to January 29. He stated that seclusion and restraint was a difficult and tenuous issue in psychiatric care. He explained that some patients, admitted civilly under Title 47, were a danger to themselves or others. This could result in seclusion and restraint through a court issuance which could only last for a short period of time and only for emergent self-protection. He added that other patients, admitted criminally under Title 12, had been evaluated for restorative care for purposes of competency to stand trial for the crime to which they had been charged. He noted that these patients could be dangerous. Seclusion and restraint were a reality for in-patient psychiatric care, although it was "a difficult line to walk."

He reported that API had a much higher rate of seclusion and restraint than was accepted in the field, noting that many examples had been posted for instances when it possibly should not have been occurred, especially for the length of time.

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CO-CHAIR SPOHNHOLZ asked about the high seclusion and restraint rates and how they compared to the national standard.

MR. WALL replied that these charts were posted on the website with a monthly standardized report showing the API rates compared to the national average.

CO-CHAIR SPOHNHOLZ mused that API did appear "a little bit high" and in "other areas we're kind of in the middle." She asked what was the concrete benchmark, and where was API in actuality. She pointed out occasional spikes in the chart, noting that one challenging patient could be the cause. She asked to better understand what the normal standard was and why it would be occasionally higher. She asked what the committee should be aware of regarding performance metrics.

MR. WALL replied that this was "both a blend of the rate of incidence and the actual incidents itself and whether or not it was appropriate to restrain them." He said that the big problem resulting from the surveys was the individual instances of seclusion deemed to be inappropriate and outside the standard. He allowed that there could be an indication for how well the institution was doing with issues of violence, aggression, and de-escalation by comparison to the rate on the charts. He pointed out that the individualized case studies with video feedback indicated what had occurred and whether the response was appropriate.

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CO-CHAIR SPOHNHOLZ pointed out that, as safety and seclusion and restraint problems were some of the rationales for initiating a very controversial approach to changing the operations at API, it would be helpful for the committee to be presented with more concrete specifics for absolute appropriates and how API had deviated from this norm.

MR. WALL replied that the reports and survey findings on the website shared very specific actions for what happened and what should have happened. Each finding cited where the action had

gone outside the regulatory standard for that instance. He explained that it was difficult, as each instance was weighed, and each may have failed in a different regard to the standard.

REPRESENTATIVE SPOHNHOLZ asked for a link to that report.

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REPRESENTATIVE JACKSON directed attention to slide 14, which noted the right to be free from physical or mental abuse and corporal punishment, as well as to be free from restraint or seclusion, and asked about the employee options when dealing with a patient acting out. She questioned whether the employee could be put in danger without having these options.

MR. WALL expressed his agreement with this dilemma. He shared that it was very difficult to work with patients at this acuity level, as they could be dangerous. He said that the primary training was based on de-escalation, adding that the training used at API was the Mandt System. He read from slide 15, titled "Seclusion & Restraint at API": "Since 2011, there have been seven separate independent reports indicating API uses seclusion and restraint inappropriately and/or excessively." He pointed out that this combination caused the problem in specific incidences. He shared an example of an individual who was ill, with symptoms of occasional violence. He pointed out that a vindictive response, using restraint as a punishment, was not the correct way to deal with the patient. He read further from slide 15: "Since 2017, API has been cited at least seven separate times for deficiencies including violations of patient rights and use of seclusion and restraint." He added that the largest areas of deficiency were with seclusion and restraint.

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REPRESENTATIVE CLAMAN asked where to draw the line, noting that many of the complaints were in the gray area, as the incident justified some use of restraint, and although it may have been for too long, it did not appear to go too far.

MR. WALL replied "I don't believe in gray areas in the regulations for that particular issue. It's a matter of patient care and human rights." He emphasized that having someone in restraints for 30 minutes longer than necessary was wrong. He shared an example of a patient who was verbally loud and assaultive, and the staff were attempting to de-escalate. The patient was asked to walk on his own to the seclusion and

restraint room. He posed whether this was clinically necessary as the patient was not violent or a danger to himself or others. He said that this was not within the standards of care if the patient was only yelling; hence, this was a violation of the individual's rights. "It's a clear line."

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REPRESENTATIVE CLAMAN said that, although it may appear to be a clear line, there may have been prior behavior that required a "five-minute time out, a fairly routine technique that's used not just in psychiatric hospitals, but parents use it all the time with children." He offered his belief that this was a grey area that could be argued on both sides and that it depended on the details of the circumstance. He asked if the incidences mentioned in the reports could be argued on either side.

MR. WALL acknowledged that there were times when a patient would voluntarily take a time out to calm down. He explained that a grey area was reviewed by a CMS professional looking at the situation for determination whether an incident broke a regulation, law, or procedure. He stated:

that's what we're looking at. I can look at things from the outside a certain way and come up with one conclusion, but, when the expert on the ground is telling you this is wrong, and here's why, and it's in the report, that's your final answer.

MR. WALL declared that in-patient psychiatric care was a legal issue. He reported that the ability for the state, or a doctor, to medicate an individual against their will or put them in restraint or seclusion against their will was a difficult line for attorneys, judges, and care providers to walk. He offered his belief that the experts on the ground had the authority to make the determination.

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REPRESENTATIVE CLAMAN asked whether a CMS review after an incident would determine inappropriate behavior even though the finding at the time had determined the staff action to be appropriate.

MR. WALL, in response, said that, although he could not speak to a specific incident, in his personal experience this had occurred. He pointed out that, although there were gradations

of an individual's perception to an action, in psychiatric care the authority rested on the surveyor's determination of legal compliance, clinical appropriateness, or the right thing to do for the patient.

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REPRESENTATIVE JACKSON asked about mental abuse toward the care giver by a patient. She opined that there must be a very high turnover of staff. She mused that it must be a very thin line between protecting the patient or protecting the care giver.

MR. WALL expressed his agreement that it was "a very difficult road to walk." He reported that, although there was a wide range of symptomology for individuals with a serious mental illness, caregivers had to change their perception to better understand this was a symptom of the illness. He shared his experience as a psychiatric nurse. He pointed out that many of the patients at API had been deemed non-competent and were not held accountable for their actions.

CO-CHAIR SPOHNHOLZ expressed her concern that API employees had called the Anchorage Police Department (APD) on patients, as, by definition, admittance into API determined a lack of competence and accountability by a patient. She asked if API employees were no longer contacting APD when, in other circumstances, these actions by patients would be considered assault or illegal.

MR. WALL replied that this was another difficult line to walk. He declared that, as all staff had a right to personal safety, sometimes the police were called. He explained that this becomes an issue when an individual taken into custody had to be charged with a crime, but they were sent back to API for care, as it was the only place to send them. He acknowledged that there had been assaults on staff, and he allowed that staff had the right to call the police and file charges even as the system was designed to return the person to API for care.

CO-CHAIR SPOHNHOLZ opined that it was counter intuitive to hold a person accountable after their civil liberties had been removed because it had been determined they were not competent to be free and accountable. She expressed that the problem was an underlying issue for not having enough staff and enough well-trained staff more than an issue of culpability for people with mental illness who had been put in the only acute psychiatric in-patient hospital in Alaska.

MR. WALL expressed his agreement. He stated that most of the API staff were there for the right reasons, to care for individuals with the symptomology, and they worked at API by choice as they enjoyed working with this population. He reiterated that staff at API had to maintain awareness for the potential for violence by the patients. He referenced slide 15, "Seclusion & Restraint at API," and directed attention to the just completed Ombudsman investigation, which read:

API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients from use of force by API staff; API does not take reasonable and necessary action to prevent and/or mitigate the risk of harm to patients due to violence by other patients; API does not consistently comply with AS 47.30.825(d) or 42 CFR 482.13(e) in the use of seclusion and restraint.

MR. WALL added that he was looking forward to working with the Ombudsman for the findings on the report.

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MR. WALL moved on to slide 16, "Safety at API." He pointed out the multiple citations issued by Alaska Occupational Safety and Health (AKOSH) to API: in December 2014, API failed to provide its employees with a safe work environment and API failed to maintain its OSHA log from 2011 to 2013, including not accurately reporting injuries or related incidents; in November 2017, there were 24 reportable incidents during 6 month timeframe and API failed to maintain its OSHA log and accurately report injuries from 2014-2017. He pointed out that these citations were very similar. He noted that the 2015 report found that API was seriously and "dangerously" understaffed, compensation was too low, and hiring takes too long. (Dvoskin report.) The September 2018 report by attorney Bill Evans found that the hospital was an unsafe work environment for staff (including a cultural divide on the use of seclusion and restraints). In September of 2018, the injury rates at API doubled and on January 29, 2019, surveyors found an unreported "immediate jeopardy" incident.

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CO-CHAIR SPOHNHOLZ stated that the issue for staffing at API had been recognized for a very long time, noting that this was

underscored by the Dvoskin report. She pointed out that the FY 20 proposal included a request for an additional 80+ staff for a total of 359 staff in order to be staffed at a safe level for both patients and staff; whereas, the proposal submitted by WellPath to the State of Alaska for management of API was for only 276 staff. She expressed her concern for this low number of staff as currently API only had a "few dozen fewer staff than that on site." She opined that without a major infusion of both training to improve expertise and staff capacity, it would not be possible for API to reach a safe and therapeutic environment and return to a place of healing and recovery.

MR. WALL replied that, as there were different methodologies and curriculum trainings by individual agencies to address certain problems, the staffing ratios changed accordingly. He offered an example for staffing based on different protocols. He explained that there was a therapeutic approach and well thought out plan by medical professionals for problem solving, and each clinic could be a little different. He reported that API had not had a comprehensive clinical approach in a very long time, as there had been so much changeover in the leadership positions. He stated that the issue was not just for numbers of staff, but was about a comprehensive, coherent, and appropriate clinical approach to a problem for which everyone was trained and in agreement.

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CO-CHAIR SPOHNHOLZ expressed her agreement with the need of consistency in leadership in order to develop and execute a plan. She noted that one problem in leadership was a failure to execute on good plans and good work. She offered her belief that the leadership at API under former Director Duane Mayes had done a lot of work to "put in place plans which were designed to improve safety." She emphasized that patient to staff ratio was an important factor, especially when dealing with very ill patients. She shared that 276 staff to 80 patients was a 4.5 [staff] to [patients] ratio in a 24/7 facility. She pointed out that, as some of these staff cleaned, cooked, and handled communications and security, not all these staff were working in direct care for patients. She reported that with 359 staff at API, as proposed by former Director Mayes, the ratio would drop to a 3.5 staff to patient ratio. She pointed out that some patients required one on one or two on one care in a very specific, "crisis melt down situation," adding that having more personnel was a good thing in a facility such as API. She emphasized that the current administration had initiated another

leadership change at API, while simultaneously arguing that leadership consistency was important. She opined that, instead, it may have made sense to stick with the Duane Mayes administration and make the investment of \$44 million included in the previous FY 20 Walker budget. She declared that this would have allowed consistency of delivery with the opportunity to execute a plan, resulting in much lower conflict, crisis, and controversy caused by the introduction of a non-Alaska partner to run API.

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MR. WALL presented slide 17, "Staffing at API," a November 2011 WICHE (Western Interstate Commission on Higher Education) report and read:

The pressures created by the combination of resource limitations, staffing shortages, recruitment challenges, admission and census increases, and limited access to decision support tools all combine to increase risk for the facility and the patients and staff of API. This set of challenges has reached crisis proportions and it is not realistic to approach these issues with modest adjustments to existing processes.

MR. WALL offered his opinion that these issues from 2011 had not changed to date and the problems had not been solved. He reported that he and the current commissioner came into office in December [2018] and discovered issues at API "at a point when, literally, the ball was rolling down the hill too fast and we had to stop it," they began to speak with potential partners about a wide variety of ways to work together to solve these issues, which included consultants to work on individual issues for a plan of care, consulting by an administrative services organization to write a plan of correction, partial privatization, and full privatization. He stated that these talks to get a plan of correction into place and remain certified with CMS were still ongoing up to January 29, 2019, when the survey team returned and found the immediate jeopardy. At that point, they decided that something had to be done immediately or "the doors at API are going to be closed." He shared his understanding for the public concern that the problem was not that dire, but "I can assure you it was. The doors at API could have closed, and frankly, still can." He pointed out that non-compliance for the plans of correction would result in the loss of certification, accreditation, and license.

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CO-CHAIR SPOHNHOLZ asked if, during the exploration of options for operating solutions, was there any exploration for staying the course.

MR. WALL replied, "yes" and he reiterated that they had been in the process of writing the plan of correction with the remaining API staff.

CO-CHAIR SPOHNHOLZ shared that many people were very interested, had paid close attention to API, and were very aware of the safety issues. She reported that since a presentation about the safety issues at API in April [2018] she had worked with partners to secure an additional 20 PCNs [primary care nurses] and other personnel on-site, and to offer hiring bonuses and raises to re-classify positions for appropriate recruitment and retention of staff, in order to be competitive with the market. She shared that there were concerns after the Evans Report detailed that the previous leadership had not been accountable and transparent enough with the problems at API and the need for resolution. She reported that Duane Mayes, a respected and credible manager, had been hired and had been working on a "very credible plan for turning around API, which includes staffing at the right levels, it includes letting go of some staff that have proven to be less than meaningful contributors to the advancement of the mission of API." She emphasized that she did not understand the reason for a change in leadership and a "pull back" on the budget, the investment, and the strategies already being implemented as they were based on proven models of leadership for getting to the correct safety level at API. She asked why there had been a change.

MR. WALL replied that it was Mr. Mayes' personal decision to move to his current position, adding that he was "good at both roles."

CO-CHAIR SPOHNHOLZ offered her belief that the desire "from the very beginning of this administration to privatize API" took precedent over any other strategy to invest in API. She pointed out that the budget proposal by the current administration was \$33 million, less than what was needed to operate the proposed contract and less than what was needed to ensure that API was safe. She expressed her concern that this would result in another debacle and asked how this proposal was any different.

MR. WALL deferred to an upcoming budget proposal to be presented to the House Health and Social Services Standing Committee. He allowed that the "emergent nature of what occurred [on] January 29th is what drove a decision for change."

CO-CHAIR SPOHNHOLZ interjected that the budget issues were "pretty damn important." She pointed to the proposed contract with Wellpath [Recovery Solutions] which stipulated that it was subject to appropriation. If the State of Alaska does not appropriate the full amount necessary to operate API meeting the contract, and the contract obligated the State of Alaska to \$44 million in FY 20, then Wellpath could step back from operation of API at any point in time. She offered her belief that this could possibly set up the state for another potential crisis, if there was not "a rational strategy to execute."

MR. WALL replied that this "can be answered from both sides of the house" during the upcoming budget proposal presentation and the Wellpath Recovery Solutions presentation.

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CO-CHAIR ZULKOSKY stated that, although there was a lot of passion behind the issue, it was important to continue with respect from both sides of the table.

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REPRESENTATIVE JACKSON asked to finish the presentation.

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MR. WALL returned to slide 18, "Recruitment." He said that there had been efforts to increase recruitment as there were several vacant positions. He reported that, as it had been since July 2017 that API had been at its full 80 bed capacity, this was used as the starting point for reviewing the net gain in recruitment. He reported that, since 2017, there had been a loss of 2 nurses, even as 12 nurses had been hired in 2017, 12 more nurses had been hired in 2018, and 2 nurses had been hired in 2019. He pointed out that this indicated a turnover rate. He stated that recruitment for social workers and mental health clinicians was much the same, reporting that the hires and job losses had resulted in a net gain of zero since 2017. He added that there had been a loss of 6 staff medical providers since 2017, which included psychiatrists, as well as advanced nurse

practitioners and physician assistants with psychiatric specialty.

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MR. WALL moved on to slide 19, "Vacancies," reporting that there was continue recruitment for state positions.

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CO-CHAIR SPOHNHOLZ asked how many positions at API had been filled since he began his position in December [2018].

MR. WALL replied that two nurses had been hired and that the lack of qualified applicants made recruitment lengthy and difficult.

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REPRESENTATIVE CLAMAN asked if any psychiatrists had been hired since the two psychiatrists at API were fired for failure to sign the governor's loyalty oath.

MR. WALL offered his understanding that no one had been hired.

REPRESENTATIVE CLAMAN asked if there was a lawsuit pending regarding that firing.

MR. WALL replied that, although he was aware a lawsuit had been filed, he did not know the current status. He shared that he understood the perspective of the two psychiatrists, and, although from one perspective it appeared to be a firing, both he and the commissioner had met with the two psychiatrists, had asked them to stay, and it had been the choice of the two psychiatrists to leave.

REPRESENTATIVE CLAMAN noted that it was the insistence by the administration on a loyalty oath, offering his belief that this was "completely inappropriate."

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CO-CHAIR ZULKOSKY reminded everyone that all comments and follow ups were to be requested through the chair.

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MR. WALL referenced the pending legal issues with financial ramifications "hanging over the State's head at this time." He directed attention to slide 20, "Forensic Psychiatric Services AS 12.47.010." He reported that when a forensic patient has been charged with a crime, and if they are suspected to be incompetent to stand trial, they are sent to API for 90-day restoration increments before re-evaluation. He reported that the evaluation process and restorative care did not happen in a timely fashion. He declared that, although API had an obligation to evaluate individuals in Department of Corrections facilities and get them into restorative care if this was the appropriate course of action, this was not happening. He moved to slide 21, "Forensic Unit (Taku)" and shared that daily there were about 80 individuals waiting for the evaluation process or waiting for a bed for restorative care to become available. He shared that the average length of stay for individuals inappropriately placed in the Department of Corrections waiting for an evaluation or restorative care could be up to 136 days, although these individuals had not been convicted of a crime. He declared that this created a liability for the state, noting that there could be a Department of Justice injunction and the state could be fined until the problem was rectified. He stated that, although this was a financial issue, it was also an ethical dilemma as it was "wrong for us to leave individuals in prison for that long of a period of time without treatment and without conviction of crime." He reported that this was one of the issues at API as there was only a 10-bed ward for 35 forensic patients and the department was moving rapidly to address this issue. He suggested that the State could find an evaluator to go into the prisons for the evaluation process, noting that there was the same wait for felony and misdemeanor charges. He pointed out that faster evaluations could reduce the number of people in prison. He added that help from partners could allow ad-hoc forensic teams to bring more beds on-line. He explained the staffing ratio for forensic units for restorative care.

[4:14:53 PM](#)

CO-CHAIR ZULKOSKY asked about the possible partners.

MR. WALL said that he went to the ASHNA [Alaska State Hospital and Nursing Home Association] meeting and "made that plea to everybody." He added that more evaluation and treatment beds had been designated statewide, and he offered examples from around the state.

4:16:05 PM

MR. WALL turned to slide 22 "Legal Involvement," and said that, although he could not speak directly to an active lawsuit, the jeopardy for liability was real and ongoing and seemed to mirror the progress in other states.

REPRESENTATIVE CLAMAN asked for the meaning of "DLC."

MR. WALL explained that this was the Disability Law Center.

4:16:56 PM

MR. WALL moved on to slide 23, "Civil Commitments AS 47.30.700." He shared that a problem in many states, including Alaska, was for a lack of psychiatric beds. In a civil situation in both hospitals and correctional institutions, if a person was found to need a bed for in-patient care, yet there were not any beds available and the patient was required to stay in their current setting without the necessary care, then the state could be found liable. He pointed out that the hospitals were bearing the brunt of the workload and the cost, which was difficult to bear.

MR. WALL shared that there were several case studies, including slide 25, "Washington," slide 26, "Pennsylvania," slide 27, "Utah," and slide 28, "Louisiana." He directed attention to the case study in Washington, an on-going case of liability. He reported that there had been a lawsuit with a subsequent trial in 2015 for constitutional rights, like the issue in Alaska. He noted that, in July 2016, there was a contempt order that stated, after 7 days, the state pay \$500 per day per person, and after 14 days the fine was to be increased to \$1,000 per day per person. He reported that currently in the Department of Corrections there were about 80 people included in this category, which carried a significant financial liability. As of June 2018, the fines in the State of Washington exceeded \$55 million, which did not include the on-going treatment. He reported that the settlement had also required a change by the state in five substantive areas, some of which required the building of new service facilities.

4:19:57 PM

MR. WALL directed attention to slide 29, "The decision to contract." He shared the goals for seeking a contractor: to ensure the safety of our staff and patients; to bring the

hospital into rapid compliance with regulatory authorities; and to prepare the facility to increase its bed capacity to 80 beds by 1 July. He relayed that following the immediate jeopardy finding in the survey, there was discussion with Wellpath for a plan of correction, which had taken more than 180 days to be accepted by both sides. He reported that the plan of correction on the findings in January had already been accepted, which he called "a good step in the right direction." He stated that it was unprecedented for the organization not to be de-certified because of the immediate jeopardy. He added that CMS was working with the state.

[4:21:04 PM](#)

CO-CHAIR SPOHNHOLZ asked about the process for the selection of Wellpath, noting that she had read the supporting documents regarding the three companies contacted. She asked if a non-profit organization or a local organization had been willing to partner in either a turn around contract or an operational contract at API.

MR. WALL replied that they had not found either, that part of the issue was the necessary speed for a company "to get experts on the ground to assist us in particular in the area of safety."

CO-CHAIR SPOHNHOLZ stated that she was "a little confused by that." She reported that she had had conversations with Providence Health Systems, which had expressed interest and had offered, to operate API. She noted that Providence Health Systems had asked for an invitation to submit a proposal, should an RFP (Request for Proposal) be offered and had reached out to help in any way. She pointed out that Providence Health Systems already had a demonstrated track record in the State of Alaska and was already doing acute, in-patient psychiatric care right across the street from API. She offered her belief that they were a natural partner and would be received more warmly by the community.

MR. WALL shared that he had also spoken with the CEO at Providence Health Systems, and acknowledged that they had expressed interest in the past. He noted that the detail for what they could take on and the speed with which they could move were also parts of the conversation. He expressed his willingness to speak with Providence Health Systems regarding a role.

CO-CHAIR SPOHNHOLZ said that she could not find any documentation of any conversation with Providence Health Systems in December. She asked if there was a conversation with them in December specifically, and whether an outreach phone call to Providence Health Systems had been made when the decision to bring in outside expertise and capacity to help operate API was made.

MR. WALL replied that he was unsure of the specific date for his contact with Providence Health Systems.

CO-CHAIR SPOHNHOLZ asked that Mr. Wall report back with the date. She said, "it strikes me as unusual to see a series of outreach to organizations, none of which are operating in the State of Alaska or have, some of which don't really have a track record of doing this specific kind of work." She pointed out that, as Providence Health Systems was already offering in-patient psychiatric care "right across the street, they seem like a much more natural partner and one which, I think, the community would be much more receptive to."

MR. WALL said that he would provide the date, adding that he had a phone conversation with [Providence Health Systems], although he was not sure of the date.

CO-CHAIR SPOHNHOLZ asked if there was a concern for the ability of Providence Health Systems to fully staff API "in a quick enough manner." She asked why exploration for this partnership had not been pursued.

MR. WALL offered his belief that the conversation with Providence revolved around the issues of civil and forensics commitment.

CO-CHAIR SPOHNHOLZ asked whether there was any way to have a hybrid model and include a working partnership with Providence Health Systems.

MR. WALL opined that, although there was the possibility of a partnership at some level, the response for the emergency on January 29 had driven the decision for a partner "on the ground and emergent control as quickly as possible." He reported that Wellpath offered a team of specialists that would quickly cover the entire spectrum of the requirements from the plan of correction and would address this with CMS. He pointed out that, although many of the API leadership positions were currently vacant, the Wellpath team of specialists mirrored

these leadership positions. He added that there had especially been a focus made toward the fulfillment for the rapid response team.

CO-CHAIR SPOHNHOLZ countered that part of the reasons for the vacancies in the leadership positions at API were because of decisions made by the current administration. She pointed out that Providence Health Systems was part of a large, seven-system network, with mental and behavioral health professionals working across the region. She suggested that there could have been exploration for a variety of operational models which she would have "received much more warmly."

MR. WALL, in response, said that he spoke to the executive director of the Providence mental health foundation and that there would be another conversation for a discussion for partnership.

[4:27:20 PM](#)

MR. WALL presented slide 30, "Immediate Jeopardy Finding." He reported that the jeopardy situation on January 29 had been a patient on patient assault and that the perpetrator had been placed on their own vacant ward. He paraphrased from the slide, which read:

Implemented new safety protocol including 24/7 video surveillance with communication to the wards; Implemented an hourly reporting system for each ward to monitor every patient on an hourly basis including behavioral risk mitigation; and requested a nationally recognized specialist in psychiatric treatment and safety, and NASHMPD to come to API immediately for safety oversight.

[4:28:38 PM](#)

CO-CHAIR ZULKOSKY asked whether, when a finding was found and immediate steps were taken for resolution, this finding would be absolved and not impact accreditation.

MR. WALL replied that "in some cases it can, and in some cases it doesn't." He clarified that the discussion was not about accreditation, compliance with a set of standards; but it was for certification. He explained that there had been a legal discussion with CMS to determine whether API was "in compliance with your conditions of participation legally to have the

contract with the federal government to receive federal funds." He stated that this was a different relationship. He offered his belief that this was the first immediate jeopardy at API and that, sometimes, when a serious deficiency was found and immediately responded to, it would fix the problem. He noted that, in this case, the question was now for resolution to prevent recurrence. He stated that the lingering effects were for procedure and how situations would be handled in the future as opposed to the immediate placement of a patient in another ward.

[4:30:16 PM](#)

CO-CHAIR SPOHNHOLZ referenced the immediate actions after the incident to ensure safety and opined that the documentation of the incident had not "made it all the way through to formal reporting." She asked if this issue with documentation had been identified by CMS as problematic.

MR. WALL, in response, said that the most egregious problem was that the perpetrator was not removed from the victim, nor was the victim assisted with any follow-up. He declared that it was not a matter of paperwork transfer. He explained that "the lack of paperwork transfer produced a lack of care in intervention."

CO-CHAIR SPOHNHOLZ noted that, in her review of the supporting documents for the procurement, she had found a curiosity in the timeline of the immediate jeopardy episode. She referenced an e-mail dated January 22 in which Mr. Wall described an upcoming CMS survey team site visit for the following week on either January 28 or January 30. She noted that the seventh bullet of this e-mail described this upcoming event in the past tense, and she asked if there had been another immediate jeopardy event to which she was not aware.

MR. WALL replied that he was not aware of another immediate jeopardy event.

CO-CHAIR SPOHNHOLZ shared that she was somewhat confused that, in the e-mail of January 22, an event was described in the past tense which did not happen until the following week.

MR. WALL replied that he would need to review the timeline.

CO-CHAIR SPOHNHOLZ said "it seemed unusual to me."

[4:32:15 PM](#)

MR. WALL directed attention to slide 32 "Documents," which listed a link to any requested documents.

[4:32:50 PM](#)

REPRESENTATIVE CLAMAN asked why the January emergency, which resulted in the immediate introduction of outside management with a short-term contract through the end of June, also resulted in a non-competitive bid process for the best services starting July 31 with this same outside management group. He declared that he was "troubled by that."

MR. WALL replied that the decision had been made for privatization with an emergency provider to solve the problem in two phases. Phase 1 had the aforementioned three deliverables attached. He explained that the decision to hire a contractor was done under AS 47.32, and he pointed to a summary statement issued by the Attorney General's office explaining the stance from this statute. He referenced the statute which stated that in cases of immediate harm or immediate jeopardy to a patient in the facility, the commissioner could step in "in a temporary or permanent fashion." He continued to explain that "after years of instability and inability to meet mission" an organization was brought in to stabilize, bring the organization back to full compliance, and provide care in its full capacity in a short period of time. He questioned why, after this had been accomplished, would the Department of Health and Social Services (DHSS) risk de-stabilizing that. He explained that the contract had been designed in two phases to ensure meeting the mission in the first phase and to "roll into the stabilization in the long term in the second phase." He declared that the desire of DHSS was to provide continuity and stability for the system and the hospital over time.

[4:36:05 PM](#)

REPRESENTATIVE CLAMAN pointed out that the decision for stabilization with only one option to provide the best management to go forward was made between January 29 and February 8, the date of the signing of the contract [with Wellpath Recovery Solutions]. He emphasized that this was "a very, very short period of time." He offered his belief that during this time there had not been any discussion with groups other than Wellpath Recovery Solutions.

MR. WALL, in response, said that this decision was made after determination for the speed at which other providers could arrive. He declared that "the conversation was not small or quick in the commissioner's office" and he listed the other participants in the decision making for how to proceed, what was the best course of action, and what best protected and provided care for the patients and staff. He stated, "that was the decision that was made."

REPRESENTATIVE CLAMAN asked for the date on which the formal decision was made to move forward with a single source contract and not to go through a procurement process for the services beginning on July 1.

MR. WALL said that he would get that date. He explained that the situation appeared very similar to another immediate jeopardy issue in Alaska, in which the commissioner [Department of Health and Social Services] had intervened in this exact way, hence the decision was made at that point. He reported that there were "a lot of long hours and much discussion" before the decision was made.

[4:38:59 PM](#)

CO-CHAIR SPOHNHOLZ opined that the primary criteria for the selection of Wellpath Recovery Solutions was "their ability to come in and take over operations of API immediately." She asked if there were other criteria reviewed, as well.

MR. WALL paraphrased the criteria listed on slide 31, which read:

Was available immediately;

Had specific inpatient psychiatric experience including both civil and criminal commitments;

Has a team of nationally recognized experts that has the experience and track record to bring noncompliant hospitals back into compliance rapidly.

MR. WALL declared that this was a very difficult set of expertise to find.

CO-CHAIR SPOHNHOLZ reported that about 23 other national corporations performed this type of work. She declared:

it seems highly unlikely that this is the only choice we could have pursued, and that it's highly atypical to take a specific emergency event to issue a contract which essentially obligates the state to over \$88 million in contract without any transparency or competition in the process, particularly when we're talking about operating an institution that cares for... our most vulnerable people in the State of Alaska.

CHAIR SPOHNHOLZ expressed concern that there was not a review of other providers when considering this extremely important responsibility with API.

MR. WALL acknowledged the concern and reiterated that, as there had been previous discussion with three organizations, when it became necessary to move rapidly when the immediate jeopardy was discovered, they were aware that Wellpath Recovery Solutions could be there quickly.

CO-CHAIR SPOHNHOLZ offered her belief that it was extremely atypical to issue a sole source contract for a project that was so important. She pointed out that in the public sector there were rules for transparency in the competitive bid process. These required review of a broad range of performance metrics and financials before undertaking a contract of this size. She pointed out that the only performance metric was for API to operate at full capacity and remain accredited. She opined that there was no incentive in the contract to ensure a safe, trauma informed, and therapeutic environment. She asked that Mr. Wall address the concern that there were not any other performance metrics in the contract.

MR. WALL reported that the three metrics in the contract were: to ensure the safety and security of staff and patients; to bring the organization back into rapid compliance; and to prepare for the opening of all 80 beds by July 1. He stated that those metrics were in the contract, adding that safety meant a reduction of assaults, seclusion, restraint, and harm and that those needed to be evident. He explained that bringing the organization back into compliance with the regulatory bodies meant that it was necessary to have the plans of correction in place and have them as an accepted practice to all the regulatory bodies. He added that it was also necessary to bring the organization back to full capacity.

CO-CHAIR SPOHNHOLZ stated that these agreements should be in the contract and possibly in a service level agreement. She asked if there was a service level agreement with the contract.

MR. WALL said that the second phase of the contract was being worked as they moved forward, and that the contract would "definitely have one."

CO-CHAIR SPOHNHOLZ commented that, typically, in the public sector with such an important responsibility in caring for the most vulnerable and the use of state resources, it was required to have transparency in this entire process. She stated that the details of a contract should be determined earlier in the process, with a competitive bid process. She expressed her concern whether this was the best possible product resulting in the best possible care for the patients at API. She emphasized that "the striking lack of transparency in this process concerns me."

[4:45:38 PM](#)

REPRESENTATIVE JACKSON asked whether Phase 2 would offer the option for other partnerships.

MR. WALL replied that Department of Health and Social Services and Wellpath were "definitely moving towards partnership with other organizations." He added that this could not be done without partnerships and "we will continue to seek them."

REPRESENTATIVE JACKSON asked to verify that Wellpath would work with other institutions and organizations to ensure that the patients at API would get everything they needed.

MR. WALL replied that there were many partners throughout Alaska to ensure in-patient psychiatric care, although API was the most visible and the most volatile piece of this care system. He stated that the partnership "that cares for patients appropriately across the state needs to be built in a ... broader capacity."

[4:47:24 PM](#)

CO-CHAIR ZULKOSKY directed attention to the procurement document which indicated a June or July time frame for the Department of Health and Social Services to assess whether to continue to work with Wellpath. She shared that her discussions with Wellpath executives indicated that, for a proper transition, the decision

would need to happen by mid-April. She offered her belief that it was not possible to accomplish all the agenda milestones outlined for Wellpath by this time. She asked how the department was handling this.

MR. WALL replied that the evaluation for whether Wellspring had met the terms of their contract needed to be made by April 15. If Wellspring was going to be successful in Phase 2 of the contract, it would be necessary to have the staffing in place to meet the terms of the contract. He stated that Wellspring would need to begin hiring and licensing staff prior to June 30 in order to move into the second phase. He explained that some of the dates were for hiring and some were for the evaluation process.

CO-CHAIR ZULKOSKY asked about the date for Department of Health and Social Services to make a determination whether to continue the contract with Wellpath.

MR. WALL replied, "April 15."

CO-CHAIR ZULKOSKY expressed her concern for such a large amount of work in such a short period of time, and that "it seems incongruent for the department to be able to make a decision by then." She asked for an explanation to the logic for this rationale.

MR. WALL echoed her concern for the workload, noting that there was a tremendous amount of work to be done prior to April 15. He declared "the reality is we need to have a point at which we can evaluate the progress towards meeting the goals" and contractual obligations prior to a date for Wellpath to build the necessary staff. He noted that the decision point had to allow Wellpath enough time to hire, license, and place staff and ensure meeting the goals.

CO-CHAIR ZULKOSKY opined that the decision to move forward with Wellpath had been made regardless of the outcome of the goals outlined in the procurement documents.

MR. WALL added that the contract also included a 30-day out-clause which he described as an evaluation point between the State of Alaska and the contractor. He said that there was an on-going consistent evaluation of progress performed on a daily and weekly basis. He reported that there were a complex number of plans of correction and points on each of those plans of correction that needed to be fixed and addressed in a

substantive way between now and the time stated for compliance. He explained that, as each individual requirement had to be tracked, "there's a heavy lift of work to be done." He said that for the goals to be attained, it was necessary to have a period of time for commitment to allow for staffing to provide the care necessary to move forward.

[4:52:31 PM](#)

REPRESENTATIVE TARR expressed her discomfort as the decision point was too early in the process to be able to evaluate success, which prevented Department of Health and Social Services from looking at other opportunities. She said this did not allow enough time "to see if this is the right thing to do." She pointed out that there was proposed legislation to prohibit the privatization of API, as well as the budget issue, and that neither of these would be accomplished prior to April 15. She opined that this would put more pressure on an already stressed situation, which could be unproductive and uncomfortable.

MR. WALL said that he also felt an immense amount of pressure for the complexities of moving forward in this situation. He shared that, as the perspective was for a mutual commitment between the state and the contractor, the contract was designed in a way for the state to commit to the contractor on a substantive level so the contractor could commit the resources to build success into the system. He stated that a half-hearted approach was "doomed for failure." He pointed out that the liability for the state with this issue required a significant investment of time and money moving forward. He added that the state continued to build relationships with partners and continued to look for solutions, noting that the contract offered a 30-day window for evaluation. He said that April 15 was a turning point which allowed the ability to commit investment of resources, while also allowing the 30-day window.

[4:56:12 PM](#)

REPRESENTATIVE PRUITT reminded that there was a specific reason for the July 1 date in Phase 2.

MR. WALL explained that the state was under provisional license regarding the issues at API until June 30. He pointed out that after that date the problems did not go away as there was still an iterative process for correction to many years' worth of issues.

REPRESENTATIVE PRUITT highlighted that there had been recognition of a problem with API during the past year. He reported that this had not been a snap decision, but that the January 29 issue had forced immediate action. He stated that there had been a disservice to the people being served. He declared that we were not serving the people who API was supposed to be serving. He said that it was a moral responsibility to take action immediately.

MR. WALL expressed his agreement that there had been warning about this crisis, which could not be addressed by a small and normal change. He acknowledged that there was a moral and financial crisis and that it was his obligation to meet both. He relayed that "sometimes you call the shot and you do your best as a group, as a team, to answer a specific need."

[5:00:43 PM](#)

CO-CHAIR SPOHNHOLZ expressed her agreement that something seriously needed to be done at API, and she asked to return to the process for how to address the issues. She pointed out that there had to be a written feasibility study when bringing any changes to the collective bargaining agreement with the employees. She reported that there had been an earlier study for privatization which had found that there were not any savings or better outcomes, so there was a decision to "stay the course." She asked about the status of the required feasibility study.

MR. WALL said that there was intent to have the previous feasibility study updated. He pointed out that it had first been done in 2016 and published in 2017, and that "much has changed since then." He noted that the beds were closed at API after that study. He said that they intended to have this completed study within the 30-day contractual obligation with the partner unions.

CO-CHAIR SPOHNHOLZ asked if this was a realistic time frame and would it affect the deadline for a decision point with Wellpath.

MR. WALL expressed his agreement that it was an "incredibly tight turn around." He reported that the organization which had previously done the feasibility study felt they could "turn it around quickly."

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REPRESENTATIVE TARR expressed agreement that this was an ongoing problem. She stated her hope that a lesson had been learned with the forced resignation under partisan political pressure of two of the top employees at API, which had exacerbated the problem at a critical time. She emphasized that, as it was hard to attract and retain these highly skilled positions, politics should not be played with those important positions.

**PRESENTATION: WELLPATH RECOVERY SOLUTIONS**

[5:05:47 PM](#)

CO-CHAIR ZULKOSKY announced that the next order of business would be a PowerPoint presentation by Wellpath Recovery Solutions.

[5:06:23 PM](#)

JEREMY BARR, President, Wellpath Recovery Solutions, said that he would provide information about Wellpath and provide an update on the progress thus far at API.

DR. KEVIN ANN HUCKSHORN, Senior Consultant, Wellpath Recovery Solutions, paraphrased from slide 1 "What We Believe," which read:

Persons suffering from mental illness can and do recover  
Caregivers first priority is to support recovery of the patients they serve  
Patient care should be individualized, trauma-informed, and evidence-based  
Staff are entitled to the training, support and guidance they need to be effective  
Staff and patient safety are interrelated

MR. BARR moved on to slide 2, "Who We Are," and stated that Wellpath was a health care company providing health care in a variety of public settings. He reported that they were organized into three operating divisions: providing health care to local government entities; providing health care to state and federal entities; and this entity at API, specializing in providing inpatient psychiatric and residential treatment. He added that this division operated at 13 sites in 8 states, served about 2,700 persons, and had about 3,000 employees.

MR. BARR shared slide 3 "Division Overview" and stated that Wellpath had experience with a wide range of patient populations who had been involuntarily committed to a term of treatment either through a civil or a forensic court process. He pointed out that each of the programs promoted trauma-informed, evidence-based, and individualized patient care which was person centered and focused on individual strengths to help empower individuals to recover. He moved on to slide 4, "Current Operations," which depicted the 12 operations currently operated by Wellpath.

MR. BARR shared slide 5, "South Florida State Hospital," and reported that Wellpath had a more than 20-year partnership with the Department of Children and Families in Florida for this 41-bed hospital.

[5:11:09 PM](#)

DR. HUCKSHORN added that there had been a virtual elimination of restraint and seclusion at that facility. She reported that restraint and seclusion had been a national issue in 1998, and the U.S. Congress had called hearings for discussion. She spoke to the success of the public-private partnership of South Florida Hospital, noting that the conflict and violence had been greatly reduced and the patient participation in treatment programs had increased. She stated that there was more effective work toward patient discharge. She reported that there was 98 percent patient satisfaction as measured by confidential surveys and grievances.

[5:14:42 PM](#)

REPRESENTATIVE TARR directed attention to the Florida Civil Commitment Center referred to on slide 4 and asked why the website listing was for Correct Care Recovery Solutions. She asked about the relationship between the two companies.

[5:15:15 PM](#)

MR. BARR, in response to Representative Tarr, explained that it was the same legal entity although there had been a name change from Correct Care Recovery Solutions, now renamed Wellpath Recovery Solutions.

[5:15:36 PM](#)

MR. BARR shared slide 6, "Bridgewater State Hospital," and spoke about the history of the hospital prior to its management by Wellpath in 2017.

[5:16:55 PM](#)

DR. HUCKSHORN detailed her involvement with the Bridgewater State Hospital program beginning in 2017.

[5:18:23 PM](#)

DR. HUCKSHORN turned to slide 7, "Treatment Philosophy," and stated that the "treatment philosophy basically lays out our values" and that these values became the template to measure. She paraphrased from the slide, which read:

- Recovery model • Trauma-informed care •
- Interdisciplinary, holistic approach • Effective, evidence-based programs • Culturally relevant •
- Integrated treatment of co-occurring disorders •
- Collaborative safety planning

DR. HUCKSHORN continued with slide 7, stating that the patient had to be included in the development and the implementation of the plan of care. She added that when untreated, psychosis patients lose brain function which would not be regained. She said that it was necessary to respect cultural differences and viewpoints. Medicine has moved from "let's hope this works" to evidence and results-based practices. She reported on the loss of fundamental civil rights of American citizens who enter a psychiatric hospital, which makes them completely dependent on staff to meet their needs. She declared that an environment of care, with respect and dignity, was critical to a successful treatment process. She concluded by stating that safety was the responsibility of everyone, from the CEO through the janitor, and included the people served. She stated that it was necessary to create a safe community of people working together to keep everyone safe.

[5:26:27 PM](#)

DR. HUCKSHORN shared slide 8, "Minimizing Abuse, Neglect, and Exploitation." She paraphrased from the slide, which read:

- Zero tolerance for abuse, neglect, and exploitation including sexual misconduct • Allegations promptly reported and referred for investigation • Staff

receive training when they are hired and annually thereafter • Patient Advocate and Peer Specialists ensure patients have opportunities to safely report incidents

[5:28:39 PM](#)

DR. HUCKSHORN moved on to slide 9, "Culture of Safety," and stated that this was the number one priority for Wellpath. She highlighted that it meant immediate failure if "the people we serve do not feel safe in the environment where they're getting treatment, and we also fail if our staff do not feel safe." She paraphrased from the slide, which read:

Communication • Collaboration • Safety Surveys •  
Trainings • Quest Rounds • MANDT System

[5:31:58 PM](#)

MR. BARR added that with inherently unpredictable behaviors associated with these populations, there will be critical incidents so that reporting and documenting becomes paramount. He shared that Wellpath had invested in a program that documented incidents and allowed for the data to be compared and assessed for appropriate triage.

[5:33:12 PM](#)

DR. HUCKSHORN moved on to slide 10, "Restraint and Seclusion," which she deemed to be "quite close to my heart." She shared her background and referenced an incident in which a child had died in restraint in Hartford, Connecticut. That death led to hearings in the U.S. Congress, resulting in a change in the rules and regulations for the use, monitoring, and documentation of seclusion and restraint. She and her colleagues had developed evidence-based practice known as "the six-course strategies to prevent conflict and violence in behavioral health in-patient settings." She pointed out that many of the strategies were a result of learnings from her work at Wellpath and that the program had since been implemented in all the Wellpath facilities. She directed attention to the graph on the slide which depicted "Hours of Restraint Per 1,000 Patient Hours" in five different facilities, noting that the two Wellpath facilities scored much better than the national aggregate. She reported that Wellpath strongly believed that seclusion and restraint was dangerous, it could hurt and kill

people, and it was traumatizing; hence, this action was avoided at all costs.

[5:36:20 PM](#)

DR. HUCKSHORN, in response to Representative Spohnholz, clarified that this was the Nashgood [indisc] Research Institute Weighted Average for 200 of the Joint Commission State Hospitals.

[5:36:36 PM](#)

REPRESENTATIVE TARR asked how Wellpath had been able to achieve such a contrast to other facilities. She asked if this was a result of more professionalized treatment for the individuals with a serious mental illness.

[5:37:46 PM](#)

DR. HUCKSHORN answered "it's complicated, because violence is complicated, and has multiple variables." She offered her belief that the only way for success was with a significant culture change that begins at the very top of the organization with specific policy statements from senior leadership. She reported that there had been a decision to only use restraint and seclusion "in the face of imminent danger and as a last resort." She added that no one would be left in seclusion and restraint, and after the incident, there would be "rigorous debriefing." She stated that it was necessary to create environments of care and avoid conflicts in order to not have to use seclusion and restraint. She spoke about the necessity for the shifting of "unwritten rules" because so many fundamental human rights were stripped from individuals when they entered the hospital. She relayed that it was important to always remember that "we are much more similar to the people we serve than we are not." She reported that Wellpath did "really good risk assessments" for trauma history, treatment intervention, remission history, anger management, sensory modulation, and violence risk. She spoke about immediate safety planning with new patients. She noted that there was also rigorous debriefing to avoid future issues.

[5:43:44 PM](#)

MR. BARR, in response to Representative Claman, explained the lines on the graph on slide 10, noting that the grey and the green lines disappeared on the graph as they were zero.

[5:44:46 PM](#)

MR. BARR introduced slide 11, "What Does Success Look Like?" He paraphrased the slide, which read:

- Compliance with all regulatory agencies • Services for up to 80-beds • Increase staffing complement • Improvements in the therapeutic milieu • Reduction in grievances • Improved linkages within continuum of care • Reduction of seclusion and restraint • Reduction in assaults • Community-based Governing Board • Improved communications and collaboration with stakeholders

MR. BARR said that they had met with stakeholders to better understand and strategize for how to integrate and operate in Alaska.

[5:48:53 PM](#)

REPRESENTATIVE CLAMAN noted that Wellpath was recommending a community based governing board, and asked if there would be proposed legislation from the administration for consideration of this.

[5:49:13 PM](#)

MR. WALL clarified that there were existing by-laws for the hospital and that the governance board, and its make-up was part of those by-laws. He reported that this make-up was being amended to match the Wellpath message and he offered to share the board members.

REPRESENTATIVE CLAMAN suggested that there had been a loss of confidence in the process, and the absence of a community governing board being actively involved in API. He asked if the administration would consider putting this into statute to specify its continuing existence and who served on the board, so this would not be lost in regulation.

MR. WALL expressed, "we could certainly look at doing something like that. I'm not sure what all that would require."

[5:50:44 PM](#)

CO-CHAIR SPOHNHOLZ acknowledged that they had checked "a lot of boxes for me in terms of talking about the way it is that you treat the people that you care for, the way that you develop your staff, you build your team," although there were still some pieces missing, which included an external governing board and clear standards for performance. She asked if Wellpath would be willing to amend the contract to include performance metrics and accountability.

[5:52:21 PM](#)

MR. BARR replied, "yes, absolutely." He relayed that the idea for associated performance measures and oversight in the form of audits were welcome.

[5:53:01 PM](#)

CO-CHAIR SPOHNHOLZ shared that there was an additional concern for how the State of Alaska can be confident about the Wellness health and safety record. She reported that a quick Google search on the web revealed some concerning reports and lawsuits with findings. She listed some of these findings to include trafficking of medications and overmedication of patients. She pointed out that these preceded Wellpath in its reputation and brought concern when "handing over care of our most vulnerable people." She asked for a response on the record.

[5:54:14 PM](#)

MR. BARR addressed the trafficking of medications and pointed out that this had been by a contracted pharmacy relationship with a consulting agreement, and the contract had been immediately terminated. Subsequently, the pharmacy role was brought in-house. Regarding quality of care, he stated that these were challenging health care environments with occasional adverse outcomes. In 95 percent of the time, these outcomes resulted from a single individual acting outside of policy and procedure. He reported that there had been an immediate action, with the individual placed on administrative leave without pay while there was an investigation by their Office of Professional Responsibility for determination. Pending the results of the investigation, there was a range of progressive disciplinary options, up to and including termination. He continued and explained that there was a longer-term action to address these situations in order to minimize the likelihood for a recurrence. He reported that there had been discrepancies between the documentation and the video footage, so they invested in

technology that allowed tracking for accountability. He described the technology.

[5:58:35 PM](#)

CO-CHAIR SPOHNHOLZ applauded their use of a systemic strategy to address safety, although it appeared that there could still be challenges remaining. She asked them to address the six wrongful death lawsuits at the RISE Program in Colorado as of October 2018, noting that this still raised serious concerns for her.

[5:59:11 PM](#)

MR. BARR offered a point of clarification, pointing out that this program was in the Arapahoe County Sheriff's office. In 2013, Wellpath Recovery Solutions entered into an agreement with the Office of Behavioral Health to provide services similar to those provided at the state hospital. He pointed out, as there was litigation surrounding people in jails, the treatment could then be brought to the individuals rather than wait for a bed at the hospital. Independent of that, the health care services were being provided by a local health care component and the incidences were related to that program and not to the Rise Program.

REPRESENTATIVE SPOHNHOLZ asked if another provider was responsible for those deaths.

MR. BARR said that the wrongful death lawsuits were not associated by the care delivered by Wellpath Recovery Solutions in association with the Rise Program in Colorado.

[6:00:42 PM](#)

MR. BARR moved on to slide 12, "Phase 1 and Phase 2 Goals." He paraphrased from Phase 1, which read:

- Assess current operations
- Regain compliance with all regulatory authorities
- Provide training to improve patient care and staff safety
- Train on trauma-informed care and de-escalation techniques
- Recruit key leadership team
- Improve communication among leadership and staff
- Improve communication with community stakeholders

MR. BARR directed attention to Phase 2, the more active transition, and paraphrased slide 12, which read:

Maintain compliance with regulatory authorities • Hire staff to fill vacancies • Prepare to increase capacity to 80 beds • Implement a culture of safety • Increase active, evidenced-based treatment programming • Reduce seclusion and restraint • Engage families • Improve, build, and maintain strong community relationships • Improve integration of API within the continuum of care

[6:01:42 PM](#)

CO-CHAIR ZULKOSKY directed attention to the dates for Phase 1, identified as February 8 - June 30, 2019, in the contract with Wellpath and the State of Alaska, which stated: "during the start-up phase the contractor shall take all actions reasonably necessary for API to be in full operation and capable of serving patients by June 30, 2019." She said that Phase 2 was identified to begin July 1, 2019 - June 30, 2024, and she asked for Mr. Barr to share his understanding of the contract beyond April 15. She questioned how April 15 could be a point in time for a decision on this contract moving forward for an effective date that was written into the contract beginning July 1, 2019.

[6:02:35 PM](#)

MR. BARR apologized for any confusion from the dates on the slide, as they were not meant to represent any contractual terms. He explained that the dates reflected the mechanics associated with the hiring process that dictated an amount of time for onboarding staff. He noted that there was an eight to ten-week process for each person hired to be ready to go on July 1.

[6:04:36 PM](#)

CO-CHAIR ZULKOSKY asked if it was Mr. Barr's understanding that the contract for Phase 2 would likely move forward if they began active transition on April 15.

[6:04:45 PM](#)

MR. BARR replied that it was his understanding so long as Wellpath continued to provide the services and meet the expectations of Department of Health and Social Services in

terms of preparation. He said if Wellpath failed to fulfill its obligations, there was a 30-day termination clause.

[6:05:10 PM](#)

CO-CHAIR SPOHNHOLZ asked when Wellpath had been invited to submit its contract.

MR. BARR replied that he was not aware of the exact date, but he would get it to her.

CO-CHAIR SPOHNHOLZ directed attention to the provision in the contract which stated that it was subject to appropriation. She reported that Department of Health and Social Services had only requested \$33 million, as the state was "facing a very challenging budget structure" and it was necessary to make very tough decisions for which basic services could be provided. She offered her understanding that the proposed Wellpath contract obligated the State of Alaska to \$44 million if API operated at full capacity. She asked what the decision point from Wellpath was for pulling out of a contract if there was not the necessary appropriation to fully meet the contract obligation.

[6:06:35 PM](#)

MR. BARR explained that, as Wellpath contracted exclusively with government entities, these appropriation clauses were in most, if not all, of their contracts. In the event there was not an appropriation, Wellpath would review the situation and see what other options existed. He stated that he could not offer a firm answer without knowing more specifics. He declared that Wellpath was committed to doing the right thing, that they had had success in other circumstances, and they believed that the plan presented what was necessary for success.

[6:07:18 PM](#)

MR. BARR announced slide 13, "Recruitment," noting that Wellpath had about as many employees as the State of Alaska; however, the key difference was that Wellpath only focused on recruiting and employing health care professionals. He cited the shortage of psychiatrists in Alaska and nationally and explained that psychiatrists were now a part of their recruitment team. He stated that the vast majority of the "line staff" would be hired from the local Alaska work force as it was not practical to recruit outside a given state. He pointed out that Wellpath had

often partnered with universities to fund placements. He declared that the first priority was retention.

[6:11:03 PM](#)

The committee took an at-ease from 6:11 p.m. to 6:12 p.m.

[6:12:33 PM](#)

DR. HUCKSHORN turned attention to slide 14, "Accomplishments," and paraphrased from the slide, which read:

Deployed team to API within 72 hours of contract execution • Assisted with responses to the Plans of Correction to the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), and other bodies • Conducted MANDT presentation to introduce new de-escalation training for direct care staff • Met with API Governing Board members and other stakeholders, including ASHNA, ABHA, AMHB/ABADA, NAMI Anchorage, et al • Partnering with South Central Foundation to provide cultural training for staff • Began staff training in trauma-informed care, patient rights, and restraint and seclusion • Held multiple all-staff town hall meetings to ensure communication and transparency to API staff • Implemented weekly meetings with API leadership • Implemented safety huddles • Began recruiting for consultant positions to support key management positions

[6:17:28 PM](#)

DR. HUCKSHORN moved on to slide 15, "Staff Feedback," and reported that the staff at API were a "committed, professional group of staff that really seem to care about what happens to that facility." She praised the staff's dedication and loyalty to API.

[6:18:23 PM](#)

CO-CHAIR SPOHNHOLZ thanked Dr. Huckshorn for recognizing the API staff. She stated that the staff needed leadership, training, and support. She cited her concerns with the privatization of API regarding staff compensation and benefits, and asked for a statement on the record as to how they intended to handle that.

[6:20:11 PM](#)

MR. BARR replied that no one would go backward in pay. He said that there were a number of areas where staff were currently underpaid, which he opined was part of the problem. He said that Wellpath would look at a compensation analysis and address the unfairness of new hires being paid more than veterans. He stated that there would be an equitable treatment of staff. Regarding benefits, Wellpath offered a retirement plan with a 401(k) and a company match, as well as health, life, and dental plans. He pointed out that there was no waiting period for benefits. He declared that staff tenure would be recognized.

[6:21:45 PM](#)

CO-CHAIR SPOHNHOLZ asked about the cost for the State of Alaska to buy out peoples' retirement in order to make this transition successful.

[6:22:21 PM](#)

CO-CHAIR ZULKOSKY recognized the people who had been invited to testify and asked that they provide written testimony.

[6:23:33 PM](#)

#### **ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 6:23 p.m.